TRADITIONAL HEALTH CARE IN THE NEAR EAST

by

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TABLE OF CONTENTS

P R E F A C E

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SUMMARY AND CONCLUSIONS

Nowhere do people live in a health care vacuum. In all cultures people become ill; in no cultures do others stand idly by. Each culture has produced over the centuries its own adaptive methodologies for coping with illness. These embody an indigenous etiology, that is, a system explaining the occurence of illness and disease based on the worldview and religious beliefs of the particular people in question. It is the underlying explanatory system, in interaction with features of the ecological niche of the population, that dictates local strategies for coping with ill-health. These are strategies that international medicine has all too long ignored.

A. OVERVIEW AND RATIONALE

Despite all the advances of modern science and massive efforts on the parts of governments and international organizations, one of the most grave of the present inequities of our world today remain the poor health of the underprivileged poor majorities in the developing countries. In many of these countries some 80 percent of the rural and urban poor population lack access to what Westerners recognize as basic health services. In the Near East, Afghanistan and Yemen are unfortunate cases in point.

This situation is compounded by the low nutritional status, debilitating frequent pregnancies, and the general environment of poverty in which the poor subsist. For the great majority life is beset by problems caused by extremely limited resources, low labor productivity, insufficient food intake, poor housing and hygiene, inadequate means of transport and communication beyond the local community, and educational and training systems inappropriate to the needs of the general population.[1]

It is now increasingly apparent that the strategies initially adopted by officials in many Near East and other developing countries for serving their populations' health needs have all too often ignored the important element of indigenous perceptions--except for the perceptions of the Westernizing elite. Most health planners have

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[1] See Djukanovic and Mach 1975:7.

sought to imitate rather than innovate and have established centrally-organized health care systems modeled after those of the industrialized Western countries. The general pattern has thus been to create relatively sophisticated health services staffed by highly qualified personnel with the expectation that services could and would be progressively expanded as resources increased until the entire population was covered.

The anticipated outcome, however, has not been achieved. This overall strategy, as a recent World Health Organization (WHO)-UNICEF policy statement emphasizes, has been a failure as far as most of the rural populations are concerned. Services have become concentrated primarily in cities and towns, are predominantly curative, and are easily accessible mainly to a small and privileged segment of the population.[1]

Recent experience unfortunately also shows that conventional health services organized along Western lines are unlikely to expand to meet the basic needs in the developing countries. In any case, it is hardly probable this will come to pass in the now foreseeable future.

The health manpower problem that is in large part responsible for this dilemma has been addressed in several ways. Most of the Near East and other developing countries have first imported foreign physicians and then established Western-type medical schools in which to train their own physicians. However, because of the health planners' specialized concern with medicine in the narrow sense and their eagerness to replicate Western medical education and delivery systems, they have tended to overlook important cultural factors.

One critical and usually overlooked fact is that Western medical schools not only train students in the art of medicine but also socialize them with consciously and unconsciously held elitist attitudes that do not place high value on provision of health care to the underprivileged. This leaves most medical graduates understandably disinterested in "serving the people"—especially when it entails living with them in the unsophiticated countryside.

Medical students in most developing countries have been educated as if they would be caring for patients in Paris, London, or Baltimore. This helps explain why a developing country, such as Egypt, may now claim to "have enough doctors" yet in fact have no doctors, or all too few doctors, in much of its rural countryside. In the Near East, like most other developing countries, the inequitable distribution in the health sector of human as well as capital resources is striking.

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[1] Djukanovic and Mach 1975:7.

In many countries the distribution of Western-type professionals is almost inversely proportional to the distribution of the population.

Clearly most developing countries' educational systems have been producing professionals neither in accord with the country's needs nor with the expectations of the professionals themselves. In this sense physicians sent to and resenting the countryside are not wholly to blame.

Paradoxically, even in rural areas where centurally-planned health facilities do exist there is widespread underutilization, as in the case of Tunisia. This is often due to such factors as passive and supercilious attitudes on the part of the health workers who are from and would rather be in the city anyway, to their insufficient awareness of the need for community understanding and involvement, and to their trained disregard for the traditional healing systems and the general constraints imposed on community members by their living situations.

In some cases the local rural health facility is even bypassed by persons who, while wanting "modern" care, lack confidence in the local facility's personnel and can garner means to go instead to more distant urban facilities. This in turn often contributes--as in Cairo--to an excessive burden on urban facilities due to inappropriate use of hospital emergency rooms for non-acute conditions and of services that should be providing secondary rather than primary care.

At the same time, within the local communities themselves important health resources lay untapped, ignored, or even outlawed--as in Tunisia. These include progressive, service-minded villagers who could profitably be trained as primary health workers, as Afghanistan is now attempting. Where such village health workers have been trained they rarely have the problems of urban-deployed physicians since they are generally members of the community to begin with and well-accustomed to functioning within the local culture and situational constraints.

The important community resources also include indigenous health practitioners--traditional midwives, herbalists, spiritualists, and other healers and health advisers, both full- and part-time. Such persons have a heritage of community acceptance and continue to play an important part in providing health care, especially in the rural areas but also in cities. This is true throughout the Near East.[1]

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[1] Beyond the question of manpower per se, the fact remains that in no country does the international science-based medical system completely satisfy all health needs of the population. Even in countries with highly sophisticated medical technology many people often turn to alternative non-establishment health providers and advisors to fill psychological, social, and also organic needs that remain unsatisfied by physicians and the associated orthodox care services. (See Foster 1975).

It is lamentable that relatively little is understood by or readily available to central health planners about indigenous healing systems. Many Westerners assume that health officials in the less developed countries know and understand all about their countries' indigenous healing systems. In fact this is often not so. In many cases prejudice on the part of health planners against traditional agrarian-based aspects of their own cultures has precluded understanding of traditional therapies.

The failure of new systems of health technology to meet basic needs in the developing countries can thus in large part be directly attributed to inadequate knowledge of social and cultural practices of the low-income majorities. A major conclusion of this study is that health care for the rural and urban poor cannot be satisfactorily provided without a basic understanding of the traditional and other local practices of the intended beneficiaries and of the value and belief systems that underpin health-related behavior.

A related conclusion is that opportunities should be sought to incorporate or accommodate the more efficacious indigenous practices and practitioners in country health programming instead of categorically dismissing out of hand everything traditional as an obstacle to improved health.

B. OBJECTIVES OF THIS STUDY

The Agency for International Development (AID) is expanding its health and nutrition programming in the Near East. Yet when the present study was initiated very little information about health beliefs and practices indigenous to the Near East was readily available to AID planners. Information was believed to exist but in scattered sources, many unpublished. It was decided that these sources should be collected and examined to obtain an overview of traditional Near East healing systems before proceeding with any actual field investigation of the subject.

Objectives of the study were thus defined to be:

1) Compilation of a descriptive inventory of Near East indigenous health systems and their underlying motivational structures on the basis of data presently available through United States, European, and Near East sources.

2) Identification of critical gaps in existing knowledge.

3) Provision of a foundation for possible future systematic collection of needed data in each of the seven Near East countries designated to receive AID assistance.

The study's overall objective has been to provide assistance to the Near East Bureau for the design of projects that are compatible with indigenous values and health practices and therefore more likely to be successful in meeting basic needs of the rural and urban poor.

C. METHODOLOGY AND SCOPE OF WORK

Information was gathered through library search, collection of unpublished reports and monographs, and consultation with personnel of United States and European universities with Middle East studies centers, of other United States agencies, and of foreign bilateral and international agencies.

The level of effort desired and funded by AID for the study was four months. It was decided that findings would be most useful for country health programming if presented on a country-specific basis. The findings were intended to constitute a preliminary overview and suggest recommendations for future research. The study was not expected to present either a definitive description or analysis of Near East traditional health systems and should not be taken as such. Nor did the plan of work require that explicit recommendations be made for AID programs and project design.

The study was nevertheless undertaken by its author with the conviction that it would be useful only if conducted and presented in the context of AID policy needs and bureaucratic constraints and with attention to the health care environments in each of the seven Near East countries.

D. CONCLUSIONS

The study produced three types of conclusions.

D.1. General Conclusions for Low-Cost Health Care Programming

a) Indigenous health practitioners. In developing countries there are three main types of indigenous health practitioners. One is indigenous midwives (traditional birth attendants) who, in addition to delivery functions, often assist in health care and fertility regulation as well. A second type is specialists in physical therapies, such as herbalists, bonesetters, and those who perform first aid and minor surgical operations. A third type is spiritualists such as seers, saints, and other holy people who are sought out for problems often psychological in nature.

b) Indigenous versus "Western" therapies. Considerable evidence shows that where people in a developing country have had access

to "Western medicine" of reasonably good quality for a generation or so, then they generally place greatest faith in the therapies of that system. This is especially true for treatment of acute, infectious diseases yielding to antibiotics since here international medicine produces demonstrably superior results. Where quality care has not been available, then populations still place primary faith in indigenous healers and therapies.

The evidence thus indicates on the one hand the ultimate eventual primacy of international medicine in those areas where services are of reasonably high quality over a lengthy number of years. On the other hand, as indicated above, such a transition to a state of widespread, easily accessible, high quality Western-type health care is proving more lengthy and costly than was previously anticipated.[1]

In either case, where both systems co-exist, resort is usually eclectic. That is, people seek out both Western-type and indigenous practitioners for different problems, for the same problem at different stages in the hierarchy of resort, or even simultaneously for serious problems.

c) Utilization of indigenous practitioners in formally-planned health care systems. This is not an "either-or" question. Instead it should be seen in the broader context of comprehensive and primary health care programming that emphasizes community participation, self-help, and appropriate technology. In this philosophy of maximal participation, education, and development of all community resources, indigenous practitioners are seen as one category of primary health worker providing services that do not require the more specialized medical knowledge of physicians and other formally-trained professionals.

But should indigenous practitoners actually be integrated directly into formal health care services? The answer varies from country to country. It depends on the existing health infrastructure, the health status of the population, and the indigenous practitioners themselves. At this time and for most categories of practitioner, informal accommodation appears easier than formal integration.

d) Utilization of indigenous midwives. Midwives are usually the most easily incorporated indigenous practitioners. This is evidenced by programs in Latin America, Africa, and Asia where midwives have been upgraded and also trained in family planning and health promotion.[2] WHO has actively investigated and supported this strategy during the past decade.[3]

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1 Foster (1975) and Taylor (1975:298).

2 See, for example, Bayoumi 1976, Rogers and Solomon 1975, Peng 1974, and Verderese and Turnbull 1975.

3 This is presented in Verderese and Turnbull 1975 and Mangay-Maglacas 1977.

e) Utilization of specialist in physical therapies. Greatest success has been reported with herbalists. Many governments are proud of their indigenous traditions of herbal medicine. Certain Egyptian Ministry of Health officials, for example, have expressed pride in Egypt's "ancient traditional medicine going back several thousands of years." By this they mean specifically the use of herbs.[1] An important part of the WHO Programme in Traditional Medicine encourages member nations to conduct research on the safety and efficacy of traditional herbal remedies.[2]

f) Utilization of spiritualists. This appears more complex than for other kinds of practitioners. However, in countries where traditional healers are formally accepted, experience shows that they may be useful in mental health services.[3]

g) Legislation and licensing. Where legislation has been passed against indigenous practitioners it does not appear to have succeeded in causing them to cease practice so long as there is popular demand for their services, as is the case in Tunisia. Nor does policy that midwives, for example, be upgraded and licensed mean they will all comply. Neither measure seems to bring full compliance. The latter, however, appears to succeed in bringing better care to areas where indigenous practitioners chooseto comply and receive training.

h) Options for AID. Only when the local government is interested in or receptive to utilizing indigenous practitioners is it possible for a foreign donor to draw upon this category of health manpower. It may then be a fruitful course of action.

In May, 1977, the World Health Assembly of WHO passed a resolution to promote traditional medicine.[4] This encourages all member nations to conduct research on and seek ways of utilizing their indigenous practitioners. The resolution was proposed by certain member nations and has subsequently stimulated others, such as Egypt, to consider (or reconsider) the training and upgrading of their traditional practitioners.

AID personnel should expect that developing country ministries of health may show new or increased interest in using their indigenous health practitioners as providers of primary care.

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[1] See the records of the 30th (1977) World Health Assembly Committee A 17th and 18th Meetings (A30/A/SR/17 and A30/A/SR/18).

[2] See the bibliography on this subject compiled by Khan (1976).

[3] Baasher 1976:67.

[4] Resolution WHA 30.49. See Bannerman (1977), the entire issues of WHO Chronicle and World Health for November 1977, and WHO documents EB57/21 Add. 2 (21 November, 1975) and Trad. Med./77.1.

D.2. Additional Conclusions Specific to the Near East

a) Indigenous practitioners in general. Especially in rural areas but also in cities indigenous practitioners remain important providers of health care for large segments of the low-income population. In all seven countries there are indigenous midwives, herbalists, barbers performing health-related services, and Quranic and other religious healers.

b) Government position. This ranges from on-going training of indigenous midwives (Afgar'stan) to legislation against all traditional practitioners (Tunisia). In between are countries that seem to have no policy on the subject (Yemen, for example) or to be preparing to revoke earlier legislation against indigenous practitioners (Egypt).[1] Some governments have also outlawed or formulated policy against certain traditional practices (such as bleeding in Morocco or the zar cult in Egypt).

c) Efficacy of therapies. Many therapies are certainly efficacious, others dangerous, and others without apparent consequence for health. This must be determined in the field, however.

d) Attitudes of indigenous practitioners toward international medicine. Most indigenous practitioners are eager to adopt and adapt modern technologies. Many also refer complicated cases to Western-type practitioners rather than risk unsuccessful treatment and may even occasionally consult them for their own health problems.

e) Attitudes of rural and urban poor toward international medicine. These appear to range from fear and distrust (among many Afghans) to great enthusiasm (by Tunisians). There is little understanding of the principles that underlie international medicine, however. Most rural and urban poor continue to interpret interaction with and advice from "modern" practitioners according to traditional beliefs. These are based on a combination of classical Arab medical theory, beliefs in spirits (jinn) and malign supernatural forces (such as the "evil eye") and the ultimate attribution of all illness and cure to "God's will."

f) Women. Throughout the Near East women are the primary actors and decision-makers in providing and securing health care for family members and they are the major preparers of food. They interact most comfortably with female practitioners but also consult indigenous male practitioners.

g) Desired characteristics in health practitioners. Health practitioners should behave according to traditional expectations based largely on general characteristics of indigenous practitioners. They should take time with the patient and display personal concern.

Practitioners should accept fees on a sliding scale based on ability to pay but provide free services for those who cannot pay.

D.3. Additional Conclusions Specific to Individual Near East Countries

These appear both explicitly and implicitly in individual country sections of the report.

RECOMMENDATIONS FOR FUTURE RESEARCH

It is recommended that further research be conducted on indigenous health care and local health practices whenever the answer to one of the three following questions is affirmative.

It is recommended that the research be conducted in the aid-recipient country. Ideally it would be conducted by a team that would include at least one public health specialist and one social scientist, at least one of whom is a country national. Given that family health is a predominantly female domain it is essential that at least one woman be a member of the research effort. The findings should include specific recommendations for project design.

A. ARE WE TRYING TO PROVIDE HEALTH SECTOR ASSISTANCE TO A COUNTRY THAT IS UTILIZING OR CONSIDERING UTILIZING ITS INDIGENOUS PRACTITIONERS IN EITHER HEALTH CARE OR FAMILY PLANNING?

A.1. Obtain An Overview of Indigenous Health Care in the Given Country

This can be done using the outline on pages 12 and 13 titled "Country-Specific Information Needs for Traditional Health Care."

A.2 Support In-depth Field Research on Indigenous Practices and Practitioners

This should provide the information that the country-specific portions of this report have sought to do. A most expedient starting point will be to use the headings of the country-specific portions as the basis of a research design and scope of work. (A rough outline of these headings is presented on page 16.) A logical second step could be to hypothesize that the beliefs, practices, and practitioners reported in other countries of the region might also occur in the country under examination. High priority should be given to understanding strategies of resort to the alternative practitioners and therapies.

B. ARE WE TRYING TO SUPPORT LOW-COST HEALTH CARE IN A COUNTRY THAT IS NOT PRESENTLY UTILIZING ITS INDIGENOUS PRACTITIONERS?

B.1. Obtain An Overview of the Official Position on Indigenous Health Practices

This can be done using the outline on pages 12 and 13. Continue to watch for changes of policy or opinion.

B.2. Support In-depth Field Research on Utilization of Existing Facilities and Strategies of Resort

Utilization rates and effectiveness of care provided are the result of complex interaction between the availability of services (including the terms on which they are available), the health status of the population, and the indigenous health beliefs and practices. There are two types of utilization studies. One takes as its unit of observation the health care facility. This type, since it observes only those who actually visit the facilities, provides only a partial picture of how the health care system is meeting basic health needs.

The second type of study takes as its unit of observation the population for whom care is theoretically being provided. Population-based studies describe strategies of resort to alternative practitioners and therapies and more accurately reveal how effectively health needs are or are not being met by the formal system.[1]

It is recommended that population-based utilization studies be conducted in communities identified for AID activity. Emphasis should be on strategies and reasons for resort to the alternative health care providers. Sections E of the country-specific portions of this report indicate clearly that the rural and urban poor throughout the Near East often consult and follow therapies of traditional healers at the same time as or instead of visiting the kind of facility that AID might be supporting or establishing. Knowledge of what motivates this eclectic health-seeking behavior is necessary if AID is to have any impact on improving the health of the poor majority.

C. ARE WE PLANNING PROJECTS IN SECTORS OTHER THAN HEALTH WHOSE SUCCESS MAY BE INFLUENCED BY HEALTH-RELATED BELIEFS AND PRACTICES?

It is recommended that any field research undertaken on indigenous health care should also identify ways in which traditional health beliefs and practices might hinder success of development efforts in sectors other than health. AID should not presume that it can change the traditional practices but should remain aware of them in project design and implementation.

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[1] See Benyoussef and Wessen 1974:287 (in Tunisia bibliography). An excellent example of this sort of study was conducted by Polly Fortier Harrison for USAID, El Salvador (AID Contract No. 519-127).

COUNTRY-SPECIFIC INFORMATION NEEDS FOR TRADITIONAL HEALTH CARE*

1. Official Position on Traditional Health Care

a. What official policies exist?
b. If so, do they support or suppress further development of traditional health care?
c. Is there licensure, registration, or certification of indigenous health practitioners? Is so, what kind?
d. Is there regulation of the practices of indigenous health practitioners?
e. If official policies do not exist, what position do high-level officials take on the subject?

2. Traditional Health Care Manpower

a. What different categories of indigenous health practitioners and advisers exist?
b. What is the estimated number of persons in each category?
c. In each category, approximately how many are below 30 years of age? Between 30 and 50? Over 50?
d. How many are literate?
e. How many have had formal institutional training?
f. How many are full-time practitioners? Part-time practitioners?
g. How were they recruited to their specialization?
h. How are they compensated for their services?
i. What position do they take toward government health services and formally-trained practitioners?

3. Modern Technology in Traditional Health Care

a. Is modern health technology employed by traditional practitioners?
b. If so, what kind of technology is used?
c. If not, in which areas of traditional health care would new technology be advantageous?
d. What kind of health technology would be appropriate?

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* Adapted from questionnaire, "Information Needs on Traditional Medicine," developed by the Programme on Traditional Medicine of the World Health Organization.

4. Traditional Medicines

a. Does regulation exist governing their use?
b. What is the approximate proportional use of medicinal plants? Of products of animal origin? Of mineral origin? Of other products?
c. Is there any pharmacopoeia or systematic list of the above substances?
d. If not, what are the most common substances in each category?

5. Research and Training in Traditional Health Care

a. Have traditional health practices or medicines been the subject of research by country nationals? (Example: arthritis, fertility regulation, mental illness, tropical diseases, etc.) Which individuals or institutions have been engaged in this work?
b. Have attempts been made in the country to train or to integrate indigenous health practitioners into government health services?
c. If so, what have been the outcomes?

METHODOLOGY AND USE OF COUNTRY REPORTS

A. METHODOLOGY

A.1. Collection of Written Materials

Sources on which the study has been based are indeed a "fugitive literature"--widely scattered and many deeply buried. Five languages were used for the search: English, French, German, Swedish, and Norwegian.

Published materials were first identified through computer searches of the literature indexed by Index Medicus, Social Science Citation Index, Sociological Abstracts, and the National Clearinghouse for Mental Health Information. Additional published as well as unpublished materials were discovered through the Technical Assistance Information Clearing House and AID's Development Information System and by examination of 7 review articles, 18 annotated bibliographies, and holdings at 13 libraries.[1] Information, especially about unpublished materials, was also gathered through wide networks of social science, development, and health professionals.

Of well over a thousand items examined for the Near East only those cited in the report bibliographies proved useful to the task at hand. Time constraints and the country-by-country emphasis demanded by AID program needs, unfortunately, precluded utilization of the Near East literature not specific to the seven AID-assisted countries.[2] Some valuable items, such as conference papers and forthcoming manuscripts, could not be quoted out of respect for this request by their authors.

A.2. Consultation with Resource Persons

Discussions with persons from the seven countries, with authors of the above materials, and with personnel of other development agen-

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[1] The most useful bibliographies for this subject are those by Akhtar, Delaney, Harrison and Cosminsky, Racy, Sargent and Rubel, and Zabarenko and Bednarz.

[2] This literature is abundant and some of it superior to many of the seven-country sources. It is possible, for example, that materials on Lebanon (some cited at end of Syria bibliography) give better insights into indigenous health practices in Syria than the few sources on Syria itself. Sources on Iran are likewise valuable for Afghanistan. See in particular entries in the general bibliography by Bahrami, Bickers, Donaldson, Ghadimi, Good and Good, Grivetti, Kirkman, Musallam, Oztürk, Sakr, Scott, Simpson-Hebert and Vieille.

cies and organizations in the United States and Europe were essential for placing the written material in the proper development context. Especially important were consultations with members of the WHO Working Group on Traditional Medicine in Geneva.

B. USE OF COUNTRY REPORTS

Information presented below is thus based on the above sources but not corroborated by the author through field investigation. The reader is therefore asked to continually bear in mind two caveats.

First, what is presented are beliefs and practices of the more traditional and conservative-minded majority in each country--the rural peasantry and pastoralists and the urban poor. Findings cannot be generalized to the urban elite and formally-educated minority who rely far more, although seldom entirely, upon international medicine.

Second, the most reliable sources of information are generally in-depth studies in a particular village or urban neighborhood. While similar practices undoubtedly prevail through much of any given country, we cannot automatically generalize to its entire low-income population. Strategies of resort and patterns of facilities utilization, for instance, differ appreciably from a village now engulfed by Cairo's urban sprawl to a village in Egypt's Western Desert.

Rather than being taken as definitive, these country reports should be regarded as partial and preliminary overviews that indicate how relatively little we know about what for millions of people in the region remains the heart of their health care.[1]

Country-specific information. In order to present information so that comparisons can be made between countries, or information on a particular subject easily found for all seven countries, an outline format was worked out. This is shown on page 16. The Egypt report, for which the greatest amount of information was available, come first as a tentative model of how local health practices can be presented when information is available. Non-availability for this study of substantive information on a given topic for a given country is indicated by the absence of a section on that topic in the country report.

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[1] The author would be delighted to receive additional information on this subject and welcomes your perspectives and critique of the present study.

COUNTRY-SPECIFIC INFORMATION

(Outline of Country Reports)

A. Health and Population Overview
   1. Population composition and distribution
   2. Population dynamics and health status
   3. Health and population planning

B. Western-language Sources on Indigenous Health Practices

C. Indigenous Etiology
   1. Supernatural causation
   2. "Natural" causation
   3. Classical Arabic medical theory
   4. Hot and cold

D. Indigenous Health Practitioners
   1. Village health barbers
   2. Traditional midwives
   3. Saints and other holy people and their shrines
   4. Herbalists
   5. Wise women
   6. Bonesetters
   7. Cuppers
      Folk opthalmologists
      Hakim (traditional physicians)

E. Strategies of Resort and Relationships with Western Medicine and its Practitioners

F. Hygiene, Public Health, and Prevention

G. Diet; Physical Disability

H. Fertility Behavior
   1. Pronatalism
   2. Clitoridectomy and infibulation ("female circumcision")
   3. Fertility regulation
   4. Sterility

I. Culture-specific Illnesses and Mental Health

REGIONAL FOUNDATIONS

The essential philosophy underlying health beliefs and practices throughout the Near East region is that all illnesses and injuries are subjective events deriving from personal actions conducted or not conducted or that are caused by someone or something possessing some kind of a power. An illness or injury does not just occur. Rather they befall a certain victim, at a given time and in a given manner, because of specific causal actions.

The attempt to explain an illness is a highly subjective, personal, and soul-probing matter in which the victim and all concerned search for extrinsic factors. According to traditional belief, every possible illness or injury has a specific knowable cause and therefore a known means of prevention, and a known treatment.[1] Often, however, any initial diagnosis is but a hypothesis (and immediate plan for action) that is proven correct only when the therapy it dictates restores the victim to normal health.

Four particular aspects of traditional health belief and practice are present in one form or another in all seven countries examined and probably throughout the entire region. These are the historical Greco-Arab medical tradition, formal and folk religion, illness-causing supernatural spirits, and the evil eye.

A. HISTORICAL PERSPECTIVES

A.1. Ancient Medical Systems

Numerous beliefs and practices in the region can be traced backed to the ancient empires of Babylonia, Persia, and pharaonic Egypt.[2] Ancient Egyptian papyri, Assyro-Babylonian cuneiform, and Hammurabi stelae record modalities that are still followed today.

A.2. Greco-Arabic Medicine

Numerous beliefs and practices can also be traced back to the once pre-eminent medical science referred to as "Arabian medicine." This dates back to the Abbasid dynasty (750-1258) but is for the most part Greek in origin with Persian, Syriac, and Indian accretions.

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[1] Shiloh 1961:278-279. See also Shiloh 1958 and 1968.

[2] See, for example, Blackman 1926b (in the Egypt bibliography) and Shaffi 1972.

When Baghdad University was founded in the Abbasid capital in about 800 A.D. Nestorian Christian scholars were recruited from the famous Persian medical school that had been established by Nestorian monks at Jondisapur in the fifth century. They brought medical knowledge and skills based on the teachings of Hippocrates, Galen, and other Greeks. Medical texts were translated from Greek into Arabic between the middle of the eighth and ninth centuries--mostly by Christian and Jewis scholars. At other great Arab universities from Samarkand to Seville and in more than 30 large hospitals (notably in Cairo, Damascus and Baghdad) the Arabic-recorded Greek medical teachings and therapies were taught, elaborated, and applied. Central to this tradition were Greek humoral theories and botannical remedies. The first Arabian formulary compiled in Baghdad about 850 listed some 800 botannical remedies. Rhazes and Ibn Sina (Avicenna) are the two great names from this period.[1]

Humoral theory. According to the Hippocratic theory, the bodily humors (blood, phlegm, black bile, and yellow bile) vary in both temperature and moistness. Health is viewed as a balance among the four. Illness in contrast results from imbalance that causes the body to become excessively dry, cold, wet, or a combination of these states. Food, herbs, and other medicaments—which are also classed as wet or dry, hot or cold--are used therapeutically to restore the body to its natural balance. Thus, a "cold" disease, such as arthritis, is cured by administration of "hot" foods and medications.[2]

B. FORMAL AND FOLK RELIGION

B.1. Formal Religion

The holy books of the region's Muslims, Christians, and Jews all discuss health, hygiene, diet, prophylaxis, illness, and healing. All three religions both prescribe and proscribe. Striking similarities exist such as the Islamic and Jewish dietary proscriptions.

B.2. "Prophetic Medicine"

In addition are many collections of traditional sayings (hadith) of or attributed to the Prophet Muhammad. "The stomach is the house of disease and rational dieting is the primary essence of treatment" is one example. These sayings and their interpretation have come to be collectively known as "Prophetic Medicine" or "Medicine of the Prophet" (Tibb ul-Nabi).

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[1] See Browne, Gruner, and numerous works by Hamarneh.

[2] Harwood 1971:1153.

According to one major source, this is based on the theory that the human constitution has seven components.[1] The first is "the elements": fire (hot and dry), air (hot and wet), water (cold and wet), and earth (cold and dry). The second is "the temperaments" (such as "evenly balanced" and "unevenly balanced") which are nine in number and also have to do with the four elements. The third is the "four humors": blood (damp and hot), phlegm (wet and cold), bile (hot and dry), and spleen or "black bile" (cold and dry). The fourth is "the fundamental organs," the fifth "the spirits," the sixth "the faculties," and the seventh "the functions."

"Prophetic medicine" identifies six causes of illness, the first, of which is air. It deal with emotions, food, drink, movement, rest, and prevention of illness. It comments on such topics as properties of foods and drugs, treatment, calling in a physician, permissability of female physicians, the evil eye, spiritual drugs, venesection, cauterization, rules of coitus, doctor's fees, and listening to singing. Every human motion and sensation is viewed as controlled by Allah.

B.3. Folk Religion

Intermingled with the precepts of formal Islam, Christianity, and Judaism are beliefs that antedate and derive from outside the teachings proper. These folk religious beliefs permeate and are an important part of the philosophical system underlying health practices. Often those who hold and act upon them believe they too are part of "the religion"--meaning the formal religion.

Near Easterners often explain traditional beliefs and practices in terms of "the religion." Thus opposition to family planning might be explained as "because of the religion" or "for the sake of the religion" when in fact Islam sanctions contraception. Such religious arguments are often brought forth when behavior is actually motivated or desired by more general reasons, such as the positive value placed on children.[2]

C. SUPERNATURAL SPIRITS

Just as the world is populated by humans it is also populated by non-human spirits who display the same characteristics and diversity as humans. They are male and female, young and old, good and bad. Usually referred to as jinn, these capricious spirits pervade

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[1] Elgood 1962. See also Gordon 1955.

[2] See El-Hamamsy 1972 (in Egypt bibliography).

the entire environment. They must be acknowledged, understood, and treated as they demand.

A spirit causes its victim to become ill by attacking or by entering and possessing. To become well the victim must satisfy the spirits's demands. Some spirits remain forever with the persons they have possessed. Persons especially susceptible are women, children, and individuals passing through a major life event. Evil spirits are always lurking ready to enter the body. A person in a susceptible state should thus not be left alone lest this be interpreted as a sign of abandonment.[1]

D. THE EVIL EYE[2]

The evil eye is a non-material, non-individualized power that can cause illness, accidents, debility, disability, and death as well as other misfortune. Its main characteristics have to do with anxieties over social relationships and with fear of envy. The evil eye is sometimes said to be an independent evil power that acts through certain people and in certain situations. It is also said that there are simply certain people whose look is evil.

Belief in the evil eye predates Islam, Christianity, and Judaism. It is feared by followers of all three faiths. Beliefs and practices concerning the eye are neither exclusive nor well-defined. In any situation there are other evil powers besides the evil eye that may be blamed. Likewise some of the means used to counteract it may also be employed for other purposes.

a) The attack. The suspected "vehicle" of the evil eye is always a person who is sonehow an outsider to the immediate group that he or she might be tempted to envy. Most vulnerable are children, pregnant women, persons in a rite of passage, and beauty. Most likely to be suspected as "vehicles" are women (especially if unmarried or sterile), beggars, and people with blue or green eyes.

b) Means of defense and counteraction. Preventive measures include fumigation, use of amulets and bright colors (which distract), dirt (which disguises attractiveness), the five fingers of the outstretched hand, and avoidance of ambition, perfection, and even numbers.

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[1] Shiloh 1961:280.

[2] This section is based on Spooner 1975, Marçais 1960, and Shiloh 1961:279.

Once the evil eye has attacked, as evidenced by illness or other misfortune, antidotal measures include fumigation, burning of alum (which pops like an eye bursting), use of salt, and recitation of special phrases. The culprit must be discovered (usually through divination) before a cure is possible, but according to popular folklore most people die as victims of the evil eye.

E. NEAR EAST AND "WESTERN" MEDICAL STRATEGIES

Proponents of international medicine should not assume that successful implementation of their programs depends on destroying these indigenous beliefs. Such a frontal assault can only be time-consuming, expensive, and laden with potential failure.

In fact Near Eastern beliefs about illness prevention and causation are not inimical to Western beliefs. The Near Eastern preoccupation with preventing attack by the evil eye and evil spirits is complemented by the Western preoccupation with preventing attack by germs. A practitioner of international medicine need not automatically condemn practices designed to prevent the evil eye or evil spirits from operating on the body. Nor should the Near Eastern patient necessarily experience conflict in preventing another evil—germs--from entering the body. The fundamental reasoning is similar.[1] Some international health experts have found comparison of jinn to germs very effective in introducing concepts of hygiene in the region.[2]

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[1] Shiloh 1968:242-244.

[2] Dodd 1934 (in Syria bibliography).

E G Y P T

A. THE HEALTH ENVIRONMENT: A VIEW FROM THE TOP

The indigenous health and illness beliefs and practices of any people are a cultural adaptation, evolved through time, to the environment in which they find themselves. This environment may be characterized as follows. It is important for us to remember, however, that the perspective of the poor majority is from the bottom up with health and illness but one part of a broad spectrum of fortune and misfortune. They do not share the top-down sectoral perspective with which national and international level planners have been trained to view health and illness.

A. 1. Composition and Distribution

Egypt's population is nearing 40 million of whom nearly all are Egyptian Arabs. The only numerically significant minority are the darker-skinned Nubians whose ancestral home is in Upper Egypt, near Sudan but many of whom have migrated to Cairo. About 90 percent of Egyptians are Sunni Muslims and about 10 percent Coptic Christians. Generally both Muslims and Copts believe themselves racially different, but this is not the case. Their differences are ethnic and religious, not racial.

Muslims and Copts both explain much of their health-related behavior in terms of their respective religions; however, the practices themselves do not seem to differ appreciably. On the other hand, health-related practices of the Nubians (also Sunni Muslims) do differ in certain regards from the rest of the population. Some differences also exist between the Egyptians of Upper and Lower Egypt.

About 96 percent of Egypt's population is crowded into only 4 percent of the land, the Nile River Valley and its Delta. The population density here of 2400 persons per square mile is one of the highest in the world.

Egypt's population is considered about 44 percent urban—that is, living in the 4 governates having major urban centers (Cairo, Alexandria, Port Said, and Suez) or in the larger cities and towns in each of the other 21 governates. The "urban" population, however, contains large numbers of people who only recently were rural poor, and who now live in make-shift squatter settlements in the cities. The distinction between the poor and the affluent may be of greater consequence or at least equal importance in health planning as the rural-urban distinction.

A. 2. Health Status and Population Growth

The country's population will double by the year 2000 if the present rate of growth--about 2.5 per annum--continues. The crude birth rate is estimated as almost 38 per 1000 persons. Infant mortality is also high--about 110 per 1000 live births. Child mortality (1-4 years)

is 39 per 1000 and maternal mortality is similarly high at 9 per 1000. At least 43 percent of the population is under age 15. Life expectancy has risen to an estimated 54 years for males and 56 years for females. Literacy is reported to be 44 percent among all persons 10 years and older but only 29 percent among females 10 in that age group.

In addition to overpopulation, the foremost critical health problems are endemic schistosomiasis ("bilharzia") and gastrointestinal diseases, both of which severely debilitate the rural poor. Epidemics of measles and diptheria have added to infant and child mortality in recent years. Typhoid and paratyphoid, malaria, tuberculosis, trachoma, and dietary deficiency diseases are also prevalent.

A. 3. Health Care Services

Egypt's Ministry of Health has extended its infrastructure into the rural areas with the establishment of "rural health centers" and smaller satelite "rural health units." These exist in a ratio of about one center per three units and one unit per 5,000 to 10,000 persons. As of 1974 a total of 2,140 rural facilities had been constructed. In principle, the several-member staffs of each health unit include a medical doctor and two assistant nurse-midwives (the government-trained hakima). In the urban areas a hierarchy of "maternal and child health centers," "health offices," and "health units" was similarly established with the hope they would divert pressure from the urban hospitals.[1]

These facilities are now part of the range of alternatives to which the rural and urban poor may resort for health and reproductive care. They are only part of the range, however. For many complex social, economic, and cultural reasons, the poor majority continue to resort to traditional cures and to indigenous health specialists and advisers for needs the Government facilities are unable to meet.

B. WESTERN-LANGUAGE SOURCES ON INDIGENOUS HEALTH PRACTICES IN EGYPT

More published information exists on local health practices in Egypt than in any other country in the Arab world. Comparing this report's seven focus countries, more information is available on traditional healing in Egypt alone than in all the other six combined. Eghpt appears first for this reason. Sources for Egypt include the following.

B. 1. Early Ethnographic Accounts

These date from the period prior to the creation of a Ministry of Public Health in 1936 and the construction of several hundred rural health centers in the 1940s. Foremost is Walker's Folk Medicine in Modern Egypt. This is a valuable description of indigenous preventive,

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[1] For sources of this information and for further detail, consult the Syncrisis report on Egypt (Furnia 1975:19-24, 40).

diagnostic, and curative practices resorted to by the majority of the Egyptian population prior to the introduction of Western medicine.

General ethnographic accounts also provide valuable information. This is because all traditional health care is intimately bound to the local worldview and religious beliefs and to the local cultural elaboration of the biological events of the life cycle. Lane's The Manners and Customs of the Modern Egyptians and Blackman's 1920s reports are examples of this kind of account. While dated, such works remain of value because information presented by contemporary sources is still so incomplete. Furthermore many of the practices and beliefs described are still very current among the rural and urban poor (and certain of the beliefs in particular even among the urban elite). It is essential to determine, however, precisely which of the beliefs and practices described in the earlier works still prevail among which sectors of the population.

B.2. Recent Ethnographic and Other Behavioral Studies

Investigations conducted since the 1950s by social scientists or long-time foreign residents in Egypt constitute the single most valuable source of information on indigenous health beliefs and practices. Still, only a minor portion of most of these works directly concern health. This must be extracted from more general discussion of rural life, religious practices, marriage customs, the formal health system, and so on. These recent works include the following.

a) General ethnographies with details regarding health, especially those by the Egyptian anthropologist Hamed Ammar and by Habib Ayrout, as well as by Harold Barclay, Hani Fakhouri, Elizabeth Fernea, and Michael Ginsenan.

b) Unpublished M.A. and Ph.D. theses. Numerous health-related M.A. theses have been written by Egyptian and other students in the Department of Anthropology and Sociology at the American University in Cairo.[1] The soon-available dissertation by Soheir Morsy will probably be the most substantive source on health practices and needs of the rural poor, while an in-process dissertation by Evelyn Early discusses health conceptualization and strategies of urban poor. Other doctoral dissertations likely to contain bits of information relevant to indigenous health practices are those by Enaam Y. Abou Youssef, M.F. El-Sendiony, Peter Gran, Laverne Kuhnke, Ahmed Kamel Mazen, Hanna Rizk, and Magda Zaki. Unfortunately none of these could be reviewed for this report.

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[1] These include theses by Francine Behman, Nazek Nosseir El-Fishawy, Aida Fahmy, Nawal Messiri, and Najwa Shukairy.

c) Articles, monographs, and chapters in books. By far the greatest numbe. of these focus on a curing ceremony Egyptians call the zar.[1] A similarly profuse body of articles describing the zar in Sudan, Ethiopia, Somalia, and Kuwait further adds to understanding of this therapeutic ritual.[2] The zar is probably the indigenous health practice best-reported not only for Egypt but for the entire region.

A second major focus has been health-related practices of the Nubians. These came under scrutiny during the Nubian Ethnological Survey carried out in the 1960s through the Social Research Center of the American University in Cairo.[3] A third topic to have drawn specific attention is--circumcision and female clitoridectomy.[4]

B.3. Other Egypt-specific Sources

Embedded in the largely biomedical statistical publications of physicians, nutritionists, and demographers are occasional articles and paragraphs presenting traditional health beliefs and behavior. An exemplary source of this type is the Journal of The Egyptian Public Health Association. The majority of earlier publications in this category, however, are highly quantitative and give little qualitative information about motivations and behavior.

The bulk of the fairly substantive literature on population and family planning is primarily reiteration of the need for family planning, discussion of the fact that it does not violate Islam, and description of available methods. Except for a few items (such as Egypt: Population Problems and Prospects edited by Abdel-Rahim Omran), there is surprisingly little information of the "KAP" (knowledge, attitudes, and practices) sort that is so-relatively available for countries outside the region (e.g., India and Pakistan) or even for Lebanon.

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[1] Researchers who have been written on the zar in Egypt include Kawthar Abdel Rasoul, Francine Behman, M.F. El-Islam, M.F. El-Sendiony, Hasan El-Shamy, Hani Fakhouri, John Kennedy, B. Lewin, Cynthia Nelson, and A. Okasha.

[2] Zar studies not specific to Egypt have been carried out by Cerulli, Constantinides, Giel et al., Kline, Lewis, Messing, Sargant, Torrey, Young and Zenkovsky.

[3] See the works by John Kennedy, Hussein Fahim, Charles Callender and Fadwa El-Guindi, Nawal Messiri, and Najwa Shukairy.

[4] See reports by Henny Hansen, John Kennedy, Otto Meinardus and Raphael Patai.

C. INDIGENOUS ETIOLOGY

Studies from Cairo and the Delta indicate that many if not most people there have probably had at least some contact with or possess at least passing familiarity with government clinics and Western medicine and that this experience has probably modified traditional indigenous beliefs as to what causes and cures illness. Sources through the 1930s usually present the view that villagers attribute illness and its outcomes, like other misfortune, to supernatural causes such as jinn and the will of Allah and to the evil eye.[1] Recent sources, however, indicate that villagers and urban poor dichotomize illnesses into two categories: "naturally caused" and "supernaturally caused."

C.1. "Naturally Caused" Illnesses[2]

In this category are chronic and minor non-chronic disabilities such as blood and specific organ-related ailments, rheumatism, broken bones, and sterility. These are said to be most appropriately treated by "natural medicine" (Tib tabi'i) of either the indigenous or international sort.

Humoral theory. It appears that "naturally caused" illnesses may be explained by some combination of traditional humoral theory plus Western medical theory. One source states that villagers believe many diseases to be caused by "dampness" (or "humidity").[3] These peasants presented themselves at clinics with the complaint of "dampness" in their heads, their knees, or their backs. Physicians treating them were able to gain much popular acceptance and cooperation by blaming "dampness" as the causative factor in cases they treated, especially the rheumatic.

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[1] See regional section above.

[2] See Morsy and Early on the dichotomization of naturally versus supernaturally caused illness. A disproportionate amount of attention is shown in the literature to the more exotic--seeming spirit--related illnesses, some of which is found in nearly all ethnographies as well as items with "Spirit," "Sheikh," "Saint," "Cult," "Possession," "Zar," and "Evil Eye" in their titles. See Ammar on Allah and illness.

[3] Gadalla 1962: 67-68.

Relatively little can be learned about ("natural illness") causation from the literature, however, except as concerns female sterility. Even sterility, which is categorized as a "naturally caused physical ailment" by some, is usually presented as supernaturally or socially caused.

C.2. "Supernaturally Caused" Illnesses

This category includes all physical and psychosomatic conditions of illness, dissatisfaction, and misfortune attributed in one way or another to spirits, spirit intrusion, possession, saints, sheikhs, sorcery, the evil eye, and the will of God. "Supernatural medicine" or healing (Tib rawhani) exists for treatment of such illnesses.

According to tradition, the world is believed populated not only by humans but also by spirits. In both categories there are "some good ones" and "some bad ones." Spirits upon whom illness is blamed include jinn (generally characterized as benevolent but capricious) and 'afrīt (usually translated as "devils" or "demons").[1] Illness is also blamed on "Nile spirits," such as "daughters of the Nile" (benat al-Nil) or "people of the river." Other spirits--sometimes identified with deceased Muslim sheikhs (holy men) and Coptic saints--are widely known as "the Red Sultan," "the Sudanese One," and "the Ethiopian One."

All such spirits have needs and desires and frequently beseech, distress, and possess certain human beings until the latter discern and meet the spirits' demands. In other cases these beings inflict illness upon humans who unwittingly or purposely fail to observe some vow, ceremony, or religious ritual or who violate local taboos, especially at the dangerous times of life's major rites of passage.

An illness is often regarded as God's test of the endurance and patience of the faithful. Since "the faithful" (virtually all Egyptian Muslims and Christians) are continually exposed to illness, their faith in God should never be shaken and therefore their endurance of affliction is considered a pious deed--even though the afflicted should still seek to remedy the condition if at all possible. God is the afflictor as well as the healer. He has also fixed the life span of each person and this cannot be lengthened or shortened unless God wills it. But it is also believed that action, hope, and propitiation may produce beneficial results--in which case this too "is God's will."

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[1] 'Afrīt may also be a category of jinn; thus, there can be malevolent jinn as well.

C.3. Socially Caused Illnesses

Illnesses believed of supernatural causation are commonly blamed on individuals within the village or urban quarter that constitutes the social world of the poor. Thus, for example, person A may become ill, blind, or sterile because person B has violated a taboo while A is in a state of culturally-defined "vulnerability" (such as after giving birth to a child). Or an individual may become sick and die because a second individual who happens to be a "vehicle" of the evil eye confers it upon the first.

The evil eye. In Egypt this potent malign force is called 'ain il-hasud or il-'ain il-wihshah. As elsewhere throughout the Near East it is believed a major cause of illness and misfortune and for this reason motivates the less-educated majority to behave in ways outsiders do not anticipate. For example, interviewers trying to collect census and household economics data have found that some rural people refuse to answer for fear of the evil eye. Villagers are also inclined to under-report, understate, and try to divert attention away from such things as income and number of children. It is feared that persons who pointedly inquire about such "assets" are envying them and may thereby bring the evil eye to inflict illness and other misfortune upon the household.

C.4. Multiple Levels of Explanation

There are few watertight compartments of causality. The death of a newborn male infant, for example, may be supernaturally caused by the evil eye yet socially precipitated by a sonless mother who happened to glance longingly at the infant.

More education will probably lead to explanations that combine traditional and "modern" reasoning. One traditional Egyptian belief, for example, is that paralysis is caused by an evil red wind emanating from the touch of a jinn; another is that tuberculosis is caused by social conceit and pretence. Villagers may well come to believe that, while on one level it is bacteria that cause infection, on another level there are supernatural forces that cause bacteria to infect a particular person. It is not uncommon that with acculturation to international medical ideas both natural and supernatural causes come to be simultaneously ascribed to the same illness.

D. INDIGENOUS HEALTH PRACTITIONERS AND SPECIALISTS

D.1. "Health Barbers" (Halag Siha)

Prior to the introduction of international medicine and through the early 20th century, the "health barber" (also called the "village barber") played the traditional health official role and had formal responsibility for registering births and deaths.

Today health barbers no longer have this function but remain a major community resource for advice and treatment regarding "naturally caused" disorders in particular.[1] The position is said to be an inherited occupational status. Some health barbers are itinerant although most apparently serve their home communities. All are men. Services performed by the health barber include the following.

a) Administration of physical therapies. Health barbers prescribe and administer herbal "folk cures" (wasfāt baladiyya) but that their main traditional specialties seem to be non-medical physical therapies. They dress wounds and provide general first aid. This commonly involves massaging or rubbing the source of pain with preparations of readily available products. These may have pharmacologically therapeutic value in addition to the beneficial effects of massage and general physical contact. Febrile persons, for example, may be rubbed with a saline vinegar solution and fed sour milk. Similar therapy is given as first aid for burns.

Health barbers also perform minor surgical operations. Rural people believe these are efficacious and seek them as treatment for specific organ-related illnesses (such as liver and kidney ailments), rheumatism, diarrhea, blood-related disorders, and dental problems. Among these therapies are phlebotomy (blood-letting), which many rural Egyptians believe effective for severe and persistent headaches, as well as cautery, localized burning of the skin sought as treatment for local ailments.

b) Male circumcision. Circumcision of young boys--both Muslim and Coptic--is regularly performed by health barbers. This is done amidst great ritual and is regarded as a religious event. In Nubia the barber may be assisted by the boy's mother in the rituals of the operation. For performing it he is given a "small gift" (usually coins) called a nokout.[2]

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[1] There is little substantive discussion of Egyptian health barbers. Nawal Messiri, however, is said to be currently conducting research on these widely-resorted to practitioners. Scattered details are found in Ayrout (1963: 68), Blackman (1927: 213), El-Hamamsy (1973), Fakhouri (1972: 15-16), Kennedy (1970), Gadalla (1962), and Morsy (1977b).

[2] Kennedy 1970, Lane 1966, Ammar 1966.

c) Other services performed. Health barbers are called upon for injections which some of them administer. Many villagers consider injections superior to commercial medicines in liquid or tablet form since injections "go directly to the blood and kill the disease" while liquids are quickly eliminated from the body.[1] Some health barbers also function as village veterinarians. In at least one village, and probably in many more, the health barber's wife is a traditional midwife and he occasionally assists in her work.

d) Fees. Health barbers are said to charge no fee because they believe that for helping others God will reward them in heaven. What this apparently means is that health barbers demand no fixed fee. Rather they are given and accept compensation, in cash or in kind, in an amount determined more by the family's ability to pay than by services rendered.

e) Relationship to the formal health care system. Steps were taken in the 19th century to give health barbers training in Western medicine after which they were considered a kind of government health official. Since extension of the Government's health care infrastructure into the rural areas, however, government officials and physicians generally have a negative orientation toward the health barber. No official position seems to have been promulgated and some officials emphasize the importance of the first aid services performed by the health barbers and their rapport with the poor. In the opinion of one official it would be rather easy to upgrade and utilize the health barbers for improving primary care in rural areas. Several Egyptian social scientists are reported interested in investigating this possibility.

D.2. The Indigenous Midwife (daya)

a) Characteristics of the daya. Dayas are the traditional birth attendants in the rural communities. They are not necessarily full-time practitioners but are decidely recognized and valued as specialists who play an especially important role given the many pregnancies of rural women.

Most dayas have inherited their profession through the female line in their natal families. They have usually born children but some young women become dayas even before marriage if the profession

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[1] Some villagers also distrust medicine in liquid form especially if they see or know it is prepared from a concentrate to which is added tap water (which they do not believe able to cure). Part of the preference for private clinics has reportedly been that they give injections (and tablets) while government facilities dispense liquids. See Gadalla 1962: 70.

is inherited. Like most of the villagers they care for, the majority of dayas are illiterate. They should behave in a manner that commands respect but are not bound by all the male-avoidance taboos that circumscribe other women. Thus they may interact with men without hiding their faces.

Dayas do not charge fixed fees. Usually they are given a bishara (literally, "thing for the happy event") on occasions such as after cutting a newborn's umbilical cord. The amount varies within a locally-prevailing range according to the ability to pay.

The most thorough account of Egyptian midwifery describes a village of 14,000 persons in the Nile Delta.[1] Contrary to earlier assertions by Ministry of Health officials in Cairo, that dayas are well on their way to "complete extinction," this village had 14 dayas. They delivered approximately 90 percent of the 600 infants born annually—a number clearly greater than the two local government health officers could handle alone. They ranged in age from 30 to 65; 13 had inherited the profession.

b) Services performed. Dayas are consulted by women upon suspicion of pregnancy and many provide prenatal care. They attend women from the onset of labor and administer traditionally--prescribed foods to speed it. Once the child is delivered, they supervise mother and infant. Dayas may also prescribe or prepare special lactation-promoting foods. A daya supervises the sebou', the important culturally demanded celebration on the 7th day after childbirth. A pregnancy that ends in miscarriage or abortion may be handled by a daya so long as it takes place without complications; dayas reportedly do not like to perform abortions.

Dayas also perform many extra-delivery services. They prescribe special foods and apply traditional remedies for minor ailments. Although they do not readily treat serious ailments they refer women to the health barber or public health unit for complications. At the time of marriage the daya attends to the culturally important "deflowering" of the new bride.

c) Relationship to the formal health system. In the 1940s Egypt's health ministry initiated a program that provided selected dayas with 6 to 12 months' practical obstetrics training. Upon

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[1] El-Hamamsy 1973. This is the major published source on Egypt's dayas. Dr. El-Hamamsy and her co-worker, Nawal Messiri at the Social Research Center in Cairo, have been primary researchers on this specialization.

successful completion of the training they were licensed and the more promising ones employed as assistants in the public health maternal and child health clinics. In 1969 the Ministry of Health changed this policy, discontinued the training and revoked all licenses (or at least stopped issuing new ones). It declared the dayas were no longer needed and would soon disappear due to the availability of "large numbers" of government-trained hakimas (nurse/midwives) and assistant hakimas--2,400 and 11,000 respectively in the early 1970s.

On the national level plans were thus to wipe out the position of daya. Public health personnel in the field, however, have said they could not carry out their work without the extra manpower and cultural mediation the dayas provide. Competitive or hostile relationships may have prevailed between daya and doctor in some communities, but the relationship in most is said to be one of peaceful coexistence if not genuine cooperation.[1]

As of early 1978 the Government is reported to be re-evaluating its stand and expressing interest in again working with the dayas. A seminar on the subject was scheduled for September 1977.[2]

D.3. Muslim sheikhs and Coptic saints

a) Characteristics. These are described as rawhaniyya, specialists in "supernaturally caused" illnesses. They are both male and female (sheikh and sheikha). Rural people especially respect them for their religiosity and perceived abilities to communicate with and interpret the desires of supernatural forces. They are believed able to both diagnose (divine) and cure illnesses and diagnose and treat illness through knowledge and use of the Quran and who may be skilled in the dissolution of sorcery. Their prestige is based on literacy and manipulation of the Quran and on the successes of some of their therapies. The second category reportedly diagnose through such forms of divination as visions, rosaries, the opening of cards, and becoming possessed by a spirit.[3]

Apparently the majority of persons who seek cures from sheikhs and saints are women who are sterile, who are unable to cope with the restrictions placed upon them because of their gender, and who are otherwise neurotic.

b) Charm practitioners. Some sheikhs and saints specialize in making the amulets and charms (higāb) that the poor wear and display in their homes as protection against the evil eye and misfortunes including, but not exclusive to, illness.[4]

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[1] El-Hamamsy 1973.

[2] WHO Regional Office for the Eastern Mediterranean 1977:12-23.

[3] See Morsy 1977b.

[4] See Blackman (1927:71), Fakhouri (1972:71), and Messiri (1967).

c) Tombs and tomb rituals. Tombs of holy men and women to whom miraculous powers have been ascribed, either during their lifetimes or after death, frequently become sacred precincts believed to possess healing powers. The precincts may include also a well whose waters are believed curative. Cults connected with such holy persons and their tombs are part of Egyptian popular religion as well as illness therapy.

Crowds flock to such tombs, especially on Fridays, seeking cures for disease and possession by 'afrīt and female sterility. The weekly Friday service (ḥaḍra) of the Sammaniya religious order, for example, is held in an ancient tomb in the Pyramids complex. It is well-attended by the lame, sick, and blind from nearby villages. Some buy votive candles to light in the tomb, having made vows (nadr) to do so in exchange for anticipated relief. Supplicants are admitted to certain areas upon paying a few piasters and for a few piasters more may receive an incensing (bakhūr). This means inhaling deeply from a censer that is then passed around all the openings of one's body. The smoke of incense is believed to be curative.

The ḥaḍra service includes a zikr (or dhikr), a religious trance ritual. Zikr much animated physical activity and allows considerable expression of individuality. For some participants this includes "speaking Syrian language," a phenomenon referred to in the West as speaking in tongues. Participants believe the unfamiliar sounds made by individuals in trance are the ancient Syriac language and regard them as direct communion with the divine. It is true in the West also that pilgrimage to famous healing sites, together with the expectation of being cured, enhances the probability of cure. So too in the Near East the journey to a tomb and performance of rites there may in itself effect a cure.[1]

D.4. Herbalists ('Aṭār)

Herbalists are presented as merchants who sell herbs, spices, and other goods. Herbalists are thus commercial entrepreneurs. They are also advisers on health matters who educate people about and prescribe folk cures (waṣfāt baladiyya) and make available the products for them. Some herbalists occasionally make diagnoses.

The 'aṭār is not a full-time health worker and Egyptians do not always purchase his products for therapeutic purposes. The products also include or may be used as cooking ingredients. Ginger,

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[1] See Barclay (1966: 202-204), Blackmann (1927: 240-242), and El-Islam.

for example, is both used as a spice and boiled as a sore throat remedy. The 'atar is paid for the products he sells on a unit basis.

a) Botanical and mineral products used in folk cures and probably dispensed by the aṭār include: aloe (ṣabr), antimony (koḥl), cumin (kammūn), fenugreek (ḥelba), seeds of nasturtium (rashād), and tamarisk (ṭarfā or atl). Many of the herbal products are known to possess definite pharmacologically-active properties. Research to assay certain locally-used products has been carried out by the University of Alexandria's Faculty of Pharmacy.[1]

Some contemporary folk cures combine herbal products from the 'aṭār with foods from the market and patent drugs from the Western pharmacy. Ingredients are prepared and employed in a variety of forms including infusions (very common) and suppositories.

b) Resort. Many Egyptians with access to physician-centered treatment and medicine may still consult an herbalist and employ herbal remedies under certain circumstances. This may be done as a first resort upon symptom presentation, in place of costlier resort to a physician and Western medicines, concurrently with Western medicines or physician treatment, when physician treatment fails to bring cure or relief, or because of female reluctance to expose themselves to male physicians.

D.5. "Elderly Women" (Sittat Kebar or Sittat Kibira)

Each village and urban neighborhood has several experienced "old women" who are frequently sought out for advice about illness and infertility. They are not full-time specialists. They request no fees but rather expect to be rewarded in heaven for their public service.

"Old women" in Cairo are said to be increasingly called upon for advice about dealing with private physicians and the health care facilities. Usually they are post-menopausal women who can walk in the streets and talk to any man without concealing their faces.[1] Some Egyptians suggest that since these women already act as health-advisors they could be beneficially trained to educate others in health and hygiene.

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[1] Osborn 1968. Marzouk (1973: 384-385) also reports positive results of chemical and pharmacological tests conducted to determine the effectiveness of herbs, dried plants, natural minerals, and chemicals used in indigenous abortifacients. Phillips (1958, vol. 2) lists 805 botanical folk cures with explanations of their application among Lebanese. See also Lane and El-Fattah et al.

[2] See, for example, Ammar (1966: 90) and Fakhouri (1972: 15).

D.6. Bonesetters

Bonesetters are specialists of "naturally caused" disabilities. They are rarely mentioned in the available sources.

D.7. Gypsy Practitioners of Clitoridectomy

"Gypsies" are briefly mentioned as carrying out clitoridectomy and being looked down upon by the dayas.[1]

D.8. Zar Organizers (Excluding the Zar Sheikh or Sheikha)

Specialists part of the zar therapy include performers of "drumming" (dagga) and sometimes "reconciliation" (sulha). They are probably the least prestigeous of all people engaged in therapy for dealing with "supernaturally caused" illnesses.

E. STRATEGIES OF RESORT

Resort is eclectic and determined by both symptom and situation. Rural and urban poor both identify some ailments as naturally caused and others as supernaturally caused. They also believe different practitioners are appropriate for different ailments. They recognize the rapidity and effectiveness of "modern" medicine and may turn to the rural health unit, the maternal and child health unit, and the hospital when illnesses--especially the naturally caused sort--become acute. Health-seeking behavior cannot be explained by characteristics inherent in illnesses and health facilities alone, however. Social and economic factors also play a major role.

The wealthier of the poor families reportedly visit private physicians more readily and over longer periods of time than do the poorest of the poor. Health care at the clinics and rural units is theoretically free but in fact it often costs a great deal more than indigenous health care. Going to the doctor--given the long waits necessary--can mean loss of a day's wages plus require payment for bus fare and medicine. It may also mean a bakshish to the doctor for extra attention or not having to return the next day. When medicine is not available at the clinic it must be bought commercially and may ultimately be too expensive.[2] Even so, many low-income people pay nevertheless, at great sacrifice, for physician's services and the prescribed medicine. The family members for which they are willing to sacrifice, however, are not determined by symptom severity alone.

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[1] El-Hamamsy 1973 and Morsy 1977b.

[2] See Fakhouri 1972: 16.

Many villagers and urban poor do not consider symptom severity the primary basis for evaluating an individual's illness and the urgency of treatment. In fact, symptoms described for various cases of illness tend to be generalized and diffuse (such as weakness, depression, and aching all over) and similar from one illness episode to another. Moreover, not everyone in the household goes to the doctor. It is too expensive. A hierarchy exists within the family that determines who goes to the doctor. More important than symptoms for determining the urgency and form of treatment extended to a family member is his or her status within the household.

Scarce resources are more frequently allocated to men--especially male household heads--than to women. It is explained that a man's illness is more detrimental to household welfare since resources may have to be diverted to hire wage laborers to work family land in his place. One survey of village family expenditures for illness during one four-month period revealed an average of L.E. 2.20 for men versus 1.50 for women.

Age is also a major factor in evaluating an illness' severity and may mediate the factor of gender. A woman who has gained the high status of mother of an adult sone receives prompter and more costly treatment than a young childless daughter-in-law or a male infant in the same household or maybe even than the adult son's wife.[1]

Many peasants have reportedly lost the confidence they once had in government medical services because of the attitudes of their personnel or the inadequacy of their pharmaceutical stock. In one village infant care clinic near Cairo, which mothers bring infants for shots and medicines, services are provided free but medicines are often lacking or rendered useless by lack of refrigeration. Other services, offered for a small fee, are not sought by patients. The reason is reportedly not the fee but frequent humiliation by the doctor--something rarely experienced with traditional practitioners. Many rural people apparently see little advantage in going to clinics for check-ups but only resort to them if in great pain.

F. HYGIENE, PUBLIC HEALTH, AND PREVENTION

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[1] See Morsy 1977b: 11-12. A woman is assigned inferior status when young but when older, especially if she has surviving adult sons, she has a position of honor in the family. A man's love and respect for his mother is characteristic for Egypt; even after his marriage, the mother usually retains her son's primary loyalties. See Blackmann 1927: 45.

F.1. Beliefs Related to Hygiene

a) Cleanliness is traditionally viewed, not as the absence of dirt, but as the absence of things that cause religious impurity. To be in a state of valid ablutions (as prescribed by Islam) is "cleanliness." Not being so means "pollution" or dirtiness (nagasa). Greater care is generally taken to be clean this way than in the secular-hygienic sense, but the two concepts of cleanliness are not necessarily contradictory. Ritual cleanliness, for example, demands that husband and wife cleanse themselves after intercourse and prevents an individual from reading or even touching the Quran after urination or defecation without washing first.

Egyptian peasants, for generations dependent on the Nile for a livelihood, traditionally consider its waters holy, purifying, and curative. The snail-infested Nile and its canals perpetuate the debilitating bilharzia from which about 50 percent of the rural poor suffer and 5 percent of them die. Yet most villagers maintain an attitude of resignation to this situation over which they have little control. "If God wills that one dies," they say "that person will die whether he drinks the water of the Nile or not."[1]

b) Pollution. Blood, especially genital blood, is regarded as dirty, polluting, and therefore dangerous. Women are considered "unclean" and polluting during menstruation and after childbirth. A menstruating woman whould not enter mosques or visit graves during menstruation and is regarded "unclean" for forty days after parturition, the traditional period of "confinement" (nifās). She is called a "breathing woman" (nafasiyya) as if her breath were not clean. According to tradition she should be segregated from the rest of the household, not cooking or washing until after this postpartum period when she cleanses herself with a purifying bath.[2] In practice, however, this demands the luxury of surplus help and space that poor families can rarely afford.

F.2. Public Health

Islam embodies numerous principles pertaining to the general well-being of the community. These are rarely mentioned, however, in the sources on indigenous health care.

F.3. Preventive Measures

Egyptians understand extremely well the principle of preventive medicine—and employ a vast range of measures in the belief they promote good health. These measures are culturally-defined.

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[1] See El-Guindi 1967, Sukkary 1976: 12, and Ammar 1966: 73.

[2] Ammar 1966: 91; Lane 1966: 511.

Since tradition says that the main illness-causing forces are jinn and the evil eye, it follows that the main consciously-employed prophylactic measures are those that stave off jinn and the evil eye. Basic among these are the use of amulets, repetition of special phrases, avoidance of "dangerous" places, and dressing children shabbily.[1]

There are certainly numerous practices too that would be considered preventive by the standards of international medicine. It is not clear whether Egyptians who carry them out consciously regard them as illness-preventive and little is written about this.

G. DIET; DISABILITY

G.1. Diet

Little is described about Egyptian dietary beliefs and behavior. It is said Egyptians do not "make much fuss about food" but eat "almost anything" in the belief that "all food is given by Allah"--who permits eating everything except pork, blood, and the flesh of animals that die without ritual slaughter.[2]

a) Bread. Childhood socialization teaches Egyptians to sacralize bread, the staple food that may provide about 75 to 80 percent of the rural daily caloric intake and about 50 percent of its protein. An adult man reportedly eats more than 3 pounds per day of this bread whose name means, literally, "life." Children are taught not to let a crumb drop and if it does to pick it up and kiss it.[3] Saying one has "had bread and salt" with another is a symbolic statement of bonds of friendship or obligation.

b) Meat, poultry, and dairy products.[4] Meat (water buffalo, mutton, and beef) food for rich people and for festivals. The poor can afford it only in small amounts, except on feast days when the amount eaten in one day may equal a normal two-weeks' consumtion. Special blessings accrue to a person who, to fulfill a vow or for some special event, kills an animal and distributes its meat to others.

Chicken ("one per day") should be consumed by a women "to bring milk" during the 40-day postpartum period. Children are customarily

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1 See regional section above.

2 Gadalla 1962: 67. See Patwardhan and Darby (1972) for a nutritional overview of the Near East region.

3 See Ammar, Ayrout, and Abdou and Mahfouz.

4 See El-Naka (1975) and Abdou and Mahfouz (1965).

breast-fed until about 2 years—as is prescribed by the Quran.[1] Eggs and meat are sometimes withheld from some children in the belief that animal foods cause "putrification in the abdomen."

c) Obesity. This is traditionally a sign of health and wealth and thus respect and prestige. For women it is regarded an element of beauty. Many people believe it desirable, if affordable, to eat rich meals and purchase obesity—producing preparations such as the reportedly common mefataka. Preparations called "cow-pearl jam" and based on ingredients such as honey and almonds are prepared and sold by local herbalists and for this purpose.[2]

d) Stimulants. Rural people traditionally consider coffee a great luxury, to be indulged in only by city people or on rare occasions. Tea, however—boiled until black and heavily sweetened and thick—is to many rural poor as necessary and symbolically important as bread. It has been called the drug of the Egyptian peasant and those addicted to it are said to do without food and may starve their families rather than give it up.[3]

G.1. Physical Disability

Blindness. The prevalence of blindness in Egypt (caused in large part by trachoma) is among the highest in the world.[4] Blind children—especially males—traditionally, go to mosque schools where they study the Quran until able to recite it well by heart. This earns them the honorific title of sheikh. The title dignifies and permits them to profit from the handicap by reciting the Quran, for pay, in others' homes.

This has resulted in the traditional beliefs that blind people have "the best voices," that blindness is not really much of a handicap after all, and that it might even be considered a blessing from God. With the greater availability of modern public school education, however, the categorical prestige of blind sheikhs has declined.[4]

H. FERTILITY: ATTITUDES AND PRACTICES

To understand attitudes of low-income Egyptians toward health and illness it is essential to recognize the supreme importance of the family for the welfare and even survival of an individual. "To

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[1] See Omran 1975. Beliefs and behavior associated with lactation are described by Sukkary (1976b).

[2] El-Fattah et al. 1974.

[3] Ayrout 1963: 80-82.

[4] Gadalla 1962: 66.

have no people" (that is, no kin) is not merely unfortunate but said to be one of the gravest insults possible.

H.1. Pronatalism

Egyptians traditionally idealize children as the glory of the world, the joy of life, gifts of God, and the immediate purpose and eagerly awaited fruition of marriage. To refuse to have children because of economic considerations means lack of faith in God, who always provides.

Not only are children valuable assets in partially relieving the household's work burden but they are also nonsalaried labor for increasing the productivity and, alternatively, bringing extra cash if hired out. Children start contributing to the family income very early in life and are not viewed by rural people as costing anything extra. If in fact children do not mean additional financial costs to the rural family, this is a view that is dramatically at odds with the realities of urban existence.

a) Valuation of sons. Sons are especially highly valued, and daughters considered a burden. The high premium placed on sons is reflected in such popular sayings as "A boy who dies is better than seven girls" and "A boy is a joy even if stillborn." Sons become the main security for parents in illness and old age and thus the number of adult males in a family has to a great extent determined its social status as well as its economic security. The more male earners and workers in the family, the higher the income and the less devastating is the sickness or death of one of its key providers. Fathers who have seven or more sons are traditionally held up as enviable models, and one of the "best" wishes that can be extended to a rural man is that he will have "seven sons and perform seven pilgrimages to Mecca." To produce these sons is regarded a woman's chief role.

b) Infant morbidity and mortality. The Egyptian poor are accustomed to seeing infants and children die. Infant death is not always a catastrophe for it happens all too often. This has made it necessary, however, for a family to have many children to insure the survival of two or more male children into adulthood. The desire for a large number of surviving sons(coupled with the realization from first-hand evidence that persistently ill children, or those born with birth defects, tend to die anyway) leads some poor parents to relatively readily relinquish a child to "God's will"--especially if female--and start over again hoping the next infant will be born healthy.[1]

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[1] Fernea's description (1970) of rural Egyptian women encouraging her to let her asthmatic child die makes clear the different orientation of poor peasants.

The high value placed upon children makes them more susceptibel to envy and thus more prone to supernaturally-caused illnesses than adults. Many rural Egyptian also believe that every infant has a "sister sout" in the spirit world who has the right to claim its human counterpart to join it. If the "sister soul" excercises this right, it does so within seven days--a belief that explains why it is "natural" so many children die within the first week after birth.

Given the prevalence of tetanus neonatorum as a factor contributing to high infant mortality in rural Egypt, such a folk rationale explains the otherwise unexplainable.

On a personal and familial level, resignation to "the will of God" may well have been a psychologically and socially adaptive response to these regularly recurring situations over which villagers, given limited knowledge and resources, have had little control.[1]

H.2. Clitoridectomy and Infibulation ("female circumcision")[2]

A variety of genital mutilations of female children are carried out in Egypt to enhance and in some cases insure female virginity and thus family honor. Westerners commonly refer to them by the collective euphemism, "female circumcision." This is misleading; it masks the severity of the procedures and the fact that they frequently result in far more pain and serious medical complications than does male circumcision. Three distinct procedures can be identified.

a) "Sunna circumcision"--the mildest form, entails removal of the prepuce and/or tip of the clitoris.

b) Clitoridectomy or excision--removal of the entire clitoris together with the adjacent parts of the labia minor and exterior genitalia except labia majora.

c) Excision and infibulation ("Pharaonic circumcision")--removal of the entire clitoris and labia minor as well as part of labia majora. The two sides of the vulva are then closed over the vagina, except for a small opening. The closure is variously made

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[1] See the more detailed discussions of these complex relationships in Ammar 1966: 56, El-Hamamsy 1972, Shawky 1965, Early 1977a.

[2] Egyptian data in this section is based on El-Hamamsy 1973, Hansen 1972-73, Kennedy 1970, Karim and Ammar 1965, and Morsy 1977b.

with thorns, catgut, or even modern surgical silk. This causes the wound (created by scraping raw the labia majora) to close the opening with scar tissue as it heals. The vagina is thus sealed off except for a tiny opening. The object is to make intercourse impossible. Infibulation ("sewing up") requires that a woman be at least partially defibulated ("cut open") to permit intercourse when she marries and fully debibulated for the childbirth.

The practice pre-dates both Islam and Christianity. It is not Quranically prescribed but many Muslim leaders sanction and promote it. Infibulation insures that one's daugher will remain virgin until married. Clitoridectomy is done to reduce sexual desire and thereby the probability of extramarital liasons.[1]

d) Health risk. Among the immediate results (especially of infibulation) may be hemorrhage, shock and fatalities due to blood loss, damage to adjacent tissues and structures, gangrene, tetanus, and other infections due to septic conditions and crude tools. Longer range complications (in addition to difficulties in urinating and menstruating) may include abcesses, keloid scarring, dermoid cysts, genital infections, coital problems, and sometimes sterility due to chronic pelvic infections.

There may also be complications at childbirth since both the hardened scar tissues and infibulation frequently require extensive cutting to permit delivery. Infibulation makes childbirth more hazardous and increases probability of pain and mortality for both mother and child. Psychological damage may also be great.[2]

e) Prevalence and motivation. All three operations are carried out on women in Egypt but the third only among Nubians. Research conducted in 1966-67 in Cairo suburbs and nearby villages revealed that 100 percent of the women coming to family planning clinics for IUD insertion had been subjected to one of the three forms. One pregnant female physician at a clinic stated that if her child were female she would "circumcize" it herself. Reasons given were: first, religious (she was Muslim but both Muslims and Copts submit their daughters to the operation); second, for cosmetic reasons--to remove something

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[1] Clitoridectomy is performed in a broad area across Africa parallel to and just north of the equator. Some sources mention it occuring in southern parts of Libya, Algeria, and Morocco. Infibulation is said to have originated in the Southern Arabian peninsula and then spread along the Red Sea and to the Nile Valley. Some sources report it in Yemen.

[2] See reports by WHO officials (Baasher 1977, Cook 1977) produced at least partly in response to international pressure against this mutilation. "Pharaonic circumcision" was an issue of discussion at the 1977 30th World Health Assembly (WHO Regional Office for the Eastern Mediterranean 1977:14).

disfiguring, repulsive, and ugly; third, to spare and protect the girl from sexual stimulation; and fourth, because of tradition—it had always been the custom and one did not want to depart from the norm.[1]

Three categories of practitioners are said to carry out the operations: itinerant gypsy practitioners, dayas, and physicians. Cairo physicians are reported reluctant to perform the operations but at least some apparently do.

It is said that through the 1920s all Egyptian women underwent clitoridectomy and that nearly all women today over the age of about 20 have been "circumcized." It is also asserted that the percentage of females being "circumcized" has now fallen in urban areas to less than 50 percent.

The subject is a highly sensitive one. The practice is deeply embedded in traditional culture and the views therein both of female sexuality and the assumed rightful need for women to be held subordinate to men. Many women with college educations (and even female physicians) tend to be reluctant to discuss the practice. Many men are ignorant of its details since it is traditionally done only in the presence of women. Relatively little exists about it in the large literature on Egyptian and other Arab women.

Campaigns have been waged at several times, including at the present to put an end to this mutilation. Results have been complex. Officials are advised not to scoff at the issue but to inform themselves well if steps are to be taken.

H.3. Fertility Regulation

In all cultures methods have evolved for regulating fertility. These are premised on local beliefs about human physiology, fetus formation, sex roles, the supernatural, and relationships between pregnancy, diet, childbirth, and lactation. Indigenous fertility regulating methods are employed to enhance fertility and speed conception, to prevent conception, to induce a "late period," or as abortifacients. Knowledge of these practices and especially of the beliefs that motivate them is important to greater success in family planning programs.[1]

a) "Spacing." Investigations in Alexandria and in two villages south of Cairo reveal continued widespread use of indigenous fertility regulating methods. They are not viewed as birth control for limiting the number of children born, since that number (as well as the number of children who survive) is said to be determined by

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[1] Sukkary (1976) and Marzouk (1973) are major sources on this subject. See also Huston.

the will of God. Rather the indigenous methods are thought of primarily as "spacing" measures employed to afford mothers a chance to recoup strength after pregnancy and to adequately breast-feed newly-born infants.

Two years--the period recommended by the Quran as the length of time a child should be breast-fed--is considered proper spacing.

b) Substances used for "spacing." Among these are afass (a spice) and Indian barley (Hindy shiriy) combined with lemon juice; aloe (sabr); novalgi; aspirin; lemon juice; and lemon juice and black pepper.[1] These are respectively purchased from herbalists, drug stores, or markets. They are inserted as vaginal suppositories prior to intercourse or taken orally. Many village women apparently believe these substances prevent menstrual blood from forming into a fetus.

Numerous herbs, natural minerals, and chemicals used in traditional contraceptives have been collected and chemically and pharmacologically analyzed. Most proved to have some effect of the sperm. Quinine powder, for example, was found to have a direct chemical effect. Some materials (such as honey and peppermint) were found to hinder sperm movement. Other materials (such as caster oil seeds and cactus) were found to have an irritating effect on the vaginal tissue.[2]

Perceived attributes of these methods are that they are inexpensive, easily procured locally (not necessitating a trip to the hospital and a several-hour wait while there), are employed without husband's knowledge, are not painful (and "cannot poison you" since they are based on items used in cooking), that they are easily inserted but do not involve insertion of artificial objects that might cause bleeding, do not cause weakness or otherwise interfere with normal body functioning, do not interfere with (shorten) lactation, and that they do not necessitate examination by a doctor.

c) "Late periods" and abortion. Women recognize that the indigenous methods are not wholly reliable and if conception nevertheless occurs attribute it to, and allegedly accept it as, "God's will." Those who observe a period "being late" but do not want to accept what others call "God's will" may seek to induce menstrual flow by drinking an infusion of cinnamon (purchased from local herbalists). This and an onion peed drink (made by boiling onion peels about an hour) are also taken as abortifacients. Other women seek

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[1] Mothers also smear their breasts with the very bitter aloe (or cactus juice) to wean reluctant children. Aloe is also used on children's thumbs against thumb-sucking.

[2] Marzouk 1973: 384-385.

to induce abortion through heavy exercise, carrying heavy loads, and by vaginal insertion and manipulation of a twig of the mulukhiyya plant.

d) The main sources for information and advice are relatives, friends, "old women," and trusted midwives. Many women avoid discussing the topic with their husbands for fear they or their families will interfere.

Clearly implicit in women's appraisal of advantages of the indigenous methods is criticism of modern birth control methodology. Even those who believe in the greater efficacy of modern birth control methods sometimes revert to indigenous fertility regulating methods when they desire "a rest" from the pill. According to some village women characteristics desired in any fertility regulating method are accessibility, cheapness, lack of bitterness, lack of insertion of "unnatural instruments," and secretiveness.

H.4. Sterility

a) Attitudes towards sterility. There is said to be no greater stress or insecurity than that facing a sterile woman. A woman who does not bear children may be called akir--one who literally "kills" her offspring. A childless woman is said to be a "sore eye" for the family since she can never make her husband proud among his peers. A "proper woman" in contrast is an "envelope for conception." A plump woman is regarded as ideal for having "more room" to bear the child, lactating more adundantly, and giving more warmth to her children.

A woman's failure to become pregnant is widely attributed only to her. In the eyes of the community, the husband of a sterile wife is fully justified in divorcing her or taking a second wife. If the second wife bears sons she is pampered and her demands readily met while the first wife is expected to work for her rival and be grateful she has not been sent back to her family. It is not surprising that folk cures abound that are supposed to cure women of sterility or that a majority of participants in the zar curing ceremony are women who have failed to produce offspring.

b) "Cures" for sterility. These include both natural substances and appeal to supernatural forces. An example of a "cure" believed pharmacologically efficacious is sufa, a vaginal suppository of cotton wool daubed with some supposedly fertility-inducing ingredient, such as sugar, fenugreek, or Ichtyol solution. Many women turn for advice to a daya who may prescribe douching powder, a suppository, or consultation with a doctor.

Other strategies involve manipulation of fertility symbols such as earth, maize, jewelry, sand, and water. Others are based on the presumed

potency of blood and the belief that a childless woman is "bound" (mushahira) or affected in some way by the moon. Crossing the Nile in a boat or visiting a faraway saint or shrine is considered one way to "unbind" a woman, the journey symbolizing that she is moving from one state to another. Many Egyptians believe the evil eye is the ultimate source sterility. In one village 10 of 16 sterility "cures" explicitly involve accusation of others for having induced the condition.[1]

c) Efficacy. A rule of thumb cited about therapeutic efficacy is that the larger the number of cures for a single problem, the less likely it is that any of them are highly effective. This appears the case with Egyptian sterility "cures"—which abound in great number. Nevertheless, while such strategies do not regularly succeed, the strong pronatalist worldview and the fact that some women do become pregnant after employing them work to maintain faith in their presumed efficacy.

I. CULTURE-SPECIFIC ILLNESSES AND MENTAL HEALTH

I.1. Mushaharai[2]

Mushahara is a pre-Islamic concept referring to an abnormal state of supernaturally-caused harm which may be manifested through various symptoms including sterility, lactation failure, illness, paralysis, wounds that do not heal, eye disease, and blindness.

Mushahara occurs in individuals in "vulnerable" states because of other persons' violation of certain taboos. Persons are considered vulnerable during the life "crises" and attendant rituals of birth, circumcision or excision, marriage, and death. Victims are usually, if not always, female. Beliefs relating to mushahara are very diverse. Few Egyptians can give little explanation other than that their ancestors "did it that way." Mushahara is reported from both urban and rural Egypt but best described as it is manifested in Nubia.

The term derives from the Arabic shahr, "month." It is believed that if certain proscribed actions are engaged in before the appearance of the next moon (the beginning of the lunar Arabic month), harm will befall an individual undergoing one of the life "crises." The rites of birth, male circumcision, and marriage all involve pain and flowing of blood in and from the genital organs. A female remains in a vulnerable state for 40 days after these events or a death and is especially vulnerable during rituals performed on the 1st, 3rd, 7th 15th, and 40th days.

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1 Ammar 1966.

2 Mushahara is discussed in most detail by Kennedy (1967a) See also Ammar (1966:88), Early (19772), El-Hamamsy (1973:28), and Messiri (1975).

Actions to be avoided for fear of precipitating mushahara in a vulnerable person include bring "dangerous substances" (gold, the barber's razor or knife, blood, and eggplant) into that person's room. Nor should a vulnerable person be visited by "dangerous persons"--those who have been "contaminated" by actions such as crossing the Nile, seeing blood in the market, having an incision or operation, having a haircut or shave, visiting a grave, or seeing a dead grave, or seeing a dead body. Mushahara may also be precipitated by parents who do not refrain from intercourse for 40 days after circumcision, excision, or birth.

Preventive or neutralizing measures and cures abound. They include crossing fire with palm leaves and salt, rituals involving blood, offerings to the Nile (and this the Nile spirit-beings), and ablutions with Nile water. These practices are motivated by the belief that blood (especially from the genitalia) is polluting and may subject a person to great supernatural danger by attracting powerful, capricious spirits. Nile water, on the other hand, is believed to purify against pollution and danger.

The extent to which these beliefs actually motivate behavior is not clear. Some Egyptians disavow any belief in and ignore the practices of mushahara while others faithfully follow them. Increased secularization on the one hand and Islamic orthodoxy on the other, as well as a higher level of formal education, tend to diminish adherence. For some women who seek to avoid pregnancy and communal pressures to become pregnant, the mushahara syndrome, even if they do not believe in it, provides a convenient and socially acceptable reason for not becoming pregnant. Lactation failure may also be attributed to mushahara.

I.2. Rabt

A related male syndrome is rabt (loss of erection, loss of sexual potency). It is believed a man becomes etrabat due to sorcery levied upon him by enemies. Rabt is psychiatrically identified as an anxiety neurosis (specifically as psychogenic impotence displaced upon malevolent witchcraft). Some victims seek counter-corcery cures from traditional healers. Manipulation of cultural symbols, such as amulets and Quranic verses, often successfully alleviates the culturally-constituted fear.[1]

I.3. Mental Health

Low-income Egyptians do not distinguish so sharply between mental and physical illness. Nevertheless they are siad to "recognize mental illness in its modern psychological meaning" and to distinguish two types of mental disorder.[2]

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[1] See El-Sendiony 1974: 104-106.

[2] See El-Shamy (1972: 19-24) on whom most of this section is based. Racy (1970) presents a superb overview of psychiatry (folk and formal) in the Arab world.

a) Mental disorders due to physiological deficiency or malfunction. These are referred to as khilqa—"due to creation," and thus to God. Disorders are largely recognized as khilqa when they can be directly attributed to an organic cause such as a birth defect or injury. Village barbers, sheikhs, and physicians are sought out for malfunction of this sort. Indigenous treatment includes physical manipulation and use of herbs. If symptoms persist they are usually regarded an act of God and curable only miraculously. It is stated that the community does not try to isolate such cases as in the West.

b) Mental disorders due to "spiritual" malfunction. Mental and emotional disorders that have been preceded by a state of normalcy and not precipitated by injury are usually attributed to possession by spirits, usually the omnipresent jinn but also identified as shaytan, 'afrit, ablees, or zar spirits.[1] Problems attributed to spirit intrusion include chronic headaches, extreme apathy, hallucinations, convulsive seizures and sterility.

Spirits tend to cluster in certain areas. They are particularly fond of filth, garbage, and ashes but they prefer dwelling in human bodies and are thus always a threat to people. Lavatories and cemeteries are the two most common places for spirits to enter and take possession of a person. This commonly happens in conjunction with some "fright" incident or to a child who wanders unattended at night during the customary two-or three-day visit at relative's graves. Spirits may also appear in bad dreams.[2]

It is believed that all humans are potentially vulnerable to possession but that individuals differ considerably in degree of susceptibility.[3] Disorders attributed to spirit possession are regarded as curable, providing that demands of the spirit can be met or pending intervention by other members of the spirit's community, especially its superiors or adversaries.

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[1] According to El-Shamy, belief in supernatural beings (especially jinn and 'afrit) is practically universal in Egypt on both folk and elite levels. According to El-Sendiony (1976), "highly intellectual" and urban Egyptians who feel extra-human forces prevailing in their bodies tend to express this in scientific or technical terms—for example, one's body being "full of x-rays," being influenced by computers that keep "boosting" the victim up and down, or being influenced by electricity and "spheric waves."

[2] Egyptians are said to place great faith in dreams, which often direct them in some of the most important actions in life. See Nelson (1971:207) and Lane (1966:268).

[3] Fakhouri 1968: 50.

c) Treatment sequence. In the case of disorders ultimately attributed to possession, three consecutive stages constitute the indigenous treatment sequence. At first sign or symptom of serious emotional or mental irregularity the aid of a sheikh is usually sought. Verses from the Quran are recited, or an amulet is prescribed, or both. Visits to local saints or to supreme saints in Cairo are usually prescribed. The holding of a zikr ceremony with food gifts to the poor on behalf of the afflicted person is often urged. The purpose is to win the sympathy of the saint (nazrah) who is expected in turn to plead with God to ease the patient's plight.[1] The afflicted person may also seek herbal, blood-letting, or other physical treatments from the health barber.[2]

If symptoms persit a specialist (referred to in the literature as a shaman) is consulted and therapy moves from the sacred realm toward non-sacred magicoreligious forms. Attempts focus on controlling the spirits rather than seeking the aid of God. The specialist first seeks to establish communication with the possessing spirit and get it to give reasons for possessing the person and to stipulate its conditions for leaving the body. If this local specialist fails to control the spirit, he or she may recommend a more powerful regional or national level specialist or one with a different religion (Muslim or Coptic) on the grounds that the possessing spirit is of a different religion or a much stronger class (sufli--evil or subterranean) than the minor specialist can control. The zar is usually the last stage of treatment.

I.4. The Zar[3]

Zar means, literally, "visit." It refers both to a ceremony and a class of spirits. Persons who regularly participate in the ceremony are sometimes said to constitute a "zar cult." The zar ceremony is a last resort which has powerful therapeutic effects for several kinds of ailments. It is said that when a patient enters the zar, he knows "this is it."

The zar is believed to have been introduced to Egypt during the early 19th century by female Ethiopian slaves who entertained in the Egyptian Turkish upper-class harems.[4] It has long since diffused spatially and socially to the poor throughout rural and urban Egypt as it is highly consistent with Egyptian beliefs in supernatural beings, magic, sacrifice, and the inferior status of women.

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1 El-Shamy 1972: 20-21.

2 Kennedy 1967: 186.

3 For the details from which this section has been drawn see the sources on the zar listed in section B above.

4 Cerulli 1927: 1217.

Today it is disparaged by both the Westernized Egyptian elite for being a "backward lower-class practice" and by conservatice Islamic orthodoxy for being sacriligious. The zar is predominantly a women's activity having little to do with formal Islam. Men of all classes generally criticize it but some occasionally join zar audiences. A few men are said to resourt to zar practitioners but only in private so as to avoid public admission of belief in the zar.

a) Basic elements and variation in the zar ceremony. There are two kinds of zar ceremonies, public and private. Most, if not all, were formally private. The public ceremony appears now to have become the more common. The major elements in both are usually the possessed person (the patient); the zar practitioner, called sheikha (female) or sheikh (male), who is also possessed but who has come to terms with her or his spirit and is therefore regarded as full of baraka (blessedness) and capable of healing others; the kudiya, a female specialist who is the "organizer" of the zar; musicians—usually male and who may include a singer, flutist, drummer, and tambourist ("tamburinist"); and the audience, many of whom are possessed persons who have "come to terms" with their spirits; and lastly the spirits.[2]

Zar practitioners usually claim professional sanction through inheritance of power and knowledge from their relatives or through dreams in which the spirits have summoned them to be practitioners.

The ceremony also varies according to the personal style of the practitioner, the severity of the illness treated, the amount the patient is able to pay, and whether it is conducted to cure a first-time patient or is only the required annual placation of a possessing spirit with whom a patient has already come to terms.[3]

Some zars focus heavily on social interaction, entertainment, and divination related to other problems. The major concern, however, is mental illness. The zar is not conducted during Ramadan since, according to the Quran, evil spirits disappear during that month anyway. In one village the zar is conducted on Fridays but elsewhere not on Fridays since these are religious days when the jinn again disappear.

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[1]Zar is reported from several Islamic countries besides Egypt—Sudan, Yemen, Saudi Arabia, Kuwait, and Morocco. See Fakhouri 1968: 49 and Klein 1963.

[2]The sources are inconsistent as to whether the kudiya only organizes and manages the ceremony or whether she may actually be its chief practitioner (sheikha).

[3]Some sources say there is never an attempt to cure but only to "come to terms." Others say the patient first seeks to have the spirit expelled but, failing this, accepts being possessed for life and seeks to come to terms. It appears the latter view is probably more accurate.

b) The ceremony. A zar is requested in an initial diagnostic interview in which a zar sheikh asks questions about eating, sleeping, and other behavioral patterns. It may be concluded that the zar is not needed. The sheikh may receive about ten piasters as a fee.[1]

If a zar is prescribed it commonly takes place in a house or at a shrine housing a saint's tomb. Those attending as "audience participants" pay a zeyara (fee) of two to ten piasters upon entering. The possessed person sponsoring the zar has paid in advance for the kudiya's services, the foods and beverages that are served to all present, and the sacrificial animals that may be slain.

The room may hold some 30 to 100 persons. Doors and windows are closed. The room is kept filled with incense and its temperature high, since "jinn are more likely to jump from the body when it is sweating." Participants all wear new or clean clothing of white or special colors to please "the masters" (asiyad), as the possessing spirits are called. Children are invited because it is believed their innocence brings baraka (blessings).

The ceremony bears great resemblance to popular weddings. A patient sponsoring a zar for the first time is called "the bride" (El-Aroosa) and the ceremony itself "the wedding of the masters" (farah ma'a el-asiyad). She is dressed in a white gown (galabiyya) and veil and prepared with henna, kohl, and gold jewelry as if marrying. Zar spirits are said to be in love with those they possess, and if they are not permanently expelled in the ceremony it constitutes a wedding, for life, of the woman and her spirit "master."

The sheikh begins the ceremony with songs and drumming while the possessed women sit swaying side to side. According to an often-quoted Arabic proverb, "Songs are the life of the soul and music helps to heal the sick." An important qualification of the zar specialist is knowledge of the special songs for summoning spirits. Each song "belongs" to a different spirit. When a spirit possessing some person recognizes its song, that person begins to shake and make her way to the central dancing area, sometimes giving a tip to the practitioner. One by one women in the audience lose their restraint and join the other dancers.

As the musicians loudly play and sing, the possessed women may dance wildly, beat their chests, hyperventilate, wail or shout for joy, and eventually go into trance.

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[1] Sums reported here are from the late 1960s and are therefore higher now.

A woman in trance is described as "leading her body to the master" and no longer responsible for her actions. Whatever she does is attributed to the spirit and thus she is permitted to abandon normal inhibitions and release pent-up energies, urges, and other emotions until she collapses in exhaustion. It is the duty of relatives and friends to gather supportively around her and pacify the spirit. She is revived by them, or by the practitioner, through massage and a drink of water. When all the possessed dancers have collapsed in exhaustion the music stops.

The first-time patient's zar spirit now having revealed itself, the practitioner attempts to get it to leave the patient and/or to transform its attitude into benevolence--to convert it from an evil to a protective spirit. This is accomplished by asking it what demands it wants to make in exchange for reducing the requency or severity of its victim's sufferings.

Only the kudiya (or sheikh) a;pme cam hear the spirit's answer. Some spirits make simple demands such as that the patient acquire and wear new or special jewelry or clothing. Others demand an animal sacrifice which the practitioner complies in carrying out. This, in some cases, provides a final ceremonial feast. In Nubia at least, some patients are then advised to sit in seclusion for 40 days like a new bride.

c) Female status and zar effectiveness. It is apparent that the zar is a response to constraints imposed upon women by their attributed inferior status. The evil dangerous zar spirits are always male. It is the male spirit that possesses a woman, dominates her, and demands things of her. She can make no demands of it but only assume a passive role in the relationship and seek to pacify. In no case are female spirits mentioned as possessing either men or women. The term used to address the spirit connotes the dominating authoritative male status--el-Sayed ("the master"). Women similarly often address their husbands Ya Sidi ("Oh, my master"). The parallel between the two relationships is apparent. It follows for several reasons that poor women who are in particularly weak power positions vis-a-vis their husbands, their families, and society at large, succumb to zar spirits.[1]

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[1] See also Morsy's discussion of the Egyptian folk illness 'uzr. The ultimate cause may be traced, she reports, to assymetrical power relations. The illness directs attention to personal grievances and distress and induces a temporary enhancement of social position among persons in subservient positions suffering social stress and role conflict. Through the syndrome barren women in particular, but also sterile or economically-dependent males who have no access to culturally-valued power bases, legitimize their departure from expected role behavior by reference to their spirit affliction. (Morsy 1978a).

Given the social pressures brought to bear upon women as females, together with the anxieties imposed by poverty, the zar often does accomplish therapeutic aims of symptom relief and improved functioning in a milieu which these poor women are quite powerless to change. Part of its effectiveness is attributed to such universal characteristics of positive therapy as faith, suggestion, symbolism, catharsis, emotional discharge, and group support. Not only is the patient bombarded with culturally potent symbols and given powerful social support, but this is done dramatically and in a way permitting temporary freedom.

The zar is also a social activity and opportunity for interaction not only with other women but also with the men who play leading roles as singer, musician, healer, and perhaps increasingly in the urban milieu as audience participants as well. It is suggested that dependence on the zar is a viable and functional adjustment for poor women under prevailing conditions of more or less perpetual stress.[2]

d) Acceptance. While patients may be temporarily cured (their spirits temporarily placated), very few are "discharged" as permanently cured. Most of them remain subject to the whims of their spirits and seek to placate them by such means as sponsoring an annual zar. These women--the more emotional, unstable, and hysteria-prone women in a poor rural or urban community--apparently make up the central core of zar cult regulars. Many regard the zar as a preventive therapy and participate to ward off trouble their spirits might otherwise cause them.

If all means have failed to persuade a spirit to depart even temparily (that is, the patient never "recovers") then the community accepts this possessed person but in a new role. She acquires the status of a spiritually-favored person with supernatural powers corresponding to the nature of her supernatural possessor. Being a *mikhawi* (one commanding a supernatural companion) sometimes confers added prestige. In addition, a possessed person may become a shaman herself, provided the spirit agree.

The indigenous culture thus accommodates the incurably mentally ill and the community as a whole is said to be responsible for their subsistence. In contrast, isolation of individuals for treatment in a mental institution is viewed very negatively.[2] Someone who has received "alien" psychiatric treatment is said to be regarded as lost or

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[1] Many husbands disapprove their wives' participation in the zar. A major reason is the expense and pressure it brings to provide the new jewelry and clothing their wives' spirits often demand. Educated children also discourage their mothers' participation.

[2] El-Shamy (1972:24) reports this attitude typical of the wealthier and more elite sector as well.

dead. Even when discharged such a person is not integrated into the previous social group but becomes a butt of ridicule and children's harrassment.

e) Official opinion. It has been government policy to suppress and eliminate the zar cult. This will be difficult, however, so long as zar spirits exist. Clearly it will take much more than mere legislation to make such omnipotent beings disappear and more culturally appropriate solutions than mental institutions for dealing with the problems of persons they possess.

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A F G H A N I S T A N

A. HEALTH AND POPULATION OVERVIEW

Afghanistan stands out among the seven countries studied in two regards. First, its population suffers perhaps the poorest level of health, challenged only by Yemen in this unfortunate regard. Second, the Government of Afghanistan appears to be one of if not the most interested of the seven countries' governments in a primary health care strategy for bringing improved services to the rural poor.

A.1. Population Composition and Distribution

Afghanistan has never had an official population census. Various Government Ministries cite estimates between 14.5 and 17 million although the actual number may be closer to 12 million.[1] Approximately two million are nomadic or semi-nomadic pastoralists. Of the sedentary population about 85 percent is rural and 15 percent urban. The sedentary population lives where there is water. Its greatest concentration is in irrigation project areas. There is great ethnic heterogeneity and in-group identification. Nearly each group speaks its own language—Pushtu, Dari, Uzbek, Turkoman, Kirghiz, Baluchi, and so on.

A.2. Population and Health Status

a) Population. Afghanistan's population is young and characterized by high fertility and high mortality. Vital rates are only rough approximations. The crude birth rate is estimated at 50 per 1000 persons, the crude death rate about 25 per 1000. Infant mortality is believed to be about 180 per 1000 live births and maternal mortality 640 per 100,000. The population growth rate is probably about 2.5 percent per annum. Life expectancy at birth is estimated as only 41 years. Among persons age 15 and above, only some 14 percent are literate.[2]

b) Health. There is neither vital registration nor an effective system of disease reporting. Causes of death are often reconstructed from relatives' unschooled memories. Many children

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[1] Afghan Demographic Studies 1975.

[2] For more descriptive information see Dupree (1970) and Afghan Demographic Studies (1975).

die of diseases which in themselves are easily preventible (e.g. measles, tetanus, and diarrheal dehydration). In a majority of cases it is the combination of disease and malnutrition that kills. Main causes of adult debility and death are reported to be malaria, tuberculosis, trachoma, venereal disease, gastrointestinal infection, and nutritional deficiency diseases.

A.3. Health and Population Planning

The Ministry of Public Health has begun trying during the past decade to develop a health center network reaching into rural areas. The Government has sought assistance from foreign donors, including AID, and shows willingness to make policy changes to facilitate health programming.[1] The groundwork has been done for a health care system of hospitals in the cities and provincial capitals and Basic Health Centers in the most peripheral minor civil divisions (woleswalis). At least 121 "BHCs" are now functioning. This strategy, however, reaches only some 20 percent of the population. The great majority of Afghanistan's 23,000 villages lie far from a BHC.[2]

Experiments are now underway that may have promise for extending services to an additional 60 percent of the population. One is training the traditional birth attendants (indigenous midwives) and upgrading their skills for home delivery and recognition of high-risk pregnancies. The midwives receive financial support from the Government.

Another is recruitment and local training of men and women as Village Health Workers (Roghtia Mal). The "VHWs" are taught to recognize and treat certain common diseases and to give health education that includes nutrition, contraception, and sanitation. They receive an initial capital input from the government for supplies to be sold at profit.[3]

B. SOURCES ON INDIGENOUS HEALTH PRACTICES IN AFGHANISTAN

B.1. AID-supported Reports

AID is to be commended for bringing to light information about indigenous practitioners and village health-seeking behavior. The major source of information on these two intimately linked topics is a body of reports produced by AID-sponsored research and a

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[1] Health Sector Assessment Paper, USAID/Kabul, 1978; Area Handbook for Afghanistan (Smith et al.) 1973: 129.

[2] Management Sciences for Health 1977 and Miazad et al. 1978.

[3] Health Sector Assessment Paper.

health sector assessment paper produced by the AID Mission in Kabul.[1] These reports are exemplary of the kind of studies that should precede, or at least accompany, all AID-health programming in order for the Agency to successfully carry out the Congressional mandate.

B.2. Other Sources

Only the work of Louis Dupree and Ludolph Fischer can be considered substantive sources on the subject although some information is scattered throughout other items listed here.

For this reason AID personnel would profit from consulting the original versions of the AID-supported work, and only an outline of the material therein is presented below.

C. INDIGENOUS ETIOLOGY

C.1. Supernatural Causation

Patterns of supernatural causation in Afghanistan seem similar to those described in other survey countries. The evil eye does not appear so fearful a threat as in North Africa and the Levant, however, "God's will" remains a powerful explanatory factor.[2]

C.2. Natural Causation[3]

Ill-health is attributed to natural forces according to several co-existing medical theories. Afghanistan is uniquely different from the other six countries surveyed here in its plurality of formal indigenous medical systems.

a) Greco-Arabic Medicine. This is called Dawa-Unani by Afghans. It derives from the Greek Hippocratic system adopted by the Arabs and imported to Afghanistan perhaps 1500 years ago and builds on the classic Arab medical theories of Ibn Sina, Razi, and others. It is a medical "great tradition" meaning that it is formally taught in schools and practiced by literate professionals.

b) Ayurvedic medicine. Ayurveda ("the science of living to a ripe age") is the classical medical system of India and also widely followed in Afghanistan. It too is a "great tradition" perpetuated in schools and by literate practitioners.

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[1] The reports are those listed in the Bibliography under Afghan Demographic Studies, Hunte, Kerr, Management Sciences for Health, Macey and Pakmal.

[2] See also Fischer (1974) and Canfield (1976).

[3] This section derives largely from Macey, Hunte, and Kamiab—(1975) and Hunte (1976).

c) Hot and cold. The humoral concept of hot versus cold permeates the theories and remedies of Afgan traditional medicine. "Hot" and "cold" have little to do with temperature as measurable by a thermometer but rather with the intrinsic nature of a person or thing. Women are said, for example, to be "hotter" than men. One prevents illness by maintaining an internal balance of "hot" and "cold." Certain illnesses are considered "hot"—in which case they must be treated with "cold" foods, herbs, and medicines to restore the balance. The same principle holds for illnesses that are "cold."

d) Germ theory. The practitioner called hakims also know about germs and say they are what make people sick.

D. INDIGENOUS PRACTITIONERS[1]

D.1. Dalaks (Barbers)

The dalak is referred to as a jack-of-all-trades who provides valuable health services to his community. In addition to barbering, these include the following: circumcising, blood-letting, tooth-pulling, treatment of khorasak (wheezing, possibly diptheria) curative burning (cauterization), cooking (at weddings and funerals and preparing khairot, food given in the name of God), and town-crying (informing people about weddings and funerals by going house to house).

The dalak often inherits his profession but may also learn it through apprenticeship to an unrelated dalak. He treats patients in their homes in exchange for payment which varies in amount with the socioeconomic circumstances of the family.

It is suggested that dalaks' services could be improved by literacy training and a basic course in health and hygiene which could be conducted by the Ministry of Public Health.

D.2. Dais (Traditional Birth Attendant)[2]

Afghan midwives are proud of their inherited profession and realize its vital importance. The greatest percentage of Afghan infants are delivered by dais. They perform their work from economic necessity but also benefit from the religious merit it confers upon them.

Maternal services generally begin with pre-natal care which may include abdominal massage, dietary advice, and miscarriage

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[1] This section is based on the outstanding report by Macey, Hunte, and Kamiab (1975).

[2] See also Hunte 1976a.

prevention advice. Some dais remain in the woman's home for a few days after delivery. The dai is also sought out for advice on indigenous methods of fertility regulation—usually to induce fertility but in other cases to induce abortions.

The dai does not request payment from her clientele but an amount understood as appropriate for the community is usually paid. This is generally only about one-fifth the fee charged by a physician or nurse-midwife. Some dais will deliver for free for those too poor to pay.

The dai's role in the community is judged to make her an ideal disseminator of new information and ideas. Dais occupy crucial positions in the female networks of their communities and are accustomed to diffusing health-related information. Usually dais are related to or closely acquainted with the women they serve. They are also extremely perceptive in their treatment and able to intimately interpret social and economic factors.

D.3. Holy-Men: Mullah, Sayeeds, Malangs

This category of practitioners is said to deal with psychological problems. One or more mullahs are found in every village; they are religious leaders who play an important role in prevention and cure. Mullahs are said to be most effective in treating emotional problems, nervousness, anxiety, mental illness, and illnesses due to jinn and other evil spirits. The major form of treatment used by mullahs and sayeeds is making and prescribing amulets (tawiz).

a) Tawiz-makers. These literate persons have studied in mosque schools and may have taken several-year courses in amulet-writing. Many inherit the role and most enjoy high status in their home communities and even beyond. Amulets are usually prescribed for the following purposes: illness, male impotence, inducing or inhibiting pregnancy, influencing relations between two people, and (especially among children and pregnant women) protection from jinn. Inscriptions written on them are frequently the specific verses from the Quran that concern health. The cost of an amulet depends on its purpose. If the patient is very poor the tawiz-maker will accept whatever sum can be offered.

b) Shrines.[1] In Afghanistan as elsewhere in the Muslim world, veneration of local saints, though forbidden by Islam, is common. Ziarat (saints' shrines) dot the Afghan landscape. Pilgrims flock to ziarat to ask a pir, khwajah, or other type of

[1] On shrines and associated practices, see especially Dupree 1976b.

saint to intercede with God for special favors. Shrines, like practitioners, are often specialized. One is famed for curing mental disorders, especially female hysteria. Another is known for curing bites of mad dogs. Still others draw women seeking cures for infertility.

Shrine caretakers (motawali) must also be classed among persons rural Afghans turn to for health problems. They watch over the shrines and usually sell tawiz for preventing misfortune and for inducing all sorts of desired future results.

c) Malang. These are wandering holy-men whom Afghans believe "touched by God." Some go naked, moving with the season. Malang are fed, honored, and sometimes held in awe by the rural poor. They symbolize the interpersonal tensions that often smolder as group pressure suppresses their expression in the tightly-knit Afghan peasant society. In the peasants' view, no one willingly leaves the protective web of relationships of kin and village. Therefore the malang must have been "touched by the hand of God" and should be tolerated. When a malang dies, villagers build a ziarat around his tomb and he becomes another local saint.

D.4. Atars (Herbalists)

An atar is a shopkeeper who sells traditional medicines and understands the medicinal properties of herbs. These are Afghanistan's most common form of medicine and thus the atars perform a major health role.

Herbs are usually gathered or purchased by others and brought to the atars. Some come from the Arab countries. Usually atars neither diagnose nor prescribe, but derive their main income from sales. If a customer cannot afford to pay for a medicine the atar usually offers it free of charge. The atar feels he is compensated by receiving religious merit (sawab) for this. Atars are much respected by the public and their medicines purchased even by well-educated urbanites.

Atars belong to the shopkeeper class and their working places are usually small shops in the bazaar. Most atars begin as apprentices in their fathers' shops at a very young age. The majority are illiterate but able to speak many languages. Many are Indian.

D.5. Wise women

Nothing is discussed about this category of health adviser.

D.6. Shikastaband (Bonesetters)

Given that physicians and hospitals are few and far between, the bonesetters perform valuable services. They are usually respected members of the community and said to have a high rate of success in correctly setting broken bones. In addition, bonesetters reduce dislocations and treat back pain (by massage and pressure), sciatica, and general body pain.

Bonesetters are usually older men who have learned their skills through experience. The specialization is usually not inherited but rather is thrust upon them by a rural community's need for bone repair. Often bonesetters have other occupations, such as farming or shopkeeping, from which they make a living. Their services as a health practitioner are performed for religious merit. It is recommended that the bonesetters be given basic courses in first aid, health, hygiene, and literacy that could be sponsored by the Ministry of Public Health.[1]

D.7. Hakims

Hakims are highly trained medical practitioners who use procedures and medicines from both the Indian Ayurvedic school and from the Greco-Arabic tradition. Hakims are literate and obtain their education as apprentices to a father or uncle and from mosque schools or public elementary schools. Some have also studied at special schools for hakims in India and Pakistan. Being a hakim is a full-time life-long profession.

A hakim is usually found in a small shop filled with medicinal preparations. These are herbal, chemical, and mineral. The hakim prepares them or may give a patient a prescription to be filled by the atar. Many medical texts, some very ancient, are studied and carefully preserved by the hakims. They are written in Arabic, Farsi, or Urdu. The hakims themselves are multilingual since their patients come from a wide variety of ethnic backgrounds. Both native Muslims and Indian Sikhs become hakims.

Hakims are found primarily in cities and bazaar towns. While some urban elite consult them, they are an especially important resource for the low-income urban population who cannot afford the prohibitively high fees charged by Western-type physicians. The hakims' medicinal preparations, too, are much less expensive than those sold by pharmacies. In addition, treatments prescribed by hakims frequently includes dietary advice as well. As stated above, hakims know about germs as disease agents.

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[1] Macey, Hunte, and Kamiab 1975: 29. The remainder of this part (Afghanistan) is extrapolated largely from this source.

E. STRATEGIES OF RESORT

"Modern" medicine in Afghanistan has by no means displaced indigenous healing but merely expanded the range of options. It appears that few Afghans confine themselves exclusively to modern medicine since even the most educated and wealthy strata are occasionally known to seek herbal preparations and advise from the atar or hakim. It is said that these medicines do not have the negative side-effects of Western-type pharmaceuticals.

Most rural Afghans, however, cannot afford and do not normally have access to physicians but continue to rely primarily on indigenous health practitioners. Some Afghans complain that doctors do not have enough time to give a patient good individual treatment anyway. Many others simply "do not trust" modern medicine.

Women, more than men, depend more heavily on the traditional sources. Mullahs and shrines are the most popular sources of aid. Many women also prefer to visit a hakim rather than "modern" physicians because with the former they may remain in chadri (purdah) while the latter ask them to disrobe. Women do, however, take their children to modern physicians.

a) Referral. There is frequent referral from one category of indigenous practitioner to another. They also refer patients to modern physicians when they recognize problems they cannot successfully treat. Some indigenous practitioners also consult modern physicians when they themselves develop such problems. There is little referral, however, from the modern to the traditional sector.

b) Contrasts between "traditional" and "modern." It is apparent that the services and medicines of the urban-trained Western-type health practitioners are beyond the financial means of the Afghan poor majority. Other factors also appear to clearly set the latter practitioners apart from their indigenous counterparts.

First, Western-type practitioners spend relatively little time with their patients and apparently show them little personal concern. Second, they do not participate reciprocatively in the local community's referral system. Third, they do not conform to established fee-for-service patterns. The Afghan sources show clearly that the rural population, even while desperately poor, still expects and is willing to pay for services and medicines rendered. But they are accustomed to doing so on a sliding scale. Indigenous practitioners likewise are accustomed to receiving their sliding-scale fees. They remain motivated since what they do not receive in money they receive in "merit" for serving the public through their profession.

c) Implications for other countries. These findings probably accurately present the situation in the other Near East countries where researchers have not yet so carefully investigated the motivations and expectations of the rural and urban poor toward health care.

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Y E M E N*

A. HEALTH AND POPULATION OVERVIEW

The first census of the population of the Yemen Arab Republic ("North Yemen") was begun only in 1975. Preliminary results indicate a total population of about 6.5 million. Yemen statistics remain spotty and incomplete, however, and about 300,000 persons were not covered by the census, some for technical reasons and others (women) for cultural reasons. Yemen's population comprises small fishing communities along the Red Sea coast, semi-nomadic and nomadic pastoralists on the coastal plain and in the east, a majority of settled agriculturalists living primarily in the mountain areas, and an urban town population.

Of the total population, however, nearly 20 percent (about 1.2 million) are estimated working outside the country, primarily in Saudi Arabia, the Gulf States, and East Africa.[1] This figure, if correct, means that over two-thirds of all male adults are absent from their families and villages. It is therefore not uncommon, according to one investigator, to see villages virtually inhabited by women, children, and elder men--"barely managing to make a living and certainly not in a position to develop the village in any dynamic sense of the word."[2]

Yemen's population is not ethnically homogeneous. The country may be divided into five ecological zones, each with differing agricultural regimes, social organization, disease patterns, and indigenous health-related practices. These are: (1) the Tihama, or coastal strip; (2) the Western slopes; (3) the southern uplands; (4) the intermontaine plains; and (5) the eastern slopes. The Tihamis are dark-skinned people of reputed African origin who have limited relations with the highlanders. The former are Shafi'i Sunni Muslims and the latter --about 50 percent of Yemen's population-- Zaydi Shi'ite Muslims. This distinction has been more important politically than theologically and today the identities "Shafi'i" and "Zaydi" are very real ethnic labels to those who hold them. A third group are the Isma'ili Shi'ite Muslims. An additional cross-cutting distinction is that between tribal and non-tribal Yemenis with the dominant social structure being based on traditional tribal groupings. In the eastern slopes are pastoralists referred to as bedouin who are engaged in "classic" Arab camel nomadism.[3] Yemen's "rural poor" are thus not simply an undifferentiated rural mass.

Yemen's economy is predominantly agricultural. The population of the country's 8 major towns (larger than 25,000 inhabitants) amounted in 1972 to about 8 percent of the total population. Fast

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* "Yemen" as used in this report refers to the Yemen Arab Republic.

[1] Nyrop et al. 1977: 169-170; Bornstein-Johansson 1974:5.

[2] Bornstein-Johansson 1974:32.

[3] Tutwiler et al. 1976: 6-16

urban growth is leading, however, to an increase of non-food producers. In 1970 farmers constituted about 80 percent of the population and non-farmers 20 percent. The ratio projected for 1980 is 60 to 40 percent respectively.[1]

Health, nutritional, and general physical standards of living are low by all comparative standards. Approximately 3 out of every 4 infants born die before the age of 2. Most surviving infants exhibit severe growth retardation and suffer from a continual state of undernutrition. This compounted by frequent gastroenteric disease, results in some 46 percent of all children born dying before the age of 15. Shortages of water are widespread and what water exists has become increasingly polluted due to the lack of sewage systems throughout the country. As of 1975 hardly any households had running water and only 4.6 percent had electricity.

With widespread protein-calorie malnutrition, polluted water sources, and absence of sewage systems, a large proportion of Yemenis fall victim to endemic diseases. The five most frequently reported in recent years are gastroenteritis, malaria, amebiasis, schistosomiasis, and typhoid. Others include tuberculosis, paratyphoid, trachoma, and helminthiasis.[2]

Yemen's population growth rate is estimated as between 1.8 and 2.4 percent per annum--about 7 percent in the urban areas and 2 percent in the rural areas. The crude birth rate is probably between 44 and 49 per 1,000 while infant mortality is estimated to be 160 to 210 per 1,000 live births. The crude death rate is probably not less than 25 per 1,000. Life expectancy is estimated as between 38 and 45 years.

Only some 3 percent of females and 37 percent of males aged 10 and over are literate; only about 15 percent of males, and far fewer females, have had more than a primary level of education.[3] Unfortunately, 50 percent of all Yemeni university graduates--both those trained at home and abroad--have chosen not to live in Yemen.[4]

Planning for development and health care are new concepts in Yemen. Under the centuries-old Imamate "modern" medical services were provided only by a handful of private physicians in the larger towns--foreigners and a few Yemenis who had received about two years training in colonial medical practice in Italy. As recently as 1951 there were apparently no trained nurses and only four physicians in the whole country--three in Taizz and one in Sana.[5] In 1962 the

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[1]Bornstein-Johansson 1974:27.

[2]Nyrop et al. 1977:182.

[3]These slightly differing estimates are presented by Nyrop et al. (1977: 169) and Allman and Hill (1977:3).

[4]Nyrop et al. 1977:173.

[5]Mount 1953:6

Imamate was replaced by a republican form of government after which civil war ravaged the country for seven years.

Only since have more serious attempts at socioeconomic development been feasible. As of 1972 there were 33 hospitals in the country with about 4,000 beds, 200 physicians, and 720 other formally trained medical personnel. In 1976 there was about one bed per 1,600 persons and ony physician per 26,000 persons). Twenty-two of the 33 hospitals and 90 percent of the phys cians were located in the three main towns of Sana, Hodeida, and Taizz. Medical services in rural areas are still rudimentary, consisting of a few newly-opened clinics and dispensaries.[1]

In the Yemen government's first development plan (for 1973-75) top priority was given to agriculture and water resources together with roads and other infrastructures on which agriculture depends. Development of health and educational services was also given high priority.

B. WESTERN-LANGUAGE SOURCES ON INDIGENOUS HEALTH PRACTICE IN YEMEN

B.1. Colonial Accounts

These derive from the 1930s-50s and were primarily authored by Italian physicians during Italy's period of presence in the Horn of Africa. Although the Italian sources could not be consulted for this study those noted in the bibliography appear especially important to a more extensive investigation of this subject.

B.2. Ethnographic Accounts

By far the most substantive are the excellent reports by Annika Bornstein-Johansson on food and nutritional patterns. Other studies (e.g. Nyrop et al. 1977 and Allman and Hill 1977) rely considerably on her data as does this report also. A second major source is an essay in German by a Red Cross pyysician, U.G. Middendorf, that in rare and laudable fashion combines biomedical knowledge with sociological and ethnomedical inquisitiveness and observation; this is a valuable presentation which, if taken as a model by other physicians working in rural areas could greatly enhance our ability to improve health care delivery among the rural poor. Additional findings from recent ethnomedical research by John Kennedy, Judith Obermeyer, and Cynthia Myntti promise to be valuable, but are not yet available.

B.3. Other Yemen-specific Sources

These include several reports by pyysicians, UNICEF, and social scientists with scattered data about indigenous health-related practices. In total, however, except for food habits, there is very little description of Yemeni health-seeking behavior.

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[1]Bornstein-Johansson 1974:1; 197-:40.

C. INDIGENOUS ETIOLOGY

The bases for Yemeni medical theory appear to be both Islamic and Hippocratic. Graduates of the traditional Quranic schools (the only schools in existence until recently) acquire there certain ground concepts about disease causation and health promotion which the general population shares but about which it is less informed. In such schools the "classical, scholarly, Arabic medicine" is also reported to be preserved and transmitted; in Sana and Taizz in particular the old medical classics are said to be collected, read, and copied. The influence of this scholarly medical study varies considerably, however, in the rural areas where knowledge is only orally communicated and pre-Hippocratic, pre-Islamic beliefs remain potent. It is reported that the population does not make much distinction between physical and psychological disturbances.[1]

C.1. Humoral Theory

Traditional Yemeni medical theory, according to Bornstein-Johansson, is based on the ancient Hippocratic medical theory, modified through the centuries by Islam and local magical practices. Its essence, she states, is the classification of humans into four basic "characters", represented in the body by the predominance of one of the four bodily humors which correspond in nature to the four elements and four seasons. The four "states," or "characters," are the hot and dry (safrā' corresponding to fire and summer), the hot and humid (dam corresponding to air and spring), the cold and humid (balgham corresponding, to water and winter), and the cold and dry (sawda' corresponding to the earth and autumn). We are told regarding Yemen, only that this theory underlies many food prescriptions and proscriptions.[2] Based on knowledge of the Arab humoral theory as it still exists elsewhere, however, (e.g. Iran, Afghanistan, Pakistan, India), we may hypothesize that certain illnesses are attributed by Yemenis to an imbalance within the body of two or more of the four "states." It is probable Yemenis view such illnesses as "naturally caused." This remains an important subject begging further investigation.

C.2. Supernaturally-caused Illnesses

Many (and perhaps most) Yemenis believe in supernatural disease-causation from the evil influence of jinn or the evil eye.[3] Minor and short-term disturbances--of which headaches, sleeplessness, anxiety, and a spouse's infidelity are cited as examples--are attributed to possession by demons. Ultimately all illnesses, accidents, and deaths are attributed to the will of Allah. This appears, however, as elsewhere in the Islamic world, to be an ex post facto explanation which does not deter Yemenis from seeking to prevent or

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[1] Middendorp 1969:2, 9.

[2] Bornstein-Johansson 1974:34

[3] Nyrop et al. 1977:182 Regarding jinn and the evil eye. See the regional section above.

cure such conditions within the range of existing knowledge and and possibilities.[1]

D. INDIGENOUS HEALTH PRACTITIONERS

A recognized hierarchy of traditional practitioners exists in the cities, according to Middendorp. At its apex is the hakim followed by native surgeons and at the base the mozayyin ("barber"). A small village of a few hundred people may have one or two mozayyin families and a traditional midwife. Quranic specialists also perform health-promoting functions for sedentary populations. Among the nomadic bedouin, however, there are said to be no specialists.[2]

Hakim is the term by which trained, literate physicians were traditionally known in the classical Arab medical system. The Yemen literature says little about this practitioner. It indicates nevertheless that hakims possess more sophisticated biomedical knowledge than other indigenous Yemeni practitioners and that this classical specialization may be better preserved in Yemen than in other parts of the Arab world where Western colonization had a greater impact.[3]

"Surgeons" is the term under which Middendorp groups two indigenous practitioners, the "bone-aligner" (Knocheneinrenker) and the cataract-operator.

D.3. The Mozayyin ("barber") or "wound-healer")

These three terms are used for the common practitioner who performs physical therapies for ailments such as headaches and "pains in the body" and who functions as barber, circumcizer, and in some villages also as butcher, marriage functionary, and organizer of harvest work teams. It is said that in towns he can be found at the marketplace. His equipment consists of a cautery iron, bowl, razor-knife, and jambia (curved daggar).[4]

The role of mozayyin appears to be inherited and it appears that mozayyin charge--or at least accept --fees. Bornstein-Johansson reports that mozayyin are one of several occupational groups without tribal membership who are called by the general term bayya'. This means "salesmen" and includes all who sell goods or services for money. These occupational groups constitute functional castes in that inter-marriage between them and tribesmen is excluded as well as, usually, between the

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[1] Middendorp: 1969:2.

[2] Middendorp: 1969:2,8; Bornstein-Johansson 1974, 51.

[3] Middendorp: 1969:2. See also Bornstein-Johansson 1974:34, 51.

[4] Middendorp: 1969:8-9, Bornstein-Johansson 1974:11-19.

groups themselves. The term mozayyin also appears to designate entire families and a woman in such a family is said to perform similar duties among women as her husband does among men.

a) Physical therapies performed. Pre-eminent among these is cautery, a widely-preferred treatment among Yemenis. It is asserted by one investigator that "there is scarcely one Arab in a hundred in all the Arabian Peninsula who has not some cautery scars on his body, for the hot iron is accounted the universal panacea for man and beast in Arabia.[1] Cauterization is said to be psychologically uplifting although overuse tends to exacerbate a morbid condition.[2] The jambia may be used for removal of foreign bodies. A scratching procedure is also used above an area where pain is felt. Yemenis believe, according to Middendorp, that superficial openings made in these ways permit demons or other evil forces to leave the body.

b) Circumcision. Male circumcision is a festive rite of passage which takes place at about 12 years of age. It is done with a jambia (curved sword) in the presence of the entire family. The mother holds incense (perhaps believed health promoting). The father, simultaneously as the foreskin is removed, reportedly awards his son with a jambia of his own and then engages him in a short foot-race to divert his attention from the pain. According to Middendorp, a small string-wrapped piece of wood is placed in each of the boy's nostrils so that he "does not smell girls" and thus will not experience an erection until the wound has healed some three weeks later.[3]

D.4. The Traditional Midwife

Childbirth, at least as of 1972, virtually always takes place in the home except if there are complications and hospital facilities are accesible. For a first delivery a woman often returns to her mother's home. She is usually assisted by her mother, another female relative, a local midwife, or--in absence of close relatives or a trusted midwife--she may prefer to deliver alone. A midwife is alternatively called a daya, dada, or mua'lida.[4] She not only assists at deliveries but has a key

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[1]Phillips 1966:59.

[2]Nyrop et al. 1977.

[3]The bedouin of Yemen according to one investigator are particularly concerned over various smells believed to hinder recovery from illness and often plug their nostrils with cloth against such smells. The "smell of a woman" is said to be high among smells believed dangerous to an open wound (Phillips 1966:61).

Bornstein-Johansson 197-:36; Verderese and Turnbull 1975:87.

role in all village health problems. A midwife often visits the mother regularly after delivery and advises and assists with infant care and feeding.

The traditional local midwives are trusted by the women and familiar with their problems. In the early 1970s the World Health Organization began training courses for them in Taizz, Hodeida, and Sana and it has been recommended to the U.N. Food and Agricultural Organization that the midwives be given basic nutrition training and used as a communication link between the FAO nutrition education programme and Yemeni families.[1]

D.5. Quranic Specialists

These are persons who have completed a traditional Quran school, which along with theology and jurisprudence presents a few Islamic medical principles, and who subsequently serve their home district as imam, arbiter, teacher, and healer. As regards healing they include a broad spectrum ranging from scientifically-oriented healers to magician-sorcerers. The former may conduct precise examinations of physical symptoms and prescribe somatic therapies. The latter heal and attempt to heal through magic-like rituals. Given the generally deep Yemeni belief in the power of magical rituals, scientifically-inclined practitioners also employ some of these to enhance the efficacy of treatment.

These Quranic practitioners do not request payment since they render services "for the religion." Among the rituals are recitation of suras (Quranic chapters), and intensive prayer and petition to Allah. Some practitioners supposedly write Quranic verses with ink prepared from a mixture of herbs; the verses are then dissolved in water which the patient drinks—thus possibly providing both somatic and psychological assistance. Other folk remedies produced from local herbs and usually incorporated into magic healing rituals appear, to some investigators, effective for mild ailments.[2] The Quranic practitioners were greatly admired by the Swiss Red Cross physicians for their dedication and round-the-clock willingness to attend to and remain with the patient in his or her home. According to the Swiss team, the services of these practitioners are eagerly sought by the Yemeni lay public.[3]

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[1] Bornstein-Johansson 1974:51. A handbook for Yemen lists in a table of "medical and paramedical personnel" 55 "village midwives" and 27 "qualified midwives" (Nyrop 1977:184). This is probably much underestimated. In a survey of traditional midwives and midwifery practices, Bornstein-Johansson interviewed 40 midwives in Sana alone—most the traditional type but 6 with 4 years nursing school training plus some hospital experience (Bornstein-Johansson 197-:30).

[2] Nyrop et al. 1977:182

Middendrop 1969:10.

D.6. Herbalists

Yemenis are reputedly well-versed in the pharmacotherapeutic use of local plant, animal, and mineral products. Many kinds of herbs and spices are used in Yemeni cooking and every kitchen has a small grinding stone for these--the mishagah.[1] A customary bedouin adaptation to their low liquid intake is the frequent use of vegetable-base laxatives such as that prepared from senna leaves. A "Yemeni toothbrush" used immediately after meals is a piece of the astringent root of the rak bush which men carry about in their jambia sheaths. The theory and classification of all foods according to one of the four combinations of hot, cold, dry, and humid is said to be disappearing somewhat from general knowledge but "still alive with the local traditional doctors and herbal specialists."

The public "Turkish" bath is important to the Yemenis whose religion emphasizes washing and cleanliness but who lack running water at home. The occupational specialty of hammami therefore should be considered health-related and, presumably, health-promotive. Hammāmis, like the barber-healers, also comprise a caste-like group belonging to the general category of bayyā' (those who are paid for goods and services).

E. STRATEGIES OF RESORT AND REACTIONS TO INTERNATIONAL MEDICINE

Little appears in the literature on hierarchy or strategies of resort except for the casual generalization that Yemeni women are reluctant to consult male physicians. The Red Cross field hospital representatives present closer insights, however. When they began to speak Arabic, showed personal concern for their patients, and were able to demonstrate advantages of their medical interventions, then Yemenis of both sexes began to trust and seek them out. Women were indeed willing to unveil and be examined by a male physician providing they were not required to uncover their pubic region.

Difficulties with these female patients derived from another cause--namely that the women seemed, to the Red Cross team, "wholly unaccustomed to thinking" and were unable to describe their health problems. They could not specify whether a problem seemed of physical or psychological origin; whether in the case of a prolapsed uterus or an unfaithful husband they similarly complained merely of "not feeling well." Frequently the Swiss physicians were able to reach a diagnosis only by consulting with friends of the patient.

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[1] Bornstein-Johansson lists these in 1974:70-71.

[2] Middendorp 1969:6-7; Bornstein-Johansson 1974:34.

[3] Bornstein-Johansson 1974:11.

[4] Middendorp 1969:12.

Given the authoritarian control men have over women in Yemen, many women whose husbands work abroad are faced with the problem of not being permitted to make major decisions. A woman, therefore, cannot, independently attend a clinic or send a child to the hospital, according to Bornstein-Johansson. Instead she must receive authority from her husband, which may take weeks or months to arrive, or from a close male relative. As a result, urgent decisions--such as for hospital assistance--are often simply not made at all.

While Yemenis resorted to and valued the Red Cross's medicine, they did not appear at all to understand it. The team found that Yemenis attributed magical qualities and powers to their measures so that even an x-ray of and by itself had a psychologically therapeutic effect. Shots and pills were also accorded magical properties. Consequently when only one of several patients bedded in a common room received a pill others believed themselves rejected and discriminated against. Miracles were expected especially of the team's surgeons to whom defective transistors and even broken-down vehicles were also brought "for surgery."[2] Since the early 1970s, however, there has reportedly been underutilization of existing hospitals and health centers due to the shortage of personnel and deterioration of services.[3]

F. HYGIENE , PUBLIC HEALTH, AND PROPHYLAXIS

F.1. Hygiene

Under such conditions as exist in rural and even most of urban Yemen, the level and understanding of hygiene is very poor. In a two- or multistory house the ground floor is occupied by domestic animals, storage rooms for agricultural equipment, and an earthen pit dug in the ground. This pit, the madfan, is an excellent storage place which keeps grains well-protected from humidity and insects for long periods of time. The actual living space in most homes is thus fairly small. Most rooms are shared by three to four persons. If space permits, the mother usually sleeps with her children in one room and the father separately in another. Personnal hygiene is carried out in a corner of the kitchen or toilet chamber, a small dark room with a hole in the floor leading directly out onto the street or into an earthen pit. Few rural houses have toilets per se.[5]

The principal problem, however, is water supply. Piped water is exceptional in rural areas. Normally all water for household consumption is carried by women from wells or rivers, often at considerable

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[1] Bornstein-Johansson 1974:33.

[2] Middendorp 1969:13

[3] Nyrop et al. 1977:183.

[4] Bornstein-Johansson 1974:17.

distances. It is generally fetched twice daily with about an hour per trip for one small bucketful. The dry season requires walking even further. A 1972 survey of villages near Sana revealed that 80 percent of domestic water sources were polluted. The average poor Yemeni does not understand this fact or its consequences. Contamination of food is thus also common.[1] Firewood that might be used to boil water is expensive. Rarely is it wasted to heat water for bathing. Baths, in fact are rare but considered desirable, and public baths are cited as priority development projects. A more easily accessible source of water was consistently listed by women in three regions as their first development priority.

F.2. Public Health and Prophylaxis

The Red Cross team had little success in its attempts to instill comprehension of hygienic measures and the difference between potable and non-potable water.[3] Concern does exist among the rural poor for the health of fellow members of a community as regards food consumption. Social bonds and responsibilities within a Yemeni village do not allow a community member to starve. The prevailing system of local aid provides at least enough food to keep each member at a subsistence level. An example is the regular distribution of free skimmed milk to poor neighbors who have no milk animals.

Many health-promotive measures are taken in the belief they will help prevent illness and misfortune. Some may be physiologically effective such as use of certain herbs. Also beneficial are the beliefs that breast milk is a "right" of an infant up to two years of age but that a mother's milk immediately becomes harmful for the baby if she becomes pregnant again. Oother measures, such as prayer and use of amulets, are psychologically supportive. Still other measures might be effective were water sources not so polluted--the pattern of washing before the daily prayers being a good example.

Still other measures, however, appear to have deleterious effects. For example, infants are swaddled for about nine months in the rural areas and for shorter periods in towns. Yemenis believe this produces strong bones and makes infants sleep well. One effect seems to be retardation of the age at which children start sitting and walking and possibly of motor development as well. Because sunshine is believed harmful for children they are kept indoors during most of their first two years of life and almost completely enveloped in clothes if taken

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1 Bornstein-Johansson 197-:33.

2 Carapico and Hart 1977:125.

3 Middendorp 1969:12.

4 Bornstein-Johansson 1974:29.

5 Middendorp 1969:3-7: Bornstein-Johansson 1974:37.

outside. This seems a key causal factor in the high prevalence of rickets among Yemeni children. Women are said to fear fresh air and thus prefer to spend time indoors in ill-ventilated rooms, a pattern which has presumably contributed to the frequency of osteomalacia in this sunny land.[1]

G. DIET AND QAT

G.2. Diet[2]

a) Food etiquette and distribution. Eating is considered a form of worship of God, like praying, fasting, or other religious practices. Food is provided by God and thus should not be wasted. This applies especially to bread, each piece of which is carefully preserved for the next meal, or given to the more needy. Sharing food and eating together is regarded as virtuous. It is said that enough food for one is always enough for two; it is "unthinkable" for one person to eat in front of another who has no food. Gifts of food are a means of establishing or showing friendship and of showing compassion. When one has prepared something special, it is customary to send a portion to a neighbor. One does not thank for this, or after a meal, for "thanks are due to God and the sharing of food is so natural that thanking for it would suggest it was exceptional."

A general pattern of food distribution is that men receive the largest and choice portions on special occasions such as feasts or when guests are present. Then men eat first and separately. This does not appear to have much impact on the diet of the family who normally eat together from the same plates with no obvious inequalities in the shares received. Cutlery is not commonly used. Food is eaten only with the right hand and with the help of bread dipped into the common dishes served in pots and on trays on the floor.

b) Food prohibitions and hot/cold classification. Apart from the Islamic prohibitions of pork and alcohol, there are no major food prohibitions in Yemen. Tihamis, however, have an aversion to beef--which they never eat--that may derive from their contact with Indian traders and immigrants.

More common are the food prescriptions dependent upon the age, sex, and physiological status of an individual. The ideas underlying these are found in traditional Yemeni medical theory (mentioned above) which classifies each food according to combinations of hot, cold, dry, and humid. Today only the division into the two categories of hot

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[1] Bornstein-Johansson 197-:38-39; Petrie 1939:359; Coulter 1974:1765.

[2] This section derives almost wholly from the Bornstein-Johansson sources.

and cold is widely known and applied. For example, foods eaten by a woman during the 40 days after childbirth should be "hot" foods--such as chicken, dates, honey, and butter fat; this is to "increase" the blood (one of the four bodily humours) of which there has been a loss during delivery. For fever--called hummā-safrā'--one should eat "cold foods," such as limes and pineapple, to mitigate the body's excess of the hot-and-dry safra' element.

c) Food preparationis an almost exclusively female role. Kitchen windows are kept small allegedly to prevent men from looking into this feminine domain. Ventilation is inadequate for expelling smoke and the kitchen itself is small and dark. As a hot, dark, smoky workplace where women spend several hours per day, it certainly has negative effects on female health.

d) Adult diet. Sorghum is the basic component in the rural Yemeni diet. With millet it represents almost 80 percent of all cereal production and the source of about 70 percent of all calorie and protein intake. Cereals are prepared as bread and porridge. No meal is complete without bread, not only because of its bulk and tastiness but also because of its convenience in picking up other food. Sorghum porridge (asid) is regarded even more essential. "Without a daily pot of asid a man cannot work" goes a Yemeno song. This is often served with madid, a thin wheat or barley gruel. Bread, asid, madid, and helbe (a protein-rich fenugreek sauce) are the main foods of rural Yemenis. Yemen's "national beverage" is gishr, prepared from a decoction of coffee husks.

Animal products, except milk, are rare and expensive items that the rural poor cannot afford other than for special occasions such as marriages and the two major Islamic feasts following the Ramadan fast. A childbirth is occasion for major 'ood expenditures. During the 40-day postpartum confinement period the mother receives female relatives and friends every afternoon in her home in celebration. A saying around Sana indicates the costs incurred: "Two marriages rather than a childbirth!"

e) Diet during pregnancy, postpartum and lactation. Pregnant women are not considered a vulnerable group with special nutritional needs. Little relationship is recognized between a woman's food intake and nutritional status and the healthy growth of the fetus. During the latter part of pregnancy, however, certain foods, such as meat, are sometimes avoided as they are believed to make the fetus grow too big and thus lead to difficult delivery. "Hot" and spicy foods are also said to be avoided for fear they will induce miscarriage. In some northern villages geophagy ("earth-eating") has been observed among pregnant women and small children. It is hypothesized that geophagy occurs when the earth eaten provides iron and other minerals lacking in the diet.

A 40-day postpartum period is strictly observed by most women which permits them to rest and regain strength after childbirth. Much attention is paid to the mother's diet so that her blood "gets strengthened." Intercourse is prohibited during this period and the mother and new baby are supposed to stay in bed, or at least indoors, for its entirety. After the 40 days there are no special restrictions or additions to her diet.

Little relationship is recognized between maternal diet and lactation. Breast-milk is considered part of the woman's body and able to transmit both temporary and permanent characteristics to an infant. A lactating woman should not become angry or afraid lest anger and fear be transmitted to the infant through her milk. Nor should a woman expose herself to the hot sun before breast feeding as that makes her milk "hot" and thus, the baby also "hot." Infant skin disorders are usually attributed to its mother having become angry or her milk "hot."

f) Infant feeding. Many infants are breast-fed up to two years, which is considered their "right" according to custom and religion. Some are breast-fed even longer and male children often about half a year longer than girls in the belief that "boys need more milk to become stronger."

If another woman is to wet-nurse a child, her character must first be carefully scrutinized. Since she will transmit her nature to the infant, she should be kind, well-tempered, and of good health and character. Suckling is regarded as establishing a permanent biological and legal relationship (the "milk relationship") between the infant and wet-nurse and also the wet-nurse's husband. The infant acquires the same status as the biological children of the couple. The infant is regarded a full sibling of their biological children, and has the same restrictions in marriage.

Supplementary feeding customarily begins between six and nine months. When a child is to be weaned the mother usually accomplishes this by applying bitter cactus juice to her nipples. Traditional weaning foods are soft carbohydrate products like porridge or tea-soaked bread. Foods are rarely prepared especially for children; children are simply taught to accept more and more family dishes as they grow older. Women seldom refer to the nutritive content of foods but only to their tastes and consistencies. Foods considered good for young children are soft, "light" foods that are bland and easily swallowed and digested. "Bad foods" are those considered "heavy" and hard to chew and digest, such as meat, eggs, and beans, which are said to cause stomach troubles in children. Vegetables and fruits are regarded as snacks rather than "real food."

g) "Modern" food habits. Increased contact with the world market has meant adoption of new food items for reasons of convenience, taste, and prestige. The new products typically cost more than the traditional

items they replace without being more nutritive, and are often less so. Examples are soft drinks and--encroaching upon the traditional whole-grain cereal foods--polished rice and "biscuits", cookies and bread made from highly-milled flour. These changes are not so harmful for the wealthier Yemenis who enjoy a rounded diet but can be hazardous for poor Yemenis.

Already "modern" food habits have had a negative effect on infants. More and more women, rural as well as urban, now bottle feed their children with over-diluted, preparations of expensive powdered milk which they do not know how to or understand the importance of preparing according to sterile procedure. Gastroenteritis resulting from dirty bottles and contaminated milk is an increasingly common aggravation of the state of undernutrition of bottle-fed infants. The ubiquitous "biscuits" which have become the main weaning food also constitute a definite deterioration in childhood diet.

Among urban elites, traditional foods such as asid are looked down on as "peasant food." But traditional foods still remain, if only for special occasions. A marriage feast is reportedly "unthinkable" without a pot of asid and an important criterion of a girl's marriagability remains her ability to bake bread. Townswomen also say that during pregnancy they prefer "good old village foods" like asid and sorghum bread which are "safe," "give strength," and "contain vitamins."

G.3. Qat (Catha edulis, also known as Khat)

Qat is a shrub cultivated in Ethiopia, East Africa, and widely throughout Yemen. One or more alkaloids give its leaves slightly narcotic properties. When chewed the leaves produce an initially physically and mentally stimulating effect. Qat is more than just a psychotropic plant, however. Since enforcement of abstinence from wine in the 13th century, qat chewing has become almost as important to Yemenis as any sacred tradition or law and is in fact considered "one of the bounties of Allah." Qat is the basis of a life style and plays a dominant role in celebrations, marriages, political meetings, and the national economy. Qat chewing is a respectable deeply-rooted social custom common among all Yemeni groups, although more so among men than women. Children are introduced to it as early as 10 to 12 years of age. Withdrawal from its use is said to bring social isolation. Qat is by far Yemen's most profitable cash crop and demand for it has been increasing with increased wages[1] and improved transportation systems.

[1] Luqman and Danowski 1976:246; Hamarneh 1972:235-6.

a) Qat chewing. Many homes are constructed with a warm reception room, the muffrage, especially designed for male quat chewing. The urban daily sessions usually begin soon after lunch and are the chief form of entertainment and preferred leisure activity among men.[1] Fresh leaves are chewed and stored against one cheek. The mixture of saliva and juice from the leaves is swallowed. As now leaves are added the cheek bulges out. (The Arabid word for this social event derives from the verb "to store:) Euphoric effects reportedly appear soon and last about two hours, followed by a mood of zeal for another two hours during which there is lively discussion of current concerns. This is followed by a serious and even irritated mood when qat's slightly depressing properties take over.

In rural areas qat chewing starts earlier and continues throughout the day. Its stimulating effect lightens the burden and relieves the monotony of daily tasks and its anorexiant properties decrease the need for the midday meal or even the evening meal. It is believed, however, that for maximum satisfaction from qat a man should be "hot" and that to achieve this he should eat "hot" foods such as mutton meat and soup, wheat bread, porridge, and helbe. For some women qat-chewing is part of the daily afternoon socializing and gishr-drinking in each other's homes.

b) Effects upon health. Qat appears to be only minimally detrimental to health. It is not addictive and produces no withdrawal symptoms. Qat-engendered behavior develops in only a minority of users but is still socially acceptable. It is recognized, however, that qat-chewing both reduces the amount and quality of breast milk and that babies become sleepless and constipated from the milk of regularly qat-chewing mothers.[2]

The prevailing conditions in Yemen seem an understandable setting for a euphoriant such as qat. It appears to fill definite social and psychological needs for a safe stimulant, relief from both the hardships and monotony of daily life, modulation of aggressive tendencies, and facilitation of social intercourse.[3]

c) Economic and political considerations. The major drawbacks of qat are economic. Its use is an expensive habit for which some households spend more than for food and according to one survey in Sana, perhaps four times more than medical care.[4] In general, the poorer the family, the larger the proportion spend on qat. Also regarded disadvantageous is its reduction of initiative in trade and agriculture and its replacement of badly-needed food crops.

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[1] Nyrop et al. 1977:179.

[2] Luqman and Danowski; Bornstein-Johansson 1974:36.

[3] El-Mahi 1962.

[4] Bornstein-Johansson 1974:31.

Qat has been a heated political issue in South Yemen and between the two Yemens. In 1957 a legal ban placed on qat in Aden resulted in public demonstrations and the collapse of the political party that instigated the ban. The new generation of Yemeni students is said to favor a ban on qat but continues to chew its leaves before examinations because of their insomnia-producing effect and some writers during a recent campaign against qat used it to help prepare anti-qat articles.[1]

In the opinion of one authority, qat cannot and should not be legislated away but rather alternative forms of motivation and activity must be stimulated through socioeconomic development.[2]

H. FERTILITY BEHAVIOR

H. 1. Pronatalism

Virtually all families desire children and prefer sons. This is explained by the patriarchal character of Yemeni society and the place of defense in tribal unity. The population of a tribal group is still often considered to be its number of weapon-carrying men. For two sons to reach adulthood the "average" Yemeni woman must bear 7 to 8 children. A survey of nearly 400 women in 4 different localities revealed their average age at first delivery to be between 16 and 17 years old

H. 2. Fertility Regulation and Family Planning

Despite the "need" to bear 7 to 8 children, one survey found that of women who had had 4 children, 70 percent did not want to have more. About two-thirds of the women interviewed, however, were reportedly unaware of contraceptive methods[4]. Other studies report a desire for means of spacing. One study mentions the existence of traditional contraceptive methods but does not define them[5]. Since Yemeni women fear "hot" foods may cause miscarriage we can hypothesize that these may also be eaten to induce abortion.

H. 3. Clitoridectomy and Infibulation ("female circumcision")

At least earlier this century, and perhaps still, clitoridectomy and probably also infibulation were performed on young females. Many

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1 Luqman and Danowski 1976:246-7; Bornstein-Johansson 1974:21,35.

2 El-Mahi 1962.

3 Bornstein-Johansson 1974:36.

4 Bornstein-Johansson 197-:35.

5 Allman and Hill 1977.

female patients are reported to have had partially mutilated genitalia and told by the Red Cross team of infibulation having also been done to Yemeni women.[1]

I. CULTURE-SPECIFIC ILLNESSES AND MENTAL HEALTH

Nothing appears in the literature on the first topic. The second is touched upon primarily only in discussions about qat.[2]

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[1] Middendorp 1969:5; see also Blasher 1977.

[2] See especially Luqman and Danowski 1976: 247.

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J O R D A N

A. HEALTH AND POPULATION OVERVIEW

A.1. Composition and Distribution

Jordan's population is relatively small--between 2 and 2.4 million--but growing and urbanizing rapidly. About 90 percent of the East Bank population is clustered in the western one-quarter of the country. Over 70 percent of the population is urban and one-half of the total population in the "explosively" urbanizing Amman metropolitan area alone. The remaining 80 percent of Jordan's territory is steppe and desert where water is only minimally available and the population sparse. About 23 percent of Jordan's population are sedentary village agriculturalists. About 3 percent are pastoral nomads belonging to four major tribal groups--the Rwala, Huwaytat, Beni Sakhr, and Sirhan. More than 90 percent of Jordanians are Arabic-speaking Sunni Muslims; the remainder belong to Shiite Muslim and to Arab, Greek, and Armenian Christian minorities. Within this framework yet two sub-groups should be distinguished: those whose ancestry was historically established in the territory east of the Jordan River (known from 1922 to 1950 as Transjordan) and those who themselves or whose ancestry derives from Palestine west of the river.[1]

A.2. Health Status and Population Growth

Children under 15 and women of reproductive age comprise almost 70 percent of Jordan's population. Gastroenteric and respiratory infections, preventible infectious diseases of childhood and conditions associated with childbirth, produce high levels of morbidity and mortality among these at-risk groups. Infant malnutrition is a major contributing factor in this. Jordan's crude birth rate is estimated in the range of 45 to 50 birth per 1000 population per year and its annual population growth rate to be about 3.2 percent. So long as infant mortality remains high, however, (currently 90 to 100 per 1000 live births), it can be expected that Jordanian parents will continue to want many children. Family planning information is available on a private basis but the Government has not

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[1] Gallivan 1977: 3, 13. Harris 1958: 24.

adopted a policy on this subject. Average life expectancy is reported to be 53 years and literacy about 60 percent. The most common diseases in Jordan, as reported by the Ministry of Health, are trachoma, measles, tuberculosis, infectious hepatitis, malaria, typhoid, meningitis, and dysentery.

Health care is administered through uncoordinated multiple providers including the military medical service, private practitioners, foreign philanthropic, concerns, and the United Nations Palestine refugee program (UNRWA). For the poor majority, initial access points to health care from formally-trained professionals are 82 urban and 250 rural clinics. The full-time clinic staff are assistant nurses (usually male) to whom only minimal serious responsibilities are delegated. As of 1976, 41 Maternal and Child Health centers were operated by the Ministry of Health, some physically integrated with the Ministry's health centers. Cross-referral of patients between the various subsectors and providers occur randomly and there is neither sector-wide health manpower planning nor a comprehensive information system on the workings of the whole health sector.[1]

B. WESTERN-LANGUAGE SOURCES ON INDIGENOUS HEALTH PRACTICES IN JORDAN

No in-depth ethnomedical or other sociological studies are available on contemporary Jordanian health-seeking behavior. Valuable detailed studies from the first half of this century (e.g. Canaan, Granqvist, Grant, and Musil) describe indigenous health practices and practitioners of that period but contemporary materials do not indicate the extent to which various traditional practices and specializations remain current today. The majority of recent sources contain only passing reference to the subject. Although sources for neither Jordan nor Syria are substantive, indigenous health-related beliefs and practices in these two countries appear to be similar.

C. INDIGENOUS ETIOLOGY

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[1] Gallivan 1977: ix-x, 17, 26, 38 and 53.

C.1. Supernatural Causation[1]

Illnesses are traditionally attributed to supernatural sources such as God, jinn and demons. Other "supernatural" sources to which illnesses are ascribed include human actors as illness vectors. The eye--the admiring eye as well as the evil eye--has long been considered one of the most dangerous causes of illness. Children, especially boys, are said to be particularly sensitive to its malign influence and a childless or unmarried woman or a person with blue eyes is likely to be suspected if a child becomes ill or injured.

A causal relationship is traditionally believed to exist between emotions and illness-both within a single individual and from one to another. Fright and horror, for example, have been believed to cause leprosy. According to tradition, both jealously and envy are illness-provoking as is mention of one's enemy. Evil people, it has been believed, may inflict wounds by means of magic and curses. People may even bring illness and unhappiness unto themselves, their own families, and their descendants. This can happen through both word and deed since both evil actions and false oaths are capable of bringing disaster. Rural people cite instances when curses and self-malediction have brought destruction to whole families. Both curses and blessings, when uttered aloud, are said to be regarded as physical powers with lasting effect.

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[1] This material/section is based largely on Granqvist 1965: 23-24. See also Cameron 1960: 347.

D. INDIGENOUS HEALTH PRACTITIONERS

The following categories of practitioners are mentioned in the sources on Jordan. With the exception of the traditional midwives, however, there is little indication of either the numbers or activities of persons in each category. Nor is there mention of any position--positive or negative--that the Jordanian Government may have taken toward these practitioners.

D.1. Village Barbers

Only one source (from 1958) mentions the barber; this says only that even in urban areas afflicted persons would first consult him before resorting to a physician or hospital.[1]

D.2. The Traditional Midwife (daya)

Between 50 and 62 percent of all deliveries are said to be managed according to largely traditional practices by a daya, Jordan's traditional birth attendant.[2] According to custom, the daya assumes major responsibilities for the child during the mother's 40-day postpartum period. This reportedly means rubbing the infant's body with salt and oil and swaddling it tightly and then returning daily to clean and wrap the child. An early investigator reported: "Woe betide the mother or any other meddler who interferes with the wrapping and other functions of the midwife, who is very jealous of the dignity of her profession."[3] (Bedouin tradition, however, is that women do not use a midwife but deliver their own children independent of assistance and even while on the road sitting in a camel-borne litter.[4])

A recent study concludes that the dayas are major community health actors who must be taken into consideration in any attempt to improve maternal and child health in Jordan. It is relevant in this context that the formally-trained (i.e., non-traditional) midwives and the Government's Maternal and Child Health clinics are said to be underutilized even while need for improved midwifery and maternal and child health care is great.[5]

D.3. Saints and Other Holy People

Persons with supernatural healing powers are referred to, alternatively, as saints, holy-men, seers, derwishes, and sorcerers--

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[1] Patai 1977: 248.

[2] Gallivan 1977: 37.

[3] Grant 1921: 66.

[4] Musil 1928: 243; Patai 1958: 244.

[5] Gallivan 1977: 50.

in Arabic, wali, shaykh, nabi, darwish, ra' as-sirr, and ashāb al-islām. They are specialists with certain physical, religious, and moral characteristics, who have special relationships both to humans and to God, and who function in the roles of healer, judge, leader, neighbor, and supernatural being. They are male and female sought both for cure and protection against all kinds of misfortune including illness. Among the Rwala it is said these persons inherit their supernatural powers and thus that the ability to heal is confined to certain families.[1] Persons called Maghrebis--itinerant mystics and holy-men from Northwest Africa--are also regarded by many people in the Eastern Mediterranean region as possessing special healing powers.

Traditionally in Jordan and Palestine rural people have sought out a derwish or other holy person for illnesses attributed to possession by jinn or demons. The belief is that a derwish can see demons, give them orders, and thus exorcise them. He could do this through recitation of prayer and massage of the patient, stroking from upper to lower body in the expectation of forcing the evil spirits out through the lower extremeties. He might also accomplish this by isolating himself for a period, frequently 7 days, during which he manipulates certain items such as dates ("the food of prophets") and garlic--items over which demons have no powers.[2]

Tradition accords great health-maintaining and restorative powers to a diversity of places regarded as saints' sanctuaries. These include a shrine (maqām) with a tomb, shrines without tombs, a tomb without a building, a cave with or without a tomb, a simple stone enclosure, a spring or watercourse, a solitary tree, a heap of stones, and a single large rock. Many Christians and Muslims alike revere such sanctuaries—including sometimes those of the other faith as well—a fact attesting to powerful religious influences quite independent of Christianity and Islam.

Traditionally everything that belongs to or comes in contact with a saint has power that may be transferred to others for healing or preventing illness. Thus conservative Jordanians and Palestinians may still use objects such as trees, grass, stones, water and earth from sanctuary precincts to prevent misfortune, ease pains, and hasten recovery. Some wear talismans procured in a sanctuary as amulets against disease. Decoctions of sanctuary plants are reportedly taken as cures. Sanctuary grass or leaves may also be gathered and dried to "fumigate" (da'aq) a febrile person. Vows are made at sanctuaries, sometimes along with food sacrifices, as contracts to bring about cures. A familiar sight has been women tying up bits of

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[1] Canaan 1927; Musil 1928: 400.

[2] Granqvist 1965: 28-29.

rags (called "knot binding") to "bind the evil" and to keep their prayers in the minds of invoked saints. One widespread old belief is that certain cures are surer at special times.[1]

D.4. Herbalists

Herbalists are simply stated to have been important sources of primary resort.[2] There is repeated reference, however, to the use of herbs as well as animal and mineral substances. Among those externally applied are henna, colocynth seeds and leaves, leban (a fermented milk preparation), olive oil, red peppers, urine (especially among pastoralists), and juice squeezed from crushed scorpions (for scorpion bite). Indigenous preparations for internal use appear less common although some herbal infusions, decoctions and other preparations are also employed, for example, as laxatives, inhalations, and suppositories.[3]

D.5. "Wise Women"

These traditional community health advisers are also indicated as manpower sources to whom poor Jordanians often turn before consulting a formally trained practitioner.[4] According to some Palestinians the "wise women" must not care for a grown male who is in isolation without first pronouncing a ritual expression that establishes a foster sibling relationship between them.[5]

D.6. Bonesetters

A bonesetter's skill in treating fractures is often more highly regarded by non-elite Jordanians than that of a physician. Many patients whould rather wear a bonesetter's splint for the prescribed 3 weeks than a cumbersome cast that interferes with work for twice as long. The specialization of bonesetting dates back in the Near East to predynastic Egypt. Methods used by the Jordanian bonesetter are said to be similar. They are passed down within families and the specialization is thus inherited. Splints are made of stocks

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1 Canaan 1927: 106-125; Grant 1921: 117; Granqvist 1965: 27. A firm belief in a set and immutable time to die, for example, is also noted to be as firmly held by many Christian peasants as by Muslims. A similar conviction is that early death is the special mark of heaven's disfavor and that the pious need not expect it.

2 Patai 1958: 248.

3 Cameron 1960: 352; Musil 1928: 66-67.

4 Patai 1958: 248.

5 Granqvist 1965: 27.

tied together and padded with cloth. These are placed on the fractured long bone with enough length to immobilize the adjacent joints. This is customarily packed with a mixture of flour, salt, and eggs which hardens to secure the padded splints. Bonesetters even manipulate and prescribe exercises for clubbed feet but they seldom attempt to deal with open or grossly infected fractures. Bedouin are also said to have bonesetting specialists among themselves.[1]

Bonesetters, and other traditional male healers are reported to initiate treatment of a female patient with a ritual formula: "Thou are art my sister in God's book. . . ." By thereby "adopting" her as a "foster sister" it becomes permissable for him to inspect and handle her. Bonesetters accept fees although these are not necessarily fixed.[2]

D.7. Cuppers

It appears that cupping has been performed by a specialist other than the village barber although this is not clear.[3] The practitioner, using gloves or tongs, heats a glass or teacup over a low flame, places it on the skin, and allows it to cool. The therapeutic rationale is based on the assumption that the noxious vapors and irritants from the affected part are sucked into the glass as the contained air cools. The efficacy of the treatment is proportional to the amount of suction perceived when the glass is removed.[4]

D.8. Other Therapeutic Measures

a) Cautery. Cautery is employed on a large scale for treatment of a wide variety of diseases and has been for thousands of years. It is not linked in the sources on Jordan to any one category of practitioner, however, as it is in several other countries to the village health barber.

A common means of producing the "counter-irritation" of cautery is application of a hot piece of metal such as a coin or iron nail, or a cigarette end on the affected area. A person with several abdominal cautery marks in various stages of healing is usually suffering from chronic intro-abdominal disorders such as cholecystitis or peptic ulcer. Often persons with fresh cautery marks are suffering from an acute condition such as appendicitis or gastroenteritis. Cautery marks on the extremeties commonly indicate arthritis.[5]

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[1] Fitzgerald 1972: 553-554; Musil 1928: 668.

[2] Granqvist 1965: 25-26.

[3] See Patai 1958: 248.

[4] Fitzgerald 1972: 553.

[5] Fitzgerald 1972: 553; Cameron 1960: 350.

b) Scarification, venesection, tattooing. A sharp instrumay be used to make a series of scratches in the skin on various parts of the body, presumably in the belief that it permits escape of illness-inducing forces. Venesection, or "bleeding," is occasionally practiced for apparently the same reason. Tattooing a ring around a palpable tumor may be viewed as a means of preventing further enlargement.[1]

c) Isolation. As indicated above, seclusion of either the patient or the supernaturally-empowered practitioner is part of the therapy for possession by jinn and other evil spirits.

E. STRATEGIES OF RESORT

It is said that when charms, cautery, cupping, and other indigenous therapies fail, the villager may then turn to the physician. In former days to do so first was regarded a violation of community norms. Today, with more formal education, villagers are seeking formal medical attention earlier. This change has been accelerated too by the influx of the more modern-minded Palestinians.[2]

Some traditional healers also appear to appreciate selected aspects of international medical technology and to cooperate with its practitioners. An American physician found during 4 years' work in rural Jordan that the more sophisticated bonesetters refer patients to a hospital for x-rays, usually asking for films of both the involved and the normal bone for comparison. Generally if patients of such a bonesetter do poorly he refers them to a physician. For this reason, explains the American physician, bonesetters' results are usually superior to those of physicians—thus reinforcing their reputations as healers.[3]

Reluctance to consult or comply with physicians still remains among many people and under certain circumstances. Women for example, are still said to hesitate to be examined by city-educated male physicians. Poor Jordanians are also reluctant to donate blood even for another family member. It is considered so precious (and presumably finite in amount) that an individual cannot imagine having enough to share with anyone else.[4]

Nor are most Jordanians willing to be left alone in a hospital room without visitors. Except for the specific isolation

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[1] Cameron 1960: 351.

[2] Patai 1958: 248.

[3] Fitzgerald 1972: 554.

[4] Fitzgerald 1972: 553.

therapy for possession, customs declares that sick people should not be left unattended. If at home, friends, relatives, and neighbors would come to comfort the patient in his weak condition, to prevent him from feeling deserted, and to convey that they are all eagerly awaiting his recovery. Especially if someone is about to die it is necessary that a large number of well-wishers gather round and give support.[1]

Regardless of whichever category of practitioner provides therapy though, traditional Jordanians reportedly still believe it is God who provides the cure. One Westerner who commented to a peasant that a certain herbal remedy had healed a wound, and on another occasion that a certain practitioner had cured a stroke victime, was told in both cases: No, men just give medicine; God cures.[2]

F. HYGIENE, PUBLIC HEALTH, AND PROPHYLAXIS

F.1. Hygiene

It is only recently that Western-type sanitation facilities are beginning to be available to the rural poor and thus only recently that they are beginning to develop Western-type ideas about personal hygiene. Still, many villages are without sanitary installations and many rural dwellings consist only of one or two rooms that are often shared with livestock at night.

Bathing is of course considered important, especially by Muslims, and public bath houses are much appreciated. There are reportedly two attitudes toward bathing, however, one emphasizing its necessity and the other its danger. Bathing and otherwise cleaning oneself to achieve ritual (religious) purity is a necessity and is promoted by bathing for cleanliness. But washing may be "risky," especially for women and small children. Many people are apparently afraid of washing small children and believe there are some children that can be bathed and others that "one does not dare" to bathe. Women are traditionally believed more susceptible to attack by jinn than men and especially vulnerable when not protected by their clothing.[3]

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[1] Granqvist 1965: 23, 42-85.

[2] Granqvist 1965: 24-25.

F.2. Prophylaxis

Amulets of all kinds but especially those with religious symbolism (Islamic or Christian respectively) are considered efficacious against the evil eye, illness, jinn, and other interrelated misfortune. Included among Jordanian amulets are blue beads, cowry shells, sprigs of rue, and charms bearing the likeness of a human eye or hand. Spoken prayers and Arabic ritual phrases are also believed effective against illness. "Modernization" does not mean abandonment of the traditional precautionary measures; talismans move with oneself from the back of a donkey to the inside of an automobile. Even pills prescribed for treatment may be guarded under a mattress amulets against illness and never swallowed at all.[1]

G. DIET

Little is reported on this subject from the perspective of the Jordanian poor except with regard to infant feeding patterns. Almost all Jordanian village children are breast-fed. Tea is said to be regarded as a food and given to children as part of the weaning diet.[2] The period of lactation is reported to last one to two years for girls but often two to three years for boys. It is said that a two- to three-year-old boy who can speak, run, and play is still the master of his mother in the sense that he may ask for her breast whenever he wants—a circumstance that often leads to an especially warm mother-son relationship later in life.[3]

H. FERTILITY BEHAVIOR AND BELIEFS

Until recently a childless woman was regarded by many with contempt mixed with commiseration and often believed cursed by God. Although this traditional attitude toward childlessness is being gradually mitigated, most women, or family members on her behalf, still search determinedly and sometimes desperately for a cure. Since all the motivations of the traditional Jordanian family are directed toward having many children, there is still widespread disapproval of birth control; many women are said to resort to it only in secret, especially if they have not yet borne "enough" children. Official pronouncements have been made by leading religious authorities at Al-Azhar and elsewhere to the effect that

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[1] Cameron 1960: 347.

[2] Hijazi 1974: 282; Grant 1921: 66.

[3] Patai 1958: 143-144.

there is no Islamic injunction against birth control. Yet the general attitude of over half of 4,811 recently surveyed Jordanians who stated disapproval of birth control is that it is "against the religion." Among those who approved, most said they did so for reasons of maternal health; only less frequently did any say they already had as many children as desired.[1]

[1] Rizk 1977: 95-97; Patai 1958: 141.

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S Y R I A

A. HEALTH AND POPULATION OVERVIEW

Syria's rapidly growing population is estimated to be 8.3 million persons. As of 1970 approximately 57 percent were rural, 43 percent urban. There are considerable ecological and ethnic distinctions as well that result in different health problems and practices. The majority of the rural population (about 55 percent of the total population) are sedentary villagers and predominantly subsistence farmers. The remainder of the rural population (about 2 percent of the total population) are pastoral nomads belonging to some 8 different tribes in eastern Syria that subsist primarily by camel-raising. Ethnically, about half the population are Arabic-speaking Sunni Muslims. The 7 or 8 ethnic minorities include Shiite Muslims, Alawites, Druzes, several Christian groups, and a small Jewish community. An acute awareness of ethnic group membership and an emphasis on cultural differences between groups influence health-related decision-making.[1]

A.1. Population and Health Status

Approximately half the Syrian population is under 15 years of age. Syria's crude birth is estimated to be about 48 per 1000 persons and its population growth rate 3.1 percent per annum. Apparently fewer than half of all deaths are actually registered with authorities; a fact that presumably renders unreliable the stated crude death rate of 16 per 1000 persons. Infant mortality is stated to be about 112 per 1000 live births and life expectancy about 54 years.

Foremost among health problems of the rural population are trachoma and conjunctivitis, schistosomiasis, malaria, and tuberculosis. In the cities, rapid urbanization has resulted in overcrowded housing and overburdened water supply and sewage disposal systems. The result is a high incidence among the urban poor of water-borne diseases such as typhoid, hepatitis, gastroenteritis, and occasionally cholera. The rural poor also suffer from water-borne diseases since many villages lack potable water or adequate waste disposal systems. In urban areas approximately 98 percent of the population has access to potable water; in rural areas only some 50 percent do.

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[1] Information in this section comes from the Syncrisis report (Weissman 1977) and Family Health Care, Inc.

A.2. Health and Population Planning

Formulation of national health and family planning strategies has not been high priority for the Syrian national government. The private sector provides an estimated 77 percent of all outpatient health care in Syria. In urban areas there is reported to be 1 physician per 1,094 persons but in the rural areas only 1 per 15,687 persons. The health education system is aimed primarily at training physicians for curative-oriented clinics and hospitals. Even the government-trained midwives also work primarily in the cities--over 60 percent in Damascus and Aleppo alone. Furthermore, the absence of trained primary health care workers means that doctors and nurses spend a great proportion of their time treating problems that could be handled by less highly-trained personnel. The first attempt to develop maternal and child health and family planning programs in Syria began only in 1976.

B. WESTERN-LANGUAGE SOURCES ON INDIGENOUS HEALTH PRACTICES IN SYRIA

Of all the seven countries examined, Syria has been the least studied in terms of indigenous health practices. Only one investigator, Syrian physician Nash'at Hamarne, focuses directly on the subject.

C. INDIGENOUS ETIOLOGY

C.1. Supernatural Causation

Many Syrians attribute illness to the evil eye and possession by jinn. The poor in particular say that death and chronic health problems come "from God". Many also ascribe the same inevitability to flies and malaria-carrying mosquitoes and accept that they too "come from God". The poor majority appear to have little awareness of the connection between disease and flies, mosquitoes, dirt, and vermin. Many reportedly consider themselves "toughened" and highly resistent or even immune to the more common ailments. Especially in the past and presumably, still today, many poorer Syrians do not perceive conditions such as dysentery and malaria as disease states; rather they are taken for granted as among a "normal" range of conditions since so many Syrians suffer in varying degree from these and other ailments throughout their lives.

C.2. Classical Arabic Medical Theory

The rural population reportedly continues to preserve certain aspects of classical Arabic medical knowledge. Hamarne states that

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[1] See Dodd (1934) and Foreign Area Studies Division (1965: 150-151).

Syria maintained many elements of medieval Arabic medicine after the fall of Baghdad—the center of that medical tradition--and that Syrian physicians continued to enjoy protection and respect through the Ayyubid and Mamluk periods (approximately 13th-16th centuries). Hamarne argues that Arabic medicine thrived longer and more vigorously in Syria than most Western scholars believe it to have done elswhere in the Arab world. Schools were maintained in rural Syria where the teachings of the famed Ibn Sina (Avicenna) and other medieval Arabic physicians were kept alive. Syria, he says, had several outstanding physicians trained in Arabic medicine even in the late Ottoman period.[1]

Hot-and-cold theory and practices are not mentioned in the examined sources.[2] Because of its importance in traditional Arabic medicine, however, it is highly probable that at least some Syrians classify certain illnesses and foods as "hot" and others as "cold". This also seems likely given the importance of "hot" and "cold" classifications just across the Lebanese border among people who are of similar cultural background as many Syrians.[3]

D. INDIGENOUS HEALTH PRACTITIONERS

Urban elites usually say there are no longer indigenous practitioners in the cities. It appears that the categories of practitioners listed below practice primarily in the rural districts and that even there some of the specializations are arracting fewer and fewer practitioners.

D.1. Village Barbers

Village barbers are reported by one source sought after for and adept at pulling teeth, using bleeding remedies, and dressing slight wounds.[4]

D.2. The Traditional Midwife (daya)

The midwife is said to have prestige in her community compable to that of a skilled artisan whose special services in time of need are appreciated. In the early 1960s training courses for the village dayas were conducted by the Near East Foundation and the World Health Organization (WHO). At the WHO Rural Health Centre of Sabka, near

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1 Hamarne 1977: 4-5.

2 See discussion of hot and cold in the Yemen and Afghanistan chapters.

3 See, for instance, the studies by Harfouche which present many such examples.

4 Foreign Area Studies Division 1965: 51.

Damascus, dayas who successfully sompleted a 4-month course were given certificates, UNICEF midwifery kits, and message flags. The flags were a means to compensate for the dayas' illiteracy and the lack of telephones in the rural areas. White was chosen to signal "normal delivery", red "hemorrhage", and yellow "difficulties in labor". A relative of the pregnant woman would act as messenger taking the appropriate flag to the WHO health centre. The average age of 18 dayas in one class was 55 years; they were trained together with teenage relatives in the attempt to avoid, or at least, minimize old-versus-new resentment.[1] Given that the newly recruited and government trained midwives (as opposed to the traditional birth attendants, the dayas) are said to perform about 60 percent of all deliveries but to work primarily in the urban areas,[2] it is probable that the traditional dayas are still an important health resource for the rural population.

D.3. Saints

Saints and their tombs, are visited for protection and good fortune and for the exorcism of jinn. It is primarily women who reportedly seek assistance of saints but saints are both male and female.[3]

D.4. Herbalists

Syria has legally barred its herbalists from medical practice and it is hard to determine how many Syrians continue to resort to them. Health officials in two provinces attest to the presence of herbalists there while others state that the traditional healers have been largely replaced by "the modern health care system".[4] Herbalists are described, among other things, as applying herb poultices to patients who fail to receive satisfaction from herbal home remedies.

D.5. Wise Women

These are health promoters who have local reputations for giving good advice. Women in general are traditionally the major providers of health care in Syria and it is said to be primarily women, rather than men, who have sought the services of the healers and herbalists.[5]

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1 Foreign Area Studies Division (1965: 154, 156) and World Health 1962: 17.

2 Weissman 1977: 103.

3 Weissman 1977: 23. Saint-curing is described in nearby Lebanon in Howell 1970.

4 Weissman 1977: 113-114. Foreign Area Studies Division 1965: 151.

5 Foreign Area Studies Division 1965: 51. Weissman 1977: 23. See also Fahmy 1956.

D.6. Bonesetters (al-ḥakīm)

Bone-setting is regarded by Hamarne as perhaps the most important of traditional practices still existing on a wide scale. He cites the example of one eminent bone-setter in a village near Damascus who receives equally many patients as formally-trained physicians and enjoys such great respect and social influence that the official health authorities are unable to close his practive. Bone-setters are refered to as al-ḥakim but so are, for example, folk opthalmologists and formally-trained physicians.[1]

D.7. Cuppers

Cuppers have been traditionally sought out for the relief brought by cupping—the practice of placing a heated cup over an afflicted area to draw out pain. Cupping, like bleeding, is a therapy that was sanctioned by the Prophet Muhammad.[2]

D.8. Folk Opthalmologists[3]

Several indigenous forms of eye treatment, prescriptions, and surgical operations are resorted to by rural Syrians. Simplest is the use of kohl (antimony) for treatment of conjunctival diseases. Kohl is usually prepared by certain families hereditarily specialized in this. The exact ingredients are kept secret and the families reportedly respected by community members for their professional secrets. A few practitioners perform operations for pterygium, trichiasis, and trachoma.

Cataract couching. The master operation in terms of dramatic and rapid success is cataract couching (cataract needling). This is performed by hereditary specialists once known throughout the Near East as kaḥḥalīn but now called by the general title al-ḥakīm (literally "the wise man"). A patient consults this specialist after having lost his eyesight. The specialist knows how to recognize a cataract and thus whether surgery is indicated or not. If indicated it is performed "in a twinkling" in his clinic in front of the patient's family.

The surgical procedure employed is the same as described in classical Arabic medical texts—insertion of a needle behind the limbus and then couching for the lens. One practitioner states he learned the proper conditions for the operation from a text on pupil

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[1] Hamarne 1977: 6, 12.

[2] Foreign Area Studies Division 1965: 51.

[3] This information is based on the personal research of Hamarne, a formally trained opthalmologist in Aleppo.

reflex and ocular perception of light. These practitioners have abandoned the traditional means of anaesthetizing although one remembers his father boiling herbs for this purpose. Instead they employ a local opthalmic anaesthetic purchased from a pharmacy. They have learned sterilization and boil or expose their needles to flame before use. They also administer antibiotics and cortisone eye-drops after the operation. In this way natural sight and a central pupil are restored to the grateful patient according to Hamarne. Most patients do not experience complications.

There are now reported to be only four folk opthalmologists--all of whom are permitted to pursue their practice. Health authorities had once sought to prevent one folk opthalmologist from opening a clinic for his operations but a large number of persons were so firmly convinced of his skills that they were willing to have the surgery performed at their own risk. When the Ministry of Health once closed the clinic of another folk opthalmologist the action was met by strong protest, including from some members of parliament. Their argument was that the government should first provide the villages with health care facilities and only then would it perhaps have the right to contemplate closing the clinics of those who had served the peasants all those long years. The Europe-educated minister of health was forced to back-down and the folk opthalmologist permitted to continue receiving patients. It is significant that he practices in his native village more than 300 kilometers north of Damascus but that about one-third of his patients come to him from south of Damascus, thus by-passing the capitol and its well-known hospitals. The reason patients give is that this doctor and his father had treated their fathers and grandfathers and done "nothing but good" for them all.

Some patients do experience later complications (the most usual being acute secondary glaucoma) which many simply continue to live with--thankful for the period of natural sight that the operation did bring them. Others are brought to a formally trained opthalmologist.

Hamarne asked once such patient whether he had not been afraid of losing his eye at the hands of the folk opthalmologist. The response was that many people have lost their eyes at the hands of physicians in the hospital. Other rural people likewise relate accounts of medical feats performed by the folk doctors and, in contrast, unsuccessful treatments in modern hospitals. Hamarne states that he and his colleagues feel great frustration when consulted by a patient to whom successful folk couching has returned excellent vision and a central pupil but whose second eye had developed a cataract. The "modern" physicians must hospitalize the patient several days but cannot guarantee good sight and a central pupil while the folk practitioner performs the job quickly and sends the patient home at once or after only one day.

E. STRATEGIES OF RESORT

Many Syrians--even in urban areas--are said to first resort when ill to a home remedy. This may be herbal, such as a poultice of tea leaves for burns or laudanum from locally grown poppies for toothaches and soothing infants.

Until recently most rural Syrians, even if suffering from conditions such as malaria and dysentery, felt no need to consult a physician or enter a hospital so long as they were able to move about, take care of themselves, and do a limited amount of work. Rural people have traditionally regarded doctors as foreign, expensive, and unpleasant. Physician's services, when available, have been very expensive and going to one was long regarded a breach of traditional mores.[1] During the early 20th century the few existing Western-trained physicians resided in the city and were usually Turkish-speaking doctors from Istanbul; the rare Arabic-speaking physician was an upper-class elite trained in Europe or Istanbul who practiced in the city.

The lack of confidence in these early physicians is reflected in the many anecdotes still told about them. One example recounts a Damascus physician who demanded payment of an exhorbitant fee even before setting out in his carriage to see the patient--something the rural population appears to find utterly ridiculous. The opinion prevailing among rural poor until recently was that patients did not benefit much in any case from "modern" physicians and that there was no practical difference in being treated by one or not. More recently, however, international medicine has reportedly come to be accepted as the standard even in remote villages—but confidence in it apparently builds only when quality services are provided. This means, for example, that village visits of regional doctors must be frequent enough and they must show interest in villagers' problems.

Folk practitioners will refer patients to a formally trained physician, according to Hamarne, once a friendly relationship has been established between the two practitioners and the latter has convinced the former of good intentions. Hamarne cites the example of patients who, believing they have a cataract, consult a folk opthalmologist who, finding no indication that surgery is required, then advises consulting a formally trained physician.[2]

Health services now provided by the modern sector are dominated by male physicians who have usurped the role of women as guardians of the family's health. There is reportedly widespread objection, however, to women consulting and being examined by male physicians—both

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[1] Foreign Area Studies Division 1965: 151.

[2] Hamarne 1977: 3, 11.

from the women themselves and from male family members. In addition the lower educational level of Syrian women, relative to that of men in general, makes it especially difficult for them to communicate with the higher class male physicians. Restrictive social and religious customs restrict female nurses from one Muslim sect from caring for the sick of another. Muslims tend to regard nursing as unsuitable for a woman and so most nurses have been Armenians or other local Christians.

F. HYGIENE, PUBLIC HEALTH, AND PROPHYLAXIS

Among the rural population hygiene is poor and there is little awareness of the relationship between insect vectors and disease. Even relatively well-educated Syrians are said to often neglect basic sanitation and hygiene.[1] One medical research team however, found an effective way to convince rural Syrians that mosquitoes carry malaria. This was to describe the malarial parasite as a jinn—too small to be seen except by wise men with glassess--which rides the mosquito; as a person would a horse; on to its next victim.

Many promotive, or prophylactic, health measures are employed. Some are beneficial by international medical standards, such as airing bedding in sunlight and the universal boiling of milk and use of leban (fermented milk). Other measures have more locally recognized promotive health efficacy, such as the use--even in Damascus and Aleppo—of prayer, rosewater, and blue beads and charms against the evil eye and other illness-inducing forces.[2]

G. OTHER HEALTH-RELATED PRACTICES

Therapies noted other than those already mentioned include perspiration baths, inhalation, rubbing the chest, cautery (said to be waning), soaking the feet in hot water, and drinking hot infusions. It is also emphasized that women resort to a wide range of animal, vegetable, mineral, and supernatural means both for inducing pregnancy and "curing" infertility.

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[1] Foreign Area Studies Division 1965: 151, 156.

[2] Dodd 1934.

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T U N I S I A

A. HEALTH AND POPULATION OVERVIEW

A.1. Population Composition and Distribution

a) Total population. About 5.6 million.

b) Ethnic composition. An estimated 97 percent are a mixture of Arab and Berber stock. About 89 percent are Arabic-speaking Sunni Muslims. A few isolated alledgedly "pure Berber" groups live throughout Tunisia and in the south are alledgedly "pure Arabs." Living mainly in Tunis are small minorities of Europeans and Jews. Language is an important socioeconomic class marker. Arabic, the official language, is spoken as one or another colloquial dialect by the majority of the rural population. French, the language of urban, commercial, professional and government life, is a first or second language for about 45 percent of Tunisians. Berber is still used among Berber groups.

c) Distribution. Three major topographical and climatic regions are: the relatively fertile north and northeastern coastal zone where the majority of the population is concentrated; the semi-arid central region; and the arid southern region that becomes the Sahara. About 53 percent of the population is rural. Among them the majority (perhaps 35 percent of the total population), live in very dispersed settlements or are semi-nomadic or nomadic pastoralists.[1]

A.2. Population and Health Status

a) Population. The natural population growth rate is about 2.6 percent per annum. The crude birth rate is approximately 40 per thousand persons and infant mortality about 105 per thousand live births. Some 43 percent of the population are under age 15. Life expectancy is about 54 years. About 45 percent of Tunisians age 15 and above are still illiterate.

b) Health. Some of the major communicable diseases (such as smallpox, typhus, typhoid, malaria, poliomyelitis, and diptheria) have been largely brought under control. Major problems for the population as a whole are now tuberculosis, respiratory infections, gastrointestinal and parasitic infections, schistosomiasis, trachoma and other eye diseases, skin diseases, and venereal diseases.

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[1] See Beamer and Anderson (1975:1-3) and Le Plan de Développement Economique et Social, 1977-1981 (République Tunissienne, 1976).

A.3. Health and Population Planning and Services[1]

a) Health. A hierarchical system exists through which health services in each governate are regionalized. Below the principal hospitals in the main cities are regional hospitals in each medical region, then rural/auxiliary hospitals in market towns of about 10,000 population, next dispensaries with obstetrical services, dispensaries with full-time medical care (but no obstetrical services), and finally rural dispensaries.

"Health manpower" in Tunisia means physicians and services are physician-centered. Legal statutes still demand that an individual have a medical degree to legally practice curative medicine--and health services are overwhelmingly curative. This means that Tunisia's auxiliary health workers, who are the primary staff of rural facilities that should be centers of first resort, are prevented by law from engaging in the curative medicine that is the substance of Tunisia's health care system.

This in turn indicates little or only a low quality of formally-provided health care in the rural areas, despite the existence of facilities and a hierarchical structure that might otherwise be well-suited for primary care. The contrast with urban areas is glaring. The two governates of Tunis are relatively well-served by physicians with a physician-patient ratio of about 1 per 2500. Rural people have few physicians. Most rural dispensaries are visited only two to three times a week by a non-resident physician. The physician-patient ratio in one souther governate (Beja), for example, is only 1 per 23,000.

As of 1973 over half of Tunisia's physicians were foreigners. They come mainly from Eastern Europe on bilateral assistance programs and serve primarily in outlying areas. According to some mid 1970s estimates, equally many Tunisian physicians live abroad (mainly France) as in Tunisia.

Prior to 1964 all Tunisian physicians were trained abroad, primarily in France. In Tunisia things European, especially French, are generally considered modern and high-class and termed *suri*. *Dwa suri*, the Arabic term for "French" or "Western" medicine, seems to carry the direct connotation that one who uses it is him--or herself "modern" and "high class." Things that are traditional and commonplace are called *'arbi*. Indigenous health practices are referred to as *dwa 'arbi*.[2]

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[1] This section is based largely upon Beamer and Anderson (1975) and Benyoussef and Wessen (1974).

[2] Teitelbaum 1975:402; Hermanson Klein 1976:82.

b) Family planning. A pilot family planning project was initiated in 1964 and in 1973 the National Office of Family Planning and Population (NOFPP) was established as a semi-autonomous agency under the Ministry of Health. Over 90 Maternal and Child Health/ Family Planning Centers exist, largely autonomous from the basic health services. As of 1975 they were heavily utilized for children but little by their mothers.

This is not surprising given the requirement that examinations be conducted only by OB/GYN specialists and the fact that only 2 of the 18 Tunisian gynecologists, and a few foreign specialists, practiced in the rural areas. A 1974-1977 NOFPP program was to improve this situation by giving greater responsibility to midwives. The government's position toward midwifery, however, appears somewhat ambivalent.[1]

B. WESTERN-LANGUAGE SOURCES ON INDIGENOUS HEALTH CARE IN TUNISIA

A more reliable and comprehensive overview of present-day indigenous health practices in Tunisia can be gleaned from a smaller body of more recent works than is possible for any of the other six countries.

Health care beliefs and strategies in an urban working class neighborhood in Tunis are presented in great detail in a doctoral dissertation by Hermanson Klein. Male and female possession and curing cults drawing participants from the region around Tunis are described by Ferchiou. Health-related practices and beliefs of the rural poor are described for the Sahel subregion of central Tunisia (by Teitelbaum), in Djebel Khroumir in the northwest (by Creyghton) and in the south (by Ferchiou). The literature on Morocco also affords a broader understanding of the traditional beliefs and practices that are similar in the two countries.

C. INDIGENOUS ETIOLOGY

Cause and cure of all illness is ultimately attributed to God. Various intermediaries exist, however, through which illness is caused. These may be "supernatural," "natural," or "personal." For each type of illness, a corresponding cure exists, but there in no

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[1] See, for example, Beamer and Anderson (1975: 22-23). "Midwives" are frequently mentioned throughout the literature on Tunisia. It is not always clear, however, whether reference is made to indigenous midwives or to the government recruited and trained midwives.

schema that consistently assigns a particular illness or symptom to the same category of causation. Under different circumstances the same illness may be considered at one time as "supernaturally caused," at another as "naturally caused." The initial diagnosis represents a hypothesis about what caused the illness. This is not proved correct unless the therapy it indicates brings a cure.[1]

C.1. "Supernaturally-Caused" Illnesses[2]

This is by far the most frequent category of illnesses treated by dwa 'arbi. Not unpredictably, it is the omnipresent jnun (plural for jinn) who are most to blame. Other supernatural spirits who also cause illness--and sometimes either equated or confused with jnun--are the ghwal ("ogres"), shayatin ("offspring" of Satan), and 'afrit. Tunisian jnun-beliefs and therapies show Sub-Saharan influences. Links have been traced to the bori spirits of the West Africa Hausa and a curing ceremony known as stambali is said to have come from Senegal.[3]

Jnun cause an individual to fall ill either by attacking, (striking) or by possessing. A jinn possesses his or her victim by entering through one of the victim's body orifices. The Tunisians' dichotomization between being "struck" and "possessed" is similar in belief, practice, and terminology to that of Moroccans (described below).

a) Misfortunes attributed to jnun. These include both physiological and psychological disorders--although most Tunisians do not make this distinction. Examples cited in the former category are persistent aches and pains, swellings, illnesses in which the pain seems to shift from one part of the body to another, periodically--recurring illnesses (such as migraine headaches), mutism, blindness, sterility, and illnesses that seem to resist all medication--that is, generally chronic disorders. Examples cited in the latter category include nervous disorders and some forms of insanity.

b) Preventive measures. Many precautions are taken to avoid jnun-caused illnesses. Jnun are automatically summoned when their name is spoken and so Tunisians avoid mentioning them by name. Among the most common euphemisms are "the other people" (n-nas el-okhra)

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[1] Hermanson Klein 1976: 84, 103, 155.

[2] This section derives from Hermanson Klein (1976:82-127) unless otherwise stated.

[3] Tremearne 1914. Stambali is performed by a cult-like brotherhood to exorcise the jinn-possessed and resembles in numerous ways the Africa-derived Egyptian zar. See also Crapanzano (1973:141-142) and Westermarck (1926:I:379) cited in the bibliography for Morocco.

and "the kings of the earth" (melkin el ard). Jnun are usually attracted to four elements; water, blood, fire, and dirt. Thus wells, drains, public baths, slaughterhouses, stoves, and toilets are all places of potential danger. To inform the jnun of one's presence one must say as a warning "Bismillah er-rahman er-rahim" or simply "Bismillah."[1] Spilling hot water on the ground, walking on blood, stepping on fire, tripping, or using one of the areas that jnun frequent without first warning them means one risks harming them since jnun do not otherwise know when to get out of the way. If a jinn is injured, the person who caused the injury will also fall victim to the same injury.

There are Muslim, Christian, Jewish, European, black, and Arab jnun. If a jinn harms an individual the jinn is frequently considered to be of a different religion or "race" than the individual harmed.

C.2. "Naturally-Caused" Illnesses[2]

These are believed caused by the blood or contact with certain material substances and objects. Except for among a few highly educated people this does not include germs--about which most villagers are unaware.

a) Humoral theory. Certain Tunisian practices are identified as a rough folk model derived from the ancient Mediterranean philosophical medicine espoused by Egyptians, Greeks, and Romans and developed by Arab physicians as a therapeutic tool. This was the preeminent therapeutic and explanatory system in the Tunis region centuries ago when Arabic medical manuscripts in Cairo and from the Arab East were copied and brought back by Tunisians on pilgrimage to Mecca.[3] Most Tunisian physicians reportedly ridicule humoral beliefs but many patients still interpret their symptoms in terms of them.

b) "The airs." According to humoral theory, sudden shifts such as going from warm dry places into cold humid outdoors must be done slowly to prevent illness caused by the "airs." Tunisians still consider the air itself a primary source of illness, including especially colds.

[1] "In the name of God, the merciful and the compassionate" or simply "In the name of God."

[2] This section derives largely from Teitelbaum's articles unless stated otherwise.

[3] Ben Miled (1972). See also the doctoral dissertation by Nancy Gallagher (University of California at Los Angeles, Department of History, 1978).

c) Blood afflictions. According to humoral theory, blood can be "heated" by certain foods and "cooled" by others to counteract chills or fever. Because human temperament is also affected there are "cold-blooded" (calm) people, "hot-blooded" (irritable) people, and those who are "weak-blooded" and "strong-blooded." After the common cold, "sicknesses of the blood" are reported to be the most frequent type of illness noted in Sahel villages. Major beliefs and practices described are as follows.

Sickness of the "blood", according to Teitelbaum is a strongly psychosomatic affliction believed created by anger, worry, and dismay. Human emotions are thought tied to the circulatory system. Strong emotions affect the flow of blood by increasing or decreasing the heartbeat. Blood that circulates too rapidly due to emotional tension turns "bad" or "black." It may then rise to the surface of the body causing headaches, sores, and pains.

Anger is considered the main cause of "rotten blood." Outbursts may enfeeble and bring on fatigue. In cases of acute weakness after a display of anger a person may be rushed to the hospital with the complaint of a "broken heart" due to rapid pounding of the blood. Worry causes anger in people with "too much blood." In those with "too little blood" it depresses the appetite and leads to thinness and weakness.

Outward signs of "good blood" are plumpness--firm fatty limbs and a fleshy face. Wealthier people are believed to have fewer worries and thus a good appetitie for health-giving fattening foods such as meat and oil.

Poor people in contrast "substitute" excessive quantities of cheap red peppers for meat in their diet. Because peppers supposedly produce anger more quickly poor people are more susceptible to blood afflictions. Peppers are also believed to stimulate sexual desire and thus account for the larger number of children among the poor--which in turn makes for more worries.

Fears about blood are also involved in the apparently common female hysteria. In forms of hysteria exhibited by girls at the onset of menstruation and women upon menopause the flow of blood becomes an important "cause" of abnormal behavior.[1]

Therapy. "Rotten" or "excessive" blood was traditionally removed by bleeding, cupping, and use of leeches. To "let blood"

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[1] Teitelbaum 1976a:22. See also Ammar and M'Barek 1961.

small incisions are made with a razor blade on the forehead, back of the neck, or earlobes. Bleeding has now been made illegal and punishable by a small fine.

The practice nevertheless continues in secret in Tunis and in absence of law-enforcement in much of rural Tunisia. In Tunis women let their own blood and that of their children at home. Men who believe in the efficacy of the practice usually know a local barber willing to take the risk and perform the service for selected "friends" at a nominal fee. The practice is said to be on the wane in Tunis; it is now done in perhaps only one fourth of all working-class families.[1]

For a person whose blood has become "bad" through anger, visits to religious shrines or treatment by a physician may bring partial relief. Real recovery, however, is possible only when the person who incited the victim to anger (or excessive worry) begs forgiveness. If this is not done, an intermediary often attempts to seek out the "sickener" and bring about reconciliation. If death occurs before reconciliation the "sickener" may be regarded as a "killer" and suffer community-wide reprimand and loss of familial honor for years.

Blood and modern medicine. The technology of "French medicine" has been accepted by many Tunisians but with little or no understanding of the underlying ideas. Thus an individual diagnosed by a physician as having high blood pressure is believed to have "excess blood." A special diet is interpreted as designed to thin or weaken the excess blood so that a bout of anger will not break the patient's heart. Tunisians take vitamin preparations in the belief they strengthen "weak blood." A physician's drugs and tools that penetrate the skin and enter the blood are believed especially efficacious in treating disease.

Visiting any sick friend or relative is an important social obligation. Most Tunisians do so without knowing about or fearing contagion. Not only do they have little familiarity with germ theory, most apparently believe that a visitor would become ill only through worry (including the worry of becoming ill) acting upon the blood. Ultimately, this too depends on God's will (maktub).[2]

C.3. "Personally-Caused" Illnesses[3]

Many "naturally-caused" illnesses are at the same time "personally-caused." In addition to those already indicated as caused by

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[1] See Hermanson Klein 1976:86, 167-168.

[2] See also Hermanson Klein 1976:127, 169.

[3] Hermanson Klein 1976:88-90. On the evil eye see also Teitelbaum 1976b.

the anger, other illnesses are brought about by the emotions of jealously and envy. This occurs through the much-feared evil eye, which Tunisians refer to as 'ayn harsha or simply el 'ayn, "the eye." Evil eye concepts—like those about blood—also function as mechanisms of social and economic control. The hurtful effect of the eye results from feelings of jealousy, greed, envy, and frustration on the part of those who find themselves obliged to admire the better fortune or well-being of another and project their feelings onto the admired one.

A person may inadvertently "take" others with a jealous glance or be "taken" by them. One should avoid being "taken" by using rituals or amulets known to deflect or neutralize the evil eye. Common amulets are the color blue, Quranic verses, a gazelle horn in images of coral, images of the "hand of Fatma" (el Khamsa), and likenesses of a fish. One avoids "taking" others by observing proper etiquette, especially when meeting or visiting someone else. An embrace of the hand or head, for example, usually implies sufficient affection to prevent the evil eye from penetrating the interaction. "The fish upon you!" is but one greeting with which village people wish each other good health and well-being.

D. INDIGENOUS HEALTH PRACTITIONERS

The Government's declaration that it is illegal to practice medicine without a license means that all traditional practitioners are "practicing illegally." An exception may be the indigenous midwives. One source states they have been outlawed since 1958. Another indicates that the Government may now be possibly willing to accept their role but not consider it "practicing medicine" in the framework of the Tunisian curative system.

D.1. Barbers

Formerly barbers appear to have played a role similar to that of Egyptian health barbers. Today, in addition to barbering, some urban barbers still perform male circumcision, although not all are trained to do so. Some are also willing to bleed clients who seek this therapy. The current term for a barber is hajjam.[1]

D.2. Indigenous Midwives (The Qabla 'arbi or Matrone)

Despite legislation against traditional practitioners in 1958, as recently as 1969 some 1400 qablas were still reported to be performing over 70 percent of deliveries in Tunisia. In Tunis the

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[1] Hermanson Klein 1976: 87-88.

estimate was 35 percent and in the more remote governates over 90 percent.[1]

a) Characteristics. Qablas are usually energetic, inventive women who are well-respected and listened to members of their communities. Most have been married and born children; they are middle-aged or older. Often they have inherited the role from an older relative. Many are also household heads who respond to community need out of their own economic need.

b) Fees. Self-respect and tradition nevertheless prevent many qablas from "stooping so low" as to ask payment for their services. Instead they are given "presents"--reportedly more often food products than money. Presents are given within a locally prevailing range according to ability to pay. Families apparently prefer to pay, but those who cannot may receive free services. Another traditional pattern observed by qablas is keeping the genital area of their clients covered (e.g., with a sheet) during delivery in accord with the religious belief that it is forbidden to let this region be seen by others.

c) Services performed. In addition to assisting at delivery some qablas perform many important pre- and postnatal functions. Some have also provided therapy for women believed to have "supernaturally-caused" illnesses. They advise about remedies for "naturally-caused" illnesses as well as about sexual function and dysfunction. In addition qablas often perform the culturally-demanded role of hanana (preparing brides for weddings) and of harza (woman who washes and prepares a female corpse for burial). Qablas are thus major actors at all critical events of the life cycle.

d) Qabla assistants. A woman called a saddada or chedada may assist the qabla by holding the client in labor while the qabla delivers her. Some of these assistants later become qablas.

D.3.a. Saints ('Awli) and Shrines

Saints are highly venerated persons who have achieved sainthood either through Sufi mysticism or theough their believed ability to perform miracles and grant otherwise impossible requests. The essential characteristic of a saint is baraka, the supernatural wonder-working force looked upon as a blessing from God. Baraka may be either inherited or achieved and is the source of the saints' powers to cure.

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[1] These figures are presented in an IBRD report.

Each saint (wali) is associated with a meeting place (zawiya) of a religious brotherhood. The zawiya is a sacred shrine to which visitors make pilgrimage to share in the saint's baraka and gain his intervention in their lives for cure and other purposes. Saints are said to command the jnun living in or around their shrines and to excell in the cure of supernaturally-caused illness.

Shrines are the scene of a weekly gale gathering called a hadra. A shauwesh is one of the brotherhood officials at ghese gatherings. In some places he leads the trance-inducing dance central to the curing ritual. His therapeutic powers too derive from an ability to transmit baraka.

Adepts of a brotherhood may also visit the home of a sick individual to perform a special curing ritual (sometimes called a Hizb Latif. Some families sponsor these gatherings on a regular basis to insure their continued health and prosperity. Numerous other specialists with the healing powers of baraka and numerous other rituals also center aroumd the saints and their shrines. Much of this activity is said to be carried on in secret so as not to provoke government officials.[1]

D.3.b. The Meddeb or Ktab

The meddeb (also called a ktab and sometimes an azzam) is similar to the Moroccan fqih. He is referred to as a scribe, a wiseman, and a Quranic specialist. He has been educated and may teach at a village Quranic school and has healing as one of several roles. In theory he can cope with any illness of supernatural origin because he can read the Quran. He cures through his usually inherited ability to communicate with jnun and his use of special books. One, for example, is the Kitab Al-Rahma (Book of Mercy), reportedly sold and used from Baghdad to Casablanca. The meddeb is also said to possess some knowledge of herbal remedies.[2]

D.4. Herbalists ("Arab Pharmacists")

These are the proprieters of "Arab pharmacies" located in local markets (suq). They are not permitted to "prescribe medicine" but they specialize in the flora and fauna needed for some of the home remedies urban and rural Tunisians frequently employ for "naturally-caused illnesses." (Other home remedies consist of ingredients regularly used in food preparation.) Most of these remedies are orally consumed, rubbed over the body, or applied to the forehead or extremeties. A common ingredient is orange blossom water.[3]

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[1] Hermanson Klein 1976: 109-127; Ferchiou 1972; Creyghton 1977.

[2] Creyghton 1977 and Hermanson Klein 1976: 104-109.

[3] Hermanson Klein 1976: 85-88.

D.5. Women Experienced in Traditional Methods

These may be consulted about home remedies. Some also perform deliveries where there is no midwife.

D.6. Bonesetters

Indigenous bonesetters apparently still provided needed services in rural areas, especially where no other practitioner is available to do so. Bonesetting (ma'allem) is said to have been done by barbers.

E. STRATEGIES OF RESORT

An ill person is attended by close kin who may resort first to herbal remedies. It appears that rural people either prefer to visit a traditional practitioner or be taken to a city hospital or doctor's clinic by taxi or bus. There is extreme underutilization (about 50 to 60 percent) of rural hospitals.[1] Village people reportedly prefer to travel to the regional hospital in the provincial capital where they believe better care can be obtained. Time and cost are not necessarily thought wasted, so great is the prestige of urban dwa suri.

A doctor is considered to have performed a good medical examination if he employs shiny, strange-looking diagnostic equipment and especially if he touches the patient firmly with his hands on the afflicted body parts. Patients may believe themselves healed merely because of this laying on of the hands since that is what the shauwesh and other holy persons do to transmit their healing baraka. Physicians who rush patients through without laying hands on them are suspect. Verbal communication is appreciated but seems secondary to physical contact. Most patients are not accustomed, even with traditional practitioners, to detailed discussion of physical symptoms.

Low-income Tunisians may consult a saint or meddeb at the same time as they are being treated by a physician. If cure results it may still be the traditional practitioner who gets the credit. In any case it appears that causation and cure are still explained in traditional terms even though the latter may have been brought about through physician intervention.[2]

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[1] Beamer and Anderson 1975:23.

[2] See the excellent discussions of this topic in Creyghton 1977, Hermanson Klein 1976, Teitelbaum 1975, and Benyoussef and Wessen 1975.

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M O R O C C O

A. HEALTH AND POPULATION OVERVIEW

A.1. Composition and Distribution

a) Total estimated population about 18 million.

b) Rural-urban distribution. Rural 65 percent, urban 35 percent. Urban population growing rapidly; estimated to reach 50 percent before end of century. Population relatively well distributed throughout country. Casablanca is sole prefecture with over 10 percent of the country's population.

c) Ethnic heterogeneity. Main distinction is between Arabs and Berbers. Arabs and Berbers regard themselves as racially different. The derive from the same physical stock, however, and have had considerable intermarriage. Differences are largely only socioeconomic and cultural. Arabs more urban and higher social status, generally speaking, than Berbers. Each speaks own language. Both are Muslims. Morocco about 99 percent Muslim with small Jewish and Christian minorities. History of tribal dissidence and independence in mountainous areas toward interior. Nomadic and semi-nomadic pastoralists migrate in the Sahara in Morocco's far interior.

A.2. Population and Health Status[1]

a) Population growing rapidly; annual rate of natural increase has averaged over 3 percent during past decade. High growth rate is attributed to general improvement in environmental health conditions and to growing availability of medical services in absence of decrease in birth rate. Crude birth rate estimated to be 47 per 1000 persons. Life expectancy at birth about 53 years. Infant mortality about 117 per 1000 live births. Adult literacy rate (age 15 and over) estimated to be about 25 percent. (Only 3 percent of rural women reported literate, however.)

b) Health. Leading causes of death in all age groups include gastrointestinal diseases, upper respiratory infections, measles, heart disease, and accidents. Pneumonia reported to be additional cause of infant mortality. Some schistosomiasis and danger it will spread with extension of irrigation projects in endemic areas. Apparently high incidence of psychological disturbance among low-income Moroccans due to strains of family life and cultural pressures (e.g., emphasis on male masculinity and female virginity).

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[1] This and A.3. based on Weissman 1977.

A.3. Health and Family Planning Services

National health policy consists of general statements concerning provision of health services for all Moroccans, development of infrastructure for both preventive and curative services, training of health manpower, and integration of family planning into health sector activities.

Public health system has expanded rapidly during past two decades. Is now extended into remote villages where 4-room rural dispensaries have been established. Yet system remains unable to meet needs of population. Only some 15 percent of eligible children are covered by the maternal child health services. Other imbalances exist in concentration of services and personnel in urban centers. Urban health centers are overcrowded but rural dispensaries are underutilized as are hospital beds throughout the country.

B. WESTERN-LANGUAGE SOURCES ON INDIGENOUS HEALTH PRACTICES IN MOROCCO

B.1. Early Sources

Rich descriptions of health practices, with emphasis on ritual, exotic, and folkloric elements exist.[1] As stated above (see Egypt), these must be complemented by contemporary sources or field research to determine distribution and prevalence. Many such early sources are unreliable in themselves (e.g. Epton, 1958) not because they are "dated" per se but because of overgeneralization and failure to indicate prevalence of beliefs, practices, and practitioners.

B.2. Recent Sources

More ethnographic and analytic. Major focus is on maraboutism, the "cult of saints"--said to be the hallmark of Maghrebian Islam. Also much concerned with jinn (jnun) and psychological phenomena.[2] Recent interest in social context of health care in works by Mernissi.

C. INDIGENOUS ETIOLOGY

Multiple theories of causation (and consequently multiple types of therapy). "Pathologies" are often self-contradictory. Is virtually impossible to identify a single systematic Moroccan theory of causation. Varies from tribe to tribe, city to city--and, presumably, especially from coastal strip to mountain regions to Sahara. Is amalgam of various pre-Islamic folk beliefs, Islamic beliefs, influences from sub-Saharan Africa, and popularizations of traditional Arabic and modern international medicine. Supernatural elements enter,

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[1] See Doutté (1908), Legey (1935), Tremearne (1914), and especially Westermarck (1926).

[2] A major source is Crapanzano (1973) on whom this report's sections C,D, and E are based except where otherwise stated. See especially pp. 1-11 and 133-140.

either directly or indirectly, into the Moroccan explanation of any disease. Still, theories of causation can be divided into two general categories: prenaturalistic and naturalistic explanations.

C.1. Prenaturalistic ("supernatural") explanations

These can be divided into those involving jnun (Moroccan for jinn) and those that do not.

a) Explanations not involving jnun. Include magical poisoning, magical curses, evil eye, and witchcraft.

b) Explanations involving jnun. Generic term most often used for a person attacked by a jinn is majnun. May refer to someone who has been struck or someone who is possessed. The person who displays symptoms of a possession state is said to be "inhabited" (maskun) by a jinn. Person who is suddenly paralyzed is said to have been struck (madrub) by a jinn. Each of the two conditions is divided into about three additional states depending on intensity of symptoms.

Jnun are whimsical, arbitrary, capricious, revengeful, quick-tempered, and despotic--and thus always dangerous. Cause and are involved in many illness states in addition to those called majnun. Persons in liminal periods associated with change in social status are most vulnerable to attack: pregnant women, newborn children, boys about to be circumcised or just circumcised, couples about to be married, and the dying. Jnun are more active at certain times and in certain places than others. Are many classes of jnun--such as 'afarit, ghwal, and shayatin--each with special characteristics. One must treat them all with great respect. They are generally feared. Moroccans take all kinds of precautions to keep them at bay.

C.2. Naturalistic explanations

Are usually mechanistic. Certain heart diseases and illness are said to be caused by eating salt. Syphilis is caused by menstrual fluid, gonorrhea by semen backing up into the kidneys if a man is not careful to urinate after intercourse. Tuberculosis may be caused by--among other things--not wearing a shirt in the heat, especially when riding a bicycle. Wasting diseases are frequently due to poisoning by one's enemies.

D. INDIGENOUS HEALTH PRACTITIONERS

D.1. Barbers

Little written about them. One of therapies sought out for is blood-letting. Cauterization is also Moroccan folk therapy; barber probably performs this also.

D.2. Traditional Birth Attendants (Qablas; Accoucheuses in French)

Qablas retain an important role. Recent survey of several thousand women in nine Moroccan cities found that three-fourths of them had delivered their last child at home, many with assistance from a qabla.[1] Percentages from rural areas are certainly higher. Qablas perform many extra-delivery functions and are important community members, especially in rural areas. Suggestion is made (in Population Council report) that qablas might be important aids in contraceptive education programs.

D.3. Saints and Shrines; Other Holy People

Extreme importance. Saints and shrines are pre-eminent in Moroccan popular therapy; Morocco itself appears pre-eminent among Arab countries in this regard.

a) Saints are male and female; very learned and illiterate. Saint in the sanctuary (shrine) said to play the role of the psychiatrist in capitalist society, channeling discontent into therapeutic processes.[2] The visit (ziara) itself has therapeutic value. Sanctuaries more frequented than women than by men--explainable in context of subordinate role of women in Moroccan society and of increased status deprivation as Morocco Westernizes. Women, in spite of modern health services, resort to sanctuaries (and their saints) in great numbers. May go before, simultaneously as, or after consulting formally-trained practitioners. Saints know no French and often no literate Arabic; their language is the same colloquial dialect, Arabic or Berber, as that of the urban and rural poor. Referred to as siyyid, salih, and wali.

b) Curing cults of saints are disparaged by Moroccan elites and many Moroccan health professionals but are successful curers in the context of Moroccan society--and, in some instances, also in terms of the standards set by international medicine. Are able to effect, often dramatically, remission of symptoms--paralysis, mutism, sudden blindness, severe depression, nervous palpitation, paraesthesia, and possession. One such group, the Ḥamadsha, are described as superb diagnosticians; they treat only illnesses they are likely to successfully resolve and generally avoid illnesses regarded by international medicine as organically caused.

c) Successful treatment for attack by jnun may move the patient through the roles of sick person and patient and back to his original "old self." Certain therapies, also regarded as successful, do not aim at restoring the distressed individual to the previous condition. Rather these introduce the person to a new social role and identity and perhaps membership in the cult. Similarities exist, in this regard,

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[1] Studies in Family Planning 1970b:8.

[2] Mernissi 1977a.

to outcomes of Egyptian zar cult therapy.

d) Fuquha (singular: fquih or fqih). Fuquha are Quranic healers who specialize in writing amulets and talismans. Widely sought after for assistance in preventing illness and other misfortune. Tkaf is a widely used magical procedure done to prevent the occurrence of a particular event.

e) Baraka is a very powerful force defined as a saint's blessing or holiness. Makes curing possible. Is associated with saints' tombs and sanctuaries, also with sacred springs and grottos, trees, stones, and animals.

D.4. Herbalists

Little discussion of this specialist. May be Arab, Berber, or Jew.

D. 5. Wise Women (the Aguza)

Is familiar with many herbal and supernatural therapies.

E. STRATEGIES OF RESORT

Increased utilization of physicians and modern sector facilities. Continued reliance upon traditional healers and therapies where modern facilities do not exist, for social and cultural problems that international medicine cannot successfully treat, and because many find modern medicine and its practitioners alienating and unaffordable.

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