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GENDER, POWER, AND ILLNESS

IN AN EGYPTIAN VILLAGE

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Soheir A. Morsy

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GENDER, POWER AND ILLNESS IN AN EGYPTIAN VILLAGE

By

Soheir A. Morsy

A DISSERTATION

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ABSTRACT

GENDER, POWER, AND ILLNESS IN AN EGYPTIAN VILLAGE

By

Soheir Morsy

This study describes a research effort which focuses on gender roles and examines their reciprocal relation to illness behaviour in an Egyptian village. In considering gender as a dependent variable, the study is guided by a theoretical orientation which identifies male-female power differentials as the outcome of distinct production relations and associated superstructural apparatuses which promote their replication. In view of the identity of the inhabitants of the research locale as peasants, it is deemed necessary to trace the determinant social relations that affect village society and which extend beyond the confines of the research locale. Clarifying the subordinate position of the Egyptian peasants (males and females) is considered important for formulating generalizations about gender roles in terms of structural types.

In the treatment of gender roles, and associated power differentials, as independent variables, the present study focuses attention on the medical system. In the course of this analysis, the dialectical relation between gender and other elements of social identity is probed. Gender is thus regarded as but one element of multi-dimensional social identities, and associated power relations, which influence the precipitation of and response to illness. Finally, definitions of illness,

which are cultural prescriptions for controlled deviance, are conceptualized as superstructural elements which bear a dialectical relation to infrastructural contradictions and attendant power differentials.

Data presented in this study derives from field work conducted over a period of one year in an Egyptian Nile Delta village. The standard anthropological techniques of participant observation and interviewing were employed in the collection of data and the latter part of the research period was devoted mainly to structured interviews and the administration of tests and questionnaires. In addition, the help of both a physician and a psychologist was secured at various stages of the research project.

The conclusions drawn from the present study have a direct bearing on the theoretical issues related to the anthropological study of gender roles. Data presented in this thesis undermines universalistic explanatory schemes of gender roles which attribute male-female power differentials to an alleged universal opposition between the public and private domains. The insignificance of such oppositions for peasant communities such as the setting of the present study is emphasized. The present study also questions another set of alleged universal oppositions, that between male authority and female power, which logically derives from the first hierarchical differentiation between the public and private domains. It suggests the definition of power in terms of control (as opposed to individualistic manipulations) over culturally valued elements of the social environment, thus allowing

for the comparison of one situation of power differential with another. Within the study community, the developmental cycle of the family is identified as a significant framework for the analysis of the dynamics of power relations and patterning of control over culturally valued elements of the social environment. Additionally, male control over valued instruments of production and the products of agricultural labour is deemed the basis of male-female power asymmetry in the study community.

The focus on the medical system in the latter part of the study emphasizes its utility as a probe which illuminates various dimensions of social organization, notably power relations. In addition to this major significance of the analysis of the medical system, the detailed analysis of its various dimensions has yielded a variety of data of particular relevance to the interests of medical anthropologists. The study presents data on local beliefs about the human body, its formation, structure and function, village medical taxonomy, the selective extension of illness explanations, and the prevalence, diagnosis, and treatment of culture bound illnesses. In its examination of medical treatment, the study emphasizes the dynamics of treatment choice and undermines the theoretical premises of the conceptual dissonance argument found in some medical anthropological studies of therapeutic strategies. Finally, it advocates a holistic orientation for the study of medical systems by underscoring the necessity of considering structural constraints imposed by encompassing social structures in studies of health care at the micro level of rural communities.

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INTRODUCTION

A. General Aim of the Study

The study of social differentiation and categorization necessitates the dissection of these complex socio-cultural phenomena into their constituent elements. These may include such factors as age, race, religion, as well as a variety of others which are products of specific social systems and historical developments. Examination of these various elements of differentiation and categorization in different socio-cultural contexts is necessary for the identification of structural regularities. This dissertation describes a research effort which focuses on one such element, gender, and its associated power relations, and examines its reciprocal relation to illness behaviour.[1] This study is undertaken in the context of a peasant community in the Egyptian Nile Delta.

B. Theoretical Perspective

The subject matter of this study is clearly a reflection of the recent trend in Anthropology of rectifying the androcentric bias of the discipline. The intensification of efforts towards more balanced accounts of Woman's role in Society has been undertaken by anthropologists of different theoretical persuasions (Stack et al 1975). Some have proceeded with the assumption of the universality of male dominance, while others, guided by a theoretical perspective which centers on individuals as rational choosers, have undertaken to show

women as rational manipulators of their social environment. Still others have approached the analysis of gender roles in terms of historically specific patterns of social organization in societies which they differentiate according to structural types. The present study partakes of the last orientation towards the study of gender role ascription. In considering gender, and its associated power differntials, as dependent variables, the present study rejects universal, heirarchical oppositions as explanatory schemes. Instead, an understanding of male-female power relations is sought in light of a historically specific social formation. Male-female power differentials are conceptualized as the outcome of a distinct production structure associated with a superstructural apparatus which promotes its replication. The analysis of power relations focuses on principles of contradiction between social categories rather than on the opposition of interests between individuals.

While the present study is based primarily on an empirical analysis of gender roles, power relations, and their consequences in a localized setting, a peasant community, the village cannot be realistically considered an adequate unit of analysis. It cannot be treated as a "primitive isolate". It is therefore deemed necessary to trace the determinant social relations that affect the peasants of the study community and which extend beyond the confines of the research locale. The recognition of the relation of structural asymmetry between the village and the larger society is essential in understanding the roles of female and male peasants. Peasants' class identity is regarded as crucial to any discussion of role constraints and choices. Clarifying

the subordinate position of the Egyptian peasant (male and female alike) is considered important for formulating generalizations in terms of structural types.

In the treatment of gender roles, and associated power differentials, as independent variables, the present study focuses attention on the medical system. In the course of this analysis, the dialectical relation between gender and other elements of social identity related to power differentials is probed. Gender is thus regarded as but one element of multi-dimensional social identities, and associated power relations, which influence the precipitation of and response to illness.

The selective concern of this study with the medical system in the treatment of gender role as a dependent variable may be clarified in light of the fact that definitions of illness are intimately related to deviations from culturally prescribed role behaviour. As Howard Stein has written,

> One must study the "well" in order to understand the "sick" and study the "ill" to understand what is hidden and latent in the "healthy", since what is explicit in illness is implicit in health. Deviation from the norm is a guide to the norm through its distortion and exaggeration....the relationship between illness and health is dialectical... Cultural role ideology may create a dichotomy between them to protect the boundary separating them, but role performance reveals the relationship between them.... the health-illness model is a single expression of the relation between norm and deviance....the "sick role" and the "healthy role" (are) dialectically and necessarily related, the former constituting the antistructural pole, and the latter constituting the structural pole (Stein 1976: 117-119; original emphasis).

In short, by careful examination of the deviation from role expectations associated with illness, we are better able to understand role

expectations themselves. In the present study, definitions of illness, which are cultural prescriptions for controlled deviance, are conceptualized as superstructural elements which bear a dialectical relation to infrastructural contradictions (primarily those associated with gender identity) and attendant power differentials.

In the cross-cultural study of health and illness, important concepts for focusing research inquiry include "medical system" and "illness" (Mitchell 1977). The use of these terms in the present study needs clarification at the outset. "Medical system" is an important conceptual element of Western society but may pose confusion when incorporated in a cross-cultural analytical framework without redefinition. Cognizant of the limitation of the culture-bound concept of medical system, Leonard Glick has suggested that we abandon conventional Western ideas about medicine and proceeded to define a medical system as "a patterned set of ideas and practices having to do with illness" (Glick 1967:32)[2]. The employment of the concept of "medical system" throughout the present study follows Glick's definition. Thus, its usage implies local identifications, explanations, and treatment of illness.

Another conceptual definition which needs clarification at this point is that of "illness"[3]. In this regard, it is essential to note "the distinction between the possession of some symptoms or illness conditions and the possible behavioural, socially relevant, consequences of those symptoms or conditions" (Robinson 1971:1). The present study focuses on the latter dimension of illness. Its primary interest is not the analysis of the <u>condition</u> of illness, but the <u>behaviour</u> associated with that illness condition. It is the behavioural

and socially consequential aspects of illness which are deemed significant for the purposes of the present study. In fact, these behavioural dimensions of illness are themselves utilized to probe other socially significant relations, namely those linked to power differentials, especially the asymmetry of power relations associated with gender identity.

In considering the behavioural correlates of illness conditions, the present study does not ignore what Fabrega has referred to as the "biological (symptomatic) indicators - which lead lay individuals to designate a state of compromised health" (Fabrega 1972:213). But its concern is not with illness as defined biomedically (i.e., disease). Illness is defined as a deviation from culturally designated states of normal health, manifested by changes in social, psychological, and/or physical states. In short, the present analysis of illness focuses on what Mechanic has termed "illness behaviour". This entails the extension of primary consideration to "the way in which given symptoms may be differentially perceived, evaluated, and acted (or not acted) upon by different kinds of persons" (Mechanic 1961: Cf. Robinson 1971: 1).

C. Methods of Data Collection

This study is based on field work conducted over a period of one year between August 1974 and July 1975 in the Egyptian Nile Delta village of FatiHa (a pseudonym). Preliminary research was conducted in the area in the summer of 1973. Throughout the period of data collection a conscious effort was made to sample the opinions and

activities of both males and females. The author's awareness of the bias in choice of informants, particularly her critical posture towards male anthropologists who provide us with information derived from male informants only, was a constant reminder to correct her "natural" propensity to women. Conformity to local codes of modesty in dress and behaviour earned her the respect and trust of both males and females. Contrary to prior expectations, she faced no difficulty whatsoever in discussing a wide range of topics, including those pertaining to sexual matters, with male informants. Both males and females of the community have different expectations of urban women like the author than they do of their local women. They had been exposed to the female physicians in the hospital of the nearby town and the female dentist whom many of them frequent. The author's identity as an urban woman from Alexandria was not alien to their expectations. Her incessant interest in their culture and their welfare formed the basis for a relation of trust seldom extended to outsiders.

Data presented in the body of this dissertation were collected through participant observation and interviews. An interview schedule was used in the preparation of a consus of the research population for which quantitative data was collected. Informal interviews were conducted with male and female members of the community as well as with indigenous medical practitioners and professional medical personnel in the vicinity of the village. Time was also devoted to observations in homes, fields, and physician's clinic, in the local indigenous practitioners' residence, and in the hospital in the nearby town.

Participant observation was also instrumental in the collection of data related to altered states of health. Additionally, the latter part of the research period was devoted mainly to structured interviews and the administration of tests and questionnaires.

Since socioeconomic status and attendant power relations within the village are defined primarily in terms of control of agricultural land, size of land holdings was the primary criterion for the selection of a representative sample of the population for close investigation. To insure proper representation of population subgroupings, stratified random sampling of the study population was undertaken. On the basis of information obtained from the records of the local agricultural cooperative and the vollage headman (ʿumda), the distributions of land holdings did not indicate much variation (see Table 1).

The census population consisted of the occupants of a random stratified sample of 100 households (approximately 21% of family households in the village). To insure proper representation of each of the socioeconomic subgroups, the percentages of families indicated in Table I were used as a guide to randomly select the appropriate number of households of each category from the records of the agricultural cooperative. For landless families (estimated by the ʿumda to constitute approximately 13% of the total population), these were selected (with the aid of the ʿumda and the field assistant) by choosing, randomly three households from each of the three named areas of the village and four households from one such named area. The final composition of the consus population is indicated in Table 2.

Census taking was a long drawn out process which stretched over

Table 1. Distribution of Land Holdings in FatiHa

Land Area	Number of Families	% of Total of 460 Families
8 feddans*	1	0.2
6	1	0.2
5	11	2.1
4	11	2.1
3½	6	1.3
2-3*	170	36.7
1-1½	79	17.1
1/8-3/4	121	26.3
0	60	13.0

*1 feddan = 1.04 acres.

Table 2. Distribution of Census Households According to Cultivated Land Area

Land Area Cultivated	Number of Households in Census
8 feddans	1
6	1
5	3
4-3½	5
2-3	37
1-1½	17
1/8-3/4	25
0	13

a period of nearly two months. However, its utility for building rapport with members of the community was absolutely indispensible. Moreover, it yielded a variety of quantitative data related to the theoretical emphasis of the study. These include household composition, differential ownership of property by men and women, types of family structures, marriage patterns, educational level of males and females, patterns of menstrual isolation, as well as medical data related to the differential incidence of illness among men and women, folk conceptualizations of illness, and the illness referral system. Data obtained through the census formed the basis for further investigation during the remaining months of field work.

Throughout the study period particular attention was placed on gender role differentiation and its relation to different facets of village life. Data on differential early age socialization of males and females was collected and interviews and observations of differential authority patterns within the households and in village political activities were made. Information on the cultural evaluation of the physical and moral qualities of the sexes was collected through interviewing males and females and through the collection of local religious beliefs and proverbs. Through participant observations, ideal patterns of gender role expectations were compared with actual behaviour and the bases and consequences for transgressing culturally stipulated boundaries were recorded. Finally, structured interviews were administered to elicit informants' conceptualization of gender roles and of male-female personality differences.

Through participant observation, the collection of census data,

and by way of structured and informal interviews with male and female villagers and traditional medical practitioners, data on illness causation and various medical practices was collected. Structured interviews were used to assess differential illness behaviour associated with males and females and the different forms of medical treatment extended to members of the two groups. Several interviews were also conducted with male and female traditional practitioners in the village and its vicinity to compare their healing power and ethnomedical knowledge. Structured interviews and tests were administered to these practitioners to evaluate the basis of their healing powers and their authority in the community.

Informants' generalized statements were supplemented by observation which provided a direct index of illness behaviour. Actual cases of folk illness recorded involved close observation of the affected person over an extended period of several weeks. Persons affected by the folk illness ʿuzr (a local variant of spirit possession) were observed and interviewed at different stages of the illness episode. In attempting to discern whether one could isolate certain patterning of specific social, psychological, and somatic criteria of illness which are independent of the folk medical system, persons affected by the illness were also subjected to professional medical examination and psychological testing. Finally, in view of the importance of male and female reproductive functions as a basis for gender differentiation and power, informal interviews with males and females, and the observation of midwives, resulted in the collection of data on beliefs and practices related to the reproductive process.

Recognizing what has been termed the anthropologist's "limits of naivety"[4], this author secured the aid of a physician and a psychologist during various stages of field work. The physician's familiarity with local linguistic variations and medical problems proved very helpful in the modification of the Cornell Medical Index[5] which was administered to over 350 male and female respondents. Psychiatric interpretations of the responses to the CMI were made by the psychologist who also constructed and analyzed the Hakky personality test[6] which was administered by the author.

D. General Organization of the Study

Following the introductory remarks of this section, Part I of the study (Chapters 1 and 2) relates its central conceptual themes (gender, power, and illness) to the relevant literature in Anthropology and delineates its main theoretical assumptions. Part II (Chapter 3) provides a description of the study area which is guided by the theoretical considerations outlined in Chapter 1. Thus, in addition to providing a general account of the social organization of the village and a detailed analysis of male-female power differentials, Chapter 3 considers village society as characteristic of the structural type "peasant society". Part III of the study (Chapters 4, 5, 6) undertakes a detailed examination of the medical system of the study community. It provides an account of villagers' perceptions about the formation, structure, and function of the human body, local medical beliefs and explanations of illness, culture bound illnesses and their distribution, and villagers' responses to illness. Throughout

this part of the study, relevant dimensions of the medical system and illness behaviour are linked to the relations of power differentials (primarily those associated with gender) introduced in preceding chapters. Finally, the concluding part of the study serves to summarize its major findings and their theoretical implications.

NOTES

[1]The choice of gender roles and the medical system as foci of research is explainable in terms of the author's academic and personal backgrounds. She has had a long standing interest in matters related to health and illness through her earlier academic training in Bacteriology and graduate studies in Medical Anthropology. Having grown up in the Middle East, her interest in the study of Woman's role in Society was initially stimulated by exposure to biased Western characterizations of women's roles in that area. This preliminary concern then developed into a serious interest in the cross-cultural variation of gender identity during the earlier part of her graduate education. Throughout the course of graduate training, this interest was maintained and intensified.

[2]The utility of retaining the concept of medical system for the purpose of cross-cultural analysis is by no means a point of agreement among medical anthropolologists. Thus, Mitchell (1977), for example, while recognizing Glick's redefinition of medicine as a "generic concept for encompassing every imaginable kind of belief and practice related to illness", and while appreciating its significance in the attempt to "counter a tendency towards ethnocentrism" (Ibid:17), has reservations about its utility in cross-cultural research. He rejects Glick's formulation on the grounds that it refers to "an extravagant array of often logically contradictory ideas and practices (naturalistic and supernaturalistic ideas and practices about illness)". Instead, he proposes that if such divergent ideas and practices are to be subsumed under a single rubric, it is just as appropriate to refer to them as 'magical systems' as it is 'medical systems'. Alternatively, he recommends the use of the concept "curvative system". Accordingly, a "medical system" would be considered "a type of curvative system that emphasizes naturalistic rationales and practices" (Ibid; original emphasis).

In noting Mitchell's proposed modification, one may recognize his attempt at cleansing the term "medical" of its Western cultural implications, but it is important to point out the restrictiveness of his proposed modification. It places selective emphasis on a specific component of the illness experience, namely the curative dimension. The conceptual model suggested by Mitchell may itself be regarded as ethnocentric in that it denies the importance of illness causation and illness prevention, which are significant components of various non-Western medical systems, including that associated with the research community of the present study.

[3]According to the recent review of the Medical Anthropological literature by Colson and Selby (1977:246), the concern of ethnomedicine is not with "disease" but with "illness and illness behaviour as a cultural category". In his discussion of this analytic distinction as defined by Fabrega, Mitchell (1977) has rightly argued that the term disease is a technical concept of biomedicine which is not helpful for the cross cultural analysis of altered states of health. Thus, while recognizing the utility of the "disease" concept for physical anthropological and epidemiologically oriented anthropological studies, he rejects its use in the anthropological quest to document and compare medical systems cross-culturally (Ibid). Mitchell is also correct in noting that unlike epidemiologists who are concerned with the same disease entities in a variety of societies, cultural anthropologists do not have a consistent data base. Their arena of inquiry includes ALL societies, thereby underscoring the need for generalized concepts and terms. The term "illness" fits this need. To quote Mitchell on this point, "By opting for this 'loose' term, we optimize the possibility that the ethnographic facts about a society's forms of curative intervention - whether ritual, surgical or physical - will cluster around the relevant ethnographic beliefs, not Western ideas of medical taxonomy" (Ibid:19).

[4]See Devons and Gluckman 1968.

[5]The CMI in its modified version consists of 186 questions which elicit physical and emotional symptoms of respondents.

[6]The Hakky personality test (Hakky 1974, Ein Shams Univ. Ph.D. Dissertation) is a projective test developed by the psychologist involved in this research project. It consists of a series of 20 photographs with a choice from four possible responses to each illustration, including a completely non-restrictive response in which the respondent is given the alternative to provide his/her own evaluation of the situation depicted in the picture. Each of the four responses is given a numerical score which is an estimation of the degree of personality maladjustment.

PART I: THEORETICAL CONSIDERATIONS OF THE STUDY

CHAPTER 1

ANTHROPOLOGICAL PERSPECTIVES ON GENDER ROLES

A. Introductory Remarks

In this chapter, gender is considered as a dependent variable and an examination of anthropological explanations of male-female power relations is undertaken. Section B devotes attention to the sociology of knowledge by focusing on the "context of discovery" associated with anthropological inquiry. This leads to a discussion of the male bias in anthropological studies of gender in Section C. Having noted the limitations imposed by this perspective on the study of women's roles, Chapter 1 is concluded with Section D which shifts our attention to recent theoretical trends in the study of gender roles. A critique of universalistic explanatory schemes of male-female relations, methodological individualism[1], and the current differentiation of power and authority is undertaken. A statement of the theoretical orientation of the present study concludes this section. It suggests the analysis of gender roles, not in terms of alleged universal oppositions, but by reference to historically specific patterns of social organization (Leacock 1975)[2]. Finally, the theoretical framework of the present study emphasizes the dialectical relations between individual choices and societal constraints and defines power in terms which allow for comparison beyond individual actions.

B. The Context of Discovery

The theoretical issues with which this study is concerned cannot be fully understood without a discussion of the epistemological framework from which they derive. Even the most superficial examination of the literature on the sociology of knowledge discloses the dialogue between Science and Society and demonstrates that reality is socially constructed (Berger and Luckmann 1966). Indeed, it has been noted that "an apparently arbitrary element, compounded of personal and historical accident, is always a formative ingredient of the beliefs espoused by a given scientific community at a given time" (Kuhn 1970:4). The anthropological community is no exception; it is evident that the anthropological reality is also socially constructed. The existential situation of anthropologists is without doubt a factor which conditions the knowledge which they acquire and use (Maquet 1964:47-48). Like members of other scientific communities, anthropologists are subjected to a multiplicity of social, policital, economic, and ideological determinants which account for their everyday existence as members of a given society and an academic tradition. Anthropology itself cannot escape the history of its development as reflective of the domination of subservient groups by European and North American societies. In the words of Levi-Strauss,

> Anthropology is daughter of this era of violence: Its capacity to assess more objectively the facts pertaining to the human condition reflects, on the epistemological level, a state of affairs in which one part of mankind treated the other as an object. (Levi-Strauss as quoted in Hymes 1974:61)

The very existence of a discipline devoted to "the study of primitive

societies" of the non-Western World reflects the sense of superiority of 19th century Europe and an attitude consistent with, and useful to, the colonial expansion of the period (Maquet op. cit. p. 51).

The past of Anthropology continues to haunt us to this very day and is clearly reflected in some contemporary practices. Societies which partake of the general Western characteristics are seen as less interesting while "exotic" peoples and their practices continue to be the ideal object of an anthropological study. An academic community controlled by western anthropologists continues to practice what Galtung refers to as "scientific colonialism" which maintains the "distinctive other" tradition. This practice finds justification in the anthropological myth of objectivity. According to this directive,

> ...(the anthropologist) must behave as if he had no judgment, as if his experience were inconsequential, as if the contradictions between his origins and his vocation did not exist. Moreover, he will imagine that he has no politics, and he will consider that a virtue. (Diamond 1974:94)

According to this philosophy, outsiders are judged better qualified to undertake the study of dominated societies and males are assumed more "objective" in the analysis of female roles[3]. Thus selective recognition of observers' social identity and its relation to theoretical formulations is practiced under the guise of scientific methodology.

Theoretical interpretations of the world are not immune from the effects of the cultural contexts in which they are formulated nor the social identities of those who propagate them, be they "outsiders" or "insiders", men or women. In fact, it may be argued that

an adequate definition of an anthropological study should not only indicate its object, but also the social identity of its subject, the anthropologist. "It is by virtue of his individuality that the anthropologist (the subject), reads into the gestures he observes (the object) the meaning that makes of them social phenomena" (Maquet op. cit. p. 52). Theoretical progress rests, not on the denial of anthropologists' social identities and culturally conditioned ideologies, but by the comparison of these different culturally conditioned theoretical interpretations of reality[4]. The utility of such comparisons is supported by the recent literature on gender roles cited below.

The recent changes in the study of Women's roles in Society constitute a lucid corroboration of the constant dialogue between Science and Society. The close relationship between social ideologies and scientific inquiry is plainly apparent in the revival of interest in theposition of Women in conjunction with the growth of the Woman's Movement. It is clear that scientific studies of women in the last decade owe their stimulus to renewed public interest in the Woman's Movement (Matthiasson 1974:xvii). The obvious intensification of efforts to investigate the role of Women is easily traced to the sociopolitical transformation taking place in Western industrial societies, the arena where anthropologists themselves play out their roles. Feminists have turned to anthropology to derive the empirical evidence which supports their politically motivated analyses.

C. The Male Bias in Anthropology

Theoretical generalizations are intimately linked to the type of questions raised by anthropological investigators. These in turn derive from the cultural milieu of Anthropology and its practitioners, as noted above. The questions raised grow out of the socio-cultural context in which anthropology and its practitioners exist (Linton 1971: 9). In this regard, anthropological studies of gender roles have been marked by a major methodological flaw - a one sided male orientation. Rayna Reiter's description of main stream anthropological accounts of women is representative of recent criticisms of this orientation:

> Too often women and their roles are glossed over, underanalyzed, or absent from all but the edges of the description. What women do is perceived as household work and what they talk about is called gossip, while men's work is viewed as the economic base of society and their information is seen as important social communication. Kinship studies are usually centered on males, marriage systems are analyzed in terms of the exchanges men make using women to weave their networks, evolutionary models explain the origin and development of human society by giving enormous weight to the male role of hunting without much consideration of female gathering. These are all instances of a deeply rooted male orientation which makes the anthropological discourse suspect. All our information must be filtered through a critical lens to examine the biases inherent in it. Theory always underlies the way we collect, analyze, and present data; it is never neutral (Reiter 1975:12-13)

As gender limits the activities of the participants in a given society, it also sets restrictions on the actions of its student, the anthropologist. Up to the present, the majority of anthropologists have been men, or women trained by men. Their work propagates the assumptions of male dominance which clearly reflect the asymmetrical relations of the sexes in their own societies and academic circles.

More importantly, the anthropologists' academic training, or sex, or both, set limits on the type of questions which they raise and/or the type of direct information which is accessible to them. This of course is particularly true if a male anthropoligst happens to work in a society where segregation of men and women is pronounced. Under these circumstances, the male anthropologist, in seeking information on women, turns to the males of their society. In some instances this option may not even present itself since such an act may be a serious breach of custom. This would be the case in FatiHa, the setting of the present study.

Males' descriptions of females may be considered useful as ideological declarations. But the reduction of socio-cultural behaviour to ideology runs counter to the anthropological commitment to holism. As ideological statements, male informants' description of women reveal superstructural elements which legitimate social relations and power differentials. They do not describe the infra-structures (the economic bases, the distinct system of relations of production) with which these superstructural elements are dialectically associated. In other words, male informants' statements to male anthropologists (in addition to being responsses to anthropologists' culturally conditioned elicitations) inform us of the manner in which existing (or presumed) power relations between males and females are justified and replicated through time. They do not provide us with a description of the social relations of production for which ideological elements are articulated by informants. The theoretical limitation of this methodological bias are serious indeed. As superstructure, males'

views of females are likely to be mystifications of underlying social relations (O'Laughlin 1975:348). Ideologies, whether related to gender or not, are not simply direct reflections of underlying socio-cultural processes. The relationship between ideological elements and their sustaining social relations is dialectical (Murphy 1971). In fact the discrepancies between ideals verbalized by informants and actual behaviour are so common that anthropologists find it important to differentiate between "real" and "ideal" culture and between "etic" and "emic" categories of analysis[5].

A number of recent studies have revealed the distortion which derive from according the "male factor" central significance and regarding the "female factor" as subordinate or insignificant in studies by male anthropologists. In a study designed to compare the findings of male and female anthropologists about Australian aboriginal women, Ruby Rohrlich-Leavitt et al (1975) have shown how male anthropologists' "etic" emphasis represents societies as male dominated with women in a subordinate degraded status. Citing Phyllis Kaberry's "Aboriginal Women" (1939) and Jane Goodale's Tiwi Wives (1971), the authors show the development of these two female anthropologists' enthnographies from a combination of etic categories and the actual lives and world view of the people they study. In contrast, reference is made to C. W. H. Hart, a male anthropologist who states that in studying the Tiwi of Northern Australia he deliberately ignored their subsistence activities because they "bored him" (Ibid). This neglect is by no means insignificant. Australian aboriginal women have been shown by female anthropologists to play a central role in economic activities, moreover,

this role is acknowledged and valued in their societies. Citing Kaberry's work of nearly four decades ago, Rohrlich-Leavitt et al write,

> ...the tools which the women make and use satisfy the bulk of nutritional needs of the group. It is by virtue of their essential economic contribution that the women are respected, and assured of just and good treatment. Women have a right to their own property, and they trade many of the articles they make with both male and female partners in the system of economic exchanges. With their female partners they also exchange secret corroborees and, like the men, the women practice sorcery against undependable partners. (Ibid:572)

Male anthropologists' descriptions of aboriginal women as pawns which are exchanged in male alliance systems, as "currency" whose control affords men prestige and influence, as "domesticated cows", and as "slaves" who are forced to do the heavier work by the "brutal" half of the society are contradicted by female anthropologists accounts. According to Kaberry,

> ...it is just as incumbent on the man to contribute this (meat) whenever possible, as it is for the woman to go out for roots and tubers....If it was compulsory to search for food, at least they did not travel like beasts of burden, with timorous docility and bovine resignation. They were not driven forth by the men; they departed just as leisurely, chose their own routes, and in this department of economic activities, were left in undisputed sway. If it was left to them alone to provide certain goods, at least it was a province in which they were their own mistresses, acquired their skill from the older women, and served no weary apprenticeship to an exacting husband or father (Ibid:571).

Male "brutality" as exemplified by wife beating is also illuminated by Kaberry,

> .."but there is no question of her accepting punishment for unwifely conduct"...Every woman has her fighting stick, which she wields with great skill, and when the man is unlucky in the hunt or the wife thinks he is just plain lazy, she may attack him 'with both tongue and tomahawk'....On the whole, however, there is very real economic cooperation between husband and wife, 'an expected and recognized feature of marital life' (Ibid:572).

While male anthropologists have depicted Tiwi women as investment commodities and have insisted that marriage arrangements are entirely in men's own interest, Tiwi social organization appears in an entirely different light from the perspective of a female anthropologist who emphasizes the benefits and powers which women derive from the marriage system:

> Goodale (1971:52) points out that the tie between the son-in-law and his future mother-in-law is 'one of the most important and enduring social relationships that either may have'. In return for the promise of her future daughter, the son-in-law becomes responsible for providing for the needs and wants of his mother-in-law until his or her death. ...Moreover, if the son-in-law does not serve his mother-in-law to her satisfaction, she may void the contract. A girl's father does not have the right to void such a contract...(Ibid:574)

Not only do Tiwi mothers have the authority to void their daughters' marriages, but they also might agree to exchange sons (Ibid).

Distortions arising from the male bias in anthropology have also been revealed in Elizabeth Faithorn's study of the Kafe of Highland New Guinea where she undertakes a reexamination of the allegation that beliefs in the polluting power of women reflect female inferiority. Her study reveals that both women and men may be considered polluting. Women are not the only polluters and men are not the only victims of pollution:

> After sexual intercourse, both men and women are required to wash themselves thoroughly to avoid contaminating others with semen and other substances produced by their bodies during copulation. If a couple has had intercourse during the night, the next morning they must both refrain from cooking food for themselves or others as semen might be transmitted to the food and ingested. The illness that results, should this occur, is the same as that caused by the ingestion of menstrual blood (Faithorn 1975:137).

The myth of female inferiority is also challenged by Faithorn:

> ...women as polluters are depicted (in the literature on Highland New Guinea) as weak, disgusting, and inferior to men, who as potential victims of pollution are portrayed as naturally pure and strong. This does not accurately represent the way the Dafe themselves regard women. They say that women are also strong and important in the functioning of society. As one Kafe man put it, women work so hard and so constantly that they are like machines. Another man explained that if it weren't for women, nothing would get done, and society would fall apart. Women themselves regard their strengths and weaknesses as different from those of men, but they do not view themselves as inherently inferior or less important. (Ibid:139).

The mix of androcentrism and ethnocentrism reflected in the above examples is also noted in the African literature. Taking the early accounts of African societies as exemplary, it is evident that British colonial officers with their Victorian values about women's roles ignored native female political institutions. Although they made an effort to understand the indigeneous political systems as far as these related to men, for the purpose of manipulating them in their system of native administration, they ignored women's institutions almost completely (Van Allen 1972). In the anthropological literature, African women have been described as transacted in a kinship system of exchange. Rubin describes the general conceptualization of this exchange as follows:

> It is women who are being transacted, then it is the men who give and take them who are linked, the woman being a conduit of a relationship rather than a partner to it... If women are the gifts, then it is the men who are the exchange partners. And it is the partners, not the presents upon whom reciprocal exchange confers its quasi-mystical power of social linkage...As long as the relations specify that men exchange women, it is men who are the beneficiaries of the product of exchanges - social organization (Rubin 1975:174 in Sacks 1976:566)

In this Levi-Straussian structralist perspective, the world is dichotomized into male actors and female gifts.

The Nuer have recently been cited by Sacks to show how the reinterpretation of the Nuer marriage by two female anthropologists, Kathleen Gough (1971) and Alice Singer (1973) suggest greater flexibility and equality in the actual structure of marriage as well as greater equality in the conceptualizations held by the Nuer themselves than the above noted structural opposition suggests (Sacks op. cit. p. 566). Gough and Singer's studies show a great variation in women's roles. They show how Evans-Pritchard's functionalist preoccupation with idealized rules of marriage and property transfer are useful only as descriptions for wealthy and socially dominant lineages:

> For the rest of the population descent is actually not traced through men nor is marriage often patrilocal. Moreover, the patrilineal is only one of many socially accepted types of union. Many do not involve the transfer of cattle, and in these, women 'are under the legal guardianship of no man in respect to their work and domestic services. Often, in fact, they own cattle, and always they are separate legal personalities'...almost half the Nuer women of childbearing age lived in unions which gave them legal autonomy. A frequent pattern among nonwealthy Nuer was for the woman's family to transfer cattle to the man's linearge. In return the husband lived in his wife's village, and she and her family gained rights to his domestic services (Ibid).

The hierarchical opposition between actors and gifts is thus contradicted by Gough and Singer's description of mostly egalitarian structural arrangements while inegalitarian relations do not seem to favour either sex systematically (Ibid). Gender is clearly portrayed in these reinterpretive studies as one element in a multi-dimensional social identity. Women's and men's behaviour does not fall into

neatly differentiated, immutable categories. Studies of the Nuer and the Lovedu cited by Sacks show that men and women are both actors and gifts:

> Both sexes then take on actor and enabling gift roles at some point in life...it appears that making gender an immutable category which has to be either actor or gift skews reality. That paradigm has both the seductiveness and the fallacy of a stereotype: it contains some truth and much error...its truth lies in the notion that gifts create alliances, that marriage has gift-like and transactor-like roles, and that these may be unequal roles. The error lies in attaching those roles and inequalities rigidly and universally to gender. It often does not fit the variety of roles and statuses held, or legitimate relationships entered into by men and women in both actor/ascendant, and gift/subordinate roles at various points in, or aspects of life, it does not seem very productive for analyses to attach dominance or subordination to gender (Ibid:567).

The presentation of universal hierarchically ranked spheres of activities is understandable in light of anthropological androcentrism and ethnocentrism. As reinterpretations of women's roles and new data on women's activities are brought to light, they pose a challenge to traditional analytical categories and interpretations of gender roles.

The general neglect of women's activities in the anthropological literature noted throughout this section is also valid for the Middle East. In view of the traditional segregation of men and women in this region and the reality that the majority of anthropologists working there were men, the female domain of activities remained off limits to anthropology. Hence the relative scarcity of systematic observations of women's behaviour and activities. Consequently, (with the exception of earlier studies concerned with the volutionary priority of female descent[6] and classical studies by the female anthropologists Hilma Granquist[7] and Winifred Blackman[8]) scholars have often relied

on religious literary sources and their interpretations thereof to infer the behaviour of female members of Middle Eastern societies.

In the absence of systematic empirical research focusing on women, anthropologists' interpretations of prescriptions derived from literary text provided a convenient substitute. Women's behaviour in the Middle East has been reduced to ideology and ideology to theology, specifically Islamic theology. But as Nadia Abu Zahra has noted in her critique of Richard Antoun's work among Lebanese peasants, these illiterate rural dwellers have minimal knowledge of Quaranic literary texts (Abu Zahra 1970). Abu-Zahra's assertion is corroborated by the present study where the author noted a great discrepancy between the prescriptions regulating male-female relations in Islamic literary accounts and those accepted by the members of the study community. The Quaranic stipulation of equal potential piety of men and women (Sura IX, 71) and the common nature of all Beleivers (Sura IV), is contradicted by villagers' belief that "women are lacking in mind and religion". The Islamic laws of inheritance are not always followed and women may not be allowed to inherit from their fathers. Moreover, the Islamic prohibition of female infanticide is contradicted by benign neglect of female infants which is reflected in the high mortality rate of female infants in Egypt (Valaoras (1972). No amount of reading of Islamic literary texts can be substituted for empirical studies of the roles of women in the Middle East. For as Carol Fluehr-Lobban (1973) has noted,

> Islam is not the monolith of values and social structure it is often considered to be...Islam was overlaid on a variety of cultures...Enormous political differences separate reactionary countries like Saudi Arabia from places

> where revolutionary struggles have been fought in the past and continue to be waged...While Saudi Arabian women are shielded behind veils and in houses from outside influences, Dhofari women to the south fight alongside their male comrades for liberation from reactionary oil rich sultans who are supported by British imperialist oil interests.

It is evident from studies in the Middle East and elsewhere that Islamic ideology has been adapted to the numerous and varied socio-cultural settings where it was embraced. At various historical periods and in different settings, Islam, in one version or another, has been used by opposing factions either to advocate the oppression of women or their liberation (Morsy 1972). In this regard it is useful to note Harris' characterization of ideology. He writes,

> thoughts must be subject to constraints; that is they have causes and are made more or less probable in individuals and groups of individuals by prior conditions (Harris 1968: 231).

It is to these conditions and the more empirically grounded subsystems of Middle Eastern culture that female anthropologists have access and from which they are gradually lifting the veil of mystery surrounding the role of women in that part of the world. A marked shift is noted in the recent literature on the role of women in the Middle East (Nelson 1973, 1974). Patai's reference to the "old established Muslim view of the God given inferior nature of women", typical of the older literature, is overcast by a current trend typified by Fatma Mernissi (1975: xvi). Based on her research in Morrocco, she writes,

> The existing inequality does not rest on an ideological or biological theory of women's inferiority, but is the outcome of specific social institutions designed to restrain her power.

Female anthropologists, including this author, have the opportunity to make unique contributions towards understanding women's roles in

Middle Eastern communities such as the setting of the present study. Privileged access to female spheres of activities and awareness of earlier biases which led to neglect of women's roles will undoubtedly enrich the improverished substantive and theoretical literature on gender in the Middle East.

To summarize this section, some male anthropologists' assertion that "women everywhere have always been subordinate to men in running society and the household" (Evans Pritchard, Cf. Sacks 1971:2) is increasingly being challenged by studies which accord central significance to the female factor in society. The recent descriptive documentations of the realities of female social life by female anthropologists[9] have emphasized the variability of roles and statuses. The variety of disciplinary and inter-disciplinary literature on the subject of women's roles is a reflection of the accretion of this grand idée. However, our present knowledge of gender roles probably represents only an increment of a wider range of cultural elaborations of the biological differences between men and women. The male bias in anthropology and ethnocentricity have undoubtedly obstructed our perspective and dulled our sensitivity to the activities of women, particularly those whose roles do not fit the cultural standards of the investigators of their societies. Anthropologists, by and large the products of Euro-American culture accept male dominance and may even assume its inevitability, especially if they themselves happen to be men.

As the recently generated interest in rectifying the androcentric bias of anthropology is translated into serious scientific analysis,

it ushers the occasion of evaluating existing theoretical concepts and methodological procedures. As in other cases of theoretical reorganization (Kuhn op. cit.), this recent change has followed a dialectical mode:

> What once seemed necessary and natural has begun to look arbitrary and unwarranted. What once could be assumed, ignored or tacitly acknowledged now seems problematic and difficult to explain (Rosaldo and Lamphere 1974:1).

It is becoming evident that the newly revived study of the role of women in Society is not simply a means of providing a more balanced and complete descriptive account of Culture. It is in fact a means of reassessing anthropological theoretical categories. Thus, theoretical concepts and perspectives such as power and authority, choice and cultural constraints, evolutionism and functionalism[10] are once again brought under close scrutiny in the male-female domains of social organization.

D. Recent Trends in the Study of Gender Roles

As illustrated in the foregoing discussion, the recent literature on gender roles indicates methodological/theoretical developments which have set the stage for reorienting the study of Man towards the study of Humankind. However, interpretive barriers continue to influence the analysis of gender roles. Anthropologists, socialized in the Western academic tradition and affected by what Karen Sacks refers to as the "state bias" (Sacks 1976), have assumed the universal applicability of their cultural dichotomies and have proceeded to explain male-female power relations in terms of these structural oppositions

and hierarchies. Misinterpretations also arise from a tendency towards emphasis of individual goals and actions and assumptions about society as the outcome of individual choices, the maximization of self interest, and competition for power.

The proponents of universalistic schemes argue that "insofar as woman is universally defined in terms of a largely maternal and domestic role, we can account for her universal subordination" (Rosaldo and Lamphere 1974:7). Following the same line of argument, Rosaldo contends that woman's maternal roles leads to a universal opposition between "domestic" and "public" roles that is necessarily asymmetrical; women, confined to the domestic sphere, do not have access to the sort of authority, prestige, and cultural value that are the prerogative of men (Ibid:8). Similarly, Hammond and Jablow write, "Women's work is always "private" while "roles within the public sphere are the province of men" (in Leacock 1975:606). Ortner also reasons that since women's bodies and their activities are considered by all societies as closer to nature, it follows that this identification accounts for their devalued social role which is characterized as a "true universal" (Ortner 1974)[11].

The above interpretations seem to be most closely applicable to male-female power differentials in certain sectors of state level societies. The alleged universality of the oppositions and hierarchies which they portray is questionable:

> It is not clear that primitive peoples dichotomize their world into power domains. Coming from an extremely hierarchial cultural milieu, we tend to construct categories to contain social differences, and then rank them in terms of power. We build master theories out of such notions of difference, but we do not know if the oppositions and

> hierarchies we construct are universal or simply reflect our own experience in a class-stratified society (Reiter, op. cit. p. 15).

In examining the proposed oppositions between the private (household and kinship oriented) and the public (non-kin based areas of activities which concern the community at large) domains, certain methodological/theoretical problems may be noted. While the proposed dichotomy rightly seeks to uncover the structural relations which underly empirical reality, it denies historical variation. Structural oppositions are held constant for the human species in its entirety. Contradictions are regarded as immutable, their qualitative variation with the historical development of material structures is neglected. The structural bases for women's alleged universal subordination are stressed but the substantive conditions which underlie their emergence and continuity remain undefined. Once the dimensions of time and space are introduced into the structuralist paradigm its historically specific applicability becomes evident. As Eleanor Leacock has argued in her critique of universalistic schemes which oppose the public and private domains,

> The...problem with such statements is their lack of historical perspective. To generalize from cross-cultural data gathered almost wholly in the twentieth century is to ignore changes that have been taking place for anywhere up to five hundred years as a result of involvement, first with European mercantilism, then with full-scale colonialism and imperialism. Indeed, there is almost a kind of racism involved, an assumption that the cultures of the Third World peoples have virtually stood still until destroyed by the recent mushrooming of urban industrialism. Certainly, one of the most consistent and widely documented changes brought about during the colonial period was a decline of the status of women relative to men. The causes were partly indirect, as the introduction of wage

> labor for men, and the trade of basic commodities, speeded up processes whereby tribal collectives were breaking up into individual family units, in which women and children were becoming economically dependent on a single man. The process was aided by the formal allocation to men of whatever public authority and legal right of ownership was allowed in colonial situations by missionary teachings and by the persistence of Europeans in dealing with men as the holders of all formal authority...The common use of some polar dimension to assess woman's position, and to find that everywhere men are "dominant" and hold authority over women, not only ignores the world's history but transmutes the totality of tribal decision-making structures (Leacock 1975:605).

The bifurcation of public spheres is a scheme which may be traced to the Aristotelian state power politics paradigm (Elshtain 1974). The state itself is not a universal feature of human society. It represents a phase of social evolution which contrasts with relatively egalitarian social relations more typical of primitive societies. Lawrence Krader has recently articulated this contrast; he writes,

> The common root of human society is life in the community, in which the opposition of the private and the public is not to be found, or is found only in a modest degree. The transition of political society, however, the emergence of the class of new men, whose ends are at once individual and class-individual introduces the opposition between the private and public sector...The surplus product is collected by the new class of private men, who are the public officers...Human beings had lived hitherto into an undifferentiated mass, without distinctions of wealth and power. Out of the disruption of this community of interest, the opposition of the public and private sphere emerge...The state,...(an) organ of the ruling class functions...(to) dominate...the entire society, of the poor class of people, of the direct workers on the land, in mines, and workshops, together with their families...(Krader 1975:246, 248).

The opposition between the private and public spheres is the outcome of specific relations of production characteristic of historically specific modes of production and systems of appropriation of

surplus. The opposition between the private and public domains and concomitant opposition between the interest of the ruling class in state societies and the "direct workers" and their families, men and women alike, is well illustrated in a study of a Middle Eastern community. In her study of a Lebanese urban lower-class municipality, Saud Joseph undermines the validity of the assumed universal existence of distinct public and private spheres which divide men and women into different power realms (Joseph 1975). Her data on the male workers of Burj Hamoud indicate that their mere participation in public activities does not confer upon them power over women. Moreover, she describes female "public" activities in which women are the primary participants and which have a definite effect on their own lives as well as those of their male relatives.

Joseph's conclusion regarding the Lebanese community are equally applicable to the peasant community of the present study. The power of the ruling elite in the study area, derives not simply from an opposition between private and public domains, but from the control exercised by the state and its benefactors over the "immediate producers in society" (The Egyptian peasants and workers). It is the private interests of ascendant social groups crystallized in the public apparatus of the state that are opposed to the common interest of subjugated men and women.

The comparative studies of female-male power differentials by Sutton et al (1975) among the Black rural proletariat of Barbados also indicate that the gender identities of males and females are by no means determinants of the private-public differentiation:

> There is among the black rural proletariat of Barbados considerable equality between the sexes. Women and men hold positions of comparable status in the economy and the local community. But as a legacy of Barbado's slave plantation past, the community has little autonomy, and the group as a whole - women and men - has little control over economic and political resources (Ibid:584).

Like the case of the Lebanese urban proletariat (Joseph op. cit.) and the Egyptian peasants of the present study, the major contradiction is not between the men and women of the subordinate social groups but between them as a group and those who control economic and political resources: For the Barbadian rural workers of Eneavor,

> ...the world of work and political power is located outside their community. The community lacks autonomy and villagers have little control over the basic resources upon which they depend for a livelihood. The island's economy remains in the hands of a resident white elite and jural-political institutions are now managed by a black middle class. In this public domain, villagers hold a subordinate position...Power...is imposed on both sexes. The concept of dominance in social relations is not identified with either sex, but with those who hold positions of power and authority outside the village (Ibid:591, 593, emphasis added).

Sutton et al have also described the egalitarian power relations among the Tlingit Indians of Alaska. Here, as in other cases, the insignificance of the public-private dichotomy for relations between men and women is understandable in terms of social relations of production.

> The traditional Tlingit economy was highly seasonal, based on fishing. Labor was divided between men who fished during the summer and women who then processed the perishable food for year-round consumption and trade. Trade was an extremely important activity and women were traders, playing a key role in negotiations and exchanges with other groups of Indians and with Europeans. Today, women and men continue to be actively involved in economic

> activities outside the household, and the traditional sexual division of labour still operates in the commercial realm of fishing and processing. In the new occupations of the modern economy, women have a higher rate of year-round employment...

Consequently,

> Not only do Tlingit women and men equally occupy positions of high status in the public domain, but husbands and wives operate in this sphere independently. (Ibid:588, 589).

If the opposition between public and private domains and their hierarchial differentiation is questionable for certain spheres of state level societies, it is truly meaningless for non-state collectivities. Ethnohistorical data collected by Brown (1975), Leacock (1975) and Sacks (1976) show that in non-state societies in Africa and the New World men and women shared authority through the collective functions and dispersed nature of decision making:

> The authority structure of egalitarian societies where all individuals were equally dependent on a collective larger than the nuclear family, was one of wide dispersal of decision making among mature and elder women and men, who essentially made decisions...Taken together, these constituted the "public" life of the group (Leacock 1975:611).

Reconstructed history of North American Indian groups shows the breakdown of such egalitarian relations as described above. As trade and wage labour undermined the collective economy, men of influence began to perform leadership, authoritarian functions out of line with the traditional egalitarianism. With these developments,

> the masculine "authority" of ethnographic accounts took shape (although doubtless exaggerated, as largely male

> ethnographers recorded the views and experiences of largely male informants). Under colonial conditions, the "public" and "private" sphere became divided, as had not been the case when the "household" WAS the "community", and the public sphere became invested with a semblance of the female power it represents in state-organized society (Ibid:610).

While ethnohistorical data reveal the absence of the presumed universal opposition between public and private domains, they also reveal role differentiation between men and women. But this differentiation itself is not synonomous with subordination of one gender to the authority of the other. As Karen Sacks has argued in her discussion of the state bias in anthropological analysis of gender,

> It is erroneous to assume that if men and women play different roles, one sex must be socially dominant...In nonstate societies men and women, or some of the roles they occupy, can be sharply segregated, or socially differentiated, and yet it may make more sense objectively to see them as equal. And, it may also be the case that the question of which sex is socially more valued has no meaningful answer to members of those societies (Sacks 1976:565).

Sack's position is corroborated by Brown's description of 18th century Iroquois women where differentiation of roles did not entail their hierarchial ranking. Iroquois women represented authority figures in the household and were also considered equal partners with men in social and political authority (Brown 1975). The separation of male and female forms of authority (men as council members initiated and executed policy concerning war and peace while women as matrons exercised veto power through withholding food for council deliberations and war parties and had the authority to dispose councillors) did not hinder the effectiveness of either. This differentiation is represented by Brown as complementary rather than hierarchical.

In sum, substantive cross-cultural data challenge the contention

that female subordination which is regarded as universal derives from the presumed, equally universal, opposition between the public and private spheres. This opposition itself represents a historically specific social formation and particular relations of production. Under different relations of production such as those cited in the above examples of non-state societies, the opposition between the public and private domains is insignificant. Women derived authority from their participation in collective social production in a use economy (Sacks 1974).

Another alleged universal dichotomy advanced to account for the subordination of women is that between Nature and Culture. Ortner (op. cit.) has expanded the Levi-Straussian opposition between women as gifts and men as actors (elaborated above). She argues that males are universally associated with the domain of Culture while women are linked with the opposite domain of Nature. Furthermore, the claim is made that all societies symbolize culture as dominant over Nature, and by extension, all cultures regard males as dominant over females whose reproductive functions symbolize their closeness to Nature and hence their relative devaluation.

In considering Ortner's claim, one should note Sacks' remark that it is not of universal validity but more illustrative of a "current kind of 'state bias' in theory making (Sacks 1976:565). The male (Culture)-female(Nature) dichotomy is cast as "inalterably unequal". A number of ethnographic illustrations contradict the assertion that women's "universal" subordination derives from their natural productive functions and their consequent association with the domestic

domain and nurturance. In contrasting the tendency in Western culture to define women as weak and needing protection since they bear children, Carol Hoffer writes:

> In West Africa the same biological facts are given a different cultural interpretation. The bearing of children demonstrates that women are strong and active agents in society, capable of holding political office. In the Mende ethnic area of Sierra Leone,...(women's) nurturing role is also consciously valued in this geographical area of high infant mortality...Women paramount chiefs in this area are seen as mothers writ large, calling into question any theoretical dichotomy in women's influence between the domestic and the juro-political domains (Hoffer 1974:173).

The debasement of female reproductive functions seems to rest, not on a universal structural opposition with undefined functional correlates, but on specific social relations of production. Karen Sacks' comparative study of four African societies shows that among the Mbuti who consider children as social members rather than private heirs, mensturation and pregnancy are not surrounded by restrictions on women's activities. By contrast, menstrual and pregnancy restrictions on women's activities operate to separate women's reproductive functions from contact with the social production of exchange goods among the Lovedu, Pondo and Ganda. Unlike the case of the Mbuti, children in these three societies are potential heirs who inherit property and continue the family line. Thus women's reproductive potential is private. Sacks' comparative study suggests that menstural and pregnancy restrictions are related to private property. Such restrictions seem to symbolize a contradiction between social production of exchange goods and private or familial appropriation. This interpretation is reinforced by the fact that restrictions imposed

on women have a corresponding form among men who are also involved in the reproductive process and are subject to the same contradictions. Among the Lovedu, Pondo, and Ganda there is imposed a separation between men's sexual relations and their participation in social production for exchange. For Mbuti men, by contrast, the hunt is regarded as an ideal time for sexual liaisons (Sacks 1974:217-218).

The devaluation of women's "natural" reproductive functions is by no means universal. A great sense of respect and awe for female reproductive functions is demonstrated among privitive groups. Among the Kimberly tribes, Kaberry shows that "Where (a woman) does bear children, they do not anchor her the more securely in a position of inferiority, nor circumscribe her activities" (Kaberry op. cit. p. 156). In the tropical forest of South America, the couvade reflects the "cultural" association of males with the "natural" female reproductive functions:

> Customarily the husband repairs to his hammock for several days during his wife's labor and immediately after she has given birth to a child...He behaves as if he had undergone the birth experience, and the geneology of the child is underscored by his actions. But, more significantly, the couvade is a visible symbol of a complex shift in the relationships involved in childbirth, centering on the male as a point of reckoning. Childbirth transforms the respective roles of and relationships between the sexes. .....The focus on the male not only compensates for the absence of a sharply defined critical event in his life, but also engages the woman in the meaning of the male experience - which includes the continuity of his connection with the child - just as he had been directed to the meaning of her experience during pregnancy and its immediate aftermath. Like other rituals which center on one sex, it also epitomizes shifts in the behaviour of the other, even when the latter transformation is less public. The couvade, then, can be understood as a crises rite socially expressing an existential transition experienced as risky and formidable within

> the cultural context of a given people. The contrast with the conventionally disengaged and disoriented male in similar situations in our society hardly needs to be remarked (Diamond: 1974:41).

In this primitive society, the natural opposition between male and female reproductive functions is not hierarchially differentiated, it is "shared, understood, and socially structured" (Ibid).

In considering the proposed immutable association of women with Nature and their opposition to Culture, it may be noted that women's own "cultural" elaborations afford them control of their "natural" reproductive functions. The culturally sanctioned practice of abortion among primitive groups shows that women in these societies have greater control over their bodies and reproductive functions than their counterparts in civilized society (Ruby Rohrlich-Leavitt et al op. cit. p. 576). Finally, an increasing number of studies and empirical data pose a challenge to the allegedly universally valid assertion that "Everywhere we find that women are excluded from certain crucial economic and political activities, that their roles as wives and mothers are associated with fewer powers and prerogatives than the roles of men" (Rosaldo 1974:3)[12]. Researchers unhindered by ethnocentric blinders have shown that women's marital and maternal roles do not necessarily define their status in society or confine them to the domestic sphere (Sutton et al op. cit. p. 599). These activities themselves are differently evaluated cross-culturally. The assertion that sexual asymmetry is rooted in the reproductive activities of women as bearers and nourishers of children cannot be accepted as universally valid. The nature and intensity of asymmetrical power relations between males and females appear to vary widely from

society to society. A realistic assessment of the presumed constraning effect of female reproductive functions and attendant maternal roles necessitates detailed consideration of the relationship between female reproductive functions, the social division of labour, and gender power relations in specific cases. Realistic generalizations may be derived from the comparative study of structural types, not the human species in its entirety. Human beings do not learn and adapt to nature as a species, but only through the traditions of particular groups (Krader op. cit. p. 240), i.e., through specific relations between people and between people and nature.

Still another trend in the recent study of gender roles is the reintroduction of women into the arena of Anthropology, not as role performers, but as social actors engaged in the manipulation of their environment and the exercise of choise (Lamphere 1975, Raphael 1975). As a reaction to the limitations of the structural functional approach with its emphasis on the "functional" utility of normative role behaviour, there has occurred a shift in emphasis of anthropological studies of gender from concern with structures to an emphasis on the adaptive strategies of social actors. Through the extension of this logical scheme, prior descriptions of male dominance have been reformulated in terms of the distinction between power and authority[13], i.e. between "the ability to gain compliance and the recognition that it is right" (Rosaldo 1974:21). Fundamentally, these two pairs of distinctions derive from Firth's more general discrimination between social structure as the normative pattern of social behaviour and social organization as the acting out of this assigned pattern. As

such, one can recognize their descriptive utility and their potential for undermining lop-sided descriptions of sex-roles, but their explanatory value is minimal.

Granted that variations in role behaviour are regular features of social discourse[14], the range of choices and power available to individuals is defined by the structural framework within which choices and power are exercised, As Alvi has pointed out,

> ...individual action...is not free. It is constrained by the social situation which an individual inherits...(he/she) ...must operate within the framework of a given set of norms and rules, whether 'informal' in their existence or embodied in a legal system (Alvi 1973:42)

Methodological individualism with its emphasis on individual behaviour has clear limitations. It undermines the fact that as a social being, an individual is not a free agent. He/she exercises choice and makes decisions within the confines of structural constraints, not only within his/her immediately social environment, but often far beyond it. The case of the Egyptian male and female peasants of the present study is illustrative of this point. While individual "organizational choices" are no doubt a social reality, it is imperative to stress the fact that an individual is never an autonomous unit. To the contrary, people individuate themselves only in society and each individual is the embodiment of a particular set of social relations. Society cannot be understood as an aggregate of individuals exercising choices, but only as a totality of social relations (O'Laughlin op. cit. p. 346). As social beings, persons must be recognized, not in isolation of, but in the context of their relationship to the structured social whole, as a sum of productive forces and a historically

created set of relations of individuals to one another and to Nature (Ibid). The social realm and the individual social being cannot be defined independently of their dialectical inter-relationship:

> The human individual has no essence, and exists only as a means of social relations; the essential core of humanity is nothing other than the set of human relations in society. The society in turn is not a passive category into which the hyman relations are poured, the society is the nexus of individual relations, just as the individual is the nexus of social relations (Krader op. cit. p. 242).

While individual actions no doubt illustrate the range of variations in social behaviour, they cannot form the sole basis for generalizations about social behaviour or for explaining it. Moreover, methodological individualism does not constitute a predictive model of behaviour enshrined in a nomothetic framework (as scientific generalizations should). As such, its limitations for the formulation of anthropological generalizations is obvious. Anthropology seeks to explain patterned behaviour, it is concerned with the evolution of social forms, not in terms of individual organisms, but as it pertains to social collectivities. Individual choices should never be the goal of a science of patterned behaviour. They are only useful means of providing us with a perspective for the identification of structural elements. They allow us to estimate the range of variations on the pattern of prescribed behaviour and to correlate this variation with specific situational variables. The value of methodological individualism lies in its descriptive function, not in its explanatory utility. It helps us recognize the existence of variation (and its correlates), it does not constitute a fruitful explanation of such variation.

While the recent literature on gender roles has emphasized the

"choice" and "power" exercised by women, scrutiny of descriptions of thepowerful, choice making females described in the literature reveals that their power and capacity for choice are ultimately regulated by structural principles similar to those which underlie male positions of power in their respective socities. Hence the reference to women's economic power base (Rieglehaupt 1967), to the land that constitutes their dowry (Friedl 1967), or to their class identity (Mohsen 1974). Even studies which focus on women's manipulative strategies concede that "where a woman has access to economic resources, her ability to influence those in authority is increased" (Lamphere op. cit. p. 126). For the power base of Middle Eastern women, not unlike the case of their men, reference is made to their control of property and its products, to their actions as mediators, to their contact with the supernatural, and to their religious knowledge (Nelson 1974). Again, as for men, reference is made to derivative power associated with patron-client, kinship, and friendship ties (Joseph op. cit.). Finally, women capable of wielding power have been described in terms of their noble descent (Beck 1975), their position as mothers of sons (Aswad 1967), and their reliance on the support of kinsmen through relinquishing their right to inherited property (Rosenfeld 1960, 1975).

At the present phase of the study of sex roles, the debate should no longer be in terms of whether women exercise choice and power or not. Power, (defined as the "control one party exercises over the environment of another" (Adams 1967:32)), is available to both parties in any social relationship. Following Adams' formulation, it may be noted that in any relationship there is inherently involved a relative

control of the environment by each of the parties to the relationship. Even in extreme cases of subordination, the subordinate party holds some threat to the environment of the superordinate party. In such cases the differential power is great, but as Adams emphasizes, it is a differential and not total control. Thus, subordinate women and men do wield power, but only in the sense that they hold some threat over the environment of others. The point to be stressed, however, is that, as inferiors, they are subject to binding decisions by dominant parties while they themselves may only beg, suggest, or request. Changes in their possible alternatives (short of organized revolutionary action) are subject to the discretion of dominant men and women.

To imagine that women are simply manipulative social actors disregards the inequality of statuses (both among women as a group and between men and women) and its attendant differential control of culturally valued resources. Such an emphasis undermines what Alavi refers to as the "structurally determined differences between interests and aspirations" of different groups of society. Thus, methodological individualism falls into a trap opposite to that of structural functionalism when it focuses on individual actions outside the matrix of the social whole (Alavi op. cit. p. 41). Structural functionalism emphasized the functional utility of normative behaviour without serious consideration of the "more functional" fundamental structures which maintain the system. Methodological individualism stresses the transgression of prescribed behaviour but ignores the structural bases which allow for such transgression.

Some recent studies which distinguish power from authority proceed from the assumption that authority is a male prerogative, while women are said to exercise informal power (Rosaldo op. cit.). According to this orientation women's individual manipulative behaviour and competition for power are accorded primary emphasis. This emphasis poses serious limitations to the comparative study of power relations even within a single society, not to mention cross-cultural comparison. By framing male/female power relations in purely relativistic or individualistic terms, we have no basis for comparing one situation of power differential with another. Comparison entails going beyond the recognition of a differential to its description in terms of indices that may be used as reference points in the examination of specific power relations. It is therefore imperative that comparisons be based on the control that one actor exercises over culturally meaningful parts of the environment of another. It is this control and not terms of the structural determinants, the bases, of authority in specific cultural contexts and under varying circumstances related to social dynamics. Thus, although we may agree with Rosaldo that "women are far from helpless...(that)...women...(through gossiping or yelling, playing sons against brothers, running the business or refusing to cook) may have a good deal of informal influence and power" (Rosaldo op. cit. p. 21), we have no basis for assuming that all the options listed by Rosaldo are equally available to all women and at all times. Neither can we assume that some of these tactics are not equally available to men. Similarly, in noting Lamphere's reference to women's power in terms of building loyalty in their sons,

resort to gossip, access to economic resources, ability to withdraw services, and even sheer defiance (Lamphere op. cit. p. 128), one must stress the differential cultural significance of these strategies. Thus, for the Middle East, the nature and duration of power that a woman acquires through her contributions of sons to the labour force, and the layalty which she instills in them, cannot be equated with the power which women are said to derive from gossip. Neither can the potential of withholding services be equated with power based on control of economic resources. Moreover, women who lack control over culturally recognized power bases and who become defiant to the point of withdrawing services risk humiliation or even divorce. Men who succumb to the charms and manipulations of their wives risk ridicule by their mothers and female relatives in private and their comrades in public. By contrast, a mother-in-law is likely to favour a son's wife who brings property or its products to the extended family.

In sum, reference to individual manipulations and individual cases of wielding power, whether in the private or public domain, under the auspices of cultural sanctions or through informal channels is incomplete without parallel attempts to isolate structural regularities associated with the availability and exercise of power. In the pursuit of the latter goal, it must be stressed that women, like men, have identities which are multidimensional. Emphasis of this reality in the analysis of gender roles will help integrate variables outside the narrow confines of gender identities. Moreover, this emphasis is necessary to explain patterned power differential among women of differing class identities, age groups, or family structures.

Finally, theoretical statements about power relations cannot be abstracted from random, individual choices, manipulations, or influences, but must be based on those which fall into patterns. Such statements should go beyond the enumeration of choices and the exercise of power towards isolating their determinants. In sum,

> We should be aware that the range of choices open to an individual in a given society are always contained within a matrix provided by the structure itself.... But to say all of this is to pose the problem and not to provide an explanation of it. The choices and decisions that interest anthropologists are those that have social meaning or content - they are not the random choices and decisions of individuals but the ones that seem to fall into patterns. Since this is so we would want to know what it is that determines that choices will be patterned in one way rather than another (Kaplan and Manners op. cit. p. 104).

Studies of power relations should allow us to predict situations where power is likely to be exercised by males or females. Predictive capacity is an essential attribute of any scientific generalization; it cannot be attained by reference to individual manipulations.

By way of summary and further specification, the theoretical orientation which guides the present study, in considering gender as a dependent variable, rejects invariant, hierarchical oppositions as explanatory schemes in the study of gender roles. Instead, an understanding of male-female power relation is sought in light of a historically specific social formation[15] (Leacock 1975). As such, it derives from the assumption that production and reproduction[16] determine the dynamic structure of human society (gender status, and power relations, included). Male-female power differentials are conceptualized as the outcome of a distinct production structure associated with a superstructural apparatus which is necessary for its

replication through time. Thus in explaining male-female power relations, society is viewed as a totality of social relations. The emphasis is on the social character of the process of production and reproduction. The analysis of power relations therefore focuses on principles of contradiction between social categories rather than on the opposition of interest between individuals (Asad 1972).

In FatiHa, the family constitutes the framework of production relations[17] and role differentiations. Since the economy of the village is expressed through family relations, the developmental cycle of the family is a convenient framework for the analysis of relations of production and their consequences for power relations. According to this scheme, variables which surpass the narrow limits of gender roles are brought into focus. These include variation in age, variation in relation to the household head, variation in contribution to the propagation of the means of production (through the birth of children), and variation of the relation of family members to groups outside the family (Morsy 1977). This approach has the benefit of identifying not only the dynamics of power relations between men and women but also among women themselves. Finally, having defined authority in terms of control over culturally valued resources (and not in terms of legitimacy) we are not forced to confine, a priori, the attribution of authority to males, but instead, move to consider the basis of its exercise.

While the present study is based primarily on an empirical analysis of gender roles, power relations, and their consequences in a localized setting, a peasant community, the village cannot be

realistically considered an adequate unit of analysis. It cannot be treated as a "primitive isolate", a society, or a culture (Wolf 1977). It is necessary to trace the determinant social relations that affect the peasants of FatiHa and which extend beyond the confines of the study community. Indeed, the various dimensions of village social organization in FatiHa, as in the case of other Egyptian peasant communities is subject to external controls which determine fundamental features of the peasants' daily lives (Ayrout 1968). The village itself is a product of a long historical development of Egyptian society, its inhabitants, like other Egyptian peasants carry the burden of the nation's economy. They are party to a relation of exploitation[18] which is enforced and maintained by a superstructural apparatus (the state apparatus) which insures the reproduction of relations of exploitation (Legros 1977:32).

The recognition of the relation of structural asymmetry between the village and the larger society is essential in understanding the roles of female and male peasants. With the exception of anthropologists using Marxist analysis in approaching the study of women's roles, the class[19] identity of women has not figured prominantly in anthropological studies of gender roles. Recognition of peasant women's (and men's) class identity is crucial to any discussion of role constraints and choices so central in the current literature on gender.

Tracing of ties between the village and superordinate power domains reveals the greater opposition and conflict of interest between the politically, socially, and economically differentiated

groups of the urban dominant class and rural peasants than is the case between males and females within either of these sectors. This fact is relevant to demonstrate that women are not just females. Their identities are multi-dimensional. Clarifying the subordinate position of the peasant (male and female alike) is also important in terms of formulating generalizations (in terms of structural types) and isolating determinants of female status associated with different social relations of production in Middle Eastern society. The difference between females like those described in this study and that of the "beauties" portrayed on petroleum corporation magazines (See Aramco World Magazine Vol. 22(2), 1971) or the "modern" women described by some anthropologists (Mohsen 1974) derive from the asymmetrical relations between the rural and urban domains of Egyptian society. Finally, it is significant to note that historically, changes in the role of Egyptian women in encapsulated communities has been contingent upon transformations in the larger society (Hammam 1977).

NOTES

[1]See Alavi 1973:42 for a description of this orientation which focuses on individual choices and action in social analysis.

[2]This perspective contrasts with studies which discuss male-female power relations in terms of alleged universal structural oppositions and hierarchies, e.g., public vs private domains, nature vs culture, and power vs authority (Rosaldo and Lamphere 1974).

[3]Despite the recent revival and increasing legitimacy of women's studies, Jane Bujra writes, "Those of us who have carried out research relating to women have noted the contempt with which male anthropologists greet our work and the condescension with which we are treated as researchers" (Bujra 1975:552-53).

[4]The present study derives from a political commitment to egalitarian relations between males and females. It perceives women's liberation in the study area (Egypt) as an integral part of the broader struggle against oppressive institutions and power differentials which are the bases of the continued exploitation of men and the oppression of women. Hence the emphasis on the identity of men and women of the research community as peasants occupying the lowest tier in a power hierarchy.

[5]It is generally agreed that adequate ethnographic presentation consists of some combination of emic and etic categories (Kaplan and Manners 1972:186). But as Ruby Rohrlich-Leavitt et al (op. cit.) have pointed out, in male ethnographies, the anthropologist's or etic categories predominate. Neglecting local significance of women's roles, male anthropologists present societies as male dominated with women in a subordinate, degraded status.

[6]e.g., Robertson Smith's study of Kinship and Marriage in Early Arabia (1885).

[7]See Marriage Conditions in a Palestinian Village (1935) and Birth and Childhood Among the Arabs (1947).

[8]See the Fellahin of Upper Egypt (1927).

[9]The theory and methodology of female anthropologists seems to "stem from 'double consciousness'...as women in a society that is also sexist, (they)...have the special sensitivity that members of subordinated groups must, if they are to survive, develop to those who control them, at the same time as they are fully aware of the

day reality of their oppression; a quality that the superordinate group lack" (Rohrlich-Leavitt et al op. cit. p. 569). Thus women anthropologists special sensitivity is not of mystical origin but derives from their own existential positions.

[10]Some British social anthropologists have argued for the functional necessity of inferred female subordination (Evans-Pritchard Cf. Sacks 1071:2). Malinowski, in reference to marriage, also stresses its function but does not attempt to explain the basis of male dominance within conjugal relations (Ibid). Functional formulations may lead us to speculate on the value or "functions" of gender roles within one society or another. But within this framework we cannot move from a presentation of the postulated consequences of these cultural prescriptions to explaining their bases. In explaining gender role differentiation then, it is imperative that our attention be directed to core institutions which differentiate one type of society (and gender identities within this society) from another. Movement in this direction is reflected in recent works which emphasize the heuristic importance of structural types. These include analyses of gender roles which are guided by the Marxist concept of mode of production (Leacock 1972, 1975, O'Laughlin 1974, Sacks 1975). Other studies which have retained more traditional anthropological categories have utilized a developmental typology borrowed from Steward's concept of "levels of sociocultural integration" (e.g. Gonzalez 1974, Martin and Voorhies 1975, Friedl 1975). Indeed, the evolutionary perspective, once a dominant orientation in nineteenth century studies of women's roles, is now again an important research directive. Some of the issues concerning the role of women which were raised in the 19th century are now subject to debate in feminist and anthropological circles. The validity of nineteenth century claims of the one time existence of matriarchy has prompted an examination of the evidence for an era of female dominance. Many anthropologists however, continue to argue for the universality of patriarchal systems, they insist that even in matrilineal, matrilocal societies, it is not the women but their brothers who wield political power. The confusion surrounding this debate stems from the confusion of the egalitarian status between men and women in societies with a "stage" of matriarchy, envisioned as a mirror image of patriarchy. But as Eleanor Leacock has pointed out, "...(to)...argue a position of 'matriarchy' as a 'stage' of social evolution is but the other face of the male dominance argument. Pleasant for a change, to be sure, but not the true story. For what (ethnohistorical) data reveal is the DISPERSED NATURE OF DECISION MAKING IN PRE-CLASS SOCIETIES - the key to understanding how such societies functioned as 'collectives' (Leacock 1975:607).

[11]Since the publication of these universalistic explanations of gender roles, numerous ethnographic illustrations and theoretical arguments have been put forward to undermine their validity. While the present study follows this trend, it recognizes the utility of these theoretical formulations in the long term progress of studies

of gender roles. In this regard it is instructive to quote Steward who noted, "...facts exist only as they are related to theories, and theories are not destroyed by facts, they are replaced by new theories which better explain the facts".

[12]Conceptualizing male-female relations in terms of such universal categories reflects the strong Western bias of viewing gender differences as part of the "natural order" (Sutton et al 1975). Consequently, studies which are motivated by a rejection of the male bias end up supporting sexist philosophies which proclaim the inevitability of female subservience to male authority. Thus, "a twentieth-century notion of 'universal roles and functions' replaces a nineteenth-century notion of 'anatomy' as the explanation of female destiny" (Ibid: 596).

[13]This dichotomy derives from the alleged opposition between private and public domains and the association of women with the former and men with the latter. It is argued that since legitimate power (authority) is exclusively a male prerogative, "women can exert influence outside the family only indirectly through their influence (power) on their kinsmen (Hammond and Jablow op. cit.).

[14]Role prescriptions cannot be equated with actual individual behaviour. Not only do males and females actually trancend culturally stipulated boundaries inherent in role definitions, there even exists institutionalized mechanisms which regulate such transgressions. Illness constitutes one such mechanism. However, even the utilization of privileged dispensation acquired through illness is ultimately regulated by structural constraints and situational variables.

[15]Social formations are generally defined as "relational systems composed of superstructure and a determinant economic base which may itself be a complex articulation of more than a single mode of production" (O'Laughlin op. cit. p. 350).

[16]In the course of social production, social groups also reproduce the conditions of their existence. In other words, there exists a dialectical relation between the productive system (the economic base or infrastructure) and juridical-political ideological relations (superstructure). These superstructural elements function to mediate contradictions within the productive system. They "appear then as the political and ideological conditions of the orderly reproduction of the relations of production" (Terray 1975:90).

[17]In this case, the determinant role of the economy is not in contradiction to the dominant role of kinship but is expressed by means of it (Godelier 1966 in Godelier 1975:24).

[18]A relation of exploitation may be defined as "the specific form in which unpaid labour is extorted from the direct producers" (Terray op. cit. p. 89).

[19]Classes are defined as "groups of people one of which can appropriate the labour of another owing to the different places they occupy in a definite system of social economy" (Lenin 1971:231. Cf. Terray, op. cit. p. 87).

CHAPTER 2

GENDER AS AN INDEPENDENT VARIABLE: POWER AND ILLNESS

A. Introductory Remarks

This chapter treats gender as an independent variable and proceeds to detail the present study's theoretical perspective regarding the consequences of gender identity and its attendant power relations on the experience of illness and related behaviour. In doing so, the dialectical relation between gender and other independent variables related to power differentials is stressed. In other words, gender is regarded as but one component of multi-dimensional social identities and power relations which influence the precipitation of and responses to illness. Thus, the earlier discussion of the bases of female social status is linked, theoretically, to the study of illness.

The selective concern with illness in the treatment of gender role as an independent variable in this chapter may be understood in light of the fact that cultural definitions of illness are intimately related to deviations from culturally prescribed role behaviour. The notion that unfulfilled culturally prescribed functions could be pathogenic (Smith-Rosenberg and Rosenberg 1973) is indicative of the close linkage between definitions of social role and evaluations of health status. In fact, the sick role may be viewed as a substitute for those whose access to socially approved status and its attendant

power base is blocked (Rubel 1964, O'Nell and Selby 1968, Cole and Lejeune 1972). The study of illness therefore, may serve as a device for illuminating and suggesting patterns of social articulation, power differentials (Glick 1967), and social stress. By careful examination of the deviations from role expectations associated with illness, we are better able to understand role expectations themselves and the limits of their transgression.

B. Illness as Probe

Patterned behaviour associated with illness in different socio-cultural contexts is embedded in fundamental premises pertaining to the nature of reality and of social relations. The study of such patterned behaviour is a means of understanding the structure of socio-cultural systems themselves. The usefulness of ethnomedical data as a probe into other aspects of social life is exemplified by Rubel's statement in reference to the study of illness among Mexican Americans. He notes,

> The empirical data indicate that when one focuses attention on topics of illness and health he discovers a new and intriguing vantage point from which to view the social system and the emotional qualities found within (Rubel 1966:155).

Thus, the attention devoted to illness and related behaviour in this study not only illuminates the consequences of gender roles but also clarifies gender roles themselves. This is possible in view of the fact that medical wisdom itself is instrumental in legitimizing and maintaining certain role prescriptions (Rosenberg-Smith and Rosenberg op. cit.).

Definitions of illness and descriptions of illness causation are intimately related to deviations from culturally prescribed role behaviour. Non-conformity to dominant social values and role expectations may earn a person the label "sick". Thus Kenney notes for Spain that "a female sexual deviant may be described as mad" (Kenney 1962:284). Definitions of healthy practices and environments may also be related to role prescriptions. A nineteenth century female physician, writing in opposition to her male colleagues' claims of the medical dangers of coeducation, pointed out that no one worked harder or in unhealthier conditions than the washer women of her time. Yet the would be male saviors of American womanhood did not advise against this abuse. Washing, she noted, unlike education, is after all appropriate work for women. Other medical views of the same period, pertaining to birth control in this case, opposed expanded roles for the middle class women, and physicians warned against the use of contraceptive devices which they claimed would cause a varied assortment of ills. Moreover, the anatomical characteristics of women were linked to illness. According to the medical wisdom of 19th century American physicians,

> The uterus...was connected to the central nervous system, shocks to the nervous system might alter the reproductive cycle, might even mark the gestating fetus...while changes in the reproductive cycle shaped emotional states...Doctors connected not only the paralyses and headaches of the hysteric to uterine disease but also ailments in virtually every part of the body...physicians often contended that far greater difficulties could be expected in childless women. Motherhood was woman's normal destiny and those females who thwarted the promise immanent in their body's design must expect to suffer. The maiden lady, many physicians argued, was fated to greater incidence of both physical and emotional disease

than her married sister and to a shorter life span. (Smith-Rosenberg and Rosenberg op. cit.).

The notion that unfulfilled culturally prescribed functions could be pathogenic is indicative of the close linkage between definitions of social role and evaluation of health status. Studies have shown that people resort to illness to justify their failure in fulfilling prescribed role obligations. In fact the sick role has been described as offering a substitute status for those whose access to socially approved status is blocked. Illness provides a cultural dispensation from normal role obligations. Behaviour ordinarily thought unfit for certain status-role complexes is allowed during the illness episode. Thus, Nelson notes that through the zar ceremony, "the woman can express herself in ways that are not open to her or even acceptable in the larger social structure" (Nelson 1971:19). Similarly, El-Shamy's work among Egyptian peasants suffering from spirit possession indicates that the patient is allowed to do certain things which are ordinarily denied him or her (El-Shamy 1972:21). Studies of hospital mental patients also reveal that behaviour which is ordinarily classified as "antisocial" in the outer world is considered "social" in the hospital due to the higher degree of tolerance and suspension of judgment among the patients (Caudill 1953:787).

The role of illness in the legitimation of failure has been reported in a variety of cultural contexts. In discussing women's roles in the U.S., Marilyn Salsman-Webb (1971:20) writes that "...when (their) roles fail to satisfy, as they do, women resort to the solves of all oppressed groups. They take to drugs and drink, and if they can afford it, to psychiatry". In another study of welfare mothers in

the U.S. where welfare recipients occupy a stigmatized status, welfare women who accept the dominant cultural view that welfare is a result of personal failure were found to be prone to adopting the sick role in order to legitimize their perceived failure (Cole and Lejeune op. cit.). Similarly, a study of culture bound neurosis among Qatari women reveals that this chronic syndrome occurs mostly in females who do not satisfy the criteria of women's role fulfillment according to its Qatari definition (El-Islam 1975). Finally, one may also refer to the relationship between role conflict and hysteria. Of her study on hysteria as a social role within the nineteenth century American family, Carroll Smith-Rosenberg writes,

> It was a period when...social and structural change had created stress within the family and when, in addition, individual domestic role alternatives were few and rigidly defined. From this perspective hysteria can be seen as an alternate role option for particular women incapable of accepting their life situation. Hysteria thus serves as a valuable indicator both of domestic stress and of the tactics through which some individuals sought to resolve that stress.

Thus, through analysis of the function of hysteria within the family and the interaction of the hysteric, her family, and physician, illness is utilized as a probe which sheds light upon the role of women and male-female relations within nineteenth century American society.

C. Gender Roles and Illness

Health survey researchers consistently show for women higher rates of physical and mental symptoms than is the case for men (Nathanson 1975, Fabrega 1974:19). Anthropological studies of culture bound syndromes (folk illnesses) also point to the higher incidence

of sickness among women (e.g., O'Nell and Selby op. cit., Uzzell 1974: 370, 374, El-Shamy op. cit. p. 23, Lewis 1971). Since current knowledge does not validate a biological basis for this difference, a number of explanations which rely on socio-cultural variables associated with gender role performance have been advanced to account for this phenomenon. Nathanson (op. cit.) has recently summarized three major explanatory models which have been advanced to account for gender differences in illness occurrence. All three types of etiological hypotheses derive from the assumption that women's illness, and behaviour associated with it, is a response to or reflection of their "situation as women", i.e., their gender role identities. These models are summarized as follows:

> 1) Women report more illness than men because it is culturally more acceptable for them to be ill - 'the ethic of health is masculine'.
> 2) The sick role is relatively compatible with women's role responsibilities, and incompatible with those of men.
> 3) Women's assigned social roles are more stressful than those of men; consequently, the <u>have</u> more illness (Ibid:59).

The argument that "the ethic of health is masculine", cannot be accepted as universally valid. Cultural and ethnic groups vary in their perceptions of physical conditions and in their expression of a state of illness. A number of empirical studies have dealt with the relationship between varying socio-cultural identities and various aspects of illness behaviour. The data provided by medical sociology reveals the existence of a variety of subcultural beliefs about illness and behaviour responses to it (Segal 1976). Thus the validity of this argument within American culture itself is questionable. For

the setting of the present study, and Middle Eastern society in general, the validity of this "ethic" is certainly questionable. In a society where the linguistic equivalent of "how are you?" is translated as "how is your health?", neither males nor females are ever reluctant to discuss their health or to voice complaints of their illnesses.

The second explanatory model, which accounts for gender differences in illness on the ground that the sick role is relatively compatible with women's roles and incompatible with men's culturally defined responsibilities, is also subject to debate. While some authors have suggested that the relative flexibility of female roles offers ample opportunities for women to adopt the sick role, others have stressed the disruptive effect of women's illness on family life. MOre importantly, while this model may explain differential sick role behaviour, it does not shed light on the social structural elements which precipitate the illness crises itself and prompt the adoption of the sick role in the first place. Like the first explanatory scheme, this hypothesis treats the behaviour associated with the sick role rather than the illness itself, and its attendant perceived stress as a dependent variable.

The third mode of explanation which is based on a stress model attributes higher rates of illness among women to the female role. Women's assigned social roles are evaluated as more stressful than those of men. This difference in role expectation is identified as the crucial element underlying the higher frequency of illness among women. According to the logic of this explanation, the impairment in women's capacity to perform their prescribed roles is the "single most

salient factor" associated with illness (Cohler et al 1974:7). In such cases of impairment of social role, "one way to adapt to social role performance is to become ill" (Insel and Moos 1974:9). Thus, stressfulness is vaguely defined as an attribute of women's roles and illness is basically represented as a form of culturally sanctioned deviant behaviour which is functional.

This third explanatory mode has certain limitations. It suffers from drawbacks typical of the structural-functional framework. The focus of the analysis is on female roles and the illness role is regarded as functional for the maintenance of the social system. While illness is described as a mechanism of social control, no attempt is made to explain why some roles are more stressful than others in the first place. No serious attention is directed to the structural constraints, to the objective social conditions, the structural bases, the asymmetrical power relations which underlie conditions of stressfulness and which are attributes of female roles. Consequently, the model, by taking female role as its central explanatory element, cannot adequately account for variations among women, all of whom clearly share the "female role". Not only does this perspective obscure structural elements which affect groups of women, and not others, and which some women also share with men in subservient positions of powerlessness, it also ignores the dynamics of female role within a group of women. In short, the concern with women's social roles has led to a neglect of societal constraints and power relations which are stressful for women and men. As Rayan has pointed out in his critique of studies which focus on social roles and ignore the larger system in

which the elements of social role operate, "What is glaringly missing from the picture are the elements of...class and power" (Rayan 1976: 156)[1]. In fact, stress itself may be defined in terms of asymmetrical power relations, in terms of the inability to influence one's environment to one's own benefit (Ibid:159), i.e. in terms of relative powerlessness[2]. Since powerlessness is not an exclusive attribute of the female role, stress among women and men should be defined, not in terms of gender role, but in terms of the elements of powerlessness in varying societal contexts.

Studies of illness (defined in terms of social and psychological elements) in the Middle East also reveal higher frequency among women (Maher 1974, El-Islam 197, Nelson 1971, Kennedy 1967). Emotional factors related to the stressful female role and to role conflict have been implicated in the precipitation of certain mental illnesses and specific culture bound syndromes. El-Sendiony, in testing a hypothesis which stipulates that the schizophrenic rate of hospitalized patients would be higher in areas of maximal stress than in areas of minimal stress, isolates female status as a significant area of stress. On the basis of a psychiatric epidemiological survey, he concludes that

> Psychoneuroses occur more frequently in the female; that suicide is higher in the female than in the male category; that extremely overt manifestations of psychopathology prevail more frequently among hospitalized women patients than among men patients, and finally, that the death rate of women patients is significantly higher than that of men (El-Sendiony 1972:iii).

The author attributes this high rate of morbidity among Egyptian women to "high sociocultural stress" which he defines in terms of the female

role.

Studies of folk illness also attribute higher incidence of culture bound syndromes among women to female identity. In his study of spirit possession in Egypt, Kennedy attributes the higher frequency of the illness among women to "low female status" (Kennedy, op. cit. p. 189). He emphasizes the functional utility of illness among women. Illness is described as a socially sanctioned "safety valve" (Ibid). Like other explanations which derive from a functionalist perspective and which stress the functional utility of the illness role for women, Kennedy's is clearly tautological. It claims that the element "illness" is functional because it has a necessary function in the total system - it functions as a mechanism of social control. What this perspective ignores is that it is the system itself which defines the necessary functions of its elements (gender roles and illness, both). To treat the elements of gender roles and illness independently of the system does not explain the continued existence of these elements. Functional considerations identify the rationality of the elements while ignoring the rationality of the system (Freidman 1971:459). These elements operate within certain structural constraints: specific systems of material production, social relation of production, and superstructural elements which give continuity to stressful roles among women and men. This stressfulness is controlled through the sick role. The sick role is the socially sanctioned concrete manifestation of structural constraints affecting women and men.

The limitation of focusing on "low female status" is clarified when one notes that Kennedy's study is confined to comparison of women

as a group to men as a group. It does not attempt to identify the variation among women or among men. Since Kennedy and others report spirit possession in Egypt among both males and females, the occurrence of illness among women cannot be attributed to an inherent biological predisposition. Neither can gender role be considered the only sociocultural correlate. The stressfulness of afflicted women and men is related, not to gender roles as such, but, more fundamentally, to a common origin of powerlessness and its attendant absence of control over culturally valued elements of the social environment. Relations of power differentials are not confined to male-female interactions. Women may find themselves subordinated to the authority of females and mean are likely to fall victims to the domination of more powerful males or females.

Another type of explanation for the occurrence of illness in the Middle East is that it results from stressfulness associated with the inability to approximate culturally prescribed role expectations. El-Islam (op. cit.), in his study of culture bound neurosis among Qatari women, emphasizes deviation from culturally prescribed role expectations as a precipitant of stress which prompts the adoption of the sick role. While this assumption is generally considered accurate, it is so only as a redefinition of illness, not an explanation of its occurrence. Illness is by definition a deviation from prescribed behaviour. One may correctly anticipate stressfulness and adoption of the illness role under conditions of deviation from culturally prescribed role performance, but only when such performance is a culturally valued source of status enhancement, i.e. power[3]. In certain

situations the culturally prescribed roles themselves are stressful, in the sense that they define the person as powerless[4]. In these cases, it is conformity to role prescriptions (and attendant powerlessness) which is a source of stress. The sick role allows temporary dispensation from positions of powerlessness which result from conformity to prescribed role behaviour. In short, stressfulness and adoption of the sick role should be explained, not simply in terms of deviation or conformity to role prescriptions, but in terms of whether these roles themselves allow control over culturally valued elements, i.e. whether these roles allow the exercise of power. In fact, powerful persons may deviate from culturally defined roles without the necessity of resorting to the sick role. This is illustrated in the study community by the case of a barren bride from a relatively wealthy family who, unlike other childless women did not seek the label "ill" from local diagnosticians and whose mother-in-law never rediculed overtly as is generally the case. This is a situation where one form of power (wealth) compensates for another (the maternal role).

To conclude, in some recent studies of gender roles, illness has been cited as a strategy of indirect control (Friedl 1975). It is regarded as a manipulative strategy open to women in their attempt to circumvent male authority. Rather than regarding illness as an index of power or manipulative behaviour on the part of women, this study assumes that illness is an index of powerlessness. It regards the sick role as a mechanism which ensures the maintenance of prescribed social roles, their attendant asymmetrical power relations, and stressfulness. The sick role is regarded as an instrument of social

control which mediates inherent contradictions in social life. It regards definitions of illness which are cultural prescriptions for controlled deviance as superstructural elements bearing a dialectical relation to infrastructural contradictions and attendant power differentials. As Waitzkin and Waterman have emphasized,

> The sick role...(is)...a convenient tool to maintain the status quo. For individuals who encounter oppressive qualities of the social roles...which are part of the objective conditions under which they must live, the sick role permits temporary deviance from usual role-expectations. It also isolates the deviant and prevents the group formation (such as the organization of dissident individuals) which would be needed for fundamental social change. In this sense, the sick role "cools out" the opposition...illness behaviour represents an adaptive response to social structures which are to a greater or lesser degree, oppressive (Waitzkin and Waterman 1976:11, 21).

In the context of the present study, it is not gender role per se which is assumed to precipitate illness. The emphasis is on stressful situations (defined in terms of power differentials), which are related to gender roles. Since stressful situations are not unique to women, one may also expect stressfulness to precipitate illness in men. Moreover, sub-groups of women may be expected to vary in their experience of stressful situations. Indeed, some stages of the life cycle and the developmental cycle of the family expose individuals to variable types and degrees of stress. Furthermore, one may expect some women to approximate the expected role behaviour (which is a source of power) more than others, with deviants representing the most extreme cases of role conflict and powerlessness. The same is expected to hold true for men. Hence, we may expect variation in the frequency of illness <u>among</u> women (and among men) as well as <u>between</u> women and

men. Validation of the assumption that higher frequency of illness among women results from stress should involve, not only a demonstration of higher frequency of illness (or perceived stress) among females than males (this would be a restatement of the proposition), but more fundamentally, it should show that a higher frequency of illness should occur among women who are identified as being under greater stress than their cohorts.

Finally, just as concentration on gender roles obscures the bases of male-female power relations, it also obscures the bases of stress associated with those roles. To explain gender roles or stress associated with them, one must move, conceptually, outside the analytic boundaries of roles themselves to consider the structural elements which maintain these roles. We must consider the fundamental means of human adaptation - production and social reproduction, and their relation to role, power, and illness.

NOTES

[1]In his critique of American psychiatry and the propensity of mental health workers to "blame the victim", William Ryan writes:

> The purpose of thinking exclusively about status is to avoid thinking about money and power...to locate the cause of disorder largely inside the poor person is to absolve the surrounding society of the sins it has committed against him..." (Ryan op. cit. p. 161).

[2]Ryan provides a good summary of studies of mental health in the U.S., which clearly reveals the direct relation between stress and social class and powerlessness.

[3]e.g. stressfulness of childless mothers in a society where children are desirable sources of labour, or stressfulness in spinsters in societies where social adulthood and its attendant prestige accrues only to married women.

[4]e.g. younger brother in extended family households, daughter-in-law in extended family households where incoming brides are subservient to the authority of older males and females, or the agricultural labourer whose only source of livelihood is his dependence on wage labour, or plantation workers whose stressful condition derives from their continued existence as slaves.

PART II: THE STUDY AREA

CHAPTER 3

GENDER IDENTITY, PEASANT STATUS AND POWER IN FATIHA

A. Introductory Remarks

The major focus of this chapter is on the village community and on gender roles within the village. But in accordance with the theoretical premises of the study which were stated in Chapter 1, equal attention is devoted to the relations between the local mode of production and the encompassing social formation of which it partakes. Section B provides a general account of the study community, noting the general features of its physical setting, history, and to a greater extent, its social organization. Elements of social organization introduced in this section are taken up in greater detail when consideration in relation to gender roles in Section C and when relevant to our discussion of the study community as a peasant society in Section D.

Section C of the chapter deals with gender roles in the village of FatiHa as they relate to the central theme of power relations. Themes covered in this section include differential valuation of male and female infants, early age socialization, adolescence, and culturally defined adult gender roles. In considering the roles of adult males and females in the village, it is noted that while gender role ascriptions related to the technical relations of production is subject to minimal differentiation, control over valued instruments

of production and the products of agricultural labour is vested in males. It is such control which is deemed the basis of male-female power asymmetry in the village. Factors which inhibit such control by women are examined. Since the family in FatiHa constitutes the framework of production relations, and gender role differentiation as well, the developmental cycle of the family is utilized as a framework for the description of gender role differentiation, relations of production, and their consequences for power relations between, and among, men and women. Having noted the dynamics of male-female power relations in light of the developmental cycle of the family, an examination of power relations which transcend the household is undertaken. Note is made of the insignificance in FatiHa of the alleged universal opposition between a private, domestic and a public, extra-familial political sphere.

Further assessment of gender status in the village in Section C proceeds by examination of the differential degree of autonomy and decision making power. Finally, an examination of superstructural elements of village culture reveals ideas and beliefs about males' and females' physical and mental attributes, which legitimize the power asymmetry related to gender identity.

The concluding section of this chapter (Section D) relates the conclusion of male dominance derived from our accounts of gender roles in Section C to the theoretical premises of the study which were introduced in Chapter 1. Rather than viewing male dominance in the village as a validation of the alleged universality of female subordination to male authority, the contention is made that this mode

of male-female power relations is representative of a specific structural type, namely peasant society. The distinguishing elements of the peasants' semi-capitalist mode of production and the social formations of which it partakes is contrasted with nonexploitative social formations where the differences between males and females are not socially converted into inequalities. This is explained in light of the differing relations of production associated with these contrasting social formations. Details of the local social relations of production are then outlined and the articulation of the study village with the encompassing society is shown to conform to the general elements of the structural type "peasant society". The impact of the encompassing society on the lives of Egyptian peasants, including those of the study community is illuminated in light of the agrarian reform program. Finally, reference is made to a number of mechanisms imposed by the larger society, which initiate and perpetuate female subordination in the rural areas of Egypt by providing privileged access of males to productive resources (land), wage labour, and education, thus supporting the maintenance of women's dependent status.

The remaining part of the chapter is devoted to an elaboration of the above noted theme through a historical analysis of the impact of changes in the larger society on the lives of rural women. Contrary to assertions of Western social scientists who contend that the underdevelopment of Third World countries and the "inferiority" of their women would be obliterated with the flow of Western capital and the diffusion of Western values, respectively, the Egyptian experience reveals the inhibitory role of Western colonial domination

on the industrial development of Egypt and the prolitarianization of her women.

B. The Research Locale: An Overview

FatiHa, the research setting of this study, is a village of 3,200 persons. It is located in the province of Kafr il Shikh in the northwestern corner of the Egyptian Nile Delta, nearly midway between Alexandria and Cairo (130 Km to Cairo and 105 Km to Alexandria). The village is connected to these major urban centers and to the capital of the province by a transportation network which includes railroads, government operated buses, and private cabs. Administratively, the village is part of the district (markaz) of Kallin. It is in this town of Kallin that the government-operated hospital and private physicians' clinics are located. Villagers also frequent this administrative center for a variety of official business and for the purchase of goods which are not ordinarily available in the village. They reach Kallin by foot, walking for a period of nearly twenty minutes.

Like other parts of the Delta, the village climate is characterized by a two-season year. The cool winter (mean maximum temperature of 20°C and mean minimum temperature of 7.2°C) extends from November to April and the hot Summer from May to October (mean maximum temperature of 34.7°C and mean minimum temperature of 19°C). Rainfall is confined to the winter months and amounts to a low average annual precipitation of below six inches. These climatic conditions

permit the cultivation of various crops (including cotton, corn, and wheat) throughout the year. This is accomplished through the reliance on a perrenial irrigation system involving the extensive use of canals.

Beyond the mention of the village in the Egyptian Geographic Dictionary as "a rural community of ancient origin", no recorded history of the village exists. A composite account of a few older informants (including an 84 year old descendant of slaves who were originally brought to FatiHa by the ruling Turkish elite), describes the origins of the village as follows:

> Our village was a vacant wilderness which was taken over by Hiddar Pasha. It was given to him as a gift for his services to the army of the Sultan...Later on it was given to a Turkish Mamluke by the name of X...About a hundred and fifty years ago, X came from Albania with MuHamad Ali. He was employed as a ruler in Disuk (a nearby provincial town). He was given our village to settle and to bring under cultivation. X gave up his administrative post, turned to religion, and settled in FatiHa. He built the mosque and a maDyafa (a traditional guest house). He owned all of the 550 feddans which were granted to him by the descendants of MoHamad Ali Pasha ...He retained the village population which had formerly been under the iltizam system (a system of tax farming) and which was doing public work. He also distributed land for sharecropping by half...He imported peasants fleeing from the hardships of the tax system imposed by MoHamad Ali. Under MoHamad Ali, all the land was under the miri system. Land was parcelled to families for sharecropping with the landlord, each paying half the expense...(yes) X was a multazim (tax farmer). Under Ismail, all the land became mulk (private property) of X. Under Tawfik (the Egyptian Khedive), land which was not distributed was sold to peasants. Other a'yan (land owning) families as the house of A. A, Sh., N., etc... who originally came as labourers then accumulated land which the descendants of X sold.

It is evident from these older informants' accounts that slave labour was also employed by X. D.N., herself a descendant of a Sudanese slave described slavery at the time of X as follows:

> X bought black and white slaves. Black slaves were not employed as agricultural labourers but as domestic servants since they didn't know the ways of the fellaHin and they were lazy...X married some of the slave women to local peasants as an encouragement to work the land. The peasants were forced to marry slave women to produce children to work in the X household. The man was given two feddans and the slave woman was given a house and became free...they (her ancestors) had no right to leave the X household...he made them marry among each other so that the slave children would remain black and remain under the authority of the X family.

In recalling the history of the village, the headman, a descendant of the X family noted, "In earlier generations we never used to marry from the fillaHin, and only with few exceptions we did not marry the black slaves. But I have broken this rule. Now you know how important education is. My own daughter married the son of a fillaH, but he is of course educated (agricultural engineer)". The belief in the function of education as a substitute for aSl (descent) is shared by other villagers. However, not all who are descendants of the ruling elite subscribe to this belief. They note that nothing can be substituted for good breeding and aSl.

In terms of the physical layout of the community, the village of FatiHa, like other villages of the Nile Delta is composed of nucleated compounds surrounded by fields. The zawya (a religious shrine) which houses the tomb of the village patron saint, Sayida Z. (a female descendant of the traditional Turkish elite) is considered the center of the village. Close by is the local mosque where Friday prayers for males only are held. These two major buildings of the village are adjacent to the house of the village headman and to that of a relative. Both of these houses differ in their construction from the mud, sun baked houses of the peasants. This

central part of the village houses two grocery stores and a barber shop and is surrounded by the dwellings of the villagers which are in turn surrounded by their fields.

Village houses usually consist of anywhere from four to eight rooms, including animal sheds. One room is usually reserved for sleeping but may also be used for food preparation and the entertainment of guest, depending of the size of the family occupying the household. A storage room usually contains large bins made of mud and used to store wheat or corn for the while year after harvest. Toilet facilities in the houses are usually absent. When a toilet is found in the house it is simply a small hole which leads to a very large reservoir inside the house courtyard. The toilet room, when available, always has a small window for ventilation. When no toilet facilities are available inside people's houses, they defecate in the animal sheds or out in the fields, or as an informant noted, "anywhere where it is convenient". Some people who not themselves own land defecate in the fields of their neighbours who view such an act with favour, given the valuation of natural fertilizers. Excreta are left exposed and are usually the locus of hordes of flies.

In the village dwellings, all the rooms usually have windows for ventilation and the dahliz (the center of the house) also has a manwar (a spot through which direct sunlight enters the house). The dahliz also has stairs which lead to the roof of the house where straw and dried wood are stored for use in the ovens for baking. The area of the house used for baking is usually not well ventilated and women generally complain of sore eyes and difficulty in breathing. They

attribute both of these ailments to the smoke. Sleeping arrangements inside the house depend on the size of the family. Among nuclear families, the whole family may sleep in a single room. In extended family households, the mother and father-in-law may sleep in the same room with all their grand children, while each of the married sons of the older couple shares a room with his wife. Among nuclear families where parents share their rooms with their offsprings, it is known that children are exposed to the practice of sexual relations between their parents at a very early stage of their lives. It is also said that sometimes young siblings may try to immitate the parents' actions during their hours of play. The long hours of field work during harvest time are also believed to afford young adults the opportunity for sexual foreplay.

Sanitation is the responsibility of individual households. No public system of sanitation exists in the village. People simply clean the area in front of their own houses. When the author naively asked informants how they dispose of their garbage they simply laughed. One person noted, "we have no garbage here, we even sell the dirt. We bake and burn and heat our garbage...we even use our own waste. We pile what comes from the bīr (pit, i.e. toilet reservoir) in the ziriba (animal shed) and we use it as fertilizer for the corn and wheat...".

Water supply for the village is obtained from two sources: the canals and the two large taps of water, one at each end of the village. About six houses in the village have running water. Water supply from the public taps installed by the government is intermittent and

villagers often resort to filling their zir (water storage pot) directly from canals. When available, water from the public taps is used extensively by the women for cooking and drinking but washing of clothes is usually carried out at the side of canals. When people are working out in the fields they are also often forced to drink out of irrigation ditches. Contaminated water supplies are responsible for Schistosomiasis, a disease transmitted by fresh water mollusks. Repeated infections are difficult to avoid in view of villagers' constant contact with polluted water during the course of daily work in the fields. The use of polluted water for drinking and bathing adds to the spread of infection. Polluted water also accounts for widespread enteric diseases and dysenteries which are known to be the major causes of death. High infant mortality in the rural areas of Egypt is usually attributed to diarrhea which results from poor sanitation and polluted water supplies. The villagers themselves are well aware of the potential hazards of canal water and its effects on their health but they note that it is their fate as peasants to work in, and drink, dirty water.

Turning to the economic organization of the village, it is noted that FatiHa is a community of small landholders. As was described in the Introduction, the range of land distribution in the village is rather narrow, varying between zero and eight feddans. Wage labour provides the only source of income for approximately 10-15% of the people of FatiHa. Both males and females work by the day in the fields of people in the village or are part of migratory labour forces which may be away from the village for as long as one or two months. Males

and single females to on such TaraHīl (migratory) trips.[1] Married women usually do not join such groups alone. However a woman who is separated from her husband or divorced from him may leave her children with her mother and go on a TarHila, this seldom happens, however.

Occupational specialization in FatiHa is minimal. With the exception of the village barber and the carpenter, all the inhabitants of the village are cultivators who work the land themselves or as in the case of a minority of families, hire laborers or rent their land to others. Land is a highly prized possession and the peasants of FatiHa seize every opportunity to convert any form of accumulated wealth, including their wives' jewelry (often against the objection of the latter, unless they are made co-owners) into land. Of the nearly 90 feddans owned by non-peasants (the descendants of the traditional Turkish elite, who reside in the major urban centers of Cairo and Alexandria), the greatest part is rented out to peasants. The few plots which are not rented out are left under the guardianship of a nazir (overseer) who supervises the total process of cultivation, harvesting, turning in the required government surplus, and selling of the agricultural products, in return for a stipulated portion of the products of the land. Sharecropping in such cases is usually by half (shirka bil niSf). This involves the equal sharing of crops. The overseer contributes the labour and the owner provides the use of the land.

Aside from private ownership, utilization of land may proceed according to any of three forms of rent: Naqd, shirka, and zar'a waHda. In the naqd or cash form of rent, the rent is fixed by the

government at seven times the tax per feddan (amounting to approximately 23-26 L.E./feddan/year). This provision followed the 1952 land reform measures which were designed to establish security of tenancy. According to these provisions, land can only be rented to a tenant who will farm it himself. The tenant is expected to pay a defense tax, a road tax, a national security tax, all of which amount to approximately 4 L.E./feddan/year. In the shirka (partnership) type of tenancy (also known as muzar'a or planting together), sharecropping proceeds by half. The owner provides the land and half the seeds and chemicals. The products are also shared by half. The tenant cannot at any time be removed from the land unless he forfeits any of the terms of the agreement. When this occurs a local council settles the dispute. Payment of taxes on the land are shared equally by the land owner and the tenant. In the case of zar'a waHda (one planting only) type of tenancy, the owner has greater control over his land, although in some cases the tenant may go ahead with a second planting and the consequent sharing of the harvest products. The most common form of tenancy in FatiHa is the naqd. In general rent on khalaS (even) is the form practiced by owners who reside outside the village while rent by shirka (sharing) is the more common form among those who reside in the village.

Beyond the formalized sharing associated with shirka tenancy, there exists in FatiHa a form of exchange labour known as zamala (partnership). According to this mutual, non-contractual form of cooperation, people help their friends, neighbours, and relatives with a variety of agricultural work. Men help each other in the

digging of cotton or the harvesting of wheat and corn, or in ploughing, where a person borrows another's draft animals. It is believed that this form of cooperation is undertaken by those who cannot afford to hire wage labourers. It is noted that "the person whose arms are wide does not become a partner, he hires labourers". Women engage in zamala for the purpose of baking, and to a certain extent for child-care. For some of the older village women who take care of children whose parents do not have the opportunity to reciprocate by providing for these older women the same kind of service, they may send the older woman small gifts of bread or some rice or sugar. Younger unmarried women also cooperate with their female friends during time of planting and harvest. Villagers are also obligated to a collective sharing of major disasters befalling fellow villagers. This is evident when a farm animal is killed at times when its death seems inevitable. Villagers buy meat from the owner of the animal as a way of compensating for his/her major loss. Other disasterous occassions when cooperation among villagers is expected are deaths and extended illness.

On several occassions people borrow a variety of items from each other. Neighbours and relatives borrow from each other food items such as corn or rice or wheat until they harvest their own crops and then they return the borrowed amounts. People develop reputations for their generosity (or otherwise) in lending fellow villagers in their time of need. On an almost daily basis several other food items such as sugar, onions, or tea are borrowed and equivalent amounts are returned at a later time. People may also use each others' ovens, and if a woman has no time to bake she asks her neighbour to lend her

a specific number of loaves which she returns when she bakes. When animals are borrowed, the person who borrows them is responsible for feeding them. Borrowing of money does not involve the payment of interest. Older informants remark that since the establishment of the agricultural cooperatives with their credit system, villagers no longer have to resort to money lenders who years earlier used to charge the peasants exuberant interest rates, sometimes reaching as high as ten percent. However, a disguised form of charging interest does exist through the pre-harvest sale of the anticipated crop yield which is then collected and sold by the lender at a higher price and with a substantial profit. Resort to such forms of borrowing results from the peasants' chronic shortage of cash. Thus, people may purchase salt, rice, or corn in exchange for other agricultural products. Services may also be paid for in kind rather than in cash. Women who help others bake take home with them some of the baked bread as a payment for their services when there is no intention of reciprocating these services. During the harvest season agricultural products are exchanged for a variety of goods and services ranging from children's sweets to the payment for field labourers, to help in baking, to the circumcision of a child, or the recitation of the Quran at funeral services.

Aside from reciprocal exchange of goods and services, donations are given, particularly around harvest time. Such donations as zakat il arD (alms of the land) are given to those who are considered needy, around the time of harvesting of corn, wheat, and rice. Nadr (vows) in the form of agricultural products or in the form of money are also

given to poor members of the community. As one such person commented, "I was given many things by people whom I do not even know. They simply give to ahl Allah (the people of God)".

While there is a high value placed on generosity and sharing with needy fellow villagers, this does not undermine the importance which villagers attribute to thrift and saving, all for the final goal of accumulating agricultural land. Women, who can afford to, accumulate cash through the buying of some chicks and selling their products (eggs), or the grown chickens themselves, for a profit. When enough money has accumulated from this undertaking, a woman may invest in a goat whose kids are eventually sold at what is generally considered a large sum of approximately ten Egyptian pounds (L.E.). Goat milk may be consumed by the woman's family or she may turn it into cheese which is either used by members of her household or sold for profit. The same venture may be undertaken for the buying and selling of water buffaloes or cows. Women who can afford to undertake such profitable deals are those who have a little money of their own and which they are able to invest in the feeding and upkeep of animals. Others who do not have access to such private cash cannot maintain such a chain of savings. Their husbands and older affines expect them to either utilize the products of purchased animals for the direct consumption by household members or to sell them and buy necessary goods for the family. Accumulated cash may be wrapped inside a rag and buried in a wall in the house and covered over with mud. As soon as a woman accumulates enough cash, she may supplement it by the sale of her jewelry which was provided by her family to her when she was

a bride, she then turns to invest her savings in land. Similarly for males who are able to accumulate some cash from the income derived from products of their land, they turn to investment in land whenever the opportunity arises. In short, any accumulated savings are ultimately placed in land. Even those who buy jewelry but it is only as an intermediate step to buying land. They buy gold when it is cheap and sell it when it is expensive. Social status is based primarily on land ownership.

Opportunity for savings among the majority of peasants in the village is very limited indeed. Rather than accumulation of wealth one notes the fragmentation of property through its division upon inheritance. The limited opportunities available for villagers to accumulate wealth makes them reluctant to invest their savings in any undertaking which is not considered fail proof. Purchase of land and its cultivation with the standard crops of cotton, wheat, and corn is the general rule. Innovation entailing the planting of flowers for the international market has been undertaken by relatively richer cultivators from the nearby village. The family which introduced the planting of flowers was the same one which introduced the cultivation of potatoes as a cash crop in the area. Villagers recognize that it is only the well to do who can take such risks and who can experiment with new crops.

Ideally, accumulated wealth is passed from one generation to the other according to the Islamic sunna. In actual practice, however, the terms of the sunna may be violated. Items which get inherited include houses, land, and farm animals. If a woman dies, her husband

inherits her jewelry and her parents take her clothes. If she leaves land, her husband and children take her land. If she is childless her husband and her siblings inherit from her. Her husband inherits half and her siblings inherit the other half. When a man dies, his wife and children inherit his property. His female offsprings inherit half the share of their brothers. The female is said to receive a kum (pile) and the males kumin (two piles). His wife inherits the timin (1/8 of the total property). Disputes over inheritance are common in the village and a lot of the time of the shikh il balad (a local official charged with the maintenance of law and order at the village level) is known to be spent over the settlement of such disputes. He recounted his role in such a settlement as follows:

> I have a case of a man who is threatening his wife and her brothers that he would divorce her if her brothers do not give her the share of her father's inheritance. Some people do not follow the shari'a (Islamic law) and will for the boys only and exclude the girls. In this particular case, before the father died, he sold over the land to his sons and kept the registration with a friend to ensure that his sons would not abuse him during his lifetime. When his daughter's husband found out about it after his father-in-law's death, he came to me. There is not much that I can do except try to tell the woman's brothers to fear God and give her her rightful share. I have only one girl and I even gave her kumin.

As was noted earlier, agricultural production is the basis of livelihood in FatiHa. Cultivation of the land proceeds through family centered labouring in private or rented plots and through hiring of wage labourers to work privately owned land. The only form of collective ownership associated with agriculture production is that of the sagya (waterwheel which is used to draw water from low levels and bring it up to the levels of the channels dug out in the fields).

The sagya, which may cost up to L.E. 350, a sum beyond the means of the majority of the villagers, is owned and maintained by a party of 5-6 families. People who cultivate adjacent fields and who collectively own and operate a sagya take turns watering their land by opening up the appropriate channels. Men are generally responsible for this task, and those with adjacent fields are known to cooperate with their neighbours in watering each other's fields. The procedure for establishing turns for watering the fields is generally informal and amiable. However, occasional acts of violence may occur when people fail to wait for their turn. In cases of such disputes, the ʿumda (village headman) is resorted to for the resolution of differences and for bringing about a reconciliation. Collective responsibility also pertains to the yearly cleaning of the village ponds. Families are expected to contribute labour according to the number of feddans which they plant, the stipulation being one person per faddan. Following drumming to announce the beginning of work, people join the work parties. Those who fail to do so are charged according to the amount of land they cultivate, L.E. 0.25/day/oerson. Cleaning of the maSarif (major channels) is the responsbiility of the government which accomplishes this task through the employment of migratory wage labourers.

Cultivation is a strenuous exercise which involves hours of back-breaking work from sunrise to sunset, with a short break for lunch in the fields. Villagers usually complain of pains in their backs, legs, and wrists and many of them use a wide woolen belt to tie around their waist for the purpose of supporting the back. Many people are found with woolen string tied around their wrist and ankles to minimize

pain and give support to the bones.

Cultivation is a year-round undertaking involving continuous work centering around the preparation of the soil, planting, irrigation, harvesting and processing of agricultural products. Cotton is considered the most important crop and one which needs lots of servicing. When cultivated, cotton covers a third of the total planted area of the village fields. The land for planting cotton is ploughed three times, this is usually considered the work of men. Eight days after the watering of the soil (tamliya), the seeds are planted by male and female children. Like other agricultural activities, the planting of cotton is regulated by the Coptic calendar. As in the case of all other planted crops, the growth of cotton depends on irrigation. Twelve days after the planting of the cotton seed the stem is expected to make its appearance. The cotton remains in the ground for six months. Following heroic efforts by the peasants to keep the plant free of parasitic organisms, the harvesting of the cotton crop starts in September. Men, women, and children join harvesting parties. During this period wage labourers may be paid as much as 0.40 L.E. per day as opposed to the usual daily wage of 0.25 L.E.

The land which is planted with cotton is not replanted with this crop until two years later. Cotton harvesting is then followed by wheat. Spreading of the wheat seeds is usually undertaken by men. Harvesting of wheat in May involves labour input from all members of the family. Villagers rent machines either from private owners or from the agricultural cooperative to separate the wheat kernels from the straw. Planting of rice follows the wheat harvest.

Shitla (sprouts) of rice are prepared in a small portion of the field and then transferred and spread throughout the entire field by men, women, and children, who stand almost knee deep in muddy water for hours. Weeding keeps all family members busy until the time of the rice harvest around October when all members of households, except older persons (and the relatively well to do) participate in the harvesting. The rice crop is in turn replaced by alfalfa which is harvested four times. The cattle are fattened at this time and they produce lots of milk which is either sold, consumed, or turned into cheese. The planting of corn then completes the agricultural cycle.

The significance of landownership is evident in villagers' ranking of fellow villagers. Following the descendantsof the Turkish elite, villagers who own larger amounts of lands, and their families, are consistently ranked by villagers higher than those who have smaller amounts or no land at all. In noting the significance of wealth as a measure of social worth, people note, "if you have a millim (1/1000 of a L.E.) you are worth a millim. If you have a pound, you are worth a pound". However, possession of cash is not considered as a reliable basis of prestige. It is land which is said to be reliable. Thus, while landless peasants with many children are known to make more money and are even said to eat better than families who cultivate privately owned or rented plots, it is also recognized that such families of landless labourers are most insecure. An informant expressed this perceived insecurity in her account of the life of her landless neighbour. She remarked,"...she has no land at all. But she is not any poorer than people who have a feddan or less. She has

no better substitute. Prestige in the community rested on the amount of land controlled by a given family and the number of men it produced. The prestige of females in particular rested (and still does) on the number of male offsprings. Literacy in the village was limited to members of the Turkish elite group. They attended school in the near-by town or were sent off to be educated in Cairo or Alexandria. Some villagers frequented the kutab (traditional school for religious instructions and reading and memorization of the Quran). According to shikhs Z. and G., who have been teachers in the Kutab for many years, male children became literate through reading and memorization of the Quaran. Both these teachers noted that in the old days the children who attended the Kutab came from well to do families. They came from families who could spare the labour of one or more of their children in return for the prestige gained from having a religious and learned member in the family, whose baraka (blessing) would shadow the whole family. Other attendants of the kutab were boys who had a physical handicap, particularly blindness, and whose families had chosen for them the career of reciters of the Quran.

According to the village headman, literacy has increased in the village and school attendance has become a desire of parents for their children. He contrasted this eagerness to earlier resistance by the villagers to sacrifice the labour of their children for educational training which they were fully aware could not be realistically completed in view of their dire poverty. According to article 19 of the 1923 Egyptian constitution, elementary education (6 years) was deemed compulsory for boys and girls. In accordance with this

ilzami (compulsory) scheme of education, the school in FatiHa was established in 1934. The incompatibility of school education with the general life style and economic constraints of the community was an important deterrent to the acquisition of a formal education by the children of peasants. Children were sent to school occasionally, only to avoid the fine for lack of compliance with the regulation imposed by the government. Thus, while children were legally registered in the village school, most of them seldom attended. Those who did attend were absent for many days during the periods of heavy agricultural work. Consequently many of the children never learned to read or write, although they had attended school for a few years. Thus, census information collected for the 214 female and 193 male adult occupants of a sample of 100 households in the village shows that those who had attended school under the ilzami system never actually acquired the basic skills of reading and writing. Today, in spite of the eagerness on the part of village parents to enroll their children in school, the economic constraints on the family mitigate against the fulfillment of such a desire. Only a minority of school age children ever complete even the elementary level of school education. Fewer still ever complete secondary school.

The census survey of level of formal education shows 114 males and 171 females as illiterate and as having never attended school. 42 males and 44 females are illiterate in spite of having been registered in school for periods varying from one to six years. Only 18 males of the sample population and 6 females have completed a secondary education. Six males and 2 females have High School Certificates,

11 males and only one female have completed intermediate level education and technical institutes. One male and no females has attended the university and the same male has entered graduate school. This man is the object of extraordinary respect from fellow villagers, including his parents, and his mother in particular. She never refers to him by his name but instead uses the honourific title of ustaz. The relatively limited education of females reflected in the census data remains the general trend in the village over the past few years. Village records show that enrollment of girls for the school year 1971/72 was 65 for girls as compared to 181 for boys. In the year 1972/73 the proportion of girls was even lower, with 51 registered females as opposed to 229 males. Finally for the academic year 1973/74 62 girls and 163 boys were enrolled in the village elementary school.

Prestige acquired through education or through any other culturally valued means is important not only to the person directly concerned but to members of his entire family, be they close or distant relatives. In this regard it is important to note that as the individual's actions reflect on his family, conversely, the individual him/herself derives identity primarily in terms of family affiliation. Individuality is not a culturally valued trait and the author usually had a difficult time explaining the concept to informants. In response to an inquiry about indivuality and about how villagers strive to promote personal interest informants noted,

> We never think of ourselves as just persons alone. We make ourselves closer and closer to relatives...if a man does not have relatives he picks a wife who will give him good affines...A man stays close to relatives and picks affines to make a ʿizwa (support group) for himself, as they say,

> one hand does not clap along. Wala waHdani yikid rigal (a single person never impresses men)...the woman who has a ʿizwa is supported by her relatives. She is courageous in her relations with women and with men, including her husband and his family.

The importance of derivative power for women who can rely on the support of their families was underscored by a female informant who noted,

> Even though I came from a wealthy family, my father was poor, so I cannot rely on him (i.e. for support), so I am good with my husband. I control my tongue and I never go to them (her family) when I am in trouble with him. A woman who has wid (support) from her family complains to them and they talk to her husband; they may even hit him...

Beyond villagers' prescribed obligations to the state (See section D below), the basic framework of social organization, notably production relations is based on kinship ties. Members of nuclear, extended, or fraternal joint families collectively cultivate private or rented plots of land and share the products of their collective labour. Among families who depend on wage labour, income is derived from the labour of all family members, including very young children. A survey of the sample population of 100 households in the village shows the predominance of nuclear family households. Of the 100 households surveyed, those headed by males included 40 nuclear family households, 4 two person households (of these three are occupied by childless couples and one by a couple whose female children had all married out), 17 nuclear families with one or more adult relative, 14 extended families (parents or parent substitutes, married sons with their wives and children, and unmarried siblings), 9 fraternal joint families (brothers, wives, children, unmarried siblings, one parent - mother -,

also occasionally older relatives). Of the female headed households, 8 are occupied by matrifocal families consisting of widowed mothers and their children and 3 by extended families (consisting of mothers, married sons, wives and children and mo's unmarried children). The remaining 5 households headed by females included 3 two three-person households (2 mo and so, 1 wi, wifa, hu) and two single occupant households (2 widows).

In FatiHa, relatives who reside together in the same household are considered the primarily socially significant unit of an individual member. The arabic word ʿayla (derived from the verb yuʿīl, meaning to help or to support) is used interchangeably with the word dar (household) to refer to a family. In accordance with the developmental cycle of the family, the size and the composition of the basic social group around which an individuals' life is centered (i.e. the family) changes. Phases of the developmental cycle of the family produce three major types of families, the nuclear family, the extended family, and the fraternal joint family. In each of these cases, these kinship units form the framework of village centered production relations, only if their members occupy the same household. In few cases, however, members of extended and fraternal families may continue to occupy a room in the family household but may have their separate maʿisha (livelihood). As is typical of the Delta region in general, kinship units beyond fraternal or extended families have no lasting corporate identity. Tribal loyalties are absolutely non-existent in the village and terms for larger kinship units such as Hamulat or Qabaīl (clans) are alien to the majority of villagers. Genealogies are remarkably

shallow and most informants cannot recall the names of ancestors beyond great grandparents. Support for distant patrilateral or matrilateral relatives occurs only on ceremonial occasions related to marriages and deaths, or on the occasion of the breakout of such disasterous events as fire or violent disputes. The villagers are all said to become yad waHda (one hand, i.e. unified) in disputes with outsiders. In this regard an informant remarked, "If someone from our village is in conflict with an outsider over women or even over the use of the sagya (waterwheel), the people of FatiHa take the side of ibn il balad (the son of the village). In these cases we are all considered ahl (kin). People say, 'my brother and I against my cousin and my cousin and I against the stranger'." This sense of garaba (kinship) is believed to extend to all Muslims. When an informant was asked about the relation of villagers to the rest of the Egyptian people, she responded, "We are all Muslims and we are all one".

The villagers of FatiHa differentiate between garaba (kinship) and nassab (affinity). It is said that the garaba (a word derived from the arabic word garib meaning near) is from the ʿassab (the lower back of the man from which the semen is believed to descend and cause pregnancy) and that nassab (derived from the arabic word yansib, meaning to relate to) is from the maʿun (a term used to refer to part of the reproductive system of women). Informants generally believe that the relatives who are from the ʿassab are closer than those from the maʿun. It is said that the paternal uncle is a father and that the paternal counsin is a brother. It is also believed that during times

of trouble one expects the support of patrilateral relatives as a duty. But beyond formalized expectations of support from patrilateral relatives, people say that the real test of kinship relations is wid (support and amiable relations). Following this logic, people refer to the fact that matrilateral relatives (who are considered more distant relatives) are kinder than relatives from the father's side. As in the case of father's brother and father's sister, it is also said that the maternal uncle is a father and the maternal aunt is a mother. Thus while it is verbalized that a person has more dalal (i.e. has more right to support) from his paternal relatives, it is recognized that women tie the families together and that the khal (maternal uncle) plays an important role in the raising of his sisters' children. The maternal uncle also plays an important role as an advisor and mediator in cases of marriages and disputes. Of a person who is illbehaved, it is said that he has no khal, meaning that he has no one to teach him politeness.

The ideal amiable relations between the khal and his sister's son is believed to be an extension of the idealized relation of a brother as a protector and comforter of his sister. According to a local proverb, "a brother is like an arm, if it falls, it can never be compensated for". However, it is also recognized that once a brother is married, he becomes subject to the control of his wife. Another proverb expresses this belief: "a brother is the brother of his wife and the naive one (i.e. his sister) swears by his life".

In summarizing villagers' differential expectations from paternal and maternal relatives, one may note that in case of the former,

these are seen as obligated to support an individual family member. They are regarded as the group from which an individual derives his/her primary social identity and material possessions. By contrast, maternal relatives are regarded as the locus of emotional comfort and sentimental attachment.

Marriage is considered the basis of all types of kinship relations. Various functions are attributed to marriage but villagers generally consider the production of offsprings to be a primary function. Marriage is also considered a supernaturally ordained means of satisfying what are considered natural human sexual desires. Informants note that the world would cease to exist if people did not get married and that marriage is God's preparation for the birth of children. While male and female informants agree about this general function of marriage, they differ in their characterization of additional functions. Women note that men marry for their mazaj (mood or disposition). A female informant remarked...,"they marry us to take their ghiya (desire) from us", i.e. to satisfy their sexual desires. Other women believe that men marry for their comfort and others say that, in addition, men marry women to serve them and to serve their mothers. While some male informants also reiterated the function of marriage as a means of satisfying sexual desire, those who were reluctant to admit this to the author simply referred to marriage as a sunna (Islamic practice).

Beyond unions which are considered incestuous (e.g. unions between members of a nuclear family other than the parents, between children and siblings of parents, and between sons and daughters-in-law and the parents of their spouses)[2] marriage may take place

between any of the members of the community. While some men and women from the village have married outsiders, one notes a general trend of preferential village endogamy. As one informant noted, "...in the village we are all kin and affines; brides from outside do not fare well." Mothers of adult males are particularly opposed to the marriage of their sons to urban women. It is remarked that if a man marries a woman of equal or lower status she would obey him, but if he marries one of higher status (notably an urbanite) she would not make him comfortable and would not obey his mother. A grandmother expressed her sentiments on this subject as follows: "I educated my grandchildren and I sold everything I owned for them. My grandson who used to live with me decided to take someone who is lower than him so that she can obey me. My other grandson who works in the South refused to marry a woman who is employed and drives a car. We are fillaHīn (peasants); we are different from the people in the city. That's why we don't want to have our children marry from them".

Within the village, marriage to close relatives is the ideal. It is said "those whom you know are better than those whom you do not know." In actual practice however, marriage to close relatives is not the predominant form. Of the 124 marriages recorded in the census, the largest proportion of 86 marriages occurred between distant or non kin from the village, and only 20 FaBrDa marriages were recorded. Nine MoBrDa marriages, 2 MoSiDa marriages, and one FaSiDa marriage were also recorded. Village exogamy occurred in only 6 cases of marriage. Beyond the sample population, 8 cases of polygamous marriages are recorded for the entire village. Taking a second wife

occurred among older men who ranged in age from 40 to 66 years. Their first marriage ranged in duration from 3 to 22 years. These males gave a variety of reasons for taking a second wife. These included, "beauty and love", "arrogance of the first and beauty of the second", "barreness of the first", "love of change and incompatibility", "wealth. beauty, and *'uzuwa* (support)", "love and affection", "beauty and the body", "wealth and some beauty".

Marriage is generally considered one of the most important undertakings in a person's life. In view of the significance of the selection of a marriage partner, the process is not considered solely the responsibility of the future marriage partners but is generally considered a family undertaking. The man's mother takes a leading role in the selection of a bride and her approval is accorded culture sanction. The significance assigned to the mother's approval of a potential bride is rationalized by reference to the fact that "she is the one who will be with her at home". Informants generally agree that a good bride must be polite, a good worker, healthy and beautiful. In defining the quality of beauty a female informant remarked, "...a woman's beauty is in her cleverness. She should be able to withstand hard work in the sun. All our women look alike, they are all related, they only differ in their capacity for hard work". In defining beauty, a group of male informants gave a different definition. They referred to a beautiful woman as one with fair skin or one who is dark skinned and has beautiful features. They generally agreed that a woman's beauty is more important than her politeness. One of them remarked, "a woman's appearance cannot be changed but politeness can be forced

upon a woman". In addition to her beauty, good nature, abilities as a domestic worker, and her aSl (origin or descent), informants define virginity as a necessary quality for a bride. It is said that only a very poor man will accept to marry a woman who is not a virgin (although she has not been married before). Such men are recognized as not being able to afford the payment of mahr (bride wealth). It is also said that a man will knowingly marry a woman who is not a virgin if he loves her very much. In this case he marries her for love and Sutra (protection, i.e. protection of her honour and that of her family). The relative devaluation of women who are not virgins (including those who had been legally married at one time), is reflected in the differential payments of bridewealth (mahr). For women who are virgins, the standard mahr in the village is about 100 L.E. For a woman who is sayib (loose, i.e. not a virgin), including divorced and widowed women, people do not pay more than 30 L.E., and in some cases such women will not be provided with a mahr at all.

The birth of children is generally believed to cement matrimonial ties. Adoption is never considered a substitute for the culturally prescribed female role of producing children. In fact, adoption in the sense of extending social recognition of parenthood to a child is non existant in the village. Barren women may keep the children of relatives in their households for extended periods of time, feed them, clothe them, and generally treat them like their own. The children may even refer to such women by the kinship term for mother (amma). However, this relationship is recognized as transient and such children are eventually claimed by their parents. Unable to

substitute for what is generally considered a handicap, the barren woman faces the threat of divorce. While additional causes for termination of matrimonial unions were noted for the 21 divorce cases recorded for the period between 1966 and 1974 (including marital infidelity, disobedience of wife, to her husband or her mother-in-law, and stinginess of the husband), barreness in women and sterility in men are generally regarded as legitimate grounds for divorce.

Marital disputes, which do not require court settlements are usually resolved within the family or with the help of the local headman (*'umda*) and the two *shikh balad*. In addition to the settlement of such disputes these local government officials are charged with the maintenance of public order. In this undertaking they are aided by the *shikh il ghafar* and his men. The *'umda* and the two *shikh balad* (elders of the village) settle most disputes within the village, only conflicts involving injuries or those which can only be settled in court are referred to the *markaz* (district) officials. Disputes brought to the attention of these officials range from those related to utilization of land to conflicts between women and their husbands. In his account of his latest settlement of a conflict between a married couple, one *shikh balad* remarked,

> ...women are hard headed. They are naturally this way. It is impossible to convince them that they are wrong. So, at least on the surface, I try to place the blame on the man, but we men understand each other. If a woman is egged on by her family, she feels that she has support and becomes very stubborn...When a man and a woman have no children, it is very difficult to convince them to stay together. People stay together even when there are differences because they are held together by children...Women like to have children. If their husbands cannot have children, the women roam around and become pregnant. Even when the man knows that the child is not his, he shuts his mouth because his wife's pregnancy is a proof of his own manhood.

The two shikh balad, one representing each of the two sections (HiSa) of the village and the ʿumda are elected official of the local government system. The two mashayikh are each elected by the villagers who inhabit their respective sections of the village. Assumption of the duties of the post is subject to the approval of a governate level committee and ratification by the Egyptian Ministry of the Interior. The ʿumda is also elected by the villagers. Eligibility for this post entails ability to read and write, age of over 25 years, and the ownership of land. These criteria are not determined by the villagers themselves but are drawn up by the Ministry of Interior. The villagers' choice is subject to approval by a governate level committee and to final conformation by the Minister of Interior himself. In 1960, the present ʿumda was the only candidate for the post. In January of 1975, the Ministry of Interior found it unnecessary for new elections to be held since no opposing candidate stepped forward for consideration. The present ʿumda is a descendant of the traditional Turkish elite. In view of the high esteem in which villagers hold urban mannerisms and personal acquaintances to officials in urban centers, they value the ʿumda as a representative of their village. While many of the villagers believe that the general misery of their life will not be greatly affected by one ʿumda or another and that government officials are primarily concerned with their own interests and not those of the villagers, supporters of the ʿumda take pride in his identity and his aSl (descent). One such supporter remarked, "...we all know that there is no better ʿumda for this village. He is ibn aSl (a son of superior origin). He is not like the other

fillaHīn ʿumad who do not know sky from blindness (il sama min el 'ama)."

In addition to his function as the villagers' representative vis-a-vis higher levels of government bureaucracy and his entrusting with implementation of government directives, the ʿumda carries a variety of local level administrative functions. He supervises all elections and referenda related to local and national representation. He is responsible for delivering young men requested for military service to the proper authorities. The ʿumda also undertakes the registration of births, deaths, marriages, and divorces. He also supervises public health services in the village and immunization clinics are held in the courtyard of his house. Mobilization of villagers for the control of the cotton crop parasites is also a responsibility of the ʿumda.

As a descendant (khalifa) of the village patron saint, the ʿumda also has certain religious functions. On the day of the mulid (patron saint's day), following the noon prayer, the ʿumda, seated on a horse and dressed in traditional village attire, leads a procession through the village streets. He is accompanied by an entourage of sword holders, drummers, and singers who chant the praise of God and the Prophet. During the day of the mulid peasants from nearby villages are hosted by the people of FatiHa who donate food for the entertainment of their guests in large open space on the outskirts of the village. Those who come to visit the shrine of the Sayida Zinab come to fulfill vows to the patron saint or to ask for her help in the resolution of various misfortunes, including the cure of illness.

While the karamat (miracles) of the patron saint are marvelled

at by those who support her descendants, many villagers say that the baraka of God is above everything else. In this regard, they share the sentiment of their Muslim Egyptian countrymen/women in the urban areas. The villagers identify themselves as being "of the religion of MuHammad". They define the practice of Islam as a series of rituals which include fasting, prayer, and the payment of zakat (alms). Pilgrimage to Mecca is a highly desired goal which is fulfilled only by a few older villagers who guard their life savings for this long awaited journey. While most adult males and females fast during the month of Ramadan, the majority of villagers do not pray. Those who do are mostly men. Collective religious practices, including the weekly Friday noon prayer, are confined to males. The majority of men turn out for this event.

In FatiHa, the illiterate peasants have minimal knowledge of orthodox Islam. For the villagers, Islam includes a variety of unorthodox practices and beliefs, many of which are related to illness (e.g. vows to venerated saints who are utilized as intermediaries to solicit the grace of God, the use of charms and amulets, and the joining of Sufi orders). In short, Islam in the village of FatiHa is an infusion of orthodox beliefs and practices and a variety of popular values and customs which may be traced to the pre-Islamic dynasties of ancient Egypt (Cf. Blackmann 1927). But no matter the origin of beliefs and practices which are labelled "sunna", Islamic values are always cited for the legitimation of a variety of village practices and ideals, notably those related to gender roles.

C. Gender Roles in the Village

As the saying goes, one is not born a woman. In FatiHa, the process of "becoming" begins almost immediately after birth. On the occasion of the birth of a male there is much rejoicing in the family and the child's face is covered from those whose evil eye is feared. The family may even say that the newborn is a female in order to avoid the envy of others. If a woman is divorced while she is pregnant, the birth of a son prompts her husband to seek reconciliation and he requests her immediate return to his extended family household. When a male is born, the infant's maternal grandfather prepares a large pan of food and the maternal uncle gives money to the child in his hand. When a female child is born to a woman, her kinsmen are not obligated to provide her with the traditional nugta (gift).

When a female is born, the outburst of joy characterizing the birth of a son is absent. If the birth of the female infant is part of a series of earlier births of daughters to the mother, members of the household are actually saddened and the mother may even cry. Women who give birth to many daughters are scorned by their mothers-in-law. On such an occasion, the paternal grandmother may sing, "why did you come O girl when we wished for a boy? Take the zal'a (urn) and fill it from the sea, may you fall into it and drown". Mothers, while lamenting their bad fortune for not being blessed with a son, still sing to their infant daughters and say, "When they said it is a girl, I said the loved one has arrived. She will sweep for me and fill (the urn with water) for me and when I die she will cry for me".

The corresponding song for a son expresses the sense of pride and enhancement of status experienced by the mother. She sings, "When they said it is a boy, his father's back became erect and he rose. (Then) they brought me the eggs, heaped with butter. When they said it is a boy, they sent the midwife out of the village. (Then) they brought me stuffed poultry and on it a heap of butter. O boy, you are your mother's only possession, O ornament of her hair. If your father gets angry at your mother, they will count you as part of her mahr (bride-wealth)". As in birth, so in death, one notes the differential valuation of male and female infants.[3] In comforting a woman who has lost her ten month old daughter, her husband and relatives said, "don't do this to yourself, it is only a bit of a girl (Hitit bit). What (more) would you have done if she were a boy?"

The seventh day after birth (sibu') is always celebrated for a boy. It is said that the boy will pull the donkeys and help his father in the field but the girl will be taken by another man for whom she will work and by whom her father will be cursed[4].

On the occasion of the birth of a girl, friends and relatives say to the parents, "may God make it up to you by granting you a brother for her". This expression of sympathy is diametrically opposed to the hearty congratulations and repetitions of the word mabrūk (blessed) directed to the parents on the birth of a male. People simply say to the mother of a new daughter, "Hamdillah 'ala salamtik (thank God for your safety)". In congratulating the father of a newborn son, on the other hand, people say, "mabrūk, you were blessed with a dahr (back). Now you have a sanad (support)".

During the early years of life there is little differentiation except in terms of feeding and general care. Mothers, in justifying the preferential treatment and feeding of sons say, "we want our son to grow up quickly so that he will help his father in the field". Physical punishment is about the same for boys and girls in the first few years of life; hitting of children is usually severe. Division of labour during these early years is not pronounced. Many villagers aspire to educate their sons and some families send pre-school age children to the local Kutab (traditional Quranic school) to learn to read. But although public education in the village is free of charge, few families can actually afford to sacrifice the labour of their children even at this very early age. Even those who eventually attend school for variable periods, their absence from classes during periods of heavy agriculture work is noticeable. As noted earlier, education of children is an important status symbol among the villagers. Education of girls, in particular, is truly a mark of their families' relative wealth.

Boys between four and six years of age load donkeys and feed the animals which they also accompany back and forth from the fields. A child of this age may also help his father spread crops during the planting season. In case a boy does not have any older sisters, he may take care of younger siblings. If his mother sends him on an errand related to domestic affairs he may refuse, but if his father orders him to perform any task related to agriculture, he will promptly comply. At a comparable age a girl sweeps, cleans the cooking utensils, fetches water for household needs, accompanies animals and their loads

to the fields, and helps her mother in baking and childcare. After the ages of six to seven, fathers are very harsh with their sons in particular. They often beat them without mercy for the slightest offense. While beating their sons, fathers often utter the statement, "Are you a woman, boy?". Girls of a similar age are expected to acquire the symbols of female modesty in dress and behaviour and are usually discouraged from playing with boys.

Socialization of children in the first ten years of their lives proceeds through constant instructions (from their parents, older relatives, and senior fellow villagers) on what is believed to be proper behaviour for boys and for girls. Children are said to learn from their parents. Daughters are believed to follow in the footsteps of their mothers while boys are expected to grow up like their fathers. Children's play activities are clearly preparatory for adult gender roles. Little girls are seen playing with pieces of dough given to them by their mothers while they are baking and little boys play with a whip-like toy and imitate men driving oxen during ploughing, which is generally considered a male activity. By ages 8-13 children are well indoctrinated with villagers' gender role expectations and have definite ideas about power relations between males and females. This internalization of gender role expectations, along with children's self perception was reflected in children's responses to a story completion test. This test was administered to boys and girls in the village. The children were asked to complete stories which were composed by the author and which depicted events which are meaningful to village children. The incomplete stories and children's

responses were as follows:

STORY 1

Once there was a girl walking in the village street. She found a crowd of people watching a girl and a boy being beaten. When she asked the bystanders who was hitting the girl and boy, and why, the people told her:

Girls' Responses:

"...their father is hitting them because they are fighting together".

"...they said it's their father. (Why) They have done something. (What?) They could have disobeyed their mother or did not want to go to school".

"...their father (Why?) because they were fighting together."

"...they said her father is hitting him. (Who was the boy?) He is her brother. (Why was he being hit?) Because he insulted her."

"...they said their older brother is hitting them because of what they did. (What did they do?) They insulted him".

"...my father was hitting them. (Why?) Because they would not obey their mother".

"...they said they disobeyed their father. (Who was hitting them?) Their father.."

Boys Responses:

"...the man hit the two children because they were quarreling".

"...they told her that the kids are hitting each other in the street and a man who was standing in the street started to take them apart and hit them both".

"...they were fighting and so their father came and hit them".

"...they said they were fighting together and their father hit them".

"...their father is hitting them because they are hitting each other".

"...their father is hitting them. (Why?) Because they are fighting in the street and making a spectacle of themselves - making the whole village see them".

"...they were walking acting silly. They walk for a while and stop for a while and so their father hit them".

These responses clearly indicate the role of males, particularly fathers, as disciplinarians. It is also evident that disobedience of the mother does not necessarily prompt punishment by the mother herself. She is likely to refer children to her husband for the necessary punishment. Indeed, children do recognize the relative subservience of their mothers and in some cases may even insult them (especially by reference to their families). A mother may chase her children with a stick but she usually does not hit them severely. Moreover, mothers are often heard threatening their children by telling them that they would complain to their fathers.

STORY 2

Once there was a girl called Zinab, she had a twin brother whose name was MoHammad. They were both in the village school. One morning as they were getting ready to go to school their father stopped them and said "your mother must go to the market today. One of you must stay home with your younger brother". They answered...

Girls' Responses:

"...her brother went to school and his sister stayed home. (Why?) Because her brother is a boy and will not do any work in the house".

"...they said 'no we will go to school' (But their father insisted that one of them must stay home and take care of their young brother). They said 'no, you stay, otherwise they (the teachers) will hit us in school'. (But does their father know how to take care of children?) Yes he can just sit and hold him. He does not have to do the housework".

"...Zinab will stay. (Why?) Because MoHammed does not know how to take care of their brother".

"...Zinab said I will take care of my brother and I will not go to school today. (Why?) Because she is the one who can take care of the child, because she is a girl.

"...they said no we will go to school (But their father said that one of them must stay) They said 'no we will go to school, we have lessons.' (But he still insisted that one of them must stay home). They decided that Zinab would stay. (Why?) Because she is a girl and she has more tenderness for her young brother."

"...they said Zinab will stay. (Why?) Because she is a girl".

"...they said no we have to go. (But their father said one of them must stay) Zinab. (Why?) Because she is a girl".

Boys' Responses

"...they said we have to go to school to get an education. (But their father insisted that one of them must stay) The girl said I will stay and take care of my brother".

"...they told him 'we want to learn in school' (But he insisted that one of them stay). Zinab stayed and took care of her brother".

"...Zinab decided to stay and take care of her brother. (Why?) Because she is a girl".

"...MoHammad went to school and his sister stayed home. (Why?) So that she would work in the house and sweep it".

"...Zinab stayed and MoHammad went to school. (Why) That's the way it should be".

"...They said Zinab will stay. (Why?) Because Zinab is a girl and she will take care of her brother and do the house work. (Doesn't the boy know how to take care of the house?) No."

"...They said 'MoHammad has to go to school' and her father told Zinab that she has to stay and take care of her brother.

These responses clarly indicate the great valuation of education by both male and female children. In fact it is evident that children are sometimes willing to defy the authority of their father out of fear of the wrath of their teachers. However, education is regarded by both girls and boys as of secondary importance for female children. Their primary functions are conceived to be domestic and maternal.

STORY 3

One day Zinab and her brother were helping their father pick cotton. In the middle of the rows of cotton they found a magic lamp. As they sat looking at it and holding it, a jinniya came out and said "Shubik lubik 'abdak bin idik, ish tiTlub (standard phraseology of Egyptian fairy tales according to which the jinniya asks for the children's demands which she would promptly fulfill). The jinniya told them "ask for anything that you or your brother want to be or to have, your wish will be granted. Zinab said...

Girls' Responses:

"...She said no, I want to leave. (Why?) Because she was afraid".

"...She was afraid of her because she does not know her. She found that she is not human. She probably wanted to kill Zinab. She may only have wanted to freighten her".

"...Build me a palace and build me all I want. For my brother, make him a teacher".

"...Zinab said I want to be a teacher and my brother also".

"...She said, 'leave me alone'. (Why?) So that she can help her father".

"...She said 'bring me clothing, bring my brother a pair of pajamas'".

"...She said 'bring me a dress and bring my brother a suit".

Boys' Responses:

"...Zinab said 'light the lantern'. She said 'make us help our father with his work'."

"..Zinab said, 'I want my brother to be a doctor and an officer in the college'."

"...She said 'I want my brother to be a teacher and I want to be a teacher. I want my brother to be a soldier'."

"...She said, 'no', and went home to have lunch. (Why?) Because she was afraid of the jinniya. (Why?) She was afraid that she would catch her".

"...Zinab said 'I want my brother to be a soldier and I want to be a teacher'."

"...Zinab said 'I want to go to college and my brother should be an aviation engineer'."

In addition to reflecting children's fears of supernatural beings, these responses indicate the high esteem in which village children hold symbols or urbanism (e.g. teacher, palace, pajamas, suit, a lighted lantern, officer, soldier, doctor, engineer). However, these indices of social mobility are associated somewhat more frequently with the boy rather than the girl of the narrative. In informal interviews, the adults of the village when expressing their aspirations for their children also refer to social mobility in terms of acquisition of symbols of urbanism. In doing so they generally refer to their male children.

STORY 4

One day Mohammad and Zinab became very angry at each other and started hitting each other. All of a sudden the door opened and their father and mother entered. What happened after that?

Girls' Responses

"...their father separated them and said, 'do not hit each other.' (What did the mother do?) She told them not to fight together".

"...their father hit them. (What did their mother do?) She hit the girl. (Did she hit the boy?) No. (Why) Because the father has a stronger heart (i.e. he is more severe), the mother hit the girl less".

"...MoHammad and Zinab told their father what happened. Their father will hit whoever turns out to be at fault".

"...the father hit the boy and the mother hit the girl. (Why) Because the girl is for the mother and the boy is for the father".

"...their father and mother hit them both. (Who hit the hardest?) Their father (Why) so that they would not fight together again".

"...their father hit them. (Why the father?) Because he is strong. (Why did he hit them?) Because they were fighting and insulting each other".

"...they stopped. Their father and mother hit them. (Why?) Because they were fighting. (Who hit the hardest?) Their father. (Why?) Because the man is stronger".

Boys' Responses

"...the father hit the two children. (What did the mother do?) She shouted to her husband and pushed him away from the children".

"...their father hit them and their mother became upset. (Why?) Because their father hit them".

"...their father and mother hit them both and they became reconciled again".

"...their father separated them and told them not to hit each other and their mother hit them".

"...their father took them apart and caught MoHammad and hit him. (Did he hit Zinab?) No. (Why?) His hitting is very hard, he will tell her mother to hit her".

"...the children stopped fighting together and the father hit them. (What did the mother do?) Their mother said, 'don't fight because the other children will think that you are weak and then they will hit you'."

"...their father asked who is at fault and they said that it was MoHammad, so he hit him and Zinab started crying".

The authoritarian role of the father is once again evident in these responses. One also notes children's perception of a mother as relatively passive, protective, and tolerant. It is also evident that more severe punishment by the father is expected for a boy than for a girl.

With the advent of adolescence, young people take on a larger share of adult responsibilities. In considering their future, marriage is taken into serious consideration. During this stage, a girl is considered ready for at least preliminary considerations of marriage. It is said that a girl at this age shows her self off to people by walking forcefully and by doing all sorts of tasks with effort. This is the time when young men start to notice girls and

begin to choose their prospective brides. During this stage a young woman contributes a good part of her day to domestic work. In addition, she is involved in agricultural labour, either on her father's land, or as a day labourer. At this age she learns to perfect the tasks which she learned as a child, all with the important thought that it is such skill which pleases a potential mother-in-law.

At a similar age, the boy takes over the major part of his father's field tasks. He also thinks of marriage and confides in his mother and asks for her opinion of the girl whom he picked out. Mothers usually prefer their sons to marry a relative over whom they may exercise control. But if a son refuses his mother's advice of marriage to a relative there is no way she can force him to comply. Initial negotiations of marriage are usually carried out by the women of the family. They are sent over to the bride's house to "feel out" the response of her family. In case it is positive the men finalize the marriage arrangements, including the payment of the mahr. Thus, while women play a role in the initial negotiation of a marriage, when serious discussion ensures, these are conducted by males whose words (kalam rigala, the words of men, i.e., serious talk) are taken as final and whose negotiations are binding. When the bride's family refer to a committment made by the women and not executed by the men, the grooms' male relatives respond that they do not abide by the words of women (kalam niswan). It is interesting to note that this "feeling out" (gass nabD) functions of women are not confined to marriage arrangements but may be part of negotiation of the sale of land or attempts to seek favours from persons in more powerful

positions. The females of one party communicate their needs to those of another who in turn relate them to the males. When final decisions are taken regarding the matter the males seal the deal. Unlike the women, their word is considered binding.

In case of young women of marriageable age, they may also express interest in a potential husband and may confide in other female relatives and friends. While a young woman who is being considered for marriage is not expected to have any say over the choice of her marriage partner, in reality, she may express her wishes indirectly through her mother or other female relatives who are known to play an important role in match-making. However, the father, backed by other adult males of the family, has the final word. For considerations of his own, he may resist his wife's influence and disregard his daughter's wishes. Thus, although exceptions do exist, a daughter is expected to accept her father's choice of a marriage partner. As one female informant remarked, "My father said, if I pick a dog for you to marry, you will marry him". Thus, unlike her male siblings who may actively participate in the choice of a marriage partner, a woman may sometimes be forced to marry a man for whom she harbours the greatest dislike.

In considering adult gender roles, it is noted that gender role ascription related to the technical relations of production are not highly differentiated. Almost all adult males are involved in agricultural production. Women, in addition to their domestic roles, contribute heavily to subsistence activities related to agriculture. In fact, with the exception of ploughing, which is viewed as a male activity, there is little differentiation in the assign-

exclusively male activity, there is little differentiation in the assignment of agricultural tasks to males and females. When necessary, as in the case of women whose husbands are sick for an extended period of time or those who are widowed, women will even plough their land.

While technical activities are subject to minimal differentiation, control over valued instruments of production and the products of agricultural labour is vested in males. Thus, although women contribute heavily to agricultural activities, one notes a marked asymmetry in the distribution of productive resources. These are controlled by men and are only sporadically available to women. In the cash oriented economy of the village, men's power base derives from their control over goods and services which have exchange value, while women, who have limited access to such control, are subservient to male authority.

Since control of the means and forces of production and agricultural products is skewed in favor of males, women's access to such resources is through their kinsmen whose own power is based primarily on wealth, measured by land holdings. The system of inheritance curtails women's direct control of land and instruments of production. The Islamic prescription of allowing a daughter half the share of her brothers may be ignored and a father's land may sometimes be registered in the name of sons prior to his death. Some women who inherit property may turn over their shares to their brothers. Through this form of derivative power, whereby women do not have direct control over a power base and depend on another party for aid, a woman's position in her husband's household and in her relations with his family is made

more secure. When a new power base becomes available to her through the birth and maturation of children, especially sons, she may demand her legal share from her brothers.

Some women choose to claim their share of inheritance and turn it all over to their husbands. Others insist on registering the land in their own names. A more common procedure involves the transfer of half the land which a woman inherits to her husband in return for his efforts in planting it. Under all these conditions, a woman enjoys a degree of security and is accorded decision making powers which are denied the majority of her cohorts who do not enjoy this complementary economic status and whose dependence on their husbands is more pronounced.

The family in FatiHa constitutes the framework of production relations and gender role differentiation as well. Since the economy of the village is expressed through family relations, the developmental cycle of the family offers a convenient framework for the description of gender role differentiation, relations of production, and their consequences for power relations between, and among, men and women: Marriage ushers males and females to adult status. The payment of mahr to a woman's kinsmen, like their role as guardians of her "honour", symbolizes men's control over women's reproductive functions and the transfer of their productive and reproductive capacities to their husbands' kin groups. However, marriage does not terminate a woman's ties to her relatives. In fact these ties are maintained throughout her life and she may utilize the support of her kinsmen to bring pressure against her husband and his family. But in such cases, the

support of kinsmen is subject to variation. A woman may count on the aid of her brother, in fact she is in a position to demand it with "an open eye" (i.e., without shame), if he is "indebted to her generosity". By contrast, a woman may be beaten by her brother or father and sent back to her husband's household when she turns to kinsmen of limited resources with complaints of illness or maltreatment. In fact, the woman's own relatives may condone the husband's action and blame his fury on her repulsive attitude and her "long tongue".

As a married adult, a man is expected to provide his wife and children with shelter, food, and clothing. In fact, the most significant role for an adult male is that of provider. Males' procreative functions are also valued instruments of propagating the male line in the village patrilineal kinship system. Hence the valued attribute of male sexual potency. Numerous linguistic expressions used by villagers symbolize positions and acts of dominance by reference to the male position of command during sexual intercourse. Much of this symbolism centers around mounting behaviour which is considered an exclusively male prerogative. Hen-pecked husbands are said to be mounted by their wives. Older men, although authority figures in their families, are known to share their position of command with their wives who in some cases are known to out-command the older males themselves. Of such men, it is said that they have "dried up", i.e., lost their potency, and by extension, their power of command over their wives. The significance of virility transcends its value as indicative of male superiority in matrimonial relations. As noted above, male reproductive functions are given cultural valuation and the fathers of many

children, especially males are well respected in the village. When a group of men were asked to describe the worst possible experience that a man can undergo, the majority responded by reference to sterility. One respondent noted, "who would ever know that a man had lived when he leaves no children to memoralize his life".

In some cases, the ideal attributes of the male role may not be realized. The less than favourable economic conditions of the peasants may force some men to abandon their culturally stipulated responsibilities as breadwinners. Women with chronically ill husbands, for example, may find themselves the sole providers for their families and widows who have no adult male offsprings are known to take on male tasks. In cases where male economic responsibilities are curtailed, the illness role is a potential refuge.

The adult female is defined primarily in terms of her domestic and maternal functions. The married women, along with helping her husband in the fields, or, on occasion, working as an agricultural labourer, is responsible for all domestic labour. She cooks, prepares for baking, bakes, and fetches water. All aspects of child care are also within the female labour domain. Women are reaponsible for feeding, cleaning, and attending to all the needs of their children. The neglect of any of a child's many needs is viewed as laxness on the part of their mother. Such neglect stirs the wrath of a husband or a mother-in-law.

While the peasants of FatiHa define their adult females in terms of domestic functions, this facet of female role expectation is only of secondary significance relative to their culturally defined principal

function of bearing children for their husbands. Women are entrusted with the production and socialization of children. Those who fail to fulfill this expectation are considered "useless". Although people try to comfort childless women by telling them that their barreness is "from God", in reality, they are despised. As one female informant remarked about her barren sister-in-law, "she does not even deserve to have a bowel movement in his (her husband's) house".

In the relatively simple technological system of peasant agriculture, human labour is by far the most significant form. Children's labour power is exploited almost as soon as they are able to run about and communicate with their elders. Thus, the birth of children ushers the rise of women's power in the family. For although the ultimate control over women's reproductive function and its products (human labour) rests with men, the actualization of this culturally valued function and the loyalty which a mother builds in her children is a woman's most significant and relatively durable power base. Mothers of female children express their yearning for a male child, who, unlike daughters who marry out, is expected to attend to his parents' needs in their old age.

The early days of marriage and patrilocal residence are undoubtedly the most stressful in a woman's life. The young bride is subjected to orders from her older sisters-in-law and is clearly subservient to the authority of her husband's mother. In this extended family setting, the products of her domestic and agricultural labour, like those of other members of the household, are under the control of the senior male and senior female (mother and father-in-law in

extended family households and older brother and his wife in fraternal joint family household). Senior males and females are the center of authority. The position of authority of mothers-in-law receives cultural sanction. A wedding night ritual symbolizes the superordinate position of the mother-in-law vis-a-vis her sons' wives. The older woman stands by the door entrance and lifts her leg up. The bride passes under her leg.

As long as the father is alive, his married sons and their wives are at the mercy of the mother who is the primary locus of authority. At this stage of the developmental cycle of the family, as a married woman's male children reach adulthood and take on responsibilities for agricultural labour from their father, her own labour efforts gradually become confined to the domestic domain. She enjoys a sense of security in her grown children, especially her male children. The woman's power in the household reaches its climax when she becomes a mother-in-law. Being freed from the burden of agriculture labour and of most of the domestic labour, she acts as a manager of the household. She organizes the division of labour and the distribution of resources within the household and may even direct her sons' agricultural activities. This is clearly a case where authority rests on performance and evidence of power rather than on legitimacy as such. Having taken over nearly all agricultural functions from their father, a woman's male adult offsprings carry on these functions in consultation with their mother and her kinsmen. Evidently, when the senior male member of the family, who is vested with authority, fails to perform accordingly, his authority is indeed challenged by the senior female who is usually younger and

in better health than her husband.

A senior woman maintains her control over extended family labour and its products until the death of her husband. At this time, with the help and support of her kinsmen, she may maintain her husband's property intact and continue to be the principal locus of authority in the extended family. If she owns property of her own, this may encourage her sons to remain as part of an extended productive unit. Alternatively, her sons may demand their share of their father's property. This brings about the fragmentation of the family property and, with it, the power base of the mother-in-law.

The break up of the extended family unit is often blamed on women in pursuit of personal gains. But as Slade has recently noted, it is incorrect to characterize domestic quarrels by reference to women's manipulative actions (Slade 1975:141). Quarrels between women in domestic groups reflect the conflicts and tensions between men on whom they are dependent. The men experience the stress of subordination to the authority of dominant older brothers, mothers, or fathers. But under certain cultural sanctions, they are curtailed from engaging in open conflict and therefore voice their dissent through women. Thus, it is through his wife that a subservient male expresses his dissatisfaction with a reward which he considers disproportional to his nuclear family's input into the labour pool of the extended kinship unit. The relatively powerless husband cannot voice his dissatisfaction with those who control the family's economic resources. In this case then the woman and her dependent husband strive for the same goal but the eventual breakup of the extended family household is

blamed on women.

Having noted the dynamics of male-female power relations in light of the developmental cycle of the family, we now turn to an examination of gender roles and concomitant power relations which transcend the household. In FatiHa, as in other Middle Eastern communities described in the literature (e.g., Nelson 1974; Joseph 1975), the alleged universal opposition between a private, domestic and a public, extra-familial political sphere does not exist. Political participation is limited for both men and women and kinship affiliation is the primary basis for political support. Only relatively wealthy men become involved in village political contests. In addition to the ʿumda and the shikh il balad who are charged with the maintenance of public order and who link the village to external institutions of the Egyptian government, the village elects ten representatives to the Arab Socialist Union. Poor persons regard involvement in such political contests as a waste of time and they note that those who run for these offices are well to do and can hire labourers to work on their land. Indeed all the ten representatives to the ASU (Arab Socialist Union) own land and none of them own less than two feddans, while three of them own six or more feddans. Out of the whole village, there are only 55 members of the ASU; only one "active member" is a woman who works as a clerk at the agricultural cooperative. The villagers constantly undermine the work of the members and representatives to the ASU and say that they are not interested in the welfare of the village but in their own personal advancement. They are said to aspire for their own well being by establishing contact with powerful persons in the towns and the

capital of the province. In terms of the concrete accomplishments of the ASU, some of its members refer to its efforts in buying land for the building of a village school through the gathering of contributions from the local inhabitants, rebuilding the mosque, and establishing a youth center. Any politicizing function is clearly absent. Those who are elected to the ASU are expected to be people who have urban connections and who are capable of dealing with the bureaucracy at higher levels of government. Through their elected representatives, the villagers have been trying for years to introduce electricity on the village streets and to improve the water supply, with relatively little success. Indeed villagers are well aware of their relative powerlessness vis-a-vis the external government bureaucracy. As one older woman expressed her perceived powerlessness, she remarked, "inside my home and in the village I have a long tongue but outside (in town) I cannot do anything". Indeed political control rests with urban elites whose patronage is actively sought by the local inhabitants (males and females) in their pursuit of personal goals.

While political participation is limited for both males and females, political leadership is confined to males. None of the ten representatives to the ASU are women. When elections are held in the village, women's votes were cast for men of their kinsmen's choice. Thus, men direct women's limited participation in political activities. Similarly, religious leadership is non-existent for women.

Further assessment of gender status in the village may proceed by an examination of the differential degree of autonomy and decision making power. From her childhood, a female perceives males as her

guardians and protectors. Indeed, some of the most crucial decisions related to women are delegated to their male kinsmen. Note has already been made of the possibility of forced marriages for women. Differential autonomy is also evident in regards to a man's right to the sexual services of his wife. This right is indisputable. A married woman is expected to comply to any subtle or overt sexual gesture from her husband. The wife also has a right to her husband's sexual services. Failure of the husband to perform his sexual duties is sufficient ground for a wife to seek divorce. However, a woman's impatience is translated into action only after her husband's repeated failures. Some women report that they are sometimes forced to engage in sexual intercourse with their husbands, and, on occasions, have been fit for refusing to do so. Similarly, while a woman's right to divorce is recognized, she is bound by social and legal sanctions which undermine this prerogative (Cf. Moshsen 1974:38-42). Women are often under the threat of divorce, especially during the early years of marriage. When faced with the possibility of repudiation, a woman may mobilize the support of her kinsmen and seek the help of intermediaries. The conclusive decision, however, rests with the husband who has the final word over the termination of the matrimonial relations and who is supported by the legal codes of Egyptian justice (Ibid).

Unlike her husband, who is by definition the dominant party in the marriage, a woman, especially in the early years of marriage, is under the threat of divorce. Some men threaten their wives with divorce if they do not turn over to them land which they inherit from their fathers. Some women who claim their share of inheritance may turn it

over to their husbands. A minority of women insist on registering the land in their own names even under the threat of divorce. The more common situation of compromise involves the transfer of half of the woman's land to her husband in return for his labour in planting it. By contrast, the husband is not expected to make his wife a co-owner of the family's residential property in which hours of female labour is invested for general cleaning, maintenance, and even repairing and building walls.

Further evidence of differential autonomy is detected in relation to freedom of movement within and outside the village. Men congregate on the village streets at night and spend hours joking, exchanging stories about their sexual experiences with their wives, and passing a good time with their friends. Women do not leave their homes after sunset except to run necessary errands. They may also stop for visits at their neighbours or relatives, after having taken permission from their husbands or mothers-in-law. In making their request, they are expected to state and justify the purpose of their visit. Women complain that their husbands prevent them from going to visit their friends from pre-marriage days. The idea is to integrate the wife into the husband's family and to emphasize his control of her actions. Thus, unlike men, who maintain their childhood friendships, women's ties to their pre-marriage friends may be severed. Restrictions are also imposed on women when they travel outside the village. On market days, women walk in groups or they may be escorted by their children. Unlike the case for men, it is considered shameful for a woman to travel unescorted outside the village. Except for older women, most adult

females abide by this principle.

The pattern of power asymmetry related to gender identity which the foregoing account has brought into focus is clearly reflected in the ideational subsystem of village culture. One finds that differential valuation of males and females extends to persons' physical and moral status. The following descriptions of males and females provided by informants are illustrative of this differential valuation and of gender role expectations:

Female informants:

"...I am lower than him, he is a man, isn't he? (Why) Because God prefers men to women...I cannot do their work and I do not have their strength. But they cannot bear to do the housework and they have no understanding or patience for children...Of course there is a difference between men and women. The woman, her menstrual blood makes her tired and slows her down...The blood of a man is stronger than the blood of a woman. When people find a strong woman they say she is like a man. She has lots of blood. That is why whenever they divide anything the man gets kumin (two heaps). This happens in everything, food and inheritance".

"...of course the man's value is greater and he deserves special respect. His word is what goes because hs is a man and is deserving of respect and esteem. God also said that a man is preferred over the woman. A man is better because he runs after our bread and he gets hired for our sake. He is the life of the woman; he protects her from hunger and nakedness because she takes care of him when he is not well. He protects her honour...A woman can do housework which men cannot do. She has more patience with sick children. The woman derives pride most of all from her husband, then her children, then her health...The man has more value than us, the woman is not as smart as the man".

"...He is better than me under any condition. Because he is called a man and he brings money...Men cannot do any of the housework. Women cannot do the heavy work of the fields ...He protects her from working for others and being needy. The man is much stronger...The worse thing that can happen to a man or to a woman is that they would not have children ...We do not have the same strength as men. Our blood is not as strong as theirs".

"...of course the man is higher than the woman, no matter what. This is in the Quran. The man has value, the man has preference. (Why?) Because he is a man. The man has a duty, he works in the field but the woman cannot plant alone...We are better than them in housework and they are better than us in the field...For a woman, it is her good work at home and her cleverness and cleanliness which men boast about. For men it is the fillaHa (agricultural work) which brings the livelihood and when he brings more gūt (life supporting food) he takes a price from the government...Women cannot plough because their blood is weak."

"...the man is better, the man is always preferred to the woman. The man protects the woman from turning in need to her father's household....Some women are stronger in character than men but most women must obey men. The man is better in some agricultural work like ploughing. Some men can even do housework".

Male Informants:

"...No matter what, the man is better than the woman, that is what the Almighty said, it is in the Quran...women are inferior in everything. Even in bringing up children. The woman is weak, it is the man who guides her activity...a woman's mind is limited...The woman is usually weaker because she has less blood. The man, because he has more blood gets a temper more frequently"

"...a man is better because he is responsible for kassb (earning a living). I am better than her in the field. She is better at home and taking care of the children...A man's body is more solid from hard work; a woman's body is weaker because of lesser work, pregnancy, and nursing. A man's brain is larger, a woman's brain is only half a brain. A man is always tough and a woman is usually docile."

"...I am better because I am a man. A man is better in his field work, a woman in her housework."

"...I am better because I am stronger; I can move about more freely than her. She has only housework but I am responsible for our livelihood. I fulfill all her needs".

"...A woman is better in the home but a man is better in the field. A woman has more patience. A man loses his temper more easily. She can be strong but the man is the one who bears the burden (for the support of the family)".

The superstructural elements of village culture reflected in the above quotations legitimize the power asymmetry related to gender

identity and the differential access to valued power bases. While the quotations of women cited above indicate that women verbalize their belief in their own physical and mental inferiority, such beliefs should not necessarily be expected to guide their daily activities. In fact, some women reject such characterizations outrightly and note that these beliefs (especially those related to the presumed religious inferiority of women) are made up by men who use them to boss the women around.

In pursuing our examination of villagers' beliefs related to gender identity, it is noted that women are generally believed to be incapable of rational decision making. It is said that "a woman's opinion, if it is correct, causes a year's worth of destruction". As noted in other accounts of female status in the Middle East (Antoun 1968; Maher 1974:91), women are also believed to be "lacking in mind and religion". Their weakness is said to make them particularly susceptible to the temptations of the devil. Thus, although the cultural prohibition of premarital sex is not universally upheld, the nature and intensity of the penalty for such transgressions is clearly a function of the culprit's gender. Women are always blamed for tempting men and a married woman who engages in extramarital sexual relations may expect more disasterous consequences than her male lover. During the author's residence in the village, a case of marital infidelity came up in the village. The wife was brutally beaten and punished by her husband. In contrast, her lover, a married man himself, was only reprimanded by village elders and made to pay her husband a compensation (fidwa).

As in other parts of Egypt, women's sexual passions are curtailed by the practice of "female circumcision", the ablation of the clitoris (Ammar 1966:121; Berque 1957:44). Although clitoridectomy predates Islam and no Quranic reference to the practice can be found (Blackman 1927:280-316; Meinardus 1970: 322-325), the residents of FatiHa justify the custom by reference to the Islamic sunna. In this respect it is similar to male circumcision which is also explained in terms of Islamic teachings. However, in the latter case, there is no conception of the procedure as a means of controlling sexual desire. Instead, the hygienic function of male circumcision is emphasized. It is important to note that clitoridectomy is primarily a practice to safeguard pre-marital chastity and virginity. Women's right to sexual gratification within marriage is recognized. Since the clitoris is identified as the locus of sexual excitement, the gypsy woman who performs the operation is always cautioned against its complete excision. It is said that women who have been subjected to the complete removal of the clitoris "drain their husbands of their strength". Informants note that for such women orgasm is delayed. Synchronization of male and female phases of heightened sexual excitement is often brought about by the use of Hashish which prolongs sexual intercourse. Women generally report that they enjoy sex and their conversation and joking often centers around this topic.

Through the identification of indices of power asymmetry in various domains of village culture, the foregoing discussion offers a basis for evaluation of male-female power relation. Since men regulate agricultural activities and control exchange value products, dominate

political and religious activities, and enjoin decisions affecting women, it is possible to characterize the village as male dominated. Men have preferential control over culturally valued power bases. In attempting to explain this asymmetry attention was devoted to an examination of the village economy and the social relations of production. These may be summarized as follows:

Gender role ascriptions related to the technical relations of production are not highly differentiated. Ideally, a women's labour should be confined to the domestic sphere and males are expected to engage in agricultural work. With the exception of very old women or those who are heads of extended families, the economic realities of the peasants prevent them from upholding this ideal. The women of FatiHa shatter the image of the secluded Middle Eastern woman. In addition to their domestic work, which includes the processing of agricultural products, women contribute substantially to agricultural work. The degree of female participation in agricultural activities is directly related to the age of women, their marital status, and the socio-economic status of their kinship groups. With the exception of the few young adult single females who attend school, all unmarried young women, like their brothers, work in the fields in one capacity or another. The daughters of landless peasants work as day labourers in the village or join migratory labour gangs. Single and married females of families who own or rent agricultural land contribute to its cultivation in various degrees, ranging from daily labouring in the fields to only supplementary help during the harvesting seasons. Perhaps the only status which exempts a woman from agricultural work

outside the household is that of older female. But the lowly economic existence of the peasants makes many exceptions to this generalization.

In spite of women's contribution to agricultural work, their help is considered only complementary and it is males' field labour which is considered prestigious and skillful. Female domestic labour, by contrast, is not considered vital. Men do not appreciate the efforts made by women in the running and maintenance of the household If a woman complains when her husband asks her to take care of some chores, he will promptly respond, "What have you been doing all day? Don't tell me you have been labouring in the fields". Moreover, a man returning from the fields and finding his children unattended while his wife is involved in baking or other domestic activities, may reprimand, or even hit her.

A woman's work in the home is seen to be readily substituted by any other female, or even a male when necessary. Men's work in the fields, on the other hand, is considered more vital for the family livelihood and informants readily attribute to it a monetary value when asked to do so. As for the monetary exchange value of female domestic labour, they note, "she can always ask her mother or a relative, or a neighbour to do the work when she does not feel well". Clearly this differential valuation of male and female labour and the differential exchange values of the two forms can be linked to the power structure of male-female relations.

Although women contribute heavily to subsistence activities related to agriculture, control over valued instruments of production and the products of their own labour is vested in males.

Through a form of derivative power whereby a woman turns over the actual control over a power base (land) to her brothers on whom she depends for aid, a woman's status in her husband's household is enhanced. When her own children, especially sons, grow up, she acquires another power base and may demand her legal share from her brothers.

Some women who claim their share of inherited property turn it over to their husbands. Others register the land in their own name. In still other cases, women transfer half the land which they inherit to their husbands in return for the latter's efforts in planting it. Under all these conditions women enjoy a sense of security and are accorded decision making privileges which are denied those who do not enjoy control over valued economic resources and whose dependence on males is more pronounced. In cases where women rather than their husbands control productive resources, the woman is clearly the authority figure in the household. A husband in this situation is clearly in a position of dependence and may suffer deep emotional stress. In short, in the cash oriented economy of the village, men's power base derives from their control over goods and services which have exchange value while women, who have limited access to such control as subservient to male authority.

To conclude this account of gender roles in FatiHa it should be noted that the foregoing description of power relations associated with male-female relations apply to the patterned behaviour of villagers. Thus while wife beating, for example, has been described, little attempt has been made to refer to exceptional cases of a woman beating her husband. One such case did occur during the period of field

work. The woman was the object of the uncontrollable wrath of her husband and public ridicule. Having transgressed norms for female subservience without having any resort to a durable power base, she was divorced by her husband. The point to be stressed (and which received great elaboration in Chapter 1) is that when a woman in FatiHa chooses to manipulate events to her personal advantage, her efforts are subject to cultural constraints, compounded by the limitations of her specific situation. These boundary conditions define the extent of her accomplishments. Her choice may be curtailed by the lack of implementable alternatives. Conversely, her gender identity and the restrictions that it implies may be mediated by her control of or access to culturally valued power bases (e.g., the ownership of land and support of powerful kinsmen, respectively).

D. Village Society as a Structural Type

From the foregoing account of male-female relations, and in light of our definition and discussion of the concept of power in Chapter 1, it is necessary to conclude that male dominance characterizes the village of FatiHa. This conclusion may be interpreted as yet another empirical validation of the alleged universality of male dominance discussed in Chapter 1. But once we recall the status of village society as representative of a structural type, namely peasant society, this conclusion appears in a different light. As peasants, the people of FatiHa are distinguished as "persons who, owning or controlling land and resources, produce primarily agricultural crops for their own subsistence, but who also produce a surplus product, a

portion of which is appropriated, directly, or indirectly, by representatives of a larger economic system" (Rosenberry 1976:47). In contrast to societies of hunters and gatherers and primitive cultivators (which were cited in Chapter 1 to undermine the validity of the above noted generalization of male dominance), peasant societies, including FatiHa, form part of wider economic, social, and political units, with which they engage in relationships marked by asymmetry. In fact, students of peasant society tend to consider peasants as "part society with part culture" and have stressed their underdog position. Thus while the economy of the study community is characterized by relative self sufficiency, with the household being the main unit for production and consumption (based on family labour), the peasants of FatiHa are also integrated into an underdeveloped capitalist system through their obligation of the provision of "surplus" to the state. In short, the peasants of FatiHa do not live an isolated, independent existence, they are part of a stratified sociopolitical entity. The structured social inequality between males and females in FatiHa, as in other peasant societies, is a local manifestation of a general feature which characterizes the social formations of which peasant societies constitute a part. In this regard, it is important to stress that the narrow focus on gender roles <u>within</u> the study community undermines the significance of social institutions which transcend the immediate environment of the village and which are the bases of the continued exploitation of men and the oppression of women in peasant societies. The men and the women of FatiHa have identities which are multidimensional. Emphasis of this reality in

the analysis of gender roles helps integrate variables outside the narrow confines of gender identities within a specific locale.

In rejecting male dominance in the peasant community of the present study as a validation of claims of universal male dominance, it is important to point out that the historical transformation from foraging and horticulture to agricultural production was accompanied by alterations in the division of labour among men and women. The position of women as primary producers was taken over by males in agricultural societies. This transformation resulted in female dependence and ideological justifications for this dependent and subservient status (Martin and Voorhies 1975:331). The differences between male and female productive roles characteristic of egalitarian social formations were socially converted into inequality in agricultural societies characterized by privileged access to productive resources.

Unlike the case of egalitarian, nonexploitative social formations (in which "all members have free access to the basic resources needed to sustain life - all can hunt, gather, and in general utilize the environment in culturally accepted ways without let or hindrance... (and in which)...there are no persons whose access to resources is priviliged and no corresponding group whose access is impaired..." (Newcomer 1977:16,17)), peasant societies are integrated into non-egalitarian social formations. The distinguishing characteristic of such non-egalitarian, exploitative social formations is the privileged access to resources and the political regulation of such access. The exploitation[5] to which peasant societies within such social formations

are subjected "can be thought of as an economic category, but it has an accompanying politics which could be called 'oppression'. Where exploitation occurs oppression has to follow; the complex of institutions which comprise the state make sense only in the context of an economics of exploitation" (Ibid:117). The distinguishing principle which differentiates peasant exploitation from other forms of exploitation characteristic of exploitative social formations is rent[6] (Rosenberry 1976). The payment of rent by peasants distinguishes the form of exploitation to which they are subjected from exploitation characteristic of wage labour in industrial societies or among rural proletariats. Unlike wage labourers, peasants, through the payment in rent (in whatever form - labour rent, rent in kind, money rent) have some degree of control over the means of production and they also control part of their surplus product for their own subsistence. (This production for subsistence by peasants entails "both the production of 'subsistence crops' and the production of 'cash crops', the sale of which will be directed toward the purchase of subsistence goods" (Ibid: 56)). The specific form in which the above noted economic-political articulation between peasant communities and dominant modes of production is operationalized defines the basic structures of these communities, including male and female productive relations at any historical moment. This theme will be addressed shortly in light of historical accounts of the division of labour in Egyptian rural communities.

The village of FatiHa is exemplary of the structural type "peasant society", the characteristics of which have been outlined above. The

social life of the study community approximates the elements of the structural type "peasant" in several ways:

With the exception of nearly 10-15% of the landless villagers who work as wage labourers, the people of FatiHa direct their efforts towards subsistence activities and the allocation of the surplus stipulated by the state. In producing the necessities of life, the peasants of FatiHa produce more than is required to reproduce themselves as peasants. The Egyptian State appropriates what is produced in excess of the required life sustaining substances in the form of agricultural products as well as in the form of taxes from the peasants. The villagers of FatiHa remain peasants "because everything that (they) do not absolutely require to maintain life (or cannot conceal) is taken from (them)...inequality is reproduced...by the extraction of surplus" (Cf. Newcomer 1977:18). In this regard, it is significant to note Eric Wolf's differentiation between peasants and capitalist farmers. Though of limited application to the study community, it is nevertheless relevant. The majority of the population of FatiHa are peasants who own or rent a limited amount of land and whose livelihood is dependent on agricultural production as a means of subsistence and not for the purpose of reinvestment and profit. However, part of the village agricultural land is used by a limited number of persons who live in the city and who regard agricultural land as capital. They have the land planted on their behalf by wage labourers, or by a form of sharecropping, for profit. This form of absenteeism is limited to the descendants of the Turkish elite who own about 90 feddans of village land. Only a few members of this group of descendants of the Turkish

elite live on the outskirts of village. They work in the government bureaucracy in the nearby town and their life style differs drastically from the soil tilling peasants. Their children, both males and females attend school in the nearby towns or leave the area for extended periods to acquire a university education in the major urban centers of Egypt. The contrast between the life style of women of this elite group and the majority of women in the village underscores the significance of economic status on the position of women in Egyptian society.

Aside from the minority of persons who utilize village land for purposes other than subsistence, and who do not themselves cultivate the land either through family labour or through the occasional hiring of wage labourers, the majority of the inhabitants of the village are indeed peasants according to the above noted definition. Following Abdel Fadil's classificatory scheme of stratification of agrarian classes in rural Egypt (Abdel Fadil 1975:41), the villagers of FatiHa may be described as predominantly poor and small peasants whose land holdings are under three feddans. The category "poor peasants" comprises those who utilize below two feddans of land and those "landless" peasants who lease-in tiny plots of land. Since members of this group cannot raise enough produce to maintain their own families, they also rely on occasional wage labour to supplement their income. "Small peasants" have access to somewhat larger land areas ranging between two to five feddans. Families of this group usually manage to raise most of their subsistence requirements. Less than 0.5% of the village families own between 6-8 feddans. Through the cultivation of their land, the people of FatiHa, like other Egyptian peasants, bear the burden of

the Egyptian economy. Their compensation for such efforts is minimal indeed. Thus, while approximately 1/3 of the Egyptian national income derives from agricultural production which is carried out by the predominantly rural population, the level of income of this population does not exceed 50-60% of the average national income of about $200 per annum (Mayfield 1974:10). In FatiHa, a community of small producers, the income is even lower. The distribution of a net income from agricultural production is L.E. 112,465 among the 3,200 inhabitants of the village yields a low per capita income of L.E. 35,145 per annum.

Privileged access to productive resources (land) in the village takes the form of private ownership or rent. Communal land holding is alien to the villagers and is not traceable to any period of village history. In fact the village itself was created around the time of the dissolution of communal land holding in Egypt, when the institution of private ownership of land was initiated by MoHammad Ali and completed by his descendants. In more recent periods of Egyptian history, the post 1952 agrarian reforms were "designed to create a regime of small peasant properties rather than a collectivist agrarian structure" (Abdel Fadil 1975:8).

With the implementation of the agrarian reform program, land from royal landholdings in the vicinity of the village was expropriated and allocated to families in FatiHa. This distribution was part of a national plan of land reform whereby, in an attempt to break up the power of the old ruling oligarchy in the Egyptian countryside, the leaders of the 1952 army coup, undertook to win the support of the rural masses through a program of land redistribution. Land

expropriated from big landlords was to be redistributed among the underprivileged inhabitants of rural Egypt.

The agrarian reform program involved "the distribution (of land) ...in plots of two to five feddans, depending upon the fertility of the soil and the size of the beneficiary's families. The size of holdings alloted by land reform authorities was calculated in such a way as to give each beneficiary and his family an annual income just sufficient to meet bare subsistence expenses" (Ibid:8, original emphasis). In addition to this limitation (which insures the reproduction of the subservient class of cultivators in Egyptian society) priority in the distribution of land favoured, first, persons who were actually involved in the cultivation of land, whether as tenants or owners, then villagers who had the largest families. In terms of the second category, male household heads with a large family were clearly privileged. In all these cases, the beneficiaries of the land reform plan were to pay for their land over a period of 30 years. The government charged the peasants 15% in excess of the compensation paid to expropriated owners. To quote Abdel Fadil, "It was clearly intended that the land distribution program should be self-financing" (Ibid, original emphasis).

In assessing the impact of the land reform program on the lives of Egyptian peasants, including the villagers of FatiHa, it may be noted that "The improvement in income and legal status for a very large section of the farm population is by far the most valuable achievement of the reforms, greatly exceeding in importance the benefits of distribution" (Warriner in Ibid:9). Indeed, for the people of FatiHa, the agrarian reform program allowed them access to productive resources

and imposed tenancy regulations which provided them with legal protection which they had not enjoyed previously. However, in terms of the distribution of land ownership in Egypt, it still remains highly skewed. Statistical data shows that although land ownership of medium holdings (20-50 feddans) constitutes only 5.2% of the total number of landowners, they own approximately 1/3 of cultivated land in Egypt (Ibid). It is this stratum of rich peasants (and not the small and poor peasants who constitute the majority of the inhabitants of FatiHa) who wield political power in the rural areas of Egypt and who have made inroads into the national political structure. In fact, while the Egyptian agrarian reforms have shifted the locus of economic-political control away from the landed aristocracy of the ancient regime, they have relocated it among a new privileged stratum of rich peasants (Ibid).

As the state regulated the access to productive resources through the distribution of expropriated land, it proceeded to siphon off surplus products of the land to finance the development of other sectors of the Egyptian economy. It proceeded to extract agricultural surplus through a "double squeeze" of taxation and claim to part of the crop yield (or all of it in the case of cotton). Through a system of agricultural cooperatives there developed a mechanism whereby the "pricing and procurement policies for the main agricultural crops were devised in such a way as to give the state the greatest overall financial control over the surplus generated in agriculture" (Ibid). Thus, while the villagers of FatiHa are held responsible for the cultivation of their plots, the local agricultural cooperative (gam'iya) implements

government regulations regarding crop consolidation and rotations, and coordination of activities related to fumigation of crops and pest control. As in the case of other Egyptian peasant communities, the village agricultural cooperative is the only source of credit, seeds, fertilizers, and pesticides. Moreover, the system of cooperatives has been utilized most efficiently for taxing agriculture through its successes in increasing the surplus which the peasants turn over to the local authorities in return for loan payments and other financial commitments to the state.

At the end of each harvest the peasants of FatiHa turn in the required amount of crops to the agricultural cooperative. They receive payment for their produce, from which has been deducted loans used to obtain the necessary substances for cultivation, and for loans related to the servicing of the land. Interest of 0.47% is charged by the cooperative on the villagers' loans. In case of a cotton harvest, the total yield of each plot is turned over to the cooperative. Two-thirds of the rice yield and about 1/2 of the wheat crop is turned in to the gam'iya. In the case of corn, there is no government requirement. While peasants get paid for the yields of crops which they turn over to the agricultural cooperative, the stipulated requirement of rice and wheat forces them to buy these very products on the open market at a considerably higher price to meet the needs of their families. In short, the agricultural cooperative functions primarily to execute government policies regarding management of the agricultural cycle, appropriation of surplus, and taxation of the peasants to insure the steady flow of revenues to finance other sectors of Egyptian

society. These cooperatives leave the peasants isolated from formulating and executing policies which influence their own lives. For although the agricultural cooperative is managed by an elected council of villagers, these members are subject to the directives of the government appointed technicians/bureaucrats who staff the agricultural cooperative in the village. These directors of the agricultural cooperative, in addition to their tasks as technical advisors and general managers, are entrusted with the responsibility of ensuring the delivery of the compulsory quotas of agricultural products by the peasants and they have the right to fine those who delay delivery. They also have the right to initiate legal suits against those who fail to comply with government regulations.

The people of FatiHa are well aware of the exploitation to which they are subjected. The villagers say that all their work is basically for the benefit of the people of the urban areas (bandar). They feel that the people of the bandar despise them and exploit them. As one informant noted, "we only like city people because we are from the same shore, but we hate them because they take all (the products of) our efforts and our struggle. The agricultural cooperative charges tax for rice, even though we work very hard and we do not have enough rice for our home and children. The government takes our rice and we end up having to buy rice from the market. But buying from the market is very expensive". A female informant, lamenting her misfortune and that of her fellow villagers, remarked, "We wish we could live like the city...with all the electricity and the clean water, and people have more money. They buy meat at least once a week, not like us.

I wish I were born in the city, I would have gone to school and learned to read and write..."

The people of FatiHa also refer to their subservient status within Egyptian society in daily conversations and even in some songs which describe the luxury of wealth and lament the misfortunes of poverty. Indeed, the urbanites hold the fellaHīn in contempt and they retain a scorn for them. Reciprocal distrust of urban people, including government officials is clearly evident among the villagers of the study community. Villagers have no illusions about their status in Egyptian society and their exploitation by the dominant urban elite.

A variety of mechanisms integrate the village into the encompassing social system. Networks of transportation and communication, public education, and government operated medical care facilities shatter the image of the isolated rural community. Migration to the urban centers and the maintenance of kinship ties also links the village to the major cities of Egypt. All this rests on the social relations of production and the articulation of peasant communities with a dominant mode of production which is semi-capitalist in agriculture and which may be described as a form of state-capitalism in industry.

The surplus product produced by the peasants of FatiHa, and which is appropriated by the larger system in the form of agricultural commodities (cotton, rice, wheat), is distributed by the government for consumption by the local urban population or exchanged on the world market as part of the integration of the Egyptian economy into the world capitalist system. This production by the local peasants of commodities which are processed and circulated within the state

capitalist system of the larger society means that the precapitalist mode of production of peasant societies and the capitalist mode of production are interconnected in ways which affect both modes (Cf. Rosenberry 1976:47). This underscores the significance of the contention that any explanation of the status of women in Egyptian rural society cannot be divorced from an understanding of the structural principles which underlie the continued exploitation of the rural sector of Egyptian society in general.

As mentioned in our introductory remarks to this section, structured inequality between males and females may be regarded as an extension of the general feature which characterizes Egyptian society as a whole. Note has already been made of the privileged access of males to productive resources in the distribution of land under the agrarian reform plan. One may also refer to the privileged access of males to work on government projects as wage labourers, and to the wage differentials favouring males. A survey carried out by the ILO and the Egyptian Institute of National Planning in thirteen villagers in the Delta shows the average daily wage of women to be about 2/3 that paid to men. The favoured position of males in Egyptian society is also reflected in the Code of Personal Status which is imposed on all sectors of the Egyptian population, including the rural areas. This code which regulates marriage, divorce, and child custody favours males in all these areas of matrimonial relations. Additionally, government stipulations of literacy status for elections to the agricultural cooperative board and to the local chapter of the ASU in the village, in addition to discriminating against the majority of

peasants in the village, selects against women in particular, since they are most likely to be illiterate. Moreover, when government efforts are undertaken to "obliterate illiteracy" in the village, females are discriminated against. During the author's residence in the village, a directive from the Ministry of Education instructed the 'umda to compile a list of illiterate males for whom a tutor from the village would be provided. Within the village the relatively wealthier families undertake to educate their daughters. Thus in the village, as in the urban centers of Egypt, education (for those who can afford to forego the labour power of their female offsprings) serves to enhance the status of women. Unlike many of the poorer men in the village, for example, the educated agricultural cooperative female clerk is a member of the ASU and her help and patronage is sought by many male villagers who are many years her seniors and who extend to her an inordinate degree of respect.

The historical record also reveals the impact of structural transformations in the larger society on the role of peasant women in Egyptian society. The historical development of the dominant mode of production and its impact on the status of rural women clearly indicates that women's productive activities have varied in form as well as in scope in relation to economic phases in Egyptian history (Tucker 1976:7).

In examining the relation between women's productive activities and the historical development of the political economy of Egypt, it is evident that during the predominantly subsistence economy phase which ended in the early 1820's, (except for the upper classes)

female labour was differentiated from male labour primarily along horizontal rather than vertical lines (Ibid). Seclusion of women of the Fellahīn was nonexistent and females laboured along side of their male kinsmen in the fields. Beyond agricultural production, women engaged in the spinning and weaving of wool, cotton, and linen, which were the primary products of domestic industry geared towards local consumption. In describing this historical phase Tucker writes:

> As spinners, women were integrated into the textile production. They often owned their own spinning apparatus and handled all transactions involved in the work. Women came to the local village market to purchase the raw materials, and took the finished thread to sell to the weaver. Involvement in domestic textile production also meant involvement in local trade; women bought their own supplies and sold their own products. Furthermore, female non-agricultural labor was not always performed in the home; in the sugar industry, women were employed in the public work place to strip the cane (Ibid).

In the following period of industrial development, during the reign of MoHammad ʿAli, female labour became particularly significant. In attempting to Egyptianize the army, MuHammad ʿAli drew on a large number of draftees from the rural areas of Egypt. With the departure of the males, the tasks of irrigation and intensive farming were left to the women of the rural areas of Egypt. In fact, "women even did the work of draft animals lost to government levies, using their own muscle power to turn the grain mills" (Ibid). Through their predominance in agricultural production, women also became greatly involved in local agricultural trade. They became the principal merchants of agricultural products in village markets throughout Egypt. MuHammad ʿAli's program for construction of irrigation networks throughout Egypt also drew women into the construction field.

Through the practice of a form of state capitalism, the MuHammad ʿAli regime undertook control of domestic and guild industry. Women therefore became integrated in the state capitalist system and were required to work for the government at a fixed salary. The place of women's work in textile production soon shifted from their homes to factories where they were recruited in large numbers for the spinning of cotton. The female artisanal spinners were thus transformed into wage labourers. In her discussion of women's productive activities during this period Mona Hammam notes that not only did women undergo the same role transformation as their male counterparts, but that they experienced a radical departure from their traditional gender roles. She adds that their entrance in the sphere of industrial production drew them out of their domestic isolation and that their newly won status as wage earners challenged the very underpinnings of their subjugation: their economic dependence (Hammam 1977:30).

During this period of incipient industrial development and transition to capitalism under MuHammad ʿAli, we note the creation of what Hammam refers to as "a working class-in-embryo". Women who were already engaged in commodity production in the towns and villages of Egypt became drawn into the factory system by the state monopolies. Hammam describes the consequences of this transformation as follows:

> Socially, as factory workers, these women were transported from one social class to another, from peasants to workers and, although the social attitudes dictating sex segregation continued to predominate in the society as a whole, there were torn asunder inside the factory as women...worked side by side with men...The engagement of women in such work underscores our findings that cultural biases were weakest at the lower social level (Ibid:210,218).

Thus, contrary to allegations of the "peasant conservatism" as the basis of continued female subordination, Hammam remarks that

> The fact that women faced the same responsibilities as men points to the correctness of the view that economic need (on the part of women) and the need to exploit cheap labour (on the part of the employer) is a much stronger force in determining women's roles than are the cultural biases dictating female confinement and seclusion. Not only did women fulfill their responsibilities to the employer as men did, but they also... engaged in defending their rights vis-a-vis their employer, confirming once again that cultural biases constitute only a contributing factor in defining women's roles and not a determining one (Ibid:34).

Under strong opposition from European powers, MuHammad ʿAli's industrialization program collapsed and Egypt was integrated into the world market as a supplier of raw materials (notably cotton) for European industry. This export-economy phase of Egyptian history was characterized by the emergence of an agrarian capitalist class which produced cotton for the market and forced smaller land owners and tennant farmers off the land. It was also characterized by competition to local industry from Western industrial products, which was devastating to artisans and small merchants (including women) (Gran 1977). With the rationalization of the economy for capitalist export production, there occurred in the rural areas of Egypt a move to consolidate land under the control of big owners and the rise of plantations which provided British textile manufacturers with crude cotton (Tucker 1976:9). With these economic transformations, there occurred a decrease of small holdings which was accompanied by a growing supply of wage labourers. Under these new conditions:

> Women still worked along side male family members in the cultivation of family holdings, but men constituted the bulk of the wage labour force...women and children were hired only for the harvest season. The pattern of family labour was eroding: sexual differentiation increased as men entered the commercial agricultural sector...it appears that the introduction of large-scale cash crop agriculture meant a fundamental change in the relation of women to agricultural production (Ibid:8).

Foreign economic penetration obstructed the industrial development set forth by MuHammad ʿAli. Combined with the interests of the Egyptian landed classes, colonial policy opposed Egyptian industrialization, except for small scale enterprises necessary for the processing of the major export crop, cotton. The colonial government was committed to keeping Egypt as 'a great cotton farm' (Radwan 1976). Under the impact of increased competition from European commodities, the economic importance of women centered cottage industries was dealt a severe blow from which it has never recovered. In sum, the decline of the traditional craft industry which had been controlled by women obliterated an important part of their productive labour.

The effects of events associated with different phases of Egyptian economic history, described above, are still evident in Egypt until this very day. Additional developments linked to the more recent historical past have resulted in an increased number of landless peasants, a high level of rural (and urban) male under- and unemployment, and the continued marginality of women in the wage labour force. Judith Tucker has summarized these recent developments as follows:

> By the time large scale industry finally took root in the 1950s, the role of women in the productive process of home industry was a distant memory - women's marginal role in the non-agricultural labour force was already established.

> Cultural traditions undoubtedly played a part; the ideal of female seclusion does not encourage women to work outside the home. But the very active participation of females in home industry and marketing in the subsistence economy phase, and their integration into the factory system during Mohammad 'Ali's industrialization suggest that cultural values do not present an insurmountable obstacle when other economic forces are at work. (Ibid:8).

To conclude this section, the foregoing historical account of gender roles as they relate to production was intended to impress upon the reader that gender roles and associated power relations in rural areas of Egypt, including the locale of the present study, realistically, cannot be divorced from the effects of the encompassing larger society. It is also significant to note that the historical record runs counter to claims by Western social scientists that Third World economic underdevelopment and the "inferiority" of Third World women is traceable to the limited penetration of Western capital and the limited diffusion of Western values, respectively. The penetration of Western capitalism into the Egyptian economy is clearly tied to its industrial underdevelopment and the interruption of the process of proletarianization of its women in its incipient stage (Radwan 1976; Hammam 1977).

NOTES

[1]A limited form of internal migration is associated with the TarHīla system. A contractor collects people from the village. These may number up to a hundred persons including males and females. Some couples and their children also join such expeditions. Poor unmarried women also join these work forces. Because of their need, they are not criticized. People recognize that such women have no alternative means of support. In reference to such women, some villagers may approvingly say, "...she is such a good daughter, she runs on her parents (i.e., supports them) and her siblings." Members of TaraHīla who are away from the village for extended periods of time may work on government projects which entail cultivation and the construction and maintenance of irrigation facilities. They are paid nine pounds per month. Only landless peasants are willing to join such parties. In case of families with limited amounts of land, only the men go for short periods of time on these TaraHīl.

[2]Incest prohibitions extend to a wife's daughter and to a husband's son. Additionally, any two persons who have been nursed by the same woman are considered siblings and are not eligible sexual partners. No explanation is given for this practice except that it is the shar' (Islamic practice).

[3]Death in early infancy is considered a normal life hazard. In the taking of census information, the author noticed that people did not usually count very young children. They would remark, "do you want to count this little squirt as a human being? Who knows whether he'll live or not".

[4]In talking about his "ungreatful" daughter, an older informant remarked "her husband, he makes her life miserable; he rides the horse (i.e., has sexual intercourse with her). But her father, who left her a field and a home, she is ungrateful to him". In some cases, a daughter is judged as important a source of material and emotional support as a son. F., who was the oldest of five children, including two males, and who considers herself as strong and as clever as any male, described her role in the support of her parents as follows: "There wasn't a job I didn't do to get money to make my parents comfortable. I would work in construction, in the fields, I used to buy HaTab (cotton wood) and strip off the leftover cotton and sell it. I raised chickens, I cleaned our house, I did everything. My father used to say, 'you are better than any man, F.' He used to say, 'F., may God bless you with two daughters who would take care of you as you have taken care of me'."

[5]Exploitation is defined as "the appropriation of the socially created surplus by some group which is not answerable to the producers in the disposal of that surplus" (Newcomer 1977:116).

[6]Among peasants, the underlying structural principle of exploitation is manifest in the payment of rent. By rent, Rosenberry implies a broad category which includes, "actual rent, taxes, interest on loans, forced presale of produce at less than market price, etc., i.e., any extraction of surplus value not based on the sale of labour power" (Rosenberry 1976:51).

PART III: THE MEDICAL SYSTEM

CHAPTER 4

THE HUMAN BODY[1]

A. Introductory Remarks

Following the discussion of the concepts of illness and medical system in the Introduction, their use denotes broad categories of behaviour which are applicable cross-culturally. Accordingly, illness is defined as a deviation from culturally designated states of normal health, manifested by changes in social, psychological, and/or physical states. The medical system then is viewed as a patterned set of ideas, practices, and social relations intended to promote health through the prevention, diagnosis, and treatment of illness.

This chapter concerns itself with the description of villagers' preceptions of the human body. Section B of the chapter is devoted to the formation of the human body from conception, through pregnancy, to the birth process. Beliefs regarding these processes clearly reflect villagers' cosmology and world view and allude to the relative powers of males and females in village social organization. At first impression, these processes, as perceived by the local culture, may not seem to be closely associated with the medical system. Pregnancy and childbirth among the people of FatiHa are not regarded as illnesses but as experiences with which illness may be associated. To the extent that beliefs and practices related to pregnancy and childbirth are concerned with reproducing life, bringing it into being, and protecting the

health of the mother and the infant, they must be regarded as part of the medical system (Landy 1977:288).

Local perceptions about the body are instructive with regards to the central theme of this dissertation. In addition to illuminating general features of village society and value system, ideas about the body reflect power differentials associated with gender identity. Asymmetrical power relations between males and females are given symbolic expression in people's belief in the more determinate role of male semen in influencing the character of the unborn child and the faster development of the male foetus. The greater significance attributed to male semen in the process of conception reflects informants' belief in male superiority and their conception of the social differentiation between males and females as natural. Their assertion that male-female differences exist at the pre-natal stage indicates their justification of existing social differentiation related to gender. Men's right to almost uninterrupted access to their wives' sexual services, including the period of pregnancy, indicates (and is recognized by villagers themselves) men's power over women. Still another point relating to power differentials which is illuminated by this section is the preferential utilization of traditional midwives (as opposed to modern delivery facilities) by village women. The reasons provided for this preference indicates the subservient position of the peasants, which derives from class differences characteristic of the sociopolitical structure of Egyptian society as discussed earlier in Chapter 3.

The great obsession of women with terminating their state of sterility, like the almost complete rejection of modern scientific

birth control methods noted in Section A indicates the tremendous valuation of children and points to parenthood as a culturally valued power base. Additionally, the assignment of blame for the birth of females, or for childlessness, to women, in contradiction to villagers assigned importance to male semen in the process of conception, is exemplary of "blaming the victim" rationalizations typical of asymmetrical power relations.

Differential valuation of male and female infants, translated into asymmetrical power relations between males and females at a later stage of the life cycle, is indicated in villagers' belief regarding the relatively deliterious effect of the female foetus on the mother's health. Finally, the belief that post-partum discomfort and bleeding are greater after the birth of a girl, like the solemn reaction on the occasion of such birth, is also indicative of the differential valuations of male and female children - the basis of power asymmetry in adult life.

Section C of this chapter deals with ideas about body structure and functions and reveals informants' limited knowledge of anatomical structure and physiological functions. These ideas are significant in that they form the bases of villagers' views about illness. The people of FatiHa, while regarding their body as a complex system of differentiated parts, attribute general functions to only a few named body structures. The body is generally regarded as a complex structure of which villagers have only limited knowledge. As in the case of other Middle Eastern societies (Shiloh 1962), the working of the internal body is the least elaborated area of the medical system.

The body is regarded primarily as the seat for crystallization of external social events which affect the individual. Bodily changes associated with illness are not described simply as disruptions in the functioning of specific body parts, but in terms of meaningful social events. The body is not only regarded as a physical structure, but more importantly, as an individual centered depository which mirrors social events that transcend the individual's physical being. Physical symptoms of illness are significant only to the extent that they are associated with psychological and social symptoms which indicate departure from culturally defined normal states of health. According to this logic, illness diagnosis and treatment emphasize the socially significant elements of individual identity rather than aiming to deal with specific body parts. In sum, an illness occurrence is the concrete expression of a socially significant episode which is experienced by a person and reflected on his/her body.

Section C also exposes indices of power differentials reflected in villagers' ideas about the body's structure and function. The emphasis on superior physical strength of males is utilized as a rationalization for male domination of women. Indications of power differentials are found in the discriminating allocation of food which is regarded as necessary for the maintenance of good health. Preferential treatment of sons in the area of food distribution indicates mothers' banking strategies which are cultivated to maximize their chances of better treatment at the hands of sons in their old age. The different rationalizations for the practice of circumcision on males and females reflect villagers' ideology of female impulsiveness

in sexual behaviour. Additionally, the cultural practice of partaking stimulants for the maintenance of a healthy disposition by males, and its relative restriction for females, also reflects the belief in males' greater ability of self control and greater license for vulgar behaviour. Finally, even in death, which is regarded as the "ripening" of the body and the termination of its viability by Divine Will, a person's misfortune of not having a son (a culturally valued power base) is lamented by mourners.

This chapter is concluded with Section D which, in dealing with the interaction between the human body and its natural and social environment, emphasizes the effect of body secretions on culturally significant events and explores the topic of female ritual pollution. Post-partum rituals, which are often regarded by male anthropologists as indicative of females' devalued status, are described (as they are indeed by the villagers themselves) as cultural elaborations designed to help restore a woman's normal state of health. In this section, the implementation of the ideal of female menstrual/post-partum confinement is attributed to relatively high socioeconomic status. The enforcement of confinement rituals is considered a status symbol, an index of women's culturally specific valuation rather than their inferiority.

B. Body Formation

Conception: According to the peasants of FatiHa, the initial formation of the human body results from the union (gam') between a man and a

woman[2]. Sexual intercourse is regarded as a natural function of all human beings. It is considered necessary for the general well being of existing generations and for the propagation of humanity. Thus, in addition to being perceived as a pleasurable exercise, the union between a husband and his wife is also regarded as necessary for leaving children behind. Recognition of the latter function of sexual intercourse is reflected in the ideal of the utterance of Quranic passages by the husband during sexual intercourse to ensure a healthy and blessed child, if one were to be conceived during the sexual encounter. During sexual intercourse, the husband calls the name of God for protection against the devil. In case a man forgets to seek this refuge, it is said that a woman who is smart will whisper the appropriate Quranic statement. This plea to God also illuminates villagers' belief that conception is basically an act of God. While sexual intercourse is recognized as necessary for conception, it is not regarded as determinate. As informants repeatedly indicated, "many times a man unites with his wife and no pregnancy occurs. It only happens by His command". In fact, the whole process of body formation starting with conception, through pregnancy, to delivery, is regarded as a proof of God's power.

Sexual intercourse which results in conception entails the formation of a nutfa (piece) which is derived from male semen (referred to as mann, tagawī-seeds-, or dūd-worms-) and female menstrual blood (dam il-HiD). An informant described the process as follows: "The nutfa is formed by the will of God. From the man's back comes the tagawī. The nourishment is the blood which comes from the mother.

Like here (in the village), when we throw the seed it is nourished by the earth". Informants who are familiar with the Quranic description of conception use a different vocabulary to describe the process. A midwife who is acquainted with the Quranic passage related to body formation described the process as follows: "This is something in the knowledge of God. It says in the Quran that the human body is created from ʿalag, which means something met ʿalaga (hanging). This is from the man, the woman has nothing but the blood of menstruation which comes from the veins of her back[3]. If the house of child (bit il wild) is clear, the woman becomes pregnant from the ʿalag of the man. If it is obstructed by dirt (natural) or by boils or growth, she does not become pregnant. It needs cleaning with a marwad (an iron wire wrapped with cotton). This is done by the gypsies who come around, not us (i.e., not midwives)". While another midwife confirmed this description of conception, the remaining two spoke of biD (eggs) which they described as being housed in bit il wild. In describing the formation of the foetus (janīn) one of these midwives said that "the woman has biD (eggs) and the man has mann (semen). These are in the shape of worms. They keep hitting each other until they become one".

Most informants agree that a woman is likely to conceive any time after menstruation. It is said that "after menstruation, the woman is clear and is receptive to the bizra of the man. The menstrual blood (dam il HiD) gets collected and unite with the mann of the man and makes the woman pregnant. With God's permission the child grows". There is generally no recognition of a definite time of conception. The semen which enters a woman's body does not necessarily cause immediate

conception. This occurs only after enough blood collects after menstruation. The precise mechanism of this process is explained only by reference to God's will. It is generally believed that part of the male semen, "a bit" (not a unit) unites with the blood from the women to form the child. Contrary to this view, some informants expect conception to occur also during menstruation.[4]

While most women anticipate intercourse at any time after menstruation to result in pregnancy, the village midwives identify the period between the tenth day after menstruation ceases to about a week before bleeding occurs again as one in which women are most likely to become pregnant. Two midwives explain this by reference to the necessity of accumulation of a sufficient amount of menstrual blood in bit il wild to unite with the mann. The other two who attribute conception to the union between male semen and female eggs state that the woman's egg comes down with the menstrual blood. The blood is its protector. "With the power of the Powerful (God) the egg comes in bit il wild when there is enough menstrual blood to protect it. This does not happen before the tenth day"[5]. Female informants generally recognize the occurrence of conception only after they miss their first menstruation. Some exceptions were reported by a few informants who claimed that they actually "felt it" at the time of occurrence during sexual intercourse. A midwife described the accompanying feeling, she noted, "I could feel and count the mann on this tenth day when I am very dry and when I feel it hit me like a rock".

The circumstances under which conception occurs, and the character of the father in particular, are said to influence the nature of the

child to be born. It is said that "a child turns out ibn Haram (child of sin, i.e., of negative qualities) if his father had been a mean person or if he had forced the mother to have intercourse with him. Ibn Halal (child of goodness) comes when the father has eaten a date or has eaten something sweet...If the mother does something bad, it does not matter, it is the seed (bizra) that counts[6]. If on the night of the game (sexual intercourse) the father had stolen something then the child turns out to be a thief. The spot that descends from the back of his father (i.e., semen) determines the nature of the child". From this description, it is clear that the bizra is considered more important in determining the character of the child. However, it is also believed that a boy inherits his disposition (tabʿ) primarily from his father and a girl inherits hers from her mother. Moreover, it is asserted that in the conception of a male child, "the mann from the father is more". Thus, social differentiation between males and females appears "natural".

Women's and men's inability to induce conception is generally regarded with pity. Sterility is said to be ultimately determined by "The Will of God", but more immediate causes are also recognized. Barrenness in women is attributed to such natural causes as weakness due to malnutrition, to the blocking of bit il wild by natural substances or growth[7], or to the narrowness of the pelvis (HuD or sink) which "prevents the mann from reaching bit il wild". Supernatural causes are also cited by informants. One such cause is the folk illness ʿuzr, a local variant of spirit possession. In this case, the inability of a woman to conceive is attributed to the "rejection

of the seed...the seeds are thrown out because of nazra aDiya (a gaze from subterranean supernatural beings which invade the body under conditions of fright and sadness)". The process by which conception is prevented in such cases of ʿuzr in bit il wild is vaguely explained as the "blocking of the mann by the assyad (spirits). If a woman is lucky she may become pregnant after an exorcism ceremony is performed to pacify the assyad and fulfill their demands.

Other supernatural causes of barrenness in women are fright, the Evil Eye and sorcery. The last cause entails either the direct rendering of barrenness in the woman herself, or the "tying" (rabT) of her husband, thus rendering him impotent. These procedures are commissioned by "the enemies" who pay a sorcerer who in turn commands the supernatural beings at his disposal to prevent conception. The sorcerer's power and his ability to command supernatural spirits are based on his knowledge and use of the Quran. To neutralize a sorcerer's deed (ʿamal), a woman resorts to another sorcerer who uses his own power and directs his supernatural servant (khadim) to restore the woman's reproductive functions.

Still another cause of barrenness in women is the kabsa (obstruction). This occurs to a bride who is visited by a man or a woman who are impure (nigiss or nigissa) from sexual intercourse[8]. It also occurs to a woman if a barber enters her room or if she is visited by a bride, or by someone carrying raw bloody meat during the forty days, when she is bleeding, after the birth of a child. During this period a woman may also become "blocked" (makbūsa) by another who has just weaned a child from the breast. In all these cases of kabsa one notes a symbolic

communication of processes and activities associated with one body to another.

The interruption of normal body functions brought about by kabsa is reversed by a number of procedures intended to restore the reproductive functions of the body. Undoing (fak) a kabsa may be undertaken by a woman "through inserting in herself from below a cotton soaked in the milk of a mother nursing her third child". She may also restore her ability to bear children by roaming the fertile fields or bathing with flowing water from the Nile[9]. These remedies reflect the villagers' perception of the intimate relations between the human body and another. This point will be elaborated shortly.

Male sterility, while recognized, is not given the same attention accorded female barrenness. In fact the woman is, with few exceptions, always blamed for the childlessness of a married couple. Male sterility is readily admitted only in cases when a man marries a woman with children by a previous marriage or in case of a man's old age. As in the case of female barrenness, male sterility may be attributed to natural causes. It is said to be the result of dead "worms" (semen), a condition which is considered congenital (khilga). Sterility is also said to be caused by a limited amount of semen, a large portion of which is dead and therefore does not cause pregnancy. A man suffering from this condition frequents a village healer known as the Shikit il ʿarab (a woman of bedouin origin) who "irons" (tikwī) on his lower back (the recognized source of semen) with a red hot nail.

Tarba (fright) is also said to cause sterility in males by causing the appearance of dead "worms". Another fright to the affected person

is said to restore the body to its original condition and results in the restoration of a man's ability to impregnate his wife. Supernatural causation due to the folk illness ʿuzr and "typing" (rabT) due to sorcery are also identified as causes of male sterility. These conditions are cured by the same procedures described for females.

Aside from malicious obstruction of conception, self initiated methods of preventing conception are also known in the village of FatiHa. But in light of the social necessity of children described in an earlier chapter, these methods are seldom practiced. The almost complete absence of reliance on contraceptive measures is reflected in a survey of 100 households (approximately 25% of all village households) undertaken to identify the use of contraceptive methods in the village. Among 75 fertile married females, only three reported following a contraceptive procedure. One woman reported starting the use of birth control pills, another had had her fellopian tubes tied after two Ceasarian deliveries, and a third followed a traditional method of birth control known as arfa (see below).

In the village, no attempt is made on the part of males to regulate their sexual desires or fertility. Birth control, when practiced, is exclusively a female concern[10]. The few women who use birth control pills obtain them from the Maternal and Child Health Center in the nearby town. None of the village women or midwives understand how these pills function to prevent pregnancy. Midwives conceded that "this is something in the knowledge of the doctor". Women who have used birth control pills complain that these medications "cause weakness...and make a woman's heart beat fast". They

point out that "strong medicine like this needs good eating and we are poor peasants. Women who have never used the pills express fear about their harmful effect. They cite weakness, barrenness, and cancer as possible harms which result from birth control pills.[11] Another of the physician's birth control methods used by a few village women is the IUD (shirīt). As in the case of birth control pills, women complain of discomforts associated with the use of this contraceptive device. They refer to bleeding, and unbearable pains in the lower abdomen and back. Those who have never used it also refer to the danger of cancer, the "eating away at bit il wild", and permanent sterility from its use.

Traditional contraceptive methods are also practiced by a few women. Of these, nursing is considered the most effective. Another traditional method for the prevention of conception involves the insertion of a cube of sugar after sexual intercourse "to absorb the mann". Still another method which a woman may resort to is a deliberate kabsa. Finally, a traditional method of contraception practiced by a few village women is known as arfa (literally, disgust). According to this procedure, women during their period, on two consecutive months, insert human excreta up their vagina "as far as the finger can reach". Two of the village midwives prescribe this treatment and perform it themselves to women who request it. It should be noted however that contraception is not always a service offered by midwives these days. All the village midwives recognize the greater effectiveness of the physician's birth control methods. One midwife noted, "People who want to prevent pregnancy have nothing to do with me. They go to the doctor and they take pills. Then they become weak from the pills and

they put the loop and it eats away at bit il wild. Many of them just leave themselves to God's will". Indeed, the women of FatiHa seldom resort, willingly, to the practice of birth control.

Pregnancy: Cessation of menstuation for forty days is considered a sure sign that a woman is pregnant. During the early months, the event is a closely guarded secret which is shared only with the closest of family members to avoid the harm of the Evil Eye. The mother-in-law in an extended family household is among the first to be informed of the joyful event about which she had been anxiously inquiring from the first month of her daughter-in-law's marriage. A young woman, in addition to sharing her happiness with her mother, readily informs the older women in her husband's household so that they will not misinterpret her weakness, dizziness, sleepiness and nausea as faking. In the first three months of pregnancy, a woman is said to suffer from these conditions. During this period, and throughout the time of pregnancy, the discontinuation of menstruation is also expected to occur. There is also a deepening in the colour of a woman's nipples and her belly button is "open". When inquiring about the reason for interruption of menstruation, informants responded by referring to their condition of pregnancy. In this regard they differ from the village midwives who say that "the blood does not come down during pregnancy because its place is taken up by the child. It remains stored on the heart until the woman delivers". The envisioned proximity of the bit il wild, with the unborn child, to the heart is expressed in the saying "The heart saw the child before the eye".

Embryonic development is generally regarded as a mysterious process which is "only in the knowledge of God". Informants demonstrate minimal knowledge about the development of the foetus. Even midwives' descriptions of foetal development is vague. As one midwife noted, "We put the eggs under the chicken and we do not know how God is going to make them turn out...I do not know except what I see". This is somewhat of an understatement; midwives describe some body parts and processes which they obviously do not see. For example, it is said that "bit il wild receives the nutfa and it grows in it...bit il wild closes until the time of birth". In describing the position of the child in the womb of the mother a midwife said "margad il 'ayil (the bedding of the child) is above the surah (belly button) of the mother. By four months he is makhalag (i.e., his parts are differentiated)". This phase of development is said to differ from the earlier phase which spans the period from conception through the third month. During this earlier time, "the nutfa is just a piece of blood".

By the third month of pregnancy, midwives describe differential development for male and female embryos. It is said that, "at three months the boy is white and you can identify his limbs and his head and everything, but a girl, she is just a clot of blood...I see them when I go with women who have miscarriage". But aside from this difference between males and females, it is believed that "up to the fourth month, the child is just a piece of meat". During the fourth month "the ruH (life force), with God's ability, comes into the child and he moves.".

There is no agreement among informants as to whether the flesh

or the bones form first. Some informants believe that the flesh is formed first, they say that "the bones start to grow after three months". Contrary to this explanation, those who are familiar with Quranic passages refer to specific sūras which state that the bone is formed first and is then covered with flesh. All the midwives disagree with this developmental scheme. They say, "we see it in the sagt (aborted child), it is just a bloody piece of meat...the veins are formed first, they are surrounded by flesh and then the bones grow inside".

Differences between midwives and other male and female informants also surround the question of foetal nourishment. While it is generally agreed that the nourishment of the foetus is derived from the mother and that "whatever the mother eats, the child eats from", the exact mechanism of this process is not common knowledge. Only midwives attribute the process of transfer of nourishment (referred to as "food") to the khalaS (placenta)[12]. One midwife described the process as follows: "In the first three months the child feeds on menstrual blood (dam il Hid). After this period, the khalaS is formed from the reserve menstrual blood and it feeds the child". Feeding in this sense is not similar to the ordinary injestion of food, it is a special method which is again attributed to God's ability. Another midwife provided a somewhat different description of the function of the placenta; she noted, "The child receives blood from the khalaS which is flat and all the food (from the mother) is absorbed in it...he does not excrete in his mother's stomach...he is pure...When she drinks, the water falls on the khalaS and the child is swimming under the khalaS which feeds

it".

Once conception takes place, sexual intercourse is generally not considered necessary for the growth of the foetus. A few informants, including a midwife took exception to this belief. The midwife noted, "the child gets more and more nourishment when the man unites with his wife and gives her more tagawi (seeds) during pregnancy...(no), it is not necessary for the child". While this disagreement about the necessity of intercourse during pregnancy is noted, all informants agree that there is no danger of intercourse during pregnancy[13]. But as one male informant advised "Intercourse during pregnancy must be gentle. If the woman is in the right position and the man is not hard on her, if he does not pick her up and put her down roughly, and if he does not put her in akward positions, the child will not be hurt". In responding to a question as to whether any precautions should be taken to avoid intercourse during pregnancy another male informant responded, "no, women are available all the time. All animals protect themselves from their mates during pregnancy except the wife of the lion who is always ready and willing to unite with her husband. That is why women who are overanxious to sleep with men are called labwa (lioness)". The implications of this story is clear. It reflects men's belief that women's sexual desires are insatiable. This belief is in turn derived from their notion that women are "lacking in mind and religion". As pointed out in an earlier chapter, these beliefs, and their expression in the above quotation, are ideological dogmas which legitimize asymmetrical power relations between males and females.

Other ideological expressions related to gender are found in the statements of informants which assert that male-female differences exist even at the pre-natal stage[14]. It is said that a female foetus has a more deleterious effect on the mother's health than does the unborn male child. The mother of a boy is said to be comfortable, his movement is near her heart. The mother of a girl, by contrast, is said to suffer from great discomfort. A female child "causes her mother a lot of misery". A female child also "bothers the mother more because she has long hair and it causes the mother to vomit". These beliefs clearly indicate the differential valuations of male and female children in village culture.

In view of the above noted beliefs, the physical condition of the pregnant woman is sometimes utilized as an index for predicting the sex of the child during pregnancy. A girl is said to be carried low whereas a boy is higher and therefore "less tiring". A boy is light and moves a lot but the girl is heavy. The sex of a child is also predicted by the size of the abdomen. If it is small, the child is a boy, because "the boy is weaker during pregnancy[15]. The sex of the child may also be surmised by acquaintenance with the woman's family's male/female composition. In this regard, one male informant noted that the sex of the child is "inherited...a woman may have four girls, her children all have four girls. This influences the choice of a bride from a family that produces males". This belief did not receive conformation by other informants. Some remarked that "this is only in the knowledge of God". Prediction of the sex of a child is also made on the basis of dreams by the mother. A handkerchief in a vision denotes

a male child while a headkerchief (part of women's traditional garb) is interpreted to denote a female child. If a woman has had a bad dream about her unborn child and does not want it to be realized she is expected to feed a dog (which is considered a guardian of her secret since he is mute).

Special precautions are expected to be taken by a pregnant woman to ensure a full term of pregnancy. During the first three months of her term it is said that a woman should avoid doing strenuous work and lifting heavy loads. During this time "the cover of bit il wild is low and a woman can easily push down the child (i.e., miscarry) by falling from a high place, eating or drinking something hot, or lifting a very heavy load...miscarriage happens only when a child is ibn Halal (i.e., not conceived in sin outside matrimony)[16]. While pregnant women and other informants agree that an expectant mother "needs rest of mind and body", in practice, women only complain of general weakness and exhaustion but continue to perform their usual tasks including heavy work in the fields. Male informants in particular noted that women use their pregnancy to get special privileges in terms of diet (a woman is expected to eat for two), reduced work load, and entertainment. But although women are indeed entitled to special treatment during this period, not all women use this situation to their advantage. Preferential treatment is a function of a woman's power status, not simply her physical condition. The case of S, a female informant, is typical of young brides living in extended family households: Her mother-in-law continued to make her wash the family clothing daily (in addition to her field chores and other housework) during

the entire duration of her pregnancy. When her twin sons later died and she fell ill, she attributed her infants' weakness and subsequent death to her mother-in-law's cruelty which caused her weakness. Brides who come from relatively wealthy families may expect better treatment than the above case indicates. They have the support of their mothers and male relatives who diplomatically ask mothers-in-law to "excuse" their daughters. Under these conditions a young pregnant woman gets attention and rest during short or even long visits of a day or two to her parental household.

The emotional state of the mother is believed to have an effect on the "comfort" of the child during pregnancy. It is said that "when the mother is unhappy the child is also unhappy inside and makes his mother sick". Informants also believe that spontaneous abortion may occur and "A woman may lose her child if she is unhappy. The woman may lose the child if she is being upset by her husband. The child may be born burned out from the distress because he gets burned from sadness and this affects the child because he eats from the blood of the mother". It is therefore recognized that men should treat their wives well during pregnancy. Male informants note that "women take advantage of the situation but the man goes along because it is for the sake of his child...the husband longs for children and so a woman takes advantage of this situation". While this statement finds its corresponding operationalization in the behaviour of some pregnant women, the degree to which a woman can "take advantage" of her pregnancy is variable. As emphasized in an earlier chapter, women, whether pregnant or not, are subject to variable constraints and differ in their

access to culturally valued power bases, including the support of relatives against the maltreatment of husbands and their kinsmen/women.

The food taboos reported in ethnographic accounts of pregnancy in a variety of cultural settings are underplayed in the village of FatiHa. Although it is generally acknowledged that some foods may cause discomforts to women or to the foetus, i.e., onions, which produce "winds" (gas) and cause discomfort to the mother and the child, people generally agree that women eat anything and everything during pregnancy. A female informant in describing the food habits of pregnant women said "we women are like the bihīma (female farm animal), we eat good food or bad food, depending on the man that we fall with (i.e., the man we marry)". When questioning informants about food taboos, they often laughed and noted "we peasants eat anything we can get our hands on...our women are not like the ladies of the bandar (urban areas)". While there are no strictly imposed food taboos for women during pregnancy, it is recognized that during this period women are particularly susceptible to "heartburn" and so they are advised not to eat spicy food. Most of them still do since they also believe that spicy food "opens the appetite" and is therefore helpful to the woman who is "eating for two". Women say spicy food and pickles (Hadig) are the only kinds of foods which they retain in their stomachs during the early part of pregnancy when they suffer from severe nausea. A midwife suggested that women should avoid drinking soup during pregnancy "or else the child will come down". Other women generally agree that this should be the case but some noted that this precaution

is necessary only in the last month or two of pregnancy.

Pregnant women are not enjoined to avoid specific foods but may themselves crave particular foods during pregnancy. It is said that "if they do not satisfy this craving, the mark (waHma) comes to the child...if a woman craves something and puts her hand on a part of her body and does not eat what she craves, there will be this thing on the same part of the body of the child.". Birth marks are said to resemble fruits ranging from grapes to watermelons, vegetables of all sorts, and even fish. Male informants generally do not sympathize with the cravings of women during pregnancy and describe this behaviour as "faking of women". Women are more sympathetic to this condition. According to a female informant, "when a woman has a craving which is not satisfied, if God loves her and if she craves a good food, God makes her dream about the food at night".

Childbirth

Pregnancy is believed to last for nine months after the planting of the nutfa. It is said that "the son of seven months survives but that of eight does not survive". Women who continue to "get their back" (menstruate) during pregnancy, and therefore do not know when they will deliver, pass under a camel to increase the Talg (labour contractions). After nine months of pregnancy it is said that a woman starts to get pains in her back and in her lower abdomen. A female foetus is said to induce more pain to the mother than a male. During the ninth month, the size of the child and his/her restlessness induces Talg (literally, expulsion). During this time, the descending (head down) position of the child which had started a few months earlier is

reached.

When a "woman's time comes" (i.e., when she is about to deliver), any older woman may assist her in the delivery of her child (or if necessary an experienced woman may deliver alone). It may be her mother, her mother-in-law, her neighbour, or anybody else. Sometimes a midwife may be asked to assist. Data collected from the village birth records indicate that there is a greater reliance on midwives than on relatives and neighbours. Of the 97 infants born during the year 1974, 62 were delivered by midwives, 14 by mothers-in-law, 13 by mothers, one by a neighbour, and 7 by female relatives. The midwife is called upon when no immediate experienced female relative is readily available or if the labour is judged as taking too long[17]. The midwife, always a female, and also an older "experienced" female, is not considered an obstetrical specialist in the strict sense of the word but is viewed as someone who is experienced and willing to share her experience with other women who need her. The village midwives do not expect to be paid for their services but some people give them small gifts in the form of money, food, or soap. The midwives derive prestige for their acts of kindness for which they expect to be rewarded in the after life.

It is said that any woman can become a midwife. There are no special qualifications except that she should be wise and know what it is that she should do. The only requirement for a midwife is that she must be experienced "either on herself or others". Some midwives "inherited" their skills from older relatives; a midwife may train her daughter or her daughter-in-law who is eager to learn and help those who are in need. The village daya's (midwife's) services are limited

to relatives, friends, and neighbours. Informants generally indicate that "anyone can cut (i.e., cut the umbilical cord) for a woman". Midwives agree that they are non-specialists and that indeed their skill can be acquired and performed by any other woman. However, they caution that "sometimes this (the cutting of the cord) may be dangerous because the tying may not be good and if the tying is not good air gets in the stomach of the child through the veins and the child becomes swollen...if this happens no doctor can remedy the child". Midwives also insist that for a woman to become one of them, she must be able to abide by a certain code of ethics. She should never speak of what she sees in a delivering woman's household. A midwife will not divulge the sex of the child she helped deliver to people outside the household. This is of course practiced to avoid potential accusations of having brought the Evil Eye to the family through exciting the envy of strangers (i.e., non family members).

The midwife, in addition to being expected to be experienced, is expected to show that experience by her age. This expectation is reflected in the following account by a female informant:

> When the old daya (midwife) of the health department died, the people at the hospital asked the 'umda to find a replacement for her. They said they want a young woman who would be sent to Kafr El Shikh to a special school for official midwives. No one from our village wanted to go. Who would ever want to go to an eighteen year old midwife who had never had a child herself. Why do you think those doctors at the hospital are so mean to women. They are men and do not know what it is like to be in pain during labour. They even hit the women when they scream during labour. They leave the woman in the room by herself until she "ripens" (i.e. with exhaustion and pain), and then they come in when she is nearly dead.

When asked if it is necessary for a midwife to be someone who has

ceased to menstruate (in light of the belief regarding the effect of menstrual blood on a new born baby[18]). The midwives responded that "it does not matter". Nor do they consider themselves (or are considered by other informants) polluting because of their association with the post-partum bleeding. It is evident that although a woman after delivery is considered nigissa (impure), this impurity is not believed to be transmitted to the midwife.

From the foregoing description, it is evident that the practice of midwifery does not rest on a rigid set of recruitment procedures. Unlike some other medical specialists, divine recruitment is not the general basis for the practice of midwifery. Only one midwife in the village (who is now too old to practice; she is about 84) reported divine recruitment. She described her experience as follows:

> My husband didn't want me to come to the N's house (descendents of Turkish village elites, including the village saint-Sayyida Zinab). After his death I was free to do what I pleased, so I practically lived with them. I loved them very much. One day I found that one of the peasant women was overcharging them for chicken which she sold them. This was during the mūlid (celebration of the patron saint's day) of the Sayyida Zinab and I was very upset that one of banat baladi (the daughters of my village) would dare to cheat the descendants of the Sayyida (saint), especially during the mūlid. I was so upset that I fell unconscious. They transferred me to the inside of the house. I slept. I had a vision of a woman with a giba (robe) and tarHa (hair veil), all in white, and a long rosary with large beads. I found myself surrounded by hundreds of babies. The woman in white, she must have been the Sayyida Zinab. She kept pointing towards the children and waving at me. When I got up and thought about the vision, I knew what it meant. She wanted me to deliver babies. At the time I was about thirty five years old. But although I had only delivered my own two girls and boy, I knew that I had baraka (blessing) of the Sayyida Zinab with me and that would help me in delivering babies.

Another midwife, not claiming supernatural recruitment, related the events which led to her practice of the trade as follows:

> When my mother died, she was a midwife, there was no one to deliver my sister-in-law's child; she always delivered with the legs first (breach). We went for official midwife but when she found the child coming down with his legs, she refused. At the time I was only 17. There was no one to deliver my sister-in-law. My sister-in-law kept getting the Talg and the legs came out but then the Talg stopped. We gave her water with sugar and it started again. Then the rest of the body came down. I used my fingers up to their end to widen for her and the head came down. The daya looked at me and said, 'your eyes are wide although you are only a girl.' I told her 'don't you know that my mother was a daya?'. From that day on, after people heard what I did and when the daya told them about my cleverness, they would ask me to come when a woman was delivering. Because I was so young some people did not believe that I could be so clever and they would ask me to come and bring another midwife with me.

The role of the midwife is realized almost exclusively at the birth event. Women generally do not seek prenatal care from midwives and rarely, and only in recent years, from any other source. As a midwife described her task,

> The midwife does not have much to do with the woman prior to the time of birth. Nowadays many of the women go to the health center when they are a few months pregnant. They go there even though they do not plan to have the daya of the SiHa (the official health center midwife) deliver their baby. They go because they give them migawiyat (strengthening substances). They give them vitamins and injections, and until a few months ago, they used to give them milk and food for the baby after birth. The women go only for these things but at the time of delivery they refuse to set foot in the hospital even if their condition is a little difficult.

During the prenatal period, a woman may consult a midwife (or any other experienced woman) when she first suspects that she is pregnant. The midwife checks the woman's breasts and abdomen for signs

of pregnancy. A midwife may also be called when a woman has a miscarriage. When asked about how she handles miscarriages a midwife answered, "I only tell the woman to rest and not to do any work and to eat well. If she bleeds I report to the 'umda's house and they send for the ambulance. Nowadays the women sometimes go to the health unit if they bleed a lot".

The selection of a midwife to assist at birth is not planned ahead of time. The choice of a midwife is a function of the proximity of her residence to the delivering woman's and of her kinship relationship to the expectant mother. People also refer to selection on the basis of the midwife's tab' (her disposition). When a midwife was asked to enumerate the bases on which she is selected to assist in a delivery, she replied,

> When one of my neighbours is in labour they send for me because I am near and when any of our relatives need help they also call on me. It just comes like that. People here are not like you, they do not plan on who is going to deliver the child nine months ahead of time, everything in good time. People also call on me because they feel the blessing of my presence. They hear that so and so's delivery went fast and easy, so when their daughter is in labour they send for me. They also know that I am capable of living up to the occasion. I am not the type of woman who drowns in a sip of water. When I am there, the mother of the woman can feel secure. They are all under my hands (at my disposal[19]) and they do whatever I tell them.

During the ninth month of pregnancy false labour pains are said to be brought about by odours of fried food (which is ordinarily given in the form of fried eggs to women during labour). A woman who is "has smelled" may get the false impression that she is in labour and send for the midwife. At the time of delivery the midwife may be

called upon for assistance at different stages of the birth process, depending on the length of labour and the assistance available to the mother from other experienced female relatives. A midwife described this variation:

> Some women send for me as soon as there is any sign of pain. But sometimes women will leave themselves to their mother or mother-in-law. But if the mother finds that the labour is taking too long she sends for the midwife. If the midwife finds that the child is coming down with the feet or if she finds that the mother is narrow, she tells the men to call the car (for the hospital).

Midwives may be called early by an over-anxious mother or mother-in-law of a delivering woman. A midwife described her response to this situation in the following manner:

> When they send for me, I go and measure and if all my finger fits in, then I go back home and tell them to give her an egg fried in oil and garlic and then I return after a while for the delivery. I keep feeding her eggs and sugar with water[20]. All this "fires up" the Talg (increases the contractions)[21].

Another midwife described the ensuing phase of delivery as follows:

> When the child comes down I press on the abdomen of the woman to make sure there is nothing left inside. I tie the woman's stomach and with my foot I push the woman's Hal (literally, her condition, meaning her lower private parts) with my foot and I say 'khush makanak lighayit ma yigilak awanak' (go back to your place until your time comes, i.e., until the next delivery). I then ask the woman of the house to prepare Hilba (an herbal tea) with honey and sometimes I ask them to give her ShīH (an herbal infusion). This is to prevent cramps. I also tell them to feed her well...If a woman is kind and generous God makes her delivery easy. The woman who marries older has more difficult births because her bones are harder.

As in conception and pregnancy, differences between males and females are also noted for the delivery phase of body formation. The Talg of the boy is said to be high and that of the girl low. The

pain after delivery of a female child is said to be more intense than that of a boy. According to the midwives in the village, a male is usually born face downwards ("because he is ashamed of his mother") while a girl is born face up.

The terminal part of the birth process is when the khalaS (placenta) comes down. In fact, the term khalaS means end or finish. Sometimes, if the placenta does not come down right away, the midwife "wraps the umbilical cord around the mother's thigh and she then keeps prodding it until it comes down". If the khalaS comes down before the child this is considered a sign of a breach birth or the child is said to be stuck horizontally. In this case, it is said that the pushing by the mother forces out the placenta, and not the child. When this happens, the midwife, or whoever is attending the expectant mother calls for the ambulance and a woman is taken to the hospital in the nearby town[22]. This reliance on the hospital for complicated birth conditions is relatively recent. A midwife remarked that in the olden days she "used to be able to turn the child and make him come down with his legs where they should and his head coming down first." Another midwife noted that she will try to turn the child over only if the woman's family tell her to.

While modern medical care facilities are available to women in the nearby town and only a telephone call from the ʿumda's house bring an ambulance to the door of an expectant mother, women prefer to deliver at home with a midwife from their village[23]. They are forced to go to the hospital only under circumstances of difficult birth. A midwife remarked, "Women have to go to the hospital only when they are

forced to, when they have a very difficult birth and they need to open their abdomen. They complain of the doctors because they are very mean and they make fun of the fellaHin's dirty clothes. They also say, 'do not eat this and do not eat that'. The doctor rushes things; they cut the woman up just to get it over with. The midwife is comforting and takes her time".

The foregoing description of childbirth is based primarily on information from informal interviews with informants. In addition, the author had occasion to observe directly a few births. Accounts of these events are recorded below as these were recalled after each birth attendance.

Case 1

They sent for the midwife after "A" had been in labour for about two hours. Then they sent her younger sister to call me. As I entered the dimly lit stuffy room I saw A standing up being fed a boiled egg (known for its high heat content). Surrounded by her mother, younger sister, paternal aunt and her daughter, "A" was obviously in pain. "M", the Midwife was sitting on the floor bearing her usual beautiful smile and radiating with sympathy and comforting words to "A" and her serene but obviously worried mother. The midwife told me to come and sit near her so that I can see. She sat "A" in the usual squatting position with her feet on two building blocks. As "A" sat supported by her cousin, "M" inserted her index finger "to check if the water bag which is over the head is near". The midwife sighed with relief and said, "thank God", its the head, I felt something hard". "A", still supported by her cousin, got up and started walking around nervously, pulling her hair as the pain of the contraction came. Her mother, her aunt and cousin, and her sister, as well as the midwife, all took turns hugging and kissing her and giving her words of encouragement such as "be strong my love", "I wish it was I who was giving birth", "just a little longer and it will be over my love".

After about ten minutes of intermittent Talg, the midwife inserted her finger again as "A" sat down in a propped position supported by her aunt. She said that there are two finger widths left. "A" kept on roaming the room followed by words of encouragement. She would squat and tiHzag (push) as each Talga came. The midwife encouraged "A" to take each Talga squatting and pushing down.

In another twenty minutes the water bag exploded. The midwife instructed "A" to sit down and they put some burlap sacks under her while her cousin was told by the midwife to support her from the back. The top of the head of the child showed through and with the next contraction the head came through and was received by the midwife with the palms of her hands. The child was facing downward (befitting folk sayings that a boy is ashamed of his mother and therefore faces down). As the child's head started to come through the midwife pushed back against the inner parts of "A"'s upper thighs with her hand to help the head through. As the head came through the body followed, still she continued with this manipulation. Finally the legs came through. It was quickly followed by the khalaS. The midwife put the child in her lap. She measured two finger widths and asked for a knife. "A's" mother brought her a knife and was told by the midwife to hold the other end of the cord while the midwife tied it with a string from her ornamental braids and cut it. She then wrapped the child in a rag that was handed to her by "A's" mother and put it in the ghurbal (a large sieve) which contained salt and bread (symbols of life) and some lentils and fava beams (symbols of fertility) after a short rinsing in a trough of warm water. As the midwife barely dipped the infant in the water, "A's" mother and relatives kept saying "enough", "enough". (In some cases the infant is not bathed for fear of death. It is said that he/she cannot take the shock of the water after being in the darkness and warmth for so long. In some cases the infant's body is simply rubbed with butter and salt.) As the infant was being placed in the sieve the midwife kept reciting Quranic prayers seeking God's blessing, His protection from evil, and taking refuge in His Protection against the Evil Eye.

After the infant was gently put down in the sieve where he will sleep till the seventh day celebration (subu‘), the midwife turned to me and said, "it is halal (blessed) to place the child in the ghurbal, the angels surround it and protect the child". The midwife then turned to "A" and pressed hard on her abdomen "to expel the blood". She then asked for a large piece of burlap which she used to Hafad by placing the cloth between between "A's" legs. She then held "A's" leg and hand, and with her right foot, the midwife pushed against the burlap between "A's" legs to "push and return bit il wild to its original place". In doing this she uttered the standard words "return to your place until your time comes again". The midwife said that the bit il wild comes down during birth and therefore has to be pushed back to its original position otherwise it will cause the woman pain if it is left handing out.

The midwife turned to "A's" mother and said thank God for her safety. She then motioned to me to get ready to leave, but "A's" mother insisted that we stay and have tea. She said that I have baraka (blessing). Attributing baraka to me was understandable in view of the fact that her daughter delivered a boy only about half an hour after my arrival to observe the process of childbirth in her house. The mother then asked, "how do you like the birth of the fillaHin (peasants)?" Before I could answer she went on to say, "She ("A") wanted to register her

name in the health center but I told her not to. Because although they come here to deliver the child, they are too impatient and if the labour takes a little longer they transfer the woman to the hospital. Besides, even if they were to deliver her at home, they would keep asking her to go there every other day until the fortieth day, once to weigh the child, and another time to check him, and if it is not one thing it is another. And who has time for all that".

As "A" lay resting, her face was rinsed with water and her messy hair was tied in the traditional kerchief. She was then seated up and supported by her cousin while her aunt fed her eggs fried in lots of fat so that "she gets back her strength".

Not once during the interval between the reception of the child by the midwife and the time we left did the sex of the child get announced by any of the women in the room. Since I was sitting close by I could see that the child was male. This fact was also known to "A's" mother who said lovingly to her daughter "your effort was well worthwhile, you got a boy. May God have him raised in the shadow of his father and may God give you health my daughter". (The high value attributed to sons is clearly expressed in this statement).

As we got ready to leave, "A's" mother slipped some money in the midwife's hand but the midwife refused to accept it and said "inshallah (with God's wish) after the safety of the arbi'in. As we left, the midwife said do you want me to take the khalaS or will you take care of it. "A's" mother said that she would ask her husband to take it and throw it in the sea (the river). It is said that as the river flows, the child's life will continue to flow. Alternatively, the khalaS is fed to the dogs. Through a form of imitative magic, the running of the dogs is believed to confer longevity on the newborn child.

Case 2

"R" the midwife sent for me and I quickly ran over to her house and we went over to S.E.'s house. It was about seven in the evening. "H" (the expectant mother) was in her room (in this extended family household). Her mother-in-law "S.E." was there as were her resident sisters-in-law and her husband's sister who lives across the street. On this summer evening when the sun sets late, the men had not returned from the fields yet. When I asked the mother-in-law why "H's" mother hadn't come she said, "the older person of us who is present will do, I am like a mother to her too". When I asked one of the sisters-in-law why the expectant woman's husband wasn't there she laughingly said, "men are like that, they do the deed and then leave us when the serious time comes."

I was most surprised to find "F.D." (another midwife) there and I think she was rather disturbed when she saw "R" (the midwife with whom I had come over) whose greetings she ignored. "H" was sitting on the traditional stone blocks, very pale and exhausted with tears running

down her cheeks and yelling, "O my mother, come to me my mother", "O, God for the love of the Prophet spare me O God". "R" asked in her usual authoritative tone how long the Talg had been going on. She got no answer from the other midwife to whom she had directed the question. Instead the mother-in-law answered that it had been going on since the afternoon prayer time (i.e., for about three hours). "H", leaning on her bridal bed in her short traditional slip had her arms around her husband's sisters whom she squeezed as the pain intensified. Her sister-in-law kept saying, "be brave sweet one", "finish, you are almost there, sweet one". The other women also shouted back words of encouragement and sympathy, one of them said, "let's hope he (the unborn child) will remember your suffering for him".

"R" obviously noticed that she was a threat to "F.D." (the other midwife) so she politely, but firmly, turned to her and said, "I am coming to help, please let her lie down, it is not time yet, she is exhausted. Let her lie down and gain her strength, this is her first time, she will need her strength later". It had been about fifteen minutes since we had first arrived and there wasn't one single contraction so I felt that "R's" judgment was accurate.

"F.D." angrily responded that the expectant mother must sit up to "help" because she could feel the child's head only one girat away and the child would come down any minute. "R" turned to the women and screamed, "I said, make her lie down, if not, then you have no need for me". The women quickly obeyed and they transferred "H" to a Hasira (straw mat) on the floor. The first contraction came no less than ten minutes later. In the meanwhile, "R" was obviously in charge. In her usual commanding manner, she ordered some sugar water and boiled eggs (to fire up the Talg) which the women helped "H" consume. Until the contraction came the women's attention seemed to wander away from "H" and they took up several subjects of conversation including their own experience in childbirth and the heavy work they are now involved in this season of planting rice and corn and harvesting wheat.

When the Talga came "R" asked "F.D." to bring "H" to her. With the help of one of her sisters-in-law, she was moved back and told to take the squatting position facing "R". "R" told "F.D." to move towards her right side to catch the child. Suddenly each Talga started coming after the other, as frequently as each three minutes. "R" asked the women to make "H" lie down. When did, "R" uncovered her and put her legs apart. As each contraction came she started to widen for her. Suddenly the child's head came through and was received by "F.D.". She placed the child on the floor on top of a rag while "R" started to apply pressure on "H's" abdomen and forced the khalaS out. "R" quickly got up and said to "F.D." to "cut for the child". "R" later told me that she did not cut for the child so that the people of the house would not feel obligated to give her the traditional gift. As "R" gave instructions to "F.D." she motioned to me to leave. I told the mother-in-law mabrūk (blessed event) and

Hamdil ala salamitha (thank God for her safety) and left with "R" who was obviously in a great hurry to leave. On our way home she expressed her anger at the family for asking her to come when they had already asked "F.D." over. She said that if it hadn't been for the sake of "H's" mother who "is dear" to her, she would not have stayed.

Case 3

They sent for "F.D." after "E", the expectant mother, had been in labour for the whole night. By the time I got there I found the child on the floor. "E's" brother came into the room to give them sugar and water to help expel the placenta. She cried, "O, brother I have another in my stomach". "F.D." started shaking her stomach and she lay down on her back on the floor. She manipulated the umbilical cord ('ing) as she applied pressure to the abdomen. As the placenta fell out "F.D." said "ya satir" (an exclamation mark; she later told me that the khalaS was unusually large).

"E" was giving birth in a room with the windows closed and the door closed. In the room with her were her mother and her sister-in-law. Her brother was out in the main entrance to the house and her husband was in the fields. He had been in the house during her labour in the night.

After the khalaS came down, "F.D." turned to the child as the woman's mother put her daughter down to lie on her back and rest from the squatting position which she had assumed since our entry. "F.D." measured the usual two finger widths (giratin), tied the cord twice with a string from her hair, measured another two girat, and then held one end between her toes and cut with a knife which the sister-in-law had brought over upon "F.D.'s" request. She then took some blood from the cutting of the umbilical cord and used it to "clear her (the female baby's) throat and the roof of her mouth". This practice is followed to "help the child eat well". Another midwife had explained to me that the practice is also followed to prevent rash inside the baby's mouth. "F.D." asked for kuHl in which she dipped her finger and rubbed around the baby's eyes to "help wash the baby's eyes". She then handed the baby over to "E's" sister-in-law. The brother, a young man of about eighteen, came into the room again, this time with dirt to cover the blood which covered the ground. The midwife sprinkled the dirt over the bloody area and then swept it clean. The mother came with a container in which she placed the placenta and took it out of the room. Proper disposal of the placenta is essential. If the khalaS "falls in the wrong hands" (i.e. of people who may take it to a sorcerer), a lot of harm is believed to befall the child. After sweeping, the midwife turned to the delivering woman. As the mother lay resting on her back, she continued to moan and groan and said "who wants children, I was doing to die, I thank you O God". "F.D." later told me that the mother did indeed have a lot to be thankful for, she was too old and older women always experience more difficult births. She said that "her bones are not soft (i.e., flexible) like a young girl".

The midwife bathed the baby's body and tied her head and placed her in the prepared sieve. We were served tea as the mother rested, now not uttering a word but with tears running down her cheeks. The atmosphere was less than jovial. Although no one had said anything, they had all obviously noticed that the baby was a female.

As the midwife got ready to leave she was given a bar of soap as a gift and as we left she said "may she have the safety of the fortieth day."

Case 4

"H" had promised to call me when her labour starts. Her mother-in-law sent for the midwife and her sister-in-law came to call me. When I got there I found "H" sitting in the squatting position and surrounded by her mother-in-law, her husband's sister, and a neighbour. The neighbour told the midwife that the water bag had broken (el garn Tash) while "H" was hugging her sister-in-law and moaning.

The midwife told me that this is the woman's fourth child and she probably does not need to "widen for her" (tewasa'). She sat in front of the expectant mother, and like the other woman yelled words of encouragement. In almost a split second I found the child's head in the midwife's hand. She placed the child on the floor nearby and as the mother remained in her squatting position, the midwife applied pressure on her abdomen and the placenta came out. The midwife then told the neighbour who was supporting "H" to put her down and she asked the siter-in-law to bring a knife. She asked the mother-in-law to help her hold the cord, measured, tied, and then cut the cord. The child was very still so the midwife asked for an onion and put it to the child's nose whereupon she sneezed.

The midwife asked if they wanted her to bathe the child. The mother-in-law said, "no, we will need the soap later for when all the blood comes down. The midwife then proceeded to push up against the delivering woman's birth opening, uttering the traditional "'ud li makanak..." It seemed to me that the mother-in-law was not very happy. I didn't know whether she was disappointed that the child was a girl. The midwife later told me that this was probably the case. The mother-in-law did not act very friendly. She did not even offer to serve us tea. Her daughter tried to make up for her mother's inhospitable behaviour and saw us out of the house while she uttered words of praise to me and told the midwife, "your entry is blessed O, khala (mother's sister)".

C. Body Structure and Function

The terms used to denote the body in FatiHa are gita, badan, and gism. In contrast to the internal body, parts of the external body are well differentiated, labelled, and assigned specific functions. The condition of the external body, like that of the internal body, is believed to influence the general well being of the individual. Thus, body cleanliness is an ideal which is often verbalized by informants and which is deemed necessary for good health. Skin is assigned the function of "breathing" for the body and dirt is said to obstruct this breathing. In reality, the realization of the verbalized ideal of cleanliness is somewhat limited. For while adult males and females may wash their bodies often, their limited supply of clothing forces them to continue to wear the same clothes for several days. Fleas, and, in some cases body lice, continue to live in garments and produce itching and rough skin patches all over the body.

Heavy bathing for adults is done once a week. This is in addition to the usual bathing after sexual intercourse which may be a daily affair for those who pray and must purify their bodies before prayer. Cleansing is done by means of a lufa (a natural fibrous plant) and soap. In the warm months males use the Nile for bathing. Young boys bathe in the river almost every day of the summer months. The mosque has running water and bathroom fixtures and is also often used for bathing by men during the summer time.

The cleanliness of children is not given the same degree of importance as that of adults. Thus, while a woman will regularly

wash up after returning from the fields, she devotes relatively little attention to the cleanliness of her young children. In fact, children may be left looking filthy purposely. This is a preventive measure against the Evil Eye. Women who leave their children dirty may be scorned by their husbands and mothers-in-law and told, "al nazafa min al iman wa al wasakha min al niswan" (cleanliness is from piety and filth is from women).

Personal cleanliness and general appearance, while recommended and idealized by such statements as "al nazafa min al iman" (cleanliness is from piety), is not without socially imposed restrictions. A female informant verbalized these restrictions as they pertain to women, she noted,

> When people see a woman whose husband is away taking care of her appearance they always accuse her of trying to tempt another man. But my mother-in-law doesn't care. In spite of the fact that she is a widow she is very clean and takes good care of her face and eye brows and always bathes and wears clean clothes. Now that my husband is in the army sometimes I am reluctant to take care of my appearance. Women with men far away are expected to leave themselves filthy and ugly so that no one will look at them. But my mother-in-law doesn't care, she says, get up and bathe and change.

The external body is the object of a variety of adornments, the practice of which is valued for its positive psychological impact on the individual. Forms of personal adornment which may be practiced for the purpose of inducing personal refreshment (na' nasha) may also be followed for their medicinal functions. Thus, tatooing (which is becoming less prevalent among peasants in general as they move to the cities and strive for integration into urban life, leaving their distinguishing 'fellaHi' - peasant - marks behind) which is used for

ornamentation of body parts is also a curative procedure. It is an operation which is performed on protruding forehead veins which result from carrying heavy loads. The tatooing is said to relieve the pressure from the vein. The same procedure is performed on persons suffering from poor eye sight. Tatooing on the side of the heat near the weak eye is said to relieve the pressure which causes the "clouding" of vision. Tatooing is also done on small children so that those born to their mother after them will survive. The idea is that a child is rafaS and taHan (knocking with head and kicking). Through a form of imitative magic, this impulse is transmitted to the unborn child which is thus born weak and then dies. Tatooing is believed to suppress the impulse of knocking and kicking thereby insuring a healthy life for the unborn sibling.

Ear piercing is another procedure which has the dual ornamental/medicinal function. For personal decoration, only the ears of girls are pierced. For illness, the upper ears of both male and female children are pierced "to allow the fever in a child's body to escape through this hole". Pierced ears with an earing with a blue bead are also placed as preventive devices against the Evil Eye. The local bedouin medical practioner also cuts notches from the upper ear of children of a mother who has been losing many children. The idea is to disfigure the child so that supernatural spirits will not want to take him/her and he/she would remain alive.

The external sexual organs of both males and females are also the object of ritual mutiliation. Boys are circumcised at any age. The operation may be delayed till the time of special occasions such as

mulid (patron saint's day) either in the village or in the nearby towns. The cutting (aS) is done by the local barber who operates with a pair of scissors and then dresses the wound with some mercurochrome. The female analogue of male circumcision is clitoridectomy which is referred to as Tahara (purification), the same term used to describe the male operation. Girls are usually circumcised at around twelve years of age, "because they are too small before that". In spite of the fact that the practice is outlawed in Egypt, gypsy women continue to perform this operation. Not a single female in the village has escaped this operation. In fact young girls boast of the fact that they have been circumcised, a sign of their approaching adulthood. The operation itself is a very painful one. Excision of the clitoris is carried out with a long shaving blade while women hold a girl's legs apart and restrain the upper part of her body. To enhance the healing of the wound, the gypsy stuffs the wounded area with an onion and salt.

As in other parts of Egypt (Ammar 1966:121; Berque 1957:44), female circumcision is practiced to curtail women's sexual passions[24]. Although clitoridectomy predates Islam and no Quranic reference to the practice can be found (Blackman 1920:280-316; Meinardus 1970:322;325), the villagers of FatiHa justify the custom by reference to the Islamic sunna. In this respect, it is similar to male circumcision which is also explained in terms of Islamic teachings. However, in the latter case, there is no conception of the procedure as a means of controlling sexual desire. For males (who unlike women are not considered lacking in mind and religion), the hygienic function of circumcision is emphasized. It is important to note that clitoridectomy is primarily

a practice to safeguard pre-marital chastity and virginity. Women's right to sexual gratification within marriage is recognized. Since the clitoris is identified as the locus of sexual excitement, the gypsy woman who performs the operation is always cautioned against its complete excision. It is said that women who have been subjected to the complete removal of the clitoris "drain their husbands of their strength". Informants note that for such women, orgasm is delayed. Synchronization of male and female phases of heightened sexual excitement is often brought about by the use of Hashīsh which prolongs sexual intercourse. Women generally report that they enjoy sex and their conversation and joking often centers around this topic.

Turning to the structure of the internal body, it is noted that informants show minimal knowledge of its composition and minimal differentiation of its parts. In responding to questions eliciting their opinion on the most crucial organs of the internal body, some of them responded, "every part is important, God Almighty put every part there with a purpose". While they could not identify these divinely planned and executed components of the human body, informants nevertheless considered all of them ("whatever is inside us") to be essential for survival. Informants were generally in agreement on defining the heart as the most important part of the body. It is said that the heart "makes us breath...If the heart stops for a second, the person dies, the heart is the most important part of the body, it makes the body move...If the blood from the heart stops flowing the whole body stops". The blood, which is said to derive from the heart is thus recognized as the life source of the body. Pulsation (nabD) is attributed to

"breathing and the moving of the blood in the body". The pumping action of the heart is recognized by informants. Using an agricultural analogy, they note that the heart "irrigates (yisgī) the whole body and the veins are the canals (ganawat) which lead to all the parts of the body ...our substance is the heart".

The heart is said to beat equally fast for men and women; it is also believed that the working order of the heart is related to the size of the body. "The heart beats faster and works better for people who are not very fat, if a fat person becomes sad his heart may stop working right away". It is also remarked that "the man who has a good body is tall and fat. Not the fatness of illness but the fatness of strength. Fatness of illness causes the person to go around heaving, the fatness of strength is with the man who is medium sized."

While people in the village generally agree that the heart is the most important organ of the body, some of them are hesitant about this opinion and when asked about the importance of the head would also agree that it is important, "as important as the heart". As a traditional practioner put it, "the head with the brain is the most important part of the body. If the head is not well, the person cannot walk or think anything; the father of the body is the head, the brain makes the other parts of the body work". According to this informant's opinion, the head is "only second to the heart in importance. The heart carries the person."

The importance of the head is explained by reference to its function as a structure for housing the brain (which is believed to be located in a vaguely defined part of the upper head). The importance of the

brain is explained in terms of the fact that "it expresses everything". It is deemed responsible for "thinking and evaluation of different situations", and to it is attributed the "power of concentration" and "making the other body parts move".

Regarding the bones, these are said to "carry the person and make him move". The bones are regarded as "the ceiling of the flesh" or "the support of the flesh". The flesh is in turn said to "protect the bones". "Soft" bones are associated with youth. Here softness implies malleability and young children who fall without injury are said to be capable of sustaining these shocks due to the softness or malleability of their bones. Older persons on the other hand, are endowed with brittle bones, hence their susceptibility to permanent handicaps resulting from injuries to their bones. Bones are differentiated from muscles. The bones are considered "only the structure of the body". The muscles, on the other hand are said to "enable the person to do hard work". The strength of men's bodies is attributed to their possession of more muscle than women and their bones are also said to be bigger and stronger.

Other named body parts include the stomach with its intestines all of which are associated with the function of digestion. The proper functioning of the stomach is associated with the kinds of food which are eaten. Men, who contrary to religious stipulations, drink beer, justify their behaviour by noting the beverage's medicinal function. They say, "it is good for the digestion, it is like coca-cola...we drink it after a heavy meal".

As is the case with other structures of the internal body, informants

reveal minimal knowledge of the composition of the reproductive system. Midwives in describing it say, "bit il wild is inside us under the area where menstrual blood comes from and under this is the opening for the water (urine) and then under it is the thing (i.e., the vagina)."

Recognition of internal body parts extends to the chest (sidr), the liver (kabid), the kidney (kila), the gall bladder (marara), and the spleen (toHal). Of all these, only the function of the chest is elaborated. Informants link the lungs (rīa) with breathing and they recognize malfunction of the lungs among people who suffer from the "sickness of the chest" (T.B.). The other organs are vaguely connected to the digestion of food. In this regard, the function of tasting is attributed to the tongue which is also associated with speech. Finally, hearing is attributed to the ears but no understanding of the mechanism was given by informants. The process of hearing, like that of seeing, smelling, and feeling were all attributed to the power of God. In responding to some of the author's questions, informants sometimes responded jokingly by saying, "what do you think we are, doctors?". Informants, including traditional medical practitioners, consistently conceded to physicians superior knowledge in understanding the functioning of internal body parts and the relation of these functions to illness of natural etiology.

Proper functioning of the body (beyond supernatural causation), and, by extension, proper disposition (i.e., psychological state)[25] are generally considered to be greatly influenced by nutrition. Good nutrition[26] is regarded as essential for the functioning of the body. Lack of proper nutrition is said to cause weakness to the body[27].

People say, "eat well eat something tisnid galbak (to support your heart) i.e., to keep you strong[28]. Thus, it is recognized that good food is an important basis of good health. It is said that "when you eat something good, the heart is supported and therefore the whole body is supported."

Food is viewed as necessary for any activity involving the expenditure of energy, ranging from work in the fields to childbirth to sexual intercourse. Women when taking their husbands' lunches over to the fields at noon time say, "I'll take him a bite to support his heart". Following the same logic, a woman after birth is ideally fed "good food, particularly meat and chicken". This feeding routine is prescribed "because a woman's strength is destroyed during childbirth." Similarly, a new groom who is expected to be expanding a large amount of energy in sexual intercourse is advised and actually given food to "support him because he tires out". A new bride, by contrast is not said to be particularly needing of good nurishment, people say jokingly, "she is well fed". Thus, energy to the body is viewed as being supplied to the body in forms other than ingested food. In this regard, it may be noted that peace of mind is believed to have the same positive effect on the body as good nutrition.

Food habits, in addition to their above noted connection to health, also have implications for social status and power differentials within the family. In households where women are independent of supervision by older females, they admit that they eat better than their husbands. In extended family households, on the other hand, the mother-in-law and adult male members eat first and are followed by junior women and

their children. While women are said to consume a larger amount of food "because they nibble a lot" while they are at home during the day[29], the choice foods (e.g., meat, cream, baked rice, milk, and eggs), when available, are offered first to male members of the household. In some extended family households, two types of bread are baked. The "better quality" type made with "good white flour" is served to the mother-in-law and her sons. The less valued bread containing whole wheat, corn flour, or ground Hilba (fenugreek) is served to the junior daughters-in-law and their children. In such an extended family setting, the valued food is served by the mother-in-law who passes out shares. In doing so, discrimination between males and females and between favoured and not so favoured daughters-in-law and their children is openly practiced. Female informants note that when they complain to their husbands about their mothers' blatant mistreatment, the husbands defend their mothers and say, "if you don't like it here, why don't you go and eat somewhere else". Women who can find a sympathetic, generous relative may in fact go and "fill (their) stomachs" at his/her house. People in the village often joke about mothers-in-law's control over food distribution. They tell a daughter-in-law, "never mind, tomorrow (meaning someday in the future) you will be with your husband and children" (i.e., in a separate household). When that phase of the developmental cycle of the family arrives, food sharing is more egalitarian, but the distribution of high quality food is assigned to the husband in the nuclear family. This privileged task passes on to the woman at a later phase of the developmental cycle of the family when she in turn acquires the honoured status of mother of married sons.

Preferential feeding practices are also noted for children and young adults. Boys are generally better fed than girls. It is known that mothers secretly give food such as eggs, butter, and cream to their sons. Young girls accuse their mothers of doing so. Older women rationalize this differential treatment and note "a woman does this because she knows that in the end she will live with him (her son) and under his mercy". Older women themselves, when complaining of the maltreatment of their sons will refer to their ingratitude "in spite of (their) sacrifices (for them) in food and drink".

In addition to attributing importance to food as a way of maintaining a healthy body, the villagers of FatiHa rely on certain stimulants to maintain a "healthy disposition". Tea and cigarettes, and to a lesser degree, Hashish are used, particularly by men, for the purpose of "straightening the head" (ʿadl il dimagh). Among men, miʿassil (tobacco saturated with molasses) is used in the guza (water pipe). Whenever possible, Hashish (which is very expensive and well byond the means of most peasants) is used. The woman may prepare the guza and takes the first puff (presumably to ensure that it is in working order) and then passes it on to her husband. When men congregate for Hashish smoking, participants contribute food, sugar, and tea. The atmosphere is jovial and relaxed[30]. The gathering is usually of men. The wife of the household head (usually in a nuclear family) may, on her husband's request, join the group. But if she finds that their behaviour is too vulgar, she may leave the room[31]. Nishug (ground spiced tobacco) is also used for mazag (proper disposition). Sniffing of this mixture stimulates the nasal linings and causes sneezing.

This mixture, when used by females, is employed by older women. Older female informants, who sometimes also use cigarettes, justify such uses by reference to the medicinal efficacy of these substances in the treatment of low level illnesses such as headaches and watery eyes. Men do not find it necessary to put forth such justifications.

From the initial stage of body formation, conception, one notes in informants' statements regular reference to supernatural power and the use of analogies related to agriculture in their description of the human body. The same holds true for death. A typical description of death states that "This is all in the hand of God. The ruH (life force) of the human being comes from God. God sends an angel to take a person's ruH when the time comes. Everything is in the hands of God. We are like plants, the one which ripens is cut off. The person whose leaves fall off, dies". An elaboration on this analogy states that "All the names of people are in a big tree in heaven, the ones whose leaves fall die forty days later". After death, the ruH is said to depart from the body, and from that instant on, everything human about the body is lost. With this loss occurs the suspension of rules applied to the wordly interaction of males and females. Men recognize the power of, and give reverence to, dead female saints; dead men and women may be buried in the same grave yard. While a man is buried in his family's graveyards, a woman may be buried in the graveyards of her father's family or that of her husband's. The location of graveyards outside the village residential area is said to be designed to prevent the diffusion of foul odour. In addition, informants note that in case of those who die of unnatural deaths (e.g. murder or suicide) their

spirits are potentially harmful (causing illness and death) to others and so the further away the graves are located, the less likely that the spirits would wander into the village and cause harm.

The preparation of the corpse is a religious ritual followed for both females and males. There are no specialists who perform this ritual but some people are known to be experienced in this procedure and may be asked by the family of the dead person to help. One such person, in expressing the deep respect for the dead, noted, "I would never refuse such a request. It would be Haram (offensive to God), even if the dead person were my biggest enemy". The procedure for preparing male and female corpses for burial are identical. The only difference is that males are washed by men while females are washed by women. The preparation of the body for burial was described by an informant as follows:

> After death the man is given ablution then they wash his right arm with his right side. The same thing is repeated for the left side. Next his anus is washed. Then the whole body is washed. He is then picked up to a sitting position and told, "this is the day of the meeting. O, slave of God". Then the body is purified with water and sprayed with cologne (if available). Now he is considered ready to meet the angels in this clean state. Next, they stuff all the openings of the body, the eyes, ears, everything and clasp his hand on a kerchief. They then wrap him in clothes and dress him in undershirt and an undershort. They then cover all his face. If the family of the dead cannot afford to buy these needs, the whole village form a ta'awin (cooperative). Then he is wrapped in the kafan. If he is rich the kafan is made of shahi (satin-like material) and silk. If he is poor, it is only the white cloth which is the sunna. The kafan has a belt which is tied by the son, if he has no sons, it is tied by the daughter.

It is interesting to note that this action of tying by a son is something that both men and women request from God throughout their lives. People in wishing well to others will also say, "may God grant you

a son and he would tie your kafan (burial wrapping)". People pity a person whose kafan is tied by a daughter. In lamenting the life of a dead person they may say, "not even a son to tie his kafan".

After the ritual preparation of the body, the corpse is placed in the khashaba (wood) which is then transferred to the mosque or in the fields where prayers are performed. The khashaba is followed by a procession of men only to the graveyards. If the dead person's family is relatively well off, they set up a tent where prayers are conducted and food is served. In any case, recital of the Quran always takes place at the time of burial. As life begins with calling the name of God, it so ends. The human body, from its formation, through its growth, deterioration, and death is perceived by the people of FatiHa as destined by "the Will of God". In answering the author's inquiry about the cause of death, informants respond, "It is His command, just as he creates us, he takes us".

D. Body-Environment Interaction

From the foregoing account of villagers' perception of the body's structure and functions, it is evident that minimal elaboration characterizes informants' knowledge of the composition of the internal body. In FatiHa, the body is perceived, not as a system of integrated parts of well defined functions, but rather as a complex mysterious reservoir which apprehends and experiences the effects of the natural, supernatural, and social environments of an individual. The body and the mind are regarded as interdependent components of an integrated

system, the proper functioning of which surpasses its own structure and depends on the articulation of that structure with both the natural and social environments. Just as villagers do not perceive themselves as individuals, isolated from a social sphere but as part of social units (especially a kinship unit), they do not regard their bodies as insulated, self-contained structures. The proper functioning of the body is not independent of its surroundings nor is it determined simply by an individual's attempt to maintain his/her body parts in working order. As will be evident in our discussion of illness theory in the next chapter, illness causation rests primarily on body-environment interactions. Thus, it is said that, as in the case of plants, too much heat from the sun and too much moisture may cause debility of the human body. Similarly, social events are said to affect either the general condition of the body or specific parts or substances in it. This belief is given linguistic expression in such saying as "itSafa dami" (my blood was drained - due to fright), "dami harab" (my blood disappeared - on being startled), and "yifga'il narara" (bursts the gall bladder - causes frustration)[32].

The social behaviour of individuals is also expressed in terms of the condition of their bodies. Of a wicked person, it is said that his heart is like rock (galbu Hagar), or his heart is black (galbu iswid). A kind person is said to have a white heart (galbu abyaD). The expressions "his eye cannot be filled" ('inu fargah) and "his hand is long" (idu Tawila) are used to refer to a greedy person and to a thief, respectively. Of an insensitive person it is said that "he has no blood" (ma'andihush dam) and in describing a person whose habit

cannot be changed, it is said that "it is in his blood" (ʿada fi damuh). Similarly, idiomatic expressions referring to body parts are used to express social relations and feelings between individuals. A person is said to be "feeling the pulse" (yigis il nabD) of another when trying to sense another's opinion or feelings about a certain issue. The expressions "inside my heart" (guwa galbi), "the hearts are with each other" (il gulub ʿand baʿdiha), and "I love him like the pupil of my eye" (aHibu zay Habit ʿini) are complimentary statements which villagers exchange regularly. Expressions of hatred such as "a strike in his heart" (Darba fi galbu) and "may his body be poisoned" (yisim badanu) are also verbalized by villagers. In addition, intimate relations based on kinship ties are also expressed in terms of the body or exchanges between bodies. Thus it is said of those who are of "one's flesh and blood", that they will always be dear, no matter what differences arise, since "blood can never turn into water" (il dam ma yibgash maya) and of their offsprings, mothers say "the pain that he feels I feel" (il wagaʿ ili yiHis bih an aHis bih).

Just as the body is believed to be affected by the natural environment and social interactions, it is also believed that bodily substances have a reciprocal effect on the natural environment and on culturally significant social events. Attributes of the body itself either in the form of natural substances (e.g., semen, blood) or powers (e.g., the Evil Eye as will be discussed in the following chapter) are also believed to affect elements of the natural and social environments which surround the human body. Thus, through a form of imitative magic, women's state of infertility during menstruation is transmitted to

plants in the fields and they in turn wither away and die. Similarly, a menstruating woman coming in contact with bread dough will prevent it from rising. Body substances, including human excreta and human sweat are believed particularly potent in their effect on social relations and are used in the practice of sorcery. Women therefore guard their menstrual blood lest it may harm others or lest others may use it to harm them. The placenta is also believed to be infused with supernatural powers which may be harnessed to harm its owner. Similarly, semen from a man may be collected by his wife and given to a sorcerer who would insure the husband's impotence with women other than his wife. In addition, the curative effect of a nursing mother's milk (which symbolizes life) is recommended to infertile females and is reflected in the procedure of dropping a few drops directly from a woman's breast into a person's infected eye[33].

Some bodily substances are recognized as being particularly dangerous to elements of the social environment. The idea of ritual pollution (nagasa or zafara) attaches to social interactions after sexual intercourse, during menstruation, and after childbirth. In the case of sexual intercourse, both males and females are considered polluting and bathing is necessary to rid the couple of this state. It must be emphasized that the state of pollution of a man after sexual intercourse is not attributed to his contact with his wife as such but to the act of intercourse itself which causes the woman herself to be polluting. In fact, a man is considered polluting if he ejaculates without engaging in sexual intercourse. Moreover, it must be stressed that after sexual intercourse a woman and her husband are not considered

polluting to each other and they may engage in several acts of intercourse after ejaculation. Their polluting power gains significance only in a social context. Both men and women must purify themselves before prayer, before fasting, and before engaging in any social activity which their state of pollution may affect. As in other parts of the Middle East (Granquist 1947:60), a woman who is impure from sexual intercourse prolongates the labour of another woman and delays the birth of her child. A female informant recalled her experience in such a situation. She remarked,

> My labour pains had already started and I had eaten two eggs to increase the Talg, I felt the head of the child. But when my mother-in-law came in, the child went in again because she was polluting (nigisa). But as soon as she left the room the child fell out.

When asked if a male who is polluting from sexual intercourse would have the same effect, the informants noted, "what would bring a man to a place where a woman is delivering"? When pressed to answer the question on the assumption of a hypothetical situation where a man's presence was actualized, they responded, "il nagasa nagasa" which implies that impurity is impurity whether it comes from a man or a woman.

Nagasa associated with menstruation is also considered to be potentially harmful to people. It is said that menstrual blood may be used as a poison which brings about gradual death to both men and women when ingested. The effect of menstrual blood on humans is no less damaging than its effect on plants. Intercourse during menstruation or during the period after childbirth when a woman is bleeding is also said to cause a man blindness and/or severe pains in the back.

According to some informants, a man may also suffer severe pains in the stomach. In explaining this effect of menstrual and post-partum bleeding, an informant noted,

> After delivery the woman is impure (nigisa) because she bleeds. The blood smells bad and it has left overs from delivery[34]. Men here are not like the bandar (the urban areas) they have sexual intercourse with their wives during menstruation and some also have intercourse with their wives after childbirth. In both cases he himself gets back pains and his smell is like that of bad blood and it lasts with him for forty days (the same period as the bleeding of women after birth is expected to last). The smell of the woman is transferred through his ʿura (sexual organ) to the man's body.

The above statement clearly reveals the belief in the communication between one body and another. The pains, including backpains which a woman experiences during menstruation and after childbirth and the smell of her impure blood are said to be transferred to the man during sexual intercourse[35]. These facts have direct bearings on the interpretation of ritual pollution of women as an index of their inferiority. The people of FatiHa do not regard women's menstruation or bleeding after birth as justifications for women's inferiority. By the same logic, they do not regard men as inferior when they are polluting after sexual intercourse. Bleeding, like ejaculation during sexual intercourse, or during males' "dreaming", are regarded as natural attributes of the human body. As Faithorn (op. cit.) has remarked for the Kafe of Highland New Guinea, these substances are regarded by the people of FatiHa as symbolic of life-producing forces, the misuse of which has harmful consequences. These substances are seen as the charge of those from whose body they derive and these individuals, men and women alike, are held responsible for protecting society from their harmful effects.

In this regard, it must be stressed that both men and women are considered polluters. Moreover, men are not the only victims of pollution derived from women and neither is the effect of pollution confined to sexual encounters. Men who experience sexual excitement and ejaculation during their sleep, without any contact with a woman, are expected to purify their bodies prior to prayer and fasting in the same manner as those who have engaged in sexual intercourse. In this regard Faithorne's work in New Guinea and her criticism of male anthropologists' obsession with female pollution is applicable to the present research locale. She writes,

> One problem has been that anthropologists...have focused their attention on women as polluting agents rather than on the substances that, out of proper context, can be polluting. Thus, they have not systematically identified what these substances are, or where they come from. The point is that menstrual blood, blood lost in childbirth, the placenta, semen...are not inherently polluting, rather they are extremely powerful substances that may be dangerous if not carefully controlled...Because of their biology, women are potentially more dangerous more of the time than men during their sexually fertile period of the life cycle. However, this does not diminish the very real danger posed by men as well.

In FatiHa, the harmful effect of menstrual blood is believed to extend to bleeding in the post partum period[36]. After child birth the woman is considered <u>zifra</u>[37]. The ideal of confinement of women after birth (practiced only in families whose economic resources permits the temporary release of women from their work obligations) is exercised, not simply as a way of protecting others from her contaminating power (<u>nagasa</u>), but primarily as a method of protection of a woman and her new born baby, both of whom are said to be particularly susceptible to the Evil Eye. As one informant put it, "people like children

and they envy (give the Evil Eye to) the woman who has them and to her child". Confinement of women after birth may be regarded as a means of safeguarding them against the possibility of kabsa which would result in their sterility. Moreover, during the period after childbirth a woman is believed to be particularly susceptible to evil and illness. It is said that "a woman's grave is open until the fortieth day" (after delivery). During this time a woman is considered weak and in need of rest and good food. She is advised to avoid drafts and chills which may allow cold and moisture to enter her body at this stage when she is considered "tender" (Tariya) after childbirth.

While the belief in women's polluting power during menstruation and after birth has been noted in studies of the Middle East (Blackman 1927, Granquist 1947, Shiloh 1962, Fuller 1961), there is another dimension of this belief which has received minimum elaboration (Ammar 1961). Although a woman in the post partum period may indeed be regarded as impure and may be expected to cause harm to others, it is also believed that a woman herself is considered particularly weak and susceptible to illness for forty days after birth. Confinement, then, may be regarded as a culturally sanctioned rest period when women are relatively well fed (ideally on chicken and other animal protein) and are the center of attention. The practice of isolation of women (when actually put in effect) may be regarded (as it is by the peasants themselves) as a culturally prescribed ritual designed to enhance the restoration of a woman's normal state of health after what is regarded as an experience which is described as "destroying the body" (yihid il badan).

The belief in the necessity of women's confinement for a period of forty days after birth expresses an ideal which is seldom practiced among the poor peasants of FatiHa. It is only relatively wealthy women who can abandon field work and housework for a long period of time. Mothers-in-law will otherwise not tolerate "laziness" on the part of women who have recently given birth (especially to female children). Junior women are expected to do their chores in the field and elsewhere. This is in spite of the belief that the blood of birth, like menstruation is a cause of stunting the growth of plants and spoiling baking and cooking. Women who feel too weak to complete these tasks may themselves stress their potential polluting and harmful effect on young farm animals and plants in the fields. But mothers-in-law will not accept these "excuses" and refuse to accept "such nonsense" when there is work to be done. Rather than being considered as an index of female inferiority, post partum isolation should be regarded as an efficacious, health improving practice. It should be perceived as a custom which provides culturally sanctioned dispensation from the back breaking work of cultivation at times of women's lives when they are considered prone to illness or even death. In fact, the practice of the ideal of menstrual and post partum isolation of women is regarded as a status symbol by the people of FatiHa themselves.

Through participant observation and structured interviews conducted in the village, it became evident that deviation from the ideal of isolation of women during menstruation and during the post partum period is largely a function of women's socio-economic status. Women in relatively wealthy households (hh) express their belief in

the ideal of segregating women from the productive functions of agriculture, cooking and baking, and from sexual intercourse, to a greater degree than do their counterparts in economically less privileged households. Mothers-in-law in households of higher SES recommend isolation of their daughters-in-law and pride themselves on being able to do so. The practice of the ideal of menstrual and post-partum isolation is indeed a status symbol. Isolation of women in these cases, as in other forms of female confinement, e.g., purdah, may be regarded as an index of privatization associated with the accumulation of wealth, private property, and private production (Sacks, op. cit.; Brown 1970, Morsy 1972:72). This assumption is borne out by data collected in the course of structured interviews in which the adult female occupants of a stratified sample of 100 households (hh) in the village were asked to express their own practices and recommendations to other women in their households regarding menstrual and post partum isolation. The results of this survey are summarized in Table 4.1 and diagramed in Figure 4.1. The percentage frequency distribution charts indicate that degree of menstrual/post-partum isolation, rated on a scale from 1-3 is directly related to the socio-economic status (SES) of the hh which a woman occupies. In this scale, 1 indicates the highest degree of isolation involving abstention from sexual intercourse, baking, and getting in contact with plants; isolation degree 2 indicates avoidance of sexual intercourse and plants; isolation degree 3 avoidance of sexual intercouse only, but since very few informants readily admit to engaging in sexual intercourse during menstruation or during the post partum period, a rating of 3 may also indicate no isolation

Table 4.1. Percentage Frequency Distribution of Isolation Ratings According to SES.

HH SES	N	Isolation	% Frequency Distribution
1	16	1	56.2
		2	18.7
		3	25.0
2	11	1	36.6
		2	27.2
		3	36.6
3	85	1	7.0
		2	51.7
		3	41.2
4	20	1	5.0
		2	30.0
		3	65.0
5	38	1	0
		2	10.5
		3	89.5
6	16	1	0
		2	0
		3	100.0

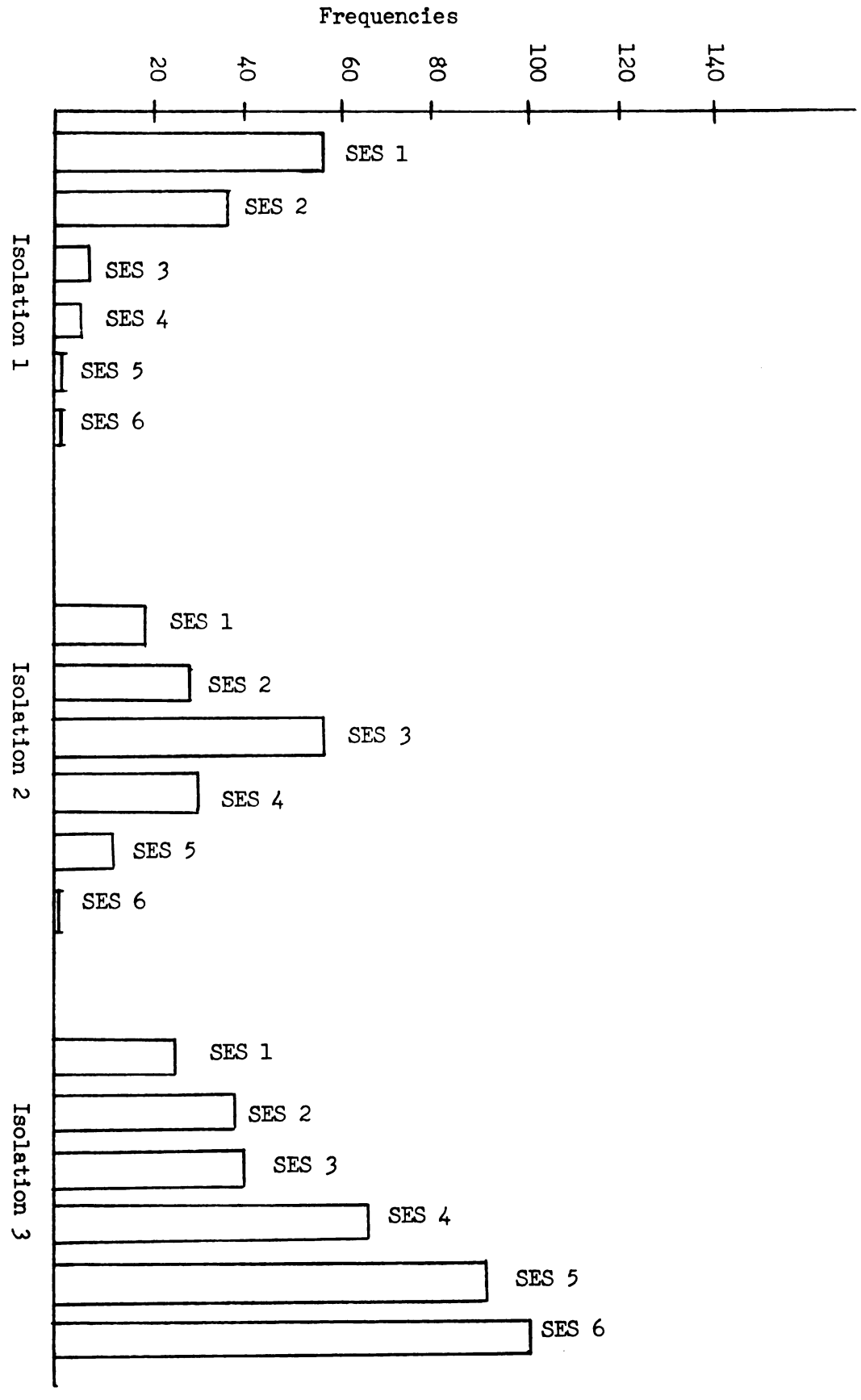


Figure 4.1. Variation of Menstrual/Post-partum Isolation According to SES.

at all. SES 1 indicates the highest land holding, SES 6 indicates the lowest.

In the Middle EAstern literature, it is only recently that a serious attempt has been made to explain the prevalence of menstrual and post-partum taboos. In reference to the isolation of menstruating women, Shiloh notes, "...It is understood that this isolation of these restrictions function ideally within the society possessing an extended family" (Shiloh 1962:282). Contrary to Shiloh's assumption, the custom is also reported in adjacent areas to the Middle East in Mediterranean Europe where extended kinship units do not prevail. Moreover, Shiloh makes no attempt to correlate specific structural features of the extended family with the maintenance of the custom. He implies that the isolation of females is possible when others are available to take over their tasks. It may be argued however, that it is the SES of an extended family unit rather than its physical structure which allows the sacrifice of female labour. On the basis of participant observation and structured interviews in the village of FatiHa, it is hypothesized that enforcement of rules of isolation of impure women would prevail in families whose livelihood is based on private production and whose members appropriate sufficient surplus to make female labour dispensable. In this case, potential surplus value derived from female labour is sacrificed for culturally valued social prestige and family honour.

In concluding this section, it must be stressed that ideas about ritual pollution in the village of FatiHa show that substances associated with both females and males, out of proper context, are thought to

be dangerous. Moreover, it should be noted that pollution, whether it pertains to a male or to a female, is not simply dangerous to others. It is advised that ritual cleansing be undertaken also for hygienic purposes. Hence the emphasis on male circumcision, which, like bathing after ejaculation, sexual intercourse, menstruation, and post partum bleeding, is considered a measure for maintaining Tahara (cleanliness). The process of purification is not simply regarded as a means of ending the body's danger to others but also as a way of maintaining the body's own cleanliness and health.

NOTES

[1]The beliefs described in this Part of the Dissertation apply to the general shared knowledge among the villagers of FatiHa. Where meaningful differences in understanding exist between males and females, midwives and non-specialists, healers/diagnosticians and non-practitioners, this will be indicated at the appropriate junctures. Some quotations in this part are composites of representative statements made by informants.

[2]Sexual intercouse is deemed necessary for the occurrence of conception. When asked about Virgin birth informants noted that "if a woman does not unite with the man, she never becomes pregnant". An older informant who is familiar with the Quranic narrative of the Birgin birth of Christ cited this as an example possible only "for prophets, by the command of Allah".

[3]Menstrual blood is generally believed to originate in the back of the woman. The word for menstruation is dahrī, meaning "my back".

[4]Ideally, sexual intercourse during menstruation is prohibited. This prohibition is given religious sanction. Deviation from this idea is recognized by the villagers who concede that "the peasants are ignorant, they don't follow the word of God". When conception occurs during menstruation, the child is said to always be born with a skin rash.

[5]The difference in knowledge between midwives and lay individuals was explained by the midwives themselves by reference to knowledge which was passed on to them from older relatives, some of whom were official midwives. Around the turn of the century there was a program in rural Egypt to train traditional practitioners, including barbers and midwives under the supervision of practicing physicians and certify them to practice in the rural areas. Since the period after World War II, with the increased, and in the opinion of this author misplaced, emphasis on modern medicine, such programs have been terminated and the surviving knowledge from the earlier trainees is rapidly vanishing.

[6]In spite of the importance which is attributed to the male bizra, it is the wife who is implicitly, if not explicitly blamed for the birth of a daughter. A disappointed husband, although recognizing that "it is the will of God", may add, "she is the one who is carrying it". The oldest midwife in the village recalls a time when village women "thought they could interfere in God's will by spreading themselves from the inside with lemon juice so that they become pregnant with a son".

[7]As mentioned earlier, this condition is treated by the use of the marwad, a long iron wire wrapped with wool and soaked in an extract of herbs and used to cover what is referred to as "the face of the vagina on the inside". Some women said that they would never subject themselves to this treatment because they had heard that it may cause excessive bleeding which results in death.

[8]After sexual intercourse a man and a woman are considered in a state of ritual uncleanliness, nagasa. Bathing from head to toe is necessary for restoration to a state of ritual purity (tahara).

[9]The valuation of children in village society makes women to to any length to counteract their barreness. A practice, not carried in the study community, but by no means unknown there, was described in a national newspaper as it occurred in a nearby village. El-Ahram (December 9, 1974) reported the story of a woman who in her desperation to become pregnant followed the recommendations of a traditional medical practitioner and stole the corpse of an infant from a graveyard. Bathing in water in which a child's dead body is washed was suggested by the practitioner as a means of neutralizing the desperate woman's barreness. Unsympathetic towards the "peasants' ignorance", the local police arrested the "suspect".

[10]Although the peasants of FatiHa and midwives recognize the practicality of contraception, it is generally believed that the number of children that any given woman may bear is pre-ordained by supernatural power. It is said that "...the children to the mother are like bunches of grapes with God. It is already decided how many children she will have when she is born".

[11]As a resident physician in one of the rural health units outside of Cairo, a friend of this author noted that she came across numerous cases of erosion of the cervix as a result of women's use of aspirin which they insert up their vagina prior to intercourse. The physician remarked that the women preferred this method to birth control pills in spite of her warnings. They said that it is better than swallowing something which they did not know anything about.

[12]Other informants regard the placenta simply as a protective envelope.

[13]As noted in an earlier chapter, a man's right to the sexual services of his wife is indisputable. This right remains valid throughout the period of pregnancy. One midwife is referring to the "animal nature" of male peasants noted that they do not observe the religiously prescribed abstention from sexual intercourse during menstruation and postpartum bleeding. She went on to relate a story where a man went so far as to assert his right to the sexual services of his wife when she

was in labour prior to the birth of her child. None of the other informants confirmed such an occurrence. However, informants, including women recognize men's insistance on unobstructed, continuous access to their wives' sexual services as indicative of men's power over women. The linguistic expression of the act of sexual intercourse is also used to denote superordinate-subordinate power relations.

[14]Informants emphasized these differences outside the context of the author's questioning about pregnancy and the human body. They point to such differences in ordinary conversation to stress their belief that male-female differentiation in social roles are natural (tabó) In pointing to women's secretive character they note that a male child. is light and turns at the fifth month of pregnancy but a girl is heavier and does not turn until the sixth month.

[15]Mothers, later on in life, refer to this belief to account for the differential feeding of male and female children. A boy is said to require more nourishment to make up for his frailty during pregnancy.

[16]An informant noted, "if a woman is pregnant and does not want the child she lifts very heavy things and suppresses her breathing or she may climb a high wall and jump. She may also drink a laxative. Tar and feathers are heated and the woman sits over the vapour coming out of them, I pushed a child down this way once".

Abortion is socially detested and there are supernatural sanctions which are cited to deter women who want to practice it. In addition to the "Wrath of God", a woman who intends to abort is made fearful of supernatural beings' revenge against her living children. It is said that supernatural subterranean spirits would make a woman's surviving children ill or even kill them.

[17]The actual time does not seem to be the critical factor which influences this decision. Judgment is made on the basis of whether the birth is the woman's first and on the basis of "her general strength".

[18]Midwives, like other informants refer to the harmful effects of a menstruating woman on a newborn child. They say that "if a woman who is menstruating looks at a baby, he becomes listless and yawns until he grows up. He remains this way until his brain grows and sometimes he remains this way even when he is full grown.

[19]The author's observations of the birth process confirms this statement. In the presence of the midwife, all other women, including older ones are subordinate to her directions.

[20]Another midwife disagrees with the administration of water to a woman in labour. She attributed the death of a village woman during childbirth a few years ago to a "midwife's ignorance", the midwife attending that birth had given the expectant mother water while the placenta was still inside her. According to the midwife informant, "the khalaS swam up to her heart and suffocated her."

While this midwife disagrees with giving water to a woman in labour, other informants and this author's observations confirm that it is a widely accepted practice.

[21]Midwives do not use any special herbs during delivery.

[22]Maternal deaths from childbirth are very low in the village of FatiHa. According to the village death records, the most recent case occurred five years ago.

[23]The services of the midwife of the Health Department are also available to village women, but are almost never utilized. This official is informed by the delivering midwife or by the village clerk to register the birth of a new child. The official daya only sees the mother sometime after birth to examine the child.

Women shun the midwife of the Health Department. It is said that women prefer bint balad (daughter of the village). They relate their experience with midwives who are outsiders and express their distrust of them. They say, "we had a woman in the village with training (by the Health Department) but no one liked her, her entry is misfortune. She was very ugly (something that a pregnant mother would certainly avoid looking at lest her child turn out ugly). People used to call her after the child was born. They had to tell her because she was the only one who could register the child with the government".

[24]Research Egyptian physicians indicates loss of sexual sensitivity in women who have been subjected to clitoridectomy (Meinardus 1970).

[25]According to a village proverb, "al ʿagl al salīm fi al gism al salīm" (a healthy mind in a healthy body). This statement reflects the absence of body-mind dualism among the villagers of FatiHa. The body and the mind are regarded as interdependent components of an integrated system, the proper functioning of which surpasses its own immediate structure and depends on the articulation of that structure with both the natural and social environment of an individual.

[26]Good eating is usually described in terms of amount of food consumed. This is not to say that different qualities of foods are not recognized but it reflects the villagers reliance on standard staples with minimal variation in quality.

[27]The body's production of natural substances ranging from nursing milk to semen, to menstrual blood, is said to depend on nutritional status. Aging women attribute the cessation of menstruation to weakness of old age. A "good" flow of menstrual blood is attributed to heat in the body, which is said to derive from good food and physical strength.

[28]This statement, in addition to reflecting the significance of proper nutrition, also refers to the importance of the heart as a crucial organ of the body.

[29]Women are accused of (and admit to) sneaking food on any occasion they can. Some women, in complaining about their mothers-in-law's stinginess openly admit to friends and relatives that on market days they buy food and eat it before getting back to their homes.

[30]In Egypt, popular jokes, including those alluding to political matters, are known to originate in such gatherings of Hashashin.

[31]Hashish is known as an aphrodisiac. Women say that it makes a man "like a bull".

[32]It is interesting to note that it is said jokingly, that women have seven gall bladders (marara). This denotes that they can withstand a lot of frustration. They are said to be able to cause frustration to others who cannot reciprocate effectively.

[33]It is interesting to note that for purposes of social welfare the traditional modesty of women may be temporarily suspended and women may practice this curative procedure on males without any sense of shame. Similarly, a woman may expose her breats without any inhibition to nurse her child.

[34]The belief in the ritual pollution of women after birth extends to animals. The water buffalo of a peasant died about a week after giving birth. A female informant expressed her reluctance to aid the animal's owner by buying some of its meat. She said that the gamusa is considered zifra for forty days after delivery and people should not eat its meat. A gamusa which is killed prior to this period is considered Tariya (the same expression used to describe women after delivery) and its whole body, like a woman, is said to be "opened", i.e., the bones are not tightly held together as a result of the expansion of the birth area and the tremendous physical effort involved in birth. The meat of the gamusa which is Tariya is believed to cause diarrhea because its meat is zifra.

[35]In this regard it may be noted that women themselves complain of back pains and pressure around the eyes during menstruation. Menstruation is also believed to affect the emotional state of women. An informant also noted, "I have a headache before it comes but I become revived and revitalized after it comes".

[36]While most informants agree that women are likely to bleed for forty days after delivering, some villagers reflect the differential valuation of male and female infants by noting that the birth of a female child is more painful and causes bleeding for forty days while bleeding after the delivery of a boy lasts for only eight days.

[37]The term zifra which is used to refer to an impure woman also applies to the description of odours especially in relation to fish, meat, and eggs.

CHAPTER 5

MEDICAL THEORY

A. Introductory Remarks

This chapter is devoted to an examination of village medical theory. Section B undertakes a general discussion of the comparative study of medical systems in terms of the classification of diverse medical theories and beliefs. This entails an examination of anthropologists' medical systems typologies. Note is made of earlier dichotomous typologies which were based on the differentiation of primitive and modern medicine and which conceived the former as essentially magical or religious and the latter as "rational". In rejecting the bifurcation of modern-primitive systems of medicine, reference is made to the work of contemporary anthropologists who have offered more generalized classificatory schemes, designed to accommodate diverse medical systems (whether primitive or modern) on the basis of diagnostic criteria (e.g., Glick 1967), therapeutic classifications (e.g., Young 1976a), and groups' taxonomies of illness (e.g., Fabrega 1976).

Section C of this chapter proceeds to examine medical theory in the study locale in terms of diagnostic indices and domains of medical taxonomy. It shows that the people of FatiHa have various explanations of illness. Causation is shown to be accorded primary significance in the process of diagnosis. Symptoms of illness and its severity

are important as manifestations of the operation of causal factors. Of minimum significance as diagnostic indices are the physical/anatomical processes associated with illness, i.e., the pathology of illness. The concept of levels of causation is deemed useful for ordering multi-causal explanations implicated in an illness episode.

In dealing with illness causation at the most general level, illness is described in terms of supernatural power. However, more immediate causes are shown to be recognized by the people of FatiHa. Generally, the ultimate determinant of health and illness in villagers' worldly environment is defined in terms of social interpersonal relations. As the people of FatiHa regard their individual lives and physical well being as inextricable from their social context, they also define illness, which is manifested in individual behaviour, as an outcome of social relations. This is not to say that illness is explained solely in terms of social interaction, but explanations of illness ultimately lead to the social environment of the sick. In dealing with natural causation, villagers clearly follow a prospective path to diagnosis. In cases of supernatural causation, on the other hand, diagnosis is always retrospective. When illness symptoms manifest themselves, they are traced to significant episodes of emotional distress and/or social relations which may be associated with much earlier time periods. In dealing with illness explanations in Section B, a description of some culture bound illnesses is undertaken and their critical diagnostic indices are noted.

Section D of this chapter is devoted to a discussion of the specificity of illness explanations. It is noted that while the

static account of medical beliefs provided in Section C informs us of the underlying logic of villagers' medical taxonomy, it does not adequately reflect the actual use to which that taxonomy is put in specific illness cases. Neither does it illuminate the social processes surrounding an illness occurrence. Through reference to specific illness episodes and the social dynamics surrounding their occurrence, Section D shows the variability of illness explanations and the process of negotiation related to claims of the illness role. In FatiHa, selection of a specific cause to explain an illness occurrence is a function of the duration of the affliction, its physical and behavioural manifestations, its response to certain types of treatment, and, of particular importance, the types of social interpersonal relations which surround the affected person and his/her significance to others.

The present chapter is concluded with Section E which focuses on case studies of the illness of ʿuzr. This culture bound illness is selected for in depth analysis which links illness causation to the dialectics of social life, particularly in terms of power relations and gender roles. In nothing the multiple levels of causation associated with reported and observed cases of ʿuzr interpersonal relations, including those associated with powerlessness, and those involving deviation from culturally valued behaviour, are identified as ultimate causes of the affliction.

Diagnosis of the illness of ʿuzr is believed to be outside the range of competence of physicians. Physicians' examination of maʿzurīn (persons affected by 'uzr) consistently ignore "ultimate causes" of illness which the maʿzurīn themselves (and/or their families)

consider crucial for the diagnosis of the illness.

In presenting cases of ʿuzr, the telescoping of explanations of illness is noted and the legitimization of deviance through the social granting of the illness label is shown. Therapeutic strategies associated with the illness are regarded as a means of controlling it, not eliminating it altogether. Indeed, from an etic perspective, the persistence of the illness is consistent with the relative stability of the structural power relations with which it is associated.

In describing the illness of ʿuzr, reference is made to the belief in the differential susceptibility of males and females to the illness. Women, who are believed to have half the nerves (aʿSab) of men, are said to be more susceptible to severe attacks of ʿuzr. As ideology, this belief legitimizes, while it mystifies, the actual power differentials between males and females. Some informants reiterate a similar understanding of the social basis of ʿuzr when they note that "the ʿuzr of women is heavier than that of men because they are bossed".

Case studies of ʿuzr in Section D also show that, as its very name suggests, the illness of ʿuzr (excuse) is a legitimate form of deviance. The compensatory value of the illness role is noted in case studies of the illness. It is evident that the illness role (when considered legitimate), mediates asymmetrical power relations and allows a temporary dispensation from expected role behaviour. However, the discussion in Section E indicates that the social sanction which allows temporary transgression of role behaviour and/or positions of relative powerlessness, is itself subject to negotiation.

Descriptions of case studies of ʿuzr involving children, in Section E show that the labelling of ʿuzr in children is undertaken by adults. In such cases, the legitimization of deviance associated with the illness label is deemed more significant for the adults themselves. In this regard it is noted that the label of ʿuzr for a child may sometimes be a means of avoiding acknowledgment of physicians' shameful label of maraD ʿaSSabi (illness of nerves). This divergenary practice is also noted for adult cases of mental illness. The label maʿzur/a is thus shown to be a generalized illness category associated with powerlessness whether this is defined in terms of subordination to the authority of more powerful males or females (e.g., mother-in-law/daughter-in-law relations), deviation from culturally valued role expectations (e.g., barrenness in women and sterility in men), or the social stigma attached to physicians' label of mental illness.

Section E is concluded with the testing of a hypothesis linking the incidence of the illness of ʿuzr and patterned power differentials. Finally, data which illuminate the patterned incidence of stress and illness as functions of asymmetrical power relations are presented and psychiatric ratings derived from the Cornell Medical Index are employed to illuminate structural principles associated with perceived stress and subservient status. In concluding Section E of this chapter, it is noted that the sick role, like other manipulative strategies adopted by the powerless, when accessible, brings about only a temporary enhancement of social position. It is not a stable, culturally valued power base which can induce permanent modification.

B. Medical System Typologies

The comparative study of medical systems requires the development of a suitable frame of reference for classification of diverse medical theories and beliefs, and the medical care strategies which logically follow from these theories and beliefs. Such a framework would necessarily have to accommodate extremely diverse explanations of persons' physical constitutions and psychosocial states, and how and why these become transformed as a result of illness. In examining studies of medical systems by anthropologists, it is noted that these have always assumed that medical practices derive from and make sense in terms of underlying medical beliefs and explanations of illness. Medical theory, therefore, has always been selected as a basis for the construction of medical system typologies. In a recent survey of theoretical orientations in medical anthropology spanning the last half century, Wellin (1977) has summarized these typologies:

The earliest attempt at comparative analysis of medical systems by anthropologists is attributed to Rivers whose classificatory scheme was based on what he referred to as groups' "attitude towards the world". His typology differentiated between magical, religious, and naturalistic explanations of illness causation. Following the same assumptions as Rivers, Clements (in his Primitive Concepts of Disease 1932) differentiated disease-causation concepts among primitive groups into five categories (sorcery, breach of taboo, intrusion by a disease object, intrusion by a spirit, and soul loss)[1]. The ensuing work by Ackerknecht was characterized by the cultural relativism typical of

British functionalism. Thus, although sharing River's and Clements' logic by postulating that medicine is best understood in terms of cultural beliefs, and by emphasizing the institutional functions of medical systems, Ackerknecht did not make an attempt to classify medical systems.

In addition to their general emphasis on medical beliefs as a basis for understanding and/or differentiating medical systems, the studies by Rivers, Clements, and Ackerknecht, all viewed primitive and modern medicine in dichotomous terms[2]. In describing the works of these early scholars, Willin writes,

> Each of the three viewed primitive and modern medicine in dichotomous terms. Conceived the former as essentially magical or religious, focused on it to the virtual exclusion of modern or "rational" medicine (Ibid:57).

The limitation of dichotomous typologies has also been noted by Glick (1967). In rejecting the bifurcation of modern-primitive systems of medicine, he offers a scheme for dealing with medicine as an ethnographic category. According to this scheme, diverse medical systems (whether primitive or modern) may be differentiated on the basis of the criteria which underlie the explanations of illness, i.e., on the basis of diagnostic criteria. As Glick explains this classificatory framework, some medical systems emphasize illness manifestations or evidence (i.e., whatever is evident about an illness to observers or to the sufferer, e.g., "signs and symptoms" or severity of illness), others accord significance to process (i.e., what is actually happening to the human body which produces the manifestations of illness[3]). Still others accord primary significance to causation, which addresses the question of how illness was brought about, or what did so, and

perhaps why this happened (Glick 1963:110). Glick describes his medical system typology as follows:

> ...any diagnostic statement about illness may take into consideration three dimensions which I call evidence, process, and cause. Each dimension may support a system or part of a system of diagnostic terms. I would argue that the third is always present as a critical consideration, and moreover, is of central importance to comparative studies...Evidence is whatever is taken as empirical indication of the existence of an illness...Process is what is actually happening to produce evidence of illness. In the absence of understanding of disease process, the diagnosis may resolve into conclusions about causation inferred from evidence, that is, the dimension of process may be overlooked altogether, or it may be relegated to strictly secondary significance.

Like Glick, other students of comparative medical systems have emphasized the importance of formulating cross-culturally valid diagnostic and therapeutic classifications (Young 1976a). In noting the limitations of earlier classificatory schemes, it has been argued that the comparative study of medical systems requires the classification of a whole range of medical theories, beliefs, and practices, including those associated with modern medicine (Young 1976b). Fabrega, in a recent article seems to have abandoned, at least momentarily, his own tendency to describe medical systems in dichotomous terms and has proposed the classification of all medical systems on the basis of groups' taxonomies of illness[4]. According to this scheme, taxonomy represents a group's rationale and way of naming and explaining illness in terms of its sources and/or causes. Fabrega thus proposes the classification of medical taxonomies according to types of entities and processes which establish contact with the person. He suggests three types of "broad semantic domains" which are implicated, to varying degrees in explanations of illness and its treatment. These are

the region of the person, the region comprising the wordly environment (which consists of both the natural and social elements), and the other wordly, or supernatural, world[5]. According to Fabrega, explanations of illness may then be regarded as formulas which contain measures derived from each of the three semantic regions (Fabrega 1976:200)[6]. Medical systems are thus differentiated on the basis of the extent to which any given type of explanation is accorded priority by the medical system's theoretical framework. While proposing the quantitative determination of the predominance of one "domain" or "region" over another, Fabrega does not illustrate how this is to be done in actual case studies.

Unlike Fabrega's quantitative scheme, Glick (1967) has suggested the analytic concept of levels of causation which is easily operationalized in the ordering of explanations of illness found within a given culture[7]. According to Glick, an analytical distinction is made between instrumental cause, efficient cause, and ultimate cause. He describes these conceptual categories as follows:

> An instrumental cause is what is done or what is used; an efficient cause, who does it or uses it. The latter, the agents of illness, are, with a few arguable exceptions, persons; they are part of the same socio-cultural system as the sick individual and they demand consideration in this wider context. Gaining an understanding of why they act, of what induces them to bring on illnesses, leads the ethnographer byond the medical system proper and into the realm of ultimate causes - kinship and political relations, property and inheritance disputes, jealousy, envy, rancor, and spite (Glick 1967:37).

Glick's concept of levels of causation for determination of priority of one type of explanation of illness over another may be regarded as complementary to Fabrega's typology. Moreover, one may note clear

areas of overlap between Glick's and Fabrega's medical system typologies. Thus, Fabrega's "region of the person" indicates similar criteria for differentiation as Glick's category of "process". Fabrega's "region of wordly environment (as it pertains to the social environment) corresponds to Glick's "ultimate cause". Finally, Fabrega's "supernatural environment" is included in Glick's broad category of "cause", or more specifically, "efficient cause". In view of these similarities and the complementary relation of one scheme to the other, a combination of elements, derived from both medical typologies will be utilized in the ensuing analysis of medical theory in the study community.

C. Diagnostic Indices and Domains of Medical Taxonomy in FatiHa

In attempting to analyze the medical system of FatiHa within the above noted classificatory schemes, it is evident that illness[8], no matter its cause, manifestations, or social consequences is regarded by the people of FatiHa as an individual-centered experience. The human body experiences the pain of illness and the individual deviates from a normal psychosocial state. But while the human body is identified as the depository of illness and while manifestations of illness are also described in terms of physical symptoms, the impact of illness, described in terms of specific physiological and anatomical changes is blatantly absent. There is relatively little attention paid to the physical processes associated with an illness occurrence. For while illness is manifested in particular individuals, its ultimate cause usually lies outside the individual him/her-self. Pathology is the

least elaborated part of the village medical system[9].

The effects of illness on the body (rather than failure of body organs resulting in illness), are usually described by the villagers in terms of generalized complaints such as headaches, weakness, dizziness, aches all over, trembling, hot-cold spells, chills, nausea, weight loss, pains in joints, and swelling, rather than by reference to alterations in specific organs of the body. Mostly gross, diffuse symptomatic indicators are noted in reference to an illness state. Illness causes collected in a census survey of the adult occupants of 100 households also indicate minimum attention to physical processes. Table 5.1 summarizes these causes and indicates that causes implicated in illness precipitation are generally seen as external to the body's physical structure. Bodily changes are generally regarded as manifestations of illnesses, not their causes. Emotional distress, interpersonal tension, and supernatural powers cause illnesses which become manifest in physical discomfort. Even in cases of illness of named body organs, i.e., MaraD il galb (heart illness) and Haswa fi al kila (stone in the kidney), external factors related to emotional distress and interpersonal conflict are advanced as causes of illness. In another survey in which a selected sample of (55) informants were asked to link specific causes to the four culture-bound illnesses of Tarba (fright), Hassad (envy or the Evil Eye), ʿuzr (a local variant of spirit intrusion), and ʿamal bil maraD (the illness of sorcery), physical constitution was selected by only a minority of respondents, as indicated by their percentages in Table 5.2. In examining these percentages, it will be noted, as will also become apparent in other tables of this

Table 5.1. Census Survey of Illness Causation.

Cause	# of Reported Cases
God's Will	22
Hassad (Evil Eye)	5
ʿamal (sorcery)	1
Smoking	2
Sexual Intercourse	2
Overwork	8
Living Creatures	4
Sadness	12
Fright	3
Blow	2
Contraceptives	2
Poverty	1
Natural Environment	36
Smoke Inhalation	1
Old Age	5
Chemicals	3
Fever	4
Pregnancy	5

Table 5.2. Culture-Specific Illness Causation: Somatic vs. Psychosocial Causes.
N=55.

Illness	Somatic Causes % Respondents	Psychosocial Causes % Respondents
Tarba	25.5	96.4
Hassad	0	98.2
ʿuzr	3.6	94.6
ʿamal	0	92.7

chapter, that they do not add up to 100%. This results from the non-specificity and variability of illness explanations, which characterizes the village medical system.

The only minor exception to the above noted tendency to deemphasize physical constitution and physical processes in the explanation of illness is related to illnesses which are considered hereditary (wiratha) and those known as "inborn" (khilga). In these cases, physical constitution is accorded primary consideration in the explanation of illness. Thus, an inborn physical defect ("from God") may be implicated in cases of habal (idiocy) and ginan (insanity). It is said that "the person's brain may be small from birth and as he grows up it does not grow like the rest of his body and he remains ahbal[10]. Afflictions which are believed to be transmitted by this mechanism include sukar (sugar illness or diabetes), azma (asthma), ura' (hair loss), and shalal (paralysis). Some informants believe that damage to the tuHal (spleen) is also inherited. They note "if the person has toHal, his children will have tuHal and some children who are just born have bilharzia"[11].

While informants emphasize somatic explanations in cases where illness is attributed specifically to khilga (inborn physical constitution) or to wiratha (inherited physical defects), the precise physical mechanisms associated with these conditions are not elaborated. In fact, there is no complete agreement among informants on which stage of physical development is associated with the wiratha (inheritance) of illness. There seems to be minimal differentiation between inheritance of illness and transmission of illness through contact between

family members. Thus, an informant stated ahat "Asma and the chest illness (TB) are wiratha (inherited). When a person who has any of these illnesses coughs or spits his children also get the illness. It is in the sputum. Children are particularly susceptible to illness". From this description it is clear that the wiratha occurs after birth, as a result of contact rather than through transmission during the period of foetal development. Some informants assert that "the child never becomes ill when he is in his mothers womb or when he is nursing". By contrast, others believe that illness or the propensity towards certain illnesses, especially mental illness is inherited from the father during foetal development. Thus, although mentally deficient persons in FatiHa (as in other Egyptian villages, see El Sendiouny 1972:23-26) are treated kindly by fellow villagers and may even be thought to be possessed of baraka (supernatural blessing power), they are nevertheless a source of shame to their families. Thus while the family of a mahbul (idiot) may put him by himself in a dark room in the hope that "the shock would bring him back his mind", other informants explain this action on the part of the family by reference to their shame. It is said that "the family members of the mahbul do not want to be ashamed in front of other people. It means that the family must have people who are mahabīl (idiots), either the father or the father's father, or the father's father's father. It must be a relative from the ʿaSab (the back of the man from which semen is believed to descend)."

Although the "region of the person" is recognized in explanations of illness in FatiHa, one notes minimal elaboration of this domain of medical taxonomy. Instead, illness in FatiHa is defined in terms

of behavioural and generalized physical changes apparent in the affected individual, and interpreted as correlates of certain diagnostic units. The system of diagnosis rests primarily on the specific causes believed to underlie these manifestations of illness. The exact physiological processes and anatomical changes leading to illness manifestations do not seem to have much significance in the villagers' illness conceptualization. In short, as in the case of other tribal and peasant societies (Glick 1963, 1967, Fabrega 1976, Foster 1977, Young 1977), it is illness causation rather than process which is the basis of the system of illness taxonomy in FatiHa..

In dealing with illness causation at the most general level, it is evident that the villagers of FatiHa believe that illness, like every other misfortune which befalls an individual, is under supernatural control. During the early interviews, when confronted with the question "what is the cause of X's illness or his/her death?", informants invariably responded, "min Allah" (from God). But while probing beyond such rhetorical statements, it became clear that the peasants of FatiHa recognize more immediate causes of illness and link these to a variety of illness states (see Table 5.3 for a listing of illnesses reported in the census survey)[12]. These beliefs about illness causation may be differentiated, for analytical purposes, according to three etiological categories: natural, social, and supernatural. In discussing each of these types of causes, it will be evident that in FatiHa, the roles of natural, social, and supernatural elements, which are external to the human body, are accorded greater elaboration than is the case for bodily structures and functions associated with illness.

Table 5.3. Illness Reporting in Census Survey.

Illness	# of Reported Cases
Rheumatism	4
Heartburn	1
Allergy	3
Headache	14
Tonsillitis	5
Weakness	20
Backpain	6
Fever	31
Stomachache	6
Cold	4
Asthma	2
Diabetes	1
Kidney	3
Bilharzia	2
Malaria	2
Paralysis	1
Pain in Joints	7
Pain in Reproductive Organs	1
Heart	7
Dizziness	1
Chest Pains	8
Shortness of Breath	2
Spleen	2
Nausea	1
Menstrual Cramps	2
Dysentary	1
Eye Irritation	1
Appendicitis	1
Liver	1
Psychological Shock	1
buzr	10
Tarba	1

In terms of natural causal elements, among the people of FatiHa a variety of natural causes are implicated in the occurrence of various illness conditions[13]. Illness is attributed to such natural causes as bad food, bad water, worms, insect bites, sunstroke, and humidity. Unsanitary living conditions associated with dirty water and flies are thus implicated in the occurrence of bilharzia (Schistosomiasis) and eye infections, respectively. People also refer to bilharzia as being caused by worms which enter the skin of people as they work barefooted in dirty water. Village school children have a good understanding of the parasite's life cycle and much of this information is proudly exhibited in front of parents and other villagers. The villagers attribute the continued proliferation of the illness to their conditions as peasants whose livelihood depends on the continued contact with the earth and river. In enumerating illness causes associated with the natural environment, the peasants also recognize mosquito bites as the cause of malaria, which is believed to cause death, if not treated by a physician. Malaria is also believed to cause miscarriage in pregnant women. In relating her daughter's miscarriage and eventual death from malaria, an informant noted, "...when one gets malaria, there is a lot of heat in the body, the heat was too much for the child".

Fever is believed to be caused by sunstroke or by ruTuba (moisture) in the air. As a result of long exposure to the hot sun, "a person's body gets more heat than it needs and the person becomes ill". Similarly, extended exposure to ruTuba (moisture) is believed to induce hot-cold spells, which, like fever in the body, causes the affected person to

be weak, or reduce his/her tolerance), and dampens his/her appetite for food[14]. Moisture from the air or from cold chills is also said to cause duzentaria (dysentery) and rumatizm (rheumatism). An informant described the effect of moisture on the body as follows:

> I was working early in the morning. The ruTuba (cold moisture) settled in my head and my heart. My headache caused my eyesight to fail me. The moisture entered my body through my cold feet in the water. It travelled through my knees and up my heart to my head. It took ten months to reach my head. It entered my bones and in spite of many medicines, I was not healed. Once moisture enters the body, it does not leave the person.

It is also believed that a chill experienced as early as the first year of life shows up years later in the form of rheumatism during old age.

Other naturalistic causes of illness extended by the inhabitants of FatiHa as explanations of illness include excessive indulgence related to food, work, and sex. Such excesses are said to exhaust the body and cause discomforts and weakness. Over eating is believed to cause ziHam (crowding) and thus bring about the discomforts of indigestion. Over indulgence in sexual activity by a man, particularly with a woman other than his wife, is also extended as a cause of illness. A man is said to become very sick as a result of such encounters because he ejaculates in fear and guilt and without much sexual excitement[15].

The idea of contagion is also reflected in villagers' beliefs of natural causes of illness. It is stated that,

> Fever is mu⁶diya (contagious)...The heat from one body transfers to the body of the other who sits near him... Influenza is contagious, it has bad air which goes to other people through sham (inhaling)...The illness of the chest (TB) is contagious and the doctor must treat the people who have marad il SaDr (the illness of

> the chest) immediately or else they make all those around them sick[16]...Dirt can also cause illness and if I drink after a person who is sick...

While the people of FatiHa refer to elements of the natural environment as direct causes of illness, in some cases, the natural environment may be cited as an indirect cause of illness. Thus, the darkness which falls upon the village at night, the roaring winds and swaying tree branches, or the dark low clouds, are believed to cause severe frights which induce the culture-bound illness of Tarba (fright)[17]. The various dimensions of this illness, including cause, symptoms, severity, age relatedness, and sex relatedness, are recorded in Table 5.4 which indicates the degree of concensus (presented in percentage) among a sample of 55 informants who were instructed to associate the illness of Tarba with various illness dimensions. In some cases, Tarba may predispose a person to the more severe illness ʿuzr (a local variant of spirit possession which will be described shortly) in which the body is affected by supernatural powers. The people of FatiHa also believe that the turbulent waters of the Nile and the dark, desolate fields, harbour supernatural beings which, through a lamsa (touch) may gain access to the human body and precipitate illness. Illnesses thus inflicted are believed to be the consequences of stressful emotional experiences and/or conflict-ridden social relations, and experiences associated with powerlessness. Under these conditions, emotional distress predisposes the individual to attacks by supernatural beings which inhabit the natural environment.

Although both the natural and social environments are implicated in illness causation, the social dimension of the environment is

Table 5.4. The Illness of Tarba: Illness Dimensions Associations. N=55.

Illness Dimension	% Positive Association
A. Cause	
a. instrumental	
1. nat. envir. & subs.	16
2. phys. constitution	25
3. spt. intrus. (malbus)	0
4. Hassad (gaze)	0
5. ʿamal (sorcery)	0
b. Efficient	
1. God	20
2. Hassid (witch)	2
3. assyad (spirits)	0
4. saHir (sorcerer)	0
c. ultimate	
1. sadness	2
2. anger	4
3. jealousy	0
4. hatred	2
5. punishment by God	4
6. fear	96
B. Symptoms	
a. behavioural	
1. sleeps more	9
2. insomnia	93
3. eats less	76
4. loss of consciousness	9
5. tayih (in a daze)	42
6. cannot bear himself	80
7. makes no sense talk.	15
8. disrespect. to super	5
9. does not socialize	27
10. depressed & unhappy	84
11. cries	38
12. cannot run after bread	15
13. cannot discipline children	2
14. cannot unite with wife	9
15. cannot pray	2
16. cannot fulfill mater. resp.	0
17. cannot fulfill duty as wife	2
18. cannot do housework	5
19. yawns often	9
20. does not speak much	36
b. physical	
1. weakness	95
2. headache	91
3. aches all over	87
4. trembles	64
5. hot-cold spells	18
6. cough	9
7. chills	13
8. nausea	5
9. weight loss	42
10. vomiting	13
11. swelling	5
12. loss of balance	40
13. diff. in breathing	31
14. lump in throat	13
15. diarrhea	27
16. fever	13
17. pain in joints	53
18. earache	11
19. watery eyes	20
20. rash	4
21. backpain	45
22. dizziness	75
23. chest pains	15
24. stomachache	16
25. excess blood in body	2
26. excess water in body	2
27. drying of blood in body parts	76
C. Severity	
1. minor illness	80
2. significant ill.	33
3. heavy illness	36
4. fatal	

Table 5.4. Continued.

Illness Dimension	% Positive Association	Illness Dimension	% Positive Association
D. Age Relatedness			
1. children only	0		
2. children mostly	61		
3. adults only	0		
4. adults mostly	61		
5. older people only	0		
6. older people mostly	16		
E. Sex Relatedness			
1. females only	2		
2. females mostly	40		
3. males only	0		
4. males mostly	15		
5. both males and females	40		

accorded greater significance. Thus, as the villagers attribute an illness to a sunstroke, chills, bad food, or worms, in a typical holistic posture, they also refer to the social identity of the peasants which forces them to be exposed to natural elements, with little protection to their bodies, either externally (by proper clothing) or internally (through proper feeding). Similarly, while a woman's poor health during pregnancy is attributed to her poor nutrition which causes weakness, informants are always quick to point out the social bases of this condition by pointing to her husband's poverty, to her mother-in-law's stinginess, or to her condition as a fallaHa (peasant woman). In terms of levels of causation, aside from rhetorical reference to "the Will of God", extended case studies show that for the villagers of FatiHa, the ultimate cause of illness is social. Even in cases where villagers attribute illness to supernatural beings and powers (e.g., spirit intrustion, sorcery, and the Evil Eye), the ultimate cause of illness is social. Supernatural causation is important, to the extent that it mediates interpersonal social relations. For while illness is manifested in particular individuals, its ultimate cause lies outside the individual him/her self. In short, the characteristic mark of village medical theory is its concern with social problems which are related to illness occurrences. The body is seen to display social problems and tensions. Illness then is considered primarily a social occurrence.

In explaining illness by reference to the social dimension of the wordly environment, diagnosis is a retrospective exercise. As is the case among other social groups whose interpretation of illness is

intimately linked to socially significant relations and events (e.g. Glick 1963, Rubel 1964, Fabrega 1974), illness cause is inferred from manifestations which are promptly linked to meaningful social occurrences. In this regard, it is important to stress informants' regular reference to emotional distress, particularly that which results from interpersonal conflict, as a cause of illness. Three culture specific illness, ʿuzr or excuse (caused by nazra ardiya - a gaze from the ground) Hassad or the Evil Eye (caused by nazra insaniya - a human gaze - which reflects feelings of jealousy), the Tarba or fright (caused by any frightening experience) are all associated with emotional etiologies. Thus, the first is precipitated by emotional distress, the second involves feelings of jealousy and envy towards others, and the third illness is caused by a frightening experience[19]. Informants regularly reveal the centrality of emotions, including fright, sadness, quarrels and rage, in their explanations of illness. Psychological state is constantly linked to physical well being or deviations thereof. The body-mind duality characteristic of industrial societies is contrasted by the conceptualization of these aspects of a person as parts of an integrated existence. Moreover, the indigenous medical system does not elaborate the differentiation between mental and physical illness states (excepting mental deficiencies which are khilga). Psychological disposition is believed to affect physical functions and physical discomforts, reciprocally, affect psychological outlook.

In FatiHa, disturbing emotional experiences are cited as causes for the occurrence of different types of afflictions ranging from falling out of hair to heart trouble and diabetis, to certain culture-

specific illnesses. In case of the latter, impotency in men or barrenness in women may be attributed to Tarba (fright) or a person may be diagnosed maTrub (frightened) when his/her behaviour, in terms of work habits, social relations, food intake, and other general activities are not up to normal standards of performance. The term Tarba refers to the experience of fright as well as to the illness which results from this disturbing emotional experience. But while fright may precipitate the illness Tarba, it may also predispose a person to other more serious illnesses.

Disturbing emotional experiences are said to shake the body, thereby reducing the person's defense against illness or precipitating certain specific types of illnesses which result from the "boiling of blood". Distressful emotional experiences are implicated in the illness of Haswa fil kila (stone in the kidney). It is said that "sadness and rage cause fawran dam (boiling over of the blood) and as the blood settles, it causes sand to settle in the kidney and gradually a stone is formed. Brostata (illness of the prostate gland) is also believed to be caused by excitement resulting from sexual intercourse. Informants note "when the man unites with his wife, his blood boils because of sexual excitement and as the blood cools it forms sand which accumulates and settles and then he gets the illness and may eject blood instead of semen".

While emotionsl distress is said to cause illness, it is also believed that restraining one's emotions also causes illness. As one informant noted, "if a person tells others of what is bothering him, he gets relief". It is also significant to note that the effect

of emotional distress and the severity of the resultant illness are mediated by the physical state of the affected person. Informants refer to the tab‘ (nature) of persons as determining the severity of experienced illness. Since it is believed that women have half the a‘Sab (nerves) of men, it is remarked that the identical emotional blow is likely to have a more deleterious effect on a woman than on a man. Similarly, children are believed particularly susceptible to emotional distress. These beliefs are reflected in Table 5.4 where 15% of respondents associated the illness of Tarba with the category "males mostly", while 40% and 61% linked the affliction to "females mostly" and "children mostly", respectively.

As emotional distress which results from interpersonal tension is advanced to explain illness, feelings of jealousy and envy are also cited as causes of illness. This theme is elaborated in the culture-bound illness of Hassad (envy or the Evil Eye)[20]. Table 5.5 summarizes various dimensions of this illness state.

Belief in Hassad among the people of FatiHa, although pre-Islamic in origin, is legitimized by reference to Quranic descriptions[21] of the malevolent power of the Hassid (possessor of the Evil Eye). The power of a gaze by a person who possesses this form of witchcraft is believed to be a great source of danger to humans, animals, plants, and even inanimate objects. The power of the ‘ayn (eye) is by far the most common element advanced to explain almost any type of misfortune, including illness, and even death. It is believed that the malevolent power of an envious gaze brings about a sure destruction to the object of that gaze, be it a human body, another living creature, or an

Table 5.5. The Illness of Hassad: Illness Dimensions Associations. N=55.

Illness Dimension	% Positive Association
A. Cause	
a. instrumental	
1. nat. envir. & subs.	0
2. phys. constitution	0
3. spt. intrus. (malbus)	2
4. Hassad (gaze)	98
5. ʿamal (sorcery)	0
b. efficient	
1. God	7
2. Hassid (witch)	96
3. assyad (spirits)	2
4. saHir (sorcerer)	0
c. ultimate	
1. sadness	0
2. anger	11
3. jealousy	100
4. hatred	96
5. punishment by God	0
6. fear	0
B. Symptoms	
a. behavioural	
1. sleeps more	18
2. insomnia	85
3. eats less	80
4. loss of consciousness	7
5. tayih (in a daze)	29
6. cannot bear himself	80
7. makes no sense talk.	13
8. disrespect. to super.	5
9. does not socialize	15
10. depressed & unhappy	65
11. cries	38
12. cannot run after bread	11
13. cannot discipline children	2
14. cannot unite with wife	7
15. cannot pray	4
16. cannot fulfill mater. resp.	4
17. cannot fulfill duty as wife	2
18. cannot do housework	7
19. yawns often	96
20. does not speak much	35
b. physical	
1. weakness	98
2. headache	100
3. aches all over	96
4. trembles	49
5. hot-cold spells	22
6. cough	7
7. chills	16
8. nausea	16
9. weight loss	31
10. vomiting	2
11. swelling	9
12. loss of balance	38
13. diff. in breathing	44
14. lump in throat	18
15. diarrhea	29
16. fever	40
17. pain in joints	55
18. earache	20
19. watery eyes	42
20. rash	7
21. backpain	40
22. dizziness	18
23. chest pains	18
24. stomachache	18
25. excess blood in body	4
26. excess water in body	2
27. drying of blood in body parts	60
C. Severity	
1. minor illness	60
2. significant ill.	47
3. heavy illness	69
4. fatal	73

Table 5.5. Continued.

Illness Dimension	% Positive Association
D. Age Relatedness	
1. children only	4
2. children mostly	91
3. adults only	2
4. adults mostly	36
5. older people only	0
6. older people mostly	11
E. Sex Relatedness	
1. females only	0
2. females mostly	4
3. males only	2
4. males mostly	29
5. both males and females	64

inanimate object. In fact, villagers emphasize the danger of the eye by reference to Islamic narrations which describe the destruction of stone by an envious glance. But although people constantly refer to others' covetousness as causes of illness, the mechanism of action of the ʿayn (Evil Eye) is conceived as supernatural and the actual processes by which illness is inflicted do not receive elaboration from informants. Neither is the power of the evil eye linked to a specific organ of the human body. As in the case of other culture bound illnesses, diagnosis is based primarily on causation which is traced retrospectively and linked to persons whom the maHsud (person affected by the evil eye) or members of his/her family consider envious. Moreover, as indicated in Table 5.5, illness manifestations, behaviour as as well as physical symptoms of the illness, are generalized and are not unique to Hassad (compare symptoms of Hassad in Table 5.5 to those of Tarba in Table 5.4). In fact, with the exception of yawning (which as Table 5.5 indicates, is associated with the illness by the majority of informants) symptoms of Hassad are also indicators of afflictions by other illnesses. Neither is the severity of the illness considered a principal diagnostic indicator. "The eye" may cause illness states ranging in severity from slight to fatal. In this respect it is similar to other types of culture bound illnesses, the effect of which may vary from slight incapacitation to death. In short, cause (defined in terms of interpersonal relations) is the single most important factor in the diagnosis of Hassad. In comparing the degree of consensus among informants linking the cause nazra (envious gaze) to the illness Hassad with those linking this etiological element to other culture bound

illnesses, the results were as follows:

Illness	Tarba	Hassad	ʿuzr	Amal bil maraD
% Positive Association	2	96	20	0

In the case of the illness of ʿurz, a gaze may be isolated as an indirect cause of the illness. A maHsud (someone affected by the evil eye) becomes sad and depressed, thus predisposing him/her-self to lamsa (touch) by supernatural beings which cause the illness of ʿuzr.

With regards to the characteristics attributed to the villagers to those who possess the evil eye, such persons are described in terms of their insatiable desire to possess whatever others have. Moreover, it is said that they make no attempt to hide their envy of others' fortune. This is indicated by their constant self pitying sighs and their lingering, longing gazes at desirable objects. Some informants assert that they can identify those who possess the evil eye by their gaze. Of such proprieters of witchcraft, others remark that "the black of their eye is actually yellow, this is the mark of those who have the evil eye, this is khilga (inborn)". But such assertions are made in reference to persons who are in fact suspected in actual cases of misfortune. While some people who do not control culturally valued resources (i.e., who are powerless) may be accused of Hassad, it is generally agreed that anyone can have the evil eye. In FatiHa, "some men are known for their evil eye, some women are this way too". Informants also note that barren women do not necessarily have the evil eye; "some women who have many children, even male children, also have

the evil eye". Such women may be pointed out as the cause of illness by persons who resent them for one reason or another. For while the evil eye is an important etiological category among the peasants of Fati-Ha, it is clearly a measure of interpersonal relations. Attributing an illness to a given person's Hassad is at once a reflection of and a justification for hostile attitudes towards that person.

Accusations of possession of the evil eye are dependent, not on culturally specific characteristics of persons, but on the nature of interpersonal relations. Thus, although some barren women are indeed believed to possess the evil eye (as is the case in other parts of the Middle East (See Spooner 1970)), barrenness is by no means a definitive criterion for possession of the evil eye. Accusations of the evil eye are situationally determined. In fact, one person may be perceived as a possessor of the evil eye by another but not necessarily so labelled by a third party. The evaluation is directly related to the nature of social relations which obtain between people. The case of Z. is instructive in this regard:

> Z., a 45 year old blind woman who is also barren is considered mabruka (possessing blessing power) by many of the village women (as is the case for other people who are mentally or physically deficient). They bring their infants to her so that she can caress them and transfer some of her baraka (supernatural blessing power) to them. In contrast, her sister-in-law, with whom Z resides, and who considers Z. a burden, says that she is a source of trouble and has the evil eye.

Such accusations are not uncommon among members of extended families who reside in the same household (for reasons elaborated upon earlier in Chapter 3). But as Rubel has noted for Mexican Americans (Rubel 1966:204), there is no indication of such accusations by one member

of a nuclear family against another, although informants jokingly remark "ma yiHsid il mal ila suHabu" (no one envies the wealth except its owners).

The power of the evil eye may be triggered by the feeling of envy on the part of the onlooker. The persons who induce this feeling are therefore likely to possess certain desirable qualities such as beauty, health, wealth, happiness, youth, or power. Children, especially males (who are recognized as culturally valued power bases) are said to be particularly sensitive to the effects of the evil eye[22]. Some informants also believe that older people are more susceptible to the evil eye because they are usually richer and have many children. It is also said that "if a woman's child is beautiful, he may be seen by someone who fills her vision and then the child would fall ill". People are said, not only to envy others' children, but particularly educated children. In referring to her son's regular illness at the beginning of the school year and towards its end, an informant attributed his illness to the evil eye. She said, "people never leave us alone, they always say, 'look, they have their children in school and they also have land'. There is no month that passes without one of us being sick". Another woman related the death of her sons from the evil eye as follows:

> The youngest one which I lost was only ten days old. There was something wrong with him since birth, he was very large, but his looks were so good. Of course he was affected by the evil eye. He was a boy after two girls. The next child that I lost was almost three years old. There was this woman who only had sons. Since this son was beautiful, I used to cover him. I left him with this woman, thinking that since she had only sons, she would not envy him. But when she saw him she said,

> 'how beautiful, how can the son of black people have such beautiful hair?'. And that was that. He died less than a week later. He fell sick. I gave him rice water instead of my milk, like older people told me. But he had diarrhea and he remaind this way and then died.

As in other cases of illness explanations, one notes the emphasis on causation in this account of the infants' death. Moreover, one may distinguish different levels of causation: an ultimate cause (envy), an efficient cause (the possessor of the evil eye), and an instrumental cause (the longing gaze).

Accusations of the evil eye are significant, not only in revealing the logic of the village medical taxonomy, but for identifying culturally valued power bases, be these male status, possession of land, or education. The significance of male status and related differential valuation of males and females is reflected in Table 5.5. This is indicated by the greater consensus among respondents that males are the more likely objects of envy (29% of respondents) than females (4% of respondents).

The examination of the village medical system also reveals its close relation to the religious domain of village culture. Villagers' ideas about illness, its cause, prevention, and cure, are closely tied to beliefs regarding the supernatural and to religious rituals. Most generally, explanation of illness in terms of supernatural causation entails reference to "His Will". Both health and illness are believed to be under God's control. As He is the source of life, He also determines its crises (including illnesses) and its termination point. It is said that no one lives byond the time that is written (maktūb) for him/her by God. In comforting a dead man's widow, his relative

said, "Allah mish Hayigayar Hukmu fi riDa ʿabdu" (God will not change his command to please his slave).

Villagers also believe that illness may be a reflection of God's wrath. In other words, illness is sometimes regarded as supernatural sanction by God for wong doing on the part of His human creatures. It is said that "God can also punish people by making them ill". The attributing of illness to zanb (wrong doing) in K.'s statement when she noted that F's brother's wife' mother got leprosy only two weeks after she had refused to give her sick relative some of the food she had cooked. Her relative pleaded to God that she may never be able to hold anything with her hands. It should be emphasized that illness resulting from God's punishment is given as an explanation for illness only in case of other people, not in case of one's self or in case of one's loved relatives or friends. Thus when the author tried to substantiate the above noted account of illness with the afflicted person's daughter by asking about the cause of her mother's leprosy, she denied that her mother suffered from this form of illness. Moreover, she did not attribute the illness to God's revenge, as did the other informant. Instead she said that, like any illness, her mother's came from God.

In another case of illness which occurred during the author's presence in the village, several informants explained T's illness, and his hospitalization for surgery, as a revenge of God for his exploitation of F.A.A.'s poverty, innocence, and ignorance. It is said that under T's pressure and intentional misguidance, F. put her stamp of approval (not knowingly of course) to a document which waived her former husband's obligation to support her and her infant son. It is believed

by some informants that T (the village clerk) was bribed by the woman's former husband who is said to have paid him five pounds for this service. More than one informant (none of whom are known to be friends of T) noted that only three days after T had done this evil deed, God's punishment came and F. was avenged, "he was on the operating table in no time".

Beyond the generalized attribution of illness to God[23], villagers implicate supernatural powers in cases of illness by reference to subterranean beings. As in the case of orthodox muslims, the peasants of FatiHa believe in the Jinn. Such supernatural beings are referred to by various names, including ʿafarit (ghosts), assyad (masters), awlad il arD (children of the ground), karīn/karīna (male/female relative), ikwatna (our siblings), and ahl il ard (the people of the ground). Such beings, which are identified as causes of certain illnesses, when controlled by sorcerers, also cause illness (or cure) on command.

A local diagnostician describes the community of subterranean supernatural beings as follows:

> Just as there is the life of the inss (adamites), there is also the world of the jinn. This is stated in the Quran and the Hadith (he quotes from saurt il jinn) our karīn (relatives) are not all muslim. Some are christian. Some heard the word of God and became muslims and some did not...They live everywhere. They do everything we do. They have sexual intercourse, they eat, sleep, but they live longer. They can also do superhuman acts. They can cause illness or cure it...ʿuzr (spirit intrusion) is spontaneous,...but siHr (sorcery) is by use of jinn in causing illness, this is of course different. In siHr, the jinn is prepared (summoned) by a saHir (sorcerer). There are good saHara (sorcerers) who for example remedy situations between lovers and if someone is ill he is cured. This saHir (sorcerer) is called ʿilwi (from above). This means that he uses khudam (supernatural servants-jinn) from above. These are angels. He is a good person who prays. He reads the oath

> which says 'in the name of God the compassionate and the merciful, may prayer and peace descend on the most honourable of messengers (The Prophet), our master MuHammad. I swear on you on Simamail (the name of the jinn) to be present this h hour and to do for me such and such by the right of what is written on the forehead of ʿazrail (the jinn of death). I beg your speed this hour. God's blessing in you and on you'. Il jinn il sufli (lower jinns) are used (commanded) for evil deeds, including the causing of illness, e.g., blindness and hemmorrhage and discord like divorce.

It is interesting to note that while good jinns are believed to be all males, among the sufli (lower) jinn, some are males and some are females.

Another informant (a diagnostician) also referred to the supernatural relatives (karīn/karīna) in the explanation of illness. He noted,

> I was called by Halag il siHā (the barber of the health department - a paramedic) to see his two year old son. He had been very ill, he would not eat. They had been with him to the doctor several times. When I saw him, I threw the rosary (a diagnostic procedure) and found that he had fallen. I asked them why they did not come to me sooner. I found that there is no use because he had been hit by his karīna (supernatural relative) because she was taking revenge from his mother in him. I knew that he was going to die but I did not tell them.

Such punitive actions by the supernatural karīn/karīna, as noted in the above case, are explained as emanating from the subterranean beings' concern for the welfare of their earthly relatives. It is said that people do not always act in their own self interest, either by neglecting their children (a culturally valued power base), by over exerting themselves in work, or by being sad, to the detriment of their health. The karīn/karīna act promptly to remedy imbalances or distorted priorities in people's lives. Initially they may give warning signals, such as illness. If these are left unheeded, they

act more ferociously and may even cause the death of unheeding mothers' beloved children. This action is illustrated in the following account by a woman who was relating the death of her child. She said, "My son died when I left him in the room by himself; his sister bit him". When the author pointed out that the woman had just told her that she has no daughters, she said, "it's his sister from the ground who killed him. Everyone of us has a sibling from the inhabitants of the earth. His sister bit him because I did not spread any salt (a symbol of appeasement to supernatural beings). A woman should not leave her infant alone[24] when he is a week old and she should spread the salt in the house". As she related this account, this informant blamed her luck of living with her husband's family, whose constant demands of her in terms of housework as well as agricultural tasks forced her to abandon her child unattended, and whose "stinginess" prevented her from spreading the protective salt.

While some informants intepret the punitive action of awlad il arD (children of the ground) as being inflicted in the best interest of the affected person or meaningful others in his/her family, other informants remark that not all subterranean beings are so motivated. It is said that "the jinn can see us but we cannot see them. Some are good and some are bad. The bad ones bother the adamites. He may hit one of us with a stone and cause us illness - lamsay ardiya (touch from the ground)". Other informants, including healers, also describe a more elaborate classification among sukan il arD (the inhabitants of the ground) and associate the action of inflicting illness among differentiated groups with specific triggering behaviour on the

part of human beings. This form of division of labour was described as follows:

> When a woman is pregnant and she is upset with her husband, and doesn't eat (an action believed to be deleterious to the foetus), the karina of ahl il ard tiltush il ganin (strikes the foetus). The karina is from beneath the earth, she comes in the shape of a farm animal and hits the woman and forces the foetus down.[25] Assyad (masters) come under fright or sadness or sorcery, but the karina (sister) only comes to a woman when she is upset with her husband or his mother, when the sadness is minor.

Supernatural causation of illness by subterranean beings may be differentiated into two broad categories: direct and indirect. Direct causation involves these supernatural creatures as efficient causes of illness. This is illustrated in the culture bound illness of ʿuzr which will be discussed in detail in Section D. Briefly, the illness may be considered a variant of what anthropologists refer to as spirit intrusion. Disturbing emotional experiences, including those associated with powerlessness, are identified as the ultimate cause of the resulting illness. The indirect action of supernatural subterranean beings is manifest when they are controlled and manipulated by other efficient causes of illness, namely sorcerers. The resulting illness is known as ʿamal bil maraD (deed for illness or illness of sorcery). Several dimensions of this illness category and informants' degree of consensus about linking these dimensions to the illness states are summarized in Table 5.6.

The efficient causes of ʿamal bil maraD are humans, who, through their religious knowledge control the actions of supernatural beings and direct them to execute specified commands, including the infliction of illness[26]. Sorcerers are mostly likely to be males who have

Table 5.6. The illness of ʿamal bil maraD: Illness Dimensions Associations.
N=55.

Illness Dimensions	% Positive Association	Illness Dimension	% Positive Association
A. Cause		17. cannot fulfill duty as wife	76
a. instrumental		18. cannot do housework	75
1. nat. envir. & subs.	2	19. yawns often	33
2. phys. constitution	0	20. does not speak much	45
3. spt. instrus. (malbus)	0	b. physical	
4. Hassad (gaze)	0	1. weakness	95
5. ʿamal (sorcery)	96	2. headache	95
b. efficient		3. aches all over	95
1. God	4	4. trembles	60
2. Hassid (witch	0	5. hot-cold spells	35
3. assyad (spirits	2	6. coughs	4
4. saHir (sorcerer)	93	7. chills	9
c. ultimate		8. nausea	22
1. sadness	0	9. weight loss	78
2. anger	47	10. vomiting	35
3. jealousy	91	11. swelling	29
4. hatred	95	12. loss of balance	73
5. punishment by God	0	13. diff. in breathing	55
6. fear	0	14. lump in throat	35
B. Symptoms		15. diarrhea	24
a. behavioural		16. fever	29
1. sleeps more	49	17. pain in joints	67
2. insomnia	82	18. earache	36
3. eats less	91	19. watery eyes	44
4. loss of consciousness	42	20. rash	7
5. tayih (in a daze)	80	21. backpain	65
6. cannot bear himself	93	22. dizziness	87
7. makes no sense talk,	45	23. chest pains	38
8. disrespect. to sup.	44	24. stomachache	38
9. does not socialize	44	25. excess blood in body	18
10. depressed & unhappy	45	26. excess water in body	0
11. cries	73	27. drying of blood in body parts	55
12. cannot run after bread	84	C. Severity	
13. cannot discipline children	58	1. minor illness	13
14. cannot unite with wife	93	2. significant illness	9
15. cannot pray	38	3. heavy illness	91
16. cannot fulfill matern. resp.	60	4. fatal	82

Table 5.6. Continued.

Illness Dimension	% Positive Association
D. Age Relatedness	
1. children only	0
2. children mostly	2
3. adults only	2
4. adults mostly	89
5. older people only	0
6. older people mostly	7
E. Sex Relatedness	
1. females only	0
2. females mostly	25
3. males only	2
4. males mostly	13
5. both males and females	53

knowledge of the Quran. Their status as males, who are more likely to be educated than females, predisposes them to control yet another form of power, that derived from literacy and religious knowledge. While the power of sorcerers rests on their control over supernatural beings and while females may in some cases have access to such control, the proper manipulation and ultimate command over supernatural beings rests, not only upon proper knowledge of the Quran, but more importantly, on knowledge of appropriate passages which are read for different types of required commands. To the extent that females have limited or no knowledge of the Quran, and to the extent that male sorcerers are more likely to pass on their secret knowledge to male offsprings or other male relatives, women's prestige as sorcerers is limited. Exceptions do exist, however, and some villagers of FatiHa are known to take their complaints to a female sorcerer in a nearby village. This woman is known to recite the Quran and has been on pilgrimage to Mecca more than once. In the village of FatiHa itself however, only males are known as sorcerers.

The instrumental cause of ʿamal bil maraD is usually a form of imitative magic, induced through the supernatural beings commanded by a sorcerer. Although informants also refer to illness object intrustion when describing the "drinking of siHr (magic), the harmful effect of the siHr is not defined in terms of its induction of specific physical and anatomical alterations in the internal body. It is described in terms of the supernatural power of the primary instrumental cause - the khadim (supernatural servant), which becomes manifest in altered social, psychological, and physical behaviour.

Sorcery is said to be effective through a variety of supernatural

acts, known only to sorcerers themselves. But informants describe some forms of imitative magic as characteristic of sorcerers' activities. An informant noted,

> SiHr can be made on an egg on which reading is done and a hole is pierced in the egg. It keeps dripping and the person keeps bleeding and bleeding, sometimes even to death. It was made for me; I think it was my neighbour. Once I kept bleeding for two months, and once for a month. The doctor said I had a miscarriage, but I know I was not pregnant. I know it was a ʿamal (sorcerer's deed) and after this my period never came again.

The sorcerer's magic may also be performed on the intended victim's aTar (a word derived from classical Arabic, meaning effect or remains). This may be anything which came in touch with the intended victim's body or derived from it. aTar may be in the form of an article of clothing, hair, a finger nail, or a rag used to wipe a person's sweat, blood, semen, or excreta. Any of these items is acquired by the sorcerer through persons on whose behalf harm, including illness, is to be inflicted on a specified victim. The sorcerer "concentrates his determination" (yi ʿazim) on the aTar by reading appropriate Quranic passages, thus summoning the khadim (supernatural servant), the instrumental cause, to bring about the specified form of harm on the intended victim.

The diagnosis of ʿamal bil maraD extends primary emphasis to the ultimate cause, the social relations which prompt the use of sorcerers' services, not to physiological, anatomical processes involved in the precipitation of illness. Neither does diagnostic procedure seek to identify the sorcerer him/her-self. The sorcerers, whose services are compensated with money, does not act on his/her own, but performs

his/her magic at the request of others. Sorcery accusations clearly reflect strained social relations and ʿamal bil maraD is considered a form of revenge. H.T. related how the people who had originally wanted to marry their daughter to her cousin's bridegroom "tied" the groom (i.e., rendered him sexually impotent through sorcery) on his wedding night. He was "released" (itfak) after three whole days of constant Quranic readings. She also related the story of a man who was known to engage in extra-marital sexual activities. His wife had him "tied" for other women, but not for herself. This account reflects the social control function of sorcery. According to H.T., the husband stopped frequenting other women when he heard what his wife had done for him, "for fear that he would be embarrassed in front of them (his lovers)".

Sorcery was also implicated in other cases of male impotency. A woman who had taken a married man from his first wife of several years related her husband's case of sexual impotence as follows:

> Fifteen days ago he was tied, then Shikh Z released him. But now S is marbūt (tied) again. He says that his first wife wrote for him. He knows that from seeing his aTar (a diagnostic procedure) with Shikh Z (a local diagnostician). The Shikh wrote Quranic words in two ceramic plates and made S. drink water from these plates. He (S.) said that after drinking from the second plate, he felt numbness coming down through his body and it went out from his toe. He was cured. Then he was tied again, he would get an erection but as soon as he approached me, he would loose his erection....(two weeks later)...He told S.N. about his condition. S.N. attributed it to excessive consumption of Hashish and advised him to abstain from Hashish and his wife for two days. He did as he was advised and when F. came to see me today in the morning, she found me bathing (i.e., after engaging in sexual intercourse).

The results of sorcerers' magic are also illustrated in the case of N. It is said that,

> First she was married to M.M.'s brother and then fell in love with a man called Shikh I.Z. who wrote for her (performed sorcery) to be divorced from her husband. After this, she went to him and told him to marry her. He married her and her first husband started to write for her in D. (a nearby religious centre). She became crazy and they sent her to the palace in Hilwan (a mental institution outside of Cairo).

Still another illustrative case of sorcery is that of R., the daughter of M.K. It is said that M.K.'s cousin wanted to marry him. But R. objected since her (sick) mother was still living. The father's pursing bride wrote for R and she became ill. She lost all her hair, she had very severe knee pains and eventually she could not walk. She remained this way for four months until they found a Shikh in a nearby town who could untie (yifuk) the deed (ʿamal). Finally, another case of ʿamal bil maraD was described as follows:

> She used to be fat and beautiful. Now she is skinny and ugly. She looks like a shadow. She is pale and weak. She drank siHr...probably from her husband's relatives. She had a big fight with them and they probably wrote for her bil mukraha (for hatred, i.e., so that her husband would hate her). They tricked her and made her drink the siHr[27].

D. Specificity of Illness Explanations

Examination of the village medical system reveals the primacy of causation as a diagnostic index as well as villagers' emphasis on the social componet of the wordly environment as ultimate causation. But while the static account of medical beliefs informs us of the underlying logic of villagers' medical taxonomy, it does not adequately reflect the actual use to which that taxonomy is put in specific illness cases. Neither does it illuminate the social

processes surrounding an illness occurrence (Cf. Fabrega 1976). Selection of one or another of the recognized causes of illness to explain a given illness condition is neither pre-determined nor random. Medical theory is important as a probe into the dynamics of social life. Elements of the system of illness taxonomy are tied to actual episodes. Consideration is extended to sociocultural factors including social role, the developmental cycle of the family, and interpersonal power relations.

In FatiHa, selection of cause is contingent upon duration of an illness, its behavioural and physical manifestations, and the social dynamics of interpersonal relations perceived to be associated with a case of illness. Thus, if a child falls ill, a natural cause may be extended to explain his/her condition. Reference may be made to poor appetite, over exertion in work or play, or to sunstrokes. But a child may be labelled MaHsud (affected by the evil eye), retrospectively, after he has been "seen" (itnazar) by someone who is disliked or feared. The label maHsud may also be assigned to the child if the illness is considered to have occurred suddenly or if it lingers on beyond the period generally associated with the illness level assigned during an earlier phase. In such cases, cause is also determined retrospectively. Thus, a child may feel tired and irritable, but if his/her condition persists, one or more members of the family may recall that earlier during the week, or even as long ago as a month or more, the child had been "seen" by a person whom the family perceives as possessing the evil eye. This "telescoping" of illness explanations, which has also been described for culture-bound illnesses elsewhere (Rubel 1964 Cf.

Uzzell 1974), also holds true for other illnesses in FatiHa. Its operation in relation to the illness of ʿuzr is noted below.

The situational determination of illness causation is also illustrated by cases where informants may attribute someone else's illness to the wrath of God as a punishment for wrong doing to other members of the community. By contrast, other informants who are friends of the sick person, or his/her relatives, will explain the illness in terms of a number of other, diametrically opposed, causes, including his/her overwork on behalf of community welfare.

Still another illustration of illness explanations is related to sorcery. Thus a wife may explain her husband's impotency by reference to sorcery because she might have taken him from another woman who is expected to take revenge for such action. Similarly, a man may be interested in marrying a particular woman but is rejected by her family. Enraged by the insult, he may resort to sorcery and "write" that the desired bride remain unmarried, fall ill, or even die. In short, the social conditions for implicating sorcery must exist in people's perception of interpersonal relations so that sorcery may be selected as an explanation of a case of illness. Furthermore, the actual verbalization of witchcraft or sorcery accusations follow a culture specific etiquette. Accusations of these supernatural acts are never communicated to the suspected person/s directly.

The difference in informants' description of the motivation of ahl il arD (people of the ground), noted in Section B, also points to the situational variations of illness explanations. Persons who are themselves the victims of supernaturally caused illness are

likely to interpret the action of supernatural beings as emanating from a sense of concern. One such person in relating her case of lamsa ardiya (touch from the ground or ʿuzr) noted,

> When my husband died he left me with three girls. They were all little. I took my share (of father's inheritance) and I brought my daughters up. I got them all married. Two are outside (her household). My second daughter's husband is very poor so he lives with me. I became ill about five years ago when my daughter got married and I became sad because I have no son or husband, and my brother, God forgive him, would not help me. My sadness turned to illness. My sister took me to the doctor, but the more of the doctor's medicine I took, the worse off I became. So people said that I am maʿzura (afflicted by the illness of ʿuzr). The assayad (masters, i.e., supernatural beings) talked. They said that they are from Saudia, from the land of the Prophet. They told everybody that when I am not happy they make all my body blue. They knew that my brother was not saying the truth when he refused to help me. The assyad from Saudia knew that I needed help. So in order to show my brother that I needed help, they spoke to them all through me and made them know that I need their help.

When this maʿzura's brother (who according to village norms is expected to help his sister financially) was questioned of his sister's ʿuzr, he stressed the malevolent power of ahl il arD and even condoned their punitive actions, of which he regarded a "greedy woman" deserving.

In considering medical taxonomies, one must be aware that illness beliefs, when considered as isolated cognitive domains (Frake 1961), differ from actual responses to illness. This reality is further underscored by the case of a village government employee who consistently rejected the "nonsense" of supernatural explanations of illness by other villagers, only to extend such an explanation himself when physicians failed to cure his own daughter. Additionally, structured interviews reveal that when presented with hypothetical cases of

illness, there is no complete agreement among informants about their associated illness dimensions (Cf. Fabrega 197). For the study community, the lack of complete consensus is reflected in Section B of Table 5.4, 5.5, 5.6, and 5.7. These summaries of the evaluation of degree of consensus among a sample of 55 informants, who were asked to associate different illness indicators with the illnesses of Tarba, Hassad, ʿamal bil maraḌ, and ʿuzr, respectively, indicate lack of complete agreement and show that the members of village society do not all share a unified, standard body of knowledge about illness. The incomplete consensus indicated among the total sample population (and summarized in the above noted Tables), is also evident when the sample population is differentiated into subgroups of practitioners and non-practitioners. This point will be pursued in greater detail in the following chapter.

In considering the situational variation of explanations of illness, it is also important to note that, as for hypothetical cases in actual cases of claims of illness, the very identification of illness is not always the subject of complete agreement. Through observations and interviews in FatiHa, it became evident that the definition of illness entails a subjective evaluation. Thus, in census taking, a common discrepancy was noted between mothers-in-law's evaluation of their daughters-in-law's health and the descriptions of these daughter-in-law's own health status. When a mother-in-law was asked about the health of one of her daughters-in-law, she sometimes asserted that it was normal by labelling her "as strong as a horse", or "like a ʿafrita (supernatural being)". When some daughters-in-law themselves

were interviewed directly, they sometimes verbalized complaints which their older affines never even hinted at. When asked if they had fallen ill within the past year, many of these young women responded by saying, "yes", "of course", or "illness never leaves me". By contrast, a mother-in-law may identify her favourite daughter-in-law, or her own daughter's limited contribution to the family work force by labelling her sick[28] ("weak", at her end in pregnancy", or "overworked").

While the illness role provides legitimacy for deviation from role expectations (Parsons, op. cit.), the dispensation of such legitimacy is itself subject to social constraints related to power relations. Thus, a woman may claim illness, only to be contradicted and overruled by her more powerful mother-in-law, husband, or older brother/sister-in-law. Only under conditions of socially agreed-upon illness is it considered permissible to subordinate the collective interest of the extended family to that of an individual member. Manipulative behaviour and strategies of indirect control by individual females are not feasible alternatives in the face of lack of control over culturally valued power bases. Adoption of the sick role is primarily subject to institutional structural constraints (including power relations), not the "tendency to adopt the sick role" (Mechanic op. cit.). It is not only the individual "tendencies" of daughters-in-law (or other relatively powerless social groups) which determines their adoption of the sick role; it is also the reality of their relative powerlessness. In extended family households, an individual, powerless woman's self interest is subordinated to the collective interest, defined by the powerful figures in the collectivity. Any deviation from such a

state needs legitimization and illness provides such justification, but only when feasible. Moreover, illness does not alter the basic power differentials. It simply mediates (momentarily) the contradictions inherent in the social relations of production, characteristic of extended families, and their attendant superstructural elements which define and justify relations of sub-super-ordination among family members.

Since the explanation of a declared illness state may vary from the assertion of stressful experience by the afflicted person (and his/her supporters) to the outright dismissal of his/her behaviour as "faking" (dala') by a non-sympathetic household member, an independent opinion from an expert, a diagnostician, must be sought. Such an opinion extends legitimacy to a contested claim of illness. The traditional medical practitioners, as one of them told the author, willingly dispense the label of legitimacy, they even anticipate the types of problems which people of different social statuses themselves perceive as the basis of their illness. If for one reason or another this label is not given by one practitioner, it is sought from another. Antagonistic persons may even quarrel about which diagnosis is the "correct" one.

When diagnostic labels fail to match affected persons' (or their families') socially defined complaints, alternate diagnoses are sought. This is precisely what happens in the village when a sick person or members of his/her family reject the physician's diagnosis (which does not take into account the person's social/psychological needs, or positions of relative subservience, in explanations of illness) and

seek explanations which are compatible with the sick person's social reality and emotional state. If there is no reason to assume supernatural etiology and if the sick person and members of his/her immediate social group believe that illness emanates from a natural cause, they will continue to frequent the physician and abide by his/her advice as long as they can afford to pay the fees and purchase the prescribed medicines.

To summarize, the foregoing discussion, it is noted that medical taxonomies do not inform us that illness explanations are highly opportunistic. As static classifications they do not inform us of the social process of selection of illness causes and ensuing labelling of illness occurrences. They ignore sociocultural dynamics. As Fabrega has pointed out, "The taxonomy is literally a cultural device for assigning meaning to an ambiguous and potentially ominous occurrence and members of a group can differ in terms of how they use such devices" (Fabrega, 1976:208). Actual explanations of illness depend on the afflicted person and his significant others' perception of social reality at any given point in the duration of the illness. In FatiHa, selection of a specific cause to explain an illness occurrence (and the appropriate treatment strategy associated with that explanation) is a function of the duration of the affliction, its physical and behavioural manifestations, its response to certain types of treatment, and, of particular importance, the types of social interpersonal relations which surround the affected person and his/her significant others.

In trying to understand why explanations of illness (and its

consequent treatment) do not always correspond perfectly to specific beliefs about illness or the appearance of specific symptoms, it should be realized that in FatiHa, illness is not a socially isolated category of negative experiences (Cf. Kleinman 1977). Illness, broadly conceived, belongs to a general category of misfortunes which transcends a sharply delineated "medical" domain (as characteristic of biomedicine). Illness in FatiHa is to be understood, not simply in terms of physical constitution[29], but more importantly, in terms of social dynamics, including social conflict and social control. It is through the critical examination of actual illness episodes that the medical system can be effectively utilized as a probe into social life, including the dynamics of gender roles and power relations. The following section undertakes this task through an in depth examination of the culture-bound illness of ʿuzr.

E. Illness Explanations and Power Relations: The Illness of ʿuzr

From the foregoing discussion of illness theory, it is clear that interpersonal relations are central aspects of illness explanations among the people of FatiHa. But as noted in Section C, the importance of medical theory as a probe into the dynamics of social life is realized only when elements of medical explanations are tied to actual illness occurrences. In pursuing this task in the present study, the illness of ʿuzr has been selected for in depth analysis which links causation to the dialectics of social life, particularly in terms of power relations and gender roles.

The choice of ʿuzr rests on the author's contention that this illness is particularly relevant to power relations and to (gender) role behaviour. This judgment, is shared by the people of FatiHa themselves. They view ʿuzr as an indicator of asymmetrical power relations. Beyond the village, cross-cultural studies have shown that possession trance (of which ʿuzr is a local variant), is more likely to be found in societies with differentiated levels of jurisdictional hierarchy than in societies in which power relations take on a more egalitarian form (Bourguignon 1968, Cf. Bourguignon 1972:11). In terms of role behaviour, the onset of the illness is accompanied by a more marked departure from culturally stipulated role behaviour than is the case with some other culture bound illnesses. Thus, a woman who has been affected by the Evil Eye, for example, may feel headachy and drowsy, but she does not withdraw from social life, and ordinarily, goes on about her business of fulfilling her maternal responsibilities (compare the dimensions "does not socialize" and "cannot fulfill maternal responsibilities" for Hassad - Evil Eye - in Table 5.5 to those for 'uzr in Table 5.7). This is in sharp contrast to the condition of a female informant who suffers from ʿuzr. She refuses to nurse her son (a most unusual form of behaviour among village women) and her participation in neighbourhood social intercourse is minimal.

The social significance of ʿuzr is also marked when it is contrasted with another culture bound illness, rabT (typing or rendering sexually impotent through sorcery). In case of the latter, although the consequences of the state of illness involve a drastic deviation from expected role behaviour, they are of a more private nature. The strikingly

Table 5.7. The Illness of ʿuzr: Illness Dimensions Associations. N=55.

Illness Dimension	% Positive Association
A. Cause	
a. Instrumental	
1. nat. envir. & subs.	2
2. phys. constitution	4
3. spt. instrus. (malbus)	95
4. Hassad (gaze)	20
5. ʿamal (sorcery)	0
b. Efficient	
1. God	20
2. Hassid (witch)	20
3. Assyad (spirits)	87
4. saHir (sorcerer	5
c. Ultimate	
1. sadness	87
2. anger	89
3. jealousy	7
4. hatred	9
5. punishment by God	2
6. fear	82
B. Symptoms	
a. behavioural	
1. sleeps more	56
2. insomnia	73
3. eats less	84
4. loss of consciousness	85
5. tayih (in a daze)	85
6. cannot bear himself	85
7. makes no sense talk.	82
8. disrespect. to super.	71
9. does not socialize	80
10. depressed and unhappy	89
11. cries	91
12. cannot run after bread	89
13. cannot discipline children	69
14. cannot unite with wife	80
15. cannot pray	71
16. cannot fulfill maternal resp.	75
17. cannot fulfill duty as wife	76
18. cannot do housework	93
19. yawns often	45
20. does not speak much	45
b. physical	
1. weakness	93
2. headache	95
3. aches all over	95
4. trembles	62
5. hot-cold spells	20
6. coughs	20
7. chills	24
8. nausea	36
9. weight loss	69
10. vomiting	27
11. swelling	31
12. loss of balance	73
13. diff. in breating	75
14. lump in throat	58
15. diarrhea	20
16. fever	38
17. pain in joints	78
18. earache	56
19. watery eyes	54
20. rash	11
21. backpain	71
22. dizziness	87
23. chest pains	51
24. stomachache	45
25. excess blood in body	7
26. excess water in body	2
27. drying of blood in body parts	58
C. Severity	
1. minor illness	9
2. significant illness	7
3. heavy illness	80
4. fatal	67

Table 5.7. Continued.

Illness Dimension	% Positive Association
D. Age Relatedness	
1. children only	0
2. children mostly	7
3. adults only	4
4. adults mostly	89
5. older people only	2
6. older people mostly	9
E. Sex Relatedness	
1. females only	2
2. females mostly	49
3. males only	2
4. males mostly	7
5. both males and females	31

more public or social nature of ʿuzr is also reflected in the therapeutic efforts to pacify the illness causing spirits. Such rituals are often performed in a public arena, in full view of an audience of relatives and other fellow villagers. Moreover, the very term ʿuzr (excuse) provides the illness with a social definition. It offers the maʿzūr/a (excused) a temporary dispensation from the requirements of social canons. The alternative term malbūs (worn or possessed), which more explicitly, refers to the pathology of the illness, is used more frequently by practitioners, but seldom utilized by the majority of villagers.

The condition which inhabitants of FatiHa describe as ʿuzr is clearly a variant of a world wide phenomenon generally referred to as spirit possession. While the local form is interpreted and dealt with according to culturally specific assumptions (see Table 5.7), it partakes of the general patterns described in the literature on spirit possession (Lewis 1971; Oesterreich; 1974; Walker 1972). As in other forms of possession states, ʿuzr entails the invasion of a person's body by a spiritual agency. Disturbing emotional experiences are incriminated in the incidence of the ensuing illness. Both physical and behavioural symptoms are used as diagnostic indices. Thus, in addition to correlating ʿuzr with non-specific bodily symptoms, informants regularly referred to impaired social behaviour in terms of interpersonal relations and to deviations from culturally recognized role behaviour.

The onset of the sumptoms of ʿuzr cannot be attributed to a single case. Instead, informants' interpretations of the onslaught of the illness disclose more than one level of causation. One is

able to isolate an efficient cause, an instrumental cause, and an ultimate cause (Glick 1967). Supernatural beings (awlad il arD or assyad), the efficient cause, are believed to be the agents of the illness. Their actions are usually explained in terms of their concern for the welfare of the persons whom they possess. Their seemingly contradictory conduct of inflicting illness upon such individuals is rationalized by both the maʿzur/maʿzura (possessed male/female) and sympathetic members of his/her family. It is said that the spirits, by inflicting harm on humans, exert pressure on them and force them to evaluate their detrimental practices[30]. The assyad's concern for the well being of their victims is reflected in the case of a female informant, whose sayid "arrived" during the course of an interview with the author. She stopped talking suddenly and said, "I feel heavy, I feel he is coming now". Her voice changed and sounded more masculine. The new voice said, "I have been coming to U. for fifteen years because she was screaming. When the author inquired, "why did you make her ill?", the voice answered, "We make her ill so that she can tell them that she cannot go to the doctor...We are from Saudia, the land of the Prophet and when good people are present we come. When she is not happy we make her whole body blue and when she regains her consciousness we make our demands which are for her. We ask for perfume. When she is unhappy we become unhappy too and so we punish her by making her ill... because we love her".

The specific mechanism by which the assyad affect the body is not a point of agreement among informants, including diagnosticians. Some people believe that illness may be precipitated by the actual invasion

of patients' bodies by the spirits. Others indicate that it is brought about simply by their touch (lamsa) or through their winds (aryaH). Since the aryaH or the jinn (assyad) are not stationary, once they enter the body, the pain associated with ʿuzr is mobile. This is a distinguishing diagnostic criterion which affected persons themselves emphasize and which is communicated to healers and recognized as a basis of their diagnosis. It is a distinguishing diagnostic index which differentiates this maraD rawhani (spiritual illness) from maraD gussmani (physical illness). The pains of ʿuzr are not allowed (by the spirits) to subside until measures are taken to rectify patients' situations of distress. Thus, the ultimate cause of ʿuzr is sought in affected persons' social relations. The affliction is known to be induced by a variety of negative emotional experiences, including those associated with subordination, sadness, fright, quarrels, anger, and generally, interpersonal conflict.

The illness of ʿuzr may also be considered a secondary illness which results from an untreated case of nazra insaniya (human gaze, i.e. the evil eye). It is noted that if a person who is maHsud (affected by the evil eye) does not get immediate treatment (through ragwa - the recitation of Quranic verses), then he/she gets a ʿuzr which results from his/her state of depression which was brought about by the evil eye. This secondary precipitation of ʿuzr may be detected by a diagnostician when he summons the assyad. When the assyad speak, they indicate that they came taHt nifss (under a wish, the wish of longing). ʿuzr is also believed to be the outcome of ʿamal bil maraD (the illness of sorcery). As in the case of the evil eye, it is said

that the writing of sorcery causes sadness and the person becomes ill and lies down all day. He/she does not want to be bothered or talked to by anyone. This depression makes the assyad come to the person and he/she then becomes ma'zūr/a.

Representative cases of reported accounts of 'uzr will help illustrate the role of emotional distress and interpersonal conflict in the precipitation of the affliction. I.N., a male household head who had gotten his first attack of 'uzr as a child emphasized a frightening experience as the cause of his original 'uzr. He also emphasized the role of sadness in prompting the assyad's return many years later. In describing his case he said,

> Eighteen years ago I was swimming in the river. I fell into the deep part of the water and got frightened. Suddenly I felt that my body was hurting. My bones were hurting and the pain kept moving around. First it came in my joints and moved around. I stayed in the bedding and could not sleep...I ate everything, the 'uzr does not prevent one from eating. It is other types of illnesses which make people lose their appetites. They (members of his household) made me a tabwika (a treatment for moisture in the body). They took me to the Hadra[31] and my body reacted to one of the Tariqa[32]. They (the assyad) talked and they said they wanted supper. They never come any more, they never came until today, I feel they are back. Now they came because they know I am sad, they know that my daughter wants to leave us alone and live with her husband in another house. Now I get the same pain all over. It starts in my head and then moves all over my body. The Shikha A (a local healer) talked to my daughter and tried to put some sense into her and she said she will make us a sulHa (a reconciliation ceremony to pacify the assyad).

A few days after I.N. gave the above account he said that he was cured. The Shikha A. had talked to his daughter and had performed a sulHa.

The case of S.A.E., a married female residing in an extended family household, in addition to identifying the evil eye as an indirect

cause of ʿuzr, also implicates sadness. It also shows how asymmetrical power relations between a woman and her husband are the bases of such sadness, which is in turn advanced to explain the occurrence of ʿuzr. S.A.E. described her condition as follows:

> My ʿuzr came in the field when I fell after some people gave me nazra (gaze). In this instance the khawaga (foreigner) possessed me. If I do anything Islamic, if I pray, if I fast, or if I give alms, he makes me ill. He makes my head pound. My body becomes feverish and I cannot sleep well. He comes when people upset me. Then he told those with me in the house that if they upset me he would kill them and would provide me with money to live in another room. He told my husband, if he hit me again he will take his revenge from them and he asked my husband not to hit me. He forced my husband to forgive me.

A few months after the above account was given, S.A.E. got another attack following a fight with her older brother-in-law's wife. S.A.E.'s husband hit her again. Her account of the incident is indicated below in an interview with the author:

> Q. I heard that the assyad came to you yesterday. What did they say?
>
> A. Yes, the khawaga came and also Mariya (a name given to a foreign - European - woman). I did not feel anything. They (members of the household) say that the khawaga caught my husband from the neck and told him, "I will kill you if you lay a hand on her again".
>
> Q. So what will you do now?
>
> A. I feel very weak and so I will wait till next week to go to the Hadra. I feel my whole body is heavy and I don't want to touch any food, and for awhile my head hurts then the pain moves all over my body. My breath goes completely.
>
> Q. Why don't you come with me to the doctor? Maybe he will give you some migawiyat (strengthening substances)?
>
> A. I know there is no use going to the doctor. He does not know anything about ʿuzr. But I will come with you just to change the scenary.
>
> Q. Do you want to forget your troubles? Let me show you something that will keep you occupied for awhile (the author then turned to administer the Hakky personality test to her).

S.A.E. was consequently given a physical examination by the project physician and the personality test administered to her was analyzed by the psychologist. The results were as follows:

Physician's Diagnosis: B.P.: 130/70 (normal)
Chest: Chronic infectious bronchitis
Abdomen: Umbilical Hernia

Psychologist's Diagnosis: Severe Hypochondria.

It should be noted that while the physician's diagnosis explains what S.A.E. referred to as "my breath goes completely" by labelling her condition "chronic infectious bronchitis", it fails to explain her 'sadness". It is the latter condition which S.A.E. considers critical and therefore finds the physician's diagnosis "incorrect". Moreover, she refers to the physician's diagnosis (which is similar to those communicated to her by other physicians) as still another proof of doctors' ignorance of ʿuzr.

The case of F.A.A., a young divorcee living with her widowed mother, also illustrates how emotional distress and asymmetrical power relations are implicated in the occurrence of ʿuzr. The following account was provided by F.A.A.'s mother in her daughter's presence. The latter was extremely shy and would not answer any of the author's questions and simply smiled back in response to the probing questions. The mother related the daughter's case as follows:

> When she was young she was in school and wanted to leave during the recess. But while she was stealing her books and getting ready to leave, the teacher caught her and F. screamed. She was about nine years old. She fell unconscious. Two years later her father scolded her and she fell unconscious. Her father made a zar (ceremony to entice the assyad). In the zar, Shikh Ibrahim, who was possessing her, spoke and said, "I've been

with her since the day of the school incident". He asked for silk and shoes when she (F.) was in the Hadra. So we had to dress her very well. By the time she was sixteen, she was engaged. The Shikh Ibrahim came again when she got married. He said that he would take care of her and when she went to her husband's home in a village near us and her mother-in-law gave her lots of work, he (the possessing spirit) said that he would help her with the housework...because no human being by herself could do the work. Everything went well with her husband and his mother at first. She became pregnant and had a daughter. When her daughter died she got a shock from crying too much and she became malbusa (worn) by new assyad. This time they were two Christian assyad. She would fall asleep while she is sitting and sometimes she would sleep all day long and at night she would shiver all over her body. When I asked them (the Christian assyad) to salute Allah (yiwahidu allah) they still would not stop (making F. shiver). So I realized that they must be Christians. I took her to several healers. The first one touched her forehead and took her to the Hadra but nothing happened. I took her to many shikhs, i.e., traditional healers. One of the healers suggested that I take her to a physician for electric shocks. So I took her to the doctor after she had been rude and mean with us and refused to nurse her son. Her husband told me that he has no use for her so I brought her here with me. When I took her to the doctor, he gave her three sittings of electric shocks. But this did no good. People suggested for me to take her to a church in a village near us. I paid the Christian healer 3 pounds. The Christian priest asked the Christian assyad to leave her and when they wouldn't, they beat her and ironed on her body and put a burning cloth near her nose. But they would not come out. She was in great pain. The sessions with the Christian priest lasted for a number of hours for three consecutive days during which three men (assistants of the healer) beat her with bamboo sticks, but all this was to no avail. When we returned home she would sleep and she would still refuse to nurse her child. Whenever I tell her to take care of her son she shivers and losses consciousness and goes to sleep.

After F. had been living with her mother her husband paid them a visit. Seeing that there was no improvement in her condition, he told the mother that he would divorce her daughter and marry another woman from his own village. Following this visit, the mother informed the author that F. had gotten the dur (the round) again and that she had been crying and shivering at night. During the following warmer months, F. usually sat outside her house while her sister and mother

worked in the fields as day labourers. F. was entrusted with the housework and the care of her son while the other women were away but her mother complained that she slept a lot.

The author managed to administer the Hakky personality test to F. It was very difficult to get her to answer the questions. It took her much longer than any other person to whom the test was administered. She answered the questions with great reluctance. F. was also subjected to a physical exam by the physician following her dur. The diagnoses of her condition are as follows:

Physician's Diagnosis: B.P. 130/70 (normal)
Chest: Bronchitis
Heart: Free
Liver: Free
Spleen: Free
N.S.: Psychic Depression, most probably due to accident or sorrow from husband's behaviour

Psychologist's Diagnosis: Paranoid (persecutory)

F.'s neighbours and acquaintances all agree that she is ma'zūra. They attribute her 'uzr to lonliness, because she was married outside the village. They say that the people of her husband's village are "without religion" (without compassion) and her mother-in-law was mean to her and that is why the assyad came to her. When asked if F.'s condition is improving at all, a neighbour noted, "of course not. This illness needs money. Her mother is a poor woman and she cannot fulfill the demands of the assyad. F. is like you have seen, she does not work in the fields and she cannot even take care of her son".

While the women in F.'s immediate neighbourhood did not express any fear of her, a distant acquaintance of the family did express

fear of violence on the part of F. She said, "you saw her joking around with me with that knife in her hand. I was scared to death. Her mother is afraid that she would kill her own son. She sometimes holds him very hard and has nearly smothered him to death on several occasions". If this claim is true, then F.'s mother's insistence that her daughter's condition is due to ʿuzr, may be interpreted as a way of avoiding the shame of having a daughter who bears the physician's diagnosis of marad ʿasabi (sickness of the nervous system). This point will receive further elaboration below.

Finally, the case of F.E.D. gives further illustration to the role of emotional distress in the affliction of ʿuzr. F.E.D. related her case as follows:

> They forced me to marry my husband. He was married to the sister of my mother. When she died they put pressure on me to marry him. After two months of marriage, I was sleeping one night and in the middle of the night I found in my dress a bunch of cats and mice. I kept saying "Ya Allah", "Ya Allah" and then fell off the bed. I ran out of the house and told him (her husband who works as a night watchman) that if he doesn't come and spend the night in the house, I would go back to my father's house. My husband answered, "is there anyone who is afraid of her own house?" and he came and sat beside me on the bed. We both stayed in the bed for forty days. He felt very headachy and his whole body was aching with a fever. He only ate water and sugar and milk. He was cured from the barber's injections. As for me, I felt pressure on my throat and I hallucinated. Sometimes I was happy and sometimes I used to scream and yell. I felt that my whole body was aching, I felt in a daze. I used to drink water and sugar and I don't know what else I used to eat. My husband took me to the doctor. The doctor told him that I only have a slight fever. But I knew that it was not a fever at all. I had a ʿuzr. (Where did your ʿuzr come from?). (It came) from Sidi Ibrahim and from the Sayid il Badawi (shrines of two saints in two privincial towns which are considered two of the major religious centres in Egypt). The Sayid il Badawi and Sidi-Ibrahim (two saints) came to me in the form of cats and mice. When they saw my aTar (a diagnostic procedure), the shikh

> (diagnostician) in B. said that I am malbūsa (worn) by two men, one from Sidi il Sayid, and one from Sidi Ibrahim. (How did this happen?). I was bathing and a woman passed me by and I had so much soap on my body. The woman said, "you have enough soap on for a full day's laundry", and that is how I became maʿzūra. I was unhappy and this is what caused all this illness...My body was affected by her eye and there was no one around to recite for me because I was by myself. My state of sadness made the assyad come to me. (Did you go back to the doctor for your illness?). In the beginning I did. But what does the doctor know about this? When I go to see him I feel fine and he says there is nothing wrong with me. After many visits to the doctor, my husband and our neighbours told me that I should give up on doctors and there is no sense spending money on doctors who know nothing of this illness anyway. The doctor said that I need an operation for my barrenness but I know that my childlessness is from nazra arDiya fi bit il wild (subterranean gaze in house of child).

Many people in the village feel sorry for F.E.D. because she is married to S.N. (who is said to be old enough to be her grandfather). Her friends agree with her explanation of her barrenness in terms of her ʿuzr. Some of them also blame her husband's old age. R., her older sister-in-law, on the other hand, feels that F.E.D.'s barrenness is khilga (inborn) and that "she would never set her eyes on children". Although R. herself once suffered from ʿuzr, she does not believe that F.E.D. is so affected and says that she is only making up excuses because "she cannot give her husband a little child for him to enjoy in his old age". On one of the visits to the Hadra by F.E.D. and the author, F.E.D. announced that R. would accompany us. She said, "maybe when she sees my condition in the Hadra she will have pity on me and her tongue will stop playing (i.e., she will stop her gossip). I want her to hear from shikh M. when he sees my aTar." The appeal to the authority of the diagnostician to lend legitimacy to her claim of ʿuzr is clear in this statement.

About three months prior to the author's departure from the village, F.E.D. suspected that she might be pregnant. She was examined by the project physician whose diagnosis indicated, "enlarged uterus of two months gestation". Following this announcement, F.E.D. stopped going to the Hadra. On occasion, during the author's presence, she even advised some women that the traditional diagnosticians are swindlers. It is also interesting to note that F.E.D. took R. (her arch enemy) with her to the doctor's office on the second visit "to make sure that she hears the doctor say that I am pregnant".

To resume our description of the illness of ʿuzr, it is noted that apart from shamanistic diagnostic practices, the identification of ʿuzr seems to rest primarily on behavioural changes and on the changing loci of physical discomforts reported by the maʿzūr/a. While there are definite signs of withdrawal from social life and deviations from social role behaviour, the symptoms of ʿuzr are anything but specific. Behavioural correlates of the illness may include such contradictory conducts as excessive sleep and insomnia. The most significant diagnostic physical symptom is mobile pain. Other physical indicators of ʿuzr are variable and may include any combination of a variety of symptoms. This variability of physical and behavioural symptoms mitigates against isolation of a specific illness yndrome. Moreover, a valid explanation for the occurrence of ʿuzr is not always readily available at the time of the adoption of the illness role. It is possible for a person to be labelled maʿzur by reference to a disturbing emotional experience which occurred several years prior to the manifestation of symptoms[33]. The case of F. illustrates this telescoping

effect of illness explanations. F. lives with her mother-in-law in an extended family household. Her mother-in-law was described by a neighbour as "unbearable". The neighbour also noted that because F. is ma'zūra, she is allowed to go to the Hadra in the nearby village. This informant noted that this departure by F. from the household was the only occasion in which she "could breath" (i.e., feel free from the control of her mother-in-law). The telescoping of illness explanation is reflected in the mother-in-law's account of F.'s 'uzr. She said,

> F. was working cleaning the wheat, she fell. But the assyad did not cause her any illness right away. Two years later she became ill. She complained that her whole body hurt and she kept sleeping all day long. We took her to two doctors but the more of the injections they gave her the worse she got. Finally her father took her to a shikh in B. who made her a Higab (charm). The death of her son caused all this. She used to cry a lot during the night.

This fluidity of the symtomatology of 'uzr and its causation, makes it a convenient, readily available, illness role, contingent upon social legitimation of the ma'zūr/a's claim of illness.

The general course of 'uzr therapy conforms to the procedures outlined in both contemporary and ancient accounts of therapeutic rituals of spirit possession (El-Shamy 1972; Lewis 1974; Oesterreich 1974). The basic objective of the shaman is to establish communication with the assyad. In the context of a zar ceremony, the ma'zur/a is the vehicle of communication. Having reached an altered state of consciousness through the stimulations of a variety of musical instruments and through the rhythmic, exhaustive, swaying of dancing to a rapid beat, the afflicted person starts to speak in an unfamiliar tone of voice. The sound is immediately recognized as the assyad's

response to the shikh's (shaman's) calling. Speaking through the mouth of the ma'zūr/a, the assyad then proceed to explain the circumstances which led to their association with their host. They also set the conditions for reconciliation and for sparing their host from the ravishes of illness. Many of their demands are directed to the patient's personal advantage.

Another ceremony, a sulHa (reconciliation), may be performed and at this time the wishes of the assyad are granted. Sacrificial offerings may be made and expensive items of jewelry and/or clothing may be worn by the patient. The affected person may also be reminded to honour his/her 'ahd (promise) to the assyad. He/she is asked to reiterate his/her commitment to paying regular visits to the Hadra and joining the tariga of the possessing spirit in the dance arena.

Once a sulHa is performed, the assyad no longer cause physical discomforts to their host. They are said to make him/her out of sorts only taHt za'la (when he/she becomes sad). Thus the assyad never leave their host/ess but the symptoms indicative of the association remain dormant and surface only when the person has another unpleasant emotional experience with which he/she cannot cope adequately. Hence, once a person has experienced 'uzr, the other members of the household become particularly sensitive to his/her needs. Care is taken to avoid the precipitation of another illness crisis, and by extension an emotional and economic crisis. This cautious treatment of the ma'zūr/a is indicated in A.M.E.'s account of her 'uzr, She said,

> About three or four years ago it started. I was very sad and then I started crying. Now I feel bored and I know it must be the 'uzr. When my children upset me or if anybody tells

> me an unkind word I become said immediately. I know it is a ʿuzr because I lose consciousness. Four days ago I did not feel myself at all. I did not even know where I was sitting, it lasted for awhile. It is mostly from the children that I get upset. My husband knows that I am maʿzūra and so he doesn't like to upset me[34].

The case of a young adult, I.S.T. also reflects the family's special treatment of the maʿzūr. His brother described I.S.T.'s condition as follows:

> Some years ago when he was playing in the street some kids hit him. When he came complaining to his mother, she hit him too. He fell in the doorway of the house. He kept crying and when we transferred him to the bed, he kept shaking. The following morning he had a fever. He became very hot. We took him to the doctor. He was cured. But every time after this, whenever anyone upsets him, he would get the dur (behavioural cycle) again. His head would shake. We took him to Shikh A.H. and he made him a Higab (charm) and he became better. But until now, whenever he becomes upset he starts shaking and so we have to be very careful with him. The shikh had said that when he was hit over the doorway, because it is inhabited, (i.e., by supernatural beings), he became malbuss (worn or possessed).

The necessity of special treatment of the maʿzūr/a is understandable in terms of people's view of the nature of curative procedure connected with his/her illness. Informants, including traditional practitioners note that efforts to control ʿuzr involve attempts at eliminating the symptoms of the illness, not its cause. Indeed, from an etic perspective, the persistence of the illness is consistent with with relative stability of the structural power relations with which it is associated.

While the potential harm of ʿuzr[35] is feared by all adults in FatiHa, informants also recognized variable susceptibility to the effect of supernatural forces in general, the illness of ʿuzr included. It is said that "there are bodies which are not touched by awlad il arD (children of the ground) but the good body gets noticed

(yitnizir)...it is only the beautiful which gets affected by the 'ayn (eye) or the assyad". Moreover, as one diagnostician noted, "the assyad, they go to those who have pure blood, they do not go to people who have dam zifir (polluted blood), Dam zifir is khilga (inborn), people who have it are born this way; even the devil himself does not come to them". When asked how one can distinguish people who have pure blood from those who do not, it is simply noted that "the aryaH (winds) come only to people who are pure". The definition of "tahara" (purity) vs. "nagasa" (impurity) is clearly dependent on the nature of interpersonal relations. People who are resented by others and considered tyranical are described as being "filled with dam nigiss". Such a remark may be interpreted as a resentment of those whose control over culturally valued power bases is considered stable and relatively indestructible.

To intrude upon an area where spirits are likely to roam is a necessary but not sufficient condition for infliction of illness. The person's own psychological constitution is considered an important intervening factor. Since women are considered emotionally weaker than men, informants generally agree that women are more likely to be affected by 'uzr than men (See Sex Relatedness section in Table 5.7). As one female informant said, "Men get ʿuzr because they are more exposed to going out at night. But women get ʿuzr by less frightening experiences than men, it's because women's emotions are limited. You know women have half the aʿssab (nerves) of men". Thus, although emotional distress is generally associated with the occurrence of the illness of ʿuzr, when cases of the illness among males were related

to the author, there was often an overemphasis on the frightening effect of the experience which precipitated the illness. In the case of women, the affliction was usually attributed to crying in the dark or sadness. When asked if the same emotionally disturbing experience produces ʿuzr equally in males and females, a male medical practitioner indignently answered, "don't you know that women have half the aʿssab (nerves) of men. Men get ʿuzr because they are more exposed to going out at night, but women get it from the slightest fright or sadness. Women's emotions are limited".

As indicated, females are believed to be more susceptible to ʿuzr due to their weakness, which is believed to be Tabʿ (in one's nature). As ideology, this belief legitimizes, the power differentials between males and females, including those which prompt the illness of ʿuzr. Although this characterization of village social organization may be regarded as "etic", it is not different from some informants' own evaluation of the basis of what is conceived to be a higher rate of incidence of the illness of ʿuzr among females. In addition to informants' generalized belief about females' greater susceptibility to ʿuzr, some (men and women) refer to a social basis for the differential occurrence of the illness. As one informant noted, "the ʿuzr of women is heavier than that of the men because they are marūsīn (bossed). If a man tells her to do something and she refuses, he will hit her and make her sad". Another informant generalized this statement to all village women, he said, "women in the village have no opinion. A man forces his (will) on her because he is dominant, so she sleeps and says that she is maʿzūra. The conceptualization of

ʿuzr as indicative of generalized powerlessness was also indicated by an informant, who in response to the author's question, "what is the meaning of the word maʿzūr?", answered, "maʿzūr means someone who is ill and because originally he wanted certain things which could not be fulfilled, he sleeps and does not get up". It is also interesting to note that outside of the context of illness the term "maʿzūr" is used to refer to someone who is short of money and, in a more general sense to a person whose behaviour is judged as legitimate.

As its very name suggests, the illness of ʿuzr (excuse)[36] is a legitimate form of deviance. Even further acceptance of the maʿzūr/a is provided by the belief which stipulates that ʿuzr comes only to those who are of pure (tahir) blood. It is said that people whose blood is zifir (polluted) do not get affected by ʿuzr. This applies to persons who are judged as mean, stingy, and generally, do not approximate the cultural ideal of a person who is judged as Tayib (i.e., kind hearted and good to others). In reference to such persons of undesirable qualities, it is said, "how can (he/she) become affected by the jinn when (he/she) is a jinn (him/herself). When the author confronted informants with a question regarding a hypothetical case of illness and raised the possibility that the maʿzūr may actually be faking and tricking other people, the answer was that "the ʿuzr comes only to the pure, it does not come to people who trick others". In light of our earlier discussion of the specificity of illness explanations in Section C, one cannot realistically anticipate this type of evaluation in all cases when claims of ʿuzr are made.

The compensatory value of ʿuzr for persons who are particularly

susceptible to social stresses and role conflict has also been recorded in cross-cultural studies of possession cults (Lewis 1970, 1971, 1974; Maher 1974:25,97; Walker 1974). In FatiHa, although the ma'zūr/a does not belong to an established institution of the type associated with traditional cults, the illness role itself forces attention to personal grievances and distress and induces a temporary enhancement of social position. The illness role (when considered legitimate), mediates asymmetrical power relations and allows a temporary dispensation from expected role behaviour.

The case of N.S. shows how the label ma'zura permits a daughter to contradict the judgment of her father, an ordinarily deplorable behaviour. N.S. related her case of 'uzr as follows:

> I was engaged at the time. My father had hit me. I did not want to marry him (the groom). My father hit me very hard. They tell me that I slept for three days. I did not eat. They found out that I have a 'uzr when they took my aTar to the shikh S. I went to the Hadra and they made me a sulHa. The shikh Abdil Salam il asmar was the sayid who was wearing me. Because of my father's hitting in the dark, the sayid came over me. He came to save me from my father's hitting. When my parents saw me in this bad state, they said that it was not necessary for me to marry the man who wanted to marry me. When I was cured, I married another person...

Powerlessness associated with deviation from culturally valued role expectations is an important correlate of the illness of 'uzr. The case of A.S.I., a married man who resides in the household of his wife's family illustrates the association of 'uzr with absence of control over culturally valued power bases: The author was first informed of A.S.I.'s condition by a neighbour of his wife's family. On arriving at the house of the sick man, the author was met by his wife and her mother and led into a room where the wife served the

traditional tea. In response to the author's inquiry about her husband's condition, the wife said,

> You heard about his doings from M.? Last night he made us the show of the whole village. We found him sitting crying. For a while he kept crying and then started singing at the top of his voice and saying 'ya lili ya ʿayni' (a melancholic singing expression). All our neighbours came over to see what is wrong. We did not sleep for a single minute. My mother suspected that he may be maʿzūr and we were afraid to leave him alone or else they will take advantage of him (i.e., the assyad would take advantage of his loneliness and inflict great harm upon him). So after he calmed down and stopped crying and singing he fell asleep and I kept sitting beside him. By this morning when we woke up he did not remember a single thing of what happened last night. When he opened his eyes and found me sitting there, he turned to me and said, 'why are you looking at me with pity like that?'. I did not want to remind him and so I kept quiet.

Following the wife's description, and upon the author's request, we moved to another room in the house where A.S.I. was lying down in a corner covered with a heavy blanket, in spite of the heat. He apologized for not getting up to greet the author and said that his legs were too weak to carry him. He said that he was feeling very cold and gets very dizzy when he tries to stand on his legs. When asked about the cause of his illness, he responded, "allah hua aʿlam" (only God knows). When questioned about whether he plans to go out to work in the fields he replied in the negative and said, "il baraka fi Hamaya" (the blessings of my father-in-law, i.e., his father-in-law would carry the entire responsibility of work in the fields). During the remaining part of our conversation he agreed to see the physician. Apart from reference to A.S.I.'s blind eye and to Bilharziasis (a wide spread parasitic infection reported throughout the rural areas of Egypt), the physician judged the maʿzūr's health as "normal". The Hakky personality test (which was administered to the maʿzūr when he started feeling

better, about two weeks after his initial attack) was analyzed by the psychologist and her diagnosis was "hypochondriac neurotic".

Following his examination by the physician and the consumption of the vitamin tonic which was prescribed to him, A.S.I. still complained of weakness. He did not go to the field and slept for most of the day. His wife and mother-in-law both reported that he would refuse to eat most of the time, and when he did, he would "only take a bite". His singing and laughing-crying session was not repeated but he continued to complain of general weakness, headache, and shivering. When no noticeable improvement in his condition was seen by the family, his father-in-law suggested that he accompany him to see a diagnostician. When A.S.I. refused to accompany his father-in-law, the latter took the sick man's aTar to a diagnostician. The mother-in-law's suspicion of ʿuzr was confirmed. When the maʿzūr's father-in-law related the diagnostician's findings he said, "when shikha A. (a female diagnostician) asked the assyad they told her that they came to him when he was in the fields and he left the farm animals, and started quarreling with his brothers about the inheritance". At this point the mother-in-law interferred and said, "His sister owed him money and would not give it to him. Everybody kept telling him to leave the money to his sister because she has orphan children but he also needs the money". The wife then commented, "he wants to get it (the money) from her (his sister) so that we can attend to our concerns. We cannot live here (in her father's household) forever".

Following the diagnosis of A.S.I.'s condition as maʿzūr, the shikha performed a sulHa for him. His sister contributed five pounds

(a large sum of money by village standards) to buy the sacrificial poultry demanded by the assyad. When the assyad spoke through A.S.I.'s mouth during the sulHa, in addition to reiterating the father-in-law's account of the circumstances which prompted them to come to A.S.I., they said that they had come taHt Tarba (under fright). They had come when he became frightened as he turned around while speaking to his brothers about the inheritance and found the draft animal falling into a ditch.

During the following two weeks A.S.I. did not go out to the field with his father-in-law and still complained of weakness, but he could now get up and move around in the house and even sat outside the house and chatted with friends and neighbours who constantly stopped by to inquire about his health. During our conversations he did acknowledge his condition of ʿuzr but referred to it only when specific inquiries about his health were addressed to him. Reference to his condition of ʿuzr and to the diagnostician's labelling of maʿzūr seemed to be more crucial to his mother and father-in-law. While his wife showed minimum interest in convincing others of his condition as maʿzūr, encouraged him to continue to take the doctor's migawiyat (strengthening substances), and, in private, even suggested to the author that the Higab (charm) which the shikha had instructed her husband to wear was "kalam farigh"(nonsense). Her parents behaved differently. The labelling maʿzūr seemed to be more crucial to his mother and father-in-law, both of whom needed to legitimize the financial dependence of their son-in-law and clearly wanted to force his family's attention (particularly that of his sister) on his unhappy condition.

In fact, one neighbour said, "tomorrow (meaning in the future), he will get his share (of inheritance) and there will be no one like him ...so that K. (the mother-in-law) will be satisfied". Another neighbour responded, "ma'zūr, or not, who else would have agreed to marry their ugly daughter. She must be at least ten years older than him". It seems that the daughter herself was aware of this fact and did not conceive her husband's inability to live up to male role expectations as a shortcoming, in view of her own culturally defined inadequacies.

The function of the labelling ma'zūra as a culturally sanctioned form of deviance is also illustrated by the case of Z. The author's initial acquaintance with her condition came during visits with two local diagnosticians. During a visit to shikh M., he described Z.'s condition to the author as follows:

> There is a woman, she is about eighteen years old. She is married...I went to see her...They said her health is not well. Her thigh was swollen. They said they had taken her to two doctors but she got worse from the injections. I threw the rosary and found that she is ma'zūra, she has rīH (winds) and when the assyad are on people they do not like injections and stuff like that. I gave the rosary to her mother-in-law and she whispered to the rosary to show the reason for the illness. I then spread the rosary and read its signs they (the assyad) had come to her taHt z'la (under sadness). The doctor had told them that the veins in her thigh were plugged up. I told them to take her to E.S. (a nearby village). Shikh M. (a prayer writer) made her a Higab (a charm, the term derives from a classical Arabic word, meaning shield), although I told them that she needed the dagga (drumming of the zar). If the pain had not been so irregular and so mobile, maybe the Higab would have worked. The assyad were still new and so they could have been pacified and they may have left her alone completely. It is when the assyad have been in her blood for a long time that they do not leave...they (the assyad) do not settle in any of the important part of the body except if the sick person is denied the status of ma'zūr by his family or in cases where they iron on him... It all started because her mother-in-law had accused her of laxness in her work and spending too much time at her father's

> house after childbirth. She became sad and she probably went inside a dark room and cried. The woman who has given birth is like the bride, she is susceptible to the assyad.

Another traditional practitioner, a diagnostician/healer who was also consulted by Z.'s family gave the following account of her case:

> She is about twenty years old. She has been married two years. She had a child and he died when he was two months. She was very sad. She became very weak; she could not eat, she could not walk. She went to her father's house because her mother-in-law could not stand her any more. They took her to many doctors. They gave her the injections but nothing happened. The pain had started in her arms first and moved to her head, and now it has moved to her legs. They came to me yesterday. The sayid on her talked last night. He said he had come because of her sadness when she screamed in the doorway when her son died. He has not made any demands yet. Tonight or tomorrow night they will drum for her. (Will you organize the drumming ceremony for her?) No, I will not go, they will call someone else. I do not do this type of thing any more. Women move a-round and expose themselves; it is not my status.

At night the author went to Z.'s father's house following a rather reluctant invitation by the father himself. During an earlier conversation with him, he had firmly denied the reality of ʿuzr and had referred to the condition as "nonsense" which reflected the peasants' ignorance. As he greeted the author at the door, he promptly referred to that earlier conversation and shaking his head said, "adi allah wi adi Hikmitu" (this is God and this is his command). "what can one do?". In a room lighted with a kerosene lantern (a mark of relative wealth), Z. lay on the floor covered with a blanket and surrounded by her mother, sisters, and their children. The whole family's attention was clearly concentrated on her. Her sister's husband came in the room, sat near her head, and started feeding her an orange which she ate reluctantly. A little while later, her mother-in-law came over to inquire about her health and referred to her presence as substituting for that of

her son (Z.'s husband) who was away from the village in the army. Z.'s sister explained that Z. left her husband's parents' household when her illness became incapacitating. She explained that it is customary for a woman to go to her father's house when she becomes ill for a long time and sometimes when she delivers her first child. Z. looked very pale and tired. She could hardly sit up and eat and members of her family took turns propping her up in a sitting position to be fed. Conversations with members of the family, including the mother-in-law, indicated that they had at that time dismissed the doctor's diagnosis, which they said, attributed her swollen thigh to a blood clot. In a later conversation with the physician, he indicated to the author his diagnosis of Z.'s condition as "post partum thrombophlibitis". He said that Z. had suffered from an occlusion and inflamation in the fumeral vein and expected her healing from this condition to extend over a period of a few weeks. Having failed to bring about the desired improvement in Z.'s condition and having ignored her emotional distress as an important cause of her state of ill health, the physician's diagnosis and consequent treatment were judged as inadequate. Everyone present at Z.'s father's house during the author's first visit, was convinced that the doctor had failed to recognize the <u>ʿuzr</u>. Z.'s mother said that they had taken her to two doctors who prescribed many medicines which brought no improvement over a period of two weeks. Her father turned to the author and said, "you never believe these things until they happen to someone you love. I would not have believed it myself if I had not heard the shikh MuHammad from the Sayida Zinab speak last night. He was speaking through my daughter's

mouth. He said that he had come to Z. because she cried a lot in the dark after her son died. He said he wants a white dress, white shoes, and a gold ring".

As we sat surrounding the ma'zūra, she intermittently gave a few whimpers to which her family responded with comforting, loving words. A knock on the door was responded to by Z.'s father who ushered in Shikh M. (who had diagnosed Z.'s condition). Shikh M. was accompanied by shikh M. from the nearby village of E.S. and the latter's assistant. These men were received warmly by the family. They had been called over to the house because Z. herself could not be transferred over to the nearby village to attend the Hadra. The shikh and his party sat down to an elaborate meal. Then the drumming and music from the salamiya (a local wind instrument) started and shikh M. started the chanting of the different tariga(s). Everyone's attention was concentrated on Z. to see which tariga her body would react to. Finally there came the tariga of Sayid il Badawi and her body started to sway from side to side. Two of her sisters pulled her up and she kept shaking her head from side to side and waving her arms. Her headkerchief became untiled and her long hair became undone from its neat braids. She kept up this dancing for about five minutes and fell exhausted into her sisters' arms. They put her down on the Hāsīra (reed mat) and covered her with blankets. She said that she was very cold and started crying. She complained of her thigh, which she shamelessly exposed in front of the men in the room. It showed a large swollen red blotch. Shikh M. said that the pain is now very severe because the assyad are HaDrīn (present). He said that she can

rest now and later they would have a sulHa when they prepare the items which the assyad had demanded. Z. fell asleep and all the visitors left her father's house.

The following day, Z. was in great pain, her mother said that she could hardly move her thigh. Relatives and friends advised Z.'s parents to bring another shikh from S., a nearby village. One of Z.'s father's friends noted that the shikh from S. is a learned man who knows the Quran, "not just a drummer like shikh M.". In the afternoon the shikh from S. was summoned to Z.'s father's household. Her father informed him of Z.'s illness progression, emphasizing the emotional distress to which she had been exposed as a result of the death of her son and also emphasizing the pain from her swollen thigh, her poor appetite, and her inability to do any housework. In elaborating the latter behaviour, he noted, "this, as you know, is not tolerated by the family of the husband, they made her psychological condition worse. The shikh from S. listened attentively but did not touch Z. or examine her thigh. He said it was wrong to have her descend to the Hadra. He said that this simply excites the assyad and gets them in the habit of wanting to hear the drumming. When he did not make any visible sign of attempting to diagnose Z.'s illness, the author asked him if he will take her aTar to make sure that she is maʿzūra. He responded rather abruptly and said, "if saHibit il maraD (the owner of the illness) says that she is maʿzūra and her family have heard the assyad, so how can anyone say otherwise?". He then turned to Z.'s anxious parents and told them that he would prepare a Higab for her to shield her from the pain inflicted by the assyad (since the Higab contains

inscriptions of Quranic verses). He was ushered into another room which he asked to have darkened and as Z.'s father prepared to close the door, the shikh asked him about Z.'s full name and that of her mother (since it is said that the mother is maDmūna - certain - while the real father may be anyone). He emerged from the room about half an hour later with a Higab with a piece of white cloth enveloping it. He told Z.'s father that the assyad who are with her include a child (reminiscent of Z.'s own dead child whose loss caused her ʿuzr). The shikh was then ushered into Z.'s room again. Her mother supported her into a propped up position to listen to the shikh's instructions. He told her to keep wearing the Higab and not to take it off for two weeks. He said that she can take it off after two weeks but she should wear it immediately whenever she starts to feel depressed. He then turned to her mother and said, "I don't have to tell you, feed her well and let her bathe every day with rose water".

On the days following the shikh's visit to Z. her condition started improving gradually. She had been following the shikh's instructions and bathing every day and eating well. As a matter of fact, she was getting the choice food in her father's household - poultry and baked rice. She said that she was starting to feel better, and she showed the author how the swelling in her thigh had started to subside. In fact, only two days after the shikh's visit, she was attempting to walk without anyone's assistance. She apologized to the author for not being too hospitable during the earlier days of her illness. She said, "I was lost (tayha), I did not even know what was going on around me". During our conversations, it became clear that Z. was

convinced that the shikh's Higab had fulfilled its intended function and was the reason for her improved health. She said that as a precautionary measure she would still hold a sulHa for the assyad when her father is in a position to buy the gold ring that the assyad had requested.

Z. remained in her father's household for three months until her husband returned to the village. Prior to her return to her husband's extended family household, whenever the author asked Z. when she would return to live with her mother-in-law, she would make such remarks as, "my condition now cannot bear it", or "you know how it is in the husband's home, the family of the husband has no pity, or "she (her mother-in-law) wants us all to work all the time. She seems to have forgotten what it was like when she was our age. She sure takes good care of her own health".

During the months that Z. remained in her father's household, she was up and around but was still the object of pampering by her parents and older sisters. She was still considered maʿzūra by her family and friends. On the occasion of a visit by the author, Z.'s mother said that her daughter would remain with her until she is completely cured from her illness. She remarked, "the house of the man (Z.'s husband), (they) do not pity..., I would sell myself to make my daughter comfortable". Z. interrupted and said, "once they see me up on my feet they will expect me to work...the sayid (she was referring only to the child sayid) is still with me. The Higab is just to make him happy. The shikh said that he may come once or twice a month but he won't make me uncomfortable like before. I could not sleep from him

and he would try to talk to my parents all night long but they could not understand the talk of the child. Now I think he will probably come once or twice a month only".

On her husband's return to the village, Z. returned to his father's extended family household and started going to the Hadra about once a month, in spite of her mother-in-law's objections. Z. said that her mother-in-law takes her son's needs into account and is not too demanding of her in terms of housework as she used to be. This shift in the mother-in-law's treatment is obviously related to the presence of her son, a relatively educated villager, deserving of the respect of fellow villagers, including his own mother.

The foregoing illustrative account of a case of ʿuzr reveals the mediating function of the illness role in asymmetrical social relations. According to established cultural norms, Z. is expected to be obedient to her mother-in-law. Like other daughters-in-law, she is held responsible for a variety of domestic chores which should be completed to the older woman's satisfaction. When Z.'s husband was away from the village for a period of three months she was expected to go on living in his extended family household. Under the labelling maʿzūra, these cultural injunctions were temporarily suspended. Z.'s neglect of her domestic duties, her disrespectful attitude towards her mother-in-law, her eventual abandonment of her husband's home, and her residence in her father's house, were all considered legitimate forms of behaviour. This shift from one category of socially sanctioned action to an opposite, but equally approved form of behaviour, needed justification. In Z.'s case, the vindication is epitomized in the tragedy

of her child's death. This shocking and emotionally devastating experience explained her affliction, and by extension, her deviant behaviour. Under ordinary conditions, such behaviour would have had some dire consequences, possibly her divorce. It is important to note however, that without the support of her father, (whose power in the village rested on his status as a respected government employee and the owner of a few feddans of land in the village), such legitimized deviance from role expectations may not have been so easily granted.

In FatiHa, the legitimization of deviance by the labelling ma'zūr/a is not confined to women. Powerless men are also accorded temporary exemptions from positions of subordination through the social legitimization of illness characteristic of the illness role. The argument that "the ethic of health is masculine" (Nathanson 1975) is not a valid generalization for FatiHa. Neither can one consider the labelling of 'uzr simply an attribute of "low female status" (Kennedy, op. cit.), Women and men in positions of relative powerlessness, when granted the social sanction of the illness role, are allowed temporary deviance from culturally prescribed role expectations and/or transgression of their positions of relative powerlessness. The case of A.E.Z., a married man illustrates this point. A.E.Z. related the experience of his 'uzr as follows:

> I was in the TarHila (migratory labour tour) and found a bunch of dates on the face of the water. I went into the water to pick the dates. After I touched it, it disappeared from my hand. I screamed and so I got a laTah (supernatural touch). My body became worn (possessed). The safīna (ship, one of the forms in which supernatural beings appear to humans). If it is upset, it drowns a person in the mud, but if it is docile, it simply makes the person ma'zūr or takes him down with her for a few days. Some times it comes to people in the form of

> food, and sometimes in the form of jewelry. It came to me in the form of the dates. At the time I was only twelve years old. The safīna (the ship, so named because it inhabits the waters of the river) is still with me until now. When I go to the zikr[37] she comes out and talks through my mouth. Whenever I am upset and if I get into an argument with anyone, she comes out and gives hell to everyone. After the argument when I come to (my senses), I apologize to everyone for what she did, they understand and forgive me...(she came to me)...during the mulid (village patron saint's day - about two weeks earlier -) I was in the zikr. She said through my mouth that she wants to be happy, and she made me faint. That day I had been very upset with my wife. She had hit the child, although I had told her not to.

Through interviews with other informants, including the ma'zūr's wife, another component of reality emerged. During the mulid he had beaten his wife severely and her screams draw the neighbours, some of whom went over to her relatively affluent father's household and informed the family of what was happening to their daughter. The wife's brothers went over to A.E.Z.'s house and ordered their sister to collect her clothes and leave with them. A.E.Z. pleaded with his brothers-in-law not to take their sister and said that it was not he who hit her. He said that he was tayih (lost, i.e., unconscious), he attributed his uncontrolled actions to the spirit possessing him. A.E.Z. kept crying and asking forgiveness but the men insisted on taking their sister along. Informants who supported the wife's brothers' action noted that they belong to a family which is mabsuTa (happy, meaning wealthy) and will not allow their sister to be exposed to such degredation (bahdala). In response to the author's question, "why is A.E.Z. afraid of his wife's brothers?", an informant responded, "money talks". Another said, "di 'aliha Tīn (she has mud, i.e., she owns land) and he has his eye on it".

The illustrative examples of cases of 'uzr presented in this

section show that the function of the illness role as a legitimized form of deviance and as a strategy of indirect control is itself subject to constraints. While illness of ʿuzr denotes a position of relative powerlessness, the social sanction which allows temporary transgression of such a position of powerlessness is itself subject to negotiation.

Thus far, our discussion of ʿuzr has centered around adults. In fact, the illness is generally considered an affliction of adults (See Table 5.7 under Age Relatedness). The illness is manifested in departure from culturally defined role expectations. Since children's obligations are not strictly defined, in their case, the label maʿzūr is not as significant for the reproduction of social relations and as a mechanism of controlling departures from culturally defined roles expectations. Thus the label ma'zūr/a when used by adults who define younger children as ill, may be considered more a ʿuzr (excess for the adults themselves). This is clearly illustrated in cases where a child's illness is diagnosed by a physician as marad ʿassabi (illness of nerves, or mental illness), which is considered shameful by the child's family and fellow villagers. Thus, while one of the author's informants defines her son's illness as ʿuzr (although the physician defines it as epilepsy), the child (a student) does not believe that he is maʿzūr and reiterates the physician's diagnosis by attributing his seizures to a "nervous condition".

The case of G., a child of about 13 years of age illustrates adults' role in defining a child's illness as ʿuzr and the fluidity of this illness label in covering a variety of culturally devalued forms of

behaviour, including what physicians refer to as maraD ʿassabi (illness of nerves). Upon hearing of G.'s condition, the author, accompanied by an acquaintance of the family, went over to G.'s house. We found the child sitting alone in front of the house, her mother was not home and her siblings were all out in the fields. The child looked very unhappy. She looked pale and more undernourished than most of the village children her age. She responded to the author's question of her mother's wherebouts in a barely audible voice and showed a degree of deference unequalled by any of the village children of comparable age. She had her head leaning against the wall as she sat and had her hand covering the part of her face exposed to us. The next door neighbour came out and told us that G.'s mother was out in the field and would be home shortly. As we sat waiting for the mother's arrival, the author tried to talk to G., but to no avail. She kept covering her face and turning towards the wall. The neighbour said, "leave her alone, don't bother yourself with her, she has assyad with her and they are making her very unhappy, the poor thing". Shortly the mother arrived. In spite of her relatively old age she still works in the field to support her orphaned children after the death of her husband a number of years earlier.

When the author asked the mother about what is wrong with her daughter, she said,

> "It seems that she has assyad with her. Her brother had taken her to work as a servant in Cairo. She worked for his superior who had promised him a promotion. The lady of the house used to frighten her and hit her at night". The mother then turned to her daughter and asked, "what did she used to do to you?, tell them". The child for the first time since our arrival in their house, raised her voice to an audible level and said, "she used to hit me with a long stick and a long hose". The

mother then continued, "when her brother went to visit her over there to take her monthly wages, she held on to him and she kept crying and saying that she wants to go with him. Her brother took the lady's permission and told her that he would take her to visit us for a few days and would bring her back. When she came back, she kept crying and saying that she will never go back. Her brother kept imploring her (to go back to Cairo) because he said that he will get thepromotion very soon, but she kept crying and did not want to eat or drink. On the third day of her arrival she was sitting with us and all of a sudden we found her misurgah khaliS (completely unconscious). She remained this way for nearly an hour. We tried to revive her but she would not answer us. We put cold water on her face and rubbed her hands and legs, they were like ice. Finally she woke up and could not remember any of the things which happened to her. Our neighbour was here and she said that she had a brother who used to do just like that and he was ma'zūr, so we knew that she has assyad with her but they may be mute...No they have not spoken yet or asked for anything. The author then asked the mother, "Does G. know that she is ma'zūra? Did she tell you that the assyad are with her?". The mother responded, "No she did not say anything, they haven't talked yet, but we knew it. She's been like this for four days now. After they (the assyad) come, she does not eat and she insults us, and when we tell her to go to the fields with her siblings, she says no. Her brother said, well then, let her rest. Her ways have changed; she used to be very clever and used to be a very hard worker. It (the 'uzr) is probably from her crying when the lady hit her in Cairo."

In following G.'s condition over the following two weeks, it was observed that it remained unchanged. She remained at home, refusing to join her brothers and sisters in work in the fields. As she sat outside the house alone, she maintained the posture of facing the wall and spoke to no one. Her mother continued to report the episodes of complete loss of consciousness, but none were observed directly by the author. During this period, G. was subjected to a physical examination by the physician. His report was as follows:

Heart: Free
Chest: Free
Abdomen: No palpable organ
Stool: O.K.
Urine: O.K.
Nervous System: Epilepsy, petit mal (absence of convulsion accompanying the state of loss of consciousness)

The physician's diagnosis of "maraD ʿassabi" was rejected outright by G.'s mother. She said that the doctor does not specialize in illnesses like ʿuzr and therefore cannot recognize the illness. In trying to prove her own evaluation of her daughter's illness condition she noted, "now she complains of her hands and knees and head and she refuses to work. It is just as I told you, the pain is moving".

To legitimize her claim of her daughter's condition as ʿuzr the mother asked the author to accompany her to a local diagnostician, shika A. G. did not accompany us on this visit and the mother took along only her aTar. The shika's diagnosis was indeed as the mother had predicted, ʿuzr. The shika said that G. had gotten a lamsa ardiya (touch from the ground) since Ramadan (the fasting month which had passed about three months earlier). She said that assyad came to G. TaHt za'la (under sadness). The similarity of the shika's diagnosis to that of G.'s mother and her precision in defining Cairo as the place where the illness was initially precipitated is understandable in light of the conversation which transpired between us and the diagnostician prior to her "seeing" the aTar. When we first arrived at the shika's shouse she had turned to the author and asked, "How are your children". The author responded that they are fine. The shika then said, "the children and their father and his family are what causes all our problems, us women". She then turned to G.'s mother and said, "isn't that right my sister". G.'s mother then responded,"yes of course, why do you think we came to you, it's about my daughter, she was in Cairo and the lady hit her and it seems that she has assyad with her..."

In studying G.'s case, it was clear that the labelling of maʿzūra

was constantly being reiterated by the mother. The power differential between the mother and G.'s oldest brother was evident. He works in the city and has thus earned the prestige and authoritative role concomitant with exposure to urban ways. The mother needed to validate her little girl's resistance to carry out a command which was clearly in the brother's self interest. The son expected G. to go back to work as a servant for his superior. As ma'zūra, the child's rejection to obey her brother's wishes, mediated by her mother's evaluation of her state, serves as a socially sanctioned avenue for rejecting the relatively powerful brother's demands. This is particularly apparent in light of fellow villagers urgent pleas to the brother not to take his sister, who is ma'zūra back to Cairo. As one neighbour of the family commented, "this would be Haram (sinful), you take her there (to Cairo) and she will be alone. Then they (the assyad) will take advantage of her (H a yistifradu bihah). The mother's advancement of the label ma'zūra is also important in relation to her rejection of the physician's diagnosis of G.'s condition as epilepsy. In this regard, it may be noted that the labelling of 'uzr is also sought by adults who reject the labelling of mental illness and its shameful implications. This is the case for N., a middle aged barren woman. The author learned from a number of villagers, including the village headman that both N. and her brother had once been committed to a mental institution. N. herself believes that her committment to the mental institution was a mistake on the part of the physician who could not recognize her 'uzr. Her friends support this explanation but those who dislike her say that she is crazy (magnūna) and that is why she was sent to the khankha

(mental institution). They say that "light mindedness" runs in her family.

In the foregoing account of ʿuzr, emphasis has been placed on linking the affliction to positions of relative powerlessness. As is the case for other forms of illness (which are defined in terms of culturally relevant causes and socially mediated responses), the ultimate cause of ʿuzr is tracable to asymmetrical power relations. The illness forces attention to personal grievances and distress and induces a temporary enhancement of social position among subservient persons who are subject to social stress, including those suffering from role conflict. Thus, barren women, sterile and economically dependent males, who have no access to culturally valued power bases, legitimize their departure from expected role behaviour by reference to their affliction by spirits. Similarly, a subservient daughter-in-law, or younger brother, may acquire a temporary dispensation from the authority of more powerful persons.

In light of our discussions of power differentials, stress, illness, and village social organization in earlier chapters, the study of ʿuzr provided here derives from the assumption that it is not gender status only which is likely to precipitate the illness. Instead, the study of this affliction in the village focuses on stressful situations, including those associated with power differentials which are related to gender role expectations. Since stressful situations are not unique to women, one may expect stressfulness and role conflict to precipitate the ʿuzr syndrome in men also. Moreover, one may hypothesize that subgroups of women will vary in their experience of stress. Indeed, some

stages of the life cycle and the developmental cycle of the family expose individuals to variable types and degrees of stress. Furthermore, one may expect some women to approximate the expected role behaviour more than others, with deviants representing the most extreme cases of role conflict and its resulting stress. The same is expected to hold true for men. Hence, we may expect variation in the frequency of the affliction among women (and among men) as well as between men and women. In view of women's relative position of subservience (which, as indicated in an earlier chapter, derives from their limited control over culturally valued power bases), it would be expected that women, in particular, would fall victim to culture bound syndromes resulting from emotional validation of the assumption that higher frequency of illness among women results from stress should involve, not only a demonstration of a higher frequency of illness among females than males, but, more fundamentally, it should show that a higher frequency of illness occurs among women who are identified as less powerful and as experiencing greater stress than their cohorts.

According to a survey designed to identify the incidence of some folk illnesses and the social characteristics of persons who become afflicted with these illnesses, 34 cases of ʿuzr were collected for the adult occupants of a sample of 100 households in the village. The distribution of 'uzr among 166 males and 202 females as a function of sex and persons' status within the household (defined by relation to household head) is summarized in Table 5.8. Predictably, one notes a somewhat higher frequency of the illness among females than males. When other dimensions of persons' identities are taken into account by

reference to status within the household, the significance of power differentials beyond those associated with gender identity are brought into focus. Thus, the higher frequency of ʿuzr among the male category of brother of household head contrasts with the low frequency of the illness among relatively powerful females, notably the mothers of married sons. Also noteworthy is the difference among groups of women, particularly mothers of married sons as opposed to sons' wives.

Of the five affected household heads recorded in Table 8, two had gotten their first attack as children, two were sterile males, and one had been diagnosed epileptic by the project physician. Among the six wives of household heads, four were barren women. The three cases of ʿuzr reported for daughters occurred among young women who were being forced into marriage against their will. The four cases of brothers of household heads were reported for younger brothers who were economically dependent on their older siblings. The only case reported for a mother-in-law involved an elderly and physically weak woman who was at the mercy of her son's wife after the breakup of her extended family. The single case of ʿuzr which was reported for a daughter's husband occurred to a man who resided with his wife's family since he did not have the support of his own kinsmen and had no independent means to live separately. Finally, by far the largest percentage of afflictions was reported for sons' wives in extended family households, a predictable outcome in view of the subservience of this group of women to the authority of both senior males and females.

Table 5.8. Percentage Frequency Distribution of *uzr* Cases: Gender and Relation to Household Head.

	N	Total # of *uzr* Cases	% Affected Persons
Gender			
males	166	13	7.8
females	202	21	10.4
Relation to HHH			
HHH him/herself	94	5	5.3
Wi	74	6	8.1
Da	42	3	7.1
So	61	1	1.6
Br	16	4	25.0
Si	9	1	11.1
BrWi	8	1	12.4
BrDa	10	1	10.0
Mo married sons	32	1	3.1
DaHu	2	1	50.1
SoWi	30	10	33.1

Power Differentials and Psychological Stress: The Cornell Medical Index

In pursuing the study of power differentials and concomitant perceived social stress, the Cornell Medical Index[38] was utilized as an independent diagnostic instrument[39] of structural arrangements that may be stressful to individuals (Scotch and Geiger 1963). The CMI (a symptom questionnaire designed to reflect various system disorders) was administered to the same sample population of adult occupants of the 100 households noted above. The scores (i.e., the number of symptoms reported by respondents) related to psychological symptoms of the CMI section of each respondent were rated on a scale of 1-4 by the project psychologist. These CMI psychiatric ratings of subgroups of the sample population, differentiated on the basis of the same social criteria mentioned for the differential incidence of *uzr (sex and relation to household head) are summarized in the form of percent frequency distributions in Table 5.9. As predicted for the incidence of *uzr, which is precipitated by asymmetrical power relations and emotional distress, higher psychiatric ratings (indicative of perceived social stress) are expected to be positively correlated with greater perceived stress and positions of subservience among the various differentiated subgroups of the sample population.

The results summarized in Table 5.9 bear a close similarity to those provided for the distribution of *uzr. Higher psychiatric ratings (3 and 4) occur somewhat more frequently among women than among men. This limited difference in the reporting of symptoms suggests that the

Table 5.9. Percentage Frequency Distributions of Psychiatric Ratings: Gender and Relation to Household Head.

Rating	1	2	3	4
Gender				
males	33.7%	34.9%	22.9%	8.4%
females	27.7	34.7	23.8	13.4
Relation to HHH				
HHH him/herself	28.7	30.9	25.5	14.9
Wi	27.0	41.9	23.0	8.1
Hu	0	50.0	0	50.0
Da	28.6	38.1	9.5	23.8
So	34.4	32.8	26.2	6.6
Br	37.5	56.3	6.3	0
Si	22.2	55.6	22.2	0
BrWi	50.0	0	12.5	37.5
BrSo	100.0	0	0	0
BrDa	66.7	33.3	0	0
SoWi	16.7	36.7	46.7	0
Mo married sons	46.9	31.3	15.6	6.3

notation of "the ethic of health is masculine" (Nathanson 1975:59) does not have universal validity. Perceived social stress and subservient status are not simply a function of sex. Higher ratings among relatively larger proportions of husbands of female household heads, brothers' wives in fraternal joint households and sons' wives suggest the importance of intervening variables related to the developmental cycle of the family and role expectations. Hence the relatively low psychiatric ratings (in Table 5.10) among higher proportions of mothers of married sons and the higher ratings among males and females who deviate from culturally stipulated role prescriptions, notably economically dependent males and childless males and females.

To conclude, the distribution of <u>'uzr</u> cases and psychiatric ratings summarized above reflect social relations of power differentials affecting both males and females. While women as a group report a somewhat higher incidence of illness, it is significant to note the patterned incidence of illness (and reporting of symptoms) and its attendant power differential in relation to the developmental cycle of the family. The data suggest that the incidence of the illness and perceived stress are related to power relations associated with subservient status and deviation from culturally stipulated role behaviour. Finally, the low incidence of <u>'uzr</u> (34 cases) among the sample population (of 368 persons) implies that even the adoption of this culturally sanctioned strategy of indirect control is subject to structural constraints[40]. The sick role, like other manipulative strategies adopted by the powerless, when accessible, brings about only a temporary enhancement of social position. It is not a stable culturally valued power base which can induce a permanent modification.

Table 5.10. Percentage Frequency Distributions of Psychiatric Ratings: Role Expectations.

Ratings	1	2	3	4
Economic Role				
standard (male, "bread-winner")	35.0%	36.3%	21.7%	7.0%
deviant (male, ec. dependent)	0	0	40.0	60.0
standard (female, ec. dependent)	28.3	35.3	24.9	11.0
complementary (female, access to ec. resources	36.8	42.1	15.8	5.3
Sexual/Reproductive Role				
standard (father	36.1	34.8	21.3	7.7
deviant (sterile male)	0	30.0	50.0	20.0
Fa daughters only	18.8	37.5	37.5	6.3
Fa sons	35.6	33.3	21.8	9.2
standard (mother)	31.4	36.6	22.3	9.1
deviant (barren female)	3.7	22.2	33.3	40.7
Mo daughters only	17.4	30.4	26.1	26.1
Mo sons	30.9	31.8	28.2	8.2

NOTES

[1]While some anthropologists have hailed Clements' classical work (Caudill 1953:722; Cf. Glick 1968:36), others see it as a "conceptual morass" (Willin 1977). Willin writes, "To be sure it includes traits that can be categorized as causes - sorcery and breach of taboo. However, the remaining three - disease-object intrusion, spirit intrusion, and soul loss - are not causes but mechanisms; each is a result of effect attributed to human, supernatural, or other causative action" (Ibid:51). Even earlier than Willin's criticism is the objection to Clements' typology raised by Glick (1963) who noted its limitations and referred to an even earlier critique of Clements published by Hallowel as early as 1935.

[2]Foster (1977) has recently restated this bifurcation of medical typology in his study of the cross-cultural patterning underlying non-Western medical systems. Following Hughes, he differentiates ethnomedicine (which is defined as "those beliefs and practices relating to diseases which are the products of indigenous culture") from the medical system which derives from the conceptual framework of modern medicine.

[3]This emphasis is typical of biomedicine with its stress on disease pathology.

[4]A taxonomy is regarded as "a culturally specific way of ordering and specifying a particular domain" and it "also reflects (and may be taken to embody) a theory about how that domain is structured and works" (Fabrega 1976:195).

[5]Fabrega's distinction between body-centered and environment related explanations bears resemblance to Young's differentiation between internalizing, non-personalistic, physiological systems and externalizing, personalistic, and etiological systems (Young 1976b).

[6]Fabrega represents his formula as follows: $I_i = S + N \neq P$ where I_i is the total amount of cultural information entailed by an explanation of an illness, i, S, N, and P represent the amount of information related to the Supernatural, Natural, and Person regions of the taxonomy, respectively (Fabrega 1976:200).

[7]The concept of levels of causation is not original with Glick and he himself traces it to the work of Rivers (in Medicine, Magic, and Religion) who distinguished agents of disease from the means employed and from their reasons for acting (Glick 1963:111). The concept was accorded further attention in the work of Hallowel who differentiated three aspects of causation ("proximate cause", "technique", and "agent"),

which he emphasized, cannot be considered as distinct causes but must be "related in some explicit and comprehensive scheme" (Hallowell 1935: 366; Cf. Glick 1963:111).

[8]The villagers of FatiHa also recognize accidents, and ailments which affect the external body, e.g., wounds, fractures, insect bites, toothaches, and strained muscles from overwork. To the extent that these have causes and effects which are socially inconsequential, they will not be elaborated upon in this chapter.

[9]Weakness associated with old age is identified as the gradual breakdown or withering away of persons' physical strength, referred to as the "ripening" of the body. This is considered a condition of general debility rather than failure of specific organs of the body. In this regard, it must be stressed that villagers do not consider old age an illness. The weakness of old age make the body more susceptible to illness.

[10]It is also believed that habal may be caused by a dog which is mahbul. It is said that the "bite of the dog causes the person to become mahbul and he barks like a dog". It is also believed that if a person is bitten by a wolf, his/her brain goes to the wolf and the human howls like the wolf.

[11]Unlike these illnesses, maladies of supernatural cause are not believed to be passed on by inheritance.

[12]Although eye diseases and blindness are common. little or no attention is given to such afflictions which are taken for granted. Only two cases of eye irritation was reported in the census when inquiries about illness were made. It is also significant to note the under-reporting of culture-bound illnesses (e.g., Tarba, ʿuzr, Hassad, and ʿamal bil maraD. During the early weeks of field work when informants had limited acquaintance with the author, some of them viewed her as a physician who accordingly "would not be interested in the nonsense of the fellahīn".

[13]The villagers of FatiHa are familiar with a variety of illness labels used by the physician, ranging from influenza to rheumatism, to illnesses of the spleen, jaundice, liver, and heart. But they simply refer to their cause by reference to the afflicted organ and its resultant state in terms of external causation.

[14]In fact, it is said that if a feverish person eats a normal meal, his/her fever increases. A feverish person is also expected to avoid the ingestion of cold foods such as watermelon or ice. This is equates to "putting a burning rod in cold water. It gives the body a shock".

[15]The significance of this belief for purposes of social control is obvious.

[16]Some of the older informants still recall the precautionary measures related to the cholera epidemic of the late 1940's.

[17]Tarba is also believed to be caused by supernatural beings which are said to appear in the shape of animals, including wild dogs, and cows. Spirits are also believed to appear to people in visions and frighten them during their sleep.

[18]There is no general agreement among informants, including healers as to the actual mechanism through which these supernatural beings actually inflict illness. Illness in such cases is attributed to their presence or to their supernatural effect on the body as such, not to alterations in the functioning of specific internal body parts and disruption of body processes.

[19]Emotional disturbances resulting from interpersonal conflict are incriminated in the incidence of a variety of other misfortunes, including injuries to the external body. B.S. who is a horse carriage driver had a fight with his wife. He then left the house very upset and set out to the station in the nearby town where he was loading flour. His father said that because B. was not paying proper attention to his work, since he was thinking about his wife and her rudeness, he did not tie the horses securely and they moved, causing him to slip and break his foot.

[20]The people of FatiHa have two labelled illness stateswwhich clearly illustrate Evans-Pritchards's classic distinction between witchcraft and sorcery and which identify persons possessing inherent power to harm (witches) and differentiates them from those who harm by tapping outside power (sorcerers). In FatiHa, the evil eye exemplifies the first.

[21]The dialogue between religion and medicine has been part of the Middle Eastern scene for a long time. The saying that "cleanliness (as a means of preventing the onset of illness) is next to godliness" originates from Talmudic teachings and Jewish laws of hygiene which originated in the area a few thousand years ago. With the rise of Christianity in the area, the healing miracles of Christ were particularly appealing to the sick and suffering. Similarly for Islam, the ancient association between medicine and religion was also part of the Islamic tradition. This association is reflected in a saying attributed to the Prophet MuHammad who said, "science is twofold, the science of religion (theology) and the science of the body (medicine) (Hamarneh 1967:14). Islamic medicine reflected the Muslim philosophy of tawHid (unification) by viewing humans

as total beings in whom bodies and souls are combined and closely intertwined.

In ancient Egypt, the acts performed by the priest, physician, and magician, all had a common goal; they were only different means of protecting the individual against dangers which threatened his/her life. Among the ancient Egyptians, priests were also physicians and "hospitals" were temples of healing where the process of curing involved spiritual as well as physical purification. In fact, in the library of the temple of Horus at Edfu there was a book containing prescriptions for driving away the evil eye (Blackman 1929:314).

[22]Gifford attributes the veiling of women and their seclusions in the Middle East to the evil eye. He suggests that the custom of seclusion was initially associated with beautiful women and eventually spread because of its complementary implications (Cameron 1960:349).

[23]Supernatural power, including the ability to cause illness and to bring about cure, is also attributed to the village patron saint, a descendant of the once powerful Turkish elites of the village, who now still legitimize their quest for controlling village political life by reference to their pious predecessors. Informants, who favour these descendants, refer to the baraka (blessing power) of the patron saint and her karamat (blessings or miracles). The patron saint is also believed to play an important role in other catastrophic events besides illness. She brings about crises to rival villagers and townspeople in the nearby areas, as well as to awlad il balad (children of the village) who mock her powers and show disrespect to her descendants. The implications of such beliefs for the status of her descendants in the village are obvious. Having lost their material power base in the village, male as well as female members of this once wealthy group try to maintain their control over villagers (in varying degrees) by emphasizing their supernatural power base. Thus far, this trial seems to have succeeded and the village headman for the last few decades has remained a member of that family. His power in the village is augmented by his kinship ties to high post government officials in Cairo and to relatively wealthy families in the village itself.

[24]Death from fire among crawling young children who are left unattended is also attributed to their supernatural siblings who punish the mothers for leaving the child unattended. Two such occurrences took place during the study period.

[25]This is also a punishment for the husband (who caused his wife's sadness) since men are known to long for children.

[26]Informants distinguish between different types of ʿamal (deeds). They refer to ʿamal bil maraD (deed for illness), ʿamal bil kurh (deed for hatred), ʿamal bil nazif (deed for hemorrhage), ʿamal bil maHaba (deed

for love), etc. Illness may be brought about through the supernatural manipulations of a sorcerer. "He (or she) may write (yiktib) (Quranic verses) with loss of hair, hemmorhage, back pain, impotency, hatred (e.g., between a woman and her husband), habal (craziness where a person looses self control and hits others).

[27]In addition to reference to drinking siHr, people describe poisoning (which they refer to but say that no one now uses it on people) which people also use to take revenge. Poisoning, whether magical or not, is traced to hatred between people (ultimate cause). The person who is entrusted with the poisoning process itself is considered the efficient cause and the poisonous substance or the means of introducing it into a person's body is but the instrumental cause of illness. Even poisoning is accidental, as was the case in the death of a whole family, through their accidental use of pesticide on their food. The poisonous substance was recognized as the instrumental cause of death. A child's ignorance was isolated as the efficient cause. An ultimate cause was described in terms of the mother's involvement in more work situations than she could handle, because of her poverty.

[28]Illness legitimizes a range of actions contrary to gender role ideal expectations. Women, who do not ordinarily smoke use cigarettes as "remedy" for minor respiratory ailments. The sniffing of nishūg (a mixture of ground spices and tobacco) which causes sneezing, is also taken up by women to expel the moisture in the chest and the head, which is believed to cause the cold.

Illness as a means of legitimizing deviance from normal role expectations is also reflected in A.Z.'s statement to F. when the latter was trying to convince her to go to the doctor who may remedy her blindness. Z. noted, "I would be ashamed to look people in the eye and to be able to see them, then everybody would expect me to work and be like I used to (before becoming blind)". Some of Z's acquaintances seem to believe that she is actually content with her state of blindness. In this condition, she obligates a variety of people to look after her and she enjoys the rather left handed compliment of being an invalid.

[29]Informants in explaining an illness may simultaneously refer to the diagnosis of a physician and that of a traditional diagnostician.

[30]The patterned opposition between the sexes is reflected in the fact that females become possessed by male spirits while males succumb to the affliction of female spirits.

[31]The term Hadra and zar are usually used interchangeably to refer to a ceremonial form of diagnosis/treatment where possessing spirits are enticed, this being a phase in the course of treatment which is formally terminated with a SulHa (reconciliation ceremony) where the demands of the possessing spirits are granted.

[32]During the zar a variety of musical melodies are performed, each of these melodies is said to represent a specific supernatural being. When a Tariga is drummed, it is believed that the corresponding spirit, couched in the body of the ma'zūr/a induces its host/ess to react by dancing, often to the point of complete exhaustion and collapse.

[33]In describing the maraD rawhani (spiritual illness), a diagnostician noted, "The person with maraD rawhani does not necessarily become ill right after he is touched, that is why people do not remember".

[34]In commenting about this ma'zūra's case a female acquaintance of hers privately said to the author, "It is because she is jealous for her husband, she is afraid that he will marry another. He is like a bull and she is yellow (pale) and ugly".

[35]Seasonal variation of the incidence of the illness was noted by one diagnostician who said that more cases of 'uzr occur in the summer "because il gary kitir (the running about is a lot) and people are out late. In winter it seldom happens because people are sheltered in their homes and they watch themselves when they move". This account was the only reference to seasonal variation, all other diagnosticians and healers, as well as non-practitioners note that 'uzr can occur to any one at any time.

[36]In questioning informants about whether it is shameful to be affected by 'uzr, they generally agreed that it is not. One informant noted, "People who know God understand that it can happen to anyone". Another said, "how can it be shameful, 'uzr comes only to those whose bodies are pure."

[37]Persons joining such processions sway in a rhythmic fashion to the loud singing of praises to God and the Prophet.

[38]Modification and evaluation of the Cornell Medical Index questionnaire was undertaken with the help of a physician and a psychologist provided interpretations of the relevant sections of the CMI. Some CMI questions had to be eliminated on the basis of their non relevance or conceptual disjunction with local culture. Others required certain terminological modifications in order to be rendered intelligible to potential respondents.

The CMI in its modified form consists of some 186 questins which collect extensive medical and psychiatric data corresponding to those elicited in a general medical history (Scotch and Geiger 1963:305). This health survey instrument which has been used in cross-cultural health survey research has been known to yield accurate general medical and psychiatric diagnostic evaluations of patients (Broadman et al 1951). CMI raw scores may be utilized for cross-cultural comparison. For the purpose of this chapter, however, the psychiatric ratings are confined to the sample population of the present research locale.

[39]As noted earlier, explanations of a declared illness state may vary from the assertion of stressful experience by the afflicted person to dismissal of his/her behaviour as faking by a non sympathetic household member. In light of this discrepancy, for the purpose of this portion of the study, a person's own perceived stress was deemed the more important judgment. The CMI (Section dealing with emotions) was therefore administered to obtain a measure of perceived stress.

[40]When a diagnostician was asked by the author how many cases of *'uzr* he gets during a year, he responded, "not more than four or five". When the author exclaimed, "is that all?", he responded, "yes, what more do you want, otherwise the whole village would come to a standstill".

CHAPTER 6

MEDICAL CARE IN FATIHA: RESPONSE TO ILLNESS

A. Introductory Remarks

The prevention of illness and its treatment are closely associated with medical theory and with culturally significant manifestations of illness. In the preceding chapter the explanatory aspects of the medical system and villagers' definitions of illness were accorded primary emphasis. In the present chapter we turn to an examination of villagers' methods of coping with illness. Preventive measures described in Section B, not only denote mechanical procedures associated with the avoidance of illness, but also reveal the differential valuation of persons to whom these procedures are administered, and the significance of associated events.

When actual cases of illness occur, the symptomatic persons, and/or significant others who attribute to them the label "sick", may avail themselves of one or more forms of treatment. Forms of treatment available to the people of FatiHa are summarized in Figure 6.1. Some are readily accessible through family members, neighbours and relatives, and through the druggist and herbalist in the nearby town. More serious cases of illness are directed towards specialized medical treatment of both the indigenous and cosmopolitan variety. Medical specialists of the indigenous variety are readily available in the village. Their failure to bring about the desired relief prompts the sick person

and/or his significant others to seek this form of medical treatment in the nearby villages and provincial towns. If necessary, indigenous practitioners located as far away as Tanta, Cairo, and Alexandria may be visited. The same pattern of gradual movement away from the village is noted in the utilization of cosmopolitan forms of medical treatment. When cure does not result from treatment by the village paramedic known as Halag il SiHa or by the physicians available in the nearby towns, villagers seek this form of treatment in larger urban centers.

Unlike physicians and the practitioners of Tib Tabi'i (natural medicine), the power of the rawHaniya (indigenous practitioners of spiritual medicine) does not rest on their control over specialized knowledge about illness. Structured interviews designed to compare shared knowledge about illness among rawHaniya and laypersons indicate that the rawHaniya do not deal with illness through reliance on specialized, exclusive knowledge. The power of the rawHaniya is derived primarily from their culturally valued control over elements of the supernatural environment. This lends an authoritative, legitimizing character to their diagnosis of illness. The exercise of their diagnostic role is contingent upon their familiarity with local culture. Finally, the administration of Shweder's cognitive capacity test reveals the rawHaniya's greater capacity (than lay persons) to impose order on ill-defined situations. This characteristic is consistent with their expected role of imposing explanation when confronted with the confusion of illness and its associated deviant behaviour.

Following the enumeration of forms of treatment available to the people of FatiHa in Section C, attention is turned to factors which

influence their choice of treatment. Section D presents a discussion of the role of illness concepts and of the situationally variable hierarchy of resort to curative practices. It underscores the complementarity of indigenous and cosmopolitan forms of medical treatment and points to significant factors which influence choice of treatment (e.g., progression of illness and its response to certain forms of treatment, the social identity of the affected person, the nature of interpersonal relations between the sick person and the medical practitioner, and the economic requirements of different therapeutic strategies). Section D-a undertakes a critique of what the African anthropologist Omafume Onoge has referred to as the "socioculturalism" of medical anthropology with its emphasis on the inhibitory role of "LOCAL IDEAS about health" in theutilization of cosmopolitan medical care (Cf. Onoge 1975:221). A survey of forms of medical treatment obtained from a sample of village adults reveals the physician to be the first choice of the villagers (See Table 6.4). Section D-b, through the presentation of illustrative examples of differential utilization of indigenous and cosmopolitan forms of treatment lends support to the contention that choice of medical treatment rests on the immediate requirements of cure rather than on the conceptual compatibility of logical categories underlying different forms of treatment. Generally, villagers utilize cosmopolitan health care facilities for symptomatic relief whereas disorders which are judged to be directly related to socially significant ultimate causes are viewed as requiring the expertise of indigenous spiritual medical practitioners.

In Section D-c attention is devoted to our central theme of power relations as it relates to medical treatment. In addressing this issue

and in considering the social status of the symptomatic person, the first part of Section D-c probes the more fundamental question of social legitimization of the sick role, upon which initiation of treatment is contingent. The remaining part of the chapter is then devoted to an examination of the differential allocation of valued resources for the treatment of persons of different social identities. A limited quantitative survey of medical treatment, participant observation, and informal interviews prompt the conclusion that gender identity influences forms of treatment extended to symptomatic persons. However, as was noted for the differential incidence of illness of supernatural etiology in Chapter 5, gender identity is mediated by the dynamics of the developmental cycle of the family. Beyond the micro-level of analysis associated with village social organization considered in the first part of Section D-c, attention is directed to the macro level of social articulation (Cf. Janzen 1976) in the latter part of the same Section. Asymmetrical power relations between the dominant urban sector of Egyptian society and the subservient rural domain (of which the village is part), is deemed an important constraint which affects peasants' choice of medical treatment. The relation between social identity and form of treatment, and their mediation by power relations may be diagrammed as follows:

SYMPTOMATIC PERSONS

Micro Analysis Village Social Organization (SES, Gender, Dynamics of the developmental cycle of the family)	power relations	Macro Analysis Peasant Status (financial constraints, subservient social status, limited availability of cosmopolitan health care facilities)

FORM OF TREATMENT

B. Prevention

In FatiHa, strategies of health care involve not only the curing of illness but also its prevention. The maintenance of health and the prevention of illness are perceived as complementary to therapeutic procedures. In fact, indigenous healers whose services are secured to cure illness are also frequented at times for the sole purpose of preventing illness. Beyond seeking such specialized services for the maintenance of good health, the people of FatiHa show a constant awareness of the threat of illness.

The villagers' perception of the potential threat of loss of health is reflected in daily conversations. It is said, "health, protect it, it will protect you" (il SiHa, Sunha, tiSunak). A variety of idiomatic expressions denote constant awareness on the part of villagers of the potential threat of illness. These include such phrases as "may you be spared the bad fortune of illness" (yikfik shar il ʿaya), "do not be sinful, spare yourself, i.e., rest yourself either physically or emotionally" (Haram ʿalik, irHam nafsak), "may good health protect you" - verbalized in response to a standard salutation - sa 'alit ʿalik il ʿafiya, "strength, or good health" - a standard form of greeting - (ʿawafi), "may God give you strength, or good health" - used in response to the greeting ʿawafi - (allah yi ʿafik).

A variety of precautionary measures are pursued by the villagers of FatiHa to prevent the onset of illness. In Chapter 4 note was made of villagers' belief in the necessity of proper nutrition, rest, avoidance of over indulgence in food, drink, and sexual activity for the preservation

of the proper functioning of the body. In addition to these precautionary measures which are advised to avoid illnesses which are attributed to natural etiology, villagers also rely on the periodic ingestion of medicinal plants and pharmaceuticals for the maintenance of good health. Infusions of boiled herbs or inorganic salts (which are purchased from the pharmacy) are taken occasionally to "flush out" the body and get rid of undesirable elements, including worms and salts which are believed to accumulate and form kidney stones. The avoidance of the latter condition is also undertaken through the occasional drinking of herbal teas which are believed to purify the blood and remove any "clouding" which causes the precipitation of salts.

In avoiding illnesses of natural (as opposed to supernatural) origin, villagers also avail themselves of the vaccination clinic which is held periodically in the village headman's court yard in the presence of a physician from the ministry of health and an assistant. On such occasions, children are vaccinated against the common childhood diseases, although the precise mechanism by which the vaccine prevents illness is not understood by the parents who bring their infants to this makeshift clinic. As one informant noted, "it has a positive effect (maSlaHa), doesn't it? That's all I have to know".

Another complex of preventive measures are employed to avoid the onset of illness which are defined as being the outcome of supernatural causes (e.g., the evil eye and sorcery). The "word of God" is generally regarded as a most effective preventive measure, a protection (Hirz) from a variety of misfortunes, including various types of illness. Utterance of Quranic phrases is a widely used preventive measure.

When the gaze of covetousness typical of the evil eye is noticed, the victim (or his/her adult relative in the case of children) immediately murmers to him/herself a specific Quranic verse which seeks the protection of God against the evil eye. People also verbalize such phrases as "in the name of God the merciful and the compassionate" (bism allah il raHman il raHīm) on numerous occasions throughout the day. They pronounce such words on entering a house, on entering a dark room, on looking at a child or an admirable object, or even on looking at their own or other people's animals or farm products. People who fail to recall the name of God before entering the Nile predispose themselves to the attack of the supernatural subterranean beings which inhabit the waters of the river. The written form of the Quran is also believed to protect its carrier from the devastation of illness. Literate healers in the village and elsewhere are frequented for the writing of charms (Higab) which are made up of folded paper in which Quranic verses are inscribed and which are worn by children as well as adults.

Preventive measures involving the use of the Quran are standard procedures which are associated with culturally marked life cycle events, including circumcision ceremonies for boys, birth, the graduation of a son or daughter from elementary or secondary school, and marriage ceremonies. Thus it is almost standard procedure among bridegrooms to obtain a Quranic charm, also known as TaHwita (fence) before their wedding night. Bridegrooms, in addition to obtaining such charms to prevent rabT (tying or rendering sexually impotent through sorcery), often invite a village traditional medical practitioner who is known to be a sorcerer. This man is well fed and entertained by the family

of the groom in an effort to neutralize his potential harm and to compete with others who might commission his services to inflict illness on the young man and/or his bride.

In view of the pervasive danger of the evil eye, several other prophylactic measures are employed as deterrents to the harmful influence of the eye (ʿayn). In their efforts to protect their children from the evil eye, one notes among mothers greater care in taking precautionary protective measures for young male children than for females. This indicates the differential valuation of male and female children in village society. Aside from this difference in degree of pursuing means of preventing illness for male and female children, one notes that parents, in their efforts to avoid the harmful effects of the evil eye on their children constantly understate their positive assets. Thus, children are often purposely left running around ragged and dirty. Mothers constantly complain about their children's ill health, their loss of appetite and every other conceivable negative quality that may be associated with a child. A mother, in response to the author's inquiry about her daughter's eyes noted, "no (I cannot wash her face), she has beautiful eyes, that would attract people's attention". Since male children are more desirable than females, boys are often dressed like girls, have their hair left to grow long, and are called by girls' names. Charms are also used to ward off the effect of the evil eye. Such charms include the verbal recitations noted above as well as object charms or amulets. The blue bead and the five fingered hand (which means that the giver of the covetous glance should have five fingers cast in his/her eye) are used to ward off the evil eye from children as well as

valued farm animals. Minor rituals may also be performed by fumigation of a child with the smoke from burning alum and tar with the aTar from the suspected giver of the evil glance. This form of imitative magic is a widespread measure to counteract a suspected gaze (nazra) before its harmful effect induces illness. The bursting crystals of alum and the melting tar symbolize the destruction of the evil eye.

The potential threat of the evil eye for adults is also guarded against. One general means of doing so is to avoid flaunting one's positive assets, including good health. As one informant stated, "if I have health (siHa), I do not expose it in front of people or else I will be affected by the evil eye and I will lose it". She then went on to relate the story of a man who had lost his miriwa (health) through its reckless exposure. She said, "A.E.M. had lots of miriwa but he showed it off in front of everybody. He even placed bets with men to eat a glass jar and since that day he had been in great pains. He went to many doctors until he got to the army and they operated on him".

C. Types of Medical Treatment

In response to perceived deviation from a state of normal health, the villagers of FatiHa avail themselves of a number of forms of medical treatment. These are summarized in Figure 6.1. For organizational purposes we may distinguish two major categories of forms of treatment: family centered forms of treatment and specialized medical treatment. The first category of treatment forms are readily accessible through family members, neighbours and relatives and through the druggist and herbalist in the nearby town. More serious cases of illness are directed

Figure 6.1. Types of Medical Treatment Available to the Villagers of FatiHa.

I. FAMILY CENTERED MEDICAL TREATMENT

home remedies, minor religious rituals, use of pharmaceuticals and herbs, visits to religious shrines

II. MEDICAL SPECIALISTS

A. Indigenous

a. Tib Tabi'i (natural medicine)

treatment of any type of physical ailment which is defined as originating from a natural cause, including headaches, rheumatism, barreness, poor eye sight, hernia, and fright (Tarba)

b. Tib RawHani (supernatural medicine)

treatment of supernaturally caused illness, e.g., sorcery, evil eye, spirit intrusion

1. diagnosticians

diagnosis of illness through practitioner's possessing spirit. Prestige of diagnostician proportional to length of affliction period. Forms of divination include use of rosary, opening of cards, and visions of precipitating causes of illness. Relatively limited power in dissolution (fak) of sorcery.

2. zar organizers

performers of dagga (drumming) and, in some cases, SulHa (reconciliation). Least prestigious of the raw-Haniya

3. Quranic diviners/healers

usually males who undertake diagnosis and treatment of illnesses of supernatural etiology through knowledge of the Quran and control over supernatural khudam (servants). Also practice sorcery and utilize their khudam for the dissolution of sorcery. Prestige and power based on literacy and manipulation of Quranic information.

Figure 6.1 - Continued.

B. Cosmopolitan Medical Treatment

Diagnosis and cure of naturally caused illness

a. private physicians

b. public clinic physicians

c. Halag SiHa

traditional trained paramedic undertakes informal consultations, prescription of medicines, and administration of injections

towards specialized medical treatment. Within this latter category, the villagers distinguish between the indigenous forms of diagnostic and curative procedures (ʿilag baladi) and the cosmopolitan form of medical treatment which they refer to as the cure of the physician (ʿilag il Hakīm). Medical specialists of the indigenous variety are readily available within the village itself but their failure to bring about the desired relief prompts the sick person and/or his significant others to week this form of medical treatment in the nearby villages and provincial towns. If necessary, indigenous practitioners located as far away as Tanta, Cairo, and Alexandria may be visited. The same pattern of gradual movement away from the village is noted in the utilization of cosmopolitan forms of medical treatment. When cure does not result by the village paramedic known as Halag il SiHa or by the physicians available in the nearby towns, villagers seek this form of treatment in larger urban centers.

a. Family Centered Treatment

In their initial response to illness the people of FatiHa relied on various forms of lay, family centered treatments. These include home remedies, the knowledge of which is generally shared by adult males and females, although it is women who are held responsible for dispensing such remedies and for the general well being of family members. Home remedies are also freely suggested by and exchanged between members of a neighbourhood and between relatives. Knowledge of home remedies is not confined to a specific group in the village and even children are aware of the curative functions of herbal infusions and drugs. Herbalists in the nearby town also give advice on home remedies to those

who frequent their shops to purchase curative herbs. Home remedies used directly by the sick person or his/her family without the intervention of medical specialists include massaging with oil[1], following an appropriate diet[2], the use of a variety of ointments and natural products for surface injuries (e.g., ground coffee or mud to stop bleeding of a wound), and the practice of informal religious rites for the curing of the evil eye (e.g., ragwa).

Independent, family-centered medical treatment also involves the use of drugs purchased from the two pharmacies in the nearby town and aspirin from the local grocery store. The pharmacies are frequented by villagers who seek diagnosis of their own ailments or those of their family by describing the symptoms to the pharmacist who then recommends an appropriate medication. The pharmacist is also frequented by villagers who, having diagnosed their illness, either on their own, or with the aid of relatives, come to purchase the required medication. A variety of antibiotics can be purchased by the villagers without prescriptions. In response to the author's question about how he treats his illness, an informant noted, "I just go down and buy a couple of penicillin injections and have Halag il SiHa give them to me".

Treatment of a sick person by his/her family may also involve reliance on the curing power associated with sacred places. As in other parts of the Middle East, FatiHa villagers and their families, in seeking cure for illness visit the shrines of dead holy men/women (awliya). It is believed that the mere presence of a person near the burial place of a holy wali is enough to transfer baraka to his/her ailing body. In case the sick person is unable to visit shrines which are believed

to be efficacious in effecting cures, a member of his/her family makes a nadr (vow) on his/her behalf. When cure is granted through the wali who is believed to act as an intermediary between the sick person (and his family) and God, it is said that the saint has "answered" (istagab) the request of the sick person and his/her family. The shrine of Sidi Ibrahim il Disuki in the nearby religious center of Desuk is the object of visits by villagers from FatiHa seeking cures of illnesses and a variety of other misfortunes. The baraka of saints (awliya) like Sidi Ibrahim is deemed to be effective even tens and hundreds of years after their death. Their power is recognized as eternal. Thus villagers from FatiHa who desire to become recipients of the wali's blessings (baraka) go and serve in his shrine during the saint's day celebration (mulid). A barren female informant noted that she would go to serve in the mulid so that the baraka of Sidi Ibrahim may come on her and she would get pregnant. Of this wali, other villagers say that "if a sick person goes to visit him, he need only touch his tomb (DariH) with his hand and he would be cured". Similar healing powers are attributed to the local female saint, a member of the one time Turkish rulers of the village.

b. Medical Specialists

(i) Indigenous - Beyond the family context, the villagers of FatiHa identify two major forms of indigenous medical treatment: Natural medicine (Tib Tabi'i), which bears some resemblance to the ancient humoral traditions of the Mediterranean and Islamic words and supernatural medicine (Tib RawHani). The first form of indigenous medical treatment known as natural medicine (Tib Tabi'i) is practiced in FatiHa

by a female practitioner of bedouin origin. The curing role[3] associated with this practitioner is deemed significant for any type of physical ailment which is defined as originating from a natural cause. People who frequent this healer may come complaining from any of a variety of illnesses which include headaches, rheumatism, barreness, poor eye sight, hernia, and fright (Tarba). Her services as a bone setter are also sought by villagers and she is also known for her practice of midwifery.

Unlike some other types of healers in the village, this practitioner of natural medicine (Tib Tabi'i) does not claim any communication with the supernatural world and neither does she attribute her healing abilities to supernatural powers (baraka). However, the people of FatiHa themselves attribute baraka to this healer and they explain this by reference to the fact that she is a good Muslim, and not in terms of inherited supernatural abilities to heal. In her own description of her curing role she emphasizes her control of specialized knowledge about the functioning of the body. She described her curing role as follows:

> I treat people who are sick and I also help deliver babies. I cut the umbilical cord and use some of the blood to push up the child's roof of the mouth so that he can eat properly, this is repeated after the fortieth day...I inherited my mother's profession. My mother originally came from Libya. I used to watch my mother and I learned. For the person whose head hurts and who has tears coming down from his eyes, I use a nail (which she showed the author), a hot nail in the middle of his head, then I put a piece of castor leaf on the burn. This stops the headaches and the tears. This headache could be from zahag (sadness or depression) and this brings about fewaran (boiling) of the blood. The blood expands and rises into the head and it plugs up the eyes. When I iron on (cauterize) the head, the nash' (watery secretion) from the burn brings out the excess pressure and the person is relieved...(Do you cure 'uzr?)...This is not my specialization, I only take care of natural cures. Everybody these days goes to the doctor, but they come to me after the doctor cannot cure them. I never charge them anything but when they are cured they give me a Halawa

(gift)...All illness is from God. A person may get moisture when he is young and when he gets older the chill shows up as rheumatism and weakness. Dirt can also cause illness and people who eat or drink after a sick person also get sick. But illness is usually caused by zahag (sadness or depression). When people get upset all sorts of illness can come to them in many parts of their bodies. First they may go to the doctor or sometimes, if they have had experience with me, they come to me first. If the person's eye hurts, it is because the main vein in the head has excess blood and so I lift the vein and tie a thread around the person's ear. If the person has clouding over the eyes and cannot see well, I pass a thread in the back of the ear and this relieves pressure from one part of the body; pressure then has to be relieved from another part of the body. So if a tiny boy comes with an enlarged testicle because of trapped air from neglect and being left alone uncovered and crying, I do the same thing. The pressure on his lower body part is relieved by the thread in the back of the ear. When the doctor tries to relieve the pressure from an enlarged testicle he cuts the boy open and when he does this he may cut the vein of birth. As for me, if the two testicles are affected, I treat the two ears to relieve the pressure. For grown men of course I cannot examine them, so I ask. If it is the left testicle I take the left ear and if it is the right testicle I take the right ear. The men get this pressure from carrying heavy loads.

If a person comes to me with a broken bone, I heat water. I feel the bone and I use hot pads to push the bones together. I use an egg and flour dough and I put a layer of this between a layer of rags. When this mixture dries it becomes just like the gibss (calcium carbonate used by the physician) of the doctor. But the doctor's treatment can harm the veins. On the third day I go to see the broken person. I use a spoon with oil to soften the dough, this moistens the veins and it allows the blood to run freely in the veins.

If a person gets frightened (matrub) I can know by looking at the lower lip, if it is yellowish I know that he is marhug (frightened). The blood disappears from this area because of the shock and he may even be unable to father children. The blood dries up and he weakens very much. If he passes semen it is just like water. There is a cure for this. I iron on ʾaDmit il zarʿ (the bone of planting). (She showed the author the lower vertebra of her back and made her feel it). The person should not have intercourse for forty days so that he should not bathe because if he bathes the water will heal the wound. We want the wound to stay for a long time so that it will bring puss and pull out the yellow water from his body.

Indigenous healers who cure illnesses of "natural causes" are also sought out by the villagers of FatiHa at patron saints days celebrations in nearby villages and particularly at the nearby religious centre of Disuk, the burial place of a highly revered saint. In Disuk, during the celebration of the mulid (birth) of Sidi Ibrahim il Disuki, the local patron saint, a variety of healers set up stalls in the large square surrounding the mosque of the patron saint. The author had the occasion to interview some of these practitioners of Tib Tabi'i, including the famous Shikh E.B., who along with his brothers and patrilateral male cousins is known for his practice of indigenous natural medicine. They specialize in curing "naturally caused illnesses", including rheumatism, male impotency, male and female sterility, and illness of the spleen (TuHal). Shikh E.B. described his diagnosis and treatment of illness as follows:

> The sick person's description of his ailment is the basis of our diagnosis. He points to the part of the body which causes him discomfort...Rheumatism is caused by cold and moisture. High fever causes the illness of TuHal (spleen) and sterility may be caused by Tarba (fright), so we try to relax the nerves by getting rid of the fawaran (boiling) of the blood by ironing...I lock a piece of coconut shell like this (he showed the author his tool kit which contained pieces of coconut shells, long nails which are heated till they are red hot and used to iron on different parts of the body, and pieces of woolen string used to tie around wrists or other sore joints) and then I place it on the affected area...We use ironing (cauterizing), it relaxes the state of excitement of the blood. It relieves headaches, eye pain, and nervousness. We also use ironing on the back (lower back) of men who are sterile. For women who are barren we give them Sufa mabruka (blessed piece of wool) which they wear before uniting with their husbands...We inherited the baraka (power) from our grandfather and we transfer our baraka to the sick persons. The coconut shell is particularly strong for this purpose. Our inherited baraka comes from our bodies and our learning and training allows

> us to perfect the art of healing. But the baraka (blessing power) is the important basis of our healing abilities. Our grandfather ironed for a man who was separated from him by the sea. Spitting on the kay (ironed part of the body) is itself baraka from us...The illness will never return to the person again after he has received our baraka, but only if he follows the special dietary routine which we prescribe. People with rheumatism should not eat eggs, fish, salty, or spicy foods. Those who suffer from sterility should eat good rich food such as meat and fish and eggs and butter and milk.

The second major form of indigenous medical treatment, known as supernatural medicine (Tab rawHani) is represented in the village by six diagnosticians and/or healers. This group undertakes the diagnosis of illness through the practice of different forms of divination which include the "opening of the book" (the Quran), the utilization of a rosary and playing cards, as well as other forms based on astrology and calculations based on the letters of the alphabet contained in the name of the sick person and that of his/her mother[4]. The practitioners of supernatural medicine (Tib rawHani) who cure illness are believed to do so through shamanistic power. These curing abilities are also sought by villagers in areas which transcend the immediate vicinity of the village. Some patients and their families frequent shamans in nearby villages, in the religious centers of Disuk and Tanta, and some even go so far as Alexandria and Cairo[5]. In fact the prestige of healers seems to be related to the location of their practice. When attempts of the local and nearby curers fail to bring about the desired result, the peasants of FatiHa seek help from traditional healers (and physicians) in the provincial towns. More desperate cases may be taken to the larger cities of Tanta, Cairo, and Alexandria[6].

In contrast to the direct treatment of the body which is practiced by the practitioners of Tib Tabi'i (natural medicine), the

practitioners of Tib rawHani (spiritual medicine), known as rawHaniya (spiritualists), practice diagnosis and induce symptomatic relief through the manipulation of supernatural forces. Their concern with the mechanisms of body functions is minimal and they specialize in the diagnosis and/or curing of illness of supernatural etiologies, e.g., ʿuzr, ʿamal, and Hassad. During visits to rawHaniya, the interaction between the healer and the sick person may be minimal and the dialogue often goes on between the healer and the older person, male or female, who accompanies the sick person on his/her visit to the rawHani. The rawHani makes no attempt to examine the body of the sick person. In some cases, the healer does not even see the sick person. Only the latter's aTar (remenant) is taken over to the diagnostician's residence and serves as the object of divination.

Among the practitioners of Tib rawHani, one may distinguish subgroups. One group consists of diagnosticians. Within this group one finds people who themselves are maʿzurīn but whose possessing spirit have been pacified and do not cause them physical pain any longer. With the aid of the possessing spirits this group undertakes the diagnosis of illness. As a member of this group noted, "the ʿuzr knows another ʿuzr". Thus, while the healing power of practitioners who are literate and who have memorized the Quran is generally acknowledged as being greater than those who do not, some diagnosticians claim that in the diagnosis of the spiritual illness of ʿuzr, "it is the ʿuzr which can recognize another ʿuzr". In other words, it is believed that a person who him/herself has been maʿzūr, and has maintained his/her control over the afflicting spirits, is the most qualified to diagnose the

illness of ʿuzr. As one rawHani noted, "this is why the doctor cannot identify the ʿuzr, because he himself is not maʿzūr". RawHaniya who maintain control over their possessing spirits also claim that they can command their assyad to search the past and even predict the future.

Diagnosis of illness of supernatural etiology proceeds through various forms of divination. Among diagnosticians who have limited or no knowledge of the Quran, divination is based on communication with possessing spirits, the use of a rosary, and the use of cards. One diagnostician who relies on supernaturally inspired visions in the diagnosis of illness described his method of diagnosis as follows:

> When the sick person comes, I ask him where the pain is. I also ask if the pain moves around from one place to another. If it does, then I know that it is ʿuzr. I ask, 'did you go to the doctor?' Then the patient says yes. So I take her handkerchief and I keep it under my head for a night only on Monday and Fridays because these are nights which are mabrūka (blessed). These are nights when the awliya roam the world. When I have the aTar, I get a vision after my prayer. The vision is like a television screen. I can see exactly what caused the patient's illness. It could be that she could have had a disagreement with her husband. If he hits her in a dark area, she may scream and become malbūsa (worn, i.e., possessed by a subterranean being). Sukan il arD (inhabitants of the underground) then enter her body. They do not remain in one place. This spiritual wind (riH rawHani) enters all her blood system.

A female practitioner in the village combines the tasks of diagnosing illnesses of natural cause and supernatural divination. She described her method as follows:

> When someone is ill they come to me. I separate the egg white and yolk. I put the yolk on the body of a child and where the pain is the egg spreads out. This is in case the child was not held properly. The yolk spreads from the heat because this area is inflamed...My mother was also a healer and taught me. I have visions of my patients before they come. My mother had learned the trade from her family; they were Arabs who used to iron and cure...My patients are mostly

> children and women. I am a widow and so if men come to me other people will talk. But if a woman's husband is not well she tells me his symptoms and I tell her what to do for him after the vision.

Still another form of divination is that practiced through the utilization of cards. One female diagnostician who practices this form of divination said, "If someone is mazūr or has nazra, I can tell from the cards. I only know how to identify the ʿuzr but I do not know how to cure it. I send people to the specialists".[8] Another form of diagnosis of illnesses of supernatural causation was described by a rawHani as follows:

> The person goes to the doctor first. If the doctor's medicine does not bring about the desired cure he turns to the tariqa al rawHaniya (the spiritual method, i.e., of curing). His family says take him to a spiritualist so one or more members of his family take him to a ʿaraf (a knowledgeable person, a religious medical practitioner). The ʿaraf takes the aTar in which is wrapped some money. The ʿaraf measures the handkerchief after reading a ʿazīma (concentration)...This involves concentration while reading the Quran, any sura of the Quran... the Quran is all baraka. The change in the length of the handkerchief determines the type of illness. If it becomes short it means that the illness is from the jinn, it is from lamsa ardiya. If it becomes long, the cause is from the inss (human), this means nazra insaniya (human gaze, i.e., the evil eye). If it remains the same then the illness is from Allah; it means that the illness is due to bodily disfunctions which are natural. If it is nazra ardiya, the pain is mobile. In this case a zar ceremony is performed and the person descends the Hadra (presence, i.e., presence of the possessing spirits) on a specific tariqa (path) or on any tariqa. After two or three Hadra(s) the assyad start to talk through the mouth of the affected person. At this time the pain becomes more severe and the assyad start to make their demands known. If the cause of the illness is nazra insaniya, the pain is localized, not necessarily in any specific part of the body.

A similar form of diagnosis practiced by the rawHaniya in FatiHa was described by the shikh as follows:

> The person's aTar is brought to me and I read a ʿazīma on it and I summon Al Maynur, the chief of khudam (spiritual

> servants) of the uturat (a plural form of aTar). Then I measure the aTar with three fingers. I then tie the handkerchief (in which the person's aTar and the shikh's payment is placed) tightly. Then I ask the khadim (supernatural servant), 'if it (the illness or other misfortune) is from a human, make it (the handkerchief) longer, if it is from jinn, make it shorter, and if it is from Allah, leave it as is'.

Once a person's illness has been diagnosed as spiritual (rawHani), diagnosticians may recommend differing forms of treatment by other indigenous medical specialists and some may administer the treatment themselves. Some diagnosticians recommend to their patients to go to the Hadra (zar)[9]. Sometimes a diagnostician may accompany an affected person to the Hadra. When the affected person's body responds (yihim) to one of the musical tunes representing the supernatural servants (khudam) of the different saints (awliya), and he/she gets up to dance until she/he reaches a point where she is believed to reach an altered state of consciousness, the shikh proceeds to ask the possessing spirit where he/she comes from and what his/her demands are. The spirit responds by saying that he/she comes from one of the shrines of the famous saints, which are found throughout Egypt. Speaking through the mouth of the afflicted person, he/she/they describe(s) the circumstances under which he/she/they came to the sick person and make(s) demands for a SulHa (conciliation).

In association with the zar ceremony one may distinguish a subgroup of rawHaniya (which is not represented in FatiHa but found in the nearby village), consisting of persons who organize zar ceremonies or private drumming sessions (daga) if the sick person is unable to go to the Hadra[10]. Usually, the zar ceremony is recommended by a diagnostician but in some cases, members of this second group may themselves

be diagnosticians of illness. Relying on the power of spirits which possess them they may also be the ones who perform the SulHa (reconciliation ceremony where the spirits' demands are met).

A third subgroup of practitioners of Tib rawHani are those who are not necessarily ma'zurīn themselves but command supernatural servants (khudam) through their knowledge of the Quran. Members of this group command their khudam to diagnose illness (and to cause it in cases where they practice sorcery). They are also known for their abilities to prevent illness through their functions as prayer writers and to counter the harmful physical effects of possessing spirits of ma'zurīn. Members of this literate group of practitioners who have studied and memorized the Quran consider themselves the only true practitioners of Tib rawHani and refer to the otherpractitioners as "nothing but musicians" (said in reference to those who organize zar ceremonies). In an attempt to undermine the power of indigenous practitioners who rely on possessing spirits, a Hamil Quran (bearer of the Quran, i.e., someone who has studied and memorized the Quran and who utilizes it for the purpose of diagnosis and curing of illness) noted, "It is true that 'uzr is recognized by another 'uzr but the power (baraka) of the Quran is above everything else".

Knowledge of the Quran and its utilization for the manipulation of supernatural spirits is not confined to the healing of illness but is also known to be used by some practitioners of Tib rawHahi who are commissioned to inflict illness through the practice of sorcery. Diagnosticians of maraD rawHaniya (supernaturally caused illnesses) are known to be able to command their possessing spirits to dissolve (yifuk) the

effect of illness causing sorcery, but they are generally recognized as possessing relatively limited power for the practice of sorcery to induce illness. Among such practitioners who have no proper knowledge of the Quran, dissolution of sorcery is brought about through a form of imitative magic. Shika A. described her method of dissolving (fak) sorcery and said, "I melt the lead in a pan of water over the head of the person for whom the ʿamal (deed, i.e., sorcery) was done. This (treatment) dissolves the 'amal...no I tell the person that he has a ʿamal made for him but I do not say by whom".

Although the treatment of ʿamal bil maraD (illness of sorcery) is sometimes undertaken by medical practitioners who are maʿzūrīn and who command their possessing spirits to diagnose the illness, it is generally assumed that rawHaniya with knowledge of the Quran are better able to dissolve sorcery (yifuk ʿamal). One such practitioner recalled his latest case of dissolution of sorcery (fak ʿamal) as follows:

> She had a hemorrhage. She went to Dr. S. and stayed in his clinic for ten days, but to no avail. She came back here (to the village) and got worse. They sent for me. I knew right away that it must be siHr (magic)...continued bleeding after injections indicates siHr. I wrote her three papers (i.e., Quranic charms). She wore one in the hem of her dress, another in the back, and a third under her belly button. Within less than an hour the bleeding stopped... I cannot know who did it (the sorcery). Only with fatH il mandal one can find out...This means that I bring a cup with a drop of olive oil and a child, a male, who has not reached puberty. The child looks in the cup and the rawHani reads a ʿazīma and the child sees the khadam and they show him a view of who did it...(Why didn't you do this?) I don't want to try because it brings hatred between people.

When the shikh's account was checked with the woman who had suffered from the severe case of bleeding, she confirmed his description and noted that the bleeding did indeed stop less than an hour after the

shikh's Higiba (charms) touched her body. Unlike the shikh, she showed no reluctance in levying accusations of sorcery against her future mother-in-law. She did not blame the rawHani for not attempting to reveal the identity of those who commissioned the act of sorcery against her. The necessity of keeping the identity of such persons secret is generally recognized by the patients of practioners. As one informant noted, "He never tells people who made the ʿamal for them. Otherwise people will all start killing each other, and he will be blamed. People of course can guess who is the one who went to a shikh for ʿamal against them".

Villagers generally believe that the diagnosis of spiritual illness (maraD rawHani) can be undertaken by anyone who has been himself/herself maʿzur/a and who maintains control over possessing spirits, but the curing of spiritual illness (maraD rawHaniya), including those caused by sorcery, is believed to be done more effectively by those who have good knowledge of the Quran. In terms of the implications of this belief for the perceived power of male and female practitioners of Tib rawHani, it is generally true that for practitioners who are illiterate, their power derives from their ability to diagnose illness. The healing powers of practitioners who are learned in the teachings of the Quran are deemed more efficacious in the healing of illnesses precipitated by spirit intrustion and sorcery. Since women are generally illiterate female practitioners seldom enjoy the prestige of literate males. The basis of their relative devaluation is not their gender per se, but an attribute (illiteracy) which is generally linked to that gender identity. Exceptions do occur. This is particularly evident in the

case of female healers in the nearby religious centre, who are also learned in the teachings of the Quran. The greater prestige accorded to literate healers was verbalized by one of them as follows: "The people who make the zar simply by drumming do not have the same ability as the others who write aHgiba (Quranic charms) and who have knowledge of the Quran and its use".

In rating of healers according to their power, it is generally believed that, "the longer a spirit possesses a person, the stronger it becomes. It matures in the body of the person. The strength of the healer depends on the strength of the assyad that are possessing him". Clearly, the prestige accorded to the maturity and wisdom of old age in village system of social organization is replicated in informants' evaluation of the creatures of the supernatural realm.

As the indigenous practitioners of Tib rawHani practice different forms of divination, they also differ in their knowledge of illness and, with the exception of knowledge of illness causation, do not share a unified view of illness symptomatology. Following Fabrega and Silvers' example of determining the extent of shared medical knowledge about illness manifestations among h'iloletik and laypersons in Zinacantan (Fabrega and Silvers 1973), a questionnaire was administered to the six practitioners of Tib rawHani in the village and to a control group consisting of an equal number of non-practitioners matched for age and socio-economic status. The percentages of respondents, in each group, who provided positive associations between illness dimensions (related to illness causation and physical manifestations) and three culture bound states of illness (Hassad, 'uzr, and amal bil maraD) are summarized in

Tables and . As in the case of the indigenous Indian h'loletik of Zinacantan, the rawHaniya of FatiHa do not rely on specialized, exclusive knowledge about illness and its manifestations. In contrast to the relatively high degree of consenus about illness causation between and among practitioners and non-practitioners (illustrated in Tables 6.1 and 6.2), the practitioners as well as non-practitioners disagree to a considerable extent about the association of physical symptomatology with the selected illness labels.

The specific mechanism by which the assyad cause the illness of ʿuzr is also by no means a point of complete agreement among indigenous diagnosticians and healers. While one diagnostician may assert that the spirit itself does not actually reside in the maʿzūr/a's body ("or else it would burn it completely"), and that it is simply the "wind" (aryaH) which actually enters the human body, another practitioner provides a diametrically opposed description. When asked about the process by which the assyad inflict physical pain on the maʿzūr/a, and whether it is only the wind of these spirits which is responsible for the pain, a female diagnostician responded, "Of course it's not only the wind, they themselves come inside the person and control the person and put him in a daze. People cannot feel themselves. The assyad move from one place of the body to another. They go from the head to the heart, to every part of the body. The doctor doesn't know them. No doctor will ever know them. People become well only in happiness".

The people of FatiHa themselves, while they recognize the special power of rawHaniya for diagnosing and curing supernatural illness, believe that the diagnosis of supernaturally caused illnesses on the

Table 6.1. Degree of RawHaniya's Concensus on Illness Dimensions Associations.

Illness Dimension	% Positive Association Hassad	% Positive Association ʿuzr	% Positive Association ʿamal bil maraD
A. Cause			
a. instrumental			
1. nat. envir. & subs.	0	0	0
2. phys. constitution	0	17	0
3. spt. intrus. (malbus)	0	100	0
4. Hassad (gaze	100	17	0
5. ʿamal (sorcery)	0	0	100
b. efficient			
1. God	0	0	0
2. Hassid (witch	100	17	0
3. assyad (spirits)	0	100	0
4. saHir (sorcerer)	0	0	100
c. ultimate			
1. sadness	0	100	0
2. anger	0	83	67
3. jealousy	100	17	100
4. hatred	100	0	100
5. punishment by God	0	0	0
6. fear	0	84	0
B. Physical Symptoms			
1. weakness	100	100	100
2. headache	100	100	100
3. aches all over	100	100	100
4. trembles	67	50	33
5. hot-cold spells	550	33	33
6. cough	17	50	17
7. chills	17	50	17
8. nausea	33	50	50
9. weight loss	67	100	100
10. vomiting	33	50	17
11. swelling	00	50	17
12. loss of balance	33	50	50
13. diff. in breathing	67	67	17
14. lump in throat	50	67	0
15. diarrhea	0	0	0

Table 6.1. Continued.

	Illness Dimension	% Positive Association Hassad	% Positive Association ʿuzr	% Positive Association ʿamal bil maraD
16.	fever	67	33	17
18.	earache	33	67	50
19.	watery eyes	67	50	50
20.	rash	0	17	0
21.	back pain	50	67	100
22.	dizziness	67	83	83
23.	chest pains	17	67	17
24.	stomachache	17	67	17
25.	excess blood in body	0	0	0
26.	excess water in body	0	0	0
27.	drying of blood in body parts	67	83	100

Table 6.2. Degree of Non-practitioners' Concensus on Illness Dimensions Associations.

Illness Dimension	% Positive Association Hassad	% Positive Association ʿuzr	% Positive Association ʿamal bil maraD
A. Cause			
a. instrumental			
1. nat. envir. & subs.	0	5	5
2. phys. constitution	0	9	0
3. spt. intrus. (malbus)	5	100	0
4. Hassad (gaze)	95	19	0
5. ʿamal (sorcery)	0	0	100
b. efficient			
1. God	5	14	5
2. Hassid (witch)	100	23	0
3. assyad (spirits)	0	90	0
4. saHir (sorcerer)	0	5	100
c. ultimate			
1. sadness	0	100	0
2. anger	10	90	57
3. jealousy	100	10	95
4. hatred	100	10	100
5. punishment by God	0	0	0
6. fear	0	86	0
B. Physical Symptoms			
1. weakness	100	100	100
2. headache	100	100	100
3. aches all over	100	100	100
4. trembles	43	52	57
5. hot-cold spells	19	19	29
6. cough	5	14	5
7. chills	5	29	15
8. nausea	10	33	24
9. weight loss	29	76	95
10. vomiting	14	24	19
11. swelling	5	33	29
12. loss of balance	29	71	71
13. diff. in breathing	43	71	48
14. lump in throat	19	57	24
15. diarrhea	0	5	29
16. fever	38	43	38
17. pain in joints	62	90	67

Table 6.2. Continued.

	Illness Dimension	% Positive Association Hassad	% Positive Association ʿuzr	% Positive Association ʿamal bil maraD
18.	earache	19	67	48
19.	watery eyes	43	71	52
20.	rash	5	14	14
21.	backpain	48	86	76
22.	dizziness	76	95	86
23.	chest pains	14	57	38
24.	stomachache	10	57	33
25.	excess blood in body	0	10	10
26.	excess water in body	0	5	0
27.	drying of blood in body parts	57	67	76

basis of illness symptomatology can also be done by lay persons. Thus when an informant told the author that her neighbours had advised her to go to the Hadra (zar) and when the author inquired about how her neighbours were able to diagnose her illness, she responded, "Because the same cases have happened to many other people before me and everybody knows these symptoms and what they mean". In some cases, frequenting the rawHaniya may be looked upon as an attempt on the part of the patient and his/her family to legitimize the illness role by obtaining a reaffirmation of their own evaluation of the illness state. In fact, it is possible to actually start the process of pacification of the spirits through the attendance of the Hadra without the services of a rawHani. The legitimizing function of the formal diagnosis and the subsequent participation in the Hadra is evident on the latter occasion when the musicians of the Hadra sing a song entitled lamūni (they blamed me), which is sung by some of the ma'zurīn who descend the Hadra and is aimed to dispell suspicions on the part of those who may describe the behaviour of the ma'zurīn as faking. The singers say, "why do you blame me? Oh free one, oh free one, what is your concern with me. Tomorrow (i.e., in the future) you will see what will befall you and what happened to me will happen to you".

The power of the rawHaniya clearly does not rest on their specialized knowledge of illness causation and manifestations[11]. Their power does not derive from their control over specific types of medical information which differs from lay persons', but from their reputation of contact with supernatural beings, their control over religious knowledge, and importantly, their culturally valued role of extending legitimacy to

deviations from social role expectations associated with illness[12]. Moreover, it should be noted that the rawHaniya accumulate a tremendous amount of information about the members of their community, they make very good listeners. Their familiarity with local culture, along with this eagerness to inquire about "the well being" of fellow villagers allows them to anticipate the types of problems which people of different social standings in the village are likely to bring to their attention as the basis of their stress and their subsequent illness. Finally, it is evident that the rawHaniya are not reluctant to change their diagnosis of illness as the need arises. This change is prompted by new information about patients which comes to the attention of the diagnosticians. Thus while shikha A. had attributed F.'s barreness to ʿuzr on the occasion of the author's first visit to her with F., a few months later when rumours of F.'s pregnancy spread through the village, Shikha A. assured F. that the assyad have been barred (inHagazū) from her and that she would have a child within the year.

In sum, the power of the rawHaniya does not rest on their specialized knowledge of illness causation or symptomatology of illness, nor even on a shared view of the mechanisms of illness precipitation[13]. It is derived from their culturally valued control over elements of the supernatural realm which lends their diagnosis of illness its authoritative legitimizing character. When the author asked a rawHani practitioner about whether any one can read a ʿazima (Quranic passage) on a sick person's aTar to diagnose illness, she responded, "only people like me can because I have shikh Y (the possessing spirit with whose help she established contact with the supernatural world). In addition to this

supernaturally acquired power, indigenous practitioners are tuned to local culture and the potential stresses of social relations of power differential which precipitate illness. Moreover, it is evident that the rawHaniya's role as diagnosticians and healers is associated with their greater capacity to impose order and control over the deviant behaviour and the uncertainties associated with an illness occurrence (Cf. Fabrega and Silver 1973:78-79). A rawHani, like other indigenous practitioners whose power is supernaturally based, "provides a response, interprets the uninterpreted, and orders the occurrence in terms of accepted patterns of meaning" (Shweder, 1968:1). This capacity of rawHaniya to impose order on ambiguous situations was assessed through the administration of a modified form of Shweder's cognitive capacity test to all the rawHaniya in the village and to a control group of non-practitioners.

Richard Shweder (Ibid) has provided an experimental procedure whereby the cognitive capacities of traditional healers could be systematically compared with those of lay individuals partaking of the same cultural tradition. Following this procedure, all six of the village rawHaniya and twelve non-practitioners, matched for sex, age, and socio-economic status, were presented with four series of photographs depicting objects and scenes which are familiar to the local population. Each of the respondents was shown four series (A,B,C,D) of photographs (of a sagya (water wheel), a field of cotton, a man ploughing, and a party of cotton pickers). Each series had been developed through six different stages of clarity ranging from a complete blur in the #1 photograph of each series to a well focused scene in the #6 photograph. All

the pictures were arranged and presented to respondents as six consecutive rounds. The first round included all #1 photographs of each of the four scenes. The second round included all the #2 photographs of each of the four series and so on, with the last round being composed of the perfectly focused photographs of each of the four scenes. For photographs of Series A and C, respondents were told to describe what they saw in each photograph, only if they were sure of what each of the photographs represented. They were instructed to give the answer, "I don't know" in cases where they were not sure of the representations in the photograph. In case of Series B and D, respondents were presented with alternative answers. For the sagya of the B series, respondents were told that the photograph may represent a stack of hay, the dome of a mosque, or a sagya. Similarly, in case of series D, the scene of a man ploughing, respondents were asked to choose between the alternatives of an animal turning the sagya, a bridge, a man ploughing. As in the case of series A and C, respondents were asked to describe what they saw only if they were sure; they were instructed to say "I don't know" if they were not. The objective of the test was to determine which group (practitioner or non-practitioner) was more inclined to impose form and order on the blurred and ill-defined scenes illustrated in the photographs and which would provide the response, "I don't know" more readily.

As in the case of Shweder's h'loletik, the rawHaniya offered the response "I don't know" less frequently (See Table 6.3). For the photographs where alternative choices were offered, the rawHaniya, when they did not provide the right answer, showed a greater inclination for guessing rather than saying, "I don't know". Moreover, in providing

Table 6.3. Practitioners'* and Non-Practitioners'** Responses to Shweder's Test.

Photograph	% Respondents' Response			
	"I don't know"		Imposed Structure	
	P	N.P.	P	N.P.
Series A				
1	50	75	50	25
2	33.3	75	66.6	25
3	16.6	50	83.4	50
4	0	18.3	100	81.7
5	0	0	100	100
6	0	0	100	100
Series C				
1	50	58.4	50	41.6
2	16.6	50	83.4	50
3	0	16.7	100	83.3
4	0	8.3	100	91.7
5	0	0	100	100
6	0	0	100	100

	Correct Answer		Guess		"I don't know"	
	P	N.P.	P	N.P.	P	N.P.
Series B						
1	16.6	8.3	50	50	33.3	41.6
2	0	16.6	83.4	25	16.6	58.3
3	50	41.5	50	8.3	0	49.8
4	66.6	58.3	33.3	25	0	16.6
5	83.4	83.4	16.6	16.6	0	0
6	100	100	0	0	0	0

Table 6.3. Continued.

	Correct Answer		Guess		"I don't know"	
	P	N.P.	P	N.P.	P	N.P.
Series D						
1	0	0	66.6	50	33.3	50
2	0	16.6	83.4	58.3	16.6	25
3	66.6	41.6	33.3	58.3	0	0
4	66.6	75	33.3	25	0	0
5	100	100	0	0	0	0
6	100	100	0	0	0	0

*P

**NP

such guesses, in some cases, they also provided answers which were not included in the alternative choices of the experimental procedure. This greater inclination on the part of the rawHaniya to impose order on the ill-defined representations of the photographs is consistent with their expected role behaviour of imposing explanation when the deviant behaviour and confusion of illness experiences are presented to them.

ii. Cosmopolitan Medical Treatment - Within the village, cosmopolitan medical treatment is available to the people of FatiHa from a local paramedic known as Halag il SiHa who has received informal training at the hands of physicians. Cosmopolitan medical treatment is also obtained by the villagers from private physicians and the government health clinic and hospital in the nearby town and in other provincial towns.

The most desirable form of cosmopolitan medical treatment which the peasants aspire to is that associated with a private physician. The most accessible cosmopolitan medical services, including those of private physicians are located in the nearby town, about three kilometers from the village. Two physicians and a dentist in this town are frequented by the people of FatiHa. Through extended interviews and observations in the clinic of a physician who operates a private practice, information about the most prevalent diseases among the peasants of FatiHa and their approximate differential distribution by age and sex was obtained.

The clientelle of Dr. E. is composed of approximately 25% women, 25% children, and 50% men. This distribution is largely a reflection of the peasants' greater willingness to invest resources for the curing

of men than women. It is said that men are the bread winners and if they are not healthy the life of the whole family falls apart. From an etic perspective, this rationalization is a reflection of the power differential between men and women and the differential valuation of males and females. Although the physician himself could not provide an estimate about the proportions of female and male children who are brought to this clinic, the author's own observations in the village indicate parents' greater willingness to allocate scarce cash for the cure of male as opposed to female children.

Among children, the physician notes that the most common ailments in the summer are due to enteritis. Intestinal inflammations due to bacterial and protozoan sources are more prevalent in the cases of young children than is the dysentry due to parasitic worms. In winter, bronchial inflammations are the most frequent afflictions. It is estimated by the physicians that between 20-30% of the sick children brought to his clinic are diagnosed as suffering from severe malnutrition. Conjunctivitis is also said to be prevalent among children in the summer. Among adults, approximately 20% are said to suffer from Pellagra, and bronchial asthma is widespread.[14] The distribution of Belharzeasis reaches nearly 100% according to Dr. E. Liver and spleen enlargement and cancer of the bladder is diagnosed frequently in males by physicians. It is a secondary effect of Belharzia parasitosis. Common among males also are a variety of renal ailments and urine disturbances which are also identified by the physician as secondary effects of Belharzeasis. Among older adults, the physician reports a large proportion of his clientele suffering from artereoscorosis, bronchitis (in the winter)

and diarrhea. In all age groups in the summer, nearly 70% of all cases examined by the physician are diagnosed as malaria. Around the time of insecticide spraying in the village, people visit the physician's clinic with complaints of vomiting and diarrhea.

In addition to the services of private physicians, cosmopolitan medical treatment is available to the people of FatiHa from a government operated hospital and an associated maternal and child health clinic in the nearby town. The 80 bed hospital is staffed by a physician-director, 2 surgeons, two interns, an endemic disease specialist, 2 dentists, and a nursing staff trained in the provincial school for second grade nurses (Hakimat). Medical facilities housed by the hospital include x-ray, a clinical laboratory, and a child and maternal health center and the school health unit. The official fee charged for examination and dispensation of medication is 3 P.T. (3/100 L.E.) and surgery is performed free of charge. In spite of the material advantages offered by this government operated facility, some informants who utilize its services out of necessity complain of the unpleasant treatment by staff members and their mockery of the peasants' garb and language.

The maternal and child health center which is connected to the hospital is staffed by a physician, a pharmacist, one senior nurse and seven junior nursing staff members. According to the senior nurse, the majority of village women do not come to the center until around the fourth month of pregnancy. Due to a paper shortage, each is asked to buy a note book in which her record is placed. The information in the note book is recorded by the nurse who includes such data as pregnancy history, weight of expectant mother, her hemoglobin count, blood pressure, and family health (which the nurse complains is very difficult to obtain).

Cases of TB are transferred to the hospital in the capital of the province. Check-ups for pregnant women are available once a week. The women are encouraged to come whenever they can and as often as possible. Once their name is registered with the child care center, they have the right to request a birth assistant who would go out to the village and supervise the birth, cut the umbilical cord, administer the necessary eye care procedure, and periodically check on the mother and child until the fortieth day after delivery. As long as the mother and child's name is on record in the health unit, the staff informs the mother, through the village headman, of the time and place for the child's vaccinations during the first five years of age. After this age the child becomes the responsibility of the school health unit (SiHa Al madrassiya) which is assigned the task of providing regular stool and urine analyses and supervises school children's health in general.

D. Dynamics of Treatment Choice

In Sections B and C we have provided an account of the types of preventive measures and the various forms of medical treatment available to the people of FatiHa. In doing so, reference was made to both indigenous forms of prevention and treatment and those which are associated with the cosmopolitan medical tradition. It was noted that the villagers have three main categories of treatment alternatives with varying underlying local explanations: Tib Tabi'i (natural medicine which derives from explanations of illness in terms of natural causation and psychological stress, which induce failure of proper body functioning), Tib rawHani (supernatural medicine - which derives from

explanations of illness in terms of supernatural etiology associated with socially significant ultimate causation), and cosmopolitan medical treatment (which, although sharing with the Tib Tabi'i the general explanation of illness in terms of natural factors, differs from that indigenous medical tradition in its emphasis on pathology rather than cause and its general neglect of psychological stress as a significant etiological element).

The mere enumeration of forms of medical treatment undertaken in the preceding sections does not give us access to the dynamics of treatment choice. For this purpose one must examine the factors which prompt people in specific situations to choose one form of treatment over another. It is therefore necessary to survey the variety of dialectically related elements of the village sociocultural system and inquire about the determinants of people's choices within a medical care system which includes a variety of explanations of illness and a corresponding variety of possible treatment stra egies. When anthropologists have undertaken this type of analysis they have often emphasized the determinant role of local illness concepts. This tendency is exemplified in the work of George Foster who writes,

> It appears as if the most important categories of culture that should be more or less completely understood to carry out successful health and hygiene programs are local ideas about health, welfare, illness, their causes and treatment (Foster 1955:20 as cited in Bonfil Batalla 1970:248; original emphasis).

While one cannot realistically discount the role of local concepts of illness as irrelevant to treatment choice, it is the contention of this author that selection of medical treatment is situationally determined and cannot be predicted from information about local ideas

of illness. Just as the necessity of integrating illness explanations into the social structure has been shown in Chapter 5, it is similarly necessary to examine the dynamics of treatment choice. This is particularly important if the medical system is to be utilized as an efficient tool of anthropological analysis, i.e., as a probe into the dialectics of social life.

As noted in our discussion of the specificity of illness explanations in Section C of the preceding chapter, selection of appropriate treatment is neither random, nor does it follow straight forwardly from an underlying logic of culturally shared categories of illness explanations. As explanations of illness are not simply based on physical symptomatology, but take into account the social structural context of illness episodes, forms of treatment are also selected accordingly. Choice of the appropriate treatment strategy is affected by the progression of the illness itself, its response to certain types of treatment, and the social identity of the affected person him/herself. In considering the latter category, one may point to such elements of social constraint as the power position of the a-fected person and how this is related to his/her access to resources which persons in positions of power may or may not choose to expend for the medical treatment of a sick person or group of persons (e.g., daughter-in-law in an extended family household and peasants in a centralized state society with characteristic social stratification and associated power differentials.). One may also note the nature of interpersonal relations between the sick person of a certain social standing and the practitioners of different therapeutic traditions, as well as the economic requirements of the different

therapeutic practices. In short, one must consider factors which clearly extend beyond the system of medical beliefs or explanations of illness in the analysis of choice of medical treatment strategies. This theme is pursued in the remaining part of the chapter, which undertakes a critique of the theoretical position which accords casual priority to conceptual factors in the choice of medical treatment, describes the pattern of hierarchy of resort to curative practices in FatiHa, and underscores the significance of power relations (at both the micro and macro levels of analysis) for medical treatment choice.

a. Illness Concepts and Treatment Choice

Anthropological studies of therapeutic strategies have often assumed that these derive automatically from beliefs about illness in any given culture. A recent critique of this theoretical orientation characterizes anthropologists' analysis of therapeutic strategies as follows:

> Anthropologists have often asserted that there are conflicts between...traditional (illness) classifications and their associated theories of cause and cure on the one hand, and the modern Western, or cosmopolitan medical practice on the other. The usual form of argument is that when Western practice applies treatment which is perceived or classified as inappropriate in the local system for the category in which the disease is logically placed, treatment will be rejected because of the "cultural conflict" or "cognitive dissonance" generated in the patient (Kunstadter 1975:376).

Contrary to the supporters of the "cultural conflict" or "cognitive dissonance" explanation, it may be argued that it is always appropriate to look for the alternative systems of explanation of illness and actions for its resolution as a normal part of any social subsystem (Ibid), whether this subsystem is associated with a multi-ethnic society (as

Kunstadter's study shows) or whether it relates to a peasant community which is integrated into a broader social constellation, as exemplified by the research community of the present study. Moreover, it must be emphasized that as evident in our description of the variety of explanations of illness in FatiHa alternative therapeutic traditions are not simply the result of the intrusion of "western" medicine. Reports of the hierarchy of resort in precontact societies have also been noted in cross-cultural studies (Schwartz 1968).

As Kunstadter points out, the above noted "cognitive dissonance" argument derives from the assumption that people ordinarily intellectualize their behaviour in the sense of making everything consistent and "rational". But while one may recognize the rationality of human behaviour and people's constant strive to consistency between goals and actions, and the constant modification of the latter to fit the former, it must be noted that human goals themselves are not immutable categories which are associated with definite appropriate actions. Individual goals and actions are not insulated from their social surroundings, and in their dialectical interaction with these surroundings, goals and actions are in a constant state of flux. To quote Kunstadter once more, "the ordinary human game, is <u>not</u> the intellectual one of conforming to a single set of rules, applicable in all situations, to reach a single goal. Rather, it involves multiple rules applicable in some but not all situations, and requires balancing between several simultaneously desired goals or values" (Ibid). For FatiHa, as for other communities described in the literature, this argument is supported by the actual existence of a variety of explanations

such as spirit intrusion, natural causation, the evil eye, and related forms of treatment such as the zar ceremony, the consumption of medicinal salts, or the fumigation with aromatic incense, do not conform to a single theory of illness. The cosmopolitan form of illness explanation and treatment is but one additional alternative, the conceptual inconsistency of which does not undermine its situation-specific utility and evident desirability. The validity of this argument is further augmented when one notes the equally real fact of anything but complete agreement about illness explanations and forms of treatment among the villagers of FatiHa themselves, who presumably share a common "cognitive map" or "ethno-medical" theoretical perspective. This variability was more clearly demonstrated in the case studies of illness presented in the earlier chapter. As Kleinman has recently written, "the sickness taxonomies elicited by ethnoscientists can seriously distort our understanding of lay beliefs about sickness if those taxonomies are divorced from the setting of actual sickness episodes and from their use as practical guides in the health seeking process of choosing among available treatment alternatives" (Kleinman 1977).

Illness classifications as isolated cognitive domains differ from actual responses to illness episodes. The sharply differentiated "formal taxonomic categories contrast with what Kleinman has referred to as "the loose, and overlapping semantic networks", which mediate between beliefs about illness causation and situational variables associated with cases of actual procurement of medical treatment. In fact, the hierarchies of resort practiced in the setting of the present study (see subsection b. below), and frequently reported in the

anthropological literature on medical treatment, reveal that the underlying classificatory elements associated with actual cases of medical treatment may in fact be contradictory. It is evident that choice of medical treatment rests on the immediate requirements of cure rather than on the conceptual compatibility of logical categories underlying different forms of treatment.

In a survey of responses to illness over a one year period among the adult inhabitants of 100 households in the village of FatiHa, it was evident that in seeking medical care byond the family context, the physician was by far the number one choice of the villagers (See Table 6.4). One may note with marvel such a result if one supports a position which requires complete consonance between the underlying logic of illness explanations and treatment strategies. The physician's medical logic which derives from a naturalistic theory of illness in which body-mind duality is pronounced, contrasts with local medical theory with its integrative emphasis as well as its naturalistic and supernaturalistic explanatory elements. But clearly, what is important for the villagers in choosing the physicians treatment, when they do, is not its underlying logic, but the obvious fact that such treatment is effective[15] for certain types of ailments. The choice of the physician is not based on the internalization of the theoretical assumptions underlying his/her treatment forms, but more importantly, on the basis of these treatments' effectiveness[16]. The overwhelming selection of the physician by the people of FatiHa shows clearly that one need not be competent in medical school physiology and anatomy nor an ardent supporter of the germ theory of disease in order to seek treatment by a physician whose

Table 6.4. Utilization of Different Forms of Medical Treatment.

Medical Personnel or Treatment	Order of Choice (1st, 2nd, 3rd)	Number of Patients
Physician	1st	69
	2nd	25
	3rd	0
Halag SiHa	1st	15
	2nd	4
	3rd	0
RawHaniya	1st	1
	2nd	12
	3rd	1
Government Hospital	1st	5
	2nd	3
	3rd	0

diagnosis of illness and its treatment rests on the principles of a naturalistic theory of disease[17]. Conceptual consonance is undermined by pragmatic considerations and by evidence of the situationally determined utility of therapeutic strategies. This point receives further elaboration below.

b. The Hierarchy of Resort to Curative Practices

The variation in the evaluation of illness according to contrasting conceptual schemes is evident in the villagers' hierarchy of resort to curative practices, which involves the selective and situationally variable utilization of the main types of medical treatments (indigenous and cosmopolitan) available to the sick person and his/her family[18]. The choice of a specific treatment depends, among other things, on what the type of medical treatment can do at any given point in the treatment procedure and the duration of illness. The selection of various forms of treatment may be understood in terms of situationally determined goals of the patient and his/her family. Villagers, including indigenous medical practitioners recognize the inadequacy of the indigenous medical care system in the treatment of illnesses where the physical dimension of malfunction is most pronounced. In this case, the physician is recognized as being most qualified for dealing with the perceived relevant underlying causes of illness. In case of the indigenous practitioners whose concern extends beyond the purely physical manifestations of illness to ultimate cause, his/her success is measured not simply by reference to relief of physical symptoms of illness, but also by patients' improved psychological disposition, work habits, and ability to fulfill culturally prescribed role functions.

Generally, villagers utilize modern health care facilities for symptomatic relief whereas disorders which are judged to be directly related to socially significant ultimate causes are viewed as requiring the expertise of an indigenous healer. In this regard, it should also be emphasized that, unlike the physician whose domain is strictly medical, indigenous diagnosticians and healers are frequented for a variety of misfortunes, ranging from loss of prized possessions, to marital conflict, to barreness and sterility, along with a variety of problems involving interpersonal conflicts and tensions. These interpersonal problems are not differentiated from a person's state of health which is seen as influenced by any such distressful event and conflicts in daily life.

It is clear that villagers do not perceive cosmopolitan medicine to be in conflict with their indigenous medical care system. They note that these different forms of health care meet different needs and expectations. In other words, villagers note the complementarity of the two systems. In some cases villagers continue to take the migawiyat (strengthening substances) of the physician, wear the Higab (charm) of the shikh, and visit the shrine of a wali or even a Christian church, all in the pursuit of the reversal of a state of ill-health. It is also significant to note that the social context in which the illness label is to be publicized is an important consideration in the selection of healers who provide legitimacy for illness. A barren woman may frequent a healer to obtain such legitimatization. An agricultural worker employed by the government, on the other hand, necessarily seeks the dispensation from his role obligations and failure to report to work from the physician. Legitimation depends on the specific power domain in

which the label of illness is to be displayed.

The resort to indigenous healers may be understood in terms of the types of illnesses perceived by the sick person or his/her family as well as in terms of the social functions of indigenous healers themselves. The types of illnesses which indigenous healers, as opposed to physicians, are believed to be expert in, are usually chronic and masked minor psychological disorders. A similar situation has been described for Taiwan (Kleinman 1975). These illnesses may be described as involving "somatization" of personal and interpersonal problems (Ibid). The indigenous diagnostician or healer give legitimacy to claims of illness arising from interpersonal conflict, a function which the physician, with his/her emphasis on biomedical dimensions of illness, does not dispense. Unlike the case of the physician whose curing abilities are defined in terms of his success in eliminating, completely or partially, the physical symptoms of discomfort, in case of the indigenous rawHaniya, their success may be gauged in terms of identifying or labelling the socially defined illness, thus lending legitimacy to the sick person's claim of stress and discomfort, and even allowing a temporary enhancement of social status (a momentary suspension of relative powerlessness).

In examining the hierarchy of resort in curative practices, it is interesting to note that indigenous healers of the village themselves recognize the above noted division of labour between Tib rawHani and cosmopolitan medical care and in cases of severe mental illness they may advise their patients to visit a physician. Furthermore, they themselves frequent physicians for the cure of what they perceive to be acute, physically based disorders. One of them described her recent

hospitalization as follows:

> I vomited and then they sent me the ambulance. Three doctors checked me and said that I must take injections. Dr. X (the director of the hospital) said I'll let you stay but don't take my business from me. The shikh Y (her possessing spirit) came and Dr. X asked him if I can take injections and medicine, he said "yes". They gave me hospital clothes to wear but my body could not stand them. Then they agreed to let me wear my clothes. I stayed for twelve days...all my loved ones from your village came to visit me.

This rawHaniya also claims that Dr. X believes in the above noted division of labour between physicians and rawHaniya and that he recommends to some of his friends from the city to visit her.

The differentiation of tasks of rawHaniya and physicians is noted in informants' descriptions of the types of illness which each is expected to successfully cure. Tib rawHani is deemed useful for the identification and cure of illnesses which become manifest gradually and the duration of which stretches over a long period of time. The physician's curing abilities, on the other hand, are recognized as being useful for the treatment of afflictions which are sudden and severe. The somatic intervention associated with the physician's treatment in the form of medications is described as adequate for what is perceived as primarily somatic disorders which are only indirectly linked to ultimate causes. By contrast, it is deemed necessary to seek supernatural intervention in treating the relatively chronic states of illness which are directly linked to emotional distress and interpersonal conflict, including those associated with power differentials. As it is a supernatural power which is believed to precipitate the physical pain associated with the latter form of distress, a supernatural form of intervention is believed necessary for their legitimation. The

distinction between the expertise of indigenous medical practitioners and physicians is reflected in villagers' differential expectations of the two groups of medical care specialists. Thus, when Dr. O. was called to examine S's daughter and did not prescribe any medicine and said that the daughter should visit the Hadra, her mother became furious. She refused the physician's advise and said, "I am bringing a doctor, not a shikh. I expect you to prescribe medicine".

Treatment by an indigenous rawHani involves attending to a variety of the patient's personal concerns which, according to the conceptual framework of the physician, are ordinarily considered outside the "medical" domain. The transaction between the indigenous practitioner and his/her patient involves matters byond what the physician defines as strictly medical issues. To the extent that the sick person's illness is perceived to be linked to social, supernatural, or interpersonal factors, the services of the indigenous practitioners are "rational choices". When naturalistic causation is believed to underlie a state of illness, the physician's services (if economically feasible) are eagerly secured. The interaction of the physician with the villagers is quite different from that of a traditional practitioner. In interactions with the latter, there is no sense of inhibition in expressing beliefs which may be considered "backwards". The physician's probing questions center around the body, with minimal, if any, consideration of interpersonal relations and psychological state. If the physician's treatment brings about the desired improvement in health, the illness label is shed and the sick person is once again reintegrated into the social domain as an active member. In case a cure does not result,

then the physician's treatment is abandoned and an alternative therapeutic strategy is pursued. Failure of the physician's treatment does not induce its condemnation by the people but leads them to try an alternative treatment strategy. It is not the physician's curing ability which is questioned, but rather, it is the validity of his diagnosis which becomes the central issue. The villagers hold the physician in a position of power and reverence. His failure prompts them to a different formulation of the basis of their illness rather than to questioning his curing abilities. If a patient and his/her family turn to Tib rawHani after treatment by a physician, they, like the rawHani him/herself refer to the physician's failure to cure the patient as a basis for the diagnosis of the yet uncured illness state as supernaturally precipitated.

Illness treatment may be conceptualized as progressing through different phases. The data collected through the census reveals that the physician is the first choice of the majority of people in the village, males and females alike. It is in cases that the physician's treatment fails to bring about the desired cure, and when circumstances of interpersonal conflict and serious departure from culturally defined role prescription continue, that people turn to rawHaniya who rely on supernatural curing skills. Thus, K who is barren, was operated upon by a physician but to no avail. When she gave up on the doctor she started frequenting a number of rawHaniya[19]. In doing so, she secured the diagnostician's validation to her claims of supernatural causation which she described as being beyond the physician's knowledge. In such cases, while the physician does not endorse failure to fulfill cultural

role expectation, the rawHaniya provide legitimacy for deviant behaviour. The very fact that a patient is taken to a traditional diagnostician is an indication of the type of diagnosis being expected, or in some cases, the diagnosis being sought to justify deviation related to economic, maternal, or other age or gender related social role. While it is true that the diagnostician will help identify the specific spirit and the circumstances under which it affected the ma'zūr/a or the method of sorcery used for theinfliction of illness, his main task is to bring the semblance of order to a situation of disorder. His/her diagnosis provides people with a framework for explaining otherwise unexplainable behaviour.

In some cases indigenous diagnositicians/healers may be frequented after a physician has been consulted and no positive results are produced, simply because people in desperation are willing to try any and every type of treatment in the hope that health will be restored. This rationale is illustrated in the case of Z.G.'s dying husband. Z.'s husband had died about three years ago following an illness which lasted for a year. He first vomited and defacated blood. He informed his wife when this happened to him for the first time. His wife then consulted her brother who decided that the situation was extremely dangerous and took the ailing man to the hospital. Z.'s husband's condition improved after returning home and taking the physician's medicine. After being told by the physician that her husband's illness is not curable, Z.G. went to a variety of traditional curers. They attributed his illness to the fact that he drank cold water when his body was warm. She said that on her part, she believed that what the indigenous healers

said was a lot of nonsense and that they are nothing but swindlers. She said that she went to them just to please her dying desperate husband. She added, "I took him there so that I will have done all I can".

In concluding our discussion of the selectivity of therapeutic strategies and the division of labour between physicians and indigenous medical practitioners, it may be noted that the latter are speciali in the treatment of illnesses which are principally defined in terms of psychosocial criteria (ultimate causation). These are usually chronic disorders (which derive from stable interpersonal relations, including power differentials) which are reflected psychologically and projected publicly through what Kleinman has referred to as "somatic masks". In contrast, physicians are entrusted with the treatment of life threatening acute illnesses defined in terms of underlying pathological processes, to which neither lay persons nor indigenous practitioners claim any expertise. But physicians may also be utilized as one point along the path of legitimation of socially rather than biomedically defined illnesses. Finally, in noting social scientiests' increasing interest in attempting to determine the differential efficacy of indigenous practitioners' and physicians' treatment by reference to the former's compatibility with local social life and symbolic structures (Good 1976), it is evident that in the case of FatiHa, as in other parts of the Middle East, the argument can be made that choice of practitioners in response to illness is indeed intimately related to patients' perceptions of relevant dimensions of their affliction. But it must be stressed that relevant dimensions are not immutable and are situationally determined.

c. Power Relations and Medical Treatment

Initiation of medical treatment and/or the choice between different forms of therapeutic strategies does not rest simply on rigid categories of cognition and local perceptions of illness, or the underlying logic of illness explanations. In the foregoing discussion note was made of the variability of theoretical assumptions associated with the procurement of medical diagnosis and cure and the coexistence and differential utilization of medical care strategies with differing underlying conceptual frameworks. Additional factors (including those associated with power relations[20]), beyond ideological elements must be considered in understanding the basis of choice of one form of treatment over another and the more fundamental initial process of negotiation of the sick role and the extension of legitimacy to claims of illness by symptomatic persons. In Chapter 5 it was briefly noted that power differentials linked to aspects of village social organization influence the legitimation of illness explanations and, by extension, may be expected to affect the behaviour of symptomatic persons. Thus, the specific form of illness behaviour of a daughter-in-law and her access to the sick role was said to be largely determined by persons who bear a superordinate power relation to her (e.g., her mother-in-law). The influence of power differentials in the labeling of illness and the consequent behaviour of a symptomatic person is equally profound in the realm of medical treatment. As power relations influence illness behaviour, they also determine whether significant diagnosis and treatment of individually perceived stress (physical or psychosocial) will be initiated at all. Just as the social label "sick" and the associated sick role do not automatically follow

individually experienced stress and claims to the illness role, but is influenced by the elements in the social environment of a symptomatic person, including his/her power status, diagnosis and eventual treatment are similarly influenced.

As noted earlier, the presentation of symptoms does not automatically grant a person the status "sick". In fact, two persons may present identical symptoms and one would be denied the label sick while the other would be granted it readily. Neither is the severity of the symptomatic person's condition as perceived by him/herself a guarantee that the illness labeling would be granted and the necessary curative regimens pursued. In fact, it is evident that people whose social roles (and health) are highly valued may be granted the label "ill" even with the presentation of the slightest symptoms indicative of ill health. Women consistently identify their husbands as ill more readily than they do themselves or other female members of the household and prompt them to seek medical treatment at the slightest sign of ill-health. It is often said that the husband is the bread winner and that his health should be protected for the benefit of the whole family.

In the cases of the relatively powerless members of village households, it is evident that while powerlessness induces stress and precipitates individually perceived illness, less than complete subordination to the authority of others is a prerequisite for access to the sick role. Thus, while women, because of their relative powerlessness are likely to experience and communicate about stressful situations, their positions of relative powerlessness itself mitigates against their prompt access to the illness role and the social validation of their claims

of illness[21]. But as indicated in our introductory theoretical discussion of power relations in Chapter 1, one cannot realistically refer to an individual who is partner to any social relation as completely powerless. Even in extreme cases of subordination, the subordinate party exercises some control over the environment of the superordinate party. Subordinate persons do wield power, but only in the sense that they hold some threat over the environment of others.

A powerless person's claim to the sick role may continue to be denied by persons in superordinate relations of power to him/her, but this denial may eventually prove to be antithetical to the needs of the powerful person him/herself, if the subordinate person is left neglected to the point of reaching functional incapacitation. When this happens, the continued denial of the powerless person's claim to the sick role by his/her superordinate social partner(s) may prove to be disasterous to the latter, whose power is in fact based on the continued performance (work, subordination, obedience, etc.) of the less powerful partner. This amounts to the powerful person's destruction of his/her own power base. Thus, while the granting of legitimacy for claims of illness may be enhanced by derivative power accessible to the sick person who occupies a subordinate power position (as in the case of Z.'s *'uzr* discussed in Chapter 5), the superordinate person him/herself may also grant the legitimacy of illness to subordinate partners to ensure their continued survival and performance of culturally defined role functions (which are deemed to be the power base of the superordinate person him/herself) in the future. Once this decision is reached, medical diagnosis is initiated and treatment undertaken to reintegrate the now

deviant sick person into his/her culturally defined social roles, including its dimension of subordination to more powerful social partners. In sum, validation of the status "sock" is not a spontaneous occurrence. It is situationally determined (Cf. Robinson 1971:12) and is influenced by power relations associated with social statuses and the performance of roles complementary with these statuses.

Denial of claims to the illness role may be reversed once illness is viewed as interfering with the performance of essential social roles. Persons in positions of power who can lend legitimacy to illness claims may determine that in the long run legitimation of a subordinate person's claim to illness may be beneficial. Consequently, measures may be promptly undertaken to correct the now legitimized deviation from expected role performance in order to reintegrate the sick person into the established framework of role prescriptions, including that of subordination to the superordinate significant others with whom the legitimation of illness rests. One obvious question comes to mind: why doesn't the powerless person present his/her significant others with behaviour indicative of inability to perform according to role expectations and earn a temporary dispensation from role obligation through claims to the sick role? Why does he or she not simply show functional incapacitation? In answering this question one must take into account elements of social status which are not immediately apparent in the study of an illness episode. This point is illustrated in the case of a woman, B., who lives in an extended family household. As the mother of female children only, her powerlessness is explicited by her mother-in-law who works her and her female children to the point of exhaustion. B.'s appearance

indicates severe malnutrition, which is attributed by the people of her neighbourhood to her mother-in-law's "tight fist". In gatherings with other women of her age B. complains of weakness and always refers to her chronic condition of illness and the continued denial of her claim of ill health by her mother-in-law. She says that she has stopped complaining to her mother-in-law and has simply accepted her fate although she feels sometimes that she will simply fall and die one day. When B.'s friends advise her to defy her mother-in-law and have her own husband take her to the doctor who would keep her in the hospital so that she would rest (an arrangement which her husband can set up readily, in view of his acquaintance with many of the government officials in the nearby town), she resists their recommendations. In response, she refers to the possibility of even more disasterous consequences that may result from her defiance of her mother-in-law. Specifically, she dreads her mother-in-law's suggestion to her son that he marry another woman. Her mother-in-law herself complains of her junior subordinate's miserable appearance and her "ugly yellow face" and underscores the latter's powerlessness by reference to her devalued status as the mother of females. She says, "will it be from all", implying that if the only useful thing that the daughter-in-law does is her work, and if even that is abandoned because of illness, she will have nothing remaining to justify the continuation of her marriage to the older woman's son. Being aware of the reality of her lack of control over culturally valued resources, which underlie her powerlessness, the daughter-in-law continues to suffer in silence, especially in view of the fact that the mother-in-law is known to have been the direct reason for her son's earlier divorces. B. has therefore

chosen to forego the illness role to ensure the maintenance of her role as wife. She has apparently chosen to sacrifice the short range gain associated with the illness label for the long term, culturally significant status of married women.

In cases where the legitimation of the sick role is denied to a symptomatic person, the stressfulness continues to affect him/her but he/she continues to perform his/her tasks as stiuplated by more powerful persons in whose hands the control of legitimation remains. The denial of the legitimation label is itself an additional source of distress which burdens the person whose claim to illness was initially denied. As B. described her condition, she felt that she is simply wasting away. As the mother of female children she was constantly scorned by her mother-in-law, she had no support from her own family and she looked emaciated and remained chronically depressed.

By contrast to B.'s case, persons whose claims to illness are accorded social legitimacy are provided with socially approved exemptions from role obligations. The person thus treated is accorded certain privileges including a reduced work load, preferential treatment in the allocation of choice food, and even the right of being disrespectful to persons who are ordinarily considered in superordinate power relations to him/her. In addition, the emotional support of the family is mobilized and the claims of expressed discomfort are attended to with great care and concern by family members and others included in the sick person's network of social relations, be they neighbours or relatives.

The initial phase of treatment, which begins with the recognition of the patient's claim and labeling as "sick", is often confined to the

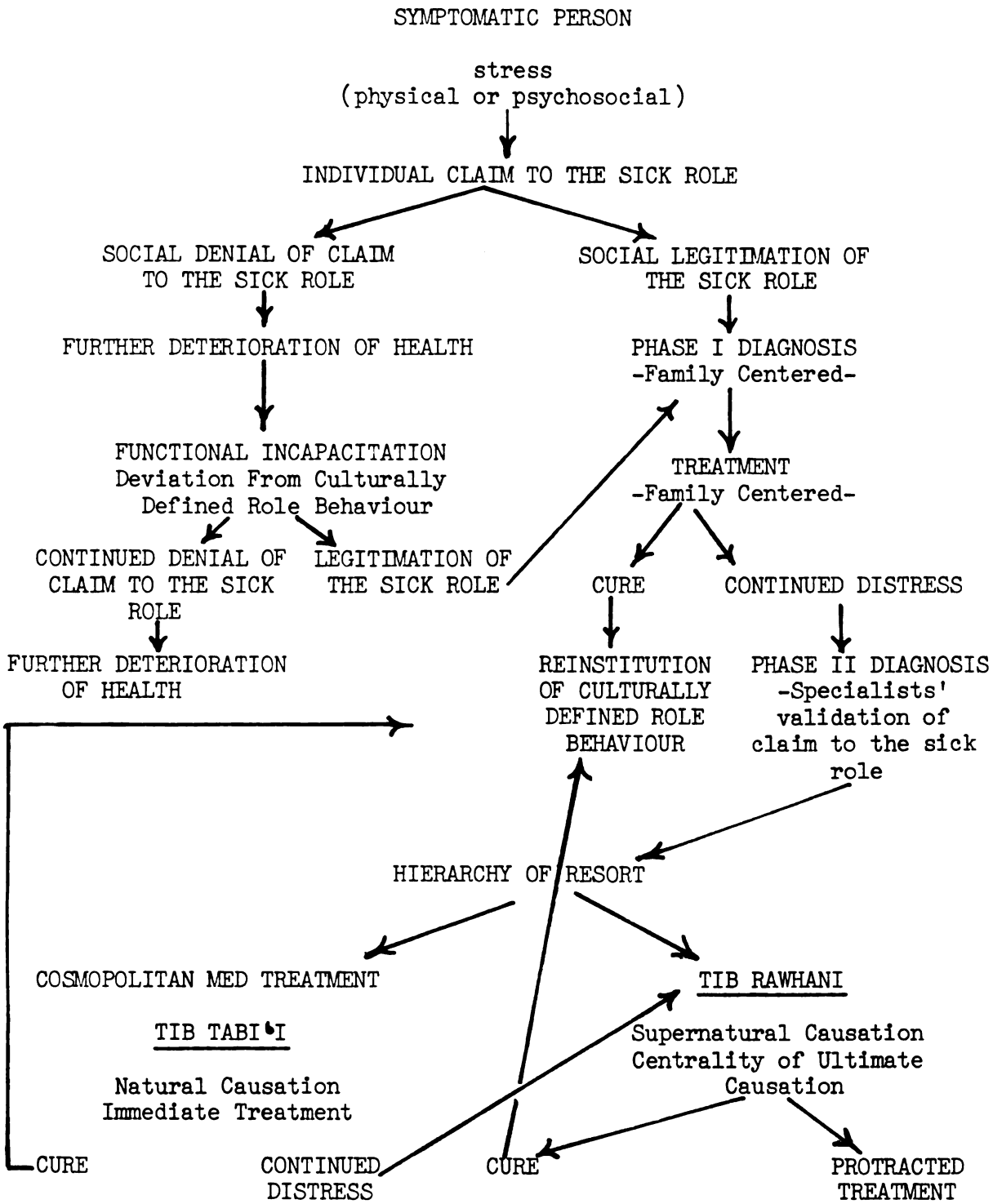
context of the family and the immediate social network of the sick person. Sometimes, depending on the perceived severity of the illness and the resources at the disposal of the family, treatment of the ill may go beyond emotional support, privileged access to prized food, and treatment with home remedies such as herbal infusions, prayers, and other minor religious rituals. If the patient's condition is judged as calling for expert treatment, a more formalized therapeutic strategy is initiated and pursued. As illustrated in Table 6.4, in seeking medical treatment beyond the family context and non-specialized cures, the number one choice of the villagers is the physician. People who cannot afford the doctor but whose explanation of the illness condition is in terms of natural causation may frequent the government clinic or the local Halag il SiHa (barber) who may prescribe any of a number of standard drugs prescribed by physicians or he may administer an antibiotic treatment in the form of an injection. The latter form of treatment is regarded as particularly effacious since the drug is recognized as being introduced directly into the body and not through the slower path associated with the ingestion of pills. The barber, in addition to administering antibiotic treatment is also likely to prescribe some form or another of migawiyat (strengthening substances) which include a range of vitamin tonics and injections of calcium.

Availability of funds, valuation of the sick person's social role and life, and perceived danger in the condition of a sick person by his/her significant others prompts them to take him/her to the doctor's clinic. Given the expense involved in such a visit, it may be judged as an added index of social legitimation of the patient's claim to

illness. In fact, the trip to the physician's office is clearly a status symbol and a reaffirmation on the part of the family of their commitment to the welfare of the symptomatic person. The physician's diagnosis, no matter its specific content, is an additional step in the reaffirmation of a legitimized state of illness. In case the family maintains a naturalistic explanation of the patient's condition, the doctor's diagnosis confirms their belief. The number of medicines prescribed by the physician is taken as an index of the severity of the illness and clearly a further sealing of the patient's claim to discomfort. In case the explanation of illness shifts to the supernatural domain, the physician's diagnosis of "normal health", or "just strained nerves" is still maintained as a support to patients' or their significant others' claim of supernatural etiology, which the physician cannot recognize. To conclude our discussion of the differential access to the sick role and the subsequent initiation and pursuit of treatment, it is evident that these do not rest simply on claims of illness by symptomatic persons nor on rigid categories of cognition and explanations of illness by the villagers of FatiHa. The process of negotiation of the sick role and the treatment of illness is summarized in diagram form in Figure 6.2.

As consideration of the circumstances of the social life of the symptomatic person, including his/her social identity was deemed necessary for understanding the basis of the differential access to the sick role, it is also true that social identity influences the type of treatment extended to a sick person whose claim to the illness role has been legitimized. Conversely, types of treatment, differentiated according

Figure 6.2. Illness Legitimation and the Hierarchy of Resort in Therapeutic Practices



to the expenditure of culturally valued resources and according to the promptness of their administration to a sick person, may themselves be utilized as an index of a sick person's social standing and his/her power status in a given social context. On the basis of this logic a survey was undertaken in the village to determine the nature and extent of differential treatment of family members of a selected sample of households in FatiHa.

In attempting to determine the form of treatment extended to family members of differing social identities in terms of gender and relation to household head, a group of sixteen families was selected from the sample of 100 households making up the sample population. Informants were asked to describe the specific forms of treatment extended to sick members of the family, their order, and their cost during biweekly interviews over a period of nearly four months. Data obtained from this survey shows that the symptoms described for the reported cases of illness were generalized and diffuse (e.g., weakness, aches all over, depression, etc.) and generally did not differ significantly from one case of illness to another. While differences in symptoms were not the primary bases for evaluation of severity of reported illness conditions and urgency of treatment, the status of the symptomatic person clearly was. The highly valued and expensive services of private physicians were systematically provided to members of the household whose health receives culturally defined higher valuation.

The average cost of treatment for illness cases reported for females was L.E. 1.50, while that for males was L.E. 2.20. In noting the order of resort to different types of treatment (beyond home remedies), it

was evident that males resorted to the more expensive treatment of the physician more readily than females, with 37% of the males selecting the private physician as their first choice as opposed to 10% of the females. When person's making up the sample was differentiated according to relation to household head (HHH), the data show that of the six male HHH who were treated for illness, four selected a private physician as their first choice. For one male HHH, the physician was the second choice, and the remaining one resorted to the public physician of the government clinic. The average cost of treatment for this group of male HHH was L.E. 3.75. Among the corresponding group of female HHH, expenditure for treatment of illness was more modest. Among three female HHH, none selected the physician as their first resort and one chose him as the second resort. The average cost of treatment among this group was L.E. 1.00. Of the eight wives of HHH who were treated for illness, only one utilized the private physician as the first form of treatment. The average cost of treatment for this group was L.E. 2.13. Mothers of married sons reported 3 cases of illness with an average cost of treatment of L.E. 2.83. Two women of this group were taken to private physicians on their initial expression of discomfort.

Comparison of treatment type and expense extended to Da and BrDa of HHH on the one hand and So and BrSo of HHH on the other, shows the higher expenditure on the treatment of males than their female counterparts. The average cost of treatment for the seven sons was L.E. 1.73, as compared to L.E. 0.92 for daughters. Among the male group, one was taken to a private physician on the first trial at cure. Two were examined by private physicians on the third trial at cure, and the

remaining sons were treated with independently purchased drugs and one was taken to the government clinic in the nearby town. Comparatively, among the five daughters treated for illness, only one was taken to a private physician. In the one case that the private physician was consulted, this occurred at the second attempt at cure. The lowest average cost of treatment is associated with young female affines of the sampled households, namely SoWi and BrWi. In the case of this group of three women, the average cost of treatment amounted to only L.E. 0.18 and none of them was taken to a private physician at any phase of their illness.

Beyond the limited data obtained during structured interviews with informants of the above noted survey, informal interviews and participant observation reveal that the form of medical treatment and investment of resources for the cure of family members is definitely a function of the afflicted person's social identity. Thus, when the author inquired from Z. about her daughter's ill-health and emaciated appearance, the mother noted that the young girl's poor health resulted from neglect when her now deceased father (Z.'s husband) was ill. She said, "...he was seriously ill. Of course I used every millim (penny) for his medical treatment. I figured his health is much more important to us than this bit of a girl. All the time that he was ill I would beg men to look after his work in the field. I would do some of the work myself, and sometimes I would even hire men to do it. I wish she (her daughter) had died instead of him. Now we wouldn't be this way and he would have kept the house open for us. As you see, all my children are girls. At least if I had a son he would have kept his father's house open". The importance of the HHH's health in the maintenance of the family

was also emphasized by other women. In justifying the expenditure of large sums of money for the treatment of their husbands women would make such statements as "he is our man. We had to pay to hire a labourer for three days (to do the field work ordinarily carried out by the husband)". By contrast, and in view of women's relatively devalued work contributions, when informants were asked about the consequences of female illness, they undermined the negative effect of such an event on family welfare. One male informant responded, "...one of the neighbours comes over and takes care of things, or her (the sick woman's) relatives will come over. If the husband knows how to do the chores of the woman, he will do them". Finally, the reluctance of investment of valued resources for the treatment of sons' wives was particularly evident. When a sons' wife asked to consult a physician, her mother-in-law mockingly remarked, "you would think that my son married a princess...she wants us to wait on her".

While gender identity and relation to HHH (which varies according to the developmental cycle of the family) affect the allocation of valued resources for medical treatment, other variables must also be considered in examining the differential utilization of available forms of medical treatment. Note has already been made of the hierarchy of resort and the situational variation of cognition related to explanations of illness. Deterrent to the utilization of cosmopolitan health care facilities include the financial burden imposed by private consultations and the long hours of waiting in the public clinic, along with exposure to humiliation at the hands of the personnel at public health care facilities. The expense of cosmopolitan medical care is particularly burdensome when one realizes that the average yearly income of a peasant family owning

one feddan of land is L.E. 120 and that a visit to a private physician costs at least L.E. 1. In this regard a female informant noted, "We do not go to Dr. X because he writes a prescription the length of my arm. How can we afford to buy all this medicine?"

Expense is clearly an important deterrent to the peasants' utilization of cosmopolitan health care facilities. Contrary to public pronouncements that health care in rural Egypt is free of charge, in reality peasants often have to pay for such services. As a peasant from Minia described to an Egyptian reporter, "The private payment for services in the public health unit is well known to all the people...I would (still) rather pay a private fee to the doctor instead of bringing another doctor from the town for a large fee, in addition to providing him with transportation" (SabaH il Khir #10061, 1975). Like the peasants of FatiHa, peasants in other parts of Egypt find it necessary to pay for medical care since "the cheap has no use" (Ibid). In this regard it should be noted that the peasants' desire for the physician's care is so great that they are sometimes willing to forego their limited savings and valued possessions to pay the physician's fee and the price of his/her medicine. Payment of a private fee to the physician by the needy peasants obtains, not only better treatment at the hands of this public servant, but also the receipt of the appropriate medication and additional vitamin tonics and drugs of general use (Ibid).

Recognizing the problem of payment to government supported physicians who are expected to provide services to the public, free of charge, the government has started an experimental plan in some parts of Egypt whereby payment for the fees of the physician is recognized as legal. Of

the fee paid by the clients to the health care unit, 20% is officially granted to the physician. This plan has not deterred physicians in public clinics from charging patients over the prescribed 20% (Ibid). Clearly, this solution does not benefit the powerless health care consumers; it attends to the complaints of the physicians who are required to serve in the rural areas. It is an official recognition that health care is for those who can afford it. This is indeed the reality of cosmopolitan health care in rural Egypt. It is not the peasants' lack of awareness of the benefits of cosmopolitan medicine, but their lack of resources which is the primary impedement to the utilization of cosmopolitan health care facilities, when these are available. The limited access to resources and the inferior quality of cosmopolitan health care services available to the people of FatiHa and other rural dwel is explainable in terms of their status as peasants who are the mainstay of the national economy and who reap minimal compensation for their efforts from a hierarchially differentiated authority structure.

In addition to the major obstacle of expense, limited utilization of government health care clinics may be attributed to time loss. Hours may be spent waiting to see a physician. Contrary to the flexible schedule of indigenous healers who may be disturbed at any time of the day or night, peasants are expected to report to the clinic during its working hours, which coincide with their own working hours. Moreover, the time expended in going to the health care center is not always rewarded with a meeting with a physician. A general problem recognized throughout rural Egypt is that of chronic abseentism among health care unit physicians who go back to the city for business (private) or

pleasure and leave their posts unattended for emergency or even for regularly scheduled work hours (Ibid). Additionally, peasants who frequent the public health facilities complain of maltreatment at the hands of medical personnel. In this regard a female informant noted that it is all right for her to go to the clinic but that she would rather pay for her husband to go to a private physician "to perserve his dignity".

The problems which the people of FatiHa encounter in their utilization of government sponsored health care services is typical of other rural areas. In his study of rural development in Egypt, James Mayfield (1974: 82,83) writes,

> After careful analysis of some 250 interviews with officials, fellahin, and private citizens, I have come to the conclusion that the vast majority of the combined units, social centers, and other government-sponsored rural development programs - in terms of effectiveness, ability to stimulate change, and success in generating enthusiasm and commitment to the goals of development - have largely failed to reach their projected aims. This rather harsh statement is substantiated by several Egyptian sources who have objectively analyzed the rural programs presently functioning in Egypt. Thus, most of the evaluation teams...generally reached the same conclusion as AHmad Tawfiq who laments over the fact that the 'combined unit, which is the center of all government services for the villagers, rarely has any peasants in it for they never go there unless it is absolutely necessary'...It is apparent that out of more than 5,000 villagers in Egypt, less than 2,000 have some form of medical service available within their borders - the one service that is the most easily accepted by the fellahin.

A number of obstacles mitigate against the utilization of even these limited available services. Note has already been made of the waste of valuable time and the expenditure of limited funds. Additionally, it is significant to note that, unlike the case of indigenous practitioners where the knowledge gap between them and lay persons in the village is limited, this is not the case for physicians and villagers. The power

differential which results from such a gap, and which is compounded by the physician's identity as a member of the urban elite, is exploited by the physician and his assistants who overtly redicule the "ignorance of the peasants".

The limited availability of health care facilities in the rural areas of Egypt noted by Mayfield is understandable in view of the power relations between the dominant urban sector and the subservient rural domain. Investment in the rural camp is made only to the extent that it helps reproduce the peasants as peasants, i.e., as subservient producers of primary commodities deemed necessary by the state which determines national priorities.

In sum, medical care strategy is dependent, not simply on conceptual consonence or its absence, but must also be understood in terms of the social organization of the community and the power relations between its members. Additionally, the social status of the peasant and the constraining function of this identity must also be considered. Contrary to popular explanations, it is not peasants' "ignorance" of the benefits of cosmopolitan medicine which limits their utilization of modern health care facilities. Medical care for the peasants of FatiHa, like the rural inhabitants of other parts of Egypt cannot be divorced from the sociopolitical superordinate power relations which direct every facet of their lives. One must consider elements of social organization beyond those associated with the village itself and turn to what Jensen has termed the macro-level of analysis of medical systems (Jensen 1976). The peasants of FatiHa do not live an isolated, independent existence; they are part of a stratified sociopolitical entity. Their subservient

power status within the nation state mitigates against independent planning of their lives in their own best interest but leaves them subject to the imposed planning and priorities of the ruling power elite.

CHAPTER 6

NOTES

[1]e.g. massaging with camphor oil or castor oil for joint pains including rheumatism.

[2]e.g., "light eating" for fever, eating mint, watercress for heartburn, drinking extracts of cumin for intestinal disorders, consumption of honey and milk for weakness, lemonade guava leaves tea, and extracts of gum arabic for coughs, ingesting sukar nabat (crystalline sugar) and Kabrit (sulphur) for jaundice, drinking coca-cola for indigestion, as well as the consumption of water in which fava beans have been soaked in TaSiT il Tarba (the pan of fright) to cure fright (Tarba).

[3]There is no specific term which the villagers use in reference to indigenous healers. They simply refer to them by their names preceeded by the title Shikh (an honourific title) and specify the curing procedure which they practice.

[4]The name of the mother and not that of the father is used in the process of diagnosis. It is said that the mother is more maDmuna (certain) whereas the father may be anyone.

[5]The most famous practitioners of Tib rawHani are located in the larger cities of Egypt. Some of them even advertise their services in national newspapers.

[6]In attempting to examine how the indigenous practitioners of Tib rawHani who reside in the larger provincial towns differ from those who inhabit the village and its immediate vicinity, the author interviewed some of the practitioners of Tib rawHani in the religious center of Disuk. Through these interviews and the observation of these healers with some of their patients, it was evident that one cannot discern any special qualifications or practices which are unique to these town healers except their fame, especially in terms of their association with a major religious center. Their recruitment to the healing role did not differ from that described for the village indigenous healers who practice Tib rawHani and only one impressed the author with his more abundant knowledge of the Quran.

[7]In describing to the author what these awliva are, the shikh said, "These are people like the Sidi Ibrahim el Disuki and Sidi Ahmad il Badawi. They are good people, they are descendents of the Prophet MuHammad. They gathered together and divided their karamat (baraka or power of good fortune) on different parts of the world. They roam

their individual corners of the earth on Monday and Friday. Each has a khadim (servant) who has known his tariqa (path, i.e., religious teachings) and these khudam (servants) are themselves filled with baraka... The awliya (saints) and their khudam reside in the shrines (e.g., at the religious centres of Sidi Ibrahim in Disuk, Sidi El-Sayid in TanTa, and Sidi Mursi Abu il 'abass in Alexandria) and from there they roam the world on Mondays and Fridays. The sir (secret, i.e., baraka) of the different awliya is diffuse throughout the sphere of influence of each wali (saint). For example, if you have an illness and I make a nadr (vow) to Sidi Ibrahim, if for example my nadr is a duck, I send out a duck during the mulid of Sidi Ibrahim. The darawish (dervishes) at the shrine of Sidi Ibrahim are khudam to Sidi Ibrahim...They include men and women. The women are not inhibited; they join the zikr, just like the men do and they sleep in the midst of men during the mulid. I am a follower of Sidi Ibrahim. In order to be a follower, one has to pray and have a special devotion to Sidi Ibrahim. When I went to Cairo, I met shikh Abu il Magd il Shahawi who is a descendent of Shikh Ibrahim il Desuki and he registered me as a follower of the tariqa il Burhamiya (he showed the author his I.D. card with his picture, which indicated that he is an official follower of the Shikh Ibrahim II Disuki)".

[8]It is interesting to note that indigenous practitioners refer sick persons not only to other indigenous practitioners but also to physicians.

[9]One of the well publicized ceremonies in the anthropological literature on indigenous medical practices in the Middle East is the zar (literally, visit, i.e., visit by supernatural beings). During the course of field work the author had the opportunity to observe several zar sessions in the nearby village and the religious centre of Disuk. (No public zar was held in FatiHa). The following observations were recorded following the attendance of a zar in the first week of field work:

We entered a peasant house of three rooms. Each of the three rooms were packed with people. Two rooms were packed with people taking part in the zar. The third room was filled with people who had accompanied some of the participants. F. (the author's companion) paid her five piasters and when the author was asked if she would participate, following F.'s advise, she said that she would be just a listener (sami'a). Towards the far end of one of the rooms stood a group of two men and a woman who sung, played the drum, and a flute. The shikh, who supervises the zar and also acts as a diagnostician when needed, started to sing the different tariqas and the men and women's bodies (segregated in the two separate rooms) swayed with the music. Their appearance reminded the author of MSU students dancing at the local taverns on Saturday nights. The author sat next to the women's room but had a clear view of the men's room. Next to the author sat a young woman of about 25 years of age accompanied by her mother-in-law. She had her head tied with a woolen scarf and was holding her head and complained of a headache. When asked about the cause of the young woman's illness, the mother-in-law responded

that she had been ill for a month. She said that her daughter-in-law has been complaining of headaches and she wants to remain in the bedding and does not want to do any work. When the author jokingly said, "are you a good mother-in-law, I hope you are not the reason for her illness", she responded, "Of course not, I care for her more than her own mother, after all she helps me when she is well, doesn't she?" She went on to say how they had taken the daughter-in-law to the doctor and said that in the beginning they did not know that she has assyad with her. The mother-in-law explained that the doctor does not understand these types of illnesses (supernaturally caused) and that the doctor's cure makes things worse. She said, "the more of those pills he gave her the worse she felt." Another woman sitting by said that she gets very violent pains every time she has her period. She said that she too has been to the doctor whom she said didn't know the real cause of her illness and gave her only some vitamins.

When some of the people in the audience were asked how the shikh diagnoses and heals their illness, one woman responded that he himself (the shikh) is affected by assyad and that he is in touch with the supernatural through his reading of the Kuran. She identified the shikh's dual role of diagnostician and healer. She did not attribute any power to him as a person; but noted that he is simply a mediator between her and the assyad. She viewed the function of the shikh to be that of making the wishes of the assyad known to human beings who do not have the capacity to see them or hear them. Like the others interviewed during this encounter, she said that she too had been to a doctor before coming to the shikh and suffered increased pains and discomforts from taking the doctor's medicine.

The shikh moved out of the women's room to give them a rest and went to that of the men who duplicated the women's performance. As far as the number of participants, male vs. female, who were in attendance, it was evident that the men's room was definitely larger than the women's and was at least as crowded. Men's gestures during their dance and state of semiconsciousness did not differ in any way from that of the women. In the "waiting room", the author interviewed a male patient who complained of abdominal pains and stiffening of his body. He said that he had been coming to the shikh and had already had a SulHa (conciliation) but the assyad started making him sick again.

[10]The HaDra is another word used to refer to the zar. It denotes the arena where the possessing spirits of the ma'zūra reveal their presence when the sick person goes into a trance after having reached a heightened state of excitement which is induced by the drumming and other musical instruments which are used to accompany the singing of the different tariqas which represent supernatural spirits from the shrines of the awliya (saints).

[11]Not only do practitioners resemble lay persons in their knowledge of the symptomatology of illness, but, with the exception of literate practitioners, the rawHaniya resemble other peasants in their social and

economic characteristics. None of the village medical practitioners are full time specialists. With the exception of one, who is the school master of the kutab (a traditional school for Quranic instructions), they are all peasants who till the land. The amount of land they own is typical of the majority of peasants in the village. The male practitioners are married and have children. The female rawHaniya are all widowed. One of them explained that their status as widowed women is probably coincidental but she remarked that when a woman is younger, she is more occupied with her young children and if men come to her house (to be diagnosed for illness), people may talk. Another female practitioner remarked that when a woman gets older she becomes more mature (rasya, i.e., settled or more reflective on her actions), "like a man".

[12]It is important to note that spiritual healers and sorcerers are not themselves the locus of supernatural power. Instead, they perceive themselves and are perceived by others as mediators between supernatural and human life. The most prestigous channel of such mediation is religious learning.

[13]The rawHaniya themselves do not claim any specific body of knowledge about the functioning of the body. When a rawHaniya was questioned about the function of the human body, he responded, "I do not know anything about these things, I only know about maraD rawHaniya (supernatural illnesses). This (knowledge of the functions of the human body) is the work of the doctor. The doctor does not know the symbols of the rosary (a form of divination used by this practitioner in the diagnosis of maraD rawHaniya...The doctor recognizes the physical illnesses which come on suddenly. Spiritual illness come on gradually. The person with maraD rawHani does not necessarily become ill right after the assyad come to him, that is why people do not remember".

[14]In the surrounding villages, informants from FatiHa report that the incidence of TB has increased in areas where jasmine and riHan (an aromatic plant) have been planted. When the physician was consulted about this problem, he noted that he had not made the correlation himself. He explained that one possible association between jasmine and riHan planting and TB may be due to sensitivity or allergy to the strong scent of the flowers which causes irritations in the mucous linings of the chest resulting in lowered resistance to infection in general, including that by the tubercullin bacillus. Informants who are familiar with villages in which the planting of flowers for commercial purposes (export to France for perfume industries) has been intensified over the past few years notethat the picking of flowers is a relatively devalued task which is taken up by women and children who work as wage labourers, and it is among this group of poor landless labourers that they notethe increasing incidence of TB. To encourage the workers to remain on the job, some landlords dispense rations of milk to their labourers on a daily basis.

[15]The pragmatism of village informants in the selection of medical treatment is evident in a local proverb which translates as "illness comes from a mountain and health comes from the eye of a needle".

[16]As Kunstadter notes, in referring to the "fad" of acupuncture which became popular in the West, roughly simultaneously with President Nixon's visit to Peking, "Surely this has nothing to do with classificatory consonance in our medical culture".

[17]Among the educated elite of the Middle East who are well acquainted with the germ theory of disease, such cognition, although clearly contradictory to the underlying logic of illness causation through witchcraft, does not deter their use of amulets, fumigation, and Quranic verses to repel the potential danger of the witchcraft of the evil eye.

[18]It is evident that in Western society where the utilization of cosmopolitan medical care is high, this occurs in spite of the cognitive gap between physicians and laypersons. In this regard Robinson (op. cit. p. 39-40) notes, "People seeking care and those from whom they seek it may have divergent and, at times conflicting interests. Some patients may be more concerned with primary symptoms, pain and social incapacitation than with underlying organic diseases. They may be oriented towards a speedy return to normal or minimum social functioning rather than complete physiological health. Members of the medical profession, on the other hand, may be likely to concentrate more on clinical illness than on the physical discomforts of its symptoms or its social consequences".

[19]Members of the community with a secondary level or higher level of education often stated at the initial meetings with the author that they do not believe or ever frequent indigenous healers. When the author pressed the point by referring to the psychological relief brought about by such practices, these educated members of the community finally started to reveal their own personal experiences with indigenous rawHaniya and even quoted from the Quran to substantiate their belief in the power of sorcerers.

[20]Clearly, power relations are not the only factors which influence the legitimation of illness. One may refer to other elements such as type of behavioural and physical manifestations of illness, the degree of functional incapacitation, or the timing of the claim to illness. An illustration of the operation of the last variable in FatiHa would be the reluctance to grant legitimacy to claims of illness at times of heavy agricultural work, e.g., planting and harvesting. Additionally, one may note that in evaluating the significance of reported symptoms in a given person, consideration of his/her age, his/her gender, are also evident. Thus, an older person complaining of weakness is not considered ill, but simply "showing his/her age". Similarly tiredness among junior women, including sons' wives is not necessarily considered a sign of

illness. It is a fact of life for young adults who work in the fields. But to the extent that the interest of this study focuses on power relations and their affect on illness behaviour, emphasis is placed on this variable with the recognition that the condition of illness is precipitated by a variety of influences and that illness behaviour is also subject to multifactorial socially significant stimuli.

[21]This is not unlike another situation of power differential involving management and workers in industrial settings where the powerful members of the management class are easily granted social validation for their unsubstantiated claims of illness while members of the working class are required to produce professional validation for their claims, although as relatively powerless members of a stratified community, the members of the latter groups are more susceptible to stress and symptomatic illness (Cf. Ryan 1976).

SUMMARY AND CONCLUSION

Theoretical formulations in Anthropology are affected by the cultural milieux in which they are constructed and the social identities of those who propagate them. The anthropological enterprise surpasses the self-imposed and unrealistic claim of total abjectivity and assertions of studying what occurs and explaining it (Hymes 1974:14). Exemplary of the dialogue between Science and Society is the recent change in the study of women's roles under the stimulus of the Women's Movement. In Chapter 1 of this study several examples were noted to indicate the distortion which derives from according the "male factor" central significance and regarding the "female factor" as subordinate and insignificant. Recent reinterpretations of women's roles and the presentation of new data on women's activities, usually undertaken by female anthropologists, have challenged traditional analytical categories and generalizations about gender roles. But whether undertaken by male or female anthropologists, theoretical analyses of the world are not immune from the effects of the social identities of those who undertake such interpretations. Theoretical progress, as evident by recent studies of gender roles, rests, not on the denial of anthropologists' social identities and ideologies, but on comparison and reconsideration of these culturally conditioned theoretical interpretations of reality.

It is not only the social identity of the anthropologist which influences the issues which he/she defines as the object of study, but one may also note the characteristics of the culture in which anthropological research is undertaken as being significant in this regard.

In Middle Eastern socieites, for example, where women are not likely to be accessible as informants to males who are foreign to their communities, long term participant observation and recording of women's behaviour by male anthropologists would not be a realistic endeavor. In light of this limitation, female anthropologists have the opportunity to make unique contributions towards understanding women's roles in Middle Eastern communities. Their privileged access to female spheres of activities will undoubtedly enrich the improverished substantive and theoretical literature on gender roles in the Middle East.

As illustrated in Chapter 1, the recent literature on gender roles indicates methodological/theoretical developments whichhave set the stage for reorienting the study of Man towards the study of Humankind. However, interpretive barriers continue to influence the analysis of gender roles. Universalistic explanatory schemes partaking of what Karen Sacks has termed the "state bias", along with a tendency towards emphasis of individual goals and actions and individual competitions for power, continue to appear in the anthropological literature on gender roles. A critique of these explanatory modes has been presented in Chapter 1. Their limitation was defined in terms of their lack of historical perspective, their tendency to undermine the differentiation of human societies according to structural types, and their proneness to equate role differentiation in primitive socities with the subordination of one gender to the authority of the other, which is typical of state societies.

The underlying basis of the assumed universality of male dominance emphasized in some studies of gender roles is the contention that

"woman's maternal roles lead to a universal opposition between 'domestic' and 'public' roles that is necessarily asymmetrical; women confined to the domestic sphere, do not have access to the sort of authority, prestige, and cultural value that are the prerogative of men" (Rosaldo and Lamphere 1974:8). The validity of the assumed universal existence of distinct public and private spheres which assign men and women to different power realms has been undermined by ethnohistorical studies and studies of contemporary Middle Eastern societies. For the village of FatiHa, the setting of the present study, this presumed universal dichotomy and its attendant power differentials is equally invalid. In Chapter 3 note was made of the insignificance of the alleged opposition between a private, domestic and a public, extra-familial, political sphere in FatiHa. In the study community political concerns are anything but extra-familial and it is not women's association with the private sphere (in the few cases of those who can afford it) which limits their public political participation. In general, political participation in this peasant community is limited for both men and women. Males of limited means do not participate in public political contests. By contrast, the educated female clerk of the agricultural cooperative is an "active member" (ʿuDwa ʿamila) of the Arab Socialist Union. Male and female villagers are well aware of their relative powerlessness vis-a-vis external political control. Such control rests with urban elites whose patronage is actively sought by the local inhabitants (male and female) in their pursuit of personal goals.

As in the case of the Lebanese urban proletariat studied by Joseph and cited in Chapter 1, for the men of FatiHa, their mere participation

in public activities does not confer upon them power over women. Conversely, the confinement of women to the domestic sphere (which the proponents of the above noted universalistic scheme contend is the basis for women's lack of access to authority) cannot be realistically defined as the basis of their relative powerlessness. In fact, the rise of women's power in the family occurs at a stage of its developmental cycle where a woman becomes the mother of married sons, a stage which is correlated with the increased confinement of her activities to the domestic sphere.

In questioning the universality of the private-public dichotomy in Chapter 1, examples were provided to show that the opposition between public and private domains and their hierarchical differentiation is truly meaningless for non-state collectivities. The study of gender roles in FatiHa shows that this alleged universal opposition is also not applicable for certain spheres of state level societies. The insignificance of the public-private dichotomy for relations between men and women in the village of FatiHa is illuminated once we consider their status as peasants. As was pointed out in Chapter 3, the power of the ruling elite in the study area derives from control exercised by the state and its benefactors over the immediate producers in Egyptian society, the Egyptian peasants, including those of the study community. The males of FatiHa are not partners to this control. It is the private interests of ascendant social groups, crystallized in the public apparatus of the state, that are opposed to the common interests of subjugated men and women of the peasantry.

In pursuing our enumeration of recent trends in the study of gender roles in Chapter 1, we emphasized the differentiation between power

and authority and their association with females and males, respectively, in some studies of gender roles. This differentiation follows logically from the private-public opposition noted above. Through the extension of the presumed universal opposition between the private and public domains, prior descriptions of male dominance have been reformulated in terms of the distinction between power and authority, i.e., between what has been defined as "the ability to gain compliance and the recognition that it is right", respectively. Thus, women are recognized as subject to male dominance but are said to counter male authority through the informal manipulation of their social environment and the exercise of choice. In pointing to the limitation of this alleged universal opposition in Chapter 1, the need for isolating structural principles which allow for the exercise of power and choice was emphasized. It was also remarked that according primary emphasis to women's individual manipulative behaviour and competition for power poses serious limitations to the comparative study of power relations even within a single society, not to mention cross-cultural comparisons. By framing male/female power relations in purely relativistic or individualistic terms, we have no basis for comparing one situation of power differential with another.

In the above noted differentiation between power and authority, women are believed to wield informal power while males are presumed to exercise formal, legitimate authority. But if the exercise of this informal type of manipulation follows a regular pattern, it should be recognized as an element of social life and its power correlates should be explicitly defined. This is particularly important in view of the

fact that the exercise of such informal manipulations is not equally available to all women nor at all phases of their life cycle. If the informal power of women is subject to patterned variation, then it must be recognized as an aspect of the dynamics of power relations. But if the variability is sporadic and inconsistent, then it has no place in a nomothetic statement about the character of social life.

The critical aspect of the exercise of power by men or women, as viewed in this study, follows from Adams' formulation (Adams 1967, 1975). Accordingly, power (defined as the "control one party exercises over the environment of another" (Adams 1967:32)) is available to both parties in any social relationship. Even in extreme cases of subordination, the subordinate party holds some threat to the environment of the superordinate party. The crucial feature of the exercise of power is control over power bases which are accorded cultural recognition. According to Adams, authority is described, not in terms of legitimacy, but as "a quality ascribed to the exercise of power, the basis of which entails control over culturally defined parts of the meaningful environment of others" (Adams 1975:24). In FatiHa, the exercise of power by men or women, in the "private" or "public" sphere rests on such control. For the few persons in FatiHa who participate in public political contests or who are affiliated with the local chapter of the national political party, such engagements are extensions of their power base in the village. For the male villagers who are so involved, their power base is identified in the control over land. In the case of the female member of the ASU, her education is the significant resource on which her power in the community rests. Finally, in the case of the descendants of the former

Turkish elite, their power in the village rests on their descent (aS1), which, when translated into concrete power indices, means access to communication channels through kinship ties and incurred obligations.

Guided by Adams' above noted definition and conceptualization of power, an analysis of gender roles and power relations in the village of FatiHa was undertaken in Chapter 3. Generally, one may characterize the social life of the village of FatiHa as male dominated. Men have preferential control over culturally valued power bases. In attempting to explain this asymmetry, attention was devoted to an examination of the village economy and the social relations of production. In brief, it was pointed out that while gender role ascriptions related to the technical relations of production are subject to minimal differentiation, control over valued instruments of production and the products of agricultural labour is vested in males. It is such control which is deemed the basis of male-female power asymmetry in the village. Since the family in FatiHa constitutes the framework of production relations and gender role differentiation as well, the developmental cycle of the family is utilized as a framework for the descriptions of gender role differentiation, relations of production, and their consequences for power relations between and among, men and women. This focus on the developmental cycle of the family illuminates the dynamics of male-female power relation. In this regard, the limitation of equating authority with legitimacy is brought to light. It is evident that the patterned, generalized authority of mothers-in-law in extended family households rests on performance, or the actual exercise of power, rather than legitimacy per se. The primacy of authority (the exercise of power through control

of culturally valued power bases) is also evident in cases of the breakup of the extended family upon the death of the senior male. While, according to custom, married sons are obligated to honour their mother, and while a mother may legitimately demand that her adult sons attend to her need and comfort until her death, a woman succeeds in keeping the extended family intact after her husband's death and continues to enjoy the prestigeous status of senior female if she owns property of her own. This may encourage her sons to remain as part of an extended productive unit. Alternatively, her sons may demand their share of their father's property. This brings about the fragmentation of the family property, and with it, the power base of the mother-in-law. In short, legitimacy does not substitute for a durable power base upon which an older female can rely to play an authoritative role.

Further assessment of gender status in the village of FatiHa (in Chapter 3) included an examination of the differential valuation of male and female children, the differential degree of autonomy and decision making power, and identification of superstructural elements of village social life which reveal ideas and beliefs about males' and females' physical and mental attributes, which legitimize the power asymmetry related to gender identity. Beliefs regarding the human body, its formation, structure, and functions were also found to allude to the relative powers of males and females in village social life. From villagers' accounts of the human body detailed in Chapter 4 it is noted that asymmetrical power relations between males and females are given symbolic expression in people's belief in the more determinate role of male semen in influencing the character of the unborn child and the faster development

of the male foetus. The greater significance attributed to male semen in the process of conception reflects informants' belief in male superiority and their conception of the social differentiation between males and females as natural. Their assertion that male-female differences exist at the pre-natal stage indicates their justification of existing social differentiation related to gender. Men's right to almost uninterrupted access to their wives' sexual services, including the period of pregnancy, indicates (and is recognized by villagers themselves) men's power over women.

Further exploration of villagers beliefs about the human body in Chapter 4 indicates the great obsession of women with fertility and their almost complete rejection of modern birth control methods. These facts indicate the tremendous valuation of children and point to parenthood as a culturally valued power base. Additionally, the assignment of blame for the birth of females, or for childlessness, to women, in contradiction to villagers' assigned importance to male semen in the process of conception, is exemplary of "blaming the victim" rationalizations typical of asymmetrical power relations.

Differential valuation of male and female infants, translated into asymmetrical power relations between males and females at a later stage of the life cycle, is indicated in villagers' beliefs regarding the relatively deleterious effect of the female foetus on the mother's health. Moreover, the belief that post-partum discomfort and bleeding are greater after the birth of a girl, like the solemn reaction of the occasion of such birth, is also indicative of the differential valuations of male and female children - the basis of power asymmetry in adult

life.

Other indices of power differentials described in Chapter 4 include villagers' emphasis on superior physical strength of males. This belief is cited as a rationalization for male domination of women. Indications of power differentials are also found in the discriminating allocation of food which is regarded as necessary for the maintenance of good health. Preferential treatment of sons in food distribution indicates mothers' banking strategies which maximize their chances of better treatment at the hands of sons in their old age. The different rationalizations for the practice of circumcision on males and females reflect villagers' ideology of female impulsiveness in sexual behaviour. Additionally, the cultural practice of using stimulants for the maintenance of a healthy disposition by males, and its relative restriction for females, also reflects the belief in males' greater ability of self control. Finally, even in death, which is regarded as the "ripening" of the body and the termination of its viability by Divine Will, a person's misfortune of not having a son (a culturally valued power base) is lamented by mourners.

In terminating our discussion of gender as a dependent variable, we may conclude, on the basis of data presented in Chapters 3 and 4 that although male-female power relations are subject to patterned variation related to the developmental cycle of the family, in general, the village of FatiHa may be described as male dominated. Rather than regarding the various indices of male dominance described in the above noted chapters as supportive of the alleged universality of male dominance, the contention is made in Chapter 3 that the pattern of male-female power relations described for the study community is representative of a

specific structural type, namely peasant society. The distinguishing elements of the relations of production of village society and the social formation of which it partakes is contrasted with nonexploitative social formations where the differences between males and females are not socially converted into inequalities.

In the treatment of gender identity as an independent variable in Part III of the study, the main focus is on the village medical system. The analysis of the consequences of gender identity for the experience and response to illness is guided by a theoretical perspective developed in Chapter 2. Briefly, Chapter 2 provides a review of the general anthropological and Middle Eastern literature on the topic of gender roles and illness. It indicates the present study's reliance on a stress model of illness butpoints to the limitations of studies based on that model, which define stressfulness as an attribute of women's roles and describe illness as a form of culturally sanctioned deviant behaviour which is functional. In pointing to the limitations of this explanatory mode, it is noted that it suffers from drawbacks typical of the structural-functional framework by focusing on female roles and defining the illness role as functional for the maintenance of the social system, without attempting to explain why some roles are more stressful than others in the first place. This mode of explanation does not extend serious considerations to the structural constraints, to the objective social conditions, the structural bases, the asymmetrical power relations which underly conditions of stressfulness and which are attributes of female roles. Consequently, the model, by taking female role as its central explanatory element, cannot adequately account for variations among women, all of whom clearly

share the "female role". Not only does this perspective obscure structural elements which affect some women and not others, and which some women also share with men in subservient positions of relative powerlessness, but it also ignores the dynamics of female role within groups of women. In short, the concern with women's social roles is believed to have led to a neglect of societal constraints and power relations which are stressful for women and men.

The theoretical perspective which guides the analysis of the relation between gender identity and illness in the present study, rather than focusing on social roles as such, extends primary consideration to the larger system in which the elements of social role operate, notably the elements of power relations. Accordingly, stress itself is defined in terms of asymmetrical power relations, in terms of the inability to influence one's environment to one's own benefit (Ryan 1976), i.e., in terms of relative powerlessness. Since relative powerlessness is not an attribute which is exclusive to female status, stress among women, and among men is defined, not in terms of gender role, but in terms of the elements of powerlessness which operate and affect men and women in different social contexts. Additionally, the theoretical perspective which guides this study regards the sick role as a mechanism which ensures the maintenance of prescribed social roles, their attendant asymmetrical power relations, and stressfulness. The sick role is regarded as an instrument of social control which is selectively assigned to symptomatic persons to mediate inherent contradictions in social life. It regards definitions of illness, which are cultural prescriptions for controlled deviance (Parsons, op. cit.) as superstructural elements bearing a dialectical

relation to infrastructural contradictions and attendant power differentials.

In the context of the present study, it is not gender role per se which is assumed to be stressful and to precipitate illness. The emphasis is on stressful situations (defined in terms of power differentials), which are related to gender roles. Since stressful situations are not unique to women, one may expect stressfulness to precipitate illness in men. Moreover, subgroups of women may be expected to vary in the experiencing of stressful situations. Indeed, some stages of the life cycle and the developmental cycle of the family expose individuals to variable types and degrees of stress. Furthermore, one may expect some women to approximate the expected role behaviour (which is a source of power) more than others, with deviants representing the most extreme cases of role conflict and powerlessness. The same is expected to hold true for men. Hence, we may expect variation in the frequency of illness among women (and among men) as well as between women and men. Validation of the assumption that higher frequency of illness among women results from stress should involve, not only a demonstration of higher frequency of illness (or perceived stress) among females than males (this would be a restatement of the proposition), but more fundamentally, it should show that a higher frequency of illness should occur among women (and men) who are identified as being under greater stress than their cohorts. Finally, it should be noted that just as concentration on gender roles obscures the bases of male-female power relations, it also obscures the bases of stress associated with those roles. To explain gender roles or stress associated with them, one must move, conceptually, outside the

analytic boundaries of roles themselves to consider the structural elements which maintain these roles.

In applying the theoretical perspective noted above to the study of illness in the village of FatiHa, it was deemed necessary to obtain an understanding of the village medical system as a whole in order to understand villagers' conceptualizations of illness and their response to it. In Chapter 4 this task was initiated through an examination of local ideas and beliefs about the human body, which form the basis of villagers' views about illness. The people of FatiHa, while regarding their body as a complex system of differentiated parts, attribute general functions to only a few named body structures. The body is generally regarded as a complex structure of which villagers have only limited knowledge. As in the case of other Middle Eastern societies (Shiloh 1962), the working of the internal body is the least elaborated area of the medical system.

Among the villagers of FatiHa, the body is regarded primarily as the seat for crystallization of external social events which affect the individual. Bodily changes associated with illness are not described simply as disruptions in the functioning of specific body parts, but in terms of meaningful social events. The body is not only regarded as a physical structure, but more importantly, as an individual centered depository which mirrors social events that transcend the individual's physical being. Physical symptoms of illness are significant only to the extent that they are associated with psychological and social symptoms which indicate departure from culturally defined normal states of health. According to this logic, illness diagnosis and treatment are applied to the socially significant elements of the afflicted person's

identity rather than aiming to deal with the functioning of specific body parts. In sum, an illness occurrence is the concrete expression of a socially significant episode which is experienced by a person and reflected on his/her body.

In our discussion of body-environment interaction in Chapter 4, it is remarked that just as the body is believed to be affected by the natural environment and social interactions, it is also believed that bodily substances have a reciprocal effect on the natural and social environment. In our description of villagers' beliefs about the effect of body secretions on culturally significant events in Chapter 4, attention is devoted to the topic of female ritual pollution. Post-partum rituals, which have often been regarded by male anthropologists as indicative of females' devalued status, are considered as cultural elaborations designed to help restore a woman's normal state of health. In fact, the implementation of the ideal of female menstrual/post-partum confinement is found associated with relatively high socioeconomic status. The enforcement of confinement rituals is considered a status symbol, an index of women's culturally specific valuation rather than their inferiority.

Continued exploration of the village medical system is pursued in Chapter 5 which provides an account of village medical theory and an in depth analysis of the culture bound illness of <u>ʿuzr</u> (a local variant of spirit possession), linking its occurrence to power relations and gender identity. Our examination of village medical theory shows that the people of FatiHa have various explanations of illness. It is evident that causation is accorded primary significance in the process of illness diagnosis. Symptoms of illness and its severity are important

as manifestations of the operation of causal factors. Of minimum significance as diagnostic indices are the physical/anatomical processes associated with illness, i.e., the pathology of illness. The concept of levels of causation is deemed useful for ordering multi-causal explanations implicated in an illness episode.

In dealing with illness causation in the village at the most general level, illness is described in terms of supernatural power. However, more immediate causes are shown to be recognized by the people of FatiHa. Generally, the ultimate determinant of health and illness in villagers' wordly environment is defined in terms of social interpersonal relations. As the people of FatiHa regard their individual lives and physical well being as inextricable from their social context, they also define illness, which is manifested in individual behaviour, as an outcome of social relations. This is not to say that illness is explained solely in terms of social interactions, but explanations of illness ultimately lead to the social environment of the sick person. In dealing with natural causation, villagers clearly follow a prospective path to diagnosis. In cases of supernatural causation, on the other hand, diagnosis is always retrospective. When illness symptoms manifest themselves, the are traced to significant episodes of emotional distress and/or impairment of social relations which may have occurred at an earlier time period.

In our discussion of the specificity of illness explanations in Chapter 5, it is noted that while information obtained from survey data informs us of the underlying logic of villagers' medical taxonomy, it does not adequately reflect the actual use to which that taxonomy is put in specific illness cases. During survey interviews informants

generally cited one cause for their illness. Extended case studies, on the other hand, demonstrated the variability of illness explanations and illuminated multiple levels of illness causation. Through our discussion of the specific illness episodes in Chapter 5, the specificity of illness explanations is revealed. Moreover, it is noted that the granting of legitimacy of the sick role to symptomatic persons is subject to negotiations which are influenced by the symptomatic person's social identity and power relations vis-a-vis significant others.

In dealing with illness explanations in Chapter 5, a description of some culture-bound illnesses is undertaken and their critical diagnostic indices are noted. Special attention is devoted to the culture-bound illness of *uzr and extended case studies of this illness are analyzed. These analyses link illness causation to the dialectics of social life, particularly in terms of power relations and gender roles. In noting the multiple levels of causation associated with reported and observed cases of *uzr, interpersonal relations, including those associated with powerlessness, and those involving deviation from culturally valued behaviour, are identified as ultimate causes of the affliction.

In presenting cases of *uzr in Chapter 5, the telescoping of explanations of illness is noted and the legitimization of deviance through the social granting of the illness label is shown. Therapeutic strategies associated with the illness are regarded as a means of controlling it, not eliminating it altogether. Indeed, from an etic perspective, the persistence of the illness is consistent with the relative stability of the structural power relations with which it is associated.

Case studies of *uzr (excuse) detailed in Chapter 5 show that, as

its very name suggests, the illness of ʿuzr is a legitimated form of deviance. The compensatory value of the illness role is evident. It is clear that the legitimized illness role mediates asymmetrical power relations and allows dispensation from expected role behaviour. However, discussion of the compensatory value of the sick role concludes that the social sanction which allows temporary transgression of socially defined role behaviour and/or positions of relative powerlessness, is itself subject to structural constraints related to the social identity of the symptomatic person. Additionally, it is noted thattthe sick role, like other manipulative strategies adopted by the powerless, when attainable, brings about only a temporary enhancement of social position. It is not a stable, culturally valued power base which can induce permanent modification. Finally, on the basis of extended case studies presented in Chapter 5, it is hypothesized that touch by supernatural beings (lamsa arDiya), resulting in the illness of ʿuzr, is a significant etiological category among both males and females who occupy a subordinate social role, which may change in a lifetime. According to this postulate, the frequency of ʿuzr among women, as among men, may be expected to vary in relation to different stages of the life cycle and the developmental cycle of the family. Thus, ʿuzr would be less likely to affect women in the dominant role of mother-in-law, for example, nor men who occupy the dominant status of older brother in a fraternal joint family household. Data recorded in Chapter 5 of this study lend support to this hypothesis.

Further exploration of the village medical system is pursued in Chapter 6 which provides an account of villagers' methods of coping with

illness. In reference to the variety of preventive measures employed by the villagers of FatiHa, it is remarked that these reveal the differential valuation of persons to whom they are administered and the significance of the events with which they are associated. Beyond prevention of illness, the villagers of FatiHa avail themselves of a variety of forms of treatment of both the indigenous and cosmopolitan variety. In noting these different forms of treatment, attention is extended to the social characteristics of indigenous medical practitioners and the type of medical knowledge on which the performance of their curative roles rests. Structured interviews designed to compare shared knowledge about illness among indigenous practitioners of spiritual medicine (rawHaniya) and lay persons indicate that the rawHaniya do not deal with illness through the reliance on specialized, exclusive knowledge. Their power is derived primarily from their culturally valued control over elements of the supernatural environment. This lends authority to their diagnosis of illness. The exercise of their diagnostic role is contingent upon their familiarity with local culture. Finally, the administration of Shweder's cognitive capacity test shows the rawHaniya's greater capacity to impose order on ill-defined situations. This characteristic is consistent with their expected role of imposing explanations when confronted with the confusion of illness and its associated deviant behaviour.

Extended case studies indicate that selection of medical treatment is situationally determined and is not predictable from information about village medical taxonomy. Differential utilization of indigenous forms of treatment are utilized when access to physicians' services is blocked for financial reasons, or when treatment by physicians fails to

bring about a noticeable improvement. Generally, choice of treatment rests on the immediate requirements of cure rather than on the conceptual compatibility of logical categories underlying different forms of treatment. In fact, the physicians' services are the first choice of villagers, in spite of the obvious fact that the peasants have not internalized the theoretical assumptions underlying cosmopolitan medical treatment.

The examination of bases of choice of medical treatment in FatiHa reveals the operations of various factors which include the progression of illness and its response to certain forms of treatment, the nature of interpersonal relations between the sick person and the medical practitioner, the economic requirements of different therapeutic practices, and of particular relevance to the theoretical premises of this study, the social identity of the symptomatic person. It is evident that the relativepower of symptomatic persons influences their access to resources which more powerful persons may or may not choose to expend for medical treatment. Within the family context, a person's identity is significant, not only in determining the form of medical treatment which is extended to him/her, but also for the more fundamental process of extension of social legitimation of the sick role, upon which initiation of treatment is contingent.

In terms of the micro-unit of village society, it is evident that villagers of higher SES utilize the services of private physicians more readily than do their less affluent cohorts. Within the family it is evident that the status of the symptomatic person is an important determinant of the urgency and form of treatment extended to him/her. The highly valued and expensive services of private physicians are

preferentially provided to members of the household whose health receives culturally defined high valuation, notably male household heads. Generally, valued resources are allocated more frequently for the treatment of males than females. However, gender identity is mediated by the dynamics of the developmental cycle of the family. Thus, a woman who enjoys the culturally valued status of mother of adult sons, for example, is provided more prompt and expensive medical treatment than a young, powerless son's bride, or a male infant occupying the same household.

In considering the peasants of FatiHa within the larger context of the encompassing social structure, the significance of their social identity in relation to national priorities for health care is particularly pronounced. Indeed, medical care for the peasants of FatiHa, like their gender roles, cannot be divorced from the sociopolitical superordinate power relations which direct every facet of their lives. The peasants of FatiHa do not live an isolated, independent existence; they are part of a stratified sociopolitical entity, the Egyptian state. Their subservient power status within the nation state precludes independent planning of their lives in their own best interest and leaves them subject to the imposed planning of health care, and other requirements of their livelihood, by the ruling power elite.

To conclude, a major purpose of this study has been to contribute to the recent trend towards more balanced accounts of gender roles, and, simultaneously, to question some of its theoretical assumptions. Just as recent theoretical insights and substantive treatments of gender roles have underscored the limitations of earlier theoretical traditions,

so will these analyses eventually be challenged in light of new data. Nevertheless, anomalies which undermine existing theoretical categories should not detract from their long term contributions to theoretical development. The refinement of theoretical formulations should not be expected to follow a smooth path through the elaboration of prior assumptions. In fact, the general mode of scientific development sometimes entails retrogressions, and, always, the formulation of a new theoretical paradigm which challenges prevailing doctrines (Kuhn 1974). Finally, no matter what contradictions to the recent theoretical orientation to the study of gender roles eventually develop, this emerging tradition is most significant in that it has set the foundation for reorientation of the study of Man towards the study of Humankind.

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