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Divergent Discourses: Development Knowledge and Malian Family Planning

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CH. 1 INTRODUCTION

The Family Planning Industry in Mali

Mali is a geographically diverse, large puzzle-shaped country in the middle of West Africa. The arid Sahara is slowly encroaching southward into the Niger River delta and fertile agricultural zones. Mali's population is likewise varied with over 40 ethnic groups and local languages, each with established customs of understanding life and intragroup relationships. These groups have also developed complex intergroup relational systems, often based on kinship, profession, and historic political alliances. Islam has been co-opted into the religious identity of over 90% of the population. However, there are numerous variations to the practice which often integrate traditional beliefs and rituals that are specific to distinct localities (Bratton, Coulibaly, & Machado 2002). A common attribute is continued reverence for a sacred well or tree. These symbols are usually incorporated into stories of the village's original settlement.

The Malian government has been challenged in recent decades to accommodate various group needs through social welfare endeavors. Among them is a rounded family planning program. Mali is home to one of the longest standing centralized family planning initiatives in francophone Africa, certainly in West Africa[1]. In 1972, with the declared aims of reducing maternal and infant/child mortality, family planning was officially integrated into the Ministère de la Santé du Mali (Ministry of Health). This was only possible with the dissolution of laws 3 and 4 of the French Law of 1920. Prior to such time the sale, manufacture, and promotion of contraceptives was prohibited. The 2 year pilot project that commenced in Bamako was expanded in 1974 to include greater

[1] There is some debate as to the degree of official government affiliation with the Association Malienne pour la Promotion and Protection de la Famille. Reunion may have been the first francophone nation to implement family planning in 1966. Mali would be the second.

distribution of services and urban outreach. Until 1990, family planning was limited to urban contexts. After this time, a national promotion campaign was constructed. Around this same time the Malian government passed a reform allowing women to seek family planning services without the consent of their husbands.[2] Malian family planning has undergone several transformations which have continuously served to increase services. The most crucial of these are the continued partnership restructurings with USAID (Embassy of the United States 2009). Today, family planning is comprised of government, non-government organization, and privately sponsored family planning facilities that offer a variety of services ranging from condom distribution to, although very rare, sterilization. However, the distinction between public and private providers is blurred; many NGOs and healthcare facilities receive funds and personnel from international government donors.

With such a robust infrastructure it is natural to assume that family planning has seen substantial progress. However, statistics cited by Malian officials, private organizations, and international groups continuously depict stagnant and often lagging advancement. Why, despite national and international efforts, is family planning failing?

The question of success, of course, depends in large part on the definition of success used. If success is a reduction in total fertility and solid trajectory on the path to "development," as USAID implies, initiatives have failed. Malian fertility, estimated at 6.48 children per woman in the early 1950s, is currently at 6.46 (United Nations, Department of Economic and Social Affairs, Population Division 2011). So too, Mali has

[2] It is generally accepted in the literature that this law functions more as a political measure to secure additional funding from foreign donors than to actually increase women's access to family planning services.

not made much progress toward achieving the "Asian Miracle"[3] of development; it is still among the poorest nations with an estimated gross national income in 2008 of $7.1 billion (United Nations Development Program 2010a). In 2010 it was ranked 160 out of 169 countries on the United Nations Human Development Index, indicating very low human development in areas such as health, education, income, equality, and gender (United Nations Development Program 2010b).

The Ministère de la Santé du Mali defines success as a reduction in maternal and infant/child mortality. Using these metrics, we must still conclude that family planning initiatives have failed or are failing. In the past 20 years and the past 10 years in particular, infant mortality and under 5 mortality have decreased but remain among the highest in sub-Saharan Africa (United Nations, Department of Economic and Social Affairs, Population Division 2011). Maternal mortality is likewise persisting apace despite advances in healthcare (ibid.). As of 2008, the maternal mortality ratio was 830 deaths per 100,000 live births (UNICEF 2009). Women have a 6% chance of dying during childbirth throughout their lifetimes (ibid.). Almost 1 in 5 children will die before reaching 5 years of age (UNICEF 2009 United Nations, Department of Economic and Social Affairs, Population Division 2011). 1 in 10 infants[4] will not survive the first year of life (ibid.).

This is not to say that progress has not been made in Mali. Mali's population, following the trend of the greater African continent, has continued to increase in recent years due in large part to improvements in infrastructure, sanitation, and healthcare. At

[3] The "Asian Miracle" most often refers to the positive development of East Asian nations after World War II. The economic success of these nations is often used to justify development projects and structural adjustment programs.
[4] UNICEF defines infant mortality was deaths before the first birthday.

14.5 million inhabitants, Mali's population is thought to have multiplied by 150% in the decade prior to 2009 (Institut Nationale de la Statistique 2009). However, available resources continue to be stretched thin as the effects of desertification and urbanization become more pronounced. While the majority of Mali's population remains rural, the capital city of Bamako has witnessed an unprecedented urbanization in recent decades. With an estimated population around 250,000 in the mid-1970s, Bamako is now thought to have a total population of over 2 million (UN HABITAT 2010).

One of the challenges of measuring family planning "success" is that outcomes are not distinctly correlated with family planning efforts or strategies; they are contingent upon multiple phenomena. Understanding these phenomena in terms of a national whole is difficult as Mali's diversity of geography, infrastructure, ethnicity, language, and levels of isolation vary greatly from one locality to the next.

With these diversities are born many of the challenges to family planning in Mali. However, the question remains, why haven't family planning services made more of an impact in the almost 40 years since their establishment? Why is contraceptive use prevalence still among the lowest in world while unmet need is among the highest? Why is maternal and infant mortality among the highest? How do we understand and measure family planning programs and their failures? The aim of this study is to understand why Malian family planning initiatives have thus far been unsuccessful and offer an explanation which lies at the very heart of family planning initiative construction.

Family Planning and Development Discourse

As I will show in this paper, there is an apparent disconnect between the stated intended outcomes of family planning initiatives (decreased fertility and improved health) and their actual effects in Mali. I argue that this disconnect is the result of a foreign knowledge which is incongruent with Malian women's lived realities. Because Malian family planning is primarily driven by USAID, ideas about womanhood, children, family, sexuality, and healthcare do not coincide with the experiences of Malian women. Thus, the provided family planning services are designed for different, perhaps imaginary, women in different contexts.

In considering this interplay, I turn to the work of Michel Foucault on discursive formations. Foucault (1972) explains that discursive practices, how we speak about and think about something, are not only abstract concepts but have actual effects. The way that these effects are enacted is through a system which links the discursive formations, unified statements, to a produced knowledge and power structure. In Malian family planning, discursive formations originating in the United States' development apparatus are reinforced by US political and economic power to produce a knowledge about the Malian woman which assumes to represent authentic Malian experiences. However, as I shall argue, this knowledge is based upon a fictitious idea of Malian life.

Family planning's portrait of a normative model for Malian women's reproductive practices is based upon a foreign-conceived knowledge. Because this model originates in a foreign context, ideas about Malian life may be based on second hand reports or observed through the western lens of development. The normative model is important because it is created by family planning discursive formations. As the model is

formed by knowledge of the centralized family planning initiative, those formations are translated to the local level as project specifics are designed according to the norm's needs. An example of this process is Project Keneya Ciwara in the commune of Kendie. The project, in many aspects, seems to be designed for women outside of the local Dogon community. Local norms and the purported norms of development initiatives are disjunctive.

Part of this incongruity is inevitable. Family planning, under the careful direction of the development apparatus, is attempting to transform the Malian woman. In order to alter the fertility of a population, family planning must change the target population's contraceptive habits. Because reproduction is a social, not only biological reality, family planning must change society in order to be effective. Thus, it is not only the healthcare of a population that must shift, but also the way a population thinks – about the body, sexuality, community, economics, and the state. There is an attempted re-engineering of social mechanisms, a transformation of knowledge that overshadows local structures with those of the import. Development initiatives like family planning are not only importing and extolling foreign medical and biological technology but also foreign knowledge with regard to a population's relationship to a series of social, political, and biological phenomena. Centralized discursive formations are packaged, moved, and reconstituted at the local level as the Malian woman comes to define herself according to family planning knowledge.

Foucault describes the process by which this transformation occurs as disciplinary (1977). In order for family planning to successfully change the fertility habits of a population, family planning knowledge must be adopted by the Malian woman. She must

discipline herself through the knowledge of family planning. This knowledge is reinforced and acted out through professionals in the institution who are sanctioned to pass judgment on and treat the object. In family planning, it is through the provision of health services that this discursive regime acts upon the Malian woman's body and transforms her into an object of the institution. This is a disciplinary process, whereby the object comes to know herself through a specific structure of knowledge. If family planning is to be successful in changing the fertility norms of a population, the Malian woman would understand herself, her community, and her fertility through the lens of the development apparatus. She would appropriate family planning's understandings of the self and society into her existing understandings of reality. (Foucault 1965, 1972, 1977, 1978, 1980)

One of the reasons family planning in Mali is failing because this process is incomplete. Because foreign and local knowledge are so dissimilar the intended outcomes of family planning are not realized. Family planning programs are failing as the local population becomes unable or unwilling to navigate family planning's knowledge. In essence, family planning is encountering resistance from existing formations. Local Malian knowledge of reproduction is persisting and what we see is an incomplete discipline of the Malian woman. While Malian women may or may not appropriate aspects of family planning knowledge, the ways in which they identify themselves and their realities remain largely untouched. Local knowledge or reproductive life prevails.

Foucault's understanding of discursive formations helps inform this process. Ferguson (1994) uses Foucault's concepts to show how discursive formations and knowledge help explain the ways in which large development initiatives work. He

explains how this knowledge of development initiatives is often inaccurate and simplifies local experience. Studying the development landscape in Lesotho, Ferguson argues that development schemes often misunderstand local existence and as a consequence fail to achieve their designs. Though few intended outcomes of development initiatives are ever realized, the unintended outcomes are almost more influential. The important "side effects" of failed schemes are expansions of political and bureaucratic power throughout the state (ibid. p. 252). Ferguson emphasizes that development is rational but not necessary intentional; the "effects of planned intervention may occur unconsciously" (ibid. p. 20). Likewise, power in and of itself is not the ultimate ambition of development practitioners. Ferguson further explains that "if the process through which structural production takes place can be thought of as a machine, it must be said that the planners' conceptions are not the blueprint for the machine; they are *parts* of the machine" (ibid. p. 276). Thus, any intentionality attributed to the development initiative can only truly apply to a small part of it. Many outcomes of these development schemes, intentional or otherwise, are agentless.

I will use a similar approach to understand the production of knowledge in Mali's centralized family planning initiative. As this knowledge does not completely represent Malian reality, I am interested in the consequences of this incompatibility. I will attempt to answer three interrelated questions: why is family planning failing? How is family planning attempting to change the social structure of the target population? And what are the unforeseen consequences of this failure to enact social change? Following sections on existing literature and methods, this analysis will first discuss local Malian experiences of reproduction. I will then situate family planning within the development apparatus where

I will examine it for the discursive construction of knowledge related to family planning itself and normative models intended to represent Malian women. I will then discuss some of the consequences of family planning's imposition of incompatible knowledge beyond the obvious failure of initiatives.

CH. 2 THE CURRENT LITERATURE

Since this study is concerned with family planning's discursive production of knowledge, it is important to understand how current analyses of family planning are undertaken. This literature on family planning is not distinct from centralized family planning discourse. It is instead a reflection of that discourse. As the development apparatus extends its produced knowledge, it also creates a specific way to speak about family planning. Sanctioned methods of inquiry are often reflected in USAID reports, the documents of private institutions, and the work of scholars. The lines between these three groups of actors are often opaque. Many scholars are employed or funded by public or private development institutions. As later sections more fully explore family planning knowledge, the similarities between trends in literature and those of centralized family planning will become more evident. They are all influenced by aspects of the same disciplinary matrix. However, before approaching the produced knowledge of family planning I feel it is helpful to first examine the field of current research. I will therefore discuss two avenues of family planning research, initiative evaluation and outcome analysis. The goal here is not to necessarily refute past and present efforts to codify family planning according to certain ideological or methodological formulae, it is rather intended to illustrate the way family planning is thought about and knowledge is produced.

While scholarly research in Mali is relatively sparse compared with many of its East African counterparts, there is a body of work devoted to family planning. This is likely a result of Mali's longstanding family planning initiative. This research is principally quantitative in nature; qualitative analyses are more infrequent and the

consideration of family planning is often subsidiary to the prevailing thesis. Studies of Mali's family planning programs tend to fall broadly into two sectors of inquiry: those evaluating family planning initiatives, usually of a centralized governing body to promote and develop a family planning initiative; and those examining initiative outcome. Outcome analyses fall into one or several of three categories: acceptance prevalence, methods to increase service and knowledge distribution, and factors behind reluctant acceptance/use of family planning techniques. I will follow an overview of these types of research with a discussion of trends and the similarities with overall family planning discourse.

Family Planning Program Evaluation

Family planning program evaluations, often described as "effort analyses," are broad measures of a family planning initiative. They are intended to be indicative of a central body's dedication to family planning. Popularized by Lapham and Mauldin in 1972, they assume that the presence of a family planning initiative or a fertility decline is not an adequate gauge of family planning success. A comprehensive theory of fertility remains ambiguous and attempts are often caught up in disciplinary debates, such as those between demography and anthropology (Greenhalgh 1995). Instead, initiatives are rated on several factors, including government support and funding. Lapham and Mauldin's examinations of family planning efforts (1972 to 2004) is the sole data tracing family planning changes throughout this time period (Ross, Stover, & Adelaja 2007). This method of assessment is very influential and has prompted various branches of family planning evaluation measurements. For example, Lapham and Simmons (1987)

identified five influences of contraceptive use that determined the effectiveness of family planning initiatives. These include: measurements of environment, demand for fertility control, population policies and programs, quality of transactions between providers and clients, and complementary determinants of fertility.

In family planning evaluation studies, family planning success is contingent upon several factors which include the type of initiative implemented, the size of the initiative, and the services offered. The number of factors analyzed is yet to reach a consensus, though newly introduced components tend to be sub-divisions of Lapham and Mauldin's original four; policies/resources/stage setting activities, services and related activities, record keeping and evaluation, and availability and accessibility of resources (1984). These four were originally derived from answers to a 30 item questionnaire distributed in various countries.

Entwisle (1989) claims that the divisions proposed by Lapham and Mauldin are too narrow in scope. She argues that such "analysts have treated effort as a unidimensional construct," thus prohibiting the full exploration of links between evaluation components and outcomes (ibid. p. 53). She proposes eight components of family planning effort, subdividing Lapham and Mauldin's four into subcategories. Entwisle based her categories on a 29 item questionnaire in 100 counties. Although the greater specificity offered by Entwisle's data analysis does propose greater precision, it does not venture beyond the delimitation of scores. The aim of her analysis, and indeed others like it is to rate the family planning efforts of a state, not to explain the phenomena behind those ratings and how they correspond to outcomes.

In recent years, family planning program evaluations have been expanded to include new trends potentially influencing overall demographics and the allocation of health resources in the global south. Among these trends is the HIV/AIDS pandemic. Ross, Stover, and Adelaja (2007) undertook their analysis primarily to update effort analysis techniques. They sought to include the implications of the HIV/AIDS pandemic. Specifically, they sought to examine the effects of any healthcare resource shortages as funds were drawn away from family planning to HIV/AIDS programs. Once again expanding upon Lapham and Mauldin's original examinations, Ross et al considered family planning program justification, phenomena negatively influencing programs, the influence of special interest groups, and the overall quality of family planning services. Their results were derived from a 125 item survey in nearly 100 countries. Unexpectedly, a material change in program effort was not indicated by the data in light of recent HIV/AIDS developments. Francophone Africa continued to be rated the lowest in overall quality of seven global regions throughout time, not exhibiting any significant drop in score as HIV/AIDS concerns became more prominent. Specific country data was not made available in the study.

Such evaluations of family planning structures, while useful in illustrating greater trends throughout time, are limited in their abilities to explain those same trends. Though past studies have called for a better "opportunity to explore the internal workings of family planning programs and to trace the ways in which program inputs translate into program outcomes," I am yet to find an effort analysis which successfully bridges this gap between quantitative components of effort and a qualitative explanation of those effects (Entwisle 1989 p. 53).

Family Planning Outcome

The second approach to analyzing family planning initiatives is an examination of their outcomes. This is usually an analysis of program success, as measured by contraceptive use prevalence and unmet need, an examination of factors or innovations potentially influencing outcome, and, occasionally, an explanation of a population's reluctant adoption of family planning techniques.

Several studies have conducted not only extensive surveys of acceptance rates but also offered conjectures as to why those rates are static. Van de Walle and Maiga (1991) make an important connection in their work between the availability and knowledge of resources and women's attitudes toward marriage and children. In a series of in-depth interviews with 78 Bamako women who had recently given birth, the researchers found that although women had knowledge of birth control techniques there was little evidence of past use or the intent of future use. They related this back to local understandings of the purpose of marriage and children. Many of the women interviewed linked successful marriage with the number of children born of the union and thus thought contraceptive use was incompatible with their goals. The researchers also identified a strong correlation between contraceptive use, spousal approval, and exposure to family planning media messages. These findings have also been elucidated in the work of Kane, Gueye, Speizer, Pacque-Margolis, and Baron (1998), Blanc (2001), and Castle (2003) as well as mentioned in various ethnographic accounts (Holloway 2007, Brand 2001).

Sauvain-Dugerdil, Gakou, Berthe, Dieng, Ritschard, and Lerch (2008) also conducted an extensive survey in an attempt to link different demographic variables with

contraceptive use. In a questionnaire of 2000 urban and rural Malians, the study found evidence to indicate the emergence of changing sexual behavior in youth. Although the researchers imply that a shift in women's sexual behavior could be due to increased female education, they do not provide any evidence beyond the suggestion. Ultimately, the study links the changes in both male and female sexual behavior to "unfavorable conditions surrounding the arrival of their first child" (ibid. p.263). These "unfavorable conditions" are primarily economic hardships which lead to a longer interval between first sex and first child. Contrarily, Sauvain-Dugerdil et al also witnessed an increase in "risky sexual behavior" as indicated by earlier sex outside of marriage (ibid.).

These studies highlight the importance of shifting norms and prevailing local ideologies when explaining the acceptance rates of family planning services. However, they do not explicitly link these changing attitudes with family planning programs. They do not include an explanation of the mechanisms that contribute to knowledge shifts nor do they address how these shifts are executed. Analyses are instead undertaken in a linear temporality. They assume that the target population will shift when a family planning program is implemented. Family planning programs' complicity in changing knowledge and normative structures is not disclosed and family planning programs' fundamental assumptions are beyond the scope of research.

Still, other Mali-specific family planning studies have paid particular attention to access and knowledge dissemination. Stanback, Dieng, de Morales, Cummings, and Traore (2005) concentrate on innovations designed to improve family planning programs by increasing a population's access to services. They increased access to birth control technology after the implementation of a clinic-administered checklist. The checklist is

intended to ascertain the likelihood of pregnancy in clinic patients and thus increase the number of women eligible for birth control resources. The researchers conclude that the implementation of pregnancy checklists was an inexpensive and effective method to increase women's access to family planning; however, Mali illustrated a high dissemination rate of birth control to those who sought services. The implementation of the checklist was materially insignificant. Despite the outcome of this particular innovation in family planning, this study is illustrative of a trend in the greater literature, particularly those projects undertaken at the behest of private institutions. Similar studies by Debpurr, Phillips, Jackson, Nazzer, Ngom, and Binka (2002) and Katz, West, Doumbia, and Kane (1998) also examine the impacts of different knowledge and service dissemination techniques on acceptance prevalence and overall knowledge of contraceptive methods.

A study by Kane, Gueye, Speizer, Pacque-Margolis, and Baron (1998) foregrounds more recent developments in family planning initiatives. Examining the effects of a family planning media campaign in Bamako, the study found that "knowledge and use and more favorable attitudes toward family planning [were] positively associated with the intensity of exposure to the project interventions" (p. 309). Media information campaigns are a popular tool used by family planning initiatives to raise awareness about available services, educate a population on a specific issue, and slowly change reproductive norms (Brown, Waszak, & Childers 1989). Currently, Mali's centralized family planning initiative sponsors many advertisements aimed to create a unification of government policy and religious beliefs. They are also used to incorporate men into reproductive health campaigns. Multi-media tools like television series and

songs by popular artists have also been widely distributed to garner support for services and foster positive attitudes toward family planning.

A general criticism of studies examining ways to increase services is that they assume a correlation between available resources and use. A case can also be made that women accepted for services at clinics are not representative of the population with an unmet need. These women are the minority who have the ability and will to pursue such services. Thus, statistically, such studies do not indicate acceptance or success of the larger initiative, but merely state the availability of resources to a certain portion of the target population. A larger analysis of the family planning structure itself is beyond the scope of the research. Ultimately, while these studies are important to ensure that resources are available to those seeking them, they fail to move beyond an initial quantitative assessment and make a claim about the effectiveness of family planning programs. The initiatives themselves escape critical examination of the structure and appropriateness of their methods.

Several studies on Malian family planning have, however, taken a more critical approach, linking more complex cultural factors with the success of family planning initiatives. Castle (2003) and Kaggwa, Diop, and Storey (2008) examine social, religious, and cultural phenomena that explain women's reluctance to use contraception. Castle (2003) found that women's precarious economic situations – dependent upon male earnings – greatly influenced their choice not to seek family planning services. A woman in a polygamous marriage can be made socially and financially vulnerable if she is thought to be infertile. Moreover, Kaggwa et al (2008) found a significant correlation between community normative factors and women's attitudes about fertility. They claim

that since the female community is collective, fertility is also a communal debate, not an individual choice.

These studies rationalize resistance to family planning techniques. The focus on women's lived realities, while limited in scope, is imperative to understanding the true outcomes, intended and unintended, of family planning initiatives. These studies provide the ethnographic data necessary to re-examine family planning structures and the services provided in distinct communities. However, other than highlighting the three-dimensionality of women's experience in Mali, they do not completely connect their findings with the current structures of family planning initiatives.

Discussion of Current Literature

It is clear from the existing literature that analyses of Malian family planning are split on their subjects of interest. On the one hand, analyses focus on the target population. Studies examining reluctant contraceptive acceptance and those examining family planning use rates are overtly concerned with the population. For these studies, the family planning initiative is an assumed constant while the reaction of the population is the variable. Another way to look at this is in terms of actor and object. The family planning initiative is the actor whose force is exerted upon an object population. The effects of this relationship are of interest.

On the other hand, the interests of some studies are reversed. Evaluations of family planning initiatives and studies of innovations to improve programs are interested in the family planning initiative. The family planning program becomes the principle of study, the success of which is the ultimate ambition. The concern is with understanding

how the program is behaving and how changes to the program affect the whole. The success of the program is measured by its ability to affect the behavior of the population.

There is, therefore, an implied causality and directionality in these analyses. They generally lack a holistic approach to the family planning situation. This trend is in line with that of the centralized family planning initiative, particularly those traits stemming from modernization principles. Moreover, many analyses tend to rely on a simplified version the diffusion of innovations theory.

First published in 1962, Rogers's "Diffusion of Innovations" has been extremely influential. It has been incorporated into several health belief models. Rogers defines diffusion as "the process by which an innovation is communicated through certain channels over time among the members of a social system" (ibid. p. 5). Diffusion, he continues, "is a kind of social change, defined as the process by which alteration occurs in the structure and function of a social system" (ibid. p. 6). According to this postulate, the diffusion of an innovation follows an s-shaped curve reflecting an initial slow adoption of the innovation followed by an acceleration of acceptance before leveling off after saturation is complete.

Many family planning studies, either intentionally or unintentionally, rely on this adoption trend, speculating that failures in the Malian family planning structure are because the amount of time passed is insufficient for the innovation of family planning to have diffused to a significant portion of the population. These same studies, while relying on the diffusion of innovations theory, do not adequately engage with diffusion theory's nuances. Rogers points out that the rate of diffusion and successful adoption of an innovation is dependent upon the social system. As Orlandi, Landers, Weston, and Haley

(1990) clarify, diffusion of innovations theory assumes that "diffusion patterns and adoption rates of particular innovations are determined primarily by the scientific attributes of the innovation and the unique characteristics of the adopted" (p. 290). This bias of many analyses is inherently detrimental to critically examining family planning structures as it assumes that with time and the dissemination of information (harkening to the banking concept of education[5]) Mali's family planning initiatives will become more effective.

The theory of diffusion is problematic.

> First, the characterization of the innovation as an intact package directs attention toward the user system and the adoption decision and away from the concept of innovation refinement as a means of improving the 'fit' between innovation and user. Second, this orientation does not provide an adequate means of evaluating the potential contribution of efforts on the part of the resource system or the user system to influence the diffusion dynamic. In this sense, as a rule, the process is viewed as static rather than dynamic. Third, the classical model fails to recognize the fact that the adoption decision is only one step in a multi-step process that ranges from the first phases of innovation development to a point beyond adoption at which the innovation either succeeds or fails in achieving a lasting and meaningful impact" (Orlandi et al 1990 p.291).

Yet, despite these grievances, the theory continues to permeate health development discourse (Greenhalgh 1995). Though many studies do not overtly ascribe to the diffusion of innovations approach, there remains an assumed and unexplored stagnancy surrounding family planning analyses. The true detriment of this approach is its anti-revisionist stance. Analyses that rely on diffusion theory ultimately limit the applicability of their own findings. This is because diffusion theory does not allow reflexivity in planning institutions.

[5] The banking concept of education, as explained by Freire (1993), refers to the student-teacher relationship wherein the student's participation in her own education goes only so far as to store knowledge (deposits) bestowed upon her by the teacher.

While these issues are important, they do not wholly refute the efforts of past family planning analyses; they instead point to the directionality of research. This directionality simply makes them obsolete for the revision of family planning structures and services. The conclusion to be drawn is that existing knowledge of both family planning structures and target populations are not separate from family planning structures themselves. Discursively, they are interdependent. The ways in which family planning is discussed is engendered to the overall discourse of the family planning structures they study.

My approach, while recognizing these discourses, is not wholly apart from them. This analysis will build upon existing studies of family planning evaluation and outcome measurements by triangulating family planning in a three-dimensional space. The goal is to link the conceptualization of norms with their actual deployment and effects. The effects of interest are the unintended consequences of family planning's produced knowledge. While previous studies examine only the tangible initiative actions, this analysis will consider the discursive formations which structure initiatives based upon a preconceived knowledge of Malian women. In addition, I will attempt to move beyond the diffusion of innovations theory. To use a term borrowed from Orlandi et al (1990), I will examine the "fit" between Mali's centralized family planning initiative and the target population.

CH. 3 METHODS AND METHODOLOGY

The Discursive Approach

This study utilizes the theories of Michel Foucault. In particular, I will rely on ideas about the importance of discursive formations as a way through which knowledge about family planning is produced. The examination of discursive formations is a point of departure from previous studies whose foci have been concrete programs and quantifiable trends. This trend in literature reflects the greater knowledge about how family planning is to be discussed and understood.

At question here are not the demographic shifts of the Malian population. Rather, I will analyze the "culture" of the centralized family planning structure and its implications for the success of family planning outcomes. Another way to view this study is through the lens of anthropology, wherein an ethnography of the initiative is undertaken and its narratives are examined for knowledge of Malian women's reproductive realities.

As an anthropology of the family planning initiative, analyzing the discursive formations is both a method and a methodology. Methodologically, discursive formations produce knowledge that structures institutions. These institutions and their professionals, in turn, allow the knowledge to affect an object population (Foucault 1972, 1978). They also constitute specific domains of knowledge, etiquette, and power which affect outcomes.

Discursive formations are the method by which centralized initiatives disseminate ideas about family planning. These formations affect the target population in both direct and indirect ways. The most direct method is through the health clinics and family

planning outreach services. As a structure of power reconstituted in program outreach, family planning services privilege certain members of a population. In Mali, the privileged members of the population tend to be those who can navigate the foreign knowledge of family planning. Malian women may be prohibited from obtaining health services because they cannot navigate the family planning system. However, Malian women who cannot navigate these structures are still impacted by family planning knowledge. Family planning knowledge is also disseminated through information campaigns engendered with these centralized discursive formations. Billboards, radio programs, television programs, and songs by popular artists are all methods through which the foreign formations are transmitted. The ultimate saturation level of these ideologies and structures varies; direct transmission leads to incomplete co-optation of knowledge, behavior, resources, and ideals. These formations are further diffused through the community and absorbed, renegotiated, and refuted along the way. Thus, Malian women who do not directly interact with family planning professionals are still likely to be exposed to aspects of family planning knowledge.

Approaching initiatives from an anthropological standpoint has been completed in studies of healthcare (Cherrington and Breheny 2005) and development (Ferguson 1994), however, it has rarely, to the best of my knowledge, been conducted at the institutional level of family planning. Newland (2001) is an exception. She approaches the study of family planning in West Java from a related perspective and draws many interesting conclusions about the attempts of a family planning structure to shape women's realities. Relying on Foucauldian ideas of biopower and normative models, she concludes that the Indonesian family planning initiative, to achieve its goals, links women's health to the

health of the state economy. Newland observes that this is successful by creating a new normative model, the *modern woman*. This is primarily done discursively through a series of public campaigns. Newland's analysis is helpful because it articulates the power of discourse to reconstitute populations. However, it is also of limited applicability for this study. Newland's West Java analysis is largely centered on a domestic program of family planning. When approaching Malian family planning, one must also contend with the fact that centralized discursive formations are predominantly of foreign origin. The likelihood that they adequately reflect local values to the degree necessary to accommodate a shift in the way a populations identifies is doubtful.

Far from advocating a normative approach to family planning, the dangers of which have been explored fully (Launay 1995), this analysis illustrates the hazard of the normative mindset. I argue that family planning programs struggle to ignite effective change in demographic trends because the knowledge employed to shape the normative model is inappropriate.

Text Selection

I will survey existing ethnographic literature to illustrate the variability of authentic reproductive realities in Mali. I will briefly explore women's experiences of womanhood, marriage, children, birth, death, and health. I obtained much of this information from several secondary sources whose foci are not family planning but other aspects of Malian women's lives.

There is no singular discourse of Malian family planning. Centralized discourse is not necessarily stagnant. Rather than provable fact, discursive structures are dominant

narratives which mirror the shifting social, political, and economic environments in which they are made. I chose these texts for analysis because they are authoritative and instrumental in formulating Mali's centralized family planning initiative. Though there are arguably many actors in the family planning structure I have identified two which are of primary importance for this examination, the Malian government and USAID. I will focus on the USAID portion of the initiative in order to highlight the globalizing character of family planning discursive formations.

Centralized family planning is composed of strategists and politicians employed through the Reproductive Health Division of the Ministère de la Santé. It is comprised of government, non-government organization, and privately sponsored family planning facilities. Despite the statements of Malian health officials there is a question of the government's autonomy over family planning programming; over 85% of family planning funding is from foreign donors. The largest of these donors are UNFPA, UNDP, UNICEF, WHO, and USAID (Brand 2001). Since the mid-1980s USAID has been the largest contributor by several multiples (ibid.). In the five years prior to 2009, USAID directly invested almost $70 million in Malian family planning (Embassy of the United States 2009). In addition, USAID and its affiliates design, import, and oversee an overwhelming majority of family planning programs (Brand 2001).

Centralized family planning is officially under the direction of the Ministère de la Santé. Government services account for over 52% of all family planning distribution[6] (USAID 2009b). In 2006 centralized family planning was composed of 858 community health centers, 59 referral health centers, and 9 public hospitals (ibid.). In 2005 there were

[6] Distribution is defined in terms of tangible provision of goods (pills, injectables,) and not education or peri-natal services.

642 private providers operating in Mali, the majority in Bamako (ibid.). The most prominent NGOs are the Association Malienne pour la Promotion et la Protection de la Famille (AMPPF), PSI Mali, Family Health International, Marie Stopes International, JIGI, SPS, the Group Pivot, Population Health, and ASDAP (ibid.). Evidence has been found that 8 of these 9 NGOs have relationships with USAID which provides financial support, advisory services, or other partnership functions (ASDAP 2009, JIGI 2009, USAID 2005, USAID 2009f, USAID 2011a, USAID 2011b)[7]. Additionally, USAID's Project Keneya Ciwara is responsible for 30% of total population outreach in 8 of Mali's 9 regions (USAID 2009b).

Sources for the documents analyzed include government publications, the internet, and academic libraries and journals. All documents used for analysis are readily available to the inquiring general public. Many are used as propaganda and marketing tools. Malian government policies, declarations, and reports and USAID reports, marketing materials, and presentations will be used to construct a dominant discourse of centralized family planning. In particular, I will analyze these documents to identify the production of family planning knowledge. Of interest are the ways these formations impact a normative conceptualization of Malian women and the consequences for program implementation when this norm contrasts with local realities.

[7] External confirmation of the 9th NGO (Population Health) could not be located beyond the initial mention in the USAID report. Thus, it is unknown whether USAID partnered with them in the past.

CH. 4 MAKING MALIAN WOMEN

What is life like for Malian women? What are their experiences? Mali is home to over 40 ethnic groups which are spread across a large and geographically diverse terrain. Capturing one collective Malian voice is impossible. However, in this section I will attempt to provide a broad overview of local ideas and realities surrounding reproduction. Relying on data from several studies throughout Mali and neighboring West African countries, I will briefly discuss some prominent themes of Malian life. My challenge here is to discuss the common-sense and often tacit meanings that inform reproductive decision-making.

I begin with a difficulty in understanding Malian women's knowledge of themselves. How are gender, womanhood, and male-female interaction understood? There is a fundamental difficulty for westerners to understand African identity. Western feminism has historically focused on campaigns of individuality and until relatively recent works on gender, a biological determinism permeated discussions of women's circumstance both at home and abroad. In the West, an individual exists as a whole system and interacts with society. For many African communities, this concept of individuality is inappropriate. Brand (2001) explains that in the Mande area[8], social "relations exist prior to the person: it is only by means of social ties that one can achieve personhood" (p. 16). Concepts of what Brand terms "personhood" are thus, socially derived. The result, however, is not a complete, autonomous person; it is a member of the community. Each step along the path to personhood serves to enrich the ties of the person to the community, thereby strengthening the person and the group. For men and women

[8] Tribes of Mande origin have been historically spread across West Africa. The majority of Mali's ethnic groups are of this region and many share similar heritage and languages.

this path to personhood is achieved through rights of passage. These rights can generally be categorized as circumcision, marriage, and reproduction. In addition, the person must display appropriate behavior in order to participate in the group. For the Mande, "a life is fulfilled when it ends in old age and the person is surrounded by children and grandchildren" (ibid. p. 17). For women, these stages – circumcision, marriage, and birth – are all centered around concepts of making Malian women, women. Further, these women appropriate the social fabric of life and transfer it to the next generation through continued cycles of circumcision, marriage, and reproduction with their offspring.

Female circumcision is a reality for many African women. It often serves to define their gender and occasionally creates female-to-female bonds between young girls receiving the procedure together (Holloway p. 113). Circumcision is often regulated by elder women in the community who possess the knowledge and authority to perform the ritual. The type of circumcision practiced varies throughout groups and ranges from more minor procedures like clitoridectomy to the more severe procedures of infibulation. Cultural and religious rationales are numerous. In Magnambougou outside of Bamako, many women report that clitoridectomy is performed simply because "it's our tradition. We all do this" (Dettwyler 1994). More common understandings, however, justify the practice as an essential step in making women, women. The Dogon of northern Mali believe that children have the potential to be either sex and that it is only through circumcision that boys become boys and girls become girls. Boddy (1989) made a similar observation when studying northern Sudanese circumcision. She found that "only after genital surgery are people eligible to become social persons, to assume the responsibilities of life as…men and…women" (p. 56). A more direct link to fertility is

cited by Holloway (2007) while living in the southeastern Malian village of Nampossela. As an informant told her, "here we say that *koloboli*[9] helps girls become good wives and bear children" (ibid. p. 114 *ital mine*). This practice also relies on normative justification in many settings, whereby women comply with the practice because it is simply what is done to attract a husband and have a family (Dettwyler 1994).

Fertility and the safekeeping thereof are tremendously important to many Malian women. Women must compete for social capital in order to secure their futures (Brand 2001). While this is obviously important for single women to attract a husband, it does not lessen with marriage. Because many Malian groups practice polygamy, women are in competition with their co-wives. Madhavan (2001), citing several other anthropologists, reiterates that family networks, like those of co-wives, may function as cohesive or competitive mechanisms. In later work with the Bamana of Mali, Madhavan, Adams, and Simon (2003) argue that the social repercussions, particularly those of women's networks, are impediments to fertility reduction measures. They argue that "a woman's social interactions will influence her capacity to use contraceptives and flout traditional fertility norms. For example, women whose social interaction is largely confined to the conjugal household may be unlikely to depart from traditional fertility norms, because such behavior may incur substantial social risks" (ibid. p. 60). Because of this competition and social pressure to conform to fertility norms – actual, potential, or otherwise – women must ensure that their reproductive potential remains high.

Part of safeguarding fertility means regulating women's biology. Women's menstrual regularities and irregularities are often causes of great stress. Marabouts, elder women in the community, shamans, and western medical practitioners are often

[9] Koloboli is the Minianka word for excision.

consulted to ensure women's fertility. Slobin (1998) highlights the way menstrual irregularity is perceived as a disease that requires traditional or allopathic intervention. One of her informants, a young Dogon woman who was experiencing chronic periods of amenorrhea[10] and menorrhagia[11], described the nature of her illness as stemming from hormonal contraceptives: "Usually, I start mes règles[12] on the 14th of the month. This time [during her illness] it continued through the 14th of the next month and stopped on the 26th. What I think is – these problems come from birth control pills. I didn't think I could do anything to help myself, so it was after days of lying in bed that I went to see the médecin"[13] (ibid. p. 373). Castle (2003) finds that this sentiment is not uncommon among Malian women. Generally, women are reluctant to use hormonal contraceptives because of the effects of limiting fertility, sometimes for long periods of time. The social consequences of infertility, or perceived infertility, are great enough that hormonal contraceptive use is avoided (ibid.).

The desire for ensured fertility and many children is not only based on economic and social survival. For many African women, children help define their womanhood. African feminists such as Nnaemeka (2005) have emphasized the necessity of a pro-natalist understanding of African women. Pro-natalist sentiments are rooted in West African reality. Children are not only intrinsically valuable and integral to definitions of womanhood, they also help negotiate social and economic value. In the agriculturally active zones of West Africa, children have been conventionally regarded as surplus labor. They contribute to the economic vitality of the family from early in life by helping

[10] Light or no menstrual bleeding.
[11] Excessively heavy menstrual bleeding, usually prolonged and of such severity that the woman is unable to assume normal daily activities.
[12] In French "mes règles translates as "my regulars." It refers to regular menstrual cycles.
[13] In French "médecin" translates as "doctor."

mothers cook, cultivate gardens, and vend certain products. They also participate in traditionally masculine duties such as tending cash crops (cotton, cocoa, etc.) and are considered retirement insurance as they grow and support elderly parents. Additionally, children can help maintain kinship and community relationships through marriage and labor services.

However, the cultural and social value of children alone does not wholly explain high fertility rates. Mali has some of the highest infant and child mortality rates in the world. The average Malian woman has 6.5 children (United Nations, Department of Economic and Social Affairs, Population Division 2011). 1 out of every 10 infants die within the first year and of those surviving children, 1 in 5 will die before reaching the age of five (UNICEF 2009). These statistics, of course, vary throughout Mali and can (arguably) be assumed to be higher in more rural areas where access to healthcare and infrastructure is limited. While studying among the Fulani and Humbebe communities of rural Mali, Castle (1994) noted that in the community of Douentza, "a woman can expect to have 7.7 live births by the end of her reproductive years. She can expect to lose about four of these children, however, to childhood illness" (p. 317).

Child death rates are due to a number of problems, including malnutrition, injury, malaria, and other vector- or water-born diseases. Often, the effects of disease are accentuated by malnutrition, and vice versa. For many children and their mothers, the process of death is slow. Dettwyler (1994) observed many experiences of wasting children while studying nutritional deficiency throughout Mali.

> Daouda took one look at me and started crying. But not the loud, vigorous wail of a healthy child, accompanied by attempts to get away. Rather, his cries consisted of barely audible whimpers as he tried, without success, to turn his head away. At 18 months, Daouda weighed only 12 pounds and

> was so weak he couldn't hold his head up or move his arms or legs voluntarily. His head looked huge for his body…His arms and legs were mere bones covered by wrinkled, papery skin. His buttocks were pathetic. Really just bags of skin hanging in folds from his spine. I could count every rib without difficulty. He felt like a bundle of sharp sticks… (ibid. p. 31)

Daouda is not an outlier in Malian life. He represents the lived experience behind child mortality statistics.

In a self-perpetuating cycle, some child deaths are due to children spaced too closely together. As women have more children – by desire, necessity, or accident - the births are often too close together. Not only is there physical trauma for the woman, who often does not have adequate access to medical facilities and personnel, but existing children often suffer from nutritional deficiency as they are weaned. Kwashiorkor is a disease that occurs when a diet is deficient in protein but very high in empty calories. Breast milk usually contains adequate amounts of protein for even older toddlers. However, in places where staple foods, like cassava and potato varietals, do not contain enough protein, children develop Kwashiorkor as breast milk is withheld from them and an adequate protein substitute is not found. In the rural village of N'tenkoni, Dettwyler (1994) encountered the following case of *funu bana*[14] and describes its effects as such.

> The little girl presented all of [kwashiorkor's] classic symptoms. Her face was round and puffy, almost as though she had been beaten. Her hands and feet appeared plump, like her face. But the defining characteristic was her enormously swollen abdomen. Bulging against her dress, it strained the fabric, giving her the incongruous appearance of a pregnant woman. Her expression was one of sadness and apathy, her eyes sunken and dull. (ibid. p. 71)

This phenomena is prevalent enough in Mali that the Malian ministry of health actively promotes birth spacing as part of its family health programs. High fertility is partially

[14] "Funu bana" literally means "swelling sickness" and is the local derivation for Kwashiorkor in N'tenkoni (Dettwyler 1994).

explained by the uncertainty of children's survival. Although child mortality statistics are swayed by a growing urban population with greater access to healthcare, there is likely great variability throughout the state.

Such is the value of children that women brave the danger of giving birth frequently, not a task to be taken lightly. Women have a 6% chance of dying during childbirth during their reproductive lives (UNICEF 2009). This is among the highest maternal death rates in the world. Poor nutrition, inadequate access to peri-natal care, and lagging infrastructure are only some of the complications with which pregnant and birthing women contend. While in the southeastern village of Nampossela, Holloway (2007) described the following birth experience while working with a local midwife.

> Monique [the midwife] and I slowly raised her by the elbow. Unlike other women, there was nothing meaty about Korotun. Her ribs and backbone protruded, her skin too thin a canvas stretched over a meager frame. Monique and I guided her, letting the contractions build, gauging when they were cresting, and ordering her to push…[The baby's] head hung there, streaked with white vernix and crimson blood, between Korotun's splattered thighs…There was so much blood…Korotun pushed the shoulders out and the rest of the being quickly surrendered to the world…there was so much blood….The right side of her vagina was shredded as if the birth had been literally ripped from her. Her vagina looked less like an organ of wonder than a hideous wound…[If the bleeding didn't stop], a woman was balanced on the back of a moped, like a goat condemned for market, and raced to the Koutiala hospital. (ibid. p. 109-10)

The average woman will endure, if she does not die first, 7 such experiences during her reproductive years.

Although women endure such hardship to give birth in Mali, the uncertainty of their children's fate greatly influences social understandings of sickness, death, and grief. Coping mechanisms are common, many of which allow women to find comfort in uncontrollable circumstances. They also absolve mothers of guilt surrounding child

illness and death. Scheper-Hughes' (1992) seminal work in northeastern Brazil concerns, among other themes, the apparent indifference with which mothers regard their children. She claims that these reactions do not necessarily reflect a mother's apathy toward her children, but are instead culturally mandated or sanctioned coping mechanisms (ibid., Castle 1994). Castle (1994) observes that among the Fulani of rural Mali the concept of *pulaaku*, a code of social behavior, "requires acceptance and stoicism in the face of physical hardship and emotional distress" (p. 314). Brand (2001) observes similar social regulations of emotion among the Mande near Bamako. "It is a feature of hòrònya (nobility) to hide one's emotions" (p. 97). The code of *pulaaku*, Castle (1994) further explains,

> is also important for understanding maternal reactions to child deaths. In the Douentza communities, it is commonly believed that at birth God gives each person a finite number of days on earth and that everyone has a prearranged day of death. The most common reason given for death was thus that the child's 'time had come' (saatu mako wari), and public complaint would have been contrary to the will of Allah and therefore irreverent. The Fulbe, in particular, believe that the child of a woman who cries at its death will not be able to testify for her in front of God on the day of judgment. (ibid. p. 322)

The will of Allah is also a common justification for premature death among the Mande (Brand 2001) and people of Nampossela in southeastern Mali (Holloway 2007).

This resignation in light of the realities of poverty, insufficient healthcare services, and lacking sanitary infrastructure is also reflected in common justifications of child death and disease. Dettwyler (1994) explains a mystical justification incorporated into childhood disease models she witnessed in rural Mali. In the village of Totokoro, developmentally disabled or delayed children were understood in the following manner:

> And then there are those children who never grow up…They just never grow. They never reach out for things with their hands, they never sit up

> or walk, they never talk. Some begin to, but then stop. You keep praying and hoping and looking for medicine for them, but nothing helps…then you know that they are evil spirits, and you give up…Well, you take them out into the bush and you just leave them…They turn into snakes and slither away…You go back the next day, and they aren't there. Then you know for sure that they weren't really children at all, but evil spirits. (p. 86)

Castle (1994) explores similar justifications for child disease in rural Mali. She explores the diagnosis of *heendu* (wind) and *foondu* (bird or owl). Among the Fulani and Humbebe, both of these mystical diseases are thought to be beyond the help of allopathic medicine. Castle claims that "the hopeless and fatal nature of foondu and heendu [appear] to permit individual mothers to maintain their psychological well-being in an environment where they are likely, on average, to lost half their children to childhood illnesses. Foondu and Heendu in such circumstances give a significance and validity to their experiences of child death and defend the role they played in the events leading up to it" (ibid. p. 331).

As I have briefly explored, local forms of knowledge and codes of conduct cannot be considered as distinct from their immediate localities and extending histories. Ideas about family, children, health, and disease cannot be separated from the social environments from which they stem. While justifications for loss and child illness may seem backward to the Western reader, they should not be necessarily be considered wrong. They exist as social, not scientific, truths. They are reflections of hardship and indicative of the manners in which local knowledge, formed within the Malian context, is employed.

CH. 5 A KNOWLEDGE OF FAMILY PLANNING

As the brief review in the previous chapter illustrates, Malian ideas about reproduction are deeply imbedded in the immediate and historical realities of everyday life. I would now like to examine the family planning institution for some of its ideas about itself, reproduction, and life in Mali.

Foucault (1972) relates that knowledge is formed by the regular exercise of discursive formations (p. 182). For my purposes I understand knowledge to function on two levels in family planning development. One, the knowledge of development itself is a larger body of formed knowledge. This is family planning's knowledge of itself and its role in the development of the global south. The second aspect of knowledge is a knowledge which defines the object, or normative model.

I divide knowledge here in order to illustrate the ways in which discursive formations create knowledge that structures institutions and concepts about Malian women. Ultimately, these discursive formations create what Foucault (1980) calls "a 'regime' of truth" (p.133). This "'truth' is linked in a circular relation with systems of power which produce and sustain it, and to effects of power which it induces and which extend it" (p. 133). Though professionals allow knowledge to act, those professionals also refine that knowledge and possess the authority and power to affect the objects of family planning.

The division of knowledge between the institution and the object serves to illustrate the vastness of the knowledge construct; it encompasses self-definition (family planning as it understands itself) and other circumscription (definitions of the object). As I explore the construction and employment of family planning knowledge, these

distinctions of knowledge will also serve to highlight the process of object transformation (or discipline) by which the Malian object comes to understand herself according to the institutional dictates of family planning.

However, despite the usefulness of this exercise, knowledge should not necessarily be conceptualized as a bound set of stagnant positivities. As Foucault reminds us, discursive formations which constitute knowledge and institutions are not "coextensive with it" (1972 p. 179). Knowledge and the elements thereof originate at various levels of and from various modes of discourse harnessed and employed by an institution. In fact, the knowledge of Malian women can be thought of as simply how a larger structure of knowledge is translated and applied to a population. The knowledge is rearticulated in such a way that it constructs the relationship between the object and the disciplining institution insofar as the object is defined by that knowledge.

Family Planning as Development

To begin to understand family planning in Mali it is first necessary to understand what development is and how family planning is subject to its inherent conceptualizations of space, time, power, society, and itself. This is the institutional knowledge. This raises questions of what family planning is and how it functions. Family planning assumes that it is a force to be exerted upon a local population. The origins of this assumption lay in the institution of development. I will thus take as the first formations of study those that constitute a broad knowledge of family planning as it is understood to function in the institution of development and in the global south.

Family planning in Mali is not state bound nor the recipient of a linear strategic trajectory. It is best understood as a mixture of local and international interests. The involvement of USAID, though dominant economically, cannot be simplified as a western state agenda but should be seen as a locus for competing knowledges resulting from several levels of public and private bureaucracies. These bureaucracies would include the central government's foreign policy, military policy, and also private corporations such as pharmaceutical and medical equipment manufacturers.

The family planning initiative itself is structured rather hierarchically. It is occupied with and swayed by political and economic interests. The manners in which family planning initiatives see themselves, their subjects, and their tasks are constructed by discursive formations bound by the realities of the institutions. One way to think about the centralized family planning initiative is as a large campaign. As Brown, Waszak, and Childers (1989) relate, "the particular political, economic and social structures of the society in which these campaigns have been conducted have affected all aspects of these campaigns, including when they were conducted, who sponsored them, to whom they were directed, what they tried to accomplish and which channels of communication were (and could be) used" (p. 86). It is thus these roots of family planning that must be understood as reinforcing constructions of discursive formations.

Family planning development, however, cannot fully reflect the social experiences of the environment in which it was formed. Nor can it capture the environment of the target population. To explain this behavior I rely on Scott (1998). In his book "Seeing Like a State," Scott details how the state, like other bureaucratic machines, is hardwired a specific way. Such structures, Scott claims, are programmed to

visualize and interpret the world in two dimensions. They will observe only those aspects of social reality that are of official interest. These observations are static, aggregate, and almost always written as documentary fact. Bureaucratic structures also have a natural tendency to group citizens in ways that permit them to make collective assessments. Further, Scott states that these "simplifications, like all state simplifications, are always far more static and schematic than the actual social phenomena they presume to typify" (ibid. p. 46).

This is the manner in which a body of accepted knowledge develops. The way bureaucracies simplify problems is problematic. The inherent nature of these structures to simplify and reduce social existence to a series of monastic inputs diminishes the potential success of development projects. Because these institutions are incapable of multi-factor analysis, projects undertaken do not consider or receive inputs from the entire strata of social life. It is thus easy to see how family planning initiatives fail to comprehend women's experience.

With these considerations in mind, I will now approach centralized family planning from the standpoint of development interests. What is it that the initiative is interested in? When asked about the significance of family planning in development, USAID responds that

> Those countries in the developing world that have invested in health and education and have provided women access to family planning and reproductive health programs have experienced faster economic growth than those that have not. When couples can choose the number, timing and spacing of their children, they are better able to adequately feed and educate their children, potentially ending the cycle of poverty. Communities thrive, and in turn, countries fare better. Today the greatest deficits in access to health services can be found in the poorest segments of the population. By channeling resources to family planning, nations can

> save lives, stabilize population growth, slow the spread of AIDS, reduce poverty and improve women's position in society. (USAID 2009c)

Many of the goals mentioned in this rationale are identical to those of agricultural and infrastructural development projects. As illustrated by this explanation from USAID, there are two driving themes of family planning as development, progress and economics.

Evolution, Progress, and Modernity

In considering the idea that family planning is a force to be exerted on the local population we arrive at the evolutionary mindset of development. This assumption undergirds family planning execution and informs the larger structure of knowledge. The development of family planning may be conceived of in two senses; as a process and as an industry. By industry I refer to the structured enterprise whose business is the process of development. Of concern is how that industry functions. How does it see itself and the objects of its attentions? How is the process of family planning development employed?

First, as an industry itself, development and family planning exist in the form of two ideologies. Although sometimes claimed to be mutually exclusive, these ideologies are just as often related by justification and procedure. Both notions of development are problematic in that they employ generalized assumptions often based on simplified and fictitious notions of modernity. On the one hand, development may be conceived in a particular linearity, the goal of which is to bring southern states through time and into a modern world exemplified by western civilization. On the other hand, development is often altruistically understood as the alleviation poverty and suffering.

These two faces of development also merge as a goal and the means by which it is achieved and measured. Successful development, that is the achievement of

modernization, is assumed to coincide with a mitigation of poverty. As expressed by Ferguson (1994), what we have is a blurring of "these two meanings, implicitly equating 'modernization' with the elimination or alleviation of poverty" (p. 15). This is apparent in USAID's rationale cited on pages 39 and 40; it is through the developmental scheme of family planning that a modernized state is achieved.

This evolutionary rationale is deeply imbedded in development and has been co-opted by family planning initiatives as they attempt to change the discursive landscape of target populations (Newland 2001). The imposition of foreign formations should not be wholly understood as coincidental. Development enterprises are incentivized to guarantee their own prosperity. They employ tactics long seated in theories of modernization which create an entire understanding of the global environment.

The rise of modernization theory in the 1950s exemplified a linearity which considered nations to share a developmental future. Generally, modernity is a "term to describe particular forms of economy and society based on the experiences of Western Europe. In economic terms, 'modernity' encompasses industrialization, urbanization and the increased use of technology within all sectors of the economy. This application of technology and scientific principles is also reflected within social and cultural spheres" (Willis 2005 p. 2). Development schemes based on such models fail to account for unique factors that impact development in the target population. They also rely intrinsically on an idealized trajectory of American (or broadly, western) development. They fail to recognize the unique influences which impacted domestic development. As Gilman (2003) claims, "modernization theory, while overtly focused on the plight of the third world, echoed and amplified unfolding American sentiments about the condition of

modernity at home" (p. 12). By creating an outward facing theory based on a romanticized concept of Americanism, theorists were hoping to validate their concept of domestic modernity and development by making it repeatable abroad.

This tenant of modernization continues in family planning initiatives currently. There is an evolutionary mindset which sees the western entity as the symbol of progress and the southern population as backward. The global south is antiquated and situated in the past. I find this conceptualization problematic for family planning not only because of its idealized ideas western deployment, but also for its ignorance of other cultures. There is a seeming cultural erasure and geopolitical and cultural unawareness. Family planning initiatives tend to conceptualize welfare in a linear and comparative framework which is incongruent with realities and experiences of actual women.

Ideas of modernity have also had lasting impacts on the theories of demography and family planning execution beyond the development apparatus. While an encompassing theory of fertility does not yet exist, traditional demographic transition theory still dominates the field. Transition theory states that declining fertility is caused by the process of modernization itself. As with modernization theory (transition theory essentially is modernization theory), transition theory is born out of an evolutionary idea based largely on the experience of post industrialization countries in the global north. While diffusion theory has garnered more supporters in recent decades, there remains a prominent loyalty to modernisms tenants. As Greenhalgh (1995) explains, "even as they abandoned the main hypotheses of classical transformation theory, demographers seeking new approaches managed to retain many of the implicit assumptions that underlay it" (p. 10).

What I have found interesting when examining documents of USAID is that the relationship between demographic change and modernization is not as straightforward as this theoretical understanding would imply. In a presentation by USAID's Health Policy Initiative to Mali's Ministère de la Santé in 2009, modernity and demographics were explicitly related. However, the relationship was implied to be more reciprocal or complex than a strict linear correlation. Fertility decline is seen as a necessity for Mali to become modern. In a classic chicken or the egg situation, modernization is seen as the desirable product which may lower total fertility once achieved, but total fertility decline is necessary for modernization to progress. Fertility becomes something that cannot be allowed to slowly and passively decline as modernization evolves. It must be controlled. The object population must come to define themselves according to a modernized knowledge. They must be modern objects if modernization is to continue undeterred. While the ideas of modernization and evolutionary progression still exist, their relationships to fertility and population behavior are more complex than contributing theories of demography imply.

The evolutionary ideology of centralized family planning also facilitates an anti-revisionist spirit. As family planning is an exerted force, the intention of which is to transform the social body of a population, it is the agent of change rather than the object to be changed. With this basic understanding of innovation and population behavior, family planning initiatives are not assumed to be responsible for populations' needs. They are the provider of services and technologies. It is up to the population to mold themselves in order to use those services and as a consequence of using those services.

Economics of Family Planning

Like concepts of modernity, ideas created in the neo-liberal revolution had drastic impacts on the global development industry. Stemming from this history are a series of formations which create an economic knowledge of family planning and its duties.

In the 1970s there was a reflexive dialogue within academia and development organizations re-examining Keynesian approaches to economic success. Returning to classical economic theorists such as Adam Smith, the neo-liberal revolution, epitomized by the Reagan (USA) and Thatcher (UK) policies, inspired an era of development promoting the invisible hand of the market. By the 1980s this idea was well established in the development community. An era of controversial structural adjustment programs tied to the IMF and World Bank truly illustrated the "focus on stressing the relationship between economic growth rates and the degree of state intervention in prices. The implication was that the most rapid growth rates were found in those countries which were most outward-oriented and where states were least involved in 'distorting the market'" (Willis 2005 p. 48).

For family planning, the implications of this structural shift lay in the solidification of economics as the method to measure progress. As the environment becomes one of economy so too do populations become economic actors. I find Marxist and neo-Marxist criticism helpful in understanding this economic structuring. Of particular importance for critics of family planning and development today are Marx's (1994) observations of the capitalist system as a whole and how the lower class, "proletariat," were disadvantaged, positioned as consumers and producers. "According to Marxist theory, capitalism needs ever increasing opportunities to create profit in order to

survive. Colonies [and arguably independent nations in the global south] provided excellent possibilities for further profit generation, through the creation of new markets, new sources of raw materials, and cheap labour" (Willis 2005 p. 65). Through this understanding, development is a mechanism to increase the expanse of capitalism globally, not only to spread its influence but to prevent its demise. The critique is partially validated in light of devastating structural adjustment programs and World Bank and IMF lending demands.

Neo-Marxists argue that a Marxist understanding is too western-centric and focus on multi-national corporations and organizations. Theories posit that "capitalism was now in a period of 'monopoly capitalism.' Large companies dominated the world economy and were able to exploit poorer parts of the world" (Willis 2005 p. 65). Development criticism based upon such suppositions often questions not only the visible actions of development but also the latent agenda. "The bulk of 'development' discourse, with all its professions of concern for the rural poor and so on, is for these writers simply a misrepresentation of what the 'development' apparatus is 'really' up to. The World Bank may talk a lot about helping poor farmers, for instance, but in fact their funds continue to be targeted at the large highly capitalized farmers, at the expense of the poor" (Ferguson 1994 p. 18).

When modernity is identified as the ideal end, the healthy state of existence, those forces inhibiting the full realization of this norm are the disease. Herein lays a point of contention among family planning initiative documents. While USAID emphasizes the economic health of the population (USAID 2009a, 2009b, 2009c, 2009d, 2009e, 2009f), the Malian government most commonly emphasizes maternal and child health. The

rationale of the Malian government for implementing a family planning program was to be "'humane, oriented towards the health of the mother and child, the happiness of the couple, and the well-being of the entire society'" (Tounkara as cited in van de Walle and Maiga 1991). USAID does mention maternal and child mortality rates in most documents, however, they are often secondary to economic interests in the way population health is linked to healthcare costs and economic burdens.

The Malian government's rational for its family planning program connects the health of the individual and the health of the society. Public health is costly (as emphasized in USAID 2009b) and high fertility rates are seen as detrimental to the health of a developing modern economy. Aside from the cost of healthcare and sick individuals, women are outside of the formal economy and thus of detriment. While I believe that the family planning institution assigns primary importance to economic health I likewise admit that the health of the population is of concern for both the sake of health itself and the health of the economy.

Such criticisms question not only the broader global landscape of development and family planning but also question the focus of family planning, locating it not in the female experience of its subjects but in the grander global economic scheme. As modernity becomes defined by economic prosperity, family planning development initiatives come to understand their purpose as approaching that ideal economy. Thus, the overarching themes of family planning knowledge are the movement of modernization and the character of economics.

Toward a Modern Malian Woman

The ideal of family planning is transformation. Fertility that is currently high needs to be low. A backward mechanism for living needs to be modernized. That which is destitute needs to flourish. In order to achieve these ends family planning must transform the behavior of the target population. Discursively, this is achieved through the disciplinary process whereby the object is self-defined according to family planning knowledge. In order for this process to progress there must be an ideal norm (the goal), an identification of maladies preventing the population from achieving that norm, and a course of action designed to remedy the identified problem. By understanding how family planning knowledge constructs the normative model, we come to understand the second level knowledge at play in Mali's centralized family planning initiative. This knowledge informs the construction of the object (Malian women) and also assigns the object certain normative qualities of behavior and belief.

The ideal object of family planning is understood to have a certain character and relation to the greater knowledge of the institution itself. The Malian woman is also understood to be malleable. It is assumed that she will be readily disciplined and come to define herself according to ideas of the modern Malian woman espoused by family planning initiatives. To ascertain the qualities of the normative model I once again return to family planning as a development discourse and ask how it primarily understands itself. Decreasing fertility and improving health, while certainly aspects of the family planning initiative, are not ends in and of themselves. They are rather the tools contributing a greater goal.

In reviewing the basic tenants of family planning I identified two phenomena which have historically driven development: modernization and economics. The ideal object of family planning is the modern woman, however, while modernization may be the process and ultimate goal of family planning development, economics is the tool by which that process and end are measured. It is thus the degree to which the Malian object internalizes modern economic traits that determines the quality and degree of her modernity.

Working from within modernization theory, family planning sees the Malian woman as backward. There is a need for progress that is explicit in nearly all USAID documents. High fertility is placed in direct opposition to the Millennium Development Goals, the rationale being economic strain (USAID 2009a, 2009e, Embassy of the United States 2009). It is scarcely possible to find a document that does not discuss a larger state-oriented economic wellbeing. In a presentation given by USAID to the Malian Ministère de la Santé, the theme behind bolstering family planning programs was to make "Mali a prosperous, serviceable, and modern nation" (USAID 2009d). However, it is not economics for the sake of economics that is being promoted. It is a specific type of economics that is emphasized. This economic structure must fit within the global capitalist mechanism and be defined by formal market participation.

Accordingly, family planning discourse formulates the Malian woman as merely waiting to fulfill her capitalist responsibilities and further modernization. Family planning programs, though exacted through government regulation and services, use the often explicit rationale (see the citation from USAID on pages 39 and 40) that family planning will help free women of forces preventing them from labor in the formal sector.

This emphasis on formal wage employment is very important. The discourse of family planning does not accommodate informal market participation. Family planning programs are intended to allow Malian women to become productive producers and consumers in the modern economic world. Women are, in this sense, simply latent commodities, who must be freed from biological, social, and cultural confines in order to participate in the economic sphere and help urge the state into modernity.

USAID documents overtly emphasize two economic benefits of decreased fertility (USAID 2009a, 2009b, 2009c, 2009d, 2009e, 2009f). It is not only the cost of implementing the programs which is addressed; it is also the cost of doing nothing about existing total fertility rates. The latter is a concern of public health. Family planning initiatives, while functioning in a developmental capacity, are also public health organizations. As such, they rely on several understandings of health and disease to inform program and policy choices. While overarching health belief models are useful when understanding the initiative construction process (see Glanz et al, 1990 for a good review), economics largely drive the construction of programs.

As Malian women are relieved of their motherly burdens and enter the formal market, their production potential increases state capital reserves. This is reciprocal to the cost of allowing fertility rates to continue their incline (USAID 2009b, 2009e). By decreasing fertility and increasing women's formal economic productivity, there is also made explicit a decrease in healthcare costs as the number of state dependents drops. Often, family planning is justified with a cost analysis. The total cost of family planning services (assumed successful in their endeavors) is contrasted with projected healthcare expenditures (USAID 2009b, 2009d, 2009e). Through this lens family planning would be

seen as a social control over the number of children a woman has, thereby lowering the state's number of dependents and freeing the woman's time for practices contributing to the capitalist market. Social mechanisms are manipulated in order to make individuals internalize state and market interests. Family planning's imposition of discursive formations is the vehicle for the transfer of these market interests in the discipline of Malian women.

Fertility, the Self, and Science

In order for Malian women to become *modern capitalist subjects,* there must be a transformation. The Malian woman must come to understand herself through family planning knowledge. One of the ways this is achieved is through the implementation of an entirely new discourse by which to understand fertility and the self. With the introduction of a scientific lexicon, family planning discourse creates a divide between the social and the biological halves of Malian women. They are divided into two realms of discourse in order to focus attentions on the reproductive. This isolation of the body from the social fabric of reality is accentuated by a distinct discourse through which to understand it and which gives rise to mechanisms of control. This discourse, Science, is individualizing, converting reproduction into personal control. Removed from social life, reproduction becomes the choice of one (or two) people; this is easier to control through the discourse of Science than an entire social milieu.

Bruno Latour (2004), in his book "The Politics of Nature," makes a distinction between the sciences (social sciences) and Science. Science, claims Latour, is "the politicization of the sciences through epistemology in order to render ordinary political

life impotent through the threat of an incontestable nature" (p. 10). What I find helpful about Latour's work, though it focuses on environmental ethics, is his emphasis on the ideological elevation of Science in western cultures. Science has become an all-knowing deity. In its omniscience, Science defines truth and its tools become the means to validate experienced phenomena.

With family planning initiatives, the science-based knowledge is transposed onto the social existence of the target population. Foucault (1972), on speaking of the interplay between science, knowledge, and ideology, states that "the question of ideology that is asked of science is not the question of situations or practices that it reflects more or less consciously; nor is it the question of the possible use or misuse to which it could be put; it is the question of its existence as a discursive practice and of its functioning among other practices" (p. 185). We should thus understand Science not as an all powerful truth-saying force, but rather as it functions within the body of family planning knowledge. Science is "localized in [knowledge], structures certain of its objects, systematizes certain of its enunciations, formalizes certain of its concepts and strategies" (ibid. p. 185). Science becomes the language through which legitimate reproductive experiences are understood.

It is through this lens that the social existence of the population must be filtered in order to be understood. This is true of the family planning structure itself, which understands fertility through the scientific vernacular. It is also desired of the Malian woman. For, as she comes to understand her fertility through Science's "objective" lens, the social ties to fertility are theoretically severed.

As primary evidence for this process I take the overwhelming reliance of family planning programs on quantitative data. In and of itself, quantitative data reveals trends. Family planning programs rely on all manners of quantifiable statistics to understand a population. It allows generalizations to be made. It rationalizes social experience into a "universal" language of Science. Census data is used in Malian government publications (Institut National de la Statistique 2009), USAID projects and proposals (USAID 2009b), and academic research (Gage 2007). In addition, fertility and examples of the consequences of unregulated fertility are expressed through quantifiable variables. This data is important for understanding grander trends and I by no means wish to discredit the usefulness of this type of research. However, the tendency to hold quantitative data as the means of validation excludes important phenomena and can obscure social reality. This is most often the case when there is an attempt to quantify qualitative experience. USAID's RAPID Model is one such example of a deployed mechanism which quantifies social reality (USAID 2009e). It is a computer model which manipulates a series of data to provide possible outcomes based on political, economic, and social factors. This quantifiable preference is not unique to development initiatives; it is also employed (often usefully) by researchers to understand larger trends in the family planning space. For example, researchers attempting to understand and rate family planning program effort begin by assigning quantitative values to a series of observations (Entwisle 1989).

Numbers and Science are being placed above the social reality of a population which is, admittedly, much more difficult to understand than a computer-generated number. There arises a question in such circumstances of how to ensure that figures are

truly representative of the lived realities of the target population and not the assumed realities.

This language of science serves another purpose in addition to separating social and biological realities. It also is the language of the tool which is intended to control fertility. Family planning initiatives operate under the assumption that Malian women will define themselves as modern women. With a reliance on science, fertility is controlled through *modern* contraception. USAID supplies the majority of these products, primarily condoms and oral contraceptive pills (Brand 2001). As a major promoter of these products, they are often sold far below the standard market price of competitors (ibid.). Scientific methods are the legitimate mechanisms to control fertility whereas previously utilized methods (some of which were useful and some of which were not) become incorrect. Modern Malian women are supposed to value scientific discourse and understand its insights as truth.

Case Study: Project Keneya Ciwara

In this section I would like to provide a brief illustration of how the knowledge of family planning development is employed in Mali. We can see that explicit and implicit ideas of modernity and global economics shape outreach projects throughout the state. I will take as my case study USAID's Keneya Ciwara, specifically the program's outreach services in the commune of Kendie.

Kendie commune is located in the heart of Dogon country. Just south of the Niger River, the commune is comprised of roughly 20,000 people in 30 villages. There is one community health center run by one nurse and two midwives. There are no doctors in the

commune. The closest center for serious medical problems is in Bandiagara, a 45 kilometer trek for most people. (CARE 2009)

USAID's High Impact Health Services (HIHS) program is designed to decrease maternal and child mortality. Deployed throughout Mali, HIHS focuses on 6 technical areas in order to improve the health of the target population. Family planning/reproductive health is only one of these foci. USAID partners with CARE, Group Pivot Santé Population, IntraHealth, and the Center for Communication Programs of the John Hopkins University, as well as local Malian NGO's to bring services and education to the population. Project Keneya Ciwara II, currently on its second phase of implementation, is tasked with increasing availability and demand of health services by enhancing community outreach. Though only one of USAID's family planning outreach projects, Keneya Ciwara is among the largest. Currently operating in 13 districts and the capital city of Bamako, Keneya Ciwara reaches 30% of the total population (CARE 2009, USAID 2009b).

Project Keneya Ciwara directs education and service dissemination through community outreach workers. With roughly 4000 outreach workers in Mali, there are currently 18 operating in Kendie. Supervised by the local NGO AMPRODE/SAHEL, each outreach worker is responsible for networking with an estimated 35 households. Keneya Ciwara primarily functions in a door-to-door sales/education capacity. Outreach workers buy contraceptive supplies (at very low cost) which they sell to their neighbors for a small profit. The profit is intended to be reinvested in a *Ka Jigiya Ton* (women's microfinance/credit group, literally "Women's Savings Club"), the proceeds from which will be used to buy more family planning supplies for further resale. (CARE 2009)

Each community worker receives only 7 days of health education training before disseminating family planning information and products. The implicit idea behind community outreach is diffusion. As members of the community become outreach workers, they spread family planning knowledge to their neighbors through education seminars and through community affiliations. Theoretically, family planning values will spread throughout the community more quickly if facilitated by several local liaisons than by health professionals alone. This idea is accentuated in areas, like Kendie, where healthcare workers are scarce.

Family planning is intentionally spread through concepts of economic transformation to achieve a more modern, healthy community. Keneya Ciwara relies primarily on women's community and professional networks to spread family planning information and goods. Women's formal employment settings, like schools, hair salons, and manufacturing facilities (karite butter) are key targets for family planning messaging. Microfinance networks and services are integrated into all aspects of the program. This is an explicit link between women's decreased domestic responsibilities with increased economic activities.

However, in order to achieve this economic transition, Keneya Ciwara must change local ideas about the relationship between children and economics. In the rural Dogon country, where the harsh terrain dictates all aspects of life, there are two primary methods of subsistence: millet farming and migration to other places for work. As with other agricultural societies beset by high infant/child mortality rates, the Dogon emphasize large families. One the one hand, large families provide workers for family crops. Children can also send remittances home when working in neighboring cities and

countries. On the other hand, because death rates are so high, families must have many children in order to have enough workers. Though this reality is acknowledged by Keneya Ciwara, it is not necessarily addressed. It is assumed that local rationales for large families will be readily overwritten in light of family planning's *logical*, science-based message.

Moussa Tembiné, the husband of a Keneya Ciwara outreach worker in Kendie, explains the primary challenge to spreading family planning knowledge in the region.

> Men, as yet, don't understand family planning…It is not going to make their women promiscuous. Rather, it will stop them getting old before their time. A woman who uses family planning can work better and contribute more to the family. This, in turn, helps men, but men don't understand this yet. (CARE 2009)

Within Moussa's observation is the key economic rationale for family planning deployed by Keneya Ciwara: women can be economic producers. The cultural reality that children are economic contributors is not necessarily challenged. Instead, the woman is replacing the contribution of children in an economic capacity. The health of women is also emphasized, though it is secondary throughout Keneya Ciwara documents. Women are encouraged to become more immersed in economic activities. Outreach workers sell family planning products and network with microfinance groups.

The success of Keneya Ciwara is questionable. As discussed, the project is overtly imbedded in western concepts of modernity, progress and prosperity. Formal, regulated economic participation is the goal of the project and also the means by which fertility is to be curbed. Currently on its second phase, Keneya Ciwara was successful in that it received increased funding and the project was renewed in 2008 (CARE 2009). USAID currently funds $16.5 million of the project (USAID 2009b). CARE (2009) reports that

knowledge of modern contraceptive methods increased from 76% in 2004 to 85% in 2008. Contraceptive use rates for women vary. Of those women involved in microfinance groups, 13.5% reported using modern contraceptive methods (ibid.). This is juxtaposed with a use rate of 6% (aligned with the national average) of women not involved in microfinance groups (ibid.). Interestingly, CARE does not report the contraceptive use rates for these groups before Keneya Ciwara projects were initially implemented in 2004.

CH. 6 DUELING DISCOURSES: FOREIGN AND LOCAL KNOWLEDGES

Having examined both local realities of Malian women's reproductive experience and the prevailing tenants of family planning discourse let us now turn to the West African context where that discourse is employed. I would like to once again highlight some of the most contentious aspects of family planning knowledge employed in Mali. This comparison is one way to broadly examine the fitness of an initiative on a large ideological scale. Rather than examine specific instances of program and population incompatibility, a task which I leave for later work, I would like to discuss general contentions to the knowledge of family planning and attempted formation of the ideal woman. This comparison, admittedly high-level, is intended to be an example of how imposed family planning discourse is incongruent with local realities and thus offer an explanation for its continuing lackluster progress.

Development, Evolution, and Economics

I will refrain from too lengthy a discussion on the dangers of modernization theory and its assumptions embodied in development discourse. Such western-centric views are well understood and explained (Ferguson 2006, Appadurai, 1996, Gilman, 2003). However, I would like to revisit the relationships between economy, fertility, and modernity. Family planning development assumes that there is an inverse relationship between fertility and modernity. This is measured primarily by the economy. These relationships harbor several assumptions that are contrary to the Malian context. The link between fertility and economics assumes that fewer children will decrease the economic strain on the state and free women's time for more market-oriented activities. This

perspective assumes three things: 1) that women who have many children do not already participate in the market; 2) that women want to or can participate in the formal market; and 3) that children are economic encumbrances.

As explained by Mikell (1997), the economic contributions of African women have historically been balanced with the number of children born. The temporal division of the sexes into a public (male) and private (female) sphere is inadequate to understand how gender, status, and economy interrelate. "The economic contributions of women are traceable beyond the household…With the growing scale of society and increased production of different economic items, many African women have had opportunities to benefit themselves and their corporate groups by playing major roles in the exchange network, particularly in the agriculturally dynamic areas of West Africa" (ibid. p. 10). Women have consistently participated in commerce, if not by choice then by necessity. Holloway (2007) describes the economic duties of mothers to their families, which requires market participation and/or agricultural work in "women's fields." In Bamako, Brand (2001) notes that during her extended study "the notion of 'working women' did not prove very useful…It turned out that there was scarcely a woman to be found who did not have some kind of income of her own…The majority of women's work is characterized by an extreme flexibility and diversification of income sources, to cope with various sorts of economic and financial insecurity" (p. 4).

Many arguments for women's incorporation into the formal economy are voiced from western feminist backgrounds (Center for Reproductive Rights 2003). In general, creating a direct correlation between fertility and economics should be approached warily. Critics from the Marxist feminist camp argue that women are relegated to a

domestic sphere because of capitalist production. Fernandez Kelly (1989) claims that "gender [is] a contradictory process that allows for the maintenance of a substratum of labor, predominantly female, outside market exchanges" (p. 613). Women are workers but function more as behind-the-scenes workers, supporting husbands and bearing children. The children could be thought of as the chains of patriarchy, tying women to the home. This reality, such researchers claim, is executed through patriarchal dominance (ibid.). It also bolsters patriarchy, giving men further control over women's access to markets. However, these claims emphasize that it is not men who necessitate this relationship, it is capitalism itself. These ideas are very often promulgated in literature emphasizing women's rights, independence, and autonomy. Western feminism is very closely associated with such rhetoric.

This idea of patriarchal dominance often extends into arguments of reproductive health and power dynamics. Many feminist scholars, such as Blanc (2001), build upon Marxist arguments of patriarchal control of production and extend theories to include control over sexual reproduction. Blanc claims that gendered power in sexual relationships impacts reproductive health because men control both the physical and financial lives of women. Such studies assume that male control, usually bolstered by capitalism, is consistent. They also tend to attribute male-female social relationships the greatest weight of all social relationships in reproductive decision-making. More recently African feminists have contributed meaningfully to the dialogue on African women's "subordination," refuting many of the assumptions harbored by their western counterparts. Sudarkasa (2005) argues against Marxist feminist ideas that modes of production and confinement to a theoretical domestic sphere are the defining attributes of

women's subordination. Instead, she and others (Mikell 1997, Nnaemeka 2005) highlight a "natural complementarity" between the genders. She argues that male-female relationships are plural and context specific, as opposed to being characterized by one larger sex-based status. However, the idea of multiple statuses is also potentially problematic because it may gloss over greater trends of subordinate-dominant relationships.

This idea is reflected in the work of Brand (2001) who challenges the male-female dichotomy in which many western feminists operate. She contends that other social actors influence intersex relationships. She argues that male-female dichotomies simplify women's interactions in the social world, essentialize male-female relationships, and ignore power differences beyond gender. I find this distinction helpful as issues of power, economy, and fertility are explored. It is clear that Malian women have historically, and continue to be, very involved in their own economic wellbeing; however, the character of that participation is ambiguous. Attempts to correlate women's formal market participation with the number of dependents remain dangerous.

The cost/worth of children is one of the more prominent contentions between family planning knowledge and local knowledge. To further explain this, I turn to Dettwyler (1994) who sums up this conflict with a simple analogy.

> If you are the only one with money, and can only afford a small pizza, but you have lots of friends, then each person gets only a little piece. The more friends, the less each one gets. However, if your friends contribute money to the pizza fund, then you can afford to buy a bigger pizza, especially if some of those friends contribute more than the value of the pizza they eat…It is a common misperception in the West that overpopulation accounts for most of the poverty and malnutrition in Third World countries. This notion, that simply limiting population growth through birth control methods, would alleviate poverty and malnutrition, comes from two assumptions abased on Western economic systems that

> simply don't apply to much of rural Africa. First, in the West, wealth tends to flow *down* the generations: parents sow and children reap…In West Africa, however,…wealth flows *up* the generations. Adults *and* children are breadwinners, and children become net income producers at a very young age. (ibid. p. 77)

Children's economic contributions are in wage work and agricultural labor (Mikell, 1997). They also are a source of social capital by maintaining communal ties and relationship networks by trading skills, labor, or spouses. Brand (2001) observes that the price/worth of children can be summed by four functions: as vessels of immortality by passing on heritage; as retirement insurance as they take care of elderly parents; as defining traits of womanhood; and as embodiments of emotional or intrinsic value (p. 233). In addition, children can function as bartering mechanisms and status symbols. This is particularly important for women in polygamous unions competing for status and favors (Brand 2001).

This fundamental contradiction in the worth of children presents a formidable challenge to family planning initiatives. Within it is a challenge to what makes Malian women, women. The pro-natalist sentiments of the Malian community go beyond access to modern contraceptive techniques and are ingrained in the social and economic fabric of daily life. Unless this reality can be understood and reflected by family planning programs, and unless they are structured in a way to provide necessary healthcare access without attempting to dismantle the ways in which women think about themselves, their families, and their realities, then the struggles and lackluster progress of family planning programs are likely to continue.

Knowledge and Power

Family planning initiatives operate within the discourse of Science. With that new knowledge, a new lexicon is introduced and new methods/objects of validation are assigned. With this knowledge, family planning programs also reinforce new constructs of power. This power is regulated by gatekeepers of knowledge. These individuals are those who are sanctioned by an existing knowledge structure or an imposed knowledge structure to pass judgment on and treat Malian women. In this section I would like to highlight the asymmetry between family planning power/knowledge structures and those that are preexisting. It is this new validation mechanism, vocabulary, and power structure that are the immediate hurdles with which the target population must contend in order to utilize the provided services.

The discourse of Science in family planning medicalizes social behavior and women. The medicalization of femininity challenges prevailing knowledge of what constitutes Malian womanhood. Science becomes the logic by which women are partially described. It is this scientific understanding of the self which family planning hopes to impress upon Malian women through the disciplinary process. For family planning, the hallmarks of femininity and the social construction thereof, are secondary to a biological and economic determinism.

When thinking about African communities *outside* the direct course of Science, there is a danger of romanticizing their *natural* knowledge. I wish to avoid this misconception. Malian women are not necessarily natural beings (or not any more natural than their western counterparts); instead, they are beholden to a different system of health belief models. As detailed by Madhavan and Diarr (2001), menstrual irregularities (a

perceived disease of fertility) are associated with witchcraft and linked directly with healthy childbearing. Pregnant women may refrain from walking about at night for fear of being possessed or cursed by jealous spirits or competing women (Dettwyler 1994, Brand 2001). Pregnancy is often hidden from those around in order to protect the woman and child from supernatural powers (Brand 2001). These mystical rationales assign a concrete culprit to maladies and also prescribe actions, if any, that women can take to remedy the situation. Thus, the conceptualization of healthcare and disease is not fatalistic but actively engages the subject and the community, assigning an agency and power. Ultimately, however, that agency is only assigned to a degree before it becomes the "will of Allah." Though the cause of disease is tangible, the actual loss itself is due to god.

Science itself contradicts these basic ideas and practices of health and disease. While it does not challenge mysticism wholly, it does attribute abstract notions to health. The biological assignment of fault removes the power of agency from the subject and also removes the contextual understanding of why the malady occurred in the first place. There is no longer any concrete rationale for health or actions related to treatment.

With the conscription of the professional is created a power dynamic. Since the professional has the authority to define the object and possess certain knowledge, they are privileged in the institution. As ideas of truth and validation are constructed in the family planning program, so too are notions of power and knowledge. Who owns that knowledge and how it is organized become structured according the development initiative.

Specific members of the community have historically held positions of power based on knowledge; they are the gatekeepers of knowledge in a sense in that they preserve knowledge and skills but also have the power to distribute that knowledge as they see fit. This same structure exists with circumcision rights, wherein specific older women of the community have the knowledge of the ceremony and symbolism and the license to carry it out (Holloway 2007, Boddy 1989). As Brand (2001) relates, "knowledge is used to mark the social structure in society" (p. 172-3). She observed the repercussions of proprietary knowledge in family planning clinics in Bamako; rather than disclosing all reproductive information to patients, Brand observed that healthcare workers would retain that knowledge and simply direct patients to follow directions (ibid.). Among the Fulani and Humbebe of rural Mali, Castle (1994) explains that the "diagnoses of foondu and heendu[15]…sustain hierarchical pathways of information transmission [within] the community, reinforce the mysticism and autonomy of traditional healers, and restrict any questioning of their competence or of the efficacy of their cures…[they] also reinforce power relations both between the group members and between healers and their clientele" (p. 331).

Family planning structures do not recognize the local knowledge gatekeeper. The post is instead assigned to a medical professional. This professional is often removed from the community and operates by a distinct set of knowledges. Women in the target population are thus surrounded by a discourse which must be navigated in order to utilize any desired services. However, those discourses are contrary to existing structures and are likely not to be readily interpreted.

[15] Foondu (bird) and heendu (wind) are local diagnoses for child illness and death. For further information see the section "Making Malian Women."

Repercussions of Incompatibility

Family planning discourse attempts to transform and discipline Malian women. What happens when this transformation is met with resistance? As discussed, the knowledge employed by family planning does not coincide with the way Malian women see the world. It is thus not difficult to see why initiatives are not achieving their intended results. However, the consequences of this incompatibility are not well understood. What are the consequences of this clash of discourses? This discussion is intended to only highlight potential avenues of future research which will be needed to study the actual effects of imposed discourse.

At the institutional level we can see that family planning is failing. As a consequence of imposed foreign structures Malian women are not seeking or receiving services that they want or that are appropriate for their health. They either cannot navigate the imposed structures or do not wish to do so as the ideology promoted is drastically divergent from theirs. The institutional consequences are ineffective initiatives. Maternal and infant/child mortality rates are relatively constant. Fertility is still on an "unregulated" path as the population continues to grow. Economically, these institutional failures are fiscally wasteful, contradicting the proposed benefits of family planning's cost effectiveness. The capital spent on initiating these programs and garnering political support is substantial and thus the fallout particularly detrimental as objective outcomes continue to be elusive.

At the community level, a side effect of this incompatibility is the incomplete adoption of technology, knowledge, and services by the target population. While I find

this avenue of research the most interesting it is also the least studied. I cite Bledsoe (2002) in this regard who states that "although increasing proportions of the world's women are turning to these contraceptives, little anthropological attention has been devoted to how people may be configuring them to their reproductive and social lives" (p. 5). She addresses this issue in her book "Contingent Lives: Fertility, Time, and Aging in West Africa" where she explores disparate views of fertility and they ways in which services and knowledge are restructured according to local understandings. One such restructuring I find relevant and interesting is that women in The Gambia have adopted long term contraceptive techniques (depo provera) in order to preserve fertility, not diminish it. This observation resonates with this study's findings that imposed ideologies are ignorant (or at least careless) or local structures.

In her detailed study of the diagnosis of heendu and foondu among the Fulani and Humbebe, Castle (1994) describes the way allopathic medicine has been absorbed into existing rationales for childhood illness and disease. Rather than overriding local justifications for child death with scientific *fact*, the communities in Castle's study revised their justifications to account for western medicine's existence.

> Once a diagnosis of foondu has been made, local opinion indicates that there is little hope for the child, and general consensus is that modern medicines are powerless against the illness. Thus, going to the hospital or doctor with a child who has diarrhea and a fever but who has been diagnosed as having foondu is considered ineffectual and inappropriate. By contrast, a child who has a simple diarrhea and fever (without clenched fists) rather than one related to foondu can, according to popular belief, respond to biomedical therapies. (ibid. p. 320)

What are the effects of incomplete knowledge adoption? What happens when resources are made available but ideologies and knowledge of those resources are not incorporated into the society? How does the discourse of the target population

incorporate the imposed discourse? These are interesting questions that could potentially inform future development initiatives. Though clearly beyond the scope of my current analysis they will hopefully be addressed in today's growing body of literature.

While it is evident that Mali's centralized family planning initiative is failing to procure its stated outcomes, it remains to be seen why the family planning system itself flourishes, continuing to receive increased budgets (Brand 2001, Embassy of the United States 2009). If intended outcomes are elusive, what are the actual effects of family planning development in Mali? Ginsburg and Rapp (1991), in their article "The Politics of Reproduction," relate the transformations within the anthropological world that have led to an increase in studies linking reproduction to control. It is not the control of the individual here that is in question, but the control over an economic and political potential. As Ferguson (1994) explains, the expansion of political influence is a side effect of development. This is certainly an affect of family planning which lends validity to biopolitical interpretations of the programs and agencies that support them. The state-oriented rhetoric that accompanies this spread of political power continues to assign a new identity to Malian women, seeking to revise identifiers, changing definitions of tribe and kin to that of Malian citizens. In addition, there is a global component to this consolidation process. The forces of globalization and westernization are employed through family planning initiatives and likely spread the effects of these phenomena. We thus have not only a state-orientation but a grander geo-political and economic identification of the Malian self.

CH. 7 CONCLUSIONS

In truth, this analysis was born out of a perceived insufficiency of current analyses of Malian family planning to fully explain not only seeming failures of centralized projects, but to also fully relate the centralized structure with those effects. Much of the research, while providing imperative insight into the population's reaction to family planning innovations, tends to lack the reflexivity and re-evaluative qualities to truly question the premises of family planning in Mali and understand the inherent tendencies, contradictions, and simplifications which impact "successful" initiative construction. In studying the existing body of knowledge I failed to locate high level analyses of why family planning in Mali is failing beyond specific implementation projects. Moreover, a general explanation of how centralized family planning is affecting the local population, how its structures are being imposed, reformulated, and navigated is elusive.

My analysis of initiative fitness (comparisons of knowledge) is not intended to replace existing, continuing, and future studies of family planning program evaluation and outcome. They are imperative to developing a complete understanding of family planning initiatives. However, analyses such as this are intended to supplement those studies and offer a qualitative assessment of initiative structures and population impact, providing a broad reminder of the discursive formations to which we are all bound. I have sought to explore family planning initiatives in three ways: by understanding how the family planning initiative functions discursively, by understanding how those discursive formations are incompatible with local realities, and by briefly exploring some of the possible consequences of uncooperative discourses.

The research exposes concerns about the nature of family planning initiatives as they are currently conceptualized by a centralized state and globalizing powers. As this analysis places family planning within the development apparatus, it assigns a depth to initiatives beyond the local actors to include states and international agencies. Malian family planning becomes three-dimensional as its program attributes are extended to overarching discourses on the nature and purpose of development. This also locates Malian family planning within a history that is both foreign, of western heritage and engineering, but also local. Malian leaders are complicit in the existing structure, blurring what is forced and what is reinforced. Examining the discursive structures which formulate knowledges and objects illustrates just how immediate the effects of far-off spaces and times are. This study aims to capture some of the dynamism of the family planning environment, illustrating the constant shifts in landscape, attitudes, and behavior.

What does this discussion of opposing discursive structures mean outside of the theoretical? How do discursive formations help explain the nature of family planning initiatives and the manners in which they impact the target population? This analysis is intended to generate more questions about family planning rather than arrive at definitive conclusions. In examining the discursive formations of an imposed initiative, it is my hope that the importance of contextual relativity be revisited in light of family planning's globalizing forces. Though this analysis focused on the larger discursive structures at work, the applicability of initiative fitness studies in future research truly lays at the local level. An institutional ethnography of a localized family planning program and

supplementary ethnographic analysis of the immediate population can reveal important information about how family planning knowledge is impacting the local population.

I have argued that family planning is failing because foreign knowledge clashes with existing knowledge. This is preventing the Malian woman from completely understanding herself and her environment according to family planning views. In light of this analysis I am skeptical if large centralized family planning initiatives can be structured in such a way as to mitigate their tendencies to simplify and erase local knowledge as means to enact change. Does family planning, as it is currently conceived, make sense in the West African context? Would the ultimate aims of family planning (decreased fertility, economic development, and fewer maternal and infant deaths) be better served by improvements to other arenas of daily life? Carefully, I would like to say that appropriate family planning structures are possible, however, significant alterations to initiative ideology would be necessary and a local rather than global interest would need to be cultivated.

Ultimately, the ramifications of this study are highly concentrated in the revisionist spirit. It is with a more complete understanding of both women's realities and the realities of the family planning industry that more specific indications of family planning initiatives' failing aspects may be identified, revised, and improved. It is with the goal of improving women's access to healthcare (whether by the name of family planning or something else) that this analysis is being undertaken. As this study has hopefully relayed, these initiative changes can be truly useful if a revisionist approach is taken to family planning initiative construction and the program and population are viewed as coexisting in a reciprocal relationship.

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