CHILDREN'S HEALTH AND WELL-BEING:

AN ETHNOGRAPHY OF AN UPPER EGYPTIAN VILLAGE

by

HANIA MOHAMED SHOLKAMY

A thesis submitted in partial fulfilment of the requirements for the degree of Ph.D in Anthropology
The London School of Economics and Political Science
The University of London

To my father, Dr. Mohamed Sholkamy
To my husband, Ziad
And
for my son, Ahmed

Abstract

This thesis is about children's health and well-being as constructed and maintained by villagers in Upper Egypt. It is based on primary data collected during eighteen months of fieldwork in a small village in the district of Abnube in the east of Assiut Governorate in the south of Egypt. The thesis also relies on secondary statistical and qualitative sources.

This work makes three propositions concerning children's health. The first proposition is that children's health is a distinct part of the traditional medical cultures of Egypt and one that should be integral to the analysis of medical culture, pluralism, and services. More over, the focus on child health and ill-health provides a critical commentary to on-going debates about health and healing in Egypt.

The second proposition is that the study of child health and ill-health is an essential and missing component of the ethnography of rural Egyptians. An awareness of the relevance of children, and of the efforts of families to keep them healthy, to the cultural, social, political, and economic construction of family and village can significantly add to anthropological understanding of the Egyptian peasant and village.

The third proposition is that the study of health as a socially and historically constructed category is as important, if not more so, than the study of ill-health. This work looks at processes whereby health is conceptualized and their relevance to the ensuing constructions of ill-health. The work also tries to establish the relationship between village discourses on health and the discourse dominant in the language, services, and structures of modern biomedicine in Egypt. In this thesis, health is viewed as an arena where cultural, historical, social, as well as economic relationships and structures come to shape family practices and choices.

TABLE OF CONTENTS

PLATES & MAPS

PLATES

MAPS

TABLES

ACKNOWLEDGEMENTS

I would like to acknowledge with gratitude the generosity of the British Council, Chevening Scholarships Scheme, for enabling me to undertake a Ph.D at the London School of Economics. I would also like to thank St. Anne's College, Oxford University who elected me for the Ioma Evans-Pritchard Junior Research Fellowship thereby providing me with essential financial, technical and moral support, without which I would not have been able to complete my degree.

My supervisors, Dr. Peter Loizos and Dr. Henrietta Moore have been kind, tolerant, generous and inspiring throughout my course of study and I would like to thank them for their warm support. Others I wish to thank at the LSE are my peers Celia Busby, Philip Thomas, Jane Canavaghn, and in particular Claudia Rezende who remains a much loved 'sister'. I would also like to remember the late Alfred Gell for the magnificent and exciting anthropologist and person he will always be.

In Oxford, I would like to thank Nathan Schlanger for his support and much needed help. Many thanks to Marriane Fillenze for her help with some of the medical aspects of this work. Robert and Judy Mabro provided a home away from home, and I thank them for it.

In Egypt, I was introduced to anthropology by Homa Hoodfar, Cynthia Nelson, Soheir Morsy, and Nicholas Hopkins. They are individuals to whom I shall always be grateful and from whom I look forward to still learning much more. I would also like to thank Reem Saad for her friendship and insights.

The people of the village which I call Rihan provided me with more good times, genuine companionship, and thought provocation than any anthropologist could dream of. I know they shall never read this, but still would like to humbly thank them, particularly Ni'mat and Fatma. I would also

like to mention in gratitude the help and cooperation of physicians, whom I can't name, in Abnube and surrounding villages, and also that of the officials of Assiut health administration and at the governorate offices.

My uncle Nabil Sholkamy and his gracious wife Laila greatly facilitated my research and stay in Assiut. They gave protection, welcome, and very good food. I thank them both and hope to be worthy of their generous affections.

My father and mother have provided more love, trust, and support than I could ever hope for. Their own childrearing challenges all gender stereotypes about Arab women. Thanks to them, I have always been happy to be myself and am proud of the household that they have created for myself and my brother. I thank them both for my past, my present , and any good that the future may hold.

Finally I turn to my own family. I thank Ziad, my husband, for our life together and for his ability to move on and move me along with him. And I thank Ahmed, our son, for putting up with a distracted and sometimes absent mother and for making both my life and Ziad's such a happy and hectic one. It is to them and to my father that I dedicate this work.

CHAPTER ONE
THE HEALTH OF EGYPTIAN CHILDREN

A. INTRODUCTION

> They dispersed one and all, and the table was cleared just as it had been laid, and the little girl cried and tossed, while her mother gazed at her and sometimes stretched her arm out to heaven. She had uncovered her head, which was not her custom to do.
>
> But the gates of heaven were shut that day and the irrevocable decree had gone forth, so the sheik could recite the Quran and the mother make supplication as much as she liked.
>
> The strange thing was that no one in all this company of people thought about the doctor. As the night advanced the cries of the little girl began to die down, her voice began to grow feebler and her tossing began to subside.
>
> The mother looked at her daughter and imagined she was going to sleep. Then she looked again and saw that the stillness was unbroken by any sound or movement; only a slight breath, a very slight breath, came repeatedly from the slightly open lips. Then this breathing stopped and the little girl had departed from this life. What was her complaint and how did this complaint cause her death? God alone knows.
>
> Taha Hussein describing the death of his sister in Upper Egypt (Hussein 1990: 64-5)

In An Egyptian Childhood Hussein tells of his life in an Egyptian village at the turn of the century. He recounts the experience of his own blindness and of the death of his little sister and older brother. Images and accounts such as these have prompted Egyptians and others to try to realize better health for children. The solution seemed to rely on modern health care for all. But government clinics staffed with trained young doctors have long been a fact of life in rural Egypt. And still the tragedies occur, albeit less frequently. There seems to be more to health than medicine. It is this premise that has motivated this work.

This thesis is about the health of Upper Egyptian children and how their families strive to protect, maintain, and restore it. It is thus a contribution to the

ethnography of Egypt and to medical anthropology in equal parts. The thesis is based in fieldwork in a village in the governorate of Assiut which I have named Rihan. This work tries to realize three objectives. First, it proposes child health and ill-health as a distinct and under-theorized field in medical anthropology. Second, the work suggests health and its restoration and protection as a missing dimension in studies of the medical cultures of Egypt. And third, it presents children, their childhood, and well-being as essential and un-examined areas in the ethnography on Rural Egypt.

In Egypt, as in the rest of the Arab world and the Middle East, children are treasured in their own right and as "generational links" who hold the key to the continuation of the family and its members (Fernea 1995: 4). Because of this important social role, because of familial love and devotion, and because of their vulnerability when very young, children's health is a major preoccupation for the majority of families in Egypt (Abaza 1987; Abdel-Kader & Afifi 1975; Abu-Lughod 1993b; Ammar 1954; Ammar 1988; Blackman 1927; Hatem 1987; Hoodfar 1986; 1995: 146; Early 1992: 106; Morsy 1993: 153; Oldham 1990: 75-7; Rugh 1988; Seif-el-Dawla 1990). Consequently the medical culture through which children are protected, diagnosed, and treated is a vital, rich, and complex one.

This research argues that health and the structures and institutions which challenge, maintain and restore it are an essential part of understanding society as a whole. Health and healing are not reflections of, or reactions to, biology and society. They are generative components of the conceptual systems which shape the intellect, culture, and experiences of individuals and of society. In investigating the medical culture of villagers in Upper Egypt as it relates to the health of young children, this work hopes to contribute to a better and deeper understanding of the Egyptian village, as well as to the appreciation of the health of its children. Because Egypt is a complex plural

society where peasantry is differentiated along class and educational lines and where the line that divides urban and rural has been long blurred, this work is also inevitably a study in medical pluralism.

The dilemmas of government intervention in child survival and health, state policies, services and authority are an integral part of the subject matter of this ethnography. As well as defining the parameters of available health resources - positively by the extension of education and health services and negatively by ridiculing local practices and blaming the afflicted for their afflictions- the state is very much a player in the affairs of children and their health.

There are two reasons for the state's high profile involvement in the affairs of children. The first relates to the current dominant international discourse which has transformed children into essential indicators of health, wealth, development, and even democracy. Infant mortality rates (IMR), under five mortality rates (U5MR), fertility rates, female education, and some child morbidity rates are core indicators which are used to assess the world. The United Nations International Children's Fund (UNICEF) has succeeded in making the measurement of these indicators an annual activity, the results of which are published in an all-country league table in The State of The World's Children Report. UNICEF statistics are consulted by The World Bank, as well as other international bodies and non-governmental associations. Whether countries like it or not, children, specifically their health, are officially an item on the international agenda (Justice 1987: 1301-6).

Egypt has a place of prominence in this international discourse. According to regional and national surveys, the National Control of Diarrhoeal Diseases Project (NCDDP), a US AID-assisted project implemented in 1983 and institutionalised in the Ministry of Health of Egypt in 1991, has reduced the under five mortality rate (U5MR) by one third (Hill & Langsten 1995: 989; Hirschhorn 1989: 26-

9; Miller & Hirschorn 1995). This astounding achievement has made Egypt an internationally acknowledged and acclaimed success story. But this marked decrease in U5MR has inspired questions about rates of morbidity, accuracy of registration, reliability of data and considerations of actual change of behaviour on the part of patients, parents, and the medical establishment to guarantee the maintenance of lower mortality and perhaps morbidity rates (Hill & Langsten 1995: 1000; Rashad & El Zeini 1993: 12-6; Murrey & Chen 1992: 481-3).

Egyptian children are also a priority for the wife of the president. Mrs Mubarak is committed to the cause of childhood and its well being and has placed children firmly on the national political, cultural, and social agenda. Her efforts have been concretized in the form of a National Council of Childhood and Motherhood, an independent authority which acts as a research and action body to promote and protect children. But this concern is based on a normative construction of how children should be and not on a socially and culturally informed notion of the childhood of different Egyptian children.

On the streets of Cairo, people are fed up with children and with the frequent gala concerts attended by the president's wife during which children are paraded onto the stage, the girls in heavy make-up and tulle dresses, the boys wearing uncomfortable dark suits, to dance and sing the praise of the country and its president. They are also tired of the rhetoric that litters the media on children and their best interest. Living in Egypt has come to mean putting up with these media blasts and frequent "National Campaigns" of one sort or another[1].

The state's interest in children , and in their health in particular, is relevant to the work at hand. Rather than limit itself to the village and villagers, this ethnography

---

[1]. For example, there is a national day for childhood, a national day of "reading for everyone" and several other national days and campaigns for children.

will relate village to state, peasant to professional middle class, physicians to healers, and practice to politics.

To justify and situate this multiplex ethnography, I shall divide my review of relevant theory and literature into three parts. First I shall attempt to locate this work in current debates in medical anthropology. Secondly I shall explain its relevance and place as far as studies of childhood are concerned, and lastly I shall consider the theoretical model and methodological precepts of this work to the literature reviewed.

B. THEORY IN MEDICAL ANTHROPOLOGY

Byron Good has described medical anthropology as the "London" of the discipline of anthropology (Good 1994: 1). Meaning it is the branch of anthropology where there is the most exciting or "cosmopolitan" air of debate and innovation. Theory in medical anthropology has indeed evolved into a diversified and stimulating number of trends. The proliferation of reviews and collections on these various trends bears testimony to this profusion of thought (Good 1994; Feierman & Janzen 1992; Frankel & Lewis 1989; Baer 1987; Colby 7 Selby 1974; Comaroff 1978; Fabrega 1971; 1990; Frankenberg 1980; Foster & Anderson 1978; Hahn & Kleinman 1983; Heggenhougen & Draper 1990; Helman 1990; Leslie 1980. Mascie-Taylor 1993; Lindenbaum & Lock 1993; MacCormack 1993; Navarro 1981; Nichter 1992; Kleinman 1980; Johnson & Sargent 1990; Worseley 1982; Young 1982).

Such activity and prolificacy make it difficult to 'summarize' or 'account' for its interests. A brief consideration of paradigms in medical anthropology will supply the models and methods relevant to the work at hand. Since my work involves both traditional and biomedical health care and practices, I shall discuss the issues of medical pluralism. Since health and its expression is as much a part of this work as are constructions and expressions of ill-health I shall next investigate the

literature and thought concerning health as opposed to ill-health.

B 1. Theoretical Paradigms

Theory in medical anthropology, as it is in anthropology in general, is driven by a quest to facilitate comparative analysis. Since medical anthropology addresses what were assumed to be natural, biological realities, comparison seemed facile and logical. However with the confluence of ethnographic detail and theoretical sophistication, the assumption of health and ill-health as natural and universalistic categories became untenable. There are four clear paradigmatic trends in medical anthropology today which are themselves enriched by an ever growing number of differentiated topical interests and which answer the comparative urge of anthropology (Good 1994: 29).

B. 1.1 An Empiricist Approach

The first is an empiricist tradition exemplified by early studies on healing rituals, healers, and notions of causation. Early anthropologists took an interest in indigenous healing systems in structurally simple, kinship based societies as an aspect of their preoccupation with religious beliefs (Evans-Pritchard 1937; Rivers 1924). There are three underlying propositions upon which these studies were conducted. First they interpreted ill-health in terms of the "metamedical" logic of biomedicine (Worseley 1982: 327). The assumption was that disease and health are universal objective realities that research "uncovers" and not cultural constructs that need to be understood in terms of their own social relations (Fierman & Janzen 1992; Janzen 1978b; Nichter 1992; Kleinman 1878:90-93; Young 1982: 257-262).

Secondly, they assumed that illness representations are reflections of "health beliefs", which more often than not are assumed to be false or irrational (Good 1994: 17;

Sperber 1984). Evans-Pritchard described in detail the "beliefs" of the Azande concerning ill-health and misfortune, how witch doctors heal and become healers only to observe:

> Witches, as the Azande conceive them, clearly cannot exist. None the less, the concept of witchcraft provides them with a natural philosophy by which the relations between men and unfortunate events are explained and with a ready and stereotyped means of reacting to such events (Evans-Pritchard 1937: 18).

For Evans-Pritchard, the value of the practice and its analysis lies in its indication of the rationalizing and adaptive value of witchcraft in explaining misfortune (Good 1994: 47, Sahlins 1976: 114)

Thirdly, this empiricist tradition stressed the positive function of healing rituals and practices and analysed the medical culture of studied communities in terms of a theory of utility (Good 1994: 60; Worseley 1982). This posture has been much criticized for its modelling of medicine as a pure science and described as an "etic" projection on the experience of ill-health in other non-western domains (Comaroff 1978: 252; Eisenberg & Kleinman 1978: 88-93; Worseley 1982: 315).

However, this empiricist tradition has merits. Early ethnographies preserved the link between health, ill-health, and social structures and did not distance health and ill-health as isolated domains. Ethnographers have also left us thick and rich descriptions of healing rituals and healers which retain their scientific vitality and interest.

B. 1.2 Explanatory Models

The second paradigm in medical anthropology today is a meaning-centred one proposed by Kleinman's Explanatory Models (EM's) (Kleinman 1978; 1980; Lock & Scheper-Hughes 1990). Kleinman's work places the relationship between culture and ill-health at the centre of an analytical project which compares and describes health care systems as holistic cultural systems/models (Kleinman 1978: 88). These

models relate etiology, pathophysiology, symptoms, diagnosis and prognosis, and therapy thus evolving a complete and coherent explanation of ill-health. As methodological tools, EM's enable the anthropologist to construct different clinical realities and interpretations for the same sickness episodes since they interpret health and ill-health as socio-political products of a specific system of knowledge. Biology and its natural categories do not limit the scope of interpretation since meaning lies in the relationship between components of health systems and not in physical 'reality' (Kleinman 1978: 87-91).

This approach has contributed a redefinition and refinement of key terms in the area of medical anthropology. Disease is defined as a concept that is specific to the explanatory model of modern biomedicine. The objectivity and reality of disease as a malfunction or affliction localized in the body is integral to the specific knowledge system and cultural models of the West. Illness is the person's perceptions and experience of the ignoble condition of being 'not healthy'. EM's describe illness representation as it is constructed by other medical systems. Illness is no less real than disease, it is the personal experience and social construction of a given condition. Sickness is a term which implies both disease and illness (Good 1977, 1994: 53; Young 1982: 264).

Explanatory models were projected as interpretive tools that "..simultaneously create order and meaning, give plans for purposive action and help to produce the conditions required for their own perpetuation and revision" (Young 1982: 267; Kleinman 1980). Although rejecting biological reductionism, this approach maintains that sickness is an individualized process and so reduces the social relations which produce it to ".. a discourse on illness and adaptation" (Young 1982: 276; also see Blumhagen 1980)[2]. But this approach succeeded in

---

[2]. Explanatory models as cultural models serve a cognitive function in that they define, interpret, and classify diseases.

challenging the dominant wisdom which assumed that biological categories are "natural and descriptive" and proposed that even biology can be "cultural and classificatory" (Good 1994: 3).

Placing meaning at the heart of social exegesis facilitated the anthropologist's understanding of the 'other's' medical culture. It has projected a kind of 'functionality' to illness and its management. But it has salvaged the coherence of traditional medical systems and enabled anthropologists to innovate by creating a space for thought that had been previously occupied by the strictures of natural categories and empiricism (see Csordas & Kleinman 1990).

B. 1.3 Political Economy and Critical Medical Anthropology

The political economy perspective on health, commonly referred to as Critical Medical Anthropology, defines sickness as the process through which experienced symptoms are given socially recognizable meaning and a socially significant outcome and so focuses on the social relations that produce the forms and distribution of sickness. As far as treatment is concerned, critical medical anthropology recognizes that the science of physical things, including biomedicine, are part of the political ideology of the dominant west. Accordingly, biomedicine contributes to the mystification of the human power relationships that are articulated in states of sickness and in therapy. (Baer 1982: 13-7; Elling 1981; Morgan 1987; Morsy 1990: 40-6; 1993: 4-5; Navarro 1984; 1986; Onoge 1975; Singer 1989; Taussig 1980: 4-8; Young 1982).

Taussig argues that "(I)t is not the cultural construction of clinical reality that is ..at issue, but the clinical construction and reconstruction of a

---

Prior to the development of these models, anthropologists had been engaged in an effort to construct emic taxonomies of ill-health and explain the implications of these systems of classification (Frake 1961, Fabrega & Silver 1973).

commoditized reality that is at stake." (Taussig 1980: 13). By focusing on the role of biomedicine in enforcing hierarchy and obscuring imbalance in power relations, political economy informed analysis brought ideology into the foreground of sickness as an event, biomedicine as a cure, and the nature of the relationship between diverse medical systems as a contest (Worseley 1982: 300; Morsy 1990; 40-6). The political role of disease and health thus established has been examined and reestablished all over the world through research in history and medical anthropology (M'Bkolo 1995; Comaroff 1993; Gallagher 1990).

Janzen provides an interesting departure from political economy. He suggest a dual focus through the analysis of social and medical systems. Micro-analysis of social systems concerns itself with illness perception, disease occurrence, diagnosis, therapy and prevention within communities. The medical system at this level is the realm of the specialists involved in the practice of health care. To account for change, Janzen employs macro-analytical tools to study resource allocation, power and the principles of organizing both (Janzen 1978: 121). His work among the Kongo of Zaïre, as well as that of Morsy among Egyptian peasants, gives equal weight to both levels of analysis and recognizes that micro-level resistance to macro-level incursions can be effective (McEwan 1990a; 1990b; Morsy 1993; Janzen 1978).

But critical medical anthropology has itself been accused of confusing and obscuring sickness. By mystifying the social relations of sickness through an idiom of "society" rather than the more conventional one of "nature", this analytical framework evades the issue of what health actually is (Young 1982: 276). There are many questions that are left unanswered even when global historical forces are included in the explication of sickness and health. The most striking one being how do some of the poor and oppressed manage to stay well if they exist in structural positions which impose sickness?

Currently political economy and critical medical anthropology are moving away from the mechanistic legacy of earlier interpretations and using the concept of culture to account for behavioural and experiential variations in sickness incidence thus identifying culture as the missing category in this approach to health and ill-health (Morsy 1993: 5; Worseley 1984: 40-2).

B. 1.4 Phenomenology

Byron Good has articulated a fourth 'way' to understanding experiences of health and ill-health. This is a proposal to view illness as a "syndrome of experiences" and to analyse the interpretive practices through which "..illness realities are constructed, authorized, and contested in personal lives and social institutions" (Good 1994: 5). Drawing on the phenomenology of Merleau-Ponty and Alfred Schutz, Good focuses on the body, not as the site of domination or the object of medical practise, but as the creative source of experience (Good 1994: 116; Berger & Luckman 1966).

Good writes within the tradition of Explanatory models and the meaning centred approach in medical anthropology to include the relationships of embodied experience, intersubjective meaning and narratives which shape the illness experience and which mark the shift in the sufferer's experience of the life world (Good 1994: 118). The anthropological form of hermeneutics which Good espouses hinges on experiential knowledge and "... how the body knows, how that knowing has been moulded by social and political forces at different times and in different places." (Duroche 1990: 123)[3]. Although

[3]. This notion of embodiment derives from Merleau-Ponty's The Phenomenology of Perception (1963) in which he posits the sensual body at the heart of any conceptualization of experience. 'Reality' preside amidst interactions or relationships between the physical body, the 'lived body' and the interpretive activities of the sufferer, healers, and others who participate in their social world (Duroche 1990: 176).

Good locates the ontology of disease in meaning and in human understanding (Good 1994: 53), he does not deny that disease is also the object of social, political, and medical significance and as such labels his proposed 'Critical Phenomenology'.

The generative function of embodied experience that is central to phenomenology as a school of thought seems apt for understanding illness, sickness, and disease (Good 1994; Martin 1989; Saltonstall 1993; Scheper-Hughes & Lock 1987; Csordas 1990; Jackson 1979; Kleinman 1994). Despite the importance of individual experience and the bridge Good constructs between this category of knowledge and its social, political, and economic context, this remains a paradigm of limited use. Good uses his suggested paradigm to analyse such embodied experiences as schizophrenia, mental illness, fainting, and chronic conditions of pain. The dramatic expressions of the body seem to be easier to theorize in cases of serious and chronic conditions. The embodiment of diarrhoea and chest infections, although both potentially fatal particularly for children, have as yet to engage medical anthropologists of this school of thought. Perhaps passing or recurring ill-health conditions are assumed to leave less of a mark on the body than do serious or chronic ones. But that does not mean that they are not in themselves 'embodied experiences'.

The rediscovery of the individual's role in constructing illness and disease and not just in expressing distress is an important one. Lewis (1993) had drawn attention to the many levels and units of analysis that medical anthropology needs to encompass. He points out that " ... people as well as the physical surroundings in which they live must be included in any study of disease, its causes and course of development. This demands investigation at the level of the environment and population as well as the cell and the molecule" (Lewis 1993: 75). Phenomenologists found a space in which to fit the individual body in this schema.

This approach is a product of the "Anthropology of Experience", a school of writing that vehemently rejects the pre-conceptualizations and normative analysis of structuralist and functionalist thought and tries to focus on expressions in the place of models and systems. The objects of analysis are narratives, performances, and other expressions and not what they represent or refer to (Geertz 1986; Turner & Bruner 1986).

Phenomenological analysis differentiates between the physical body, the lived body, and the 'mindful body (Duroche 1990: 176; Scheper-Hughes & Lock 1987: 36-41). The physical body is our material tool with which we engage with the world to realize the 'lived body. The mindful body is realized when the mind and body experience critical events, ill-health being one of them, when they become a ".. proximate terrain where social truth and social contradictions are played out as well as a locus of personal and social resistance, creativity, and struggle" (Scheper -Hughes & Lock 1987: 29-30). In other words one can imagine the mindful body as the lived body in emergency or crises mode! Others writing in this tradition have focused on the body to illustrate it as the site of resistance to manipulation with relation to women's experiences of childbearing and their reproductive health (Martin 1989; Oakley 1986; Rapp 1993; Ratcliff et al 1989) specially with reference to reproductive technology (Franklin 1997).

Critical phenomenology offers a synthesis of ideas which enable medical anthropologists to account for emotions, personality, and suffering as generative principles in the construction of ill-health and not as by-products of cultural (in the case of EM's) or socio-political (in the case of critical medical anthropology) events (Kaufman 1988: 350. More importantly it retains the social significance of embodied experiences of ill-health. Aside from the drawback of its essential selectivity, critical phenomenology fails to account for ideology (Young

1993: 120-9).

Phenomenologists would argue that that which is not experienced and embodied does not really exist. But health and ill-health are organized by principles which have a collective, not just a personal genesis and significance. Moreover, health and ill-health are potential as well as actual categories. One does certain things so as not to 'become' sick or as to become 'healthy' or 'healthier'. Some of the most dangerous things to our health such as pollution, toxins, and radiation for example are 'embodied' over a period of decades. Phenomenology does not quite resolve questions of time, embodiment, and collective ideas and ideals of health, risk, or ill-health.

The four paradigms of medical anthropology described are distinct in their postulation of culture. The early empiricists portrayed culture as the holistic system which justified or rationalized non-clinically justifiable healing practices. The meaning-centred approach redefined health systems as cultural systems which have an internal coherence of their own. This approach creates a cultural system out of illness and its management. Critical medical anthropology rejected this relativism and in a sense adopted an empiricist approach which sees health and ill-health as a product of the dialectical relationship between the individual, society, and world economic and power relationships. Here culture has a functional role in that it is merely a vehicle for the elaboration and expression of these greater forces and powers. Lastly, phenomenology gives ascendence to embodied and experienced culture which constitutes ill-health as a human reality and not merely represents it thereby constituting a concept of practised culture, or the embodied world (Bourdieu 1977), as opposed to an externalized over arching structure.

There is little justification for purposefully separating these methodological projects as separate schools as the above review would seem to suggest. The potential complementarity of these approaches as tools, far

outweighs their mutual exclusivity, particularly when placed in the context of different historical situations, aspects of health, and of disparate societies. This work will try to illustrate the complementarity of a variety of methodological tools in the study of child health and ill-health.

B.2 MEDICAL PLURALISM AND MEDICAL ANTHROPOLOGY

Medical Pluralism is defined as the condition where there are several medical systems; each with its own set of etiologies and proofs and which compete, albeit on unequal ground (Frankel & Lewis 1989: 1; Finkler 1994; Nichter 1992; Leslie 1980; Janzen 1978; Young 1982: 271; Feierman 1979: 277; Feierman & Janzen 1992; McEwan 1979; Gran 1979)[4]. It is the field of medical anthropology which goes beyond the analysis of ill-health causation and definition and focuses on ill-health management.

One of the principal studies on pluralism is Janzen's The Quest for Therapy (1978). He projects the sufferer not as a passive patient but as an agent active in the "quest for therapy". In so doing, people who are unwell manipulate resources available in the environment to achieve health. The author thereby rejects the mechanistic model of therapy. He submits that Western medicine has been accepted into the consciousness of local people in Zaïre but not at the expense of tradition-derived therapies. The pursuit of health leads people to use medical traditions that are complementary in the course of a particular set of therapies relevant to a single case, but mutually exclusive in their cultural logic. Each therapy system employed is based on social and cognitive consensus. (Janzen 1978: 123-8).

Work in Papua new Guinea confirms the complementarity

---

[4] Worseley does however note that even in the West the process of therapy starts with self-medication then is followed by lay referral, recourse to a therapy managing group and/or chemist before finally knocking the door of the physician and then the specialist (Worseley 1982: 325).

of healing systems in the process of therapy. The Huli of the Southern Highlands of Papua New Guinea choose between traditional ritual, Christian healing and/or the public health service in accordance to the degree of commitment that they have to the knowledge systems that these therapeutic options represent. There is no strict division between these traditions. (Frankel 1986; Frankel and Lewis: 1989; Strathern 1989; Chowing 1989).

Nyamwaya writing on the Pokot of Kenya argues that pluralism, or rather the distinction between medical systems, is a figment of the anthropologist's imagination. Kleineman defined medical systems as the total cultural organization of medically relevant experiences and of integrated personal and social perception, use and evaluation of medical resources (Nyamwaya 1987: 1287). Nyamwaya accordingly argues that as far as the patients are concerned the variety of medical traditions are diverse resources in a single cognitive, affective and behavioral environment in which illness occurs and therapy is sought (Lane & Millar 1987: 151, 177-80; Ngubane 1977; Ngokwey 1988; Nyamwaya 1987; Banerji 1981; Jacobson-Widding & Westerland 1989).

There are other factors that relate to patients use of health resources besides the existence of multiple medical traditions. Transport, financial cost, attitude of physicians, history of efficacy, are but a few of the relevant factors (Last & Chavunduka 1986; Davis 1989). People do not reject or favour a given medical tradition without reasons. They can and do however, reject the politics of medicine, whether modern or otherwise when they believe it in their best long term and general interest to do so. The most profound and militant of these efforts has been in the field of family planning where the anti-natalist policies of states collided with the pro-natalism of men and women who found advantages in procreation (Kim & Norsigian 1989; Gordon 1978; Fakhr el-Islam et al 1988;

Hartman 1987)[5]

Peoples' simultaneous use of various aspects and services of plural medical systems has however become a truism in medical anthropology (Good 1994: 155). This is partially because anthropological observation has repeatedly confirmed it, but also because the hegemony of western medicine has yet to be denied by the majority of anthropologists. Anthropologists became interested in biomedicine as a historically and culturally specific medical tradition. The practise of biomedicine and its and its interaction, and not just co-existence , with traditional medical traditions became topical to anthropology (Baer 1987; Comaroff 1982; DiGiacomo 1987; Ehrenreich; Eisenberg & Kleinman 1981; Glick 1967; Hahn & Kleinman 1983; Hahn & Atwood 1985; Finkler 1991; Kaufert & O'Neil 1993; Lock 1985; Lock & Gordon 1988; MacCormack 1986; 1993; Martin 1989; 1990).There would seem to be little left to say about pluralism.

However, it is impossible to look at health or ill-health, in any society, without finding a degree of medical syncretism (Furnham & Smith 1988). The case of child health is particularly relevant to considerations of pluralism because both biomedical and other medical systems, in Egypt at least, have very definite ideas about the health, illness, and diseases of early childhood, both have a sub-speciality in paediatrics. The vulnerability and value of children are such that all existing medical cultures have had to provide for their protection and survival (Oldham 1990; Sholkamy 1990).

The question remains as to whether different medical systems are exclusive in their logic or are single cognitive and affective models of behaviour. The field of child health and ill-health widens the scope we should consider to answer this question. Because child health implicates wider medical spheres of action such as diet,

---

[5] For a discussion of the politics of health bureaucracies in Sudan see Gruenbeaum 1981.

prophylaxis, and kinship ties and positions, it permits us to locate the articulations and disarticulation of medical traditions, and accordingly ponder their essential diversity or unity.

B 3. THE DEFINITION OF HEALTH

Medical anthropologists have failed to engage with the cultural and social construction of health to the same degree that they have engaged with the constructions and expressions of illness and sickness (Janzen 1981; Kleinman 1981; Pierret 1995). One obvious reason for this comparative neglect may be that health is not an urgent or critical issue and is only problematized when absent, that is when one is sick. But another reason is the expropriation of health by modern medicine (Illich 1976; Janzen 1981). Modern medicine had medicalized modern human societies and spread into all aspects of daily life. In England today, GP's are supposed to provide their patients with advice on handling grief, stress, and relationships; all of which have been drawn into the sphere of biomedicine.

The hegemony of biomedical technocratic rationality renders health a product and not a process. Modern medicine has come to care about relationships and emotions because of their perceived possible effects on the human body. Far from becoming socialized and emersed in its human context, biomedicine has simply admitted the social and the emotional in its field of the potentially physically significant. This may explain why 'health' is still viewed as a dimension of medicine and not of social life.

The emerging sociological and anthropological literature on the body does address the issue of 'health'. Much of this literature is educated by phenomenological thought, consequently, their writings of the body, are in fact about embodiment (Csordas 1990: 35-40; Desjarlais 1992a; Duroche 1990; Jackson 1979; Jacobus et al 1990; Lock

1993; Scheper-Hughes & Lock 1987; Saltonstall 1993: 27-33; Turner 1991). Health becomes a bodily function and state and a personal experience.

At the level of general observation, one has the impression that 'Health' is a first world concern and disease is a third world domain. This is a crude distinction but a defendable on. In the affluent West, concerns over life style, exercise, ideal 'body mass', weight, and diet are all historically specific constructions of health. Indeed, modern medicine has transcended its allopathic legacy and has evolved health prescriptions. Britain, France, and Canada have developed "Health of the Nation" plans which are long term health goals that take into consideration not only human biology and curative health services but also imply life-style and the state of the environment. As Pierret puts it "Health was seen as a collective patrimony to be protected and reinforced" (Pierret 1995: 180). The 'modern' notion of health being the right to get health care when ill has become an obligation to stay healthy (Ibid). This is recognized in the affluent west, but less so in the rest of the world. Philosophical discussions of the definition of health and of the possibility of having a truly healthy society seem to be luxuries affordable only to those who are at the 'top of the pile' whether they are states, societies, individuals or social classes (Wright 1982). I contend that this may be why the traditional sites of ethnographic research have rarely merited a contemplation of the meaning of health.

But what are the available definitions of health? The World Health Organization specifies that it is "the state of total physical, mental, and social well-being". This blanket definition could be criticized in many ways. Health has been defined in moral terms as ".. a moral code that defines societal membership" (Litva & Engels 1994: 1089). It has been described in biological terms as a set of optimal readings on various machines, that is when one's

'tests' all read well then one is healthy (MacCormack 1993). But for the anthropologist, the more interesting ideas lie in the social constructions of health.

Pierret argues that health poses the relationship between normality and pathology. This is an essentially social relationship which is culturally and historically constructed and which serves as an index of social organization (Pierret 1995: 179). Pierret asked workers from Paris, the residents of a housing estate in the Essone department, and farmers from an area in the Herault department to define health. She found that the responses could be grouped into four definitions. Each definition reflected the age, tastes, social and economic situation, and politics of the respondents. One group said that health is not being sick; another that health 'is the most important thing' and that it is a potential created during childhood, a capital one uses for life. A third group viewed health as a product created by one's behaviour, for example by life style and social values. The fourth group located health in the institutions which provide it. (Pierret 1995: 184-190). Pierret's work establishes a simple fact. It reaffirms that health is not a residual category, that it is not an ahistorical reality , nor is it a universal experience. Health is socially constructed, specific and variant.

Ethnographic research can establish the significance of health to social analyses in a more profound and interesting manner. Janzen has outlined the components of a methodology to understand health. He suggests an emphasis on practices and ideas of hygiene, adaptation to the environment, normative health and the conscious maintenance of health ideals and a consideration of disease taxonomies from a health point of view (Janzen 1981: 185). One can add to this list a consideration of personal, national, and international discourses on health, their construction, and their expressions.

The international discourse on children has somewhat

standardized the definition of children's health (Boyden 1990: 184-90, Bogden 1990: 184-8). Charts to plot weight, height, and head circumference in accordance with a percentile average have become part of model medical paediatric and public health practice. When asking one close friend and a mother of nine with whom I lived during the research her opinion about percentile charts she answered: "But Asma[6] is not like a hundred other children, she may be like her sisters but how can she be measured against others we don't know". Ethnographic anecdotes aside, this standardization of health merits critical examination. To do so, this thesis will consider health as well as ill-health amongst children in terms of the various discourses which shape the experiences and expectations of children and their families.

C. THE STUDY OF CHILDHOOD

C.1 ANTHROPOLOGY AND CHILDHOOD

Children are present in some capacity in all ethnography; after all, they are the 'substance' of kinship, the objects of socialization and 'enculturation', and the subjects of many rituals. But this presence has only attracted occasional anthropological attention. One of the first full length ethnographies on children is Margaret Read's Children of their Fathers (1960). Read's description of the day to day life of children, and of parent child interaction and on childrearing practices amongst the Ngoni focused on socialization and education. But most importantly, Read applied the tools of cultural anthropology to the study of childhood so as to overcome the limitations imposed by the use of psychology as a reference point for analysis (Read 1960: 166-7).

Early anthropology had been considering socialization, and the formation of personhood, and to that extent had commented on children (Firth 1936; Fortes 1938; Kaberry

---

[6]. Her newborn daughter.

1939; Richards 1939). But the accounts of rites of passage, initiation ceremonies, and formalised socialization were comments on the culture described and not on the space and place of children within that culture (Richards 1956; Turner 1968). However the study of socialization remained unpopular in the context of British Social Anthropology mainly because a Durkheimian structuralist functionalism was averse to psychological analysis (Jahoda & Lewis 1988: 9; Mayer 1970; Richards 1970).

In the United States of America, Margaret Mead had succeeded in popularising the understanding of childhood as a stage in development that is culturally contingent in its duration and content (Mead 1928). She engaged in a debate shaped by childhood development theories and psychoanalysis as elaborated by Piaget and Freud (Jahoda & Lewis 1988: 10). The logical extension of her work came to be known as the Culture and Personality school (Benedict 1947; Mead & Wolfenstein 1963; Sapir 1949). This approach focused on socialization and emotional growth as the foundations of adult personality. Proponents of culture and personality were interested in children's responses to such emotional crises as weaning, and tried to trace the resonance of such trauma in adult personality (Jahoda & Lewis 1988).

Further development came at the hands of Beatrice Whiting who popularised the study of the day to day life of families and their children. In a number of publications, Whiting and co-authors described children in their 'natural environment' and created lists of variables by which social behaviour could be predicted. Special attention was given to aggression, emotional security and identity as adult traits (Whiting & Whiting 1975; Whiting & Child 1966; Whiting 1988). This concern with culture yielded somewhat static and de-contextualised accounts of the lives of children within families. There are some exceptions as in the work of Leiderman in East Africa and Konner's description of !Kung infancy (Konner 1977: 280; Leiderman et al 1977).

In the past decade there has been a revival in the study of childhood. At a political level, the plight of third world children, their labour, enslavement, prostitution, and deprivation, have spawned a number of revealing and intense studies (Blanchet 1996; Boyden & Hudson 1985; Burman & Reynolds 1986; Fyfe 1989; Freeman 1983; Reynolds 1991; Stephens 1993; Winn 1984). There have also appeared a number of ethnographies and collections which are rendering childhood and its study as interesting anthropological problematics (James & Prout 1990; James Jahoda & Lewis 1988; Stafford 1996).

Toren's work on gender and the construction of cognitive categories amongst Fijian children introduces the tools of cognitive anthropology to the field of childhood studies (Toren 1988a; 1990). Rabain's work on Wolof infancy argues that kinship is structured and reproduced through childrearing practices such as breastfeeding (Jahoda & Lewis 1988: 28-9). Dragadze introduces political economy to childhood studies by showing the effects of a community's structural position vis-a-vis the state on childrearing practices. She shows how the caretakers dual role of disgruntled citizens and as agents of traditional morality and culture affects the childrearing practices and the childhood of a community in Soviet Georgia (Dragadze 1988).

There has also developed an interest in gendered childhood, particularly with regards to education.[7] This degree of sophistication in the new generation of childhood studies marks a true departure from previous work. The cultural construction of childhood and its social definition, historically (Aries 1962, DeMausse 1976) and sociologically (Coles 1986; Stephens 1995; James & Prout 1990; Winn 1984; Kessel 1983; Zeliger 1985) has made its way to anthropological research.

The first Ethnography on childrearing in Egypt is Blackman's The Fellaheen of Upper Egypt (1927). As a female

---

[7]. For Yemen Vom Bruck 1994; Taiwan Stafford 1996.

anthropologist interested in survivals from Pharonic Egypt in the behaviour of 'modern' Egyptians, Blackmen undertook the detailed description of family life in Egypt. Her work was mainly in Assiut in Upper Egypt and is thoroughly descriptive and as such remains a work of value. Granqvist's extended study of Palestinian families and their childrearing and childbearing practices is another mine of information and detailed description (Granqvist 1937). Both these works make up in the depth and wealth of their ethnographic reporting what they may lack in terms of theoretical analysis.

Subsequently Ammar wrote Growing Up in an Egyptian Village (1954), an ethnography of the writer's own village of Silwa in Aswan province. The study is typical of the socialization and education studies of its time and is written in a deliberately pedagogical style of analysis. It has remained as a land-mark study in terms of its value to both childhood studies and the ethnography of Upper Egypt.

Despite the prominence of issues such as child labour, female circumcision, and childhood diseases, little in the way of childhood studies on Egypt have appeared (Seif-El-Dawla 1990; Ciaccio 1979; El-Mofty 1979). The recent collection by Fernea is an attempt to fill this vacuum. Children in the Muslim Middle East (Fernea 1995) is an impressive collection of writings on issues pertaining to childhood, on children, and of lullabies, songs, and stories for children. It is unfortunate that Fernea's only intellectual rationalization for the book is that children are important as she points out that the under 15 years of age group constitute more than forty percent of the population in the majority of Middle eastern countries (Fernea 1995: 4). But the diversity of the collection makes some important points about the significance of law, health, art, history, politics and war, and ideology to children and the location of children at the crossroads of these research traditions.

C. 2 The Field of Children's Health

I am proposing the field of children's health as a distinct one in terms of the theory and research of both medical anthropology and of childhood studies. Research on children's health has predominantly been on 'disease' and its traditional and household management (Bentley 1988; Charles & Charles 1979; Coreil 1988; Mull & Coreil 1990; De Zoysa et al 1984; Finerman 1987; McKee 1987; Mull & Mull 1988; Nichter 1988; 1989; Oldham 1990; Patel et al 1988; Scheper-Hughes 1984; 1987; Tekce 1990). The relationship between childrearing and child health has mainly been described in normative terms which give an idealized description of how families raise their children (Hoodfar 1995).

Berry Mayall who writes on the sociology of childhood in Britain has focused on child health and its construction. She ties the public to the private and the social to the individual to show how the articulation of these orders shapes the lives of individual children and constructs dominant notions of childhood (Mayall 1996). Mayall's critical look at health, social, and educational services for children rests on the assumption that "... notions of child health are constructed out of essentially political considerations." (Mayall 1996: 23).

The ideas put forward by Mayall are essential to this work. Child health is both a personal and a public affair. It is an area of study which necessitates consideration of both the individual experiential meaning of health and its social and political economy dimensions. It is a field of study which requires an understanding of not only diseases and therapy, but also of society and of the family.

Mayall (1993) has called children's health the "Intermediate Domain" (Mayall 1993: 77; 1996). Although her work is about health services for children in the UK, Mayall locates a space which is somewhere between the medical and social where childrens' health is negotiated and structured. This space is as medical as it is social

and cultural. It is an intermediate domain not only in the sense of the interests of health professionals and parents, but also in its social and medical relevance.

It is within this location that I hope to situate my ethnography of child health. A good example, and one of the few available, of a similarly situated ethnography is Scheper-Hughes work on children and child mortality in a community in the North East of Brazil. In Death Without Weeping, The Violence of Everyday Life in Brazil (1992) Scheper-Hughes tells of her old relationship with a community and the multiple roles with which she has engaged with its members. After presenting beautifully detailed and rich description of the people and the place, Scheper-Hughes tells us of what she describes as "mortal neglect", a practice whereby children are left to die, often of dehydration or starvation. Far from condemning this as a form of contemporary infanticide, she wonders about the meaning of this practice, how is it rationalized, what does it result in, and how can mothers emotionally bear to do such a thing. Scheper-Hughes does not validate this practice as an aspect of the 'native other'. She tries to take the reader into the world of these Brazilian families and let us contemplate this practice in that context.

By immersing mothers and children in a historical and social context and by maintaining the dimensions of culture and individual emotions, Scheper-Hughes considers violence, financial and family crises, the problems of women, the medical beliefs of the community and the syncretism that shapes their faith to help her reader fathom "mortal neglect". In this ethnography child mortality is neither justified nor mystified. It is interpreted in the language of emotions, culture, dire straits, and family relationships which is the language in which it is experienced.

This study approaches child health by an examination of the concept of risk and its social construction. 'Children at risk' are children in situations of war,

famine, communal violence, racism, poverty , or in-equality (Allesebrook 1989; Fyfe 1989; Garbarino 1992; 1991; Reynolds 1991; Scheper-Hughes 1989; Sholkamy 1992; Stephens 1993). This work examines the social and cultural construction of health risks to children with particular reference to folk theories of affliction and therapy. Egyptian folk and Egyptian modern medical systems construct notions of risk. According to the 'folk' view, children are at risk because they are precious, enviable, or because of the configuration of familial, and social circumstances and relationships into which they were born and live. The biomedical model finds that children are at risk due to negligence in the observation of principles of medical prophylaxis or because of malnutrition or environmental conditions.

Theories of risk express the moral order and principles of the medical culture of which they are a part (Douglas 1986). Modern western rationality ties morals to moral persuasions and ill-health to disease agents identifiable through modern medical technologies (Douglas 1994: 9). 'Folk' views of risk, on the other hand, display an acute awareness of context and of the individual. To understand both orders of risk and thus fathom the medical systems that they structure, we need to understand childhood and child health in their social context.

C. 3 THEORETICAL CHALLENGES POSED BY CHILD HEALTH

The ethnography of child health challenges much in medical anthropological theory. There is an "everydayness" about early childhood ill-health which is rare amongst adults. It is difficult to imagine how we could theorize a situation where perfectly healthy adults are falling ill all the time and where their afflictions were not minor ones. Adults often get colds and indigestion but these conditions are not usually life threatening[8].

---

[8] An exception to this is women's reproductive health where the normal and the dangerous are also continuously juxtaposed.

The everydayness of children's ill-health and the specificities of childhood, have necessitated the creation of separate spheres of medical knowledge, not only within biomedicine, but also in traditional or alternative medical cultures and systems of health care. This distinction between the health of adults and that of children in itself creates a domain for the anthropology of child health. In my work I hope to show that the potential of danger located in the everyday gives a distinctiveness to villagers' definitions of child ill-health, their preventive strategies, and their health seeking behaviour for their children.

Children's health is also an intermediate domain because of the prescriptive nature of the medical discourse which it inspires. As mentioned earlier, the international discourse defines a healthy child in terms of weight and height for age. It also specifies that a healthy child is a vaccinated and educated one. These are very obviously cultural constructs.

There is an emic construction of child health in which kinship, everyday life, ideas and ideals about the physical and metaphysical world, and emotions are articulated. Villagers also want healthy children. But they have a definition of health which, in part, coincides and, in others, transcends the current biomedical model. Children's health is an ideal field of study for these definitions because it is one where both the management of ill-health and the management of health are active, not passive or residual processes.

Children's health, particularly in Egypt, perhaps, is also an important and intermediate arena for the study of medical pluralism. Because children are so dear, and because potential dangers lurk in everyday occurrences, the health seeking behaviour of adults expresses more than preferences and beliefs about efficacy and cure. The processes whereby families look for cures and for good health expresses their view of their whole social,

cultural, and political world.

Parenting is not a simple act of altruism and there are many morally and ethically contentious aspects to how parents treat their children (Hatem 1987; Rugh 1988). However, small children are by and large treated with love and with care. The process of parenting the under fives, as observed in Rihan, is a loving and caring one where the best interest of the child is invariably observed. Mothers can be seen literally taking choice morsels from their own mouths to give to greedy toddlers. In looking at how choices are made and how therapy is sought this work reveals an essential part of the experience of life in the world view and structural position of peasants in Egypt, as expressed through acts of parenting.

Finally, the field of child health is an important domain for theoretical and methodological contemplation. Children's health requires a method and theoretical references which can explain its specificity. In communities where child survival cannot be taken for granted due to conditions of hardship, poverty, strife, or lack of basic services, the purpose of parenting is physical survival[9](Levine 1977). But we need to appreciate how this goal of survival affects parent's expectations of the social and moral survival of their children? In trying to insure that their children do not prematurely die, do these parents forgo their children's other rights? Such questions illustrate the wider and more significant meanings and implications of child health.

This definitiveness does not necessarily mean that childrearing and care is utilitarian. It is an activity charged with meaning and is a process which defines and is defined by culture. This process is also structured by macro-economic, political, and historical forces. Finally, childhood, the role of parent and the processes of childrearing and nurturing are perhaps the most important

---

[9]. In the west, and in affluent communities elsewhere, parents presume, to some extent, their children's survival.

and consequential of human experiences. These experiences structure our lives and generate much of what is essentially human. Consequently, the field of child health and ill-health requires a theoretical and methodological approach that can accommodate these features.

D. THE STUDY OF CHILD HEALTH IN RURAL EGYPT

D. 1 The Theoretical and Methodological Approach

In writing and researching the work at hand I have been guided by two theoretical orientations. The first is an awareness of political economy and critical medical anthropology. The "facts" about material and social subjugation, poverty, and powerlessness are important to this study. The position structured by these macro-level realities in which the villagers of Rihan find themselves is assumed to be of manifest and manifold significance to their medical cultures.

But this work does not linger on these "facts". The written text describes the culture generated by the practices of villagers in Rihan. Material facts of poverty and power relationships are part of the structures and experiences which generate this culture. This work is not about how people "cope" but about how they create and authenticate their material, moral, and personal options for health and therapy.

This study is also informed by the "logic of practice" as described by Bourdieu (1977). It tries to recount observation, relay narratives, but also to engage with "...the silences, ellipses, and lacunae of the language of familiarity." (Bourdieu 1977: 18). The primary focus is on the discourse of familiarity as practised, without privileging too much the outsider oriented discourse generated by the questions of the anthropologist. For this reason, the thesis focuses on everyday life.

Time is an important dimension of this focus on practice. Bourdieu suggests the reintroduction of time into the theoretical representation of a practice (Bourdieu

1977: 8). Childhood demands such a reintroduction. Time is an essential variable. A child's age, the experiences of the parent, the duration of the sickness episode, the time lapse between afflictions, all structure the meaning of health, risk, and ill-health.

Within the space structured by history, economy, and polity, this work tries to account for personal initiative and collective capability in generating a medical culture. The study takes into account time and personal representation and experiences of this generative process, but maintains that 'experience far', and not just 'experience near' occurrences and developments play a role in the generation of culture (Geertz 1973; 1983). Through this synthesis, the study hopes to be able to account for the specificities of the field of child health, but also to contribute to an understanding of the broad outlines which aid or hinder better child health.

I hope to realize and use a definition of culture as an active faculty created by human initiative and creativity. I do not see culture as a reified object that exists outside nature and society. If villagers now use traditional cures that they had not used for decades this is not a linear regression into tradition or a retreat into rigid culture. These villagers are using their intellectual and material resources to move ahead, beyond expensive medicine and beyond poverty, and to realize a medical culture that can extend comfort and care for their children.

D. 2 Being in the Field

This study is based on fieldwork undertaken from May 1991 to April 1993 in a village in the region of Abnube in the north east of the Governorate of Assiut in Upper Egypt. The village has a population of approximately 1200 people. They are predominantly Arab Muslims. They are Arab in the sense that they descend from nomadic Bedouin ancestors. They have been sedentary for less than one hundred years.

I have given this village the pseudonym of Rihan, the Arabic for Basil[10].

I spent 18 months in the village during which time I lived with the family of Mr. Hashem, his wife Ni'mat, and their nine children; one of whom was born during my stay with the family. During that time I undertook several weekend trips to the city of Assiut, and spent holidays with my family in Cairo.

During my stay in the village, I attempted a number of research and data collection strategies. All plans hoped to realize the elusive goal of true participant observation. Favret-Saada (1994) has experienced the role of true participation. In her study of witches in French mountain community she had to accept the role that she was cast in as a trainee healer. Most women working amongst rural communities, at least in Egypt, have had to deal with the same assumption of role play. They have had to be the **"doctora"** or the female physician (Kuhnke 1974). Villagers all over Egypt have met the government assigned female doctor who lives in villages, away from her family and home, much more frequently than they have met anthropologists. Consequently the social researcher finds it difficult to initially create space for another role and to 'prove' that she is not a physician.

My situation was made all the more difficult because I was interested in health and ill-health. After a few weeks I was cast in the role of "the doctor who does not heal" since I neither gave injections or prescriptions. To my advantage, my medical knowledge was demeaned and placed on an equal footing with everyone else's. After all as one woman put it "We have children and we have been much more

---

[10]. This is already an error on the side of caution. The village's real name is that of the Coptic saint shrine which is built on its southern border. The anomaly of a predominantly Muslim village having a distinctly Coptic name is a sociologically interesting one, but conveying it may betray the real name of my village of fieldwork. Rather than do so, I opted for the fragrance carried by the very early morning breeze; that of sweet Basil.

sick than you have". To this extent, I was considered open to suggestions and not partial to a particular medical tradition. More importantly, this perceived impartiality enabled me to insist that children in distress get immediate biomedical care on the few occasions when in my lay opinion, it was a matter of life or death.

I am a native Arabic speaker and as such feel that I am not quite an anthropologist. After all, I did not have to learn a language, although I am writing in a language that is not my own. The people of **Rihan** speak Arabic that is slightly different in its dialect and vocabulary from other Upper Egyptians of peasant origin. Their language is akin to classical Arabic in its construction[11]. Little three years old girls have better syntax than television news anchors and reporters. My fieldwork was a chance to get my feminine plurals and other elusive structures of the Arabic language right. The varied vocabulary took a few weeks to iron out. I enjoyed hearing children try to speak as I do. My imitation involved high pitch of voice, over expressed hand and facial gestures and talking too much. I learnt however to relax a bit and let them, let me, speak. My field was in my country but was far from my home. For that reason, and despite being an Egyptian native I was and still am quite a stranger.

D.3 DATA COLLECTION

I had worked in this village before revisiting it for the purpose of my doctoral fieldwork (see appendix 1 for an account of my first experiences in **Rihan**). I remember during my previous work in **Rihan** asking a woman how many children she had and she happily said "one". Later I discovered that she is the mother of twelve. "But 'Amr is

---

[11]. To relay the distinctiveness of their vocabulary, I have transliterated all the Arabic words in this text in accordance with how they are pronounced and not with the rules of standard written Arabic. I have used the transliteration rules of the International Journal for Middle East Studies.

the one who is close to my heart" she explained when I asked her why she had denied the eleven others. This incident remained in the back of my mind making me wary of aggregate numbers and of quickly amassed censas data (Kamal 1994).

On my return to the village, I began my fieldwork by attempting a survey of all the village households (Pelto & Pelto 1978; March 1982). I visited all the homes in the village and asked questions to discern the type of household, the number of people in the household and other individual family details. With the families that I knew well, I could revise and verify data with ease. Other families who lived out in the fields or to whom I was not close, I had to make do with the few somewhat formal visits that I could undertake.

Of the 180 households of **Rihan**, I completed my survey questionnaire in 112 households. The other households were either

a. Closed and un-occupied during my period of field research.

b. Isolated in remote outskirts which I could not access frequently enough to make several visits.

c. Occupied by families who felt uncomfortable with my questions and presence.

I did not print out questionnaires (for survey questions, see appendix 2), but rather employed a semi-structured interview technique. My in-depth case studies and observations are drawn from this sample of 112 households. The survey data that I collected was recorded on d-base and analysed on SSPS (Social Science Package) computer software.

To structure the first few months of my stay, I undertook this household survey. It meant that I had something to do all day, and helped me draw a map on which I could mark the homes covered. It also provided a specific task for my field assistant, Laila. I asked Laila to walk me around the village from one house to another and to help

me write down the answers to our questions. Laila is in her early twenties, educated, but as yet un-married. She explained to people that I was doing a **bahth** (research). The common understanding of research is the questionnaire put to people during the national census field data collection or to get their welfare money. They are questions about numbers of people in the household, age, sex, etc... My questions were no different and this made my village tour easier.

This thesis is not only about this survey material. It is mostly about the few families with whom I lived, interacted and whose relatives and friends I also knew well. These are the families whose adults and members I have interviewed several times, observed, and argued with, and whose children I attempted to befriend

I relied on such in-depth interaction as well as on group discussion and interviews. Some of these interviews were somewhat formal. By this I mean that I notified individuals or groups that I wanted them to explain to me such a cure, or recount the village history, or help me calculate the needs and expenditures of households in the village. By making my purpose clear, I received the serious attention and time of those interviewed. It also gave others the opportunity to reject the topic and decline my request.

I also observed and interviewed healers from both the medical profession and the local community. In some cases I resorted to their help so as to get the chance to understand their practices. Other professionals interviewed included teachers, governorate officials, and local agricultural cooperative and village council employees.

My core group of informants are twenty five children from 13 families (Chapter IV). They are the children whose experiences I try to describe. Many of them did not get sick and they are therefore not the only children whose health and ill-health I describe. But they are the boys and girls who explained some aspects of the world and outlook

of children living in Rihan.

The focus of my work was on children and their health and ill-health. Through observation, participant or otherwise, and conversation, I managed to broach the issue of health. Ill-health presented a problem. I could not be at enough places at the same time. When a child had diarrhoea I would decide to confirm this and follow it up. An hour later I would hear that she was cured, she had been massaged by a healer who happened to be visiting her mother, or as happened in several cases, that she was on an IV drip in hospital. The course of the sickness event and its management would always surprise and confound me. The cases that I have compiled are a fraction of those in which I participated and/or witnesses. In this work I do rely on narrative and on recollections and accounts of events. But sharing the event is a part of this narrative construction. It is this aspect of the work which I had hoped to be able to complete to my own satisfaction. Ultimately, my main 'friend' in the field was the permission to quietly observe. However, in addition to observation and conversation, I have tried to use survey techniques and secondary materials

D. 4 ORGANIZATION OF CHAPTERS

In Chapter two I locate Rihan socially and ethnographically in the landscape of Egypt. I describe the village and its people in the context of the facts, figures, and the 'fictions' of Upper Egypt and of Assiut.

In Chapter three I discuss marriage and its implications to kinship, social organization, and children. Unfortunately, studies of marriage, fertility, and kinship have all too often ignored children and their concerns as important components in any appreciation of kinship and of social organization (Inhorn 1994, 1996). In this chapter, I shall attempt to highlight the essential significance of

children without whom the alliances forged by marriage would be meaningless.

Chapter four is about healthy childhood. By sharing the days of a number of child key informants, I discuss methodological issues pertaining to work with children. I also try to elaborate on the emic constructions of ideals of what a child is, and should be, and what childhood means. The daily life of children at home, at school, at work, and at play tries to explain the world of children when they are well so that the reader can appreciate the meaning of their ill-health.

In Chapter five I examine the relationship between constructions of health and constructions of ill-health, and tries to locate both in the historical and social experiences of the village and of villagers. The chapter also discusses health narratives as methodological tools for understanding the meaning of health.

Chapter six presents an example of how families conceptualize health through a look at prophylaxis. This chapter contrasts the principles of public health as propagated by the state and embodied in immunization campaigns with villagers actual resort to childhood immunization and the logic that they adopt in so doing. The chapter relies on a detailed survey of one street in Rihan which attempted to estimate the prevalence of full immunization coverage amongst children.

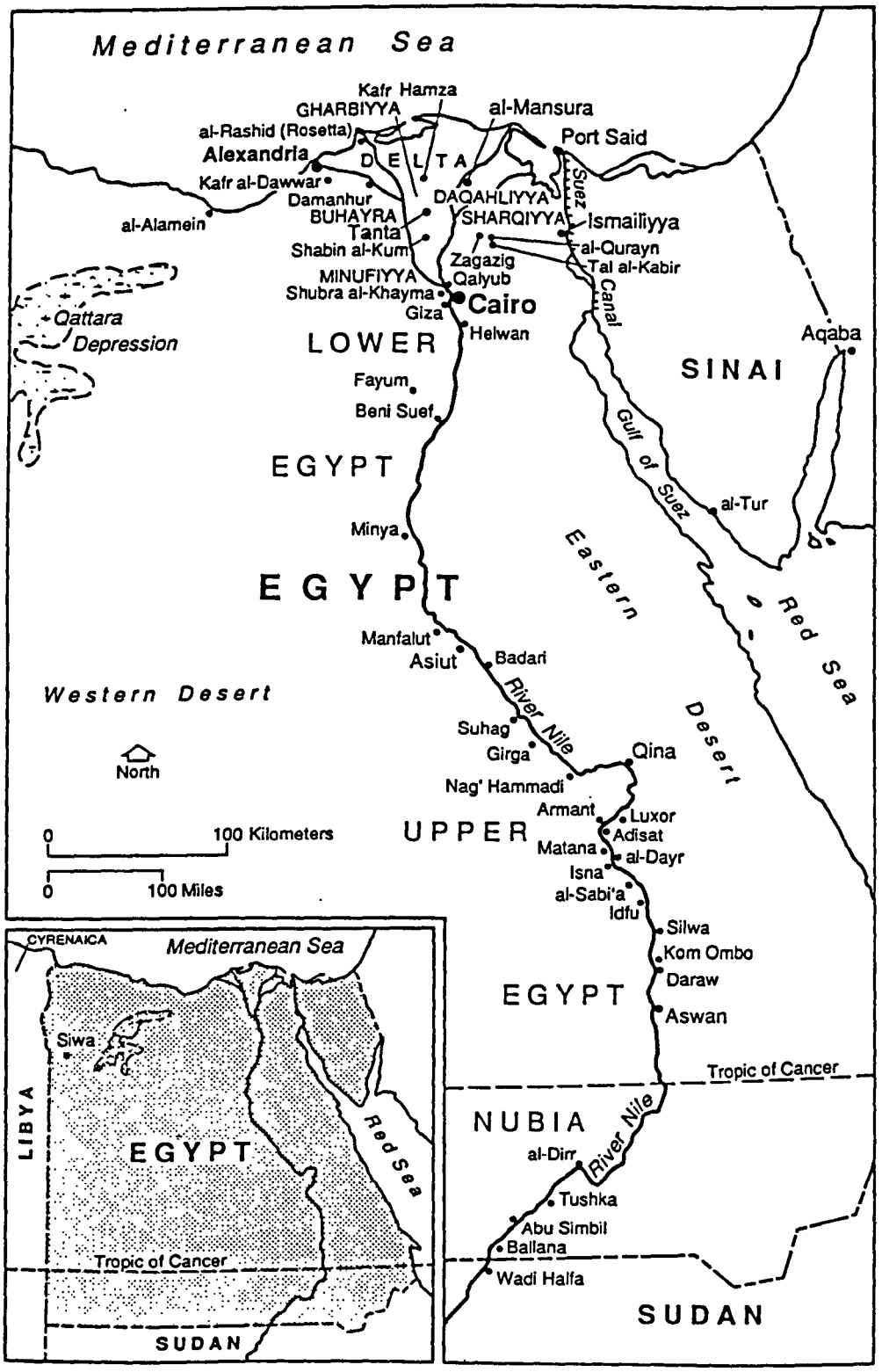
Chapter seven presents an account of the medical practitioners with which villagers engage in their pursuit for health. It is important to establish the parameters of health care before questioning or commenting on people's choices of therapy. The chapter includes some in depth, and rather long, interviews with the most frequently consulted practitioners. They include physicians and healers. It would have perhaps been simpler to just focus on the ethnography of traditional beliefs and neglect the presence of modern medicine and its utility. This would in some ways fit better with the image of peasants which assumes a

degree of cultural and intellectual isolation from modernity and a tenacious adherence to tradition and superstition. But the ethnography of **Rihan** does not permit such license. Questions on health invariably mention physician, healer, medicine, money, and at least one or two interpretations of causation that have nothing to do with biomedical disease etiology.

Chapter eight examines the management of ill-health amongst families in **Rihan**. Here, case studies of the most important illnesses, as identified by families, are presented according to age groups. In a sense this chapter and the one that precedes it illustrate two experiences of illness; the experience of the healer and that of the sufferer and suffering family.

The thesis ends with a short conclusion which proposes children and child health as a distinct area for research and conceptualization for medical anthropology and for ethnographers working on rural Egypt.

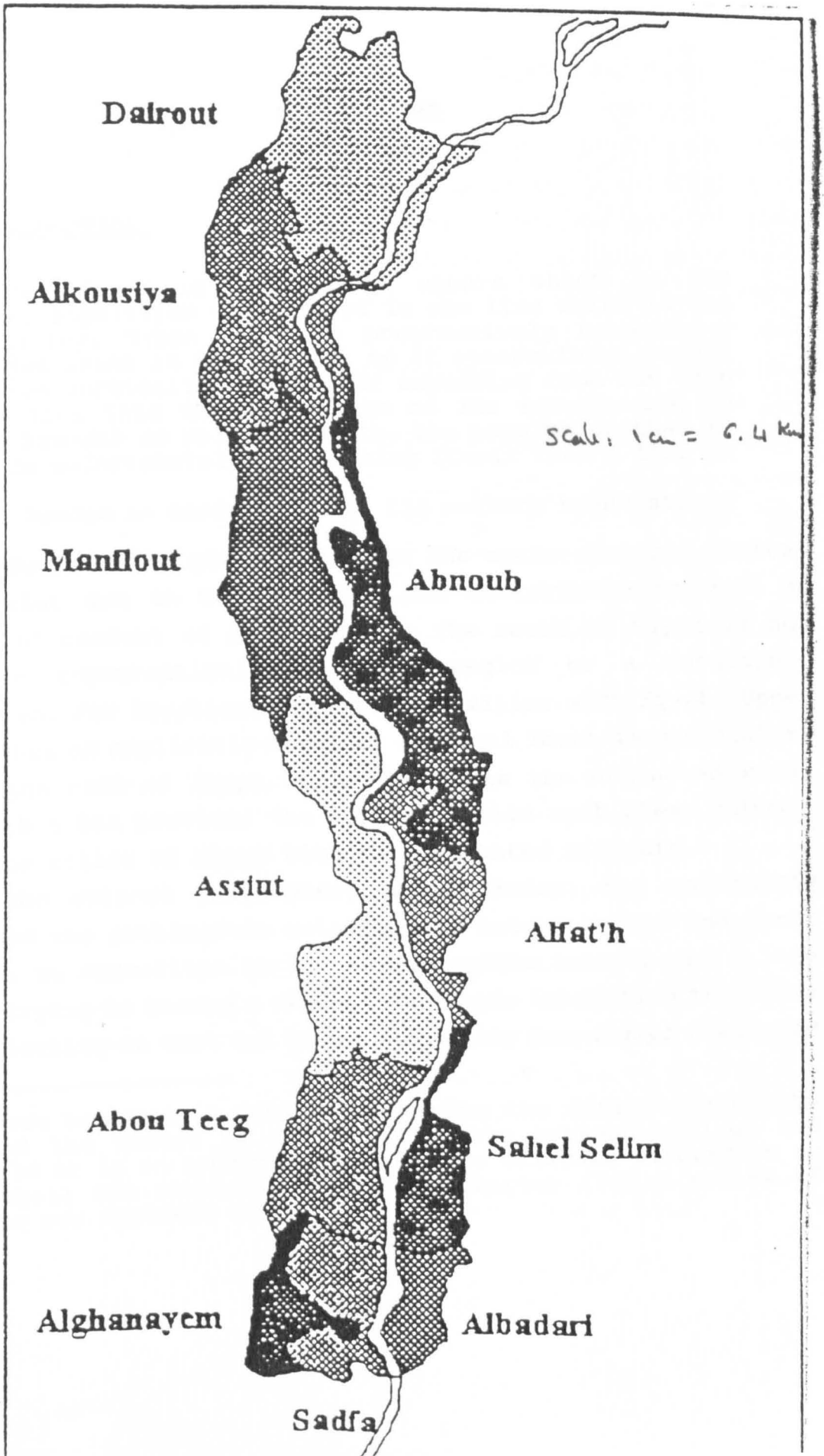
Plate 1



Source: Gallagher, 1990 : 2

Assiut

Source : Fergany 1993 , 1



CHAPTER TWO
LOCATIONS

A. INTRODUCTION

> Political Egypt is a complete square which is its borders. Population wise, Egypt is one line which is the Nile valley. Urban Egypt is progressively becoming a large dot which is the capital as it encapsulates itself and rises vertically. Instead of expanding from its thin single line into the parameters of its square, and so having breadth as well as length, the population that is Egypt is unfortunately compressing itself from a line to a dot!
> (Gamal Hamdan in Kerdousy 1996: 128 authors translation)

This chapter places Rihan in the socio-economic context of Assiut and in the cultural and historical, as well as 'health' context of Upper Egypt[1]. The south of Egypt is not just a topographically distinct region or a geographic location. For Egyptians and others familiar with Egypt, Upper Egypt has an explicitly distinct cultural identity and history from the rest of Egypt. Upper Egypt is the neglected rural land that has provided the Arab gulf with much cheap labour, and the cities of Egypt with many unwanted migrants.

The eminent geographer, Gamal Hamdan, has succinctly phrased the problematic relationship between urban and rural Egypt. He summarizes it in the impossible tension of a long line trying to become a small dot. People inhabiting this line are flocking to that dot because the city has always dominated

---

[1]. There has been a debate concerning the definition of the peasant and the nature of the relationship between village and state. While it is an important part of the existing literature on Egypt, I shall not consider it in this chapter (For a review of this debate see appendix 3).

the land outside it. Egypt has been described as Cairo with a front and backyard (that is the delta and the south).

Rural Egypt has always been underprivileged. But Upper Egypt more so. Upper Egypt is a region of ancient definition. Thousands of years ago, it used to be a separate kingdom that was unified with its northern neighbour, the Egyptian Delta, by king Menes in app. 3000 BC. But, the division between north and south has never faded. At various times of instability the south and north have been separated by virtue of their invasion by, or voluntary allegiance to, belligerent imperial powers. The border between the two regions has been Memphis, the city built by king Menes to signify his victorious reunification of the two lands and given the epithet "The Balance of the Two Lands" by its founder. Memphis lies 15 km south of what is now Cairo. The space upon which Cairo is built has, for centuries, been the point that defines south and north (Wissa 1994).

In ancient times North and south were separate kingdoms. In modern times they have retained near separate cultural identities. The south, called in Arabic the **sa'eed**[2], and its people, called the **sa'yeda** (sing: **sa'eedy**), are neither ethnically nor linguistically different from other Egyptians. Yet all the nuances of their day to day lives, moral codes, art , social organization, history, and identity differentiate them and their land from the rest of Egypt.

The narrow strip of fertile land that is the **sa'eed** is flanked by desert from the east and west. South of Cairo to Maghagha is the land known as Middle Egypt. South of that and as far as Aswan is Upper Egypt (see Map 1). This Nile valley

---

[2]. **Sa'eed** means the upper land and refers to the land where the Nile is elevated before flowing down into the delta.

has been the fertile home of Egyptians for thousands of years. The natural protection offered by the surrounding desert has made Upper Egypt a less accessible part of Egypt than the Delta and the coastal areas. Consequently it is a land that has a long history of subjugation, but has rarely been inhabited or penetrated by its subjugators.

As a people, Upper Egyptians have maintained a lifestyle and relationships that seem to be immune from the cosmopolitan and liberalising effects that emanate from Cairo. The stereotype of a **sa'eedy** is a mixed baggage of ridicule and respect. The **sa'yeda** of Egypt are the brunt of jokes, just as the Irish are in the UK[3], but they are also respected for their dignity and adroitness. Upper Egyptians have come to bear the burden of the state's neglect. They are less educated, poorer, and in worse health than their compatriots in the rest of Egypt.

Assiut is the major governorate of the **sa'eed**. After the virtual 'war' between Islamic radicals and the national police and security forces which began in Assiut in the 1980's and continued through the 1990's, the Egyptian state began to look to the south and contemplate its development. Suddenly the neglected **sa'eed** became a critical issue. This chapter examines this history of neglect and relative poverty which is the history of **Rihan**. Little has been written specifically about Upper Egypt (see Ammar 1854; Blackman 1827; Hopkins 1988) and even less about the situation in the 1990's. I shall therefore devote this chapter to the introduction of the culture, history, and relevant demographic and health statistics of Assiut to explain the relevance of my work in

---

[3]. In the 1990's, a member of parliament from Upper Egypt tried to pass a by-law to censure jokes about his fellow men.

Rihan to the ethnography of Assiut and Upper Egypt.

B. UPPER EGYPT AND ASSIUT

B.1 THE GOVERNORATE OF ASSIUT

> The governorate of Assiut spans an area of 1553 km2 surrounding the Nile in Upper Egypt, a region of the country that has been traditionally neglected due to a combination of scarcity of natural resources, long distance from the centre, rugged terrain, and independent people. The result has been a state of overall backwardness relative to the rest of the country that is both amply documented as well as keenly felt by the people of the region. Recently, Assiut has become notorious as a hotbed of sectarian strife and extremism.
> (Fergany 1993: 1)

The above is a quote from a report on **Social Development in Assiut** prepared for a multi-agency UN/World Bank project aimed at providing technical assistance and enhancing the development of the governorate of Assiut. Even in this most technical of documents, it is evident that stereotypes abound. 'Independent people' 'backwardness' and other value judgements are neither explained, justified, nor rendered problematic by this report. Indeed, they are taken as self-evident statements which need no corroboration. Upper Egypt as a whole, and Assiut in particular, have been subject to this stereotypical reconstruction by the dominant urban discourses of Egypt.

Assiut is approximately 400 km to the south of Cairo. The governorate stretches for 160 Km along the Nile and is only 20 Km wide at its widest point (Wissa 1994: 12) (see Map 2). The city of Assiut has been a regional capital since pharaonic times and is now the third city of Egypt after Cairo and Alexandria (Fergany 1993: 1). It is at the intersection of

the main caravan routes that traverse the eastern and western desert and has therefore been an important centre for trade and commerce for thousands of years (Wissa 1994: 15).

The governorate of Assiut is currently divided into 11 districts distributed along the eastern and western borders of the Nile. Each district has an urban centre or town and is divided into large villages, known in the language of Egyptian administration as 'mother villages' and smaller hamlets called 'satellite villages'. All in all Assiut has 238 villages and around 700 hamlets (Fergany 1993: 5).

B. 2 THE POPULATION

Assiut has a population of 2.2 million, 70% of whom live in rural areas and the rest dwell in the city and towns. The governorate has always had a large Coptic population at 19% of total population. The national percentage of the population who are Coptic is 7% (Fergany 1993: 7- 10). Indeed, Assiut is associated in the minds of most Egyptians with the large Coptic families who have been living there for hundreds of years. The beautiful villas that flank the Nile as it winds its way through the city were once the homes of these prominent families (Wissa 1994)[4].

Perhaps because of the Coptic character of the

---

4. Assiut also has one the biggest and most important Coptic monasteries in Egypt. Saint Mary's Monastery of the **Mu'harraq** built on the mount of Qusqam was built in the fourth century AD and is where the holy family are supposed to have lived for six months during their flight to Egypt (Wissa 1994: 20). It is a holy place to which pilgrims pay homage throughout the year. There are several other important monasteries in Assiut as well as many saint's shrines. Assiut also stages the most important celebrations of the Virgin's Festival (around the 8 th of August) for which Copts from all over Egypt flock in.

governorate, it has also witnessed some of the worst clashes between police and Muslim radicals. In Assiut began the persecution of Copts by young Muslims who terrorized whole villages. These outbreaks started in villages like el-Codia, in the district of Dairut where there has always been a division between Codiat el-Islam (the Codia (name of village) of the Muslims) and Codiat el Nasara (the Codia of the Christians). Such close proximity between Muslims and Copts coupled with the numerical and financial clout of the Coptic people of Assiut may well have been some of the elements which were used to ignite sectarian strife[5].

The average family size in Assiut is 5.1 but is higher for rural areas at 6.2. The governorate also has higher total fertility rate than the rest of Egypt at 6.7 birth/woman while the national average is 4.55 birth/woman (Capmas 1993: 139).

The population of the governorate has a young age structure. Overall, more than 21% of the population are under the age of six years. Abnoub, the district in which Rihan is located, has an even younger age structure with 24% of the population under the age of six years (Fergany 1993: 8-12). This population structure in itself, and apart from any other consideration, justifies the importance of the study of children in Assiut.

B. 3 THE LAND

> As the land moans "your spade hurts me" he answers, still stooping "oh, you!" and as she raptures "you have smashed me to pieces" he says with a heart full of the

---

[5]. There is an automatic assumption concerning origin and religion in Assiut. If someone says that they are from Assiut city, and unless they have a clearly Muslim name, they are assumed to be Coptic.

weakness of those in love ".. and who can save me from you and your love".

(Kerdousy 1996: 80)

The love affair between the Upper Egyptian peasant and his land has been immortalized by the prose of Kerdousy (1996). In such poetry and prose, the land that is the object of love is not a metaphor for nation or country. It is the actual fertile land and the magic chemistry with which it transforms toil to abundance.

Assiut has very few industries. The main economic activity in the governorate is agriculture. The major crops of Assiut are cotton, wheat, maize, onions, sesame, beans, and vegetables. The vast majority of residents are peasants who have benefitted from the land reforms of the 1960's which gave the peasants the right to land ownership as distributed by the government and which fixed land rents at a low enough rate to enable peasants to expand their holdings through cheap rent. These reforms extended to peasants a sense of dignity and security from which they had long been deprived (Saad 1988, Brown 1990, Hopkins 1988).

Now there is a crisis in rural Egypt in general due to the impending changes in land laws. The price of land is being deregulated. This effectively means that hundreds of thousands of families will be deprived of the land that they have been farming for decades. Peasants have the first option to buy and so at this very moment, the majority of poor families are pooling all their resources from remittances, gold, occasional activities and savings in an effort to buy even a fraction of the holdings which they already have.

With labour migration in the 1970's came some differentiation of economic activity. The remittances of

labourers created job opportunities for builders, traders, and others who attempted to provide migrants with the services that they could now afford to buy. Fergany estimates that there were two million migrant labourers from Egypt (Fergany in Hoodfar 1993: 114; Weyland 1993). However to date, 63% of the residents of Assiut still work only in agriculture. Even in urban areas such as Assiut city, over 25% of the population are employed in agriculture (Fergany 1993: 37).

B. 4 HEALTH

The health statistics for Assiut show it to be one of the most underdeveloped areas in the country. Table 2.1 compares some basic infant and child health indicators as estimated for upper rural and urban governorates.

TABLE 2.1 HEALTH INDICATORS FOR UPPER RURAL AND URBAN GOVERNORATES

INDICATOR	UPPER RURAL[6]	URBAN[7]
* NEONATAL MORTALITY/1000	41.0	23.0
* INFANT MORTALITY/1000	85.0	33.0
** U5MR/1000	229.0	106.0
** % STUNTING U5	39.8	15.4
** % WASTING U5	6.0	3.0
** % UNDER-WEIGHT U5	18.0	5.7

Sources: * Unicef 1993
** CAPMAS 1993

Looking at each indicator, we find that children in Assiut are

---

[6]. Data applies to Assiut

[7]. Data is for Cairo and other urban governorate.

significantly worse off than urban children. They are at double the risk of mortality and malnutrition.

The governorate of Assiut has long been underprivileged in terms of basic services such as clean water, sewage, sanitation, electricity, and access to health care. International agencies, most significantly Unicef, have been working through the government to extend basic services and to improve the health profile of the governorate. Currently it is estimated that 15% of the population are deprived of clean water and of health service outlets. Eight percent of the population have no electricity (Fergany 1993: 49).

B. 5 "ONCE AN UPPER EGYPTIAN ..."!!

"Once an Upper Egyptian..." is the opening line of any joke about the sa'yeda. These jokes rest on the assumption that Upper Egyptian men are very strong, very dense, and/or very naïve[8]. Villagers in Rihan never deny the humour in their acts of misapprehension or naïveté. Hashem, my host once told me of his now blind old mother and of her first interaction with a transistor radio

> My uncle Sewify brought the radio into our house and switched it on. There was a soap opera and then singing. After a while my mother slipped inside . When I went to see what she was up to. I found her preparing dinner. When I asked her who for? She relied "for all those people in the black box that your uncle just brought into our house!"

Hussein had another 'radio' story about his own mother.

---

[8]. Some examples: Once an upper Egyptian wanted to commit suicide so he swallowed a gun.
Once an Upper Egyptian had a building fall on him so he shooed it away (like one does a fly)

She did not know it works. So once when we left it on and left her alone in the courtyard, she covered it with a basket because she said she had a headache[9].

The villagers of Rihan like others in Assiut are familiar with their stereotypical constructions as propagated by the radio and other vehicles of public media. They refer to these constructions when 'explaining themselves' to others. They reject the negative elements of these stereotypes such as the stupidity assumed of Upper Egyptian men, but not women, but will jokingly yell out at a friend or relative who does something stupid **"dah inta mokhak sa'eedy"** (You have an Upper Egyptian mind).

But villagers in Rihan conform to some aspects of these stereotypical constructions. The most essential of which is the ascendence of the collective over the individual. In the sa'eed men and women are more than themselves, they are their families and communities. For example in the case of blood feuds, when a man is killed, revenge is not sought from the killer, but from the most prominent member of the murderer's family. Villagers have succumbed to the dominant discourse of the urban middle classes and have come to see themselves as seen by others (Abercrombie et al (1980).

Urban discourses on Upper Egypt linger on this negation of the individual without really seeing it. The processes whereby women and men marry families not individuals is portrayed as an example of insensitivity and backwardness. Within my own family the story of an uncle whose father told him one day as he was off to work "Don't be late coming home,

---

9. When little chicks are cackling around, they are covered with a basket to make them go to sleep. His mother did the same to the radio thinking that if she covered it it would also think that it was night time and go to sleep.

your wedding is this evening" was always cited as an example of the funny old ways of our ancestors. However, this uncle did marry this anonymous bride and remained married to her till his death.

What we were not told was that the institution of marriage as practised in Upper Egypt is a family alliance. The woman marries a whole family. The individual personality of the husband is not more relevant than that of his parents and siblings with whom she will work, eat, very often sleep, and who will have as much authority over her as will the husband.

Male virility and female fecundity, both in terms of her fertility and productivity, are key elements to the local construction of gender in the sa'eed. Whether in jest or seriousness, men are proud of their sexual prowess and drive and they also flaunt the productivity of their mothers and wives. "My mother had twelve of us and she never stopped working, even when she was in labour" was the fond description one man in Rihan gave of his now deceased mother. A bride who delivers nine months after marriage is a credit to her husband and his sexual drive, and to her mother from whom she has inherited her fertility. She is also the apple of her fathers eye for having proved her modesty, by being a virgin at her wedding night, and for having proved her fecundity and so lifted his head amongst others in the village.

Much has been made of male preference and of the situation of women in the culture of Upper Egypt. While having a son is the ambition of every man, having a daughter is also a blessing that few would scorn. As Kerdousy explains as he tells of the tragedy of a man who could have no children at all.

Abdel Al died although he would have settled for semi-

blindness[10]; a little girl to carry on his shoulders and whose snot he would wipe with the tale of her dress, and who he would tickle and watch as she rolled on the ground and whose cheeks he would tweak and watch as they turn red and for whom he would upturn his upper lip like a camel yawning .. and who he would tell "tomorrow you will be better than the girls on television" (Kerdousy 1996: 68, author's translation).

These broad contours of the situation and characteristics of the governorate and people of Assiut are an important introduction to Rihan. This village is neither exceptional nor representative of the whole governorate. But it does not exist in a void and its history and current development are part of those of Assiut as a whole.

C. THE VILLAGE OF RIHAN

C 1. THE SOCIO-ECONOMIC CONTEXT OF Rihan

Rihan is a pseudonym for the 'ezzbeh (hamlet in Arabic) where I did my fieldwork[11]. Rihan is one of the small hamlets of the district of Abnube. The town of Abnube is of ancient origin and was called Per Hor Noup or Hat Boubt. It is still a predominantly Coptic town and was called the Abnoub of the Christians until 1890 when it was defined as a district (Ramzy 1963: vol. II, 4, p. 3). Rihan is in the administrative jurisdiction of the mother village of El-Hammam which is also an ancient village that has been referred to in all of the geographical surveys of Egypt as a

---

[10]. This is a reference to a proverb that says 'semi blindness is better than loosing your sight' meaning that it is better to settle for second best than nothing at all.

[11]. For an explanation and discussion of the historical and socio-political genesis and evolution of the Egyptian 'ezzbeh see Saad 1988.

completely Coptic village (Ramzy 1963: vol II, 4, pp. 3-5).

The district of Abnube lies to the east of the Nile and about 20 Km north of Assiut city. Despite its ancient origin and continued survival through the years, Abnube is currently one of the most deprived regions of the governorate of Assiut. Locally it is known as the murder capital of the sa'eed. It also displays one of the worst socio-economic, health and demographic profiles as compared with the rest of Egypt.

The picture drawn by the statistical and demographic health survey collated by Fergany is a dismal one indeed. Abnube has the youngest age structure in Assiut with 24% of the population under six years of age. The illiteracy rate for rural women there is 90% and illiteracy rates in general are the highest in the governorate. Of the 6000 children enrolled in 1991/2 in pre-school education in Assiut, only 100 were children living in Abnube. However of those enrolled 43% are girls indicating that the families who are well enough to attempt pre-school education did not discriminate against their daughters (Fergany 1993: 15 -23; Wahba 1996).

However, primary enrollement in Abnube is the lowest in the governorate, with girls trailing behind boys at 36%. Class density is also the highest in the whole governorate with 43 pupils/teacher in Abnube schools. This reflects the limited number of teaching facilities which may explain low enroll ment. By secondary school, only 27% of enrolled students are girls (Fergany 1993: 26-32).

The activity rate of females in other than household employment is estimated at 1% for rural Abnoub. Employment in agriculture for both men and women stands at 87% (Fergany 1993: 37). Fergany compiled a poverty index with six variables

representing real and monetary indicators of welfare [12] and where 1000 expresses maximum relative poverty. According to this index, both rural and urban Abnoub are the poorest in the governorate with the index for rural Abnube being 921 (Fergany 1993: 55-57).

The argument that distance from urban centres creates deprivation cannot apply to Abnube. Despite its dire conditions, Abnube and its town and villages are well within easy access of Assiut city. Perhaps this proximity is the reason for the districts problems. Out-migration from the district is high. Educated people are lured away by the nearby city.

C. 2 THE HISTORY OF THE VILLAGE

Rihan is a small village by Egyptian standards[13]. It has

---

[12]. The variables in order of importance are
1. Female illiteracy rate
2. Proportion of individuals in households without drinking water from a public network
3. Proportions of individuals without a kitchen
4. Ratio of expenditure on food to total household expenditure
5. Relative drop in the average expenditure per person in household (where relative drop= (Max-value)/(max-min)
6. Proportion of households using kerosene as their only source of energy

[13]. I would like to clarify my use of the word hamlet (**'ezzbeh** in Arabic) and village (**qaryiah** in Arabic: plural **qura**). **Rihan** is officially a **'ezzbeh**, as its original name incorporates the word **'ezzbeh**. However, villagers when trying to construct a discourse

a population of approximately 1200 people. They are all Muslim and are mostly Arab Bedouin in origin. They are from the **'Arab Matteer**, a clan of Arab Bedouins called **'Arab El-'A'sar** who came from the East and settled in Giza near Cairo. Sometime during the last century they moved south and settled in a village, to the south of **Rihan** and which came to be known as **Arab Matteer** in 1906 (Ramzy 1963: vol II, 4, pp. 5).

Villagers in **Rihan** are divided into three groups of families. There are the Sewify who all derive from three brothers. They moved to **Rihan** from **Arab Matteer** to guard the lands of the Copts of Abnube. As one of their progeny narrates:-

> Our grandparents were poor. They were wandering Arabs. They could marry as they liked. My own grandfather married nine times. From each marriage he had many children. Once he married a woman the very day he saw her fetching water from the well. Poor peasants would give them their daughters. Later when they got a bit wealthier from the protection money even not so poor peasants would give them. You see, peasants give women to Arabs but Arabs give their women only to each other. My great uncle married once and had three sons. Two died before having children and one lived on. He has one son. The other two took many women and they filled the world (with children). Imagine, the weight/value of young Mohamed is equal to the whole Sewify family. If our other two grandfathers had met the same fate, where would we be?!

The other kin groups in the village are those of the Moroukh and the Thokala. The Moroukh are the children of one man called Salem Eid who came to **Rihan** with his wife, his father's brother's daughter, from **Arab Matteer**. He had five

---

that mirrors that of the urban middle class will use the word **el-qaryiah** (the village) or **qaryitna** (our village) to describe the geography, history, or other official or impersonal aspects of **Rihan**. The two words are in that sense both correct and interchangeable.

sons and two daughters. They are called Moroukh as this is the clan which their father came from in **Arab Matteer**. They are a small family but are allied and have intermarried with the Thokala, who are the two sons of Omar Thakeel who also came to **Rihan** in search of opportunity.

In addition to these large clans there are the people known as the **'abeed** or 'slaves'. They are dark skinned men and women who used to be camel drivers for the **'Arab el-'A'sar.** There are also a few households of strangers. They are the families of men whose mothers came from the village but had married out but whose children for a variety of reasons had decided to move back.

These first settlers were not of an influential or well known clan of the **Arab Al-'A'sar.** Some describe them as rogues and thieves. They were part of large groups dispersed by poverty, need, and the opening up of opportunities for work and income in the empty desert land surrounding the Coptic cemetery which has become the village of **Rihan.**

The image relayed by their many daughters and sons is one which is alien to the traditional ethnographic wisdom as it relates to rural Egyptians. Women explain, often in exasperation at the inaccuracies recounted by their husbands, that at the time, they were too poor and desperate to care about kin and patriline. These men were married to their fathers brothers daughters when they still lived in **Arab Matteer**, but when they moved their first wives were left in the village. However some of their sons joined them. Fathers and sons began taking wives. They took relatives, but also **'abeed** (slaves), **halaba** (Gypsies), and peasants poor enough to have them; although few will admit to it.

Before settling on the land that is now the nucleated

settlement of the village of **Rihan**, the families of **Arab Matteer**, used to camp on this land at harvest times. Om Abdelwahab remembers these times. She remembers how they would come out here and camp by the cemeteries of the Copts and the adjacent saint shrine and how they would be joined by gypsies who would entertain them at night by making their monkeys dance for them. These gypsies would also de-worm small children, tell fortunes, dance, and perform tricks. She recalls their lives in the tents and the long walks women use to undertake to fetch water .

> We would starve. We did not know rice or wheat flour; just corn flour. We used to cook cracked wheat with goat milk at the time of harvest and often with no ghee and eat. We would add molasses when it was harvest time and there was **kheir** [14]. We did not know tomatoes or how to cook with them. We were even unfamiliar with buffalo milk. The men had their **mokhedirat**[15] now they no longer take it since we have become modernized. I used to walk at least an hour to the nearest well and fetch water in carriers made of goat skin not even in clay pots.

This is how Om Mohamed (Family K), the daughter of one of the first settlers and the wife of Awadallah, her cousin and the father of her 9 children, described their early lives.

Rihan came into being in 1910 as a result of the installation of a water pump. 'Awadallah, one of the oldest men in the village explains that the location of the current nucleated settlement where villagers live is part of an estate that belonged to a woman called Balsam Wissa.

Balsam Wissa was a the daughter of Wissa Boctor Wissa,

---

[14] Plenty/goodness/charity in Arabic

[15]. Opium and Hashish.

who was one of the wealthiest men in Assiut during the 19th century. He and his brother rose from rags to riches through trade and land acquisition (Wissa 1994). Consequently Balsam was rich in her own right. In 1883 she married Akhnoukh Fanous, an educated lawyer from one of the most prominent Coptic families of Abnube. The Wissas came from Assiut city itself.

Balsam owned, along with her husband, much of the land that is now **Rihan**. This is land upon which she installed a water pump thus providing water with which the land was reclaimed. To protect this outlying and promising land she hired, amongst others, the father and uncles of 'Awadallah as guards and servants.

It is not clear why villagers associate the genesis of their village with Balsam rather than with her husband, Akhnoukh. There are three possible explanations which are accepted as being plausible and probable by villagers. The first is that this land was Balsam's dowry from her parents and actually belonged to her. The second is that it belonged to her husband, but that she was in charge of its reclamation and cultivation because he was a lawyer who practised in Assiut and she was from a well known family and was one of the first girls in Assiut to be educated at the hands of American missionaries. The final explanation could be that the land belonged to the Fanous family, but that villagers remember Balsam because many of them were servants in her household and so knew her personally.

Awadallah notes that his uncles and father came to live on this land to work for Balsam and that they were the first residents of **Rihan**. They owned no land but worked as guards and as occasional labourers on her land. But other men from

Arab Matter had been employed by small land owning peasants from **El-Hammam**. They were the night guards and the mercenaries hired by the Copts. They carried arms to protect the land and livestock of the peasants of **El-Hammam**.

Arab Bedouin men were notorious for their raiding and plunder of the lands of Coptic peasants. The only protection that the Coptic peasant and landowner found to work was the employment of other Arab Bedouins to protect their land. Guards were responsible for dealing with raiders. As Mazin explained:

> An Arab will not steal from another and will not steal from a Copt if he is protected by an Arab. It is as though the theft is from the Arab guard and not from the Copt. If a chicken is stolen, the guard will get it back even if the thief is hiding in the heart of the desert.

The guards slept during the day and stayed on the plots that they guarded at night. However, the reputation of some of the guards was enough to keep the thieves away. Guarding was one, if not the main, income earning activity of the Arab Bedouin families in the area. It was lucrative enough to necessitate strict regulation. To maintain good relations amongst the Arab Bedouin families and insure equity in distribution, elders insisted that each family should have an equal share of land to guard. The men who undertook the responsibility had a duty to distribute their income amongst their brothers and dependent kin.

Guards retained a **qirat** (1/24) of each harvest, they were not payed money as such. Some of the Coptic peasants of **El-Hammam** described this protection money as a bribe to the Arabs not to steal and not pay for them to actually protect the land. This agreement of protection is called **hirasah** in the

village[16]. **Hirasah** means the task of protection and the remuneration that derives from it. Land that has been the traditional territory of protection of a particular family remains as such even if it is sold to a Muslim or to an Arab. This land called **ard hirasah** is designated as such and regardless of who owns it, the protection dues traditionally levied on this land are paid.

These guards settled with their families in the village in the 1930's. Mazin remembers how poor they all were when they first came here. If the harvest was wheat or maize, their women folk would use it to bake bread for the whole season. If it was another crop they would sell it to buy food. "The men had their **mokhedirat** and sometimes the women would have to go and do the stealing from the fields to buy food" he said. His reference to drugs implies both their use and their sale. The guards used to cultivate **afyun** (opium) to sell and use.

Rihan is known in the area as the home of thieves and thugs. As one elder from nearby **El-Hammam** reminisced:

> Those Arabs have come a long way. They were thieves and servants. Their children were naked and they all, men and women would marry each other and remarry. When they took the land, they became something. Then they started going to the Gulf and really 'took their breath'.[17]

Villagers in **Rihan** themselves do not deny their notoriety

---

[16]. The word **hirasah** here should not be confused with land sequestered by the Egyptian government after the 1952 revolution and the land reforms that it carried out. **Hirasah** in Arabic is more commonly taken to mean sequestered land but this is not the meaning of the word in **Rihan**.

[17]. 'Took their breath' is reference to an Arabic phrase. When a person takes his breath, it means that he evolved into something important.

and their poverty. They remained involved in the cultivation of opium until a major police raid in the late sixties which landed some of the village elders in jail. Since then, and because of the major financial opportunities of labour migration, they have stopped many of their illicit activities.

But their heritage of being outside the law remains. Hashem explained:

> In the past people were guards. They used to steal pigeons from the rich and run off to the hills on their camels with their wives. Because of their poverty, people used to eat beans in their shells. The ruler would have them chased in the mountains. We used to uproot the zar' of the Christians and have our animals destroy it so as to scare them into hiring us as guards. We had no buffaloes. Just camels and goats. We all used to drink camel milk and live in hair tents. The gypsies used to come in the season of wheat and maze with donkeys and monkeys to entertain us and to do ta'zeem (de-worming) for small children. Burns would be treated with "Qalb el-Taleese" which are the remains of bodies mixed with dew. Because we are Arabs and did not mix with the peasants or the people in the city, none of us had birth certificates. We also don't have marriage contracts. We never went into the army. It is only since my generation[18] that some people started doing these things. For example, I have a birth certificate and I went to school and went into the army and am employed as an agricultural overseer. Because of this, I was able to go to Iraq when the opportunity came. But my older brother and all of my sisters don't exist as far as the government is concerned. And I don't have a wedding contract. I am special, many of the ones much younger than I am do not have any official documents and have not done their army service. Then when they wanted to travel to Iraq and Saudi Arabia they paid thousands of pounds to forge their documents and get a passport. Up to 3000 LE[19] were paid by each man to forge ID's and birth certificates.

---

[18]. He is in his mid-forties.

[19] The official exchange rate is $1= LE3.3.

Om Mohamed and Ni'mat gave further evidence of the climate of poverty and violence which dominated **Rihan**. Ni'mat explained saying:

> I will not name them but you know who they are, well the first blood that happened between them was when the brother accused his older brother that he was not giving him his share of the **hirasah** and threatened to kill him if he did not give him what he owed. What happened was that the older brother killed him instead and stopped any of the others from making claims to his protection money.

Ni'mat was referring to a family who live just outside the village and who are infamous for the blood feud that exists till this day between brothers and uncles.

Om Mohamed cited the case of a neighbour who was slowly dying from a degenerative nerve and muscle disorder. She said:

> He lies there on the ground on his mat in pain and unable to speak because the disease has got hold of his throat. Om Hamada (his wife) lifts him out to lie in the sun outside the house and then they carry him back in. We all hear him screaming and calling out at night. He was a bad man, he stole from his own brothers and would not give them their share of **el-hirasah** and let their children go hungry, and now look at his state/condition.

After the revolution came the land reforms of 1956 and the people of the **'Ezzbeh** found themselves entitled to land. When they had worked for Balsam Wissa, she had donated to them 5 feddans upon which they built their homes. The revolution and its land reforms bestowed them with another 50 feddans. They became the owners of the plots that they had been reclaiming and guarding. It was at this point that they became "more like peasants and less like Arabs" as Om Abdelwahab put it. They began to cultivate and to buy livestock. They built new homes and/or expanded old ones.

Despite this surge in wealth and property, and according to their neighbours they have remained **Arab**. They are

considered to be rough, harsh, unsophisticated, aggressive, and altogether different.

The village is now divided into north and south because there is a blood feud between the Sewify clan and the Moroukh. The Tokala have sided with the Moroukh, their allies. The feud is over a piece of land bought by a Sewify from a Moroukh but subsequently sequestered by the state for the building of a youth centre. The buyer wanted his money back. The seller refused and there was an open fight in which the women joined by throwing stones. These stones murdered a man from the Sewify clan. There was a **solh** (appeasement meeting) presided over by the local police. The Moroukh had to banish one of their own from the governorate in compensation. However, the hard feelings are still very much there and the land lies empty since the youth club has not been built. This feud started in 1981.

C. 3 THE PHYSICAL VILLAGE

Rihan is just off the main road which has recently been extended to join the new eastern desert road that has brought Assiut and Cairo closer and made the drive from the capital of Egypt to the capital of the **Sa'eed** as Assiut city is known, take a mere four hours. Prior to this new extension, **Rihan** was considered to be one of the somewhat remote villages that dot the eastern fringes of the Nile Valley in the region of Abnube and which were built on desert land that had been transformed by successive waves of land reclamation (see Map 3).

All of rural Egypt has witnessed dramatic transformations since the "service taxi" was introduced and succeeded in conquering the isolation to which many villages and hamlets had been condemned and becoming a known and easy method of

transport linking the remotest of places with commercial and administrative centres[20].

Typically travellers to and from hamlets and villages like **Rihan** would have to take a tractor or donkey ride or walk to the nearest public transport stop or station. However the extension of roads, whether asphalt or dirt, to practically all places of human settlement in the delta and the **sa'eed** coupled with the proliferation of "service" taxis has established facility of access and movement between villages and cities in rural and urban Egypt.

In the main station of the city of Assiut, all drivers have licences, Taxis only take as many passengers as legislation allows, and the cars are by and large in good shape. But further out in towns and villages the situation is different. The handsome Peugeot seven seater is replaced by small trucks which have no seats, cars whose make is impossible to recognize since they are in fact mobile collages of bits and pieces of various cars stitched together with wires, rope, and canvas, or vintage models which date back to the 1940's.

In these out of the way stations most drivers do not have a driving license and some are under age. I have often been driven by a 12 year old who operates his father's car. Usually the father starts the car then gets off a few meters from the station and the son takes the wheel and speeds off with many frightened passengers.

Rihan has become an easy destination by virtue of the network of service taxis. To get there from Cairo one takes

---

[20]. Service Taxis are privately owned cars which travel on specified routes and charge a tariff per passenger depending on the passengers destination.

the train to Assiut, a journey of 450 Km and about 7 hours[21]. From Assiut the traveller takes a service taxi from Assiut city to the city of Abnube which is 12 Km away. From there one takes another taxi to travel the 10 km to **Rihan**. This last Taxi does not stop in **Rihan** since the hamlet is too small to be a station. One gets off and walks the 1.5 Km on the dirt road which leads to the small settlement which this work refers to as **Rihan**.

It is a bit more difficult to get to anywhere from **Rihan**. Since it is not a stop or station a traveller from the hamlet has to wait by the main road until a car comes which has room for another passenger. At peak hours, from 7.00 am to 11.00 am and around 4.00 pm to 5.00 pm, many taxis, trucks, and other vehicles can be readily found. Otherwise one may be stranded along the road for a few hours. In emergencies one of the three service taxi owners who live in **Rihan** can be entreated for a lift. Since privately hiring a car can cost up to LE 10 ($3), it is not common and is a measure taken in only medical emergencies.

This hamlet covers a surface area of roughly 8 km sq. and is situated on the eastern side of the Nile valley. **El-Hammam** is the mother village of the **'ezzbeh**; meaning that it is the basic administrative and agriculture unit within which the **'ezzbeh** is situated. The mother village has the agricultural and consumer cooperatives, the village council offices, primary and preparatory school, a flour mill, the social affairs offices, a health unit, a phone booth and the headquarters of the **Omda** (village chief). It also has 3 churches and 3 mosques; for there is a Muslim minority in El-

---

[21]. Time can vary depending on the train one takes.

Hammam.

The village has a primary school but otherwise there are no local government services. There are no health services, no water pipes, no phone lines and no officials. There are a few little retailers/grocers/convenience stores which buy goods from the nearest **Markaz** (town) and which also barter in the village exchanging eggs for salt or kerosene, buying up the ground harvests of cotton from children and giving them sweets, ..etc. Many of these ventures are run by women. Moreover the bartering is invariably done by women and children.

Rihan lies to the north west of the cemetery of the Coptic inhabitants of **El-Hammam** and the saint shrine and church around which the cemetery was built. Buried there is a Coptic holy man. He came to Assiut from the north. To his credit there are many deeds of sacrifice, and bravery the history of which is confirmed and included in the annals of the Coptic church. There are 3 interrelated Coptic families which live on the site of the church.

One of these families is the official church keeper. They have the key to the shrine and they take care of and clean the church. These families do not consider themselves residents of **Rihan**. They are from **El-Hammam** but just happen not to live there. They are seldom seen in the village of **Rihan**. In fact I never saw any of them in the village at any time.

The majority of families live in mud brick houses which usually consist of a number of rooms which vary in their number and size that open out to an unroofed yard. Some houses have their main entrances off the yard. Others have a small front room through which one enters and through which is the access to the yard (see plates 2, 5, 7). Animals are kept in

separate sheds which are part of the house. Small fowls wander the yard by day but are cooped up on the roof at night.

Very few of these old structures have latrines or piped water (Plates 3, 4). Families relieve themselves in the cow sheds or at back walls in the yard. Most of these houses have access to water pumps either inside or just outside the house. They do have electricity in at least the front room. There are a few abandoned houses in the village which belong to families who have moved out to the fields in search of space or to separate from the extended family (see Map 3).

There is no sewage system in the village. Homes with latrines have trenches in which the sewage accumulates. Because the village is built on sandy soil, the ground absorbs the moisture and pits tend not to fill up. Unlike other villages, Rihan does not benefit from the sewage collection schemes run by local councils.

Returners from the gulf have built some cement houses (plate 6). These modern houses have latrines and running water. But a passer by familiar with the Egyptian countryside would be struck by the predominance of mud over cement when viewing the village's architecture. Unlike bigger, wealthier villages, Rihan still looks like a village used to look before the labour remittances changed the landscape of nucleated settlements all over Egypt.

The village is built on the sites of ancient cemeteries. Mazin claims that:

When you dig you find Zila'(urns) with buried children inside who are buried there by magic. How else can they have gotten into these tiny urns. When you break them you find a full body of a child. Once we found the body of a woman with beads around her neck. They are now used to facilitate delivery for a woman whose baby is not forthcoming. They just used them with the wife of el-Baghew.

He substantiated these claims by digging up various chards of , what looked to me like, very old pottery. On another occasion a sarcophagus of a child was found, but left where it lay out of superstition. Because of these ancient cemeteries, healers find it easy to oblige people with any bits of the long dead which can be used in healing rituals such as **mushahra** (see Appendix 4)

C. 4 THE VILLAGE SURVEY

During my fieldwork, I conducted a village survey to help me know some of the general features of the village and its people. My sample was 100% Muslim. [22]

I did my survey in 1/2 of the 180 households in **Rihan.**

TABLE 2.2 VILLAGE SURVEY

TOTAL NUMBER OF SAMPLE	860
TOTAL NUMBER OF MEN	123
TOTAL NUMBER OF WOMEN	139
TOTAL NUMBER OF CHILDREN	598
TOTAL NUMBER OF CHILDREN U5	156
TOTAL NUMBER OF GIRLS	277
% OF GIRLS NEVER IN EDUCATION	57%
TOTAL NUMBER OF BOYS	321
% OF BOYS NEVER IN EDUCATION	20%
AVERAGE FAMILY SIZE	6.6*

---

[22]. I did not include the three Coptic families. They did not want to be in a survey about **Rihan** because they don't consider themselves to be from the village. They are from el-Hammam but just happen to live in **Rihan.**

* 130 families living in 112 households

% HOUSEHOLDS WITH MIGRANTS	23%
% HOUSEHOLDS WITH EMPLOYEES	22%
% OF LANDLESS HOUSEHOLDS	25%
% OF MEN MARRIED TO KIN	69%
OF WHICH ARE FBD	45%

The survey is useful in showing some very general features of the village of Rihan. It shows that families are large. It also shows that many girls are still not taken to school in the first place. It shows that people will choose endogamous marriage when they can. The reasons and explanations for these results are the substance of this thesis.

Only 13% of households are extended. I did not consider families with whom one elderly parent lives as extended ones. Households who had more than one married couple in them were counted as extended households. Some of these households had up to 4 married couples in them. But, household structure and composition is changing and villagers explained that money from the gulf encouraged men to separate from brothers and branch out on their own.

Families who live in the nucleated settlement area are the older folk. Consequently this is where most extended households are. Others who live out in the fields are mostly the young men who separated from their families and built a house on agricultural land, usually bought with remittances from their labour abroad.

The survey confirms the problems of female literacy and education. All of the older generation of women are illiterate. There are some middle-aged women who were put into

primary school for a couple of years then taken out. Some say that they did not like it at school and asked to leave. Others explained that they were so hopeless that the teachers recommended that they be taken out.

To this day some girls are never taken to school. This is the predicament of the first born daughter. She is expected to stay in the house. These girls are usually not recorded and not included in any official documents. They may not be vaccinated because they have no birth certificates. They are a part of the house until they marry.

The low figure of migrants is due to the slump in labour opportunities. Many households had migrants until the second Gulf war. The high numbers of households with employees is not a reflection of male education. The majority of these men are employed as guards, construction labourers, and cleaners. They also mostly work in other Egyptian cities and construction sites in Cairo and on the Red Sea. But the overwhelming majority of men are employed in agriculture.

The survey did not address health issues. Questions about child mortality and morbidity yielded unreliable answers. Mothers do not see the point of questions on mortality. Some would not consider neonatal mortality as a death. "He was barely born" is the reason they give for failing to mention such a death.

D. LAND, LABOUR, AND ECONOMICS IN RURAL EGYPT

Before describing the economic profile of Rihan, I would like to convey some of the current wisdom concerning peasants and their livelihood in Egypt. This is the theory against which I would like to place my own collected data.

In rural Egypt, households are integrated into a profit

oriented system of production in so far as land and machinery as well as profit are essential for their reproduction. Individual households are however the locus of the management of production and consumption. Here is the site where production inputs are articulated and managed by the head of the household. Within the household there is a major and traditional division of labour based on distinctions of gender and age. In this sense it is a structure outside the centralized one of the state (Glavanis & Glavanis 1983; Glavanis 1984; Stauth 1984; Abdel Fadeel 1975).

It is, according to Hopkins, a "coalition of individuals" with varied functions including remittances from labour abroad, part-time bureaucratic or clerical work, part-time farming, child labour, and women' productive inputs in animal husbandry and food (specifically dairy foods) processing. These efforts combine to form a strategy for the sustenance of petty commodity production and in for the reproduction of the household itself (Hopkins 1988: 179).

Since each household develops its own survival strategy, one can understand why there is no "typical" peasant household despite of the participation of all in a collective moral economy. Each group pursues its own efforts for survival in its own way and in accordance with material and cultural resources (Brown 1990: 35).

Both women and children work. Women tend to household affairs, taking care of children, tending livestock and helping out in some agriculturally related activities. Children take care of siblings, herd livestock, take part in harvests and do other chores in the fields and the home (Abaza 1987; Ammar 1954; Ayrout 1963; Blackman 1927; Hopkins 1988; Sholkamy 1990; Zimmermann 1982). The fruits of the labour of

both women and children becomes the property of the household. Since elder male members are usually the "managers" of the household, it is to them that the fruits of labour often go (Hopkins 1988). However, it should be stressed that this is not locally viewed as stark exploitation since women do not permit themselves to conceive of an alternative arrangement. As far as they are concerned all are working for the household to which they collectively belong, albeit with varying degrees of power.

Rihan complies with this model in that household members employ a variety of strategies to survive. Men, women, and children work to be able to sustain their agricultural household mode of production. Households in the village are characterized by what Weyland has called the stability of instability. That is to say that autonomous households are locked in a perpetual struggle to insure their own continuity and reproduction. Their continuity is contingent on their access to land.

Households are forever trying to attain the level of subsistence but are never too far below it to give up. This position is perpetuated by the nature of agricultural production and of rural economic activity. This struggle dictates a continuous search for other sources of income to augment the economic position of the household. It is within these parameters and in this context that migration is to be understood.

Remittances are invested in the purchase of land, animals, or agricultural machinery. This is a case where cash is spent to consolidate the production capacity of households. However remittances are rarely enough to radically change the economics of the household. Consequently they go towards the

improvement of living conditions and to building new homes, buying clothes, and financing some small local projects (Weyland 1993).

Households in Rihan are engaged in this struggle for subsistence. The following discussion will describe economic activity, production, and expenditure, and the experiences of migrants to elaborate on the roles that men and women play in sustaining the household.

D. 1 AGRICULTURE

The main economic activity in the village is agriculture and landholding and rights of use are still the main instruments of social stratification. It has been estimated by economists that the minimum landholding required to support a family of 5 people and to keep them from dropping below the poverty line is 5 feddan. The average land holding per household in Rihan is 1.8 feddan. Table 2.3 shows some basic data on land and its distribution in Rihan.

TABLE 2.3 : THE STRUCTURE OF LANDHOLDING IN Rihan

1	TOTAL LANDHOLDING	170. 45 FEDDAN
2	NO. OF REGISTERED LANDHOLDERS	90 MEN
3	AVERAGE LANDHOLDING	1.89 FEDDAN
4	% OF OWNED LAND	77%
5	% OF RENTED LAND	23%
6	LARGEST LANDHOLDING	8 FEDDAN
7	SMALLEST LANDHOLDING	8 QIRAT[23]
8	% LANDHOLDING < 1.8 FEDDANS	APP. 48%
6	% LANDHOLDING > 5 FEDDANS	APP. 12 %

SOURCE: Agricultural Cooperative registers.

These are the figures recorded in the agricultural cooperative and revised by Hashem who is an agricultural overseer. Ethnographic reality somewhat belies the figures. There were some female landholders registered including Hashem's wife but in revising the lists he quickly pointed out that these were just names and replaced them with those of the men who really work and own the land. Although he is registered as holding just under 5 feddan, he actually has a 2 feddan share in his deceased father's 8 feddan, which are still registered in the dead man's name. In fact it is this dead man who is the largest landholder.

But despite such deceptions and even if one does gives or take a few feddan, the whole population of Rihan is hovering around the poverty line. If we assume that a farmer has an average landholding of 2 feddan of very good land that can

[23] A qirat is 1/24 of a feddan. A feddan is equivalent to 1.04 acres.

yield one harvest of cereals, one of a cash crop like cotton, and a vegetable, then around 48% of residents would be making less than LE 350/month ($100). But this is the highest possible estimate of monthly income from the main economic activity available to a wealthy family.

TABLE 2.4 : ESTIMATED AGRICULTURAL YIELD AND INCOME/FEDDAN FOR 1992

	COST		INCOME		
CROP	CHEM.[24]	LABOUR	YIELD	GROSS	NET
BEANS	40 LE	100 LE	6 IRDAB	900 LE	760 LE
COTTON	150 LE	200 LE	4 QINTAR	1200 LE	850 LE
WHEAT	40 LE	80 LE	10 IRDAB	800 LE[25]	680 LE
MAIZE	80 LE	80 LE	9 IRDAB	540 LE[26]	380 LE
ONION	100 LE	200 LE	15 TON	3000 LE	2700LE
SESAME	80 LE	80 LE	3 IRDAB	900 LE	740 LE
KHYAR[27]	80 LE	80 LE	8 TON	800 LE	640 LE
BAMYA[28]	80 LE	80 LE	2 TON	900 LE	740 LE
TOMATO	90 LE	80 LE	8 TON	1500 LE	1330LE
AUBERG	90 LE	80 LE	8 TON	900 LE	730 LE

SOURCE: Agricultural coop employees.

---

[24]. Chemical fertilizers, pesticides and seeds.

[25]. A family of five needs about 4 irdab a year of wheat for bread so much of the wheat is not sold.

[26]. Like wheat, at least 4 irdab go to family bread.

[27]. Khyar is a small cucumber.

[28]. Bamya means ladies fingers. It is the most common vegetable in Upper Egypt as it is eaten fresh in the summer and dried for the winter.

These figures do not reflect the fluctuations of the newly liberalised market. For example, last year, onions fetched astronomical prices. The ton was sold for 500 LE ($151). The feddan yielded 6000 LE ($1818). Hashem made a killing with his half feddan of onion. He attempted to do the same this year but so did everyone else in the village and prices have crashed. So much so that they have had to go through the expense of trucking their produce to Alexandria to sell it there.

D. 2 Household Income and Expenditure

There is a near strict division of earning and spending in the village. Hussein explains:

The man gets flour, meat, tea, sugar, and his cigarettes. She gets the vegetables, salt, and soap. Also if they have chicken, pigeon, or rabbit, then she gets it. Of-course ghee and cheese, and milk comes from the house, but those who don't have animals, then the woman gets them.

A woman has to generate this income through her food processing and other activities. For this reason, the single most important possession which can insure the welfare of the whole house is a healthy cow or **gamousa** (water buffalo).

A two month old cow or **gamousa** costs 400 LE ($121). If pregnant a cow costs 1300 LE ($393) while a pregnant **gamousa** can cost up to 1800 LE ($545). But the returns on such a large investment make it more than worth while. After one year, the offspring of the pregnant **gamousa** fetches 1000LE ($303). The animal itself is considered a fountain of gold.

After the animal gives birth, its first few drops of colostrum are given to the calf and the rest is baked in small clay ramekins and distributed to the neighbours as a sweet

delicacy. For the first 40 days, the milk is shared between the house and the calf. The calf is used to stimulate milk production and then the milk is taken by the family. Afterwards, an average cow or **gamousa** yields at least 4 lb of ghee a week, milk for the whole family every day, and enough cheese per week to feed the family and make at least 25 pieces which are sold, along with the ghee at the weekly market bringing in 20 LE ($6).

Although the man pays for fodder and pasture, and the children are responsible for the day-to-day care of the animal, this money belongs to the woman. More accurately, this is her share of household income with which she has to make enough good investments to insure that the family survives during the months when the cow/**gamousa** is pregnant. Most women invest in chickens, ducks, and geese. They then raise them, sometimes for the family to eat, and more often to sell both the fowls and their eggs.

Ni'mat explains this practice:

> My sister in law is a bitch! She has filled her arms with gold bangles and has put a gold earring on the ears of her three month old daughter. This is because she refuses her children and her husbands' the chickens, pigeons and ducks which she raises. A woman can make gold from them but most of us just get up and slaughter a couple of pigeons or a chicken to see our children eating and filling their stomachs. Once from just one lot of fowls I bought one string of a gold necklace, 3 rings, and some earrings.

Women do make a substantial and recognized contribution, particularly to expenditure on food. If we follow the logic of micro-economics which claims that the poorer people are, the more they spend on food, then this means that amongst the poor, women are the main contributors to household income

(Fergany 1993).

For example Ni'mat recently sold her last bit of jewellery. In view of changing land ownership laws, Hashem is keen on buying the land that he currently rents. She sold her necklace for 3000 LE ($909) and he promised that he would buy her another one as well as earrings for their daughters. He also promised to take out insurance policies for her, and her two sons. The three policies would cost 24 LE ($7)a month.

But these financial decisions have little to do with household expenditure. While she and the **gamousa** were pregnant, Ni'mat had been spending from the 150 LE ($45) she had saved 60 Le ($18) from her trading in rabbits and 80 Le ($24) from chickens. She had also been selling eggs at 1 LE ($0.3) /10 eggs and pigeons at 5 LE ($1.5)/2 pigeons.

Ni'mat's income generating capital is in the form of:

One pair of breeding rabbits which breed every 40 days (18 days of pregnancy and 22 of rearing). Each pair of offspring is sold for 2 LE ($0.6).
She has twelve pairs of pigeons who also breed. A pair is sold for 5 LE ($1.5).
She has 70 chicks which she bought for 30 LE ($9). If they survive they will bring in 5 LE ($1.5)/laying chicken. She also has ducklings which will sell for 25 LE ($7.5)/a male pair and 12 LE ($3.6)/a female pair.
She has 2 **gamousa** which as she puts it "fill the house with ghee, milk and cheese, and fill my purse with enough cash from week to week". She earns 15 LE ($4.5) from selling ghee (at 4.50 LE/lb), and at least 5 LE ($1.5) from her cheese per week.
She also has two goats, bought at 50 LE ($15) each and who she hopes to sell them for 100 LE ($30)each. The problem with them is that they are both male so when she sells them she will try to buy one female goat.
In addition she has two sheep which she is breeding for slaughter.

Ni'mat's income generating operation is a successful one because, aside from the fodder for livestock which her husband

buys, the rest of the inputs are for free. They eat from their produce and as well as from left-over scraps, they are tended to by her, and are taken out to pasture by her children. Her oldest sleeps out in the fields with the animals after the maize harvest so that the animals can have their fill from the green stalks that are left. Her smallest son and her nine year old and ten year old daughter take out the sheep and goats everyday after they come in from school. In return, Ni'mat spends almost all of the income, whether cash or kind, from the animals on them and their nutrition. In retrospect, I also realize that while I was paying my room's rent to her husband, she was feeding me from her own earnings.

She is exceptional and her family is recognized as one of the wealthiest in the village. But the seasonality of the income makes it so variable that it is impossible to assert that theirs is a continuously well nourished and financially secure family. The hard times are those in between harvests and when the **gamousa** is pregnant. Then there is no produce either from the field or from the house to sell.

Livestock are so important to the well-being of the household that they are important targets of envy (Ghosh 1982: 216). It is little wonder that when a family loses their cow or **gamousa** due to accident or disease, they lament its loss as they would a family members death. Women wail and scream as the body is being carried out by meat merchants. And neighbours and family come to commiserate with the family. When Hassan lost his cow to a vicious disease, the family mourned and accepted the condolences of others.

Mourning ceremony for the dead cow of Hassan abu Kharaba. Aziza, Ni'mat and myself went to pay our condolences. The women of the house were screaming and the little girls were

crying bitterly. The wife was in the animal yard next to the dead carcass wailing. Next to her was an elderly neighbour who was trying to console her saying, it is not dearer than your children! Then a Suzuki car came. They are merchants who come and buy the dead animal. "They are bad people who cheat and sell it as meat" explained Aziza. The three of us, along with Fatma, Abdouh and auntie Salma went to sit in the field so as not to see the horrible sight. When the carcass was being carried out of the house, the screaming reached it's highest pitch and then the house was quiet. On our way back in we heard his wife sobbing next to the wall and so decided to leave and not disturb her any more.
(Fieldnotes).

It is important to remember that peasants in Rihan and elsewhere do not live in rural bliss bartering their produce and drinking fresh milk in the morning. They are engaged in a modern economy which demands cash. Table 2.5 shows the cash expenditure of a family of six persons. It excludes items which are produced within the house. So even amounts included for flour and cereals are what this family has to buy to make up for the shortfall in their own grain production.

TABLE 2.5 : ESTIMATED ANNUAL CASH EXPENDITURE FOR A FAMILY OF SIX PERSONS

	ITEM OF EXPENDITURE	LE/MONTH	LE/ANNUM
	MEAT & VEGETABLES	50 ($15)	600 ($181)
	FLOUR	20 ($6)	240 ($73)
	KEROSENE & COOKING OIL	20 ($6)	240 ($73)
	SOAP, TEA, SUGAR	35 ($10)	420 ($127)
	TRANSPORT	15 ($4.5)	180 ($54)
	CLOTHES & FURNISHINGS		100 ($30)
	SCHOOL FEES		120 ($36)
	ELECTRICITY		140 ($42)

	FATHERS' PERSONAL [29]	45 ($14)	540 ($164)
	HEALTH	20 ($6)	240 ($73)
TOTAL		205 ($62)	2820 ($856)

Source: An aggregate of budgets drawn up with five different families in the village over a period of 14 months.

This conservative estimate excludes private tuition, prolonged sickness and expensive prescriptions (see chapter 8), seasonal expenditures for feasts and weddings, and the costs of daily life for those too poor to have livestock or land. Obviously they lead a more expensive life, even if they do forgo meat, new clothes, and their childrens' education.

The wealthy who do make more than they spend are very few. They are the people, like Hashem, who are increasing their landholding. But the vast majority of people in Rihan are well below the poverty line.

D. 3 The Migrants

Labour migration from Egypt to richer Arab countries has enriched the lives of migrants and their families. However, during the absence of the men, women and children fluctuate between ultimate wealth and sometimes abject poverty. Many women in Rihan had to sell their livestock and/or jewellery to finance their husbands' migration. 'Aziza did it, so did In'am, so did Rawayeh, so have tens of their neighbours and relatives. This has meant that until the husband managed to send home some remittances, these women have had to run homes without livestock or the returns of their husbands' work in

---

[29]. Father's expenditure includes cigarettes and the gifts he has to buy others as part of his role as representative of household.

the fields. They have either lived on benefits from the male kin of the husband or had to work themselves as labourers, albeit in the fields of kin and friends.

When men return, they bring with them savings that go into repaying debts and primarily into buying livestock and land. However they rarely become wealthy. Weyland has argued that labour remittances go into subsidizing the 'poverty of peasants'. She illustrates how these remittances are just enough to maintain the petty commodity producing household unit from dissolving (Weyland 1994).

Rihan certainly attests to this analysis. True, Mazin did manage to buy a taxi after twenty years of hard agricultural labour in Saudi Arabia. His landholding is still a mere 5 feddan. There is the example of Abdelwahab el-Baghwe who also left two decades ago to work as a mechanic in Saudi Arabia and who has built a huge house, bought a tractor which he rents out and married wife number three. But he has done this from his own and his three brothers' savings.

The most significant implication of labour migration opportunities has been to the 'slaves' of **Rihan**. These families are still called **el-'Abeed** (the slaves) and to date, no Arab family has married into them or taken women from them. Their wives are peasant women from nearby non-Arab Bedouin villages. But they are now land and house owners thanks to their toils in the Gulf and in Libya.

It is difficult to estimate the total value of remittances from labour migration for all the households of **Rihan**. But the affects of labour migration are clear for the eye to see. The new houses, the fancy synthetics that women wear, the taxi's that many men now operate, and the electrical appliances that grace some lucky homes are all testimony to an

influx of money the source of which was the very hard labour of migrant villagers.

D. 4 Other Economic Activities

There are very few men with college degrees and who still live in the village. There are two men with law degrees, one is unemployed (he has a father and brothers active in the fields but he has yet to find work) and the other has a law practice in the nearby town of Abnube. Most young men have diplomas. Some girls also hold secondary school diplomas (not more than 10 girls in the whole village).

But even the educated live off agriculture. The village school teachers have land and it is their main source of income. Ni'mat's educated brothers used to live in Cairo but now that her father has permanently moved to Cairo to mind their spice trade and be with his new wife, they have come to Rihan to mind his land.

There are a few small shops that trade in spices, vegetables, sweets, toys, and groceries. One belongs to Kamel who has started making **Ta'miya** sandwiches to sell during the school lunch break. He is making some profit, however this is just a pass time. He is waiting for his army conscription and is whiling away the time. He also depends mainly on the income coming from his father's land which is managed by his older brothers.

Many men in the village who have no land or very little land work as guards or labourers in the nearby government run chicken and cow farms. Others are employed in other petty posts such as school guards, office cleaners, and drivers. The petty commodity producing small farmer household remains the corner stone of the agricultural sector in Egypt in general and Rihan

is no different.

Control over household income and expenditure has an obvious impact on health choices. Healers are paid in kind or in instalments. Modern care and medication need money that women are not in control of (Hoodfar 1988). In her study on budgeting strategies in urban Cairo, Hoodfar makes brief reference to the complete control over household income and expenditure that men have in Upper Egypt. Even in cases where women are the vector through which income is distributed, this does not give them freedom of decision. Moreover, even in urban households where women are responsible for the full housekeeping allowance, it is the man who buys medicine for children and who pays visitation fees (Hoodfar 1988: 127).

E. CONCLUSION

In this chapter I have tried to make a number of points. First I have tried to convey to the reader a sense of what the **sa'eed** is like and how it is viewed by Egyptians. It is our backyard of dark mystery, conservatism, poverty, and neglect. Not only is it such in our imagination, but its vital statistics and health profiles substantiate this view.

Secondly, I have introduced the village of **Rihan** in detail. The following discussions on children, their health, and ill-health need this context of basic facts. The above descriptions are essentially of the conditions in which these children live and in which their health is at risk.

Thirdly, I have described the village and its socioeconomic conditions in a way which would supply a material context for the following discussions of medical culture. This description shows the extent of economic differentiation that exists between households and the nature

of the productive activities of men and women in the village.

The position of the village vis-a-vis the region and the country, of the household in the village context, and of various actors inside the domestic unit; each determines an aspect of child rearing and of issues pertaining to health. The determinants of child health and of the practices of parents vis-a-vis their children are part and parcel of the material and cultural environment of peasants.

The account of the economic and political organization of village life is important because it shows the material, historical, and social context of the village. Rihan is a village unified by its past and differentiated by its present. In my next chapter, I shall go on to discuss marriage and the creation of the family to try to complete this descriptive context of the lives of children and their health.

Plate 2

Plate 3

1

Plate 4

Plate 5

Plate 6

Plate 7

Plate 8

CHAPTER THREE
THE BOUNDARIES OF THE FAMILY

A. INTRODUCTION

Ethnographies of Egyptian peasants emphasis the distinctions between kin and non-kin (Ammar 1954; Ayrout 1963; Blackman 1927; Fakhouri 1972; Harik 1974; Hopkins 1988; Morsy 1993; Rugh 1988). The patriarchal family line is drawn to mark the boundaries which define the social life of peasants. The patriline and to a lesser extent the often intersecting matriline, define conjugal ties, business partnerships, residence patterns, and other relationships through which both production and consumption are organized.

One cannot take issue with this representation of the social organization of life in both upper and lower Egyptian villages, for by and large it holds true. However, the process by which individuals learn and experience these family boundaries is one that is well worth description and analysis. In this way, one can begin to understand questions of choice and selection in the context of the household, family and village. Moreover, one can begin to understand how individuals recognize, sustain, and interpret these boundaries.

How do people juggle the demands of modern life and modern economies and the particular type of, often individualistic, rationality that clash with the necessities of village social structure which promote values of unity and integration? Indeed a main component of cultural, political, and intellectual survival in a village lies in an organised solidarity that prioritises obligations and expectations. The marvellous feats and the contradictions that they thrive upon can best be

appreciated when looking at the personal life of men and women and at the children who exist at the intersection and in the shadows of both the private and the public persona/s of the adults with whom they live.

The ethnography of Middle Eastern societies has posited kinship and marriage rules as the organizing principles of people's lives (Eickelman 1989: 124-34) . In this chapter I shall consider marriage in the village to argue that children are at the heart of social organization and its principles.

Father's brother's daughter marriage is the marriage preference of choice for both men and women in the village[1]. I

---

[1]. I shall not attempt to enter the debate in kinship theory on this form of marriage alliance. In discussing **bint el-'amm** (father's brother's daughter) marriage I am taking the position of Bourdieu (1977). Bourdieu (1977) has proposed the dismantling of the construct altogether since ".. any two marriages between parallel cousins may have nothing in common" (Bourdieu 1977: p. 48). The alliance is not between a man and his father's brother's daughter. It is between two individuals whose actions reference not only their lineage but their affine, land, position in society, and social relationships.

Bourdieu criticizes the very language of prescription wondering if ".. we can make the genealogical definition of groups the only means of differentiating between social units and of assigning agents to these groups without implicitly postulating that the agents are defined in every respect and for all time by their belonging to the group, and that, in short, the group defines the agents and their interests more than the agents define groups in terms of their interests?" (Bourdieu 1877: 32). He thus re-focuses the issue on the practice of individuals of this form of marriage.

Undoubtedly, much of the confusion concerning this form of marriage can be placed at the ethnographers feet. By abstracting a principle from a practice and isolating this practice from its historical and social contexts, genealogists have created an 'aberration' to accepted rules of social organization, and reproduction. For example, kinship charts that only chart patrilineal descent, ignore the essential and critical affinal relationships which are as pertinent to kinship as are agnatic ties (Boddy 1992, Bourdieu 1977). Individuals may be equally related from both mother's and father's side, yet in studies of

shall present individual experiences of patrilateral parallel cousin marriage to discuss marriage in general in the village and to consider the processes whereby the family is created and into which children are born.

B. DESCENT AND MARRIAGE IN RIHAN

B. 1 THE SIGNIFICANCE OF MARRIAGE

Descent in Rihan is patrilineal and residence is ideally and empirically patrilocal. Marriage preference is for the Fathers Brothers Daughter and Son (FBD/S). In fact there are a surprising number of people who are married to their patrilateral parallel cousins. Marriage also cuts across generations with people marrying their classificatory aunts and uncles.

In the old days the inhabitants of this village were too poor and too unruly to be concerned about marriage proscriptions. They kept their women to themselves and added to them with marriage to others. Even in those old and wild days marriage for females was endogamous. But the men married any woman who would agree to have them. As old Ghelmy remembered:

> At the time life was easy. What was marriage? A word with the male responsible for the woman, a silver anklet or two, some food, and the women would bring their own Barazi (the woollen tent set up for the married couple outside the nucleated settlement area) to marry in. When he left her she and her children would live as everyone else did. They would remarry other men. So men married and divorced and the result is this village.

---

societies where FBD/S exists as an ideal, only the fathers side is considered (Bourdieu 1977: 36, 43 Also see Eickelman 1989: 129; Khuri 1970: 610-18, Davis 1987, Murphy & Kasdan 1959; Barth 1970).

Until recently Arabs did not register their marriages. Only when they took peasant wives were they asked to do so. This was due to the mistrust between Arabs and peasant and which made the families of the bride feel that they may not be able to enforce the marriage or extract her rights in case of dissolution of the marriage if they did not have a legal contract to aide them in negotiation with the Arabs.[2] These contractless ties are called Sunni marriages. This used to be the case for all Moslems until official registers were introduced at the turn of the century.[3]

It becomes clear from tracing the descent lines of different household in the village that concerns about marrying from within the patriline came as a consequence of the sedentary life style which villagers had adopted by virtue of settlement in Rihan. The income they got from guarding land and crops and their subsequent acquisition of land and property enabled them to create a pool of cousins from which sons and daughters could marry. In other words, the adherence to the rule of marriage preference for parallel cousins, although a highly esteemed Arab ideal and practice, became more important with the relative upward mobility of some of the inhabitants. Perhaps an illustration would help explain the point.

Ni'mat's grandfather married 7 women and had 10 boys and a number of girls she is not sure of the

---

[2]. Needless to say, not all Arabs married without contracts and not all peasant-Arab marriages were registered. However, the requisition of contracts was one of the ways in which peasants sought to protect their daughters.

[3]. In Islam, marriage is proposal, acceptance, and proclamation ('Ard, qoboul, Ishhar in Arabic). Contracts are the terms of the marriage. If there is no contract, there are no terms but there is a marriage. Official registration of contracts was/is a feature of modern Egypt.

exact number. She can remember 8 of her great aunts. The boys include her own father, her husband's father, her sister's husbands father, her other sister's husband father who is also the brother in law of her two younger brothers and the ex-father in law of her third brother who has divorced her cousin for a Cairene. Her third sister is married to the son of her father's cousin (from his father's side). She and two of her sisters and her three married brothers [4] are married to their patrilateral parallel cousins. The ten sons of Ni'mat's grandfather fathered 48 sons and 35 daughters; excluding those who did not survive till adulthood.

Her mother and father are not related although her mother is an Arab and her grandparents from her fathers side were unrelated, moreover her paternal grandmother was a peasant.

Her daughter is engaged to her own fathers brothers son and her eldest son is supposed to take his fathers brothers daughter but does not want to for personal reasons.

The family prides itself on its ability to intermarry. Constant comparison is made with the other families in the village who are less numerous and so have not managed to achieve an equal number of parallel/cross cousin or other family marriages. As one prominent member of the Sewify family explains comparing his own family to that of the Moroukh who live in the southern part of the village:

> We have many men and fewer women but they, aha, the wonders of God, have many daughters. So we take from them but we do not give them. It is very rare that we give them Sewify women. But it has happened. But this was before we fell out. And so, they have a lot of unmarried women amongst them. It is not only that they have few men, but also because their men take from the outside because by their own admission, their women are bad. They wish that they had enough sons to take their daughters like we do.

---

4. Her 4th brother is still a young boy of 12 and is in school and her step mother has 3 children all of whom are under the age of 7 years.

Indeed, the Sewifys derive a part of their social prestige from the fact that they have enough men for their own women. They can adopt the famed Upper Egyptian and old Arab Bedouin ways of arranging marriages from childhood and so avoiding the anxiety that partner-less girls precipitate.

The second generation of one branch of the Sewify family illustrates this marriage preference clearly. This generation ranges between the age of 56 years and 3 years. Of the 34 men who are married, 17 (50%) are married to their patrilateral parallel cousins. Of the remainder, 5 are married to other cousins, 10 to further removed relatives or to women from other families in the village, and only two have taken complete strangers[5].

For some of the Sewifys the boundaries of the family are almost the boundaries of the village. A male elder proudly boasted: "There was no village, but we brought children and filled the world, and now there is a village."

However, even among this same group issues of personal choice and preference are not absent from the consciousness of individuals. A closer look at the experiences of marriage and of motherhood and at the deliberations and considerations that both involve as well as the communal and personal significance of both roles of mother and wife will illustrate this well.

---

[5]. One of them is a radical Muslim whose bride was chosen by his cell not by himself or his family. In fact, his family only learned of his marriage by coincidence when he was caught and imprisoned.

Women who have married outside the village have been married to kin in Arab Matteer and in cases where they have been widowed or divorced have returned to the village as single mothers (only if they fall out with their in-laws and are kicked out of the household). Women who marry strangers are often surplus daughters who are sacrificed to strangers rather than become spinsters. This is rare but has occurred.[6]

B. 2 NOTES FROM A WEDDING

The bride sat on a broken dikka (wooden bench) for over two hours. She was beautifully made up by her Cairene sister in law whose wedding dress she was wearing. The dress was only two months old so her father saw no reason why his 15 year old and youngest daughter, el-Nina, should buy a new one when this dress was available.

El-Nina is a beauty by village standards. She has fair hair and skin, wide expression-less green eyes, and is quite tall. Her mouth detracts much from her potential as a stunning looking young girl. Her mouth is quite wide reaching almost from ear to ear, yes ear to ear, and is crowded with numerous long horse like teeth.

Yesterday was her henna. She was neither happy nor excited. Actually she told me that she was bored and a bit scared. She wore a shimmering yellow dress and a silver scarf. She sat on the floor surrounded by tens of neighbours and relatives and what must have been hundreds of children. There was much clapping and singing but not a lot of dancing. Her mother, Om Atef (mother to nine children ranging from the age of 35 to 8 years) danced the way Arab Bedouin women do. Despite (or perhaps because) of her huge buttocks and large figure she swayed to the Tabla beat while clapping her hands over her head and lightly lifting one foot and then the other just a centimetre or two off the ground but with such grace that she seemed to be dancing on the air and not touching the ground at all.

---

[6] Providing one does not consider marriages to men and women in Arab Matteer as exogamous since people are marrying Kin.

We went to the house at about 3.00 pm. She was sitting waiting to be taken to her groom and to her wedding. There was singing and clapping as the night before but her mother and sisters, all dressed in their best, looked anxious. El-Nina looked pale and limp as she waited. In the **mandara** (parlour) sat her brothers and male relatives. Her father was not in the village at all. He had been taken to el-Hammam so as to avoid this part of the wedding.

Finally the cars arrived at about 4.00pm. The shouting and running were phenomenal. The ululation was disappointing, the Sewify's claim that they are not good at such things (how Cairene!) so just to make a point I ululated loudly and clearly, Ni'mat was impressed and el-Nina was flattered enough to offer me a well concealed smile.

There were two Peugeot seven seaters and two small trucks. Mansour's eldest brother, Mohamed, had come to fetch the bride. el-Nina was taken in one Peugeot and with her was Mohamed, her mother, Ni'mat, myself, her youngest brother, and three other male relatives. I wanted to give my place up but Ni'mat told me not to be ridiculous since I would have to walk the 3km to the grooms house if I did not go with them since this was not a time when people were going to be courteous,"its a wedding", she explained.

As we rode through the fields there was clapping and singing. The slowly disappearing but strong sun made a clear silhouette of our car as we cut through the winding lanes. I could see the shadows of the three or four men on top of the car and could see their upwardly pointed shotguns as they offered their salutes to the bride and announced our imminent arrival to the groom.

As we approached the house the clapping and singing grew louder. Outside the house there was Mansour standing with his father, and his elder sister and mother, hands entwined, were doing a jig and dancing in front of the house. To the left were seated hundreds of men and boys while the women and young girls were inside the house. As the cars screeched to a swerving halt, the doors were opened, Mansour snatched el-Nina and literally pulled her up to the room that he had just finished plastering days before. He had to fight his way up the stairs because of the crowds. Ni'mat bundled me up along with the rest of the women of the family.

Mansour and el-Nina entered the room and slammed the door behind them. His brother Mohamed barred anyone else entrance with his shotgun. Ni'mat argued,

shouted and screamed. She hurled herself at him, saying let me in you dog, let el-Doctora in but he bluntly refused saying that his brother wanted his entrance to be 'a la mode', only he and his bride would be in the room. Outside the room the singing and the shouting had grown to a frenzy. Youth and children were shouting SALI, Sali, Sali[7]. Gharam was called up and began beating her Tabla and leading the chanting.

The door was thrown wide open, Mansour had a huge smile on his face but he also looked embarrassed. He cast his eyes to the floor as his brother Mohamed snatched the handkerchief from Mansour's hand and rushed past el-Nina's brother thus smearing his clothes with some of the blood soaking the white handkerchief which he carried in his up-lifted hand. Mohamed took the bloodied kerchief and waved it in the air to show all those assembled downstairs. As Mansour went out, Ni'mat rushed in and shoved me ahead of her. El-Nina was crouched in a corner of the small room. She had tears streaming slowly down her face and an expression of pain intensified by the size of her mouth. There was blood on her dress, her panties, a pillow which was next to her on the floor and a tiny puddle of blood underneath her on the ground. Ni'mat wiped her clean and got her to sit down on the floor with her legs apart and her back rested. She took her bloodied under garments and stuffed them in her inside pocket. She took some fresh ones from the cupboard in the room and helped her put them on. The girl was in pain because of her injury. I thought that lying down might cause her less pain but Ni'mat took this of yet another indication of how ridiculous I can be. "How can she lie down, My mother, his mother and all of them will be coming in now." I took el-Nina's hand while Ni'mat shouted out for a glass of sugared water. Ni'mat was mumbling to herself, cursing marriage and what it brings. This all took a few minutes. Then the door burst open and Mansour's sister ran in singing at the top of her voice:

Tell her father if he is hungry to eat
Her blood has poured out and has soaked the sheets.

Then people began to pour into the room. There were women, children and even some youth. El-Nina's brothers came in and kissed her. Her mother looked on

---

[7]. Sali 'ala el-Nabi means praise the prophet but the word SALI is chanted by itself. It means praise/pray.

proudly and joined the singing and the clapping begun by some of the women inside the house. I counted 49 people in the room. They kept coming in through the door and even through the window. A fight broke out between two ten year old boys who were both trying to clamber in through the window. They began prying wooden planks loose from the house and hitting each other with them.

Mansour's sister and mother came in with trays of sherbet for the guests. His sister was encouraging people to come and sing. I was suffocating and Ni'mat noticed my discomfort. The still bloodied bride sat in the middle of the crowd with her legs wide open, in pain and uncomfortable because of the heat and blood. As we left, I wondered how she felt about the people and noise?

El-Nina is a 15 year old girl whose father is one of the wealthiest men in the village. She has lived in Cairo for most of her life since her parents moved there when she was a little girl, however, they did not close their house in the village. Her father has a second wife whom he keeps in one house while his first wife (El-Nina's mother) stays in the other; one in the village and the other in Cairo regardless of which one is where. So she, along with her siblings spends varying periods of time in the village.

She was brought up in Imbaba, Cairo. She never went to school, she does not even have a birth certificate. A couple of her numerous brothers however suggested that she be taken to illiteracy classes. She did very well in these classes and also learnt dress making. She had to suspend all such activities when the question of her marriage came up. She came back to the village with her very Arab mother and began preparations for her wedding.

El-Nina has a reputation for being one of the most eligible girls in the village. She used to do most of the work on behalf of her mother who admits to making her work like a slave and describes how "She used to get up before dawn and start mixing the dough for bread, and then clean

under the animals and make dung cakes, then collect fuel for the oven, all before I even woke up."

El-Nina's two brothers are married to their patrilateral parallel cousins (FBD). The two girls have different mothers, one from Cairo and one from the village. The elder girl is the Cairene who fell in love with her cousin who is a very attractive young man, el-Nina was wearing her wedding dress. The younger girl married his brother because the fathers arranged it. Due to her jealousy of her Cairene sister, and despite or because her age, she is 15 years old, she likes to say that she too had eyes for her cousin.

When el-Nina's brothers "took" their wives, their uncle and prospective father in law made it a condition of his approval on the family's consent to "giving" el-Nina to his 19 year old son Mansour. El-Nina and Mansour had been clutching hands on the landing and sharing mementoes and subtle hints for some years. She had no objections to the idea whatsoever. Neither did her father and brothers. Indeed, once her uncle had asked for her, there was not much anyone could do. She is Mansour's rightful bride to take or leave. In claiming her he had only done the right thing.

However, her family bestow el-Nina with many virtues and talents. They see her as being a perfect bride. She has 'family', beauty, the correct demeanour and disposition, and a reputation for being a very hard working girl. So while no one could deny her to Mansour, they did balk when it came to the details. They did the official signing of the marriage contracts(Katb el-Kitab) on the same day as her brothers got married, but wanted to postpone the wedding for a year. The groom refused and insisted on getting married in August. This was seen as small

mindedness and inconsideration. August is a parched month. People have spent their money and have not yet harvested cotton, the main cash crop in the area. No one has money in August, no one can invite, celebrate, and make the appropriate gift offerings to the newly weds. But he insisted and who can deny a man his legal wife.

The family was completely split on the issue. Many cousins swore that they would not attend. Some said that this was the work of women. His mother and sisters were blamed for this awful timing, but neither he nor his father would back down. Needless to say, when the day came, the celebrations were extensive and much food was consumed. All did attend, and Mansour and his father made their point clear. As el-Nina's sister put it "when you are giving the woman, you are the weaker party". Fathers for this reason do not attend the daughters wedding. It is unbearable for their dignity and for the sake of modesty to attend this event. Indeed, a woman cannot lift her eyes to her fathers until a reasonable period of time has passed.

El-Nina entered into the perfect match. Mansour is a **areeb** (relative) not a **ghareeb** (stranger). He cannot discard her. As her sister explained, if he did not keep her because she is his wife he would have to because she is his cousin. It is also a happy coincidence that they have been "in love" for some time.

Yet this very obvious alliance was never taken for granted and was not free of distress. When I was discussing the issue with el-Nina's sister several month after the wedding and saying that all is well that ends well, she agreed with reservation. They would never forget what a hard time Mansour's family gave them. But what does it matter I asked? Her retort was:

Well haven't you noticed that she has not been to

visit her father's home yet. Mansour is playing hard with her. But she has become as bad as they are. She has not left the house once since they married. She did not come to visit me after I gave birth. She herself says that it is because her own brothers did not let their wives visit their father's house till many months after the wedding. Do you not remember that they did not attend the wedding?! Well even if my brothers did that, she should try to go and see her mother!

Understanding the framework of blood ties against which people make individual choices is requisite for the understanding of the significance of events and of decisions. The linkages are a background against which people live their daily lives. These ties are more pronounced at times than at others. However, when called into play in day to day life they do not act in isolation. In the realm of the mundane, personal likes and dislikes, as well as affections, emotions, bad habits and economic hardships have room to design and structure the interaction of individuals and families.

In the case of el-Nina and Mansour, their match was at once condoned and anticipated by their blood ties, but it was made by them and coloured with tension and obstinacy by their mothers, sisters and brothers. One can argue that all of the details don't really matter since the commonly held general principles and preferences seem to prevail in any case. But to understand parenting, child rearing and the situation of women as mothers, boys as sons , and girls as daughters demands an understanding of the details and a sensitivity to the relationship between structuring axioms and daily life. Perhaps one can even locate the potential for change in these details.

B. 3 BEING A BRIDE

Love, romance, and longing are not alien to the

culture and intellect of peasant women. Young women know how to look at a boy and make him nervous, how to recognize interest, and how to reciprocate it; all within the boundaries of utmost decency. However, young girls see marriage as something that 'happens' to them, not as a step that they take with someone. The issue of a girl's trousseau sheds some light here.

Wafaa once took me into their storeroom to show me something. We are friends and often discuss her fiancé and how she will make him suffer by not saying goodbye to him, "..not even with the eyes", when he leaves for Saudi Arabia. We sat in the darkened room and she took one cardboard box from underneath many which she dumped in the middle of the room. She also took down a battered suitcase and placed it next to the box. "Look, I want to show you my trousseau." Out came pink, red, and baby blue lingerie sets:

My uncle 'Atef got me that one from Cairo, the other was sent to me by Khaled (her aunt's brother in law) from Jordan, his wife did not want it so my aunt took it for me, the third I got when they went shopping for my aunt when she was getting married. They are complete sets with underwear and all. They are silk and they shine.

Then she showed me a stainless steel tray, a pretty glass jug and its sherbet glasses (In Europe they would be called wine glasses), two pots, 9 different pieces of cloth mostly shimmering synthetics, a shoe, and many head scarves and two proper veils like those worn by urban women.

These are things that she and her mother have been collecting over the years. The most prized possession for Wafaa is the lingerie and the glass jug and glasses. I assumed that Hassan, her fiancé had something to do with the value of the lingerie. I was wrong. Yes, she does love Hassan, but "what does that have to do with the lingerie?"

she asked me!

Her mother and aunts and she herself have seen many trousseaus, but they have never seen the frilly underwear with the shine that she owns. She is known to be the owner of such prized items all over the village, and this gives her an edge over the other girls. She is planning to keep the lingerie forever not to wear it, even when she is married so as not to see it sullied or damaged.

Over time, I came to see many trousseaus. I saw those of six brides/brides-to-be and those of some women who have become mothers, but who have kept items of their trousseau unused. Lingerie and clothes (whether pret-a-porter) or material/cloth (cf Abu-Lughod 1990 on lingerie) are the most significant items along with hina and glass objects/utensils that women possess. These items are collected over a long period of time and collection often begins during a girl's childhood. Naturally the groom is irrelevant to the collection if only because he may be unknown.

Lingerie is a luxury that peasant women have come into only since their men began working in the Gulf. It has figured in one way or another in most conversations I have had in Rihan. Mothers in law say of despised wives of their sons "..she wears red and silk as if she is worth looking at", or "..she only had two shirts (petticoats or negligees) when she came into this house, now look what he has gotten her". Middle aged women discuss the lingerie they used to have and what happened to it. Poor women swear that they used to be able to afford buying petticoats from town. Young girls discuss shapes, materials, and colours of those who have shown their trousseaus. Most importantly, rumour about who got what for whom from the Gulf. I remember going to welcome one

of the poorer men in the village upon his return from Jordan. He lives in a house with no electricity and is considered the poorest of the migrant labourers. The next day, his wife came by and wanted to give me a negligee which he had gotten for her. I refused flatly. She then said that he had actually gotten her 5 excluding those for relatives. All in all he had bought 9 sets of lingerie.

Lingerie is seen as the stuff of sexual fantasy. That is why men buy it for their wives. But for the women themselves, wearing it is one thing and having it is another. There is no shame or shyness to it. It is discussed in the fields and by the oven. It is discussed with other relatives who are male. As Ni'mat once said to a cousin who had just returned from Jordan **"inte ya kalb tgeeb lee mandeel we Hashem kan yegeeb likm kolokm qomsan"** (You dog, you only bought me a scarf and Hashem when he was away used to buy all of you lingerie). She was saying it in jest.

The essence and significance of lingerie has little to do with any anticipated intimate relationships or nights of pleasure with the prospective groom. These possessions are symbolic of the onset of womanhood and the independence which will permit the bride to actually covet and own this and other collectibles like glass goblets and stainless ste l trays; all perceived to be luxury items. I find the discussion of the bride's trousseau significant because it is an expression of a meaning of marriage that is not contingent on the man. This is a dimension to marriage that is only relevant to a completely feminine world with its own values and preoccupations in which men figure as assets and as points of distant reference. The trousseau is important to a bride-to-be because it embodies the possessiones which marriage will enable her to claim

from her family, and which neither the groom nor his family will be able to take from her.

By contrast, gold is a different issue. Women love jewellery partly because it is property but also because they enjoy wearing it. Gold is part of the marriage transaction. Very often, women are asked to give it up and they do. As proud as they are of the gold that they possess, it is not as personal as china and clothes. Gold becomes family property in times of crisis. Ni'mat sold the gold she had to help her husband buy a plot of land. 'Aziza sold hers to help fund her husband's trip to Saudi Arabia, Adila sold hers when their water buffalo died, Amina sold hers to pay a debt, Batta sold hers to pay for her daughter's surgery, the list is endless. Some women are more ready than others, some put up a fight, some refuse and are referred to as those who refused to sell their gold. Fancy clothes are marks of distinction which figure in this feminine world. Bright scarves and lingerie are even more distinguished. Elder women compare the smoothness of their black velvet gowns and their black over-gowns since one does give up lingerie beyond a certain age.

B. 4 MARRIAGE AS SECURITY

Men and women choose, or wish, to marry patrilateral parallel cousins because marriage is not just a way to consolidate wealth, control women, or compete for power (Barths 1970, Bourdieu 1977). Marriage is a route to personal security and to the creation of a secure environment for procreation. This becomes evident when analysis transcends marriage and looks at married life, specially from a woman's point of view.

Children make or break marriages. Procreation is the essence of marriage and should not be absent from the

discussion. Islam determines descent through the father hence the predominance of agnatic links. But the mother and her family also count and affines have an important cultural role to play in the lives of children. The romance of the mother and father rearing their own children in their own way has yet to delude villagers. Children are born into households and into families. Marrying close means knowing who the extended and very influential kin of sons and daughters will be.

It makes sense for both men and women to be safe in the knowledge that their children will be born into a known and secure network. Choosing the mother of the child to be is an implicit choice of a future head of a household. For many new brides of today are the matriarchs of tomorrow. Most men would choose to marry a patrilateral parallel cousin, if an eligible one existed, so as to consolidate the heritage, if not the inheritance of their children.

Marriage is also a source of security for women Aziza explains:

> You get educated and when you finish you have the guarantee of your job that gives you a monthly salary. Here our guarantee is our children. If a woman has no man her brothers won't let her starve but they have wives and families too. With no children a man can throw her out but not if she is his blood and has no where to go. Even if he is made of stone he could not throw out his own blood. Of-course you never know and we hear of all sorts of things happening these days. As Arabs we have many divorces and marriages but now people have hardly enough to feed their families and no one can afford a divorcee/single woman. No, marriage is the way for women.

Aziza talks of marriage, marriage to kin, the children that result and the economic and social security they extend to the mother as one thing. By and large these things are interconnected. They are the perfect benefits which a mother aspires to see her daughter enjoy. However, this clear design and the security that it extends does not negate the individual concerns of girls and of families

upon venturing on a marriage agreement and celebration.

The historical meaning of security has influenced choices of marriage partners. Labour migration to the gulf resulted in fathers refusing parallel cousins and opting for distant relatives with contracts in Saudi Arabia. Dramatic socio-economic change and urbanization led to many parents preferring a rich **ghareeb** to a poor **areeb**. But in **Rihan**, security still meant blood ties that created respect and a welcoming home.

Often cousins are like brother and sister before they marry but as the saying goes **illy yetkissef min dem-oh ma-yekhlefsh** (He who is shy of his blood will never have children). Indeed, some divorces are explained by the man's inability to approach the woman because he feels that she is like a sister to him. This is an extreme case which has been known to happen, but families try to protect their children from such mishaps by separating cousins who are eligible from quite an early age.

It is well acknowledged that close marriages do not always work and there are even some notions floating around concerning the development of genetic defects when successive generations of cousins intermarry. But there are considerations other than those relating to the marriage partner. For a woman, marrying a stranger can be a dangerous bet. Women in **Rihan** know that they can consolidate but cannot forge alliances. A woman who marries a stranger cannot create an alliance with his family. At best, she can offer only herself. In case of divorce, she is not entitled, even to her own children.

Batta, for example, lives with her mother and daughter since her divorce. She had married a stranger from Arab Matteer. He is a drug addict and has abused her to the extent that she asked for a divorce. She had a daughter and son by him. His family took the boy and refused to take the girl.

> He is a stranger. I have no leverage over him except by the courts but I cannot go to court, his family would scandalize me and my mother. Now he pays me nothing. I wanted him to take the girl too as I can't feed her but he won't. His mother said, the boy belongs to them and that I can take the girl since they do not want her.

If a tie already exists between the two families, a daughter's marriage can consolidate this tie. But a woman cannot be a link between families who are unrelated. Consequently there is very little security for a peasant woman who marries a stranger.

In Rihan affinal ties are recognized but only if they exist against a background of agnatic ties, even if distant ones (for Sudan see Boddy 1992). Such ties known as uterine links are highly regarded and are seen to create affections and intimacy between people who are thus related. They also create an alternative marriage pool for men and women. Women play an important role in structuring the pool of marriageable partners not just through marriage, but also through breast-feeding. Fostering of children through milk ties, which make marriage impossible, is a means for women to regulate marriages (Khatib-Chahidi 1992: 109; Altorki 1980). Marriage in general has been portrayed as a male concern, but the role of women in structuring incest and thereby defining legitimate partners is of great importance[8]. While this point does not relate to FBD marriages per se, it is an important silent ingredient in the construction of marriage and marriage preferences.

The marriage of a daughter is both a blessing and a loss. Once they are married off, they really do not belong to the father's family any more. This is no less serious for those marrying a cousin. A woman's labour belongs to

---

[8]. Islam prohibits children who have been breast fed by the same woman to marry.

her new home. She must keep their secrets, be prudent when it comes to their belongings , food and animals, she must be very clear as to whose household she now belongs. But keeping women within the family is judged to be better then letting them disperse.

Young girls know that they are headed for marriage, and some of them do not relish the idea. For them it means going to live with another family, having children, working very hard, baking and breeding animals, and a departure from home and the life they have always known. Marriage for a woman signifies departure. She is leaving her family, hopefully for good. She must therefore be assured of a dignified reception and place in another family, and who would take better care of her than her own kin?!

A woman who marries within the family is assured a bottom-line in terms of dignity and fair treatment. More importantly, she is assured a place in her own patriline. Because girls are viewed as belonging to their husband's family, and not their own, they are often treated as strangers within their own homes. The saying has it that **el-banat marbat-hin khaly** (The stable of women/girls is empty). In other words, you cannot rely on a girl giving returns on her parents' investment in her future. One cannot, when poor, afford to invest in girls as they leave home and join their husbands. His and his family, their problems, joys, sorrows, responsibilities and projects become hers. And "..when they come to tell her that her father has died she goes to scream at the grave and then returns to her husband's home, fills her belly with food and forgets all about the dog who died", said one man who has 5 daughters.

A girl who marries into her own patriline reconfirms her own ties to the family. She also remains amongst her family and friends, and she keeps her children close to their maternal kin but, more importantly, they become part

of her own patriline.

If a woman marries out she has fewer guarantees. She may be lucky in terms of her husband loving her or even by just being a good man who will take care of her. She may be un-lucky and in that case she can only rely on her kin to argue her case if the need arises. Alternatively, her security may lie with her children and in the role of "mother" not that of "bride". Over time, and as she grows older, she may become completely estranged from her paternal kin.

Perhaps people do idealize FBD marriages because married life, divorce, polygyny and above all procreation are present in the mind and the imagination when marriage looms on the horizon. The contemplation of these potentials is not confined to men. Women have a role in choosing to be chosen as partners.

The dry and abstract concept of FBD mistakenly relays an image of dry and abstract act of consolidation and alliance (Bourdieu 1977: 43). In Rihan the most passionate of couples were direct cousins. At least they had a chance to know each other before marriage. Sexual encounters between engaged cousins are not unknown. Couples had time and space to nurture love and compassion. A luxury un-related couples in rural areas cannot afford.

Kinship as an abstraction of an official representation that is only valid in particular situations is not really helpful in understanding marriage preferences, how they structure society, and the functions that they perform in maintaining and reproducing it. Perhaps at one level FBD/S alliances exist as a 'white lie', as Bourdieu calls it, that serves to re-affirm gender and the sexual division of labour by completely denying the role of affine (Bourdieu 1977: 43-4). But this view ignores the fact of women as marriage partners and sees them only as representatives of a group of affines. In accepting to

marry their patrilateral parallel cousins, women in Rihan are not forgoing their affines; they are securing their agnates.

Marriage is also a life-step, what could be called in the context of modern European discourse, a career move. It has profound implications for the personhood of the woman and all its individual manifestations. Marriage is important and marrying close is a calculated tactic even at the personal level. Marriage is getting a husband and access to children, status, a different position in another house, and in many cases it means re-admission into a network of mothers and of grandmothers, but as a married woman.

The importance of close kin marriage is a testimony to the importance of kinship to social life. Security, identity, and the future still lie within the folds of kinship. Men and women do not only marry cousins, they also vote for, work with, migrate to and invest in kin. The continued advocacy of the FBD marriage and close kin marriage in general, also indicates a lack of trust in modern social indicators of status and of security. Despite the ascendence of money, moral righteousness and education as markers of status and as desirable assets the importance of networks of kin remains the mainstay of social relations.

The individual is an unreliable partner, the group is a safer bet. Marrying close consolidates the group but it also assures both parties in the marriage that their alliance is guaranteed by their co membership and their equality within that group. This provides the couple and their children with protection from the outside and with the language and rules with which to communicate within their group.

This does not mean that social ties are stagnant or conflict free. On the contrary, brothers fight and cousins

can become worst enemies. People are not denied the frustrations and tensions which clutter social relationships. But maintaining consolidated patrilineal descent which women play an important role remains a way by which many people want to define, negotiate, and live in society. Children are a part of this mesh of meanings and its implications. In this context, one can begin to discuss the social world of girls and boys.

C. RECREATING THE FAMILY

C. 1 CHILDBEARING

> Khadra swore that she had a big argument with el-Ghazaly last night. He got so angry with her that he swore that come the feast he would take on another wife. She is his third and he is her second. As Khadra told of their argument Aziza replied "**heya el-mara laha iyeh gheir awlad-ha**" (of-course he would do it, a woman has nothing but her sons/children").[9]

Indeed, what does a woman have but her sons/children. In fact, come to think of it, what does a man have but his sons? Fertility and child bearing are the most significant faculties that women and men possess. Aziza explains:

> Of-course children are a blessing. What would life be like without them. Many a time women have almost lost their lives, lost their minds, even almost lost their religion just to see the nail of a child. This is why God created us and it is he that creates children. Here we say **al-ab ye'sseb wa al-om ma'oun we faragh** (The father connects progeny and the mother is a vessel that is emptied). It is a poor woman indeed who does not bear children, but women must never lose hope in the ability and will of God.

The centrality of fertility and of child bearing to the

---

[9]. The word **awlad** comes from the root **walad** which means boy. But the word for delivery is **wilada**. Generally, **awlad** is used to mean children but in rural Egypt it usually implies male children only. A classic misunderstanding occurs when urbanites ask women how many **awlad** do you have, meaning children, and she replies 1 meaning that she has one son although she may have 5 daughters as well.

life of men and women in Rihan, and all over Egypt, and their vehement pursuit of parenthood are only tempered by a deep belief in God and the many ways in which God challenges his believers. So if a woman falls victim to infertility or to the inability to bear boys ideally she should not be persecuted because of it. Many will argue on her behalf that it is the will of God which human beings should not challenge. However many men do seek other women if their wives are infertile. This is explained as being a "Qilit Iman" (dearth in religion) but this harsh pronouncement is abated and complemented with "but what can a man do, does he not need children, maybe he will be lucky with another woman"; and other expressions of understanding and empathy. Moreover when a man has many sons and takes on another woman just to have more this is referred to as Tama' (Greed). Not only is fertility pursued and celebrated, but its rewards are almost immediate, specially for women (Morsy 1981b)[10]. These rewards begin with seemingly trivial issue connected to health, both psychological and physical, to real issues concerning property and long term security.

When a new bride becomes pregnant the issue is not publicised. Mayza, for example, became pregnant 3 month after her wedding. She is 18 years old. I was the only one of the women I knew who considered her pregnancy an event. Her in laws and relatives treated it as a matter of course. When she complained of morning sickness and pains she was usually told to shut-up by any female members of her family who happened to be around. If she did not, she would hear a profusion of comments to the effect that she "..is not the first or the last to bear a child"; "..first babies are always difficult but that never stopped anyone having

---

[10]. For a comparative perspective, see Aijmer 1992; Kay 1981; Chalmers 1990; Kaufert & O'Neil 1993; MacCormack 1982.

them"; "pregnancy is not a cause for complaint"; "did you think that you just lie down next to him (her husband) and that is it!" and many other formulations of similar meanings.

Moreover, the mere thought of pre-natal care was met with consensus as to my eccentricities. It is basically not done. Specialists, whether they are local midwives or government health professionals can confirm pregnancy but have no role to play except in termination whether by abortion, miscarriage, or delivery[11]. Out of 10 women whose pregnancies and deliveries I attended while in Rihan, not a single one had received any pre-natal care. There was a time when some basic food supplies were distributed to pregnant women. This did encourage women to frequent health centres but since no such distributions were made in 1991-3, none of these mothers-to-be felt the need or saw the benefit of pre-natal care. The only possible exception is the case of tetanus shots for mothers. There are mobile vaccination units which vaccinate women but mothers are pretty erratic in making use of this service.

There are suspicions as to what these tetanus shots do. They "..cannot save a life because only God can do that" several women explained. Maybe they make women stronger, maybe they cause miscarriage, maybe they are insipid contraceptives, who knows?! But since health centres require that mothers take these shots in order to register births and issue birth certificates, women tend to take them. Others refuse completely often citing the story of a woman who is said to have taken the pill so as not to get pregnant, but did deliver a baby who was missing the fingers of one hand on which was written "Ana khalakt we

---

[11]. By specialists I am including traditional birth attendants.

inte kamil" (I have created now you complete the job) and in the other hand the baby had a pill. It is surprising that this story is quoted in connection with tetanus toxoid shots which is not a contraception, but the morale of the story relates to the dangers of drugs during pregnancy.

Women in Rihan feel that they do not need to be told 'how to behave during pregnancy'. Their one extravagance is el-waham or cravings. The popular belief is that women suffer from el-waham and so crave food-stuffs. If their cravings are not satisfied the baby will be born with an imprint of the thing that they craved but did not get. Amongst the Cairo elite, women crave Maron Glacé or rare fruits which the husband dutifully gets. In Rihan, women generally crave salty things which are not difficult to get. Husbands acquire the craved food-stuff to satisfy the wife, protect the baby from birth-marks and to prove their love, devotion, and tolerance. Mayza craved salted fish which was difficult to get at this particular time of year, but her husband , Hamed, did get her some from Cairo. In the case of women who have delivered many times before craving is less of an issue and the more children they have, the less concerned husbands are about cravings. Many women (three out of this sample) craved mud and clay. Some crave gypsum. All three are important sources of iron, minerals and calcium. One woman told me "Last time when I was pregnant with 'Amr I crunched my way through nearly a whole clay water pot".

Pregnancy is cause for apprehension if a woman has a history of miscarriage or if she has had new-borns die frequently. In such cases, women pursue several courses for therapy including begging from people so that God gives her or "begs unto her" a child. Women also make amulets which they carry in their clothes or sew into a pillow to make the new born live (see chapter 6).

However pregnancy itself is subduedly received with

hope and with fear of complications. It is a very good thing to happen and cause for relief, but the baby and its mother, once the baby is born, are what is celebrated and protected. First time mothers, like Mayza, have much to look forward to. Once the delivery is behind them their rewards begin. First, they are given the illustrious title of "Om" (mother) followed by the name of the first baby. This title is carried with pride. Now she is a real OM. Until giving birth a married woman may be called OM of her own father. So for example I was called Om Mohamed because Mohamed is my father's name and partially in anticipation of the boy that I might have. Women who keep trying to have a child, but fail are called **Om el-Ghayeb** which means mother of the absent one (for Alexandrian women, see Inhorn 1994).

The name **Om** (mother of) so and so is the first thing that a new mother hears when the woman who delivers her usually says "Thank God for your safety, you have given birth to a boy Om so and so". The name of the first boy is never a mystery. It is the name of the husband's father unless there are other grandchildren bearing that name, then the woman may be called **Om el-mawloud** (mother of the newborn) until after the seventh day ceremony when a name is chosen for the baby. Modern couples such as Mayza and Hamed may have already picked a name before she delivers.

If the first born is a girl the mother is also called Om followed by the girl's name. This, of course, does not have the same ring to it and is often done just to make the mother feel better about herself and to celebrate her motherhood regardless of the gender of the baby.

Following the name, the mother is given a sweet mixture of molasses, ghee, and water which is called **Foura**. It is drunk hot almost immediately after delivery (Morsy 1981b; for Iran, see DelVecchio-Good 1980). The baby is taken, wiped clean, given a few sips of sugared water to wash down any hormones/fluids retained and is then given to

the mother. The baby is not put to the breast immediately since colostrum is generally perceived to be too heavy/fatty for the new-born. However babies are put to the breast soon after delivery to initiate lactation. The word for initiating lactation is **tihin** which literally means softness and compassion. In this context **tihin** means the flow of breast milk which is the bond now between mother and child. This is called 'let-down' in English.

During the first week, a first time mother must eat of everything. This is quite a reward for women who are usually the last to eat, and in a community where choice morsels and titbits are always saved for men and for children. But a first-time mother must have milk, ghee, meat, pigeons and other fowls, vegetables and greens, sweets, and fruits. This has nothing to do with energy or strength. This closely observed practice is to protect mothers from fever and sickness the next time they deliver. If in their next post-partum they eat anything they have not had before, they will develop fever and colitis and no one, not even niggardly mothers-in-law, will risk that.

During the first 40 days, but particularly the first couple of weeks, a mother must not go through the trouble of dressing up or putting make-up. A mother must not look in the mirror for a week until the **Sebou'** (seventh day celebration). She must also not make herself look pretty. These are things which anger her sister spirit **tabi'a**. And when angered, the sister spirit may take the baby, make it sick, or disturb the flow of breast milk. The father has also a role to play. His happiness angers the **tabi'a** and so for 40 days he must not let his gaze linger on the baby his child. This one of the few instances where fathers are enjoined in protection and in being asked to heed the health and concerns of mothers. Most significantly, mothers must not be caused any anguish or grief (see Chapter five).

C. 2 THE BIRTH OF A GIRL

The birth of a girl is never lamented. First for religious reasons : "It is god that sends not we who create. Can anyone create a finger nail"?! This is a typical retort. But, in the case of women who are still young/ish, older mothers will say cheerfully that her **nassib** (lot or share but more accurately fate/destiny) remains. "As long as there is one boy to keep the house open, then whatever God sends is a blessing." One grandmother said as she fondled her new born granddaughter (who was 30 days old) " You, You will enliven a home and bear boys", and laughed at such a distant but wonderful prospect. With the birth of a boy, a mother acquires status. With the birth of a girl, she is assured of her fertility and she can go on trying. And it is always made clear that girls are "**'atiyet rabina**" (gifts from God) a are cherished as much as boys are.

Aziza is a case in point (family C). In February 1992 she had another girl. The baby was delivered by Aziza's mother and aunt. Her grandmother from her fathers side decided to call the baby Karima after her own eldest daughter. The father was absent abroad and when they found it to be a girl they felt no urgency to wire him with the news.

When I went to see 'Aziza, a few hours after her dawn delivery, she was lying on some mats on the floor covered with a tattered quilt. Around her were two of her sisters, her sister and mother in law, her aunt and her cousin and neighbour. Her daughters were being chased by their aunt who wanted to bathe them. "Be gentle and let them wear what they want" 'Aziza shouted out to her sister in law. Then she explained to me that they had both been there when she had delivered, and that they had become very nervous and the youngest was frightened.

I had anticipated 'Aziza's worry because her new born

was not a boy. Her mother-in-law told me that she is young and that there is still hope for her to bear Ibrahim[12]. She added that 'Aziza was very tired and quiet because girls are always more difficult to deliver than boys. They are heavier, gestate for a longer period of time, and take time to deliver. This is an observation and a belief that is commonly held in the village. Mothers say "I had an easy delivery although it was a girl", as Ni'mat told me when she had her latest.

Aziza was also suffering from post partum pains known in Upper Egypt as **om el-khawalef** which means mother of those who deliver. They had sent for some pain killers which are called the **Om el-Khawalef** pill. Actually it was an anti-spasmodic. **Om el-Khawalef** has nothing to do with the gender of the child. It is something which most women get and which is made more severe if post partum blood is delayed. Aziza's mother however had an explanation which was condoned by three of the women present and rejected by two. She said "Perhaps when Aziza was sitting on the bricks and was told that it was a girl she held in her blood out of disappointment!"

Aziza was disappointed but thankfull that it was over. She was also proud of her beautiful baby daughter which she began to feed by the next day (plate 9). "Raggab won't throw me out", she joked several months after her delivery, "he is not exactly a millionaire to need an heir". Aside her mother told me that Raggab and Aziza are cousins, he will not harm her. If anything, it is Aziza who comes from the larger and richer part of the family. The fact is that despite this being her third daughter, there was a sense of disappointment, but not panic.

Sakina, on the other hand, has also failed to bear her

---

[12]. Ibrahim is the name of 'Aziza's father in law who died 3 years ago.

husband a son. Despite the fact that they are un-related, he has refused to repudiate her. They are very much in love and her husband has said that on no circumstances will he give her up. To appease his family, he has taken on another wife. But not only has he kept her, but as she puts it: "He is only trying to get the boy from me, he hardly looks at the other wife". Sakina was proudly boasting of the rate of their lovemaking.

C. 3 THE SIGNIFICANCE OF SONS

Women who have no sons also have no property, no home, no family, and no source of income. El-Ziniyeh has only daughters. She lives alone in a small mud house. Her daughters are married. One is in the village and the other two are in Arab Matteer. They are all married to Cousins. El-Ziniyeh used to work even when her husband was still alive. Her three brothers are perhaps the wealthiest men in the village; predominantly because they have been working in Saudi Arabia for 20 years and operate a thriving business in visa procurement for others. Because of this elevated status, they have stopped their eldest sister, el-Ziniyeh from working. She used to sell eggs in the market and run errands, sell, and shop for other women. Her brothers have ordered her to be discreet about her activities.

El-Ziniyeh was pointed out to me as one of the poorest women in the village and one who leads a wretched life.

> What can daughters do for me. When I visit, they get worried that I will upset their mothers-in-law. As for my brothers, well brothers give their kheir (goodness) to their wives and a bit of meat and their ghadab (anger) to their sisters. If I had a son, wouldn't his knock on my door and his entrance be like an angel stepping through the gates of heaven?!

As she spoke, Karima told her "Don't make it worse for yourself, don't lose your religion now". Women like her

really have no source of income except what they get from their work and the pittance of a pension which they receive from the government which is called the Sadat pension[13]. Om Zeinab is in the same situation only she has one daughter who is married in Arab Matteer and no brothers. There are another three women without husbands or sons in the northern part of the village. Ni'mat explained that they are the ones who really deserve charity. During harvests, people send them crops that they eat or sell. They also go out to work as day labourers during harvest times. Then they go back to the field at the end of the day and pick any left overs.[14]

Such is the lot of widows who have no sons. This is partly why fertility and male children are more than requisites of the social order. In their day-to-day life, women bear their burden and feel the pain of their problem. They also pay a clear price. With children, and especially sons, women create families in which they have an elevated status. This transformation bridges the personal and the structural/formal aspects of their lives.

D. CONCLUSION

In this chapter, I have presented a discussion of the principles which affect marriage and the creation of families in **Rihan**. The chapter discusses patrilateral parallel cousin marriage and other endogamous alliances since these are the marriage preference held by villagers. Through analysis of the ethnography, I have tried to make three points. I have argued that marriage is meaningless if not contextualised in married life and in the creation of family. Secondly, I have demonstrated the meaning of

---

[13]. Now it is 6LE/month ($1.80)

[14] This practise is known as **al-sayf** and is particularly lucrative at the cotton harvests (see chapter 4).

marriage from a woman's perspective to illustrate the importance of women's experiences in the creation of alliance and family. Lastly, I have highlighted the centrality of children to social organization and to questions of marriage preference.

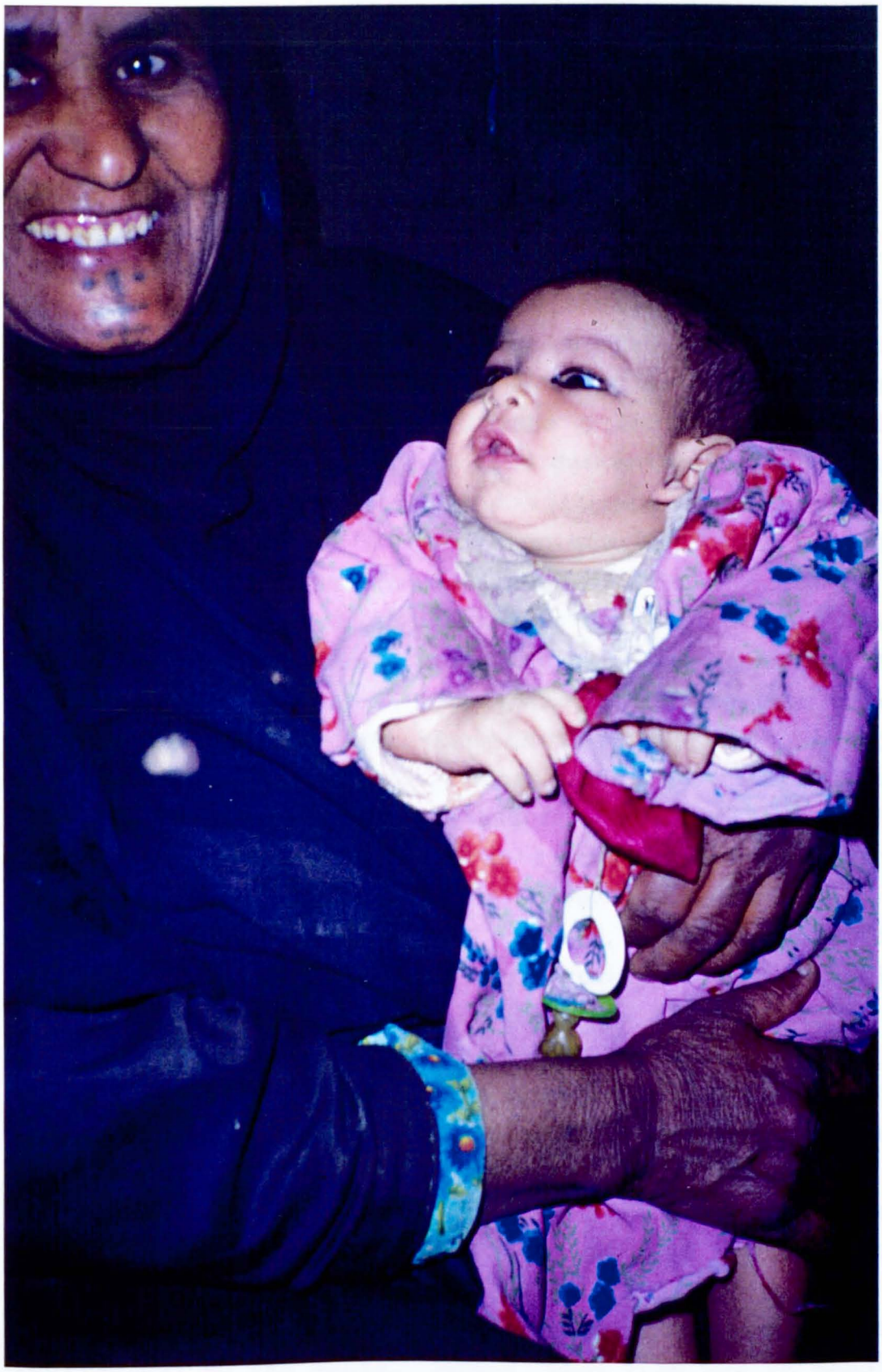


Plate 9

CHAPTER 4
CHILDREN IN THE FAMILY

A Introduction
A. 1 Who are Children?

In Rihan as is the situation elsewhere in rural Egypt, children are not separated from social life. Children constitute social life in their capacity as individuals and as social actors who consolidate principals of social organization, extend identity, and guarantee the future and security of their families and village. In villages all over Egypt, it is not the children who are known by their family's name, but the mothers and father's who come to be identified as abu (father of) and om (mother of) the child.

When historians and social theorists describe 'The construction of childhood', they are in fact telling us who society and culture describe as children and how this description is formulated (Fernea 1995: 4-7; Aries 1962; DeMausse 1976; James & Prout 1990: 30-5; James 1993; Winn 1984). Debates around children's rights and children's wrongs are discussions of different constructions of childhood (Freeman 1983). For example, legal systems, and the moral and social codes which produce them sanction different degrees of child labour (Fyfe 1989). Whereas in the modern west no degree or form of children's labour is tolerated, other societies accept agricultural and household labour while still others tolerate enslavement (Reynolds 1991).

In Rihan children are distinct and differentiated. Their gender, kinship, position in the family, and their unique characters render them as social beings and not as anonymous members of the institution labelled el-tofoula (childhood) by the media. Hence, when they are in need of protection, therapy and care, they are treated not as

simply members of this 'institution' of childhood, but as the men and women that they will become and as the boys and girls they are.

This chapter will attempt to give a child-centred and child-sensitive account of the local understanding and experiences of childhood in **Rihan**. The focus here is on children in the context of their relationships with each other and with their families. This is the chapter where children make their strongest appearance since in most of the following chapters they are too unwell to participate.

I shall try to describe the world of children in **Rihan** so as to create a bridge between children's lives and children's health. In this chapter, the expectations and experiences of children, when healthy, are presented so that the reader can appreciate the full meaning of their experiences and those of their families when they are not well. The chapter contributes to the known ethnography of Egyptian village daily life by establishing the active participation of children in the creation of social life. Their social roles are important to this discussion of ill-health, health, and medical culture.

I argue that children in **Rihan** have a presence and a present essentially distinct from their anticipated future, and from the issues of socialization and becoming. They have a role as children not as mini-adults or as tomorrow's villagers. They therefore have obligations like everyone else and they have rights which they may or may not enjoy. Unlike their construction through the international discourse on childhood (Boyden 1990), children are not sacred, but they are very dear.

A. 2 Working with Children

Anthropologists have found it hard to work with children (Reynolds 1991; 1986; James 1993; James & Prout 1990). As far as the village ethnographies that I am familiar with are concerned, "children" are often

considered as outcomes of or inputs into processes of social organization. So we know of the importance of fertility and see children as part of that issue. We know about the roles of sons and daughters, about circumcision, and about household organization but all from an adult's perspective. I think that this approach fragments and deconstructs the role of children as social actors/agents.

But the inclusion of childrens' points of views as data upon which to construct social analysis is problematic. The main difficulty lies in the validity of children's accounts and in the ethics of eliciting information from minors who may be too vulnerable or impressionable to desist from playing the role of informants. These are two problems with which I had to contend while working with children in Rihan.

One solution which seemed to have worked for me was to rely on groups of brothers and sisters as informants. Siblings offered each other the comfort and security necessary for each boy and girl to feel at ease and not to feel that they had been singled out for close inspection. They also validated each others' accounts of events. Very often, the boys tried to overwhelm the girls and the old demanded more attention than the young. But even then, they were acting out principles of age and gender power relationships which are important dimensions of the experiences of childhood.

The main informants upon whose authority I report the following discussions are:

Table 4.1 Key Informants

	NAME	FAMILY[1]	SEX	AGE	SCHOOL YR[2]
1	OSAMA	A	M	14	1-2 PREP
2	ATTIYEH	A	M	7	1-2 PRIM
3	NORA	A	F	11	4-5 PRIM
4	POUSSEY	A	F	10	3-4 PRIM
5	FATMA	A	F	3	TOO YOUNG
6	ATEF	B	M	3	TOO YOUNG
7	AHMED	B	M	9	NO SCHOOL
8	MOHAMED	B	M	10	NO SCHOOL
9	SAWSAN	C	F	5	TOO YOUNG
10	RACHA	C	F	4	TOO YOUNG
11	QUUT	D	M	13	NO SCHOOL
12	NA'IMA	E	F	9	NO SCHOOL
13	MOHAMED	E	M	7	1ST PRIM
14	SHADIA	F	F	12	NO SCHOOL
15	'ARAFAT	F	M	10	NO SCHOOL
16	AMR	G	M	5	TOO YOUNG

1. For a brief profile of each family see appendix 5.

2. I was there for over 18 months. This column shows which year the child was in, and the one which he/she moved to.

17	HUSSEIN	H	M	5	Too Young
18	ALI	H	M	14	2-3 Prep
19	KHALED	I	M	14	3-3 PREP
20	SAMIA	I	F	5	TOO YOUNG
21	TAM TAM	J	F	8	NO SCHOOL
22	MAHMOUD	K	M	7	1ST PRIM
23	SHARBAT	K	F	6	1ST PRIM
24	ABDEL_AL	L	M	15	2-3 PREP
25	OLA	M	F	12	NO SCHOOL

These twenty five children come from 13 families and range between the age of 3 to fifteen, about half of them are boys (14 boys and eleven girls). The first five in the table are my "key informants". They are the children in whose house I lived, with whom I shared most of my meals and the ones that showed me how and when they worked, studied, and played. I observed the way in which these children structured their world and their relationships, and how their experiences of being young were structured by their circumstances.

The other children are those of families with whom I interacted every day. They were neighbours, old friends, and relatives of my host family. The sample includes two children with disabilities. Arafat is deaf and consequently has a speech impediment. He lost his hearing as a result of measles. Ola was born with a slight mental

disability and also has a paralysed hand. The diversity of age, gender, schooling and of health profiles is not due to careful sampling. Although I was keen to understand the experiences of different children, ultimately I had to rely on my ability to befriend these boys and girls and on their acceptance of my friendship.

B. The Arrival of a Newborn

Ni'mat was pregnant with her ninth baby for most of my time in her house. Ni'mat gave birth to her ninth child and fifth daughter (see plate 10). Asma, the new baby, did not have a big **sebou'** (seventh day celebration). It is surprising that she had one at all. Ni'mat said that they were holding the celebration so that her brothers and siters would be happy and not hate the new arrival. Asma was bathed on that day, although Ni'mat had wiped her with warm water before then saying "what fear have I of her being given the evil eye, thank God she has many brothers and sisters and anyway, she is so dark no one will look at her".

But long awaited children always cause some confusion once they survive their first week of life. On the one hand families want to celebrate and properly name them, on the other, they fear that celebration may draw the gaze of envying eyes. In'am faced such a dilemma when she had her first son after the death of two boys and the birth of four successive daughters. The following are some notes from the day before and the day of her son's **sebou'**.

There they were in the dark room, the mother, the baby tightly wrapped and placed next to the wall and the mother-in-law. Ni'mat took nothing with her. She had already sent a bottle of Sherbet and 1Kg of sugar to the house of the mother-in-law where the father officially lives. Inside In'am's own small house at the edge of the village there were some neighbours with their small children, mostly girls. To the side their was an aluminium tray with an **abriq** in it. Around it there was some bread and salt and candles stuck all around it. In it was the bath water from the 6th day bath, the baby's first. There was also an egg on the tray. The candles are to be left burning and

the last out signifies the name that he shall be given, however, she had already called him Mohamed after his dead brother. But the candles signify the writing of angels. The children were sitting around a **Tabliya** in the soft light (she has no electricity) and singing "happy birthday to you". What they were actually saying was neither English nor Arabic and was to a different music. "That is from television " In'am said. Her mother-in-law whom she hates and who has been the reason for her years of marginality and depravation is the one who helped her deliver and who cut the cord for her. She was also there interjecting with sing-a-longs. Mohamed was next to the wall completely covered in a black veil. Ni'mat who accompanied me on this visit said **"Moush lazemm yefrahou bih"** (they must be so happy) meaning that their happiness may be the cause of the baby's demise. Next morning was the actual ceremony. There were few people there and again the mother-in-law was officiating. They put him in a mesh sieve and shook him around while his mother-in-law beat a brass pestle and mortar and his mother crossed over and around him. Meanwhile the mother-in-law praying that he may **Ye'amar beit** (live long enough to marry) and shouting injunctions to him such as that he not obey his mother. His father was not at the ceremony. His sisters were very happy. "Of course" his mother said, "he has come to shelter and protect them".

That day they had a generous breakfast of **rishta** (noodles with butter and sugar) for guests. Later In'am informed me that she did not have a **sebou'** for the girls. Her first born died when he was eight years old and her second son died just before his fortieth day. In those days Ni'mat said "she was cheap and so was the boy", she later explained that her mother-in-law threw them out after a fight and it was then that the boy died.

For some children, the period of their mother's pregnancy and delivery can be fraught with anxieties. When Sawsan and Racha got a new sister, they were overjoyed. True that Racha, the younger girl (4 years), cried when she heard her mother cry out while delivering, but by the next morning the two girls were playing make-believe that babies were coming out from between their legs. Sawsan (5 years) had been told by her cousin Sharbat (6 years) who herself had just acquired a brother a few month ago what delivery was like, but it was not the same as seeing it.

Sawsan and Racha had for the previous nine months been frequently threatened by the consequences of their mother

getting a boy. They have a young uncle, Saber, who had taunted them by saying "your mother will get a boy and then she will only care for him". Their grandmother and aunt had tried to rectify the situation by promising them that a brother will come and protect them and fight their cousins if they ever bothered them. When little Amina arrived they were glad although their aunts tried to claim that they were sad because the brother did not arrive. The girls themselves said that they liked the baby. Their mother had a **sebou'** for their sakes. She also decided to celebrate her third girl so that none of relatives and neighbours think that she is frustrated by the birth of a third girl and by the absence of a son.

Even newborns are differentiated by the family contexts into which they are born. This is made most explicit by the different forms of, and reasons for, **sebou'** celebrations. The traditional distinction between adults' happiness and celebration for baby boys, and muted acknowledgement of the birth of a girl fail to mirror the views of children. The meaning and implications of a new birth become clear when one takes into consideration the views and reactions of children. Gender is important even to brothers and sisters, but for purely personal and not just for societal or cultural reasons.

C. The Daily Lives of Children

C. 1 Children at Home

*** Sleep**

Children are free to go where they choose inside and around their homes. They are not excluded from any part of the house. The only areas that are off-limits are the bedrooms of adults who are not their parents. Otherwise children can go where they like, and if they get the urge, they can sleep there. None of the children in this sample had ever slept in the bedrooms of married uncles, aunts, or cousins.

Children are rarely put to bed. They are left to run

around until they are so tired that they drop off to sleep. There are few preparations that they have to go through. When one night Attiyeh disappeared and I asked him the next morning where he had been he said "I dozed, so I slept where I was". He had been visiting his grandfather's house and his mother assumed that he would sleep there when he did not come back till late. When children do sleep in the homes of relatives they are usually left there and are not carried back home. Hussein tires himself out when he is at his grandmother's because he likes to sleep there. Racha and Sawsan also like sleeping with their cousin Sharbat, but according to Sawsan, their mother never lets them because she does not like her own parents to think that her children are begging anything from them, even bedding!

*** Diet**

In the morning sweet tea with plenty of full fat milk is the staple breakfast for all members of the household[3]. Households who do not own milk-giving livestock have tea with plenty of sugar and no milk. Those who can afford it try to buy fresh milk either from neighbours or from the nearby public sector cattle farm.

Older children then go to work or to school, the younger ones begin their day of snacking and playing. Fatma loves to scrape the bottom of pans in which her mother has been making ghee or cooking. She takes bits of breads and sweeps the bottom. Fights ensue with Atef and Ni'mat either pleads with Fatma to share the pot or she gives Atef an alternative goody such as bread and sugar. At around 10 am the little ones may be given some left-over cooked vegetables or some bread and cheese. This is always on demand. More often the morning is spent without a proper meal. Children are given bits of bread or savoury pastries to dip in cups of quite strong tea.

. Only milk drunk in the morning is full-fat. What remains over from breakfast is skimmed into cheese and ghee unless the milk is kept aside to be sold as milk.

Soon after, those in the field and at school come home for lunch. This meal is usually bread, cheese or left overs. An egg is a treat and is offered only in compensation if, for example, a child has been to the doctor or some other difficulty. In season, melted ghee is also offered and maybe **kishk** (cracked wheat balls made with sour milk and dried).

In the afternoon, and on their return after the end of the school day, children are given food if they ask for it. "Mother I am hungry" is the prompt for cheese, bread, onions, **kishk** and other such items which are "from the house". Poor families offer children bread and spices mixed with salt. Young agricultural labourers can be seen toiling in the fields and then come lunch time reaching into the pockets of their **galabiya**, usually taken off during work, and unfurling a big round loaf of bread with salt and hot chillies placed inside it. This mixture is not the same as **dokka** (a mixture of ground nuts, sesame, salt and spices) that is sold on the streets of Cairo and other cities in the region. In Rihan bread is eaten just with salt, cumin, and red chilies.

The main meal is in the evening. Children eat with their parents unless there are too many of them, then they eat on a separate **tabliya** (round, low table). If there are no guests, the father, and older male family members eat together. The boys in the family may be invited to join them. Otherwise, the father eats with the guests and the rest of the family eats together inside. Fatma is always invited by her father as he likes eating with her. Sharbat and Mahmoud eat with their cousins and never with the adults of the extended family household.

Mothers lay out the food for children and if **Zafar** (meat) is on offer than the division of fair shares becomes a complicated task only a mother can master[4]. Each

---

. Zafar is a difficult word to explain. In some contexts it means meat. In others it means the aftertaste or smell of animal protein. Yet another meaning is dirty or dirtied with

child gets his or her fair share according to age, and in some households gender. Special requests figure in these careful equations. Sawsan eats only lean bits, Abdel-'Al cannot stomach fat, Osama loves sucking the bones, Fatma eats anything, Essam relishes very fatty bits. Such likes and dislikes are taken into consideration in each family.

Children of the same age get exactly the same amounts. Racha and Sawsan, Poussey and Noura, Mohamed and Ahmed are given similar shares. Older boys get more meat because they work hard in the fields, even if they are in school. Young girls can act greedy and may even mumble about their small shares of meat. But as they get older, they are expected to become shy and demure; even with their own parents and siblings. Girls about to be married may refuse meat altogether. This is in preparation for the abstinence they are expected to exhibit in the homes of their husbands where they are expected to decline food at first to show that they come from good homes and are not greedy.

There are table manners to be observed. Atef and Fatma explained them:

> You eat your **nayeb** (share) and you eat from in front of you and you cut the bread and dip it in the **tabikh** (cooked vegetables) and you do not dip your hand and you don't take the **nayeb** of anyone else.

Nayeb specifically refers to meat, whether beef, lamb, chicken, duck, fish, sardines, or pigeon. Everyone gets a fair but not equal share unless they are of the same age. If there is differential treatment then the siblings, of the same age group, can fight it out. No one questions why girls get less or why older siblings get more. Hamada explained why:

> For us to all get alike means that my mother has to cook nine pigeons. We each get as she divides and she is my mother just as she is Fou Fou's. I don't like meat so I don't care if Essam gets more. And when we were small we ate like the small ones. Anyway, Fatma cannot eat as much as Essam, can she?

---

animal protein which could include **semn** (butter ghee).

Children eat quickly and the little ones often must stand around the **tabliya** to be able to make their way to the common plates out of which all eat. Once I caught Fatma, Atef, and Gammal playing make believe. Actually it was Fatma entertaining the boys. They sat in the shade of a wall in the street and Fatma was showing them how I ate. She reached out very slowly with her hand as though she had some bread in it then swayed it as though dipping it in **tabikh** and put it in her mouth which she then kept closed and imitated my chewing. She put on the performance again for my benefit and laughed saying "My mother eats a loaf by the time you've had a **loqma** (mouthful) and she gulps and does not chew with a closed mouth like you do".

Children are asked to wash their hands before eating only if their hands are visibly dirty. Coming in from school does not require hand washing, but coming in from the fields does. Sawsan and Racha were picking onions when their aunt arrived with bread and cheese. They did not wash because there was no water and because their hands were dry not wet. Racha explained that their hands just had **torab** (dust) which she could dust off and not **Ttina** (mud) which would get in the way of her ability to eat.

After eating, hand washing is optional. Meals that include meat necessitate washing the hands. This is because "Meat is **Zifra**" (adj. from the root **zafara**) explained Abdel-'Al. Even vegetable stews eaten with bits of bread do not necessitate hand washing (Oldham 1990, Hoodfar 1986, 1995).

*** Treats**

The early afternoon and late evenings are the times of visits. These visits often mean treats for small children who are not yet school age. Children are the medium through which women and men pay tribute to their hosts; 5 piaster coins and even 10 piaster coins are fished out of breasts and pockets and given to the little ones. Equality is a requirement if peace and quiet are to be preserved. Those

of the same age set are given the same amount. Slightly older children may be ignored but toddlers and those under the age of five years never are.

The sight of these little ones clambering at the many sweet stalls/shops and thinking of how to spend their money is a familiar one. The first to arrive makes his/her choice and is usually imitated by the rest; just in case the chosen treat is something that is not to be missed. The selection includes lollipops, whistles, sunflower seeds, paper masks, wrapped sweets, or biscuits. Little Racha exchanges corn for dates when she has no money of her own. Tooth decay is common because of sweets. Children are under no control. As long as they themselves or their parents can afford it, they get them what they want.

Hussein always regrets using his money to buy biscuits since he can always get from his older brother the biscuits distributed at school. Yet every time he goes to the stall, he can't resist buying the biscuits. Atef buys whatever Fatma does and then regrets it because he wants to imitate his older cousin, Hassan who saves his 5 piasters and buys a substantial item like a ball or a packet of crisps, or even a sandwich. Most mothers encourage the purchase of salted sunflower seeds which they also enjoy since **el-qazqazah** (cracking them between the teeth and eating them then spitting out the shells) is a favourite pastime, especially when conversations are interesting.

Street snacks in the village are confined to **foul** (stewed fava beans) and **ta'miya** (minced fried bean patties) sandwiches. The shop owners buy the bread from town. This is what is so special about the sandwiches, the bread is not like that at home which is unleavened and cannot be made into a pocket-like sandwich. Children love **ta'miya** because it is hot, crisp and spicy.

*** Housework**

Home life, for girls is associated with chores and rough skin, baking, and maybe stopping school. Noura once

came to announce "Next year I will stop school, my father will take me out, because I will begin to learn. When I grow up, I will be a peasant". She and her peers often discussed and compared my assets (soft hands) and liabilities (my slowness at gathering cotton and my inability to carry a full can of water) (plates 11, 12, 13).

Girls, whether in or out of school, have cooking, cleaning, child care, water fetching, and baking responsibilities. Noura and Poussey, for example, sweep the house yards before going to school. Their mother does not insist that they collect dung from underneath the animals to make dung cakes for fuel. She does it herself or has Fou Fou, her oldest who does not go to school, do it. But the majority of their school friends undertake this responsibility before going to school. "I hate it because sometimes the dung is steaming hot and sometimes it is wet with urine then it is difficult to gather" said one of their school friends.

Girls in school often have to milk animals early in the morning. The churning of the milk to make semn and cheese is left for mothers or sisters who are not in school. All activities which take place during the morning and early afternoon fall on girls who have been kept at home. This includes clothes washing, child minding, food processing (like making cheese, kishk, and bread), and taking care of fowls and other household animals.

Some mothers try not to over exert their daughters. Aziza, for example, is proud that she did not let Zeinab, her 15 year old daughter, help her with the washing until the girl was over ten years old. "Although she was big and has never spent a day in school, I did not let her wash because when they are young they are not strong enough to wash properly" she said.

Small girls are asked to stoke the fires of burning ovens, sweep animal yards, peel garlic and onion, fetch and carry back and forth, and bring water. Ni'mat said that fetching water was the most important thing for a girl to

learn because if her back does not get used to the heavy load early on, she would be like me, unable to master the trick or carry the weight. From the age of seven, or even younger if the girl is tall, she is taught how to fill and carry water.

Poussey (10 years) can carry a gallon of water on her head. She sweeps the floors, feeds the cattle and minds her younger sisters. She does not cook, wash, or bake yet, but Noura who is a year older does. Fou Fou her eldest sister is still training her. At the end of baking sessions she permits her to do a trial loaf or two.

Now that Fatma is close to turning four, Ni'mat has decided to begin training Fatma. She has started having her go with her brother and sister to herd the sheep and goat. They go at about 3.00 pm in the afternoon or whenever the 'assr prayer is called. They take the two sheep and goat out to one of their own fields where they can eat what has remained after the harvest. Attiyeh is in charge of the goat and Noura of the sheep. Fatma can still do little except be a nuisance. Ni'mat has also taught her how to sweep, although she does not rely on her sweeping.
Meanwhile, Poussey who is almost eleven is beginning to learn how to bake fatteer (unleavened savoury pastry) and Noura, who is turning twelve, is being given the responsibility of making dung cakes by herself.

Other children who come from smaller households, such as those living in nuclear families and who have fewer brothers and sisters, have to work even harder at home. For example Zeinab who is fifteen and has three younger brothers used to work all day. She explains:

> Before my uncles got married I had to do all the housework because my mother took care of my brothers and cooked for all of us. I also carried my small brothers for her if her hands were busy. I tend the animals and sweep the yard and fetch water and prepare vegetables and do everything in the house and that is why I did not go to school. When my uncles married the work became less especially since my uncles are in Saudi Arabia and so their wives have nothing to do.

There are no tasks that are specific to children. As

soon as they can physically and intellectually manage to, girls begin to take on the responsibilities of the mother who may be herself unable to perform these tasks due to pregnancy or to childbirth and child care.

The fortune of having animals and land results in an increase in women's workload. Animals need milking (and the consequent processing of the milk into ghee and cheese), watering, and feeding, and collection of dung and making dung cakes which are a major source of fuel for household purposes. All of these are chores which usually fall onto young girls.

Land means that there are harvests to sift, sort, and to store. Women also dry vegetables for use in the winter and insure the proper storage of flour and grains for the whole year.

Then there are the needs of the house. Water is not piped in the village and has to be drawn with pumps. Floors are swept daily and pots, plates and pans are washed and stored. Women with daughters rarely perform these functions. Baking and washing need the expertise of adult women or at least girls over fifteen. The younger girls carry water in and out for washing and may hang the clothes out to dry. As far as baking is concerned, young girls bring in the fuel and have to continuously feed the fire while the older women bake.

Cooking is never left to young girls. As Salma once exclaimed "Food is too precious, will you give a girl a piece of meat to spoil or cook it yourself?!" But they do peel vegetables, stir pots, and clean up after the cooks.

For girls, the idea of starting to help around the house from a young age has to do with training their bodies to be able to perform and tolerate the chores of women. Starting early is the only way of developing the body habitus a woman needs to run a house in rural Egypt (Bourdieu 1977). Boys also learn to ride animals, carry heavy loads and till the soil early on for the same reason. Young girls assured me that no matter how hard I tried, I

would never be able to carry a heavy load on my head and walk with it. "Your posture is wrong" Sharbat and Shadia would shout at me when I tried. Such subtleties as who can withstand more heat while toasting bread and who can carry more to and from the tabliya are often occasion for competition between sisters and cousins. As Sharbat explains:

> We learn how to take the heat of the oven and how to quickly pluck pigeons and chickens. My mother is much better than my uncle's wives so I am better than my cousins.

These are all skills that one learns with one's body as well as with one's mind. Om Mohamed , the old midwife explained:

> If the body does not get used to these things, a girl will never learn. You see the women who men bring here from Cairo to marry. They are unable to manage their homes and cannot turn out a decent loaf of bread. With time they learn, but it is easier to learn when you are young

So the young teach their bodies to work and when their bodies learn, they begin to be able to take on the responsibilities of the tasks which they have learned.

Boys help out in the house if they do not have sisters. Their chores involve work in the fields or doing errands such as shopping, milling flour at the nearest mill, herding animals, and helping in house repairs. Going to market is a service that boys may be asked to perform. Middle class village women do not go to market and usually ask another neighbour who is old or poor or both to sell their produce and buy their needs. Boys may go on a donkey to buy flour or other heavy items. They never, to my knowledge, sell in the market place. Another important service is to take wheat to the flour mill. While reward is rarely monetary, boys are permitted to buy take away sandwiches of ta'miya or foul or to buy sweets. They must account for this money on their return. The girls serve the boys, but never the other way round.

* Homework

Home is where children study if they can. Mothers feel genuinely sorry for their children because they have so much to do. It is only after all chores are completed and after the very small have gone to bed that those who still have the energy to be in school can get time to study. Usually the **tabliya** is cleaned and placed under an electric lamp if one is available. Osama, Abdel Al, Saber, Kahareb, all usually fall asleep in this position and are either left to lie there and are covered or just manage to get to their bedding. As Osama explained:

> School work is so hard and especially the homework. My brothers and sisters steal my pen and the ducks walk all over the books and all of my books are torn because I have taken them from my older brothers. And when they are all watching television it is hard.

Studying is a disruption of the comforts, customs, and conditions of home. The discrepancy between the security of home life and the modernizing effect of school is important to see from the student's point of view.

> Today Osama (14 years old in 1st Prep) asked me to help him with his English language homework. The paragraph we read together was about Cinderella. The book explains that she is a poor girl because she wears torn clothes and has no bed so she sleeps on the hard mud floor. WELL, SO DOES OSAMA!! When we got to the exercise question on why Cinderella is poor we chose the right answer being her torn clothes and the mud floor. I asked Osama, who really had no idea what the words meant and was just reading the English words in Arabic script, what he thought of all of this? His reply was a shrug to which he added, "maybe she also does not eat meat or her family do not have animals anyway, this is just the book from school, it is English and we just learn it. I do not know why she is poor! People here do not sleep on beds." When I explained a bit more about Cinderella and her situation he was very touched by the fact that she does not have a mother or any brothers. (Excerpts from fieldnotes).

Children who study have to make the time to do so. Saber once asked me to help him with his lessons. As we were about to start, his mother shouted out to him:

> Have you taken the fodder to the animals and put water and have you bought me salt and matches from the store and where are your sisters, if they are playing

outside go get them and then go borrow gasoline from the neighbours and see when they are going out for the harvests tomorrow and then you can sit and waste her time!

Her demands are in no way unreasonable or exceptional. **Ya Tiqoum Tir'a, Ya Tisayef, Ya Tizaker** (Herd, go to the fields or study) is how Ni'mat encourages Osama to study. All children in this sample who are at school can never get round to their homework except after the late evening meal and by then they are so tired that their books become their sleeping companions.

C. 2 Children at Work

The following is a composite of time/activity charts collected over a period of 3 weeks during the autumn of 1992 for 15 children.

Table 4.2 Time/Activity of Children in Rihan

	6 am - 11am	11 am - 3pm	4 pm - 7pm	7 pm 11pm
TODDLER	Breakfast bathing, playing, running errands, visits	Lunch, sleep, herd or go out to the fields.	Herding, playing, helping in minor household chores.	Dinner, TV. visits, sleep
BOY < 12 IN SCHOOL	Breakfast , playing outside, school	In school till 1.00. eat, play in school yard or at home	Herding, fetching food stuffs errands, guarding crops, play football	Dinner, Homework, TV, Bathing
GIRL<12 IN SCHOOL	Breakfast sweeping the yard, milking, taking care of younger ones, school	In school till 1.00, eats.	Herding, help in cooking, house chores	Dinner, homework, Bathing

GIRL<12 AT HOME	Doing dishes, sweeping floor and animal yard, feeding fowls, fetching water, child care, day labour (in season) dung cakes milking	Lunch, take lunch to workers in the field, clean up, fetch water, help mother, mind young ones,	Herding, house chores, errands, playing outside house.	Dinner, clearing up, TV, Bathing, Chatting.
BOY<12 AT HOME	Herding, Shopping, agricult. work	Lunch in the fields or at home, fetch fodder for animals.	Herding agricult. work, playing.	Dinner, TV. Playing in the streets.
BOY> 12 IN SCHOOL	In school	In school	Agricult. work, errands	Homework, TV, bathing Irrigate
GIRL> 12 IN SCHOOL	In school	In school	Housework fetching water cooking.	Dinner, clearing up, TV, Sewing/mending, homework.
GIRL>12 NOT IN SCHOOL	Baking Milking skimming, bathing little ones, work in fields, making dung cakes, sweeping, doing dishes	Continue chores, rest, sewing/mending, sleep	Cooking, making bread for evening meal, milking.	Dinner, clearing up, making tea, TV, chatting.

Boy > 12 NOT IN SCHOOL	Agricult. work	Rest, continue work.	Contin. agricult. work, visits out of town	Sitting with other men, irrigating, playing board games, visiting.

The schedules of children, similar to those of adults, are subject to seasonality. The above is an autumn- winter schedule. In the summer the days begin earlier, most people rest or stay in doors from high noon to the afternoon to avoid sunstroke, and although school is not in session, the harvests of the summer make for much more work.

The most lucrative of the crops for most Upper Egyptian villages is cotton. Before harvest time, those who have cotton crops send their children to guard them. Usually children go in groups. Osama says:

> I guard our crops from boys like Quut who want to make quick money. He knows I would not steal from their crops but we all suspect each other. Instead of taking from your fathers field, you take from another, sell it in the shop and buy some sweets or some like Quut buy cigarettes.

It was on such a mission that Poussey got beaten. Out in the fields, children sometimes play but are discouraged from doing so in case their attention is diverted from thieves.

At the time of the harvests, all are hired as pickers. Abdel-Al, whose father has no land, explained that families hire their own kin. So a man rents out to his cousin's children, and they rent out to his own children. That way everyone gets cash and everyone gets crops. When you work for your own father you do not take cash but you take

payment in kind; that is a lapful of cotton that you can sell on the side.

In the summer of 1992, a child's wages for one day was LE. 1.50($0.45), while an adult man was payed LE 5.00 ($1.5) . This is serious money. Children feel the crunch of not being hired. Ola, who has a physical and mental disability, is hired by her own grandfather because no one else will give her full wages. Ola needs the money since her father also has a disability, and she and her mother have to earn their living. Unlike other girls who can keep some of their earning to save up to buy jewellery or clothes, Ola has to put all of hers into the household. Because she rarely gets hired she is one of the village's expert cotton scroungers. She roams the already picked fields and gathers the buds left over by the pickers and sells them to local shopkeepers.

This scrounging is know as taseef (picking up the summer crops). Aside from the first and second round of cotton picking, there is the lucrative potential of gleaning what may have been left behind on the ground or on the bushes. Old women of 70 years as well as toddlers of four and five years can be seen in the fields in the late afternoons picking what they can. The owners of the fields would rather that their own children rummaged their own fields. Aziza is forever telling off her two young boys saying "why don't you go to the cotton fields instead of the strangers? Take Atef with you, but mind the thorns, and whatever he picks, don't you cheat him out of it". Even little Fatma dabbles her hand in scrounging and disappears with her sisters in the late afternoon and comes back with her tiny hand full of wisps of cotton. Her mother buys them from her.

Old women who have little income are not above this rummaging through the fields. While smaller children exchange their pickings for money or sweets, older women take soap, salt, gasoline, cheese, and vegetables in return. Ola however asks for cash which she gives to her

mother to buy food.

Girls who are lucky enough to keep part of their earnings save up to buy gold with it. Earrings and rings are the most sought-after objects. But when they are older they also try to buy items for their trousseau. It may take the girls up to five years to save up enough for these prized items but buying a bit of gold, in particular, is a priority especially for very young girls. Vanity and the wish to tease peers are involved in this decision as well as prudent savings for the future.

Usually those who are harvesting visit the homes of children and pay in advance for their daily labour. This money is kept by the parents. The person whose crop is coming in should offer lunch, but this has become a rare practice unless close family are harvesting. Children who collect with extra zeal and bring in more then a standard days pickings, which differs from one harvest to another, are given a tip in kind and once they sell it, this money forms the bulk of their annual savings.

Many children in school save their summer and other earnings to pay for their school needs. The money that Attiyeh made from cotton scrounging was LE 1.75 ($0.53). He left them with his cousin Mansour, the shopkeeper, after buying two exercise books. Everyday he takes a **ta'miya** sandwich from this credit. Poussey bought ribbons to wear to school, as well as all of her exercise books. Abdel-Al and Saber also bought their books and school bags from their savings.

In most agriculture processes, there is a role for little hands and a need for the energy of young boys and girls. Onions require slashing as well as uprooting, wheat requires sifting after threshing, fields require guarding, irrigation pumps need watching, the maize field need clearing after harvest and so children are sent to graze animals there (plate 14). Unless employed as labourers by others, children are not paid for these services although families and households rely on their efforts. However in

the case of cash crops, children do get monetary benefits even when they have been working for their own families.

For his onion harvest (1992), Hashem had his own three boys working as well as another three. The other boys were the two sons of Quut, his neighbour, and the son of a cousin. His boys were not paid but the others were given LE 1.50($0.45) each to slash off the long shoots of the already harvested onions which had been left to dry in the fields. Hashem had not hired any one for the harvest leaving it to Essam and Hamada to do it. He is skimping because the harvest is great but the market is terrible. He is selling his produce in Alexandria and is investing his money in transporting the onions there where the market price is higher.

Some children work outside agriculture. Children of shopkeepers are relied upon to mind the shop and to carry stock into storage. Large families with ties to Cairo may send a male member off to work in Cairo during the Summer. Both Essam (18 years) and Hamada (15 years) have spent a couple of summers in Cairo; once working as apprentices in a welding shop and another time helping in a relative's spice shop. These experiences are cherished by these two young men. They worked very hard, but loved living in Cairo. They each got part, but not all of their earnings.

C. 3 CHILDREN AT SCHOOL

Rihan has a well-attended primary school. In the school year 1992/3 the school's five classes had the following number of students.

Table 4. 3 School Enrolment in Rihan

CLASS	STUDENTS	BOYS	GIRLS
1st Prim	40	30	10
2nd Prim	35	29	6
3rd Prim	49	37	12

4th Prim	37	30	7
5th Prim	48	25	23

Source: School Register

The school has had an average success rate of 80% which is extremely high by national standards. The headmaster explained this phenomenon by the "well known" intelligence of Arab children as compared to peasant children. Despite such high rates, very few boys go on to middle and high level education and hardly any girls at all. This he said is because villagers in Rihan were too poor to educate their children, and after the opportunities of working in oil rich countries presented themselves, they were more keen on getting their sons passports than educational degrees.

On the walls of the headmaster's office is a certificate from the Ministry of Education certifying that in 1982, this school had one of the highest overall scores in the final year of primary school in the whole governorate. Of their total number of students, 92% had passed the primary school phase and were eligible for preparatory education (also see Sholkamy 1990: 102).

There are 12 employees in the school: a headmaster, a deputy, 7 teachers, a secretary, an exercise and activities supervisor, and a cleaner. They are all employed by the educational authorities of the district of Abnube but three of the teachers come from and continue to live in Rihan. All said that the school was a good place to work since it was small. The school is right in the middle of the village and this was mentioned as an important asset since it meant the children were not only under the supervision of teachers, but also close enough to their homes for their male kin to be called in to keep them in line.

The teachers however complained that children came to school only when they had nothing else to do. On Saturdays

and Thursdays, the market days of 'Arab Matteer and Abnube, attendance drops sharply. During planting and harvesting seasons there is never a child in sight. Girls who get baby siblings also disappear from school. Families are fined for letting their children drop out, but by the time the child returns, he or she may have missed so much that they might as well stay at home.

One of the teachers in school agrees that there is not much point in educating girls since they will not work. He and his brothers are keeping the daughters of his recently deceased brother from school.

Children know that school fees are unaffordable to their families. Annual school fees are Primary school 11LE($3.3), Preparatory school 29LE($8.7), Agricultural Secondary 20LE($6) reduced from 35LE($10.6). Consequently children who are not good at school prefer to be kept at home. Noura has such a problem. During one fit of crying over her multiplication tables she explained her feelings towards school and towards her own future:

> Next year I shall stay at home whether I pass or fail **Akhbiz, we Aqdy, we at'alem we arig** (to bake, work, learn and knead). My father says that money paid for me at school is money wasted. My teachers say that I am not for school and I hate to study. I want to stay at home because then I can learn all these things and work.

Not educating girls can be the mothers choice and not just the father's. Naggat for example does not want to educate Samia. Her husband wants her to go to school because he is a pious man and wants his children to be **mit'alimeen we mo'dabeen** (educated and polite). Naggat is thinking of not sending her because she cannot meet the daily expenses. Children who go to school need 10-25pt/day ($0.07) for exercise books, sandwiches, and the other things that they buy, not to mention shoes and fees. Naggat does not see why she should educate her daughter anyway or what good education will do her.

Wealth has a lot to do with how long children, both girls and boys stay in school. Kahareb has failed her

preparatory school final year for the last three years, but her parents keep her in school anyway. Her cousin was taken out in fifth primary because she failed, and her parents felt that school for her was simply a waste of money. Kahareb's father works for police intelligence and has a large land holding. His connections and his position of power bring him much income and status. He is adamant that Kahareb stays in school until she passes, then he will keep her at home.

Children who do well in primary school go onto preparatory school in Abnube or in one of the nearby villages like el-Kom. Some girls in the village go to preparatory school, but not many. The majority of boys who start school stay on until at least this stage unless they are asked to leave by the school itself because of their poor educational standards. Girls however may drop-out at any stage in their education. Fifth primary is usually the last year for girls intended for housework and early marriage.

Secondary schools are in the town of Abnube only. Laila is one of the very few girls in the village who went on to this stage of education. She did a degree in commercial secondary[5]. Laila was very clever at school and is also the youngest of seven brothers and sisters. Their home is full of women since three of her brothers are married. Because she did well in school, was not needed for work at home, and is the 'last of the bunch' for her old parents, she was encouraged to stay at school. She graduated four years ago and does not work. She is also not married. As her aunt said "she is proof why you should not educate girls, her education did not make her prettier and now she is like us, making her income from the chickens and the pigeons". That education did not make her look prettier is a snide remark on Laila's plain looks and her failure at

---

. There are four options for secondary school: General, agricultural, industrial, and commercial secondary school education.

catching a husband.

Education is important for children and their families but not because of the qualifications that one can get in school. Parents send children to school so that they become polite, well-mannered, and 'intelligent'. The boys stand to gain degrees which could possibly get them jobs or make their employment abroad easier. Girls do not stand to gain much, from their families point of view, and are sent to school either to avoid fines, or to become literate and well-mannered.

C.4 CHILDREN AT PLAY

Children play when and where they can (plate 15, 16). The games and toys of the fields differ from those played when herding, and from those played in and around the house. At home, toddlers run around, climb bags of produce and mountains of harvested cereals. They threaten to throw each other into wells and clamber over their mothers and relatives. They occupy their time with make-believe play. Fatma is fond of telling everyone **ana hairakib shareet** (I am going to get fitted for an IUD), simple proof of how often contraception is discussed.

Fatma also loves to imitate the chores of older women. She uses discarded plastic jerkins in which oil is sold to put on her head and sway her hips pretending that she was carrying a heavy load of water or vegetables to market. Her mother gives her home-made toys, never bought ones.

After we began to get along, Fatma asked me to make her a whistle. She gave me a piece of **barseem** (ⴱⴰⵔⵙⵉⵎ) reed and looked on. She realized that I did not know how. She took it back and began to tear away the leaves and chew it free of sap. I asked Ni'mat and she said that that is how it is done. But the one I had was **shayekha** (old) and instead of becoming hollow, it cracked.
When Ni'mat got up I asked Fatma to make me a doll. She ran into the animal yard, shouting back at me **ageeb rihteen tein?** (shall I get a few pieces of mud?). She came back with a clump disappointedly saying that all the mud was dry. She tried to wet it on my advice but her mother insisted that she throw it away, and told her off for having forgotten her

sandals at her aunt's house that morning. "I have my shoes!" the girl defended herself and pointed at her orange plastics. She then went over to the oven and gave me a bit of the hot bread her mother was making. Meanwhile, Ni'mat told Poussey to go over to the fields to take some hot bread to the boys. Osama had come in with fenugreek stalks. Fatma took some and began to chew at it and gave me some as well. I thought she wanted another whistle and began to imitate the way I saw her making it. Ni'mat broke out in laughter, "You don't even know what it is" she said, and explained that it is fenugreek to eat and that one never ever made whistles from their stalks. Fatma meanwhile stood gazing at me bewildered at what I had been trying to do.
(Fieldnotes)

There are plastic toys to be bought in the village and in nearby towns. The favourites are the screeching whistles, trumpets, and dolls. But children do not buy and keep these toys. They use them as they do the dolls they make from mud and the whistles made from reeds. These plastics can be seen discarded in lanes and streams[6]. They are items of amusement, and not toys that are kept after play.

A toy made for every child is the walker. It is a long wooden stick with two wheels at the end made of metal and coca cola tops. Children trail it around or push it and so perfect their walking skills. Other toys such as swords, rifles, and rattles are also made of wood and coca-cola bottle tops. Older children love to make their own toys and those of their younger siblings. Paper, biscuit wrappers, straw, plants, and old clothes are used to make rag dolls, boats, ornaments, kites, whistleś, and dolls houses and other figures. They are also used in game play.

The most popular games are those in which only pebbles and a board drawn with a stick in the dust are needed. Children play dominoes, and other favourite board games in this way. These and story telling are favourite pastimes of children herding animals, usually in the afternoon. Children whose fields are close and who herd together run

---

. Unlike other refuse, they are not biodegradable so they litter land and waterways.

championships. The champion at **siga** (a variant of dominos) is Noura, but Sharbat is competing for the title.

During herding, story telling by the old to the young is an important part of the day. There are many stories, some of which are inspired by television. Sometimes children retell soap operas or make up endings for ones currently running. The following story was the one voted for by the children in this sample. I told them that I could include in my writing only one story and this is the one they chose. They insisted that I hear it from Om Mohamed, the local midwife and a noted local story teller so that I write it out well.

Story telling has an etiquette. Before a story the teller says **hakakom Allah** (god brings a story to you) and the listeners answer **Kheir min 'ind Allah** (It is goodness from God). At the end the teller says **loula 'am Abdel Fattah daye' el-moftah kona wekilnakom sa'hn tofah we loula el-sayala makhrouma kona weklenakom mabrouma** (If it was not for Abdel Fattah we would have fed you a plate of apples and if it was not for the hole in the pocket we would have fed you sweet pastries). This funny ending is not a must but the introductory remarks are.

Om Mohamed began telling me the story chosen by the children with these words and then she continued:

> Once upon a time there was a boy who dreamt that he had the moon on his left and the morning sun on his right. When he went to school he told his teacher of his dream. The teacher said that it was a good dream and that for it to come true the boy must only trust those who say **Kheir Allah- hom Ma Ig'aloh Kheir** (Good tidings, please God may it be good tidings) whenever he tells them that he has had a dream. Those who do not say this have no good in them and must not be told the dream. The boy went home and told his father that he had had a dream. His father said nothing and got very angry when the boy refused to tell him the dream. So much so that he swore he would sell him in the market which he did.
>
> He was bought by a rich foreigner from **Bilad Bara** (abroad). He told him that he had a dream but when the rich man asked what it was without saying the phrase, the boy told him that he had forgotten it. The man told him maybe the executioner will make you remember and so sent him to **el_sayaf** (the executioner) to kill

him. The executioner had a beautiful daughter whose match God has not created. Her name was **Shams el_Doha** (morning sun) and she had a very beautiful friend called **Qamar el-Zaman** (the moon of time). She found out that her father was going to execute this young man and so she sneaked into his prison and asked him of his crime. She had taken her friend with her for protection. So **Qamar el-Zaman** the **sa'eediy-ah** (upper Egyptian) sat to the east and **Shams** sat to the west and he sat in the middle. He told them that his crime was his dream. So they both exclaimed in one voice **kheir Allah-hom ma ig'aloh kheir** and so although he did not know their names he told them his dream. So they replied well here we are, the moon to your left and the sun to your right. And so they entreated the executioner for his life and he married them both on the same day.

Neither Om Mohamed, nor the children who had chosen the story attempted to extract a moral from the tale. They said that the story was just for amusement and added that the important thing about it was that the boy was a clever and wise one. The children liked his reward of marrying both girls at the same time. Om Mohamed said that formerly it had been the boy's uncle and not the teacher who had told him to recount the dream only when his potential listeners said **kheir Allah-hom ma ig'aloh kheir** and that the uncle's replacement with the teacher was a way of modernizing it. All agreed that these stories were for entertainment, and that they were not enjoyed for any educational purposes. Most children however find television and its stories more fantastic, and much more exciting than anything Om Mohamed can tell.

Older boys play football in cleared areas just outside the nucleated settlement area of the village. They play with a plastic ball or with one which they themselves make out of rags. Many wished that there was a proper Youth club in the village so that they could play in a proper field with goal posts and with a real football. Young boys play football with small rag balls or by kicking stones or discarded plastic bottles.

Older girls do not play. They visit one another or talk while fetching water or working around the houses and

village. The prized pastime for them is the radio. They enjoy songs and programmes and retell each other the news and views captured from the air waves.

Parents in Rihan say that their children are luckier than those who live in cities. "True they don't have bicycles or clubs, but they have the fields and the dirt ground on which they can do what they like" explained one father. In the villages there is no traffic, no fear of strangers, and no precautions to be taken except perhaps late at night when wild animals come to prey on fowls.

The freedom of expression through play is mirrored in the freedom of self-expression that children display in their use of language. **Hakeem yegata'ek** (may the doctor chop you up) or just **hakeem** for short, **Hasba** (measles) **Mi'afin** (rotter) are the words to be heard from babies under the age of three cursing one another. Much stronger language is to be heard from both girls and boys of all ages. Not using foul language is viewed as a Cairene hang-up.

Children do not guard their language, even in the presence of old people. Grandmothers are no cause for respect. Grandfathers who are heads of households command a measure of respect, but even they are quite permissive. During play all sorts of swear words and graphic descriptions of genitals and what to do with them fly around the village lanes. Swear words are freely used in the presence of both men and women, but are never directed at older male kin. Mothers are showered with verbal abuse, but never fathers, older brothers or uncles. Ni'mat and others rationalize their own children's abusive language saying "It is because we used to bite and kick them when they were young".

The permissive attitude of families towards children is exemplified by the common practise of letting boys as young as six years smoke at weddings and feast day celebrations. Smoking is the mark of a man and at these huge celebrations boys play at being men. The boys are

either given whole lighted cigarettes or puffs from their fathers, uncles, or older brothers and cousins. At his aunt's wedding, Attiyeh was given a whole cigarette to smoke by the groom who is also his uncle.

The equivalent license for girls is make-up. At henna celebrations, feasts, and weddings, small girls get to wear bright blue eye shadow, pink lipstick, face powder, and nail varnish. They get the make up that they can either from their own families or by being present at a brides make-up session and later helping themselves. They also wear their hair loose and do not have to cover or braid it.

At such occasions both young girls and boys can dance and sing to their hearts content without penalty or care. For all of the children involved in this chapter the real fun to be had was not in the course of their games or when playing with toys. They most enjoyed weddings and feasts when they pretend to be adults, and could dance, sing, and eat as much as they like.

D. GROWING UP

D.1 RITES AND EXPERIENCES OF PASSAGE

*** Toddlers**

To conclude this chapter about children in Rihan, I shall discuss the ways in which children grow-up and how they perceive their own futures. Children's physical, moral, and intellectual development is marked by events and experiences. Temper tantrums are one mark of the painful development of character and will. How families handle these tantrums indicate how they wish to shape the personal development of their children. Aziza completely ignores the tantrums that Atef throws. Amina beats Racha before she even throws herself on the floor to mark the beginning of a tantrum.

The word temper tantrum is not known in Rihan but the concept is definitely a familiar one. Mothers say that these fits are fits of jealousy and can only be dealt with through treats or through beatings. If the child is

justified in his or her jealousy, then a cherished treat or outing are the cure. If the child is developing into a jealous one and throws these fits frequently or if a mother thinks her daughters must know their limits from early on, then beatings are the answer.

Fieldnotes: Yesterday Fatma threw a temper tantrum which lasted for an hour. It was caused by her wish to stay naked and not wear a dress. She got a stick and began to beat her mother who beat her back. She threw herself on the ground and began to kick and scream. Then her mother offered her 10 piasters and I took her photograph which offended her more. **Koloh min el-dood** (it is all from the worms of jealousy) said Ni'mat. She is jealous from Atef because you took his picture.

On another occasion, a tantrum thrown by Atef was said to be because I had ignored him and that had made him jealous of the other children I was with. He threw himself on the ground and began to beat and scream. Aziza was sifting wheat. She began to call to him lovingly, but to no avail so she threatened to beat him and that brought on more tears. He only quietened down when threatened with the wrath of his cousin Essam.

Mothers do not believe that such crying and screaming fits are a natural part of growing up. Rather they relate each fit to a particular situation which has inspired the child's jealousy and consequently the fit of screaming and crying.

* **Small Children**

Sharbat described circumcision as follows:

The boy sits on the magour and is circumcised. The girls thigh are held apart and "Hob!" they cut her thing off.

These are the simple facts of circumcision or **tohoor** as it is called in Arabic. But the rite of passage of circumcision means different things for both boys and girls. Although a must, circumcision for boys is often tied to a **nadr** (promise). A family makes a **nadr** to a saint, in this case the coptic saint buried in the church at **Rihan**, and they will celebrate the son's circumcision by making an offering at the saint shrine. This is often a promise made in return for the fulfilment of a request such as the survival of the son. This **nadr** is described as a **tazayoun** promise. **Tazayoun** means shave. Boys circumcised in this context first have their hair shaved at the shrine, then they are circumcised. Some families insist that this be the first time a boy shaves, so they leave one lock of hair unshaved/uncut until the boy is circumcised.

Thus a family says if our son survives we will **nizayin loh** (shave him) him at such and such a shrine. Circumcision there implies sacrificing an animal and feeding the shrine keepers, the poor in the village and the boy's extended family on both sides. Om Ahlam for example had made a **nadr** for her two sons. She had to wait until one was eight years old, and the other was six years before she could fulfill it.

Om Ahlam circumcised both her sons a few months ago when their father was home. **Zayenet-lohom** (cut their hair) for the sake of Abu Isaac (the local saint) although the barber actually cut their hair at home. They feasted at home and hung up loud speakers for three days playing music. On the third day the boys were circumcised. Her husband had been away for two years and came back for 40 days. Before Saudi Arabia

he had worked in Jordan. During the ceremony she had henna on and Ni'mat commented that the next baby was on its way. She borrowed pots from Ni'mat to feed the attendants.
(Fieldnotes)

Attiyeh is as yet uncircumcised because Ni'mat and Hashem have made a **nadr** which they are as yet unable to afford. Attiyeh said that other boys tease him, but his brothers defend him saying it is more important to fulfill a **nadr** than to be circumcised when young. He is looking forward to the festivities his parents have promised him and says he does not mind anticipating the pain that the operation involves.

For boys circumcision is not a rite of passage or a mark of growing up. Some are circumcised much earlier than others. A rare few are circumcised as babies. For boys the whole operation is viewed as one that completes their coming into being. It is as though this is the last stage of being born. It does not mean that they are big or small. It is a necessity that no one even considers foregoing, and one which is to be celebrated as the final stage of becoming.

For girls, circumcision is a rite of passage to womanhood. Girls are circumcised when they are close to menarche. Once circumcised, they are requested to observe codes of modesty. Circumcision is the first qualification for marriage. Salma remembers her youth saying "I was married before I began to menstruate so they had to circumcise me for my wedding."

Noura and Poussey were circumcised together despite the one year difference between them. They were circumcised at the age of nine and ten years. Noura recounts the experience

When the barber came they called me and Poussey and we lay on our mats, you know, like the one that you sit on. My aunt Aziza held my legs apart and when I struggled she said "Be quiet, you are already breaking my heart!". Karima held Poussey. My mother and Fathiya went and stood at the corner of the lane, they both

could not bear to hear us cry[7]. The barber took out the blade and Aziza tightened her grip around my thighs and then I cried out "**Balash, Ilhaqiny ya ma**" (Don't! Help me mummy). He held the blade in one hand and a big piece of cotton and then "Tickk"[8] and
I felt such pain that I thought that I fainted but I didn't because I remember seeing the blood and the barber putting the cotton between my thighs and Aziza putting my thighs together and telling me not to cry and scare my sister. Then he did it to Poussey and she passed out.
My mother came and gave me milk and sugar and gave some to Poussey but she threw it up but I didn't. Then she congratulated us and told us that we had done well.
We had to stay for days lying down because we could not move. I was so sore that I could not pass water. My mother changed the wound for us everyday or so. Poussey got a fever but I didn't. The women camein the evening to wish us well and my grandmother sent us a chicken so we could drink the broth. I even had a bit of the breast.

The girls are relieved that it is over and done with, and love to tease Fatma telling her that come next summer, they will ask their father to call in the barber to cut her thing off. They still play around the village lane and are very rarely advised to act in a demure way. One could easily assume that the rite of passage of circumcision had not really effected their transformation from girls to women. But that is not the case. Although they often behave and act like young girls, their suitors have begun to approach their families.

Poussey who is fair has been asked for by a cousin. He was told to wait for three years or so until she grows up. Nora has not been asked for. Perhaps because she is a little envious of her smaller sister, she tends to over react whenever any talk of marriage comes up. Even if a visitor asks her an innocent question like "Will you take a cousin or a stranger?" Noura begins to cry and withdraws

---

[7]. Fathiya and Karima are the sisters in law of Aziza, the girls' maternal aunt. They and Aziza and Ni'mat and their husband' are all first cousins.

[8]. She mimicked the sound of ripping.

to a corner. When I asked her she said that she wants to work in the house to clean and bake and milk but she never wants to marry or have children. She said that marriage is very painful and so is child birth and that she wanted neither. Poussey on the other hand is a bit shy about it all, but with a bit of encouragement relishes contemplation of her distant marriage.

*** Morals and Manners**

An important aspect of growing up is learning morals and manners. Young children are exempt from such pedagogy and their behaviour is either accepted or admonished on the spot. A small child may be slapped for a deed that may on another occasion go unheeded. "They do not understand a thing" is how small children are excused for their behaviour. The only exception are temper tantrums or jealousy fits which mothers sometimes try to keep from getting out of hand.

Older children are taught basic principles which they must not transgress. Self respect, honesty, fortitude, and religiosity are important traits in a man. While families may differ in their actual behaviours, they are similar in holding these principles as ideals.

Once Hashem discovered that he was missing two pounds from his wallet. He realized who had stolen them when Attiyeh came to his mother crying saying that Osama had taken his one pound. When Ni'mat asked him where he got a whole pound from, he had to admit that they had taken it from their father's pocket. This was the first time the boys did such a thing. They had been tempted by the large amounts of money Hashem had in his pockets after selling the onion harvest.

The boys got a terrible beating and could hardly walk for days. Ni'mat said that some people teach their children to steal and say that it is a necessary part of life. She and Hashem were honest people and would not accept it if their sons turned out to be thieves. That is why the boys

were punished severely.

There were few incidents during my presence in the village that necessitated severe punishment for girls. One story that happened some years ago still circulates as evidence of how necessary it is to be strict with girls. The story goes that four girls, two of them cousins and the others neighbours talked each other into escaping from Rihan to Cairo to become television stars. They were all under the age of 15 years and had all left school at various stages. One day their families woke up to find them gone. All four had absent fathers working in Jordan and Saudi Arabia. Their uncles and mothers felt an added responsibility due to the absence of the fathers.

A thorough search was undertaken and the four were dragged home from Cairo railway station by relatives who went in search for them. All in all they had been gone for less than twenty-four hours. They were beaten and each one locked up for weeks. One was burned with hot blades by her mother. Another was starved by her family. At the same time, their families made sure that everyone knew that they had been absent for a very short time and that their honour was untouched. The girls had not run off with men, they had escaped together to become actresses.

Thanks to the wide circulation of these explanations, three of the girls were lucky enough to find cousins who married them and all are now wives and mothers. The fourth who is a neighbour of Salma is yet un-married and is a very shy girl who is never permitted to leave the house by her mother. She is waiting for marriage.

The one thing a girl must do is guard her honour and ensure her marriageability. Otherwise, little is expected of a young girl. Once married, girls are reminded that they must be kind to their neighbours, obedient to their husband, and generous with their time, efforts, and belongings. But such injunctions are part of the ideal of being a woman and are rarely put to un-married girls. For these girls honour is paramount.

D.2 AMBITIONS FOR THE FUTURE

All children devote part of their imagination and discussions to wondering what they will be when they grow up.

Some of the girls in this sample who are in school had dreams of learning how to sew or of getting a middle school qualification. All, except Noura, took it as a matter of course that they would marry and have children.

The boys were ambivalent about their prospects for the future. Essam had wanted to be a footballer. His uncle Atef, his father's brother who now lives in Cairo, had a magnificent future in the game ahead of him, but was forced by his father to give it up.

> Our fathers care about the land and the work. My father used to beat me when he found me playing football. We are young and have the right to play football. But they just want us to go and irrigate or plough.

He is frustrated because he had hoped to pursue this dream, but knows that he never will. He is the oldest son and he feels that his father wants him to work the land and his mother wants him to marry. Already his paternal uncle's wife is dying for him to marry her not very pretty daughter, but he has so far resisted. On the other hand he often says "She is **bint 'ammy** (my father's brother's daughter) and who else will take her but me?!"

Saber is as realistic about his prospects. "What can I be when I grow-up, **mohandiss touriya** (an engineer on the plough)?!" he said sarcastically. When I asked him and other boys one evening as we all sat on one of the village lanes what they wanted to be when they grow-up, few had any imaginative answers. I was surprised since the answer 'jet pilot', 'police officer', 'army officer' are to be expected from boys their age. My question extracted smirks and amazement from them and from their families when in turn I asked them. On another occasion when we had the same discussion, Abdel-Al said that he wanted to be rich and the other boys agreed.

Speaking on behalf of her son, Naggat said that

villagers have no expectations because a son will grow up to be like his father. She re-phrased my question to four year old Amr asking him would you like to 'read' meaning to be educated. His reply was a firm "No". "Then would you like to get fodder for the animals?" "I'll drop it" he laughed. "Would you like to go to Saudi Arabia?" He smiled and did not answer.

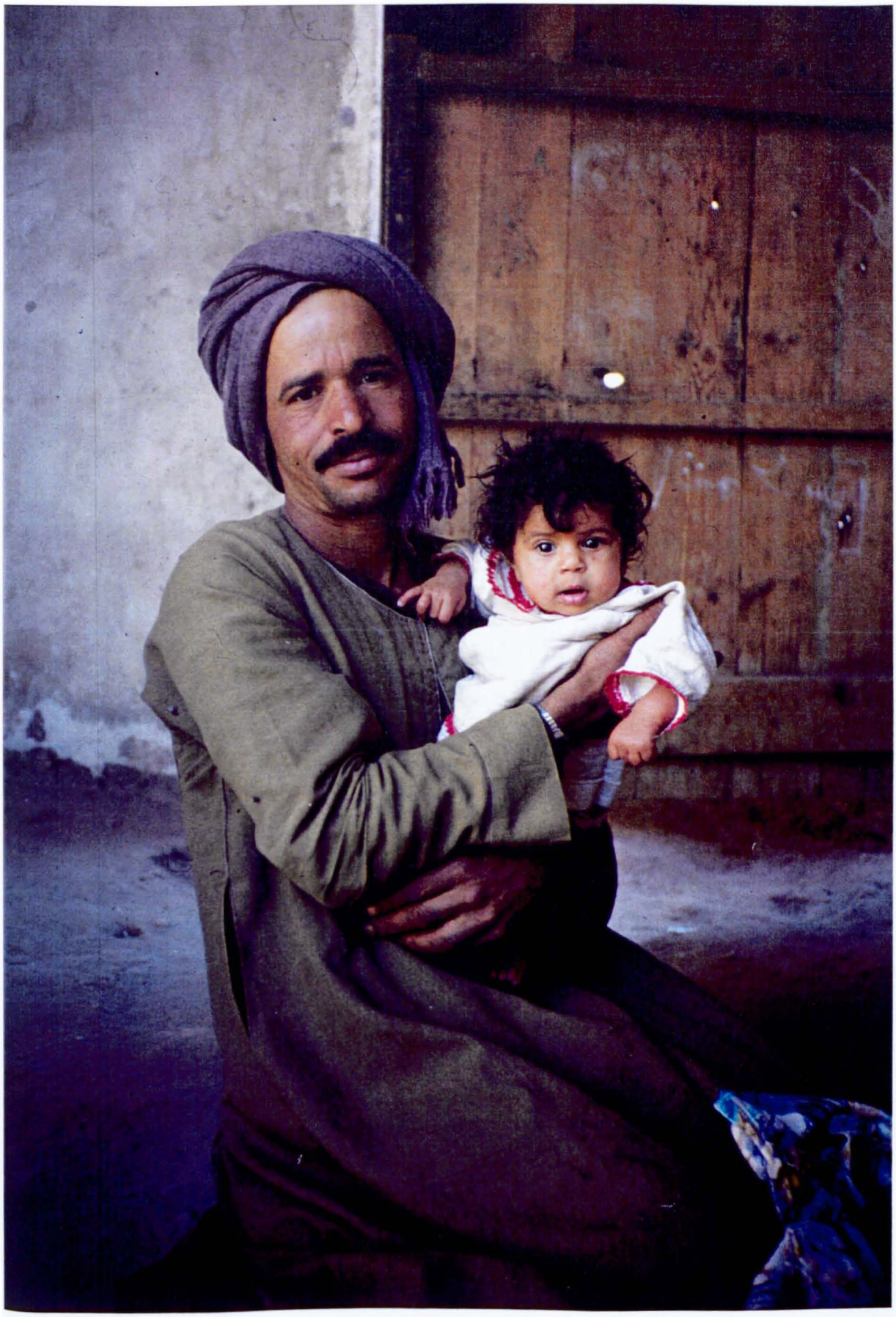


Plate 10

Plate 11

Plate 12

Plate 13

Plate 14

Plate 15

Plate 16

Chapter Five
Health Narratives and Meaning

A. THEORY AND METHODS

A. 1 INTRODUCTION

This chapter addresses the definition of health and well-being as well as that of ill-health and its causation within the parameters of village relationships and resources. The everyday processes, experiences, and values which colour and shape villagers' social, economic, and political lives, also engender their concerns, conceptualizations, and experiences of health and ill-health.

In Rihan modern medicine coexists with other medical cultures. However, while modern medicine is powerful, it is not always convincing. In its shadow lie other intellectual traditions which construct health and ill-health in wider and more diverse terms. These concerns form an epistemology of health and ill-health which transcends both as physical experiences and constructs them as social and historical categories. In Rihan mothers and fathers have a very different view of why a child becomes sick from that held by medical practitioners. Similarly, how one goes about keeping a child well makes explicit the conflict in points of view between physicians and villagers (Kaufert & O'Neil 1993; el-Aswad 1988; Nichter 1980).

This way of knowing and of constructing health and ill-health and its relationship to some biomedical principles is the topic of this chapter and a key point in the general argument of the thesis. Establishing these processes of conceptualization is an essential introduction to the description of health services and management which will follow. This chapter describes the processes whereby the health of children in Rihan is conceptualized by their families, and showing how such processes of conceptualization and articulation reference the social, cultural, and material circumstances of villagers in Rihan.

A. 2 MEDICAL PLURALISM IN EGYPT

The coexistence in Egypt of medical traditions and their competition and complementarity is a field and a fact that medical anthropology has investigated and established (Early 1992; 1988; Gran 1979; Inhorn 1994; Morsy 1993; Oldham 1990; Sholkamy 1990). Many of these works have established the hierarchy of resort which people in various communities employ in their health seeking behaviour (Lane & Millar 1987). They have shown that people use both local and biomedical services and medical traditions to restore health.

The way health is conceptualised is different from the process by which it is procured and protected. While biomedicine may be an often used material resource, it is not clear if it is a popular or effective intellectual one. Morsy explains that villagers use modern medicine for symptomatic relief but rely on traditional healers for disorders that are considered to be directly related to socially significant ultimate causes (Morsy 1993: 176).

Early comments that the curative system of poor Cairene women replicates the dichotomies that they construct in their social world between **baladi** (local) and **afrangi** (foreign) with regard to their conceptualization of traditional versus biomedical curative traditions. But this pluralism is not a wholehearted adoption of either type of medicine. Early observed that women either never finish prescribed courses of drugs or take less than the prescribed dosage (Early 1988: 78-80). They use different health care systems, but retain their own medical ideology and so have an impact on whichever system they use. But the work of both writers does not linger on the input of biomedical categories in processes of conceptualisation of health.

In **Rihan** there is a similar dichotomy, to that described by Early, in terms of peoples simultaneous use of different medical traditions. But the way in which health and ill-health are conceptualized in the first place lies

solely within the baladi or traditional realm. In the village, ultimate causation, social significance, and historical meaning and consequences are thought to lie at the bottom of all major health mishaps. While, as Morsy describes, modern medicine is used to relieve symptoms, a different medical culture is referenced to explain, predict, and rationalize health and ill-health.

Inhorn (1996) and Morsy (1993) have both discussed gender and power relations as important health determinants. But the conceptualization of children's health and ill-health in Rihan points to the importance of social relationships within the family and the community as the most significant of health determinants. Health and ill-health are community bound and are expressions of the individual's and the family's world view (el-Aswad 1988).

In this chapter I shall attempt to go beyond the description of medical syncretism, the eclecticism of health seeking behaviour, and the political economy notions of ill-health as powerlessness. I shall discuss determinants of health as they relate to children so as to understand the social origin of the epistemology of health and well being as it is articulated in language and narratives connected with child health in Rihan.

A. 3 HEALTH NARRATIVES

The health narrative has emerged as a major methodological tool of medical anthropology. Health narratives are the stories that people tell about their ill-health experiences. They are the patient's answer to the physician's case history. Medical anthropologists have used the health narrative to illustrate the articulation of physical and spiritual experiences, of past and present, and of the personal and the social in the construction of health and ill-health experiences (Early 1982; 1995; Frankenberg 1995; Good 1994).

Early (1982; 1985) who has written of the health narratives of Cairene women, shows how narratives change over time and how they are socially constructed and contextualised. When women tell their stories of their own and their children's health problems, they are also telling of their perceptions of the past and the future, of their beliefs concerning causality and therapy, and of their definitions of health and ill health.

Narratives do change over time but also from one listener to another. Like any story, health narratives are a reflection of a relationship between narrator and audience. The narrative told to the ethnographer is not the same as that shared between neighbours. At all times, these narratives can only tell 'partial truth' (Clifford 1986). Narratives of ill-health conditions changed dramatically as did my relationship with the family whose child had been the victim of this condition. My interest in collected narratives came to be focused on their taken-for-granted notions of health and ill-health rather than their factual content.

More interesting than their value as reconstructions of chains of events, health narratives are illustrations of how health and ill-health epistemologies are used and constructed. Consequently, the narratives that I collected are indicative of what goes without saying, what is taken to be a matter of course, and what is recounted as uncontroversial fact (Bourdieu 1977: 16-18).

In this chapter, 'untidy' narratives of children's health problems will be used to further illustrate how health and ill-health are defined through recourse to non-biomedical health determinants such as kinship, poverty, biographical events and dramas and super-natural causality.

The chapter will first present the definition and construction of health and ill-health as expressed by families in Rihan so as to estimate what villagers believe are the determinants of health. A consideration of time and history as

they are relevant to health will be offered. Next the use of narratives as methodological tools for the understanding of ill-health and health constructions will be illustrated.

B. THE DEFINITIONS OF ILL-HEALTH

B. 1 Being Sickly

Batlan , Mareed, or **'Ayaan ,** are analogous words which mean to be sick. These are words used to describe the condition of a child or adult who has been unwell for a protracted period of time which could extend for months, even years. The child who is **batlan** may regain health but will very soon become sick again and so good days and bad days merge and form weeks, month, or even years of anxiety, expenditure, and uncertainty.

Short term afflictions such as the occasional flu, headache, sunstroke, diarrhoea, or minor accidents leading to cuts and sprains are distinguished from the condition of being sick. A child suffering from any of the above is said to have a headache, a runny nose, a broken arm, **latshit shams** (sunstroke), **bi-yetmasha** [feminine: **bi-tetmasha**] (has runny stool and defecates frequently), all words which specifically describe the condition.

Children born with congenital problems or those who suffer disabilities are not described, nor do they describe themselves as **'ayaan** or "sick". 'Arafat (family F) was left deaf by measles and has consequently been unable to master speech. 'Ola (family M) was born with a mental and physical disability. Zeinab is severely mentally handicapped. None of these children are thought of or described as being "sick". Congenital and chronic conditions are accepted as the way these children are. Ola's mother told me **"Heya Kidah"** (This is how she is). 'Arafat is also accepted as being mute and deaf; this is how he is.

Mareed and **'ayaan** both mean to be ill/sick. **Batlan,** however, is the word most commonly used in **Rihan** and in Upper

Egypt in general. The term literally means unwell and implies weakness and lack of energy. When a child or an adult is described as **batlan** it does not just mean being sick but also intimates being sickly. Physicians at the general hospital in nearby Abnube, at the clinic in Arab Matteer, and at the government clinic in Al-Hamam all expressed their frustration at this category of ill-health. Adults bring their children and when asked for symptoms they say that he/she is **batlan.** The physician is then obliged to go down a whole list of possible symptoms to diagnose the case. What is most frustrating to them is that they sometimes cannot diagnose a particular condition and wind up prescribing expensive vitamins so as to avoid the embarrassment of prescribing nothing in particular.

In fact, the word is not just a generic, glossing term. When used in retrospect it implies a series of illnesses which affect the general well-being of a child. When used in the present it means that a person is generally incapacitated. The condition of being **batlan** affects appetite, energy, the physical body, and perhaps even the mind. Typically Mohammed Abdel Bassit is **batlan.**

Mohammed is a 3 year old boy. Since he was born he has been weak, refused to feed properly, and has had bouts of diarrhoea. His parents have taken him to several private doctors who gave them medications. A few weeks after their last visit to the doctor, he had a severe bout of diarrhoea and vomited. They took him to the hospital in Abnube very late at night. From there he was transferred to Assiut where he spent eight days accompanied by his mother and father. There he was put on an IV drip before being released. Two days after his discharge his mother found his faeces mixed with blood. His father came and took him to another private doctor in Abnube called Kamal Hassan Issa, who gave them a cure for dysentery. But he keeps vomiting and defecating blood from time to time. Every 3 or so weeks he is taken to the doctor. Last visit yielded a prescription which would have cost 16LE had his father bought all of it. They do take him to the government clinic from time to time where Oral rehydration salts have been prescribed. He refuses to

take them and the other private doctors have told them that he is a weak child who needs medication and vitamins. He has in the past suffered urine retention, acute respiratory tract infection and several nasty falls.

The above is a summary of the condition of a boy who is described as **batlan**. Although some of these events took place in my own presence and although I knew of days when Mohammed was well; I could see why these days did not figure much in the minds of his parents since overall he had been **batlan** for most of 6 months.

During the intervals when his parents were not coming and going from hospitals and clinics, his mother was consulting relatives, neighbours and spiritual healers. She sent his **Riha** (an item of his clothing which is then used by a **khateeb** [spiritual healer and sheikh] to diagnose his condition) with his father to Arab Matteer. There he was told by the spiritual healer that his son is **manzour** (an envious eye is focused on him). This explained why he was not getting well and did not conflict with, nor interrupt, resort to government and private clinics.

One could well ask if Mohammed was **batlan** because he is sick or sick because he is **batlan**!? While some children are thought to suffer the cumulative effect of successive bouts of ill-health and thereby become sickly, others are defined as sickly and consequently expected to be in continuous ill-health. The distinction between the two groups lies in their structural position in the community and in their biological, social, and political heritage.

"Only the precious get sick" announced the local midwife and village sage. Some special categories of children, such as only boys, boys with many sisters, children born into grief or family strife, or those who become afflicted by some spiritual agent may have a weak disposition to begin with. Such a child is prone to being **batlan**. A child who is born with a disability or with a very weak body is said to be **madrour**

(suffering from a defect) and is also expected to be sick often. These children are either over-protected, as in the case of only boys, or neglected as they are condemned to their poor health. In either case, this weakness may last until these children are 5 or 6 years old. In general, if they have survived these bouts, they will be able to survive their childhood. Children who are born strong to fertile couples and who have many brothers and sisters are expected to be well and to be able to overcome ill-health with ease.

'Ezz is another small baby who has become **batlan**. Following is his mother's and sister's joint account of how it happened.

> He drank bad milk. His mother was grieving for his dead brother so her milk was sour. Despite which he was strong with a round face. He was so strong that by the age of 40 days he was already eating boiled potatoes. But on the 40th day (they remember because it was the 40th day after his brother's successful suicide) and as his mother was bathing him he froze in her hands and became rigid. She thought that he had swallowed soap. She was sure that this could not be the case, after all he is her 8th and she has bathed her children hundreds of times. She had used the soap to do his head and had just splashed his body with water.
>
> She thought that he had died as he lay frigid in her arms. She carried him all over the house trying to see if he would breath. She carried him into the animal yard, the clay oven and the store rooms. She tore her hair and called her daughter. Fayza called the neighbours and they took the child into a closed room and lit the electric light. He was like a piece of wood and his teeth were set. He produced a sound as though he was choking. He came to but remained in this state for three days. The doctor was not consulted immediately. His mother took him to a woman in Arab Mateer who said that he has **al-warraniya**[1]. So she treated him with lemon, coffee and ghee daily and took him to see the woman every Friday until he was better. He has been **batlan** since. They have spent fortunes on him. He gets diarrhoea often, they try massage, oral rehydration salts, and antibiotics. They go to physicians and to healers. He is still breast feeding and the breasts of the mother are full but the milk is not making him well with a round face as it once did.

---

[1]. A form of diarrhoea. For details see chapter 7.

Baby 'Ezz is still batlan. He is a fussy eater and a nervous boy who cries a lot. He was alright until he got sick and has remained sickly.

Being batlan comes to express the child's disposition. A child who is prone to be sickly is expected to be sick. This in turn alters adults' expectations of this child's physical conditions and affects their health seeking behaviour and their recourse to therapy. Families do react in different ways. While some neglect the sickly, others overprotect them. Families with strong healthy children may pay their price for their confidence as did Mahasin who tells of her son's death:

> He was 4 years old and in good health. His face was round and red and he was such a good boy. He was playing up on the roof and it was a hot day. Then a playmate struck him on the head and he fell. He came inside and I was so scared because he was shaking. His grandmother said that it was latshit shams and she tied his head with a cloth after rubbing it with salt to draw the heat. He did not get better and vomited. It was only after 3 days or so that we took him to the doctor. He said that he had meningitis and gave him medication and said to take him to hospital. We brought him back so that his father could see him and take him to hospital. We all went and I stayed with him but he died that very night. He had been crying from his head. He was not batlan or anything he just died. Now I know that it was ignorance of his grandmother to not let me take him to a doctor.

Mahasin was justifying the family's reluctance to take her son's condition seriously by the fact that he was not batlan to begin with. In his case, she was expecting him to overcome his headache because he was a healthy boy.

The definition of a child as healthy or not also affects parents/relatives expectations of recovery. Medications are viewed as palliative which do not address the root of the problem. In some extreme cases, such as that of Ezz, children are considered to be in a structural disposition of being sickly. But because these children are expected not to promptly recover, their therapy is not seen as an issue of

urgency. There is no purposeful neglect as described by Scheper-Hughes for children in the North East of Brazil (Scheper -Hughes 1992). But there is a degree of acceptance of ill-health as far as some children are concerned which verges on being detrimental to the health of these children.

Being **batlan** marks a split in levels of exegesis and interpretation. At one level, the sickness event is addressed; on another the context in which these events take place is confronted. Thus families may seek immediate therapy for the particular bout of vomiting, diarrhoea, fever, or whooping cough at hand. But they also address the perceived root cause for the child's general condition. In the case of Mohammed, he was **manzour** (subjected to **nazra** or the envious eye). In the case of 'Ezz he was born into a structural disadvantage, he was born the day that his brother died, which affected his mothers milk and ultimately condemned him to ill-health.

Adham is also **batlan**. His mother says that his father used to beat her a lot when she was pregnant with him and that he had been born **madrour** (very weak baby) as a result of these beatings. Moreover she had become pregnant with his younger brother straight away so he did not breast feed enough. The problem with his early weaning is not that he had been nutritionally deprived, but that his early weaning had instilled in him a jealousy from the younger brother who had "taken his milk" and that this jealousy was the cause of his frail disposition. His mother remembers:

> Once he got diarrhoea and fever and it was so bad that his stomach was like a balloon and the veins around it protruded. When I went to the doctor he transferred me to the hospital in Assiut where they kept me for two nights and three days. Each day we had to buy him a bottle of medication for 5LE. I borrowed the money from his uncles.

The important distinction to make here is that **batlan** is not a diagnosis, it is a disposition which endows meaning on children's experiences of ill-health and the shapes the

responses of adults who are responsible for these children. It shapes these responses in seemingly contradictory ways. In some cases it leads people to address root causes as they perceive them such as the evil eye, malevolent spirits, **khar'a** (susto), or bad feelings in the family, to the neglect of other more immediate remedies and therapies. In others it makes people weary of any deterioration in a child's condition and they become aggressive in their pursuit of therapy for a particular sickness events. **Batlan** describes actuality as well as the potentiality of disease and of affliction.

This distinction between health and not healthy rests not only on the condition of the child, but also on their structural positions which may render them at risk.

B. 2 Risk as a Vicious Cycle

Once placed in this position of risk, it is very difficult for children to escape it. Children who have been sick in successive bouts for long periods of time are at times said to be caught up in a drug use cycle. They are taking as much medication as their families can afford and consequently suffering from their side effects and addiction. As the village mid wife put it **el-dawa keif** (medication are an addiction). All the mothers who had children with chronic conditions or whose children fell sick often were under the impression that their children are addicted to the medication (Melrose 1982). Insaf, for example believes her three year old to be addicted to the anti-allergy medication the doctor has prescribed for him.

> Insaf came back from the doctors where she had been all day. The doctor prescribed some shots. She had gone to Abnube to take her youngest, Abdelfattah who has a chest condition. He consumes a bottle of **Zaditen** every week. It costs 8.10LE($2.5). The boy had a fit the day before so she thought she would take him during the day when transport is cheap rather than wait to go with his father in the evening when a car costs 7LE($2). Today she booked a 60pt($0.18) ticket. They prescribed 7LE worth of medication for him. She stopped the **Zaditen** in Ramadan

because they needed the money. He has been booked in hospital three times since his birth (20/11/89). Once he stayed two weeks and the other times he stayed a week each. Each week of medication used to cost 20LE($6). In the village, they believe that he has a heart condition. The doctor said that it would go away when he is 4 years old but it hasn't. The condition began 15 days after birth. The boy seems alright. He was wearing kohl. His father says that the medicine is making his chest better but making him **batlan**. "Medications are strong and small children cannot bear them but you have people here coming and going to the doctor and bringing medication that their children become addicted to (**Ye-ghwah**) and fall sick if they do not have it. He has become addicted to this medicine that he has been taking for years!" asserted his father.

The more medications prescribed, and the more their families buy for them, the more dependent they become, and the weaker they are if deprived of these medicines. That is how families explain this cycle of addiction which they perceive as one of the main problems of a child who is **batlan**.

Dysentery is another condition which places children in a vicious cycle of risk. Dysentery is endemic in **Rihan** and very few households are free of it. Those children who have dysentery and who frequently defecate blood are rarely treated for their bouts of diarrhoea. When they become dehydrated, they are taken in for rehydration. But none of the parents whose children had dysentery thought that dysentery could be cured. Moreover, they feared that continuous episodes of bleeding would just weaken the child and make even temporary recovery impossible. These children are accepted as ones who are at risk and less healthy than others.

Sickly children also tend to eat less. Because they have less of an appetite, they are expected to be able to eat less than other children. Consequently they are often offered less food. Abdel Bassit's mother lamented that she could not afford to make him special foods or give him more meat because they were a poor family. She admitted that because they were so poor, she was unable to offer Abdel Bassit special foods like

eggs and meat,knowing that he would not eat them.

> If I give him a morsel, I know he won't eat it and I wind up having it anyway, so sometimes when the other children are hungry, I just give them the food and buy him a fizzy drink as compensation as he likes them very much.

Other women concurred that it is pointless to offer children food when they are too sick to eat. Meat was mentioned as the food that both gives health and needs health as it is difficult to digest and a heavy food. Mothers strive to give their weak children what they want rather than what they need. Sweets, fizzy drinks, savoury snacks, and the like are given whenever there is enough money to buy them. These foodstuffs gladden the hearts of children and help them overcome their distress and discomfort.

But children are not condemned to being sickly all their lives. Time, events, and growth may make them one day healthy again. Perhaps, after the family get over the tragedy of their loss, Ezz might begin to get better. That is, at least, what others in the village say.

B. 3 THE SICK BODY

Villagers in Rihan believe in the fluid body. They view the human body as a completely fluid and open one and not as one of interlocking or articulated systems (for Cairo see Early 1988). This view of the body has two important consequences for the conceptualization of children's ill-health.

The first is that since the body is one thing it cannot be fragmented and therefore one part of the body cannot be ill while the rest is healthy. Ill-health is expressed by the whole body. A child is not viewed as unwell unless all of him or her are affected. Children are described as vegetables, once they are sick, they completely wilt. The fluidity of the

body also extends to link psyche and soma. Children and adults who are going through difficult circumstances such as grief, or strife are expected to physically express these conditions and to become unwell (Morsy 1993: 112).

The second important effect of the notion of the fluid body relates to therapy, particularly for children. For example, the practise of **tamrees** (massage), described in chapter 8, rests on the notion of the **'amoud**, a continuous column inside the body which if obstructed or ruptured causes severe diarrhoea. Also cautery rests on the assumption that the crown and nape are the points of access for the whole internal body and are the places where children are cauterized if they are suffering from shock due to **khar'a** (Chapter 8). The fluid body expresses a notion of social fluidity and of balance which is important to health.

C. THE DEFINITION OF HEALTH

C.1 The Description of Health

The term **batlan** stresses well-being as a core concept for people in **Rihan**. Even if a child is not diagnosed as suffering from a clinically defined condition, but is not well, is not energetic, is not eating as much as he/she can lay their hands on, this is cause for comment and concern. To describe a healthy child, women and men put the thumbs and index fingers of both hands together to make a circle which they hold up saying "the face was/is like this". To do this is to bring the envious eye unto the child being described. It is only sanctioned to do so in the past tense so as to describe how a child was before he became **batlan** or before the child, God forbid, died. In addition, such a healthy and round countenance is usually described as being red. In this case, red may refer to fairness as well as to the wide-spread ideal of "rosy cheeks".

Healthy children are active to the extent of being rowdy

and disobedient. They should have a robust appetite and be able to overcome minor mishaps or health problems without falling victim to a vicious cycle of sickness and weakness. The generic word healthy is therefore not a residual category. It is a positive definition of a state of well being and not a negative one that describes the absence of disease.

C. 2 The Sturdiness of Girls

There is consensus in the village concerning the sturdiness of girls. Girls are in general healthy and healthier than boys. When small they are hungrier, have better immunity, and are much stronger than boys. The list of assumptions concerning the health of girls is a long one. When ever it is the topic of discussion, exceptions are made and stories of fragility come up.

There seem to be genetic factors which favour girls and so create a situation where female infant mortality is lower than that of males in Egypt. However, this small advantage that girls have is redressed by cultural factors which favour boys and so female under five mortality rates are higher than that of males (CAPMAS: 1993: 226)[2]

Mona, the two year old daughter of Mahmoud Abdel-Ghaffar gets sick often and her mother always takes her to the private clinic. Mona is always given as an example of a girl who is **batlana**. Sometimes those gossiping would wonder if it was because her father was making a lot of money in Saudi Arabia that she was so often sick. Once she had itchy genitals and was taken by her mother to a private clinic where she was given a long prescription that cost her, along with the

---

[2]. Out of every 1000 girls who survive their first birthday 29 do not survive to their fifth birthday. Out of every 1000 boys who make it to their first birthday, 20 die before their fifth.

visitation fee, 23 LE ($7)[3].

But the rule undoubtedly is that girls are **shodad** (sing. **shadida**) meaning that they are both healthier than boys and healthy in general. The mother of Adham, mentioned above, likes to remind people that she once had twins ".. the boy died and the girl lived" she marvels. Now this daughter is in 5 th primary and has never been sick a day in her life. As Salma, jokingly likes to say "girls are such devils, even their own **qarina** can't kill them!".

Girls cause a more difficult delivery and the labour pains they induce are not spaced as they are for boys. Also when pregnant with a boy, a woman may get nausea, but girls do not cause this sickness.

. These are all opinions of various women who were trying to determine the difference between boys and girls. Ni'mat and another woman present on this occasion disagreed. But they all agreed that baby girls eat well and enjoy better health than boys. Om Hassan compared her own daughter and son.

> The girls are strong and that is why they survive while the boys don't. My daughter Rida who is 4 years old only once got a bit of diarrhoea from mixing food when she was weaned but she took some medication and became well. But my small son is always sick. They live in the same house and eat the same food but one is strong, and one is weak. This is how God made us, otherwise, how would we be able to bear the pain of childbirth?!

The determinants of health or ill health, of **batlan** (fem: **batlana**) or **shadid** (Fem: **shadida**) transcend the actual experience of ill-health. At the simplest level, children who often get sick can't really be getting well in between incidences of ill-health. On a more complex level, children are born with predispositions defined by their social,

---

[3]. Dr. Samir Nakhla's fee is 3.50LE($1). He prescribed Solu cartef 100mg/2ml, Penecillin G. ampule, Oblong Novalgine Ampule, Mynophylline Paediatric suppositories. The girl had a severe urinary tract infection.

biological, and spiritual heritage and context. Children who are born physically weak cannot be strong and healthy. Girls are born well and tend to stay that way. Precious boys who are predisposed to risk because they are cherished need to be protected and nurtured.

C. 3 FOOD AND HEALTH

Healthy children can eat anything and indeed should be hungry all the time and eat a lot. Having good food is part of being healthy. Ideally children should have red meat at least once a week. This is the practice of most peasant households who cherish Thursday nights when meat bought earlier on in the day is cooked and consumed on the night and maybe even on the next day for Friday lunch. Red meat is a delicacy which supplies strength and energy. Because of scarcity and poverty the meat that is bought often contains more fat and bone than meat fibre.

Milk and meat are the important ingredients which children need to grow. If they are not getting enough of either than they are expected to become sickly and eventually become sick. Sick children should be given meat and broth to revive their energy (chapter 8). The same prescription applies to weak children who need special protection from sickness. The belief in the efficacy of meat and ghee is universal to rural Egypt. In the good old days, wealthy Egyptians used to have chicken on their non-meat-eating days. Now with the soaring price of meat chicken is considered a replacement. The following account is typical of Thursday mornings in Rihan when families are getting ready for the meal of the week, the meat meal.

Ramadan knocked at the door as Ni'mat was skimming the morning's milk. He said that he had bought a goat from the market to slaughter with others and divide the price. The practise that is common in Rihan is for a man to buy a goat or sheep and to offer to slaughter and cut it up in return for the normal fee of the skin and head. The

rest of the carcass is sold off without obvious profit. Some people buy meat, others who cannot afford meat get bits of bone, fat, and or entrails. These local part-time butchers do not slaughter the animal until they have presold all of it. They can neither afford to treat their own households to the unsold meat, nor do they have means of storing it and selling it later. They must be wealthy enough to make the down payment for the animal in the first place but they can rarely afford not to be repaid in full, including their transport to and from the market. If the animal is not pre sold then it is kept until there is enough demand.

"I have already sold three quarters of it" he said. He wanted Ni'mat to pledge to buy a kilogram or two. She refused saying that Hashem, her husband was buying meat on his way back from Assiut. "You have a fridge, you can keep the rest" he challenged her. "Don't you eye my fridge, even so, where can we get twenty pounds for more meat" she replied.

He began to plea with her saying "Are our children to starve, they'll be sick, mine haven't tasted meat for weeks, they'll forget the taste". But Ni'mat would not budge. She suggested that he ask her aunt who might be interested.

Ramadan knocked on Auntie Salma's door and explained the situation. She refused saying that her husband was away and she was alone. "Treat your two grandsons he suggested, they need meat". She still refused saying that the boys eat with their mothers in their fathers' homes. He then joked saying "then feed your granddaughters!" As he left she ran after him and asked if any one had bought the neck. He said no. She then told him that she would ask her daughter whose husband was also away if she would share the neck with her "Let the children eat" she said. Ramadan continued his round but failed to find buyers."this village cannot afford meat on a Thursday, this is how poor we are. Now all of those who had promised their children meat will give them a can of sardines instead."

The next morning I saw his elder child Sha'ban in the street. The first thing he said was that towards the afternoon, his father had sold the rest of the animal and had slaughtered it. "We had meat and broth and my father ate all of the head" he said with a huge grin. Then he added "Even my sister took a share just like mine". (FIELDNOTES)

While all food comes at a cost, villagers make the distinction between **illy min el-beit** (what comes from the house) and **haget bara** (things from the outside). The former

are foods produced by household members from their land and livestock. These are foods for which the family does not pay money. The latter are items which cost hard-to-come-by cash. Many families cannot spend money on food and try to make do with what they can produce themselves (chapter 3).

Vegetable and fruit merchants in **Rihan** specialise in rotten produce. One merchant explained "in this village they cannot afford the top quality stuff so we go to the market and buy some good stuff for the few who will buy it and we collect the rotting stuff which is what people can afford". Some families buy a mixture of rotting and good tomatoes and put them together in the evening salad so that the plate is affordable and not too offensive.

Children need a house with a water buffalo or cow in it so that they are guaranteed a supply of fresh milk, cheese, and ghee as well as money. "Ezz comes up to the **magour** (clay container) while I milk in the morning and licks the milk from it like a cat" said Om Ezz of her toddler son. She says that it is the only proper nutrition he gets and without it he would be even sicker than he is. When their water buffalo was pregnant she had to buy milk from the nearby dairy farm owned by the government. However this milk is often adulterated with water. The milk was expensive and not as nutritious as that of the house. She stopped buying it and relied on the generosity of neighbours who offered Ezz the occasional early morning cup until the buffalo had her calf. "Then I distributed **Sarsoubiya** to all those who kept Ezz well with those sips of milk" she said.

Sometimes the children get bones with no meat on them. When chicken or pigeon is on the dinner **tabliya** the task of distribution becomes an intricate one where meat, entrails, skin and bones are figured in calculations of equity and entitlement. For example when the family of Awadalah (family K) sat down for a dinner that included a chicken and two pigeons. The babies in the family got bits of fried liver and

kidneys. The rest of the children like Mahmoud, Sharbat, Mostafa, and Ola got the bones which they cracked and munched to an ingestible mass[4].

It is not an exaggeration to say that the provision of meat to the house and family is one of the main roles of the head of the household. Meat has nutritional, near medicinal, social and economic significance. Adila (Family L) for example, would often say that before her Beloved Sayed died of cancer she had tried to keep him strong with meat and broth. When his head ballooned into double its size because of the tumour growing inside it she use to "Bring him meat to gladden his heart, and books because he was so intelligent and Pyrosol (insect repellent) so that he could sit in cleanliness". Now she only has Abdel'Al and his sisters. She laments that she cannot give them the food they need to be well. I once innocently suggested lentils as an alternative source of protein to Adila. Her response was tears in her eyes as she repeated "Yes I can give them lentils but no meat, my children can only eat lentils, we poor people can only eat lentils". For Adila lentils are poor food. She could not strip both foods down into their nutritional values. For her foods are more than calories masquerading as proteins and carbohydrates, etc. Meat is more than the sum of its calorific content. Meat is a good energy-giving, satisfying and tasty symbol of well-being. Lentils are lentils.

In Rihan good health lies in breast milk and a proper nourishing diet that includes semn and meat. All these foodstuffs have a highly valued symbolic significance. Breast milk is a completion of a process begun in the womb and for that reason it is important. But the quality of breast milk can be contaminated and so it becomes dangerous for the child

---

4. The family is an extended one. Awadallah and his wife have two married sons and their wives and children living with them as well as their own two unmarried daughters and two unmarried sons.

to take[5]. Meat, Semn, and house milk are important for older children. The indication that they are valuable in and of themselves is the fact that there are no satisfactory substitutes for them. Children in the past had plenty of these food items and so were kept in good health. Now they eat sardines and prepacked snacks as well as sweets vended by street sellers and convenience stores in the village. One mother lamented her sons favourite food is pasta, an item that can only be bought in the nearby town. Her worry was not that it was good or bad for him. It was that it was expensive and she could not supply him with enough of it and also buy **Semn** and meat.

Children in **Rihan** and villages in general do not go hungry. This is seen as one of the major difference between village and urban children. As long as houses produce food than there is enough to feed on. The poor in cities are perceived to be less fortunate because they have to buy everything, even their bread and that is a tragedy since money can never stretch far enough to cover food that satiates as well as food that nourishes and strengthens. As Auntie Salma, a wise older women asserted "the best protection for a child is to have a **beheema** (dairy producing animal) in the house, the child gets a sip of milk, a little **Semn** and the family buys meat and eats".

D. HEALTH AND HISTORY: A DISCOURSE OF CONTRADICTIONS

The pursuit of my line of inquiry about health and sickness amongst children created a degree of controversy. "All these women complain to you about the health of their children because they think that you are offering free medication or that you can get them money from the government"

---

[5]. Breast milk is can be contaminated by the mother's health, The mother's pregnancy, or the mother's grief or anxiety. Formula and tisane become replacements as they keep a baby calm, satisfied, and chubby.

my host told me. I protested that I had been documenting the ill health of many children and that I could tell the difference between truth and falsehood. He retorted saying

> We were all brought up in the dust and mud, these children are sick but they bounce right back. They eat and play in the sun and they are better than children in cities. Mothers now run to the doctor for every little thing. This is what has spoiled the health of our children.

This well-intended warning against gullibility became a common refrain heard from mostly men, and some older women. It reveals a genuine interpretation of the health situation of children. Before the proliferation of both public and private medicine children died more, but when they survived they were healthier. This is not an accurate sociological observation and is not mentioned in this written work as one. It is an aspect of a discourse of recollection that somewhat romanticizes the not too distant past. As such it is a discourse that is teeming with glossing generalizations and serves as a commentary on the present more than as a rendition of what life was like before (Vasina 1985).

In making this assertion I am relying of the contradictions and controversies of this discourse. In harkening back to the old days, people almost simultaneously recollect the treachery and the hardships of the time. Typically Om Abdel-Wahab recalls the good old days when her 12 children would eat what was there to eat and all grew up healthy and well, only to remember the five unfortunate ones who had died while small children from fevers and from "nazla, you know what they now call gafaf" she said referring to diarrhoea and dehydration. Comments like "we never used to go to the doctor" are rebutted by younger members of the family who may reply "There was no doctor to go to!" or "No, people just died like chickens!"

These discussions intimate a historical dimension to health. As well as being a predisposition, a natural state,

and a social position, health and ill-health are subject to time and what it has to offer. Some people believe that long ago the quality of their food was better even if the quality of their life was not. Om Mohammed explains why children were nowadays so sick and weak.

> Now **el-marad** (sickness) has increased. It is because of **el-gaw** (Environment). Now children eat sardines and snacks. They eat sweets and the quality of food is now different. Now children know about macaroni and potato chips. In the olden days children were reared on rice or **Disheesha** (cracked corn or wheat) heated up with sugar and milk. When there was no sugar molasses is added. Today they do not have the benefits of the old diet. Although now people are richer they are in worse health. Even the rich can no longer afford good milk, molasses and most importantly semn. Before, if a baby is a **batlan** he is given rice and sugar boiled together as **aseeda** (porridge).

Women in **Rihan** say that modern times have brought with them modern diseases. "We never had **gafaf** (dehydration) before" said 'Alia, Ni'mat's mother. When I described the symptoms of dehydration, she laughed saying, "Aha, that is what they used to call **hagma**" she said. She is like many others in the village who believe that children were healthier because there were none of the terrible diseases of the day around then. Other excerpts from fieldnotes may illustrate the point.

> Om Mohammed was sewing. Her sister in law came out carrying her son Hassan who is **batlan**. His family have spent fortunes on the boy. The last two examinations yielded eight medications which the mother showed me. I asked why children were so sick. The answer came "because **el-gaw** is full of diarrhoea". The father and grandfather of Hassan genuinely felt that people used to fall sick less often. The sister said that until now, she had never taken an injection. Her sister-in-law said that she had only taken the tetanus shot when she was pregnant.
>
> The boy has chronic diarrhoea. He was playing with a kitten which he had almost killed (he had tried to crush its head). His aunt lamented that he was weaker than a kitten!

This uncertainty about the past and the present plays a

key role in the definition of "healthy" and "sick". One widely held belief, as mentioned above is that new medications are for new sicknesses. Diarrhoeal diseases are a good illustration. **Amrad el-Ishal** means diarrhoeal diseases. It is an urban and scientific category that describes diarrhoea and its possible complications, the most problematic of which is dehydration or **gafaf** in Arabic. The National Campaign for the Control of Diarrhoeal Diseases Project (NCCDDP) mounted very successful television and radio spots that advertised the benefits of Oral Rehydration Therapy and warned against the dangers of diarrhoea and dehydration.

Although the item being introduced in these media spots was the medicine, the oral rehydration salts and therapy, and not the malady, for many viewers, it sounded as though **el-gafaf** was also new on the market. Invariably, women interviewed and observed during the course of fieldwork referred to **el-gafaf** as something new that did not afflict children before.

The local lexicon that has currency in this and other villages differs from that used in the official discourse of radio and television. **Horar** means watery stool, **bi-yetmasha** (feminine: **bi-tetmasha**) means frequent defecation, **el-sakta** means dysentery, **nazla** is the word that describes gastro-enteritis and the possible complications of dehydration and death. While everyone knows what **ishal** means this word, which could refer to a simple bout caused by cold, was rendered by the spots to be of grave and dangerous consequences.

The spots provided parents with simple diagnostic tools to identify dehydration. This seemed to add to the novelty of the disease. These tools included the detection of sunken eyes, loose, dry skin, and loss of appetite all of which are part of the formula for being **batlan** and indicators that a child/infant is on the verge of suffering from a serious **nazla**. However, these were specified as proof of a new thing

called **gafaf**.

In the past small children died or were seriously ill with a **nazla**. Now mothers and fathers refer to the spread of "what they call **el-gafaf**"; here they are referring to the medical discourse of the media campaign and of physicians. In response to my question concerning **el-gafaf**, Om Mohammed the midwife answered saying:

> There was no **gafaf**. Children would get a **nazla** and would either be cured from it or not. There was no oral rehydration therapy or medications. We used to tie a child's head with a rag after massaging it with salt to absorb the heat, massage the body with ghee or oil, or even a bit of soap to mend **el-amoud**[6] and other such local prescriptions. Now these things don't work because the causes and the diseases are different. And like our local prescriptions did not always work neither does the therapy or the drugs always save the child.

Talking about health and ill-health always gives rise to the issue of whether people were better off before than they are now or vice versa. This question masks a deception. Rarely do people specify what they mean by "before". Is it the pre-revolution days of the large Coptic landowner Balsam Wissa for whom many of the villagers worked as labourers? Is it at the dawn of the revolution when the village was too small to benefit from many of the pro-peasant legislations? Is it twenty years ago when the out migration began and money followed, pouring into the village and reviving the lot of many of its people?

By and large the old refer to the days when there was no money, no water, no electricity, no services, no roads, and no transport. These days are called "**ayam zamman**" (Days gone by) and life then is alternatingly describes as being **'isha souda** (Black life) or **'isha kola-ha kheir** (a life of goodness). The reasons for this seeming eclecticism may be put down to the

---

[6] Literally El-Amoud means the column and refers to the passageway from mouth to anus which is the central pole of the human body and which once broken or disrupted causes diarrhoea

fickle nature of nostalgia.

In thus describing the past, villagers are expressing two aspects of their experiences of the present. The first is their entitlement to medical care. This is a service that used to distinguish city dwellers from villagers and rich from poor. Now this situation is no more and villagers feel that they have 'a right' to a medical consultation and so they seek it out whenever it is available and affordable. But this leads to the second component of this view of the medical present, that is peoples's experiences of the quality of care which they receive.

This would seem to prove the widely circulated belief amongst physicians which claims that "as villagers become healthier they have more health complaints" as one paediatrician at the Abnube general hospital explained. Meaning that the more access people have to health services, the more conscious they are of their health and the less tolerant they become of minor complaints. But this is far from the truth. Villagers are not pampered consumers of health services, neither do they find pleasure in their attempts to seek public and subsidized health services.

"Once you fall sick, you are never as you were again" Naggat proclaimed as we viewed her son's burn marks. She feared that now he had scalded his arm, her 5 year old would consequently suffer in pain, stop eating, get bad tempered and then only God knows what will befall him. As far as children are concerned, it is better to not fall ill at all for fear of the prolonged cycles of weakness and potential complications in which children could become entrapped.

It is true that private health care remains a luxury that villagers flaunt once they can afford it. Being taken to see a private physician remains a gesture of affection made from husband to wife and from son to elderly mother. However, being healthy is still a point of pride. "I have always been like a horse" said Nimat "So are my children, not one of them has

been sick when they were little." On the other hand more and more children and their parents have come to suffer from various maladies, diseases and general weakness. "Now there is not a single house that does not have a sick person", lamented the self same Ni'mat on another occasion.

This constant to-ing and fro-ing between past and present in search of generalizations is not specific to child health. People wonder if economically, spiritually, and morally they were better off in the old days or not too. The significance of this discourse is the extent to which it provides a historical dimension to health and well-being and thus transcends the limits of the biomedical model. The emphasis here is placed as much on the provisions of everyday life in terms of a clean environment, the goodness and integrity of food (no alien ingredients such as vegetable fats, synthetic oils, frozen meats and canned/preserved foodstuffs), and the homogeneity and coherence of the village community as it is on the availability of modern health care and drugs. The conversation is one that continuously and interchangeably favours one era over the other.

The differences between local and official discourses and the lexicons that they employ have been plotted on time rather than on space. Now el-gafaf is known but [illegible] seen as a new thing not another name for a familiar condition. Similarly, cancers, hypertension, kidney failure, and diabetes made their appearance in the village community when they were given a name and that name was qualified with symptoms. Before, they are not recognized as having existed.

Cancer took the life of a 10 year old boy Sayed. He had a brain tumour and no one had ever seen anything like it nor could anyone recall a case of cancer. "This is all new to us" said one neighbour. My host asserted this by giving an example from his own family. His brother, Mohammed, is a man in his sixties who suffers from Leukaemia.

They say all of these bad diseases are hereditary but

that is not true. Mohammed has cancer in the blood but none of our ancestors had anything like it. We had a great aunt who had **faqr dem**[7]. She used to be very pale and when she turned her eyelid it would be white not red like healthy people. They used to tell us that she would be cured if she ate meat but she became too weak to eat. That is the only person we know who had anything in their blood. These bad diseases did not exist before.

Sayed's mother got to know all about tumours, Chemotherapy and the relentless pains of cancer as she carried her son to and fro from Assiut to Cairo where he was treated at the National Institute for Cancer and in other specialised hospitals. Amidst her grief at the loss of her son after his death she said:

It is the will of god that I lose one so dear. Before we were just peasants and slaves but we did not know these diseases [8]. Sayed saw bitterness as he lay there sick at my door. Before those who went just died but did not see the bitterness that I have seen.

Just as there has been a proliferation of new diseases and of old symptoms which now have a name, some diseases are no more. Skin diseases are fewer thanks to soap and to the various ointments readily prescribed by physicians and pharmacists. In both cases of health improvement thanks to medical services and the efficacy of drugs, or health degeneration due to environmental, nutritional, and what we can call 'moral' factors, time is a relevant dimension.

E. UNTIDY NARRATIVES

"Disease belongs to culture, in particular to the specialised culture of medicine. And culture is not only a means of representing disease, but is essential to its very constitution as a human reality." (Good 1994: 53)

---

[7]. Blood poverty or **Faqr Dem** is anaemia

[8]. Sayed's father is of Slave descent. His mother is a peasant, not an Arab, from the nearby village of Kom Abu Sheil.

Culture implies the past, the present, and what people expect of the future. It is within this matrix that ill-health is experienced by the sufferer and other actors and in which the event is defined, described, and communicated. It is within this framework that narratives are constructed. Early has written of therapeutic narratives as

> ..a commentary on illness progression, curative actions, and surrounding events both relevant and irrelevant. It is constituted for incident specific fragments which are codified into an elaborated version that is referenced and recounted for years to come...The essential aspect of therapeutic narratives is that they provide the biographic context that is central to any understanding of illness." (Early 1982, p.1491-2).

This biographic context is more than a situating of objectively definable pathological conditions. The articulation of symptoms with subjectivity creates an illness representation which interacts with social, psychological and physiological process " .. to produce distinctive forms of illness and illness trajectories." (Good 1994: 54).

Interpretive anthropologists have posited the interaction of culture and illness at the heart of their analytical interest. (Good 1994: 52; Lock & Scheper-Hughes 1990). Cross cultural studies of diseases written in this tradition have stressed the different idioms which people employ to express pain, distress, and disorder so as to illustrate how symptoms translate from one culture to another. However this implies that peoples' experiences are the same and the differences are questions of style and language. At one level, there is a universality to the body and its experiences. At another, however, we must realize the meaning of illness experiences in terms of those who experience them without attempting to reduce symptoms to the common denominator of biology and pathology.

Therapeutic narratives highlight this meaning because they link disease and its experiences to the life trajectory

of the sufferer and to that of others affected by the suffering. These narratives are ever changing and yet they inscribe in the memory of the community affected a set of definitions about disease, its causes, its implications, its cost, its consequences, and what all those implicated did about it. Narratives are ever changing because the implications of a sickness event are relative to the life events of the sufferer. A woman who loses a baby may not know the significance of her loss until she has another. If she fails to conceive, she may feel the extent of her loss grow day by day. If she is quick to conceive she may be better able to come to terms with her miscarriage. The significance and the causation of a sickness event can only be understood once its outcome has happened.

During fieldwork, I was present during the unravelling of sickness events of both children and adults. During the event accounts, speculations, and recommendations vary from one hour to the next. It was only possible to understand the event once it has passed and sometimes, not even then.

Om Abdel-Bassit found a connection between her son's illness and the fact that she had lost the amulet she had made for him at birth long after the boy was taken ill and when he began to get better. In her narrative she eclipsed the doctors diagnosis of dysentery partially because she could not see how it could be infectious **mo'di** as the physician had told her, and because she could establish a link between the value of her son as a boy after many girls, his need for a protective amulet, and the resulting situation where he became **manzour** and consequently sick.

Mahasin lost her son to meningitis. The sub-text encapsulated in her narrative is that he was an only boy amongst girls and her only protection against her mother-in-law with whom she never got along. In Mahasin's case had she never been able to bear a boy it would have increased the significance of her first loss.

In so far as definitions of sickness and of appropriate courses of action are concerned narratives constructed around past events implicate but do not determine the understanding of the present and of the future. Past experiences cannot determine future action because each sickness event is unique. Early maintains that the interpretation of physiological problems rests on three components; the symptoms, the biographical situation, and the events associated with the onset, or with new developments, of symptoms. Consequently, it is rare to find identical situations (Early 1982, p. 1496). **Batlan** as a disposition relies on the cumulative experience that children, and adults, have of being sick. A mother who has lost children in the past and who has defined her loss in terms of the **nazra** (envious eye) or the **qarina** (sister spirit) has more of a reason to suspect both.

These narratives place experiences right at the heart of webs of significant relationships and structures. As well as being vehicles for the expression of beliefs and chronicles of past events, they are illustrations of the meaning of sickness event and the way in which this meaning defines aspects of the sickness experience itself.

Throughout this work, the quotes and long excerpts are bits of narratives. They are all accounts that feature repetition, gaps in reasoning, contradictions, and a constant revising of causes and what their 'real' effects are. These are points which writers tend to 'solve' or iron out in the final writing. An example of one narrative recorded during fieldwork may illustrate this point. This is a written account of a conversation between Fayza and her mother-in-law in connection with Fayza's son. He is a year old and seems reasonably healthy.

Mother in law: Your son is so weak, his scars don't heal.
Fayza talking to me: A boy who succeeds girls is sick and weak. After I gave him his 40th day shot he got a cyst in his armpit. It is from the shots that those sons of dogs give at the unit. I had it surgically removed two month

ago. It cost 150LE ($45).
Myself: He had a cyst for a whole year?
Fayza: He kept getting it. At first I took him to a doctor who gave him Remacten 2% ointment for 6 month. The bottle costs 4LE ($1.2) and he needed one a week. He was very weak and only ate biscuits bought from the store.
Mother in law: He tasted nothing else he was going to die from hunger and weakness.
Fayza: He just ate sweet biscuits
Myself: No milk
Fayza: Yes of course, he took my breast, he never stopped taking my breast. Then I took him to another private doctor who said I must give him penicillin because this cyst kept coming back. But I could not afford it and I did not want him to take any more injections. He is so weak. When he was 40 days old he got a **nazla** on his chest. I gave him donkeys milk but it did no good. I took him to a doctor who gave him vapours and antibiotics but he got this cyst and I stopped the medication, it is very expensive and his father was away.
Mother in law: We used to milk a goat for a child with the new moon and give him the milk to drink and then he would never get anything.
Fayza: Now this is no use because new diseases have come from **el-gaw**. Now there is **ishal** and cough and new diseases which old cures can do nothing to.
Myself: He walks alright and has teeth thank-god
Fayza : Yes he walked early but he is an only boy
Myself: You think he may be **manzour**?
Mother in law: No. We don't let anybody see him and we keep him upstairs and we never mention him in front of strangers.
Fayza: Another son would take the eye off him but I do not believe in all of this.
Mother in law: His father is an only boy, you must fill his house with sons and gladden his heart. Do you want your son to stay like this?
Myself: So is his armpit alright now?
Fayza: Yes we went to the best doctor in Abnube and he is alright. But he is weak and **batlan**, it is his nature.

Good in his work on "Narrative Interpretations of Illness" (1994) claims that these irregularities succeed in "subjunctivizing reality". By this he means "... to be trafficking in human possibilities rather than in settled certainties," (Good 1994: 153). The above is a conversation not a straight narrative. It is the material from which narratives are constructed. In each of Fayza's lines was an

attempted narrative which varied from belief in modern medicine, to a worry about her capabilities to produce another son, to anxiety about finance, the environment, and the efficacy of modern and traditional cures. Ultimately, the only reality Fayza stressed consistently is that as long as her son is an only boy (he does have two sisters) he will remain weak even if he breast feeds well, has met all his developmental milestones, and is on the whole recovering from surgery quite well.

Good explains that narratives are subjunctive because they preserve the potential for multiple readings by maintaining multiple perspectives. They ".. represent alternative plots, a telling of the story in different ways, each implying a different source of efficacy and the possibility of an alternative ending to the story." (Good 1994: 155). Fayza sees her son as a victim to his privilege of being an only son to an only son. She also sees herself as a modern mother in comparison to her mother-in-law. The open endedness of the issue is whether she will be able to see her son through either by bearing more sons or by protecting him as her mother-in-law protected Fayza's husband. This whole story may lose significance if life events see this boy with many brothers or may gain significance if he remains an only son. The gaps and contradictions that come through the conversation highlight the density of questions and possibilities that exist in a tale as simple and seemingly simple such as this one.

Another example comes from the narrative given by Adeela, Sayed's mother concerning the ear problems that her son, Abdel-'Al 15 years (Family L), was suffering from. I had taken Adeela and 'Abdel-Al to a private clinic in Abnube and as she waited she described the whole condition as follows.

Since the deceased passed away I have none left except Abdel-'Al. He is a good boy and he is good at school, like Sayed was, God bless his soul. Their father is away

and me and the girls have no one but Abdel-'Al. The little girl takes up expensive boxes of formula milk each week or so.

Yesterday when Abdel-'Al came back from school I sent him to get formula milk for the girl from Arab Matteer. We had none left and no rice. Each box costs 11.00LE($3.5), but sometimes you can get them subsidized for 4.00LE ($1.2) each. When she was a baby and I had no money I gave her ground rice boiled with water and sugar. Now I make it with **semn** and she and her sisters eat. I gave Abdel-'Al the money and he left. I waited and waited and then I got so worried. I only have him and I was afraid that something had happened to him. He is the one who is opening the house[9] and when he grows up he will **ye-'amaroh**[10]. Like his father, he is now an only child. I went out to the bridge and waited for him and I asked those passing by in cars if there had been an accident on the way. Just before sun-set he came back. He found the pharmacy closed and had sat waiting for it to open. When they opened they had none left so he sat waiting until the evening delivery arrived. He did not want to leave his sister hungry. But he came back and his head hurt, he had fever, and when I looked in his ear I found pus.

Last year we took his tonsils out in the hospital. He had it done in the public hospital but it still cost us hundreds. His father slept underneath his bed to clean and feed him. The boy came to and kept vomiting and his father would clean him from the vomit and blood. For days his father slept on the floor underneath his bed. But since then his ears have been no good. I have not treated them but after yesterday when I thought that I had lost him like the other one I swore that night would not come again without him seeing a private doctor.

He is weak. He has not had meat for a month. Last Thursday I bought them half a Kilogram. I swear, the little girls did not even get to touch it. Abdel-'Al had a few morsels of meat. But still, he is weak. This is our lot. Last week I bought a tin of molasses for 50pt($0.15) and we had **maslouka**[11]. The girls left nothing, I swear,

---

[9]"Fateh el-beit or opening the house means that he is the only male in the house.

[10]Ye-'amaroh means he will populate it. He will marry and bring a woman to the house and bear off-spring thus insuring the continuity of the house.

[11]. A sweet noodle dish made with home-made wheat noodles, milk, semn (ghee) and molasses. Hot water is used as a milk substitute.

Abdel-'Al did not even taste it. Girls eat a lot, they leave nothing on the tablia[12]. What can I do? This is our nassib[13]. The man is away and he sends no money, we have no cattle in the house and we have only Abdel-'Al. Is it a wonder that he is so sick. But I will spend all I have, I will borrow and beg to cure his ears.

Abdel-'Al turned out to have a severe ear infection. The doctor cleaned his ear for him and prescribed an anti-biotic. On the way home we stopped at a bakery where Adeela bought him some 'Fino bread' (a local kind of baguette) and told him to eat it on the way home before his sisters took it from him and ate it themselves.

As illustrated, narratives remove the focus of sickness events from the body and posit the whole experience in the day to day life of individuals in communities. As Good puts it, "Illness is grounded in human historicity, in the temporality of individuals and families and communities. It is present as potent memories and as desire. It embodies contradictions and multiplicity of meaning" (Good 1994 157-8). By closely examining rather than dismissing untidy narratives, we come to better understand he meaning of sickness and the extent to which it is contingent on much more than the body of the sufferer. As mentioned above, more important than the facts and events are their presentation in webs of relationships and the extent to which this is taken for granted by the narrator.

Abdel-'Al's ear infection only became a matter of urgency because of recent and immediate history. 'Adeela later told me that the night before we went to the doctor she had dreamt a terrible dream for Abdel-'Al and that made her insist even more not to take his ear problem lightly.

In her article on therapeutic narratives amongst 'Baladi' women in Cairo, Early (1982) gives three examples of

---

[12]. Low round eating table.

[13]. Lot or luck

narratives that she has recorded but all are of women talking about sickness events which their children suffered. The explanation may be that the sickness experiences of children are as much their own as they are the mothers'. Very young children cannot narrate their own experiences because they may not have enough language skills to do so and as they get older, they tend to forget the various diseases and problems that they have suffered. However, children do comprehend causation and can express beliefs in what diseases and problems things do or can cause.

Attiyeh (6 years) believes that eating red meat is good for his legs and makes him play football. Fatma (3 years) had this to say about her diarrhoea:

Yaah mother, it hurts, it burns. (tears) I will not eat from the hot stuff again. (later), Fou Fou[14] made me eat from the hot cheese she was eating and now I am sick and I can't play. But my mother said she would not take me to the doctor and he would not give me an injection. Fou Fou said that my father would take me for an injection if I ate from her food again. (later) Asmaa[15] **bit-horr** (has runny stool) she did not eat from Fou Fou's cheese she can't eat. I tried to put some in her mouth. I am older and I can eat anything but my stomach hurts. If Asmaa had eaten it she would have died.

Fatma had both burning from having eaten cheese with chilies, and diarrhoea. She got better quickly and did not need any medical attention.

The above are all narratives, or are narrative like texts, which concern a variety of health problems. They are not cited as evidence of poor health amongst children in **Rihan**. They illustrate how the body and its experiences are inextricably connected to the social, temporal, political, and economic dimensions of the sufferer's experience. As trivial as an ear ache, or the occasional bout of diarrhoea may be,

---

[14]. Fou Fou is her teenage sister

[15] Asmaa is her 4 month old sister.

they are not separate from the more serious conditions from which children suffer. Both are subject to the same conventions which people employ to define, construct, comprehend, manage, and accept diseases and medical problems.

F. CONCLUSION

In this chapter I have attempted to explain how peoples experiences of health and sickness transcend the biomedical model. **Batlan** is a definition of ill-health which assumes well-being and not just the absence of clinically detectable diseases as the ideal and the entitlement of most children. It does not matter what the clinical definition of 'health' is. If a child is not as his family wishes him/her and if the child falls sick repeatedly than the child is **batlan.**

But health is also an important socially constructed category. Healthy relationships, successful and repeated childbirth, and gender define this category. Girls are healthy and strong except if born into extreme hardship or in an enviable position. The symbolic . . value of food is also important to these definitions of health. The social meaning of food is as important as its actual calorific properties.

The section on the past and the present illustrates the extent to which people are conscious of the quality of care that they receive and the relevance of other moral, environmental, and economic factors on their health and that of their children. The romance of nostalgia may obfuscate some of the issues, but still most people are sure that not all of the past was bad and that the best thing about it was the degree of integrity that life had. Villages were not as wealthy and not as open or 'cosmopolitan', but life was manageable and money mattered less. All would opt for the wealthier, better served present, but that does not imply accepting poor medical care, poor quality foodstuffs, or the consciousness of poverty which the here and now imply.

In a sense this is also an understanding of disease and

sickness which transcends the biomedical model. Disease is not just located in the body. It is not independent of peoples situation. Moreover, it is not separate from the consequences of medical care and drugs. The disease and the cure are part and parcel of one thing.

The section on narratives relays the connectedness of health and the events that precede, are contemporary and those which succeed it. Again it shows the extent to which the biomedical model only addresses a partial aspect of health and ill-health. Having diarrhoea or even meningitis does not mean the same thing to all people. They are not caused by the same antecedent nor are they even cured in the same way. Villagers deploy their conceptualizations of health and ill-health in many ways. In the next chapter, I shall present a study of prophylaxis and immunization and try to illustrate how conceptualizations of health are applied.

CHAPTER SIX
IMMUNIZATIONS AND PREVENTION

A. INTRODUCTION

In this chapter I shall compare and contrast local ideas concerning prophylaxis with the biomedical model embodied in the preventive and primary health services offered by the state. The chapter will focus on childhood immunizations, and illustrate the intellectual distance that exists between the state's childhood immunization scheme and those who the scheme targets. The conflict in perceptions of what health is and how to maintain it becomes evident not only in terms of immunization coverage, but also in the health and demographic statistics which purport to measure coverage and prevalence.

Prophylaxis has become an important component of biomedical philosophy. According to the World Health Organization, there are a list of things to do to decrease infant and child mortality and morbidity. Examples of which are breast-feeding, immunization, regular hand washing, protection of food from flies and insects and the observance of other hygienic practices. These recommendations come in the context of the **Health For All Strategy** agreed to at the WHO assembly in 1981. The initiative designed to secure lower infant mortality and morbidity rates for infants and children is summarized in the GOBI-FF principles [1]. The GOBI-FF plan is a supply oriented strategy. It assumes that the supply of oral rehydration salts, immunizations, contraception, etc will create a demand for better health and a tradition of biomedical prophylaxis (Chen & Moseley 1988). But how do the principles of GOBI-FF differ from those of men and women in Rihan?

---

[1].Growth monitoring, Oral rehydration, Breast feeding, Immunization, Food supplements, Family planning.

The difference between the WHO and some families in Rihan is not a difference in rationality. It is a difference in how each conceptualizes health and risk. Biomedical prophylaxis recognizes micro organisms that cause infectious diseases and against which babies can be protected through immunizations given early in life which enable infants to develop anti-bodies to these diseases. Villagers have established other orders and agents of sickness causation which necessitate a different class of protective practices. These protective practices and the theories by which they are defined and determined have withstood the test of time and have survived the campaigns mounted by public health authorities to undermine them and encourage people to disclaim their efficacy and logic.

Anthropological literature has focused on the strong tie between notions of affliction by disease/misfortune and traditional beliefs. Evans-Pritchard's book on witchcraft amongst the Azande is a pioneering study in this field (Evans-Pritchard 1937). However, in the presence of extensive medical services and in view of the hegemony of modern medicine and its infiltration of public discourses on health one cannot discuss traditional, non-biomedical beliefs in isolation from peoples' experiences of doctors, drugs, clinics, and hospitals (Chapters 7 & 8). Traditional medicinal practices, whether curative or preventive, currently exist in a historical context in which modern medicine is now 'king'. In this chapter on protection both biomedical and non-biomedical cultures and their clients will be investigated to understand the logic of medical prophylaxis in Rihan.

B. BIOMEDICAL RISK: THE EXAMPLE OF IMMUNIZATIONS

B. 1 SOURCES

It is difficult to summarize the Egyptian governments' public health programmes with the detail and illustration required by anthropology. There are several documents which state the policy as it "should be". To understand the

reality of the situation this research relies on statistical sources, other secondary data, as well as on the qualitative research undertaken by the writer in Rihan. The first important source is the 1991 Egypt Maternal and Child Health Survey (EMCHS), which is a national survey of 11,074 households drawn from a multistage sampling design developed by the Central Agency for public mobilization and statistics (CAPMAS). The sample is a probability stratified one which gives equal probability of selection. The survey included a basic household survey, a reproductive health survey, a child health survey, and a community level survey. The survey is part of a larger effort sponsored by the Arab league and known as PAP-Child or the Pan Arab Project for Child Development which seeks to determine the situation of the Arab child through research and the collection of credible, comparable statistics in all member states of the league (CAPMAS 1993: 12).

The other statistical data set used in this analysis is one collected, but yet to be published, by UNICEF. It is a study of 4 small villages /hamlets in Assiut one of which is very close to Rihan. The data was collected and analysed by a team of public health professors, lecturers and teachers at Assiut University school of medicine. The sample (n=11399) was 52.2% male (n= 5949) and 47.8 female (n= 5450) and focused on reproductive and child health, and most importantly on the degree of utility of available health services. According to Dr. Magdy Bayoumi, health officer at UNICEF Cairo Office, the statistics are very interesting and worrying because they show the discrepancy between national rural averages and the situation of small under-serviced villages and hamlets.

There are two important secondary sources which basically rely on various national cens .s and on the EMCHS for their data. The first is The Situation Analysis 1992 by UNICEF, Cairo Office. This is a comprehensive report compiled by the office which attempts to provide, amongst other things, an accurate description of the health of

women and children and to establish the main points of advancement and areas of need that persist. This report is thorough and precise since UNICEF have the full cooperation of the Ministry of Health (MOH), of the various medical schools, and of the centre for public mobilization and statistics (CAPMAS). Moreover they have the findings of their own commissioned consultants whose reports often yield critical data which completes, usually by contrasting with, the official picture. The statistics provided by MOH for the situation analysis veer towards the real rather than the politically flattering because this report is referred to by funding agenc[illegible] in their negotiations with Egypt. Consequently the data is by and large reliable. However the report does rely heavily on EMCHS.

The second source concerns the governorate of Assiut in particular. The study is one commissioned by a group of international aid organizations interested in working in Assiut and undertaken by a renowned statistician and economist. The study is an evaluation of the existing data on Assiut. The report paints a statistical picture of the governorate while simultaneously making a poignant critique of these statistics. The report questions the validity of available health statistics because of under-registration and the inconsistency of information, particularly on children' health. This report provides data on the town and villages of Abnube and is therefore unique in that respect (Fergany 1993).

Living in Rihan meant frequent visits to nearby clinics, hospitals and health units. Trying to discuss health and well being always implied stories about doctors, hefty pharmacy bills, and the merits and problems of private and public health services. Old tattered prescriptions carefully wrapped in clear nylon bags and kept in little crevices high up in mud walls so that they may be repeated without resort to physicians if conditions should reoccur were frequent exhibits produced mid way through conversation. Unexpectedly, it was more difficult

to engage in discussions on non-biomedical theories and practices than it was to discuss anti-biotics, immunizations, and the experiences of parents and children at clinics and hospitals.

The following discussion of biomedical services and programs for prevention relies on these village based experiences as well as on interviews with physicians at the two most frequented rural health units and on discussions with paediatrician at the local general Hospital (the nearest town hospital to Rihan)[2]. This methodological collage seemed to be the only way of gauging an amorphous and multi-layered institution such as public health and its use and success. The use of statistics which are not collected in Rihan is intended as a backdrop to qualitative data and as a check on the exaggerations of doctors and patients. Most doctors thought that "everybody immunizes" while many mothers were surprised that "anybody" did. The statistics from the governorate level and from the nearby hamlet locate a middle ground.

B. 2 READING THE BIOMEDICAL DATA ON PREVENTION

Immunization is commonly seen as the most important primary health care and preventive measure to have been developed this century. It is responsible for the near eradication of some diseases and the survival of millions of children. Immunization is considered an intervention which protects against the debilitating and possibly fatal consequences of some infectious childhood diseases. A related benefit of immunization concerns nutrition. Since infections in early childhood are also nutritional setbacks which can take weeks or even month to overcome, protection from infection is a way of preventing malnutrition (CAPMAS 1993: 321).

In Egypt the National Programme of Immunization

---

[2]. Texts of formal interviews are in appendix 1

initiated in 1976 has a goal of universal immunization against tuberculosis, diphtheria, pertussis, and tetanus (DPT), polio, and measles. Recently, Hepatitis b has become of major concern but as yet the National campaign does not offer immunization from this disease as part of its mandate. The schedule followed by the campaign provides one dose of BCG vaccine soon after birth, three doses of polio and DPT vaccine at 2, 4, and 6 months and one dose of measles vaccine at 9 months. Booster doses of DPT and polio are given at 18-23 months (CAPMAS 1993: 321).

According to the EMCHS, immunization coverage in Egypt is high (CAPMAS 1993: 338). At a national level, 91% of children under five years had received at least one vaccination. In rural Upper Egypt, the coverage was lower at 83%. The survey found that the two most important variables which affect immunization coverage were region of residence (rural or urban, upper or lower Egypt) and mothers' education (Capmas 1993: 340).

However, one vaccination out of nine does not show that the vast majority of Egyptians share a belief in the necessity of full immunization coverage as an important prophylactic measure. The high national figures are for 'some form' and not for 'full' immunization. The figures for full immunization fall to a national average 64.6%, and to 50.0% for rural upper Egypt (CAPMAS 1993:328).

The data from the four small villages of Assiut shows that of the number of children who had health records available for inspection by data collectors an average of 71.85% had some form of vaccination. Figures for full vaccination were not worked out by the study. While this seems to be a high figure, it does mask a variety of considerations that are not reflected by quantitative data. It does not account for immunization amongst children who are not registered at all. This means that there is no way of knowing how many children who should be immunized had not taken any doses at all.

According to UNICEF, Assiut is one of the six

governorates (total number of governorates in Egypt is 26) with the lowest reported vaccination coverage for different antigens amongst children who are 12-23 months old. However the report also questions the reliability of documentation based on mother reporting on child immunization, which overestimates coverage. The alternative is to derive levels of coverage from the child's birth certificate which serves as the child's health card in Egypt. The problem here is that the certificate involves a degree of inaccuracy. First of all, in roughly 50% of the samples of the different statistical surveys, the mother did not have the certificate to show the interviewer (CAPMAS 1993: 323, UNICEF 1993: 105). This means that half the children of immunizable age at the time of the survey do not show up in what are considered reliable figures.

Those who did have their certificates available reported that their children had actually received more vaccinations than those shown in the certificate. The explanation was that, either the mother did not have the certificate with her when the child was being vaccinated, or that the immunization provider did not make a record of the dose provided (UNICEF 1993: 105).

It is puzzling to note that for rural upper Egypt in particular, the coverage for BCG and measles is much lower than it is for the other vaccinations and much lower than the national average (see table 6.1).

Table 6.1 Vaccination coverage by antigen in Rural Egypt in EDHS[3] & EMCHS[4]

	EDHS	EDHS	EDHS	EDHS	EMCHS	EMHCS	EMCHS	EMCHS
ANTIGEN	BCG	DPT1	POLIO	MEASLES	BCG	DPT1	POLIO	MEASLES
RURAL	37.9	60.7	35.5	48.0	87.7	93.1	93.3	71.4
RURAL UPPER EG	22.0	52.4	49.9	35.1	85.3	93.2	93.2	73.3
TOTAL	56.2	72.6	68.7	61.7	90.9	94.1	94.8	76.0

Source: UNICEF 1993: 107

The discrepancy between the figures in the two surveys is also notable. The EDHS has generally much lower coverage figures than does the EMCHS. This is noted but unexplained in the analysis provided of the figures (UNICEF 1993: 106; Rashad & el-Zeini 1993: 4-10).

The surveys also show that complete immunization is very low. A study commissioned by UNICEF showed that less than 69% of children who are under 3 years and eligible for vaccination actually finished their immunization courses[5]. Again BCG and Measles were the least popular vaccinations (UNICEF 1993: 108).

The conclusion of the above mentioned study was that the main hurdle to complete coverage was "...(R)elated to women's knowledge and behaviour."(UNICEF 1993; 109). The report goes on to elaborate that "although mothers and influentials have quite high level of awareness of immunization and its importance in general, there is limited understanding of the specifics" (Ibid: 110).

The study found that mothers did not know the significance of giving vaccinations at the designated age and were also unaware of the difference between partial and complete coverage. Consequently they missed vaccinations or asked for them when their children were months above the right age. Many mothers interviewed felt

---

[3] Egypt Demographic Health Survey

[4]. Egypt Mother and Child Health Survey

[5]. The study was conducted by SPAAC, a private consultancy firm in Cairo who have worked extensively with UNICEF. The study in question was presented to UNICEF in 1992.

that an infant's very young age, small weight and minor ailments such as fever were contra-indications which merit the postponement of vaccination.

The study asserts that ".. in comparison to the high level of awareness of the benefits of immunization, there is a low level of awareness of the specific diseases themselves by the mothers and their influentials" (UNICEF 1993: 110). The study argues that people would be better convinced of the importance of strict observance if they actually recognized diphtheria, tetanus, and the other disease from which vaccinations immunize children. Moreover, and again along the same lines of argument, the study mentions that the "normal side effects of immunizations" tend to put mothers off since they exaggerate the significance of these side effects, probably because they are unfamiliar with the worse evils of the diseases themselves (Ibid).

Interestingly enough, when the same study was done with health providers in villages, a similar deficiency in accurate information and understanding was detected. Health providers were found to be ignorant of the processes of building up immunity hence their complacency concerning incomplete immunization courses. Health providers also felt that there were contra-indications which make it preferable to postpone vaccination. This is reported to be further proof of their unfamiliarity with the mechanism of immunization, and of the potential dangers of the six diseases and their dire consequences. They were also ill informed of the normal reactions to immunization and their management, and were unable to detect the difference between these expected reactions and real complications (UNICEF 1993: 111).

The conclusion then from the data available is that while immunization has been a success story in Egypt, the coverage levels are still lower than the public health authorities would like them to be. According to officialdom, ignorance or deficient understanding is the

main problem. A less partial view may rephrase the problem as a difference in experiences of child health and of the variety and multitude of dangers which threaten it.

C. THE VIEW FROM THE VILLAGE

C. 1 EXPERIENCES OF IMMUNIZATION IN RIHAN

Rihan is probably similar in its view of immunization and prophylaxis to any other village in Upper Egypt that does not have easy access to health services. Here, as elsewhere, mothers and those who the public health statisticians and professionals like to call 'influentials' have a valid interpretation of their eclectic use of public health services.

The problematic relationship with the institution of immunizations begins with the first BCG injection. In Rihan, there were five babies in a period of four weeks who had been taken for their BCG injections and who had also developed nasty abscesses in their armpits. None had been advised that this is a possible risk of the sub-cutaneous BCG injection. All these cases said that they went home and later on their babies developed fever and then the swelling began.

These babies cannot keep their arms lifted and feel the pain of the pressure of their own arms and they suffer for long periods of time during which they are too poorly and in too much pain to eat. They become generally weakened by their condition.

The 40th day of a bab · life is an important event. Before the fortieth day a baby is still part of the mother and prone to death by tabi'a (chapter 8). Making it to the fortieth day is quite a feat for a baby. It is marked by, amongst other things, giving a baby his/her first bath, and showing the baby to strangers. It is also the end of the mother's period of recuperation. Many mothers feel that the 40th day is a day/period to savour rather than a time to give the baby an injection that is supposed to prevent a terrible disease but which has been known to cause its own

problems. As 'Aziza put it "When he can pull up his back then they can inject him with all they want to" (meaning when the baby can sit up by himself). She was referring to her own eight-month-old and to babies in general.

The general wisdom concerning the injection is either not to take it or to give it to the babies when they are older. The experiences of babies who develop an abscess due to a mistake in injection is a point of reference for others. This does not mean that people reject vaccinations altogether. But it also indicates why many mothers think twice before taking their children for the BCG injection.

Measles is the other injection which mothers and so-called "influentials" seem to be less observant of. Omar, the one-year-old son of Hassan, a peasant who is from the important Sewify clan, is registered and has a birth certificate. He is the youngest child of Hassan and there is a 14 year difference between Omar and his elder brother who is also registered and in school. There are four girls between the two boys. Omar got measles although he had taken the vaccination. "What can you say to that?!" his father challenged. The boy wears a **tahreeza** (a protective amulet) and is kept safely inside the house. The father said that he, unlike his siblings, gets sick very often and was at the time of one several visits to the house on anti-biotic and anti-diarrhoeal medication. "He vomits and has diarrhoea all the time" added his mother. The father believes that he was too weak to take all the injections "But we are pleased with him and wanted to do the best thing for him so we gave them all to him and then he still got measles." The conclusion he has come to is that these injections are not for everybody, they may work with some people but they don't with others. He said:

> Who knows, maybe it is the injection that gave him the measles. They say that these injections are the disease but watered down, so maybe the one he took was not watered down enough. It is difficult to trust these people. It has happened to other boys. Arafat took the injection and also got measles. Now he is **atram** (deaf and mute). Other children get the measles and get better and their health is as strong as iron;

but not these boys. now my son is weak and sick and Arafat is laughed at by the other kids.

The parents of Abdel-Basit (Chapter 5 & 8) have a similar experience. He also got measles and then developed a secondary condition of asthmatic bronchitis. His father said that he had decided to give him his vaccinations because he had heard that they were good for children. Abdel-Basit is **batlan** and neighbours had told him that he would not be able to withstand the injections. But the father had thought that on the contrary, because the boy is **batlan** he needed the boost that these injections are supposed to give.

Abu-Zeid, a young man and the father of a five-year-old girl and a two-year-old son lost his first born son. The boy was a year old and in good health but then he got measles. Abu-Zeid and his wife say that he got better but soon afterwards got a flu and a fever, and died suddenly. "If he took the vaccine he would not have lived" Abu Zeid said. "The vaccine cannot ward off God's will and anyway, measles does not kill, he died after he got better" he added.

According to the statistical sources, the three injections for diphtheria, tetanus and pertussis as well as the polio vaccine seem to be more popular amongst upper Egyptian peasant families. The study conducted by SPAAC for UNICEF argues that people are more aware of the hazards of polio, and therefore keen on having their children immunized against the disease because of the polio specific media campaign which has been running on television and radio for years. In Rihan people are aware of polio or **'shalal el-atfal'** (the paralysis of children) as it is called in Arabic. Partly because the name of the disease expresses it symptoms and is in an Arabic that is familiar. Tetanus for example is either called tetanus, a foreign word, or **el-Qazaz** which is a classical Arabic word referring to the locking of the jaws in unattended tetanus cases. Diphtheria does not have an Arabic name. Pertussis

is called **el-so'al el-deeky** (crackling cough). The word **so'al** is a rarely used term meaning cough. The word **deeky** is very close to **deek** which means turkey in Arabic. Of these diseases polio is the only one with recognizable symptoms, a name that means something to ordinary people, and a campaign which is clear and has become familiar.[6]

In Rihan the families who 'vaccinate' always mention polio. "We vaccinate, even the girls because there are diseases and **shalal** (paralysis) in the atmosphere" said one proud matriarch in reference to her own children and those of her sons who lived with her.

There seem to be people who 'vaccinate' and others who don't. Hassan, the father of little Omar mentioned above said on another occasion:

> It is God who vaccinates, not the government. We gave those injections to Omar because they came by and I said he is dear and maybe this will do him some good, anyway they make you pay a fine if the child has a certificate and does not take the injections.

In his case giving the vaccination had a little to do with protection, something to do with the coercive measures adopted by the government to force people to immunize their children, and a lot to do with the facility of getting a service which is provided at one's door step.

Ni'mat's nine children have never taken a single injection. **"Mouch binist'aged feehom"** (we don't believe in them) she explained. Despite the occasional fine and the many health workers who have come in vaccination caravans to the village to offer their services, she has managed to avoid immunizing all of her nine children. "What about **el-shalal** (polio)"? I asked her. "God preserve us" was her reply. Ni'mat is not alone. 'Aziza has also never immunized any of her 5 children. Om Touba, a neighbour who has a

---

[6]. Tuberculosis in Arabic is either called **Daran**, the unfamiliar term used to describe the vaccine or **Sol**, the term by which people know the disease. Measles is **Hasba** a word that is familiar enough to be commonly heard being said amongst children wishing evil upon one another.

teenage girl and another boy who is fifteen as well as Touba who is six years old lost the son she got four years before Touba.

> I said that God had guarded his older sister and brother and that this one I would register and immunize. Then I gave him a injection and he died. Look how I had been challenging to the will of God! It is only he who can guard and cure.

Touba of course has not received any injections.

Om Hassan, whose husband is a labourer in Jordan, has a nine-year-old girl, a 7-year-old son, a 5-year-old son, a 3-year-old toddler and an 18-months-old baby. She vaccinates the boys but did not vaccinate Thana' her daughter. She takes them to the Islamic charitable hospital in Arab Mateer (the neighbouring village) because "**'and-hom Il'ilag bi yenfa'**" (there the cure/therapy works). She once payed a fine of 14LE($4.2) because her children are registered in el-Hammam, the mother village which Rihan is administratively connected to, and it is there that they should be immunized. She explained

> Once a woman I met in the hospital told me that these injections affect the fertility of children and makes them unable to get children when they grow up. I have heard this from in-laws out in the fields as well. But I told this woman, why would the government do that. Have they gone mad? But people believe what they want to. These immunizations can be good but I only like the service in this hospital

When asked why she had not vaccinated her daughter she said that vaccines were not available at the time. She later said that perhaps they were available, but they were not known and common. "Anyway, girls are **shodad** (strong)" she added. The view that girls are larger, stronger, sturdier, healthier and hungrier as discussed in chapter five is one of the most often given reasons for not vaccinating girls.

Om Hussein vaccinates her children when the caravans come round. Her eldest son, Hussein has no birth certificate so she has not taken him for vaccinations for

fear of being fined. She had a younger son who died last year at the age of five, He had taken all the vaccines but was killed when he was run over by a tractor. She says that perhaps the vaccines prevented the disease but what did they do for her son?!

Om Moussa is selective about who she vaccinates of her children and who should have a certificate. Her two daughters who are 6 years and 7 years old respectively don't have certificates but have taken some vaccinations. "When they come round I take the girls and when they ask for their certificates I lie and tell them that they are at the health unit in el-Hammam" she said. Other women present agreed that it is easy to lie and say that the certificate is in the health unit, with the father, or at an old home, "No one bothers " one added.

Om Moussa said that most people "**mouch bi-tista'gad**" (don't believe in) vaccinations. "They do it to ward off **Hassad** (envy) and jealousy" she added and the three other neighbours and friends visiting her agreed.

Abu Quut and his wife did not immunize any of their four sons (family D) and have lost a daughter to polio. Abu Quut said.

> I take my children neither to doctor nor sheikh, she died after getting polio but it was <u>Hassad</u> (envy/evil eye) her nose was like this[7], her face was round, and her eyes were wide I ran with her here and there but she died

These are suggestions not statistics but they imply that many, or most, children in **Rihan** do not take their full vaccinations. They point to an explanation of why some parents regret that they followed the advice of the public health campaigns and professionals and why others refuse to follow this advice in the first place. It is difficult to produce reliable statistics on immunization that are specific to **Rihan**. The main obstacle to such a data set does not lie in the challenges of statistical data

---

[7]. Meanwhile making a gesture with his hands indicating a large well defined nose.

collection. The problem is in ascertaining the number of children who are immunizable at any given point in time.

C. 2 BIRTH REGISTRATION

Despite the perceived advancements in child birth and mortality registration at a national level, the situation in Rihan reflects a continuance of evasion and confusion in registration. For example, In'am has registered her two elder daughters together as twins because "... their father was in Saudi Arabia when the first one was born and no one was free to register her" she explained. When Ferial, her next daughter was born, she just wrote Loula, who was two years old with her. She has just had a baby boy and intends to register Shereen, her three year old unregistered daughter with him.

It is difficult to state every case where registration has been ignored. There are 30 households in Rihan who have at least one child either unregistered or inaccurately registered with a sibling as twins. Another common practice is to pass a child as an older sibling who had died. Very often, families refuse to register a child until after the 40th day as the likelihood of death lingers until that date. Then either the father travels, or there is a harvest, or someone gets sick, or someone gets married and they just never get round to it. Children who have a certificate and die are not reported so that a subsequent sibling may benefit from the existing certificate.

The data from Rihan seems to imply that there are far fewer twins and far more girls than reflected by national census statistics. Many siblings are described as having been "written together" and the difference between them may be more than three or four years. Officially, these siblings are registered as twins. Girls are under-registered because, as Hashem explained, "You get nothing from registering a girl except a headache". He registered his daughter Fou Fou but regretted it when he had to pay a succession of fines to keep her from continuing in school.

Boys are a different matter. They are registered so that when they grow and need to get a passport to work abroad they do not suffer as their fathers have. Men with no certificates had to forge papers and pay thousands of pounds or go the official route and expend time, effort, and some money as well to get a birth certificate and a passport.

The degree of under-registration and mis-registration is not insignificant. It bears on the issue of immunization and on the perceived position of power assumed by urban and official authorities and institutions vis-a-vis the village. This work has failed to quantify immunization coverage in Rihan. However, a random example of one small street in Rihan may give some worthwhile indications[8]

C. 3 STREET SURVEY

The street has 10 houses.[9] Over 40% of the girls and 13% of the boys in this sample are not registered. Moreover in three out of the ten houses, there are false twins and one family who intend to write two sons together. As far as immunization is concerned, 90 % have not taken the specified nine doses necessary to extend full immunization from the six major communicable diseases. However, the message delivered by such aggregate figures is also misleading. The important information lies in the setting in which decisions to register and immunize are made.

The view from the village presents some basic

---

[8]. After it became apparent that doing a survey of the whole village would be beyond the capacity of a lone researcher, I decided to just go thoroughly through one street picked at random and there go from house to house over a period of 6 months and ask to see certificates, ask the same questions many different times, discuss the same issues with as many household members as possible and in general make the kind of demands which if made of the whole village would imply a sojourn of many years and make mine an unwelcome presence.

[9] For a brief description of each household that includes the number of children who are fifteen years old or younger and the immunizations they have received as well as registration of birth see appendix 6.

conclusions. The national and accepted statistics may be correct that the majority of registered children who should be immunized do receive some immunizations. But many are not registered in the first place. If taken into account they would adjust the figures and show lower coverage.

Those who are immunized are not fully so. While this is a step ahead in the fight against communicable diseases, this step is one based on misunderstanding and miscommunication. The discourse on prevention in which peasants and professionals are engaged cannot be gauged by the current statistics[10].

The immunization programme is not operating in a vacuum. There is the problem of wilful non- and mis-registration. There are the lingering doubts in many peoples minds as to whether the government could really be providing a good service for free and with no concealed undeclared intentions, especially in view of the coercive methods employed by the government represented by the system of fines (see Heggenhougen 1990b).

There are also people's real experiences with reactions and side-effects of immunizations. As long as they are denied by health providers, this will continue to act as a deterrent against peoples enthusiasm for immunizations. Biomedicine has established these communicable diseases as the most dangerous and at the same time preventable childhood diseases. But peasants perceive many other dangers which fall outside the domain of concern and legitimacy created by biomedical models.

The cognitive dissonance of peasants regarding immunization can then be explained in terms of the nature of their relationship with the medical and political establishment. Villagers reject immunization because they still harbour some mistrust vis-a-vis the state. This

---

[10]. The reliability of the statistics is doubted by many statisticians. Fergany who has done a situation analysis of the governorate of Assiut refers to the existing medical statistics as "Information poor administrative data" (Fergany 1994: 20)

mistrust is enhanced by the poor quality of care that they receive.

But rejection of the biomedical model of prophylaxis can also be explained in terms of villagers own medical beliefs and traditions. Immunization protects from some agents of ill-health causation. But children are at risk from many other dangers, and it is these dangers which local medical models of prophylaxis can address and prevent (for similar comparisons with other components of primary health care see Nichter 1993: 60-7; 1989; 1988: 47-50).

D. Alternative Protection

There are a variety of protective amulets used to help children, at risk, stay healthy. A **tahweeta/tahreeza** (protector) is an amulet made with a coin tightly wrapped with a number of other ingredients in a piece of old cloth. Another form of amulet is a paper written out by a **khateeb**. The paper is folded and placed with some seeds and salt in a leather casing and hung around the neck of a child, or carried in a pocket or pinned to clothes by adults. Like a **higab laban** this amulet can also be placed under the pillow.

Begging is a significant means of protecting children. Women who have lost a child or more decide that they must humiliate themselves in front of their neighbours and in the sight of God by begging. In that way not only will people wish the woman well and not envy her, but also God will take pity on her and beg unto her a child. The woman who is in need of such pity usually takes a **magtaf** (braided rope basket) and goes begging from one house to another. People give her some grains, dates, flour, or whatever they can afford. Some women go to the extent of going to town and begging in the market. This is a degree of effacement that is deemed unacceptable by most husbands and is only condoned if specifically recommended by a healer or a sheikh. A small quantity of the items and money collected are used to make a protective amulet.

Supplication to God through begging is an old tradition in rural Egypt. The old and still used names of **Shihata** (begged/begging) and **Shahat** (beggar) for boys and **Mashhouta** (begged one) for girls are testimony to this means of protecting a baby that is yet to be born.[11] There is a lullaby sung to little boys which includes a line that says "I thanked him and from God I begged him". Perhaps modern Cairenes translate 'begging' as praying to God for a healthy son. But any peasant woman can rectify this misinterpretation. Begging refers strictly to women begging in the streets so that God begs unto her a healthy child. Prayer is another matter and would be referred to with different vocabulary.[12] Begging is a practise which protects unborn babies and as such is perceived to be one of the most efficacious ways of making penance and acquiring the favour of God. Simultaneously it precludes any possibility of envy since begging is the ultimate act of self effacement.

Some prophylactic rituals are performed to preserve the character and not just the body of a young child. Shyness amongst men for example is not a health hazard but is certainly an undesirable trait. Boys are protected by having their face splashed with their own urine a few times when they are still very small. This way he grows up to have a **wesh makshouf** (brazen face) a description which implies a man is bold and therefore attractive. Naggat is the one who did away with the embarrassment of Ali and Ahmed, her cousins. She washed their faces with their own urine. This practise is exclusive to boys. Girls are not shy and if they are, this is not a bad thing. It is

---

[11]. The practise of using a child to beg with is a completely different one. This is merely a means of manipulating the feelings of passers by through the child.

[12]. The Lullaby says "Ahmed ana hamadtoh we min Allah shahd-toh . Shahd-toh means I begged him. Prayer to God would be the translation of saleet-loh or da'eet-toh.

important for boys to have unveiled faces (**wesh makshouf**). Ahmed is still shy but not with Naggat.

E. CONCLUSION

I hope to have illustrated some of the points made in chapter 5 concerning health and its conceptualization. The practice of prophylaxis provides a good example of how definitions of health and risk educate peoples use of both biomedical and traditional protective instruments and recommendations. The case of immunization shows that villagers' views of health and its protection are not formed in isolation from their national political and medical context. Many villagers do not immunize their children because they don't see the relevance of the technology to their lives. Others reject the public health principle because the service they are offered is not a very good one.

An accord between villagers and biomedical service providers on the definition of ill-health, diseases, risk, and causation is necessary to achieve the aims of public health. Otherwise, the state would have to rely on coercion, which is an unreliable tool that requires a virtual army of enforcers to change people's daily behaviour. To realize its public health goals, the establishment has to 'reach out' to people and communicate with credibility and clarity. This requires some adjustments to the established power relationship between patients and medical professionals. It also requires some effort at understanding how villagers conceptualize health, ill-health, and risk.

The next chapter will look at the medical services that are available to villagers so as to further investigate and understand the relationship between village, traditional, and biomedical medical cultures.

CHAPTER SEVEN

RIHAN AS A MEDICAL SYSTEM: RESOURCES, SERVICES, AND HEALTH PROVIDERS

A. INTRODUCTION

Matters relevant to children's health and well-being in Rihan require a thorough understanding of the medical context in which decisions pertaining to therapy are made. Pivotal to this context are the persons who provide medical services. A better word for services would be resources since this account will refer to both actual services and the medical and intellectual reasoning of which services are an explicit representation.

The medical resources of Rihan constitute what Kleinman has called a Medical System[1] which he defines as "..socially organized responses to disease that constitute a special cultural system" (Kleinman 1980: 24). These systems give meaning to and organize illness experiences, patient healer transactions and the healing process (Ibid: 9).

At an immediate level, this chapter makes a comparison between structures of healing within the medical system of Rihan. At another less manifest level the chapter is addressing issues of medical efficacy and the success of therapies on offer to villagers. Even if at an implicit level, this discussion compares indigenous medical structures and knowledge with modern western medical models to contemplate the merits of different systems of healing and prophylaxis.

The following discussion focuses on the health providers with whom villagers in Rihan interact. Medical anthropologists have for some time been describing and

---

[1]. I am not claiming that Rihan has a medical system that is unique to the rest of Egypt. But then again I can not claim that it is similar to or representative of other Egyptian communities.

explaining medical premises, beliefs, and values as they are represented by medical models and as they are encountered, constructed, and reproduced by patients. The service provider has been, by and large, considered a mouth piece for his/her system. But these service providers are also active participants in the creation of medical knowledge. Their own views and experiences are as important for the understanding of a medical tradition as are the abstract principles of the tradition itself. Indeed, the ontology of medicine rests on its practice and practitioners.

Medical anthropologists have succeeded in including biomedicine and its structures as part of medical systems and their definition as cultural systems (Kleinman 1980: 375). The examination of biomedicine as culture and not as objective science has indeed enriched the field of medical anthropology (Baer 1987; DiGiacomo 1987; Finkler 1991; 1991; Gordon & Lock 1993; Hahn 1985; Martin 1992). Some medical anthropologists have compared illness narratives of patients and healers in their account of specific episodes of ill health so as to contrast the formulations and premises to which these narratives refer (Frankenberg 1993, Good et al 1994).

This chapter will report on clinical reality as observed during a number of encounters between healers and those in need of healing. The descriptions of principal health providers includes relevant biographic details, their perceptions of the people with whom they work, their understanding of the health problems prevalent in the area where they work, and an account of some observed interactions between themselves and their patients. Observed clinical encounters will be placed in the intellectual context of the medical tradition with which the healer identifies.

Most health care systems can be divided into popular, professional, and folk arenas (Kleinman 1978: 86). Villagers in Rihan frequent the professional clinics and

hospitals of physicians and surgeons who practise modern biomedicine. They also resort to folk healers who practise their skills in return for payment. Villagers also partake in the communal and family management of ill health in accordance with a medical heritage that spans more than one area of medical knowledge. However the primacy of biomedicine with its strong and ubiquitous institutions cannot be denied. In Egypt as a whole, biomedicine is representative of scientific accomplishment, and is symbolic of social prowess, economic affluence and political clout.[2] Yet folk medicine is still central to the medical rationality and to the epistemology of human well-being.

B. PHYSICIANS AND PATIENTS IN THE CONTEXT OF Rihan

B. 1 The Patients

The inhabitants of **Rihan** have access to the government run clinic of **El-Hammam** (approximately 5Km away) which also provides a Mother and Child care clinic (for contraception and other reproductive and paediatric health care services). This is the clinic that they should go to since administratively they are part of El-Hammam. For about ten years, there had been a Muslim, veiled, female doctor there. She was popular with the people of **Rihan** but has recently been replaced by a Coptic male physician who is not so popular. During my time in **Rihan** I did not come across a single family who used this clinic unless they needed to register a birth or required an official document from the health centre in **El-Hammam.**

In **Rihan** many families favour the Poly-clinic run by an Islamic charitable organization and situated in **Arab Matteer.** Although the clinic charges 1 LE for consultations, this fee is acceptable to most clients. The clinic is perceived to combine the advantages of both

---

[2]. The opposition also speaks the language of modern Biomedicine and has used the clinic as one of the mainstays of its Populist agenda (see Morsy 1988).

private and public health services. The clinic is subsidized and therefore affordable to most people. Moreover it is not an official government clinic and is therefore dissociated from the negative images of underpaid and demoralized physicians incapacitated by lack of modern equipment, technology and medications.

Rihan was also the site for several attempts by young doctors to start private clinics in the village itself. All of these attempts failed since villagers tended towards paying private fees and going to what they describe as proper clinics in Abnube rather than their home grown ones in the village. The last two such attempts were by doctors who were assigned to nearby government clinics and who thought that they had discovered an untapped market for patients in clinic-less **Rihan**.

The hospital in Abnube (app 8 Km away) is one of the largest and oldest in Assiut. It is a general hospital that has daily out-patient clinics in different specialities. Abnube out-patient clinics serve the whole area. They are usually crowded but villagers in **Rihan** favour them, specially the paediatrics clinic, because the doctors there are perceived to be more specialised and "..have diplomas" as one educated father in **Rihan** told me. Since my study is village based, I did not spend prolonged periods of time in the hospital. Besides time, the major hurdle to observing and interacting with the physicians there was the director's insistence that I acquire a special research permit from the Egyptian ministry of health. Despite which however, I did have the chance to get to know and interview one of the peadiatricians there as well as meet others through my accompaniment of mothers from **Rihan** when they took their children to the out-patient clinic.

Physicians who are employed in the public sector invariably have private practices. Consequently the relationship between the two medical sectors is never one of simple competition. It is a commonly acknowledged fact that private health care is better than public care.

Conspicuous proof of this wisdom lies in the difference of diagnostic effort which physicians make between those who are consulting them on a 60pt($0.18) ticket and those paying a consultation fee. Those who can afford to utilize private care do so. Those who can't, find themselves seeing the same doctors but knowing that they are not getting the doctors' best. It is even more of an insult when you have to pay for the costly medication as well.

Besides the cost and efficacy of care, there is the actual encounter with the physician. This encounter has social as well as medical significance. Women come to each others aid by offering their companionship on the road to the clinic. They also offer each other tips on medications and preferences for certain doctors over others.

> I was supposed to just attend a baking session that day. Then as I was steaming in front of the oven I was told that Om Raggab is sick and that she was going to the doctor (Family C). I went over and found her and Om Mohamed sharing their tribulations of the night before. Om Raggab had defecated blood. She knew that it was an attack of dysentery. I accompanied the two of them to the doctor. Om Mohammed's daughter, Aziza came with us.
>
> I payed 1 LE($0.30) for the taxi ride. We got off in Abnube and walked for about 20 minutes till we reached the clinic of Dr. Ahmed Hassan. The daughter had been telling me that he specializes in fevers. His sign says that he has a Masters in paediatrics.
>
> I payed 3.50 LE($1) for each. I hope that was not overdoing it. I knew that Om Raggab had to beg Raggab for the money to go and we had to wait until he sent it from the fields. We were later joined by Abu Farrag[3].
>
> In the clinic we sat talking for two hours. The doctor then came. Used a stethoscope, took the temperature and pulse of each one individually, then wrote a long prescription. That of Om Raggab cost 12.50 LE($3.7) It included antibiotics, vitamins, and four other kinds of pills. Om Mohammed was given many more drugs plus antibiotic shots to be taken every twelve hours. The doctor did not tell either of them what she was suffering from.

---

[3]. Abu Farrag is Mohamed Abu Roussa, the eldest son of Om Mohamed who had decided the she felt weak and needed to see the doctor.

Om Mohammed loved the shots. She had the nurse in the clinic give her one on the spot after her son went and bought the medications. She said that he was fantastic at giving the shots. That he "poured them in" rather than having a heavy hand. She kept prompting Om Raggab to take one herself. Abu Farrag bought a disposable syringe which the nurse used but then he returned it and Abu Farrag wrapped it up for later use.

Abu Farrag treated us to sugar cane juice and paid for the taxi back. It was a nice enough outing. In the clinic, Om Raggab told of the weddings of long ago which took place in the barazzi (the name given to the woollen tents which were set up in the desert for the occasion). We also talked about sex. The daughter told of a woman in the fields who has 16 kids and had much energy and lovely looks. She was surprised how she could look at her ugly husband when he was on top her.
(FIELDNOTES)

The above account is typical of such trips to town when women and men brave the world of physicians. The three women enjoyed the suspension of village routine effected by the journey to town, the long wait in the reception room and the process of examination and prescription itself. Invariably women try to sit on the chairs provided in waiting rooms before expressing their preference for the floor when the wait lengthens. The wait is itself a part of the experience, as much as is the consultation itself. During this often long interval women talk. They do so in low tones befitting the strangeness of the place where they are talking. Finally they are admitted, armed with their symptoms and hopes for cure but otherwise defenceless.

B. 2 THE PHYSICIANS

Physicians play a vital role in shaping villagers' experiences of medicine. It is difficult to 'summarize' attitudes or 'quantify ' physician/patient relationships[4]. It is impossible to describe every single encounter

---

[4]. There are studies where such quantification is attempted whereby scores are given for length of consultation, ratings given by patients in exit interviews, ..etc. (see Abdel-Tawab Nahla 1995)

observed, nor can I aggregate these encounters and construct a 'representative' profile of the nature of the relationship between doctors and their patients. To convey detail and nuances, I shall describe some encounters in detail and try to complete the picture by presenting the views of the physicians as explained in interviews.

The doctor whom I shall refer to as Dr. Mahmoud was one of the first members of the hospital paediatric department staff to encourage my presence there. I had gone with Om Abdelbasit to the out-patient clinic because her son had a rather acute bout of diarrhoea and we went on my advice. When I introduced myself and explained about my research in Rihan, he was enthusiastic and proposed that I sit in on the rest of that morning's clinic. Meanwhile he prescribed some oral rehydration salts to Abdelbasit saying to me, "Of course it is the first thing we give just like the campaign tells us, but because of the dirt in which these people live, I shall give him some antibiotics and something to clean his stomach"(interview on 11/3/93).

Dr. Mahmoud graduated from Medical School, Assiut University in 1983 and received his Diploma in paediatrics 1990. He has been employed in the hospital since April 1991. He is from Assiut city. He is in his middle thirties and has a family of his own. He also has a private clinic in the town of Abnube. "But it is not working like a house on fire as other clinics in Abnube are, this is all a matter of luck, but thank God things are alright" he said. Like his peers he is government employed during the day and self employed on his time off.

On that first day in the hospital out-patient clinic he saw 15 cases. The majority were either suffering diarrhoea or from respiratory tract infections. There were two cases of severe burns, and one child who had a urinary tract infection. He admitted one case of acute respiratory tract infection on the spot. All fifteen cases were accompanied by their mothers or other female relatives. None by male relatives.

During consultations Dr. Mahmoud sits behind a desk and is dressed in his everyday clothes without the stereotypical "white coat". He is assisted by a female nurse who is in uniform. The consultation room is bare save for the wooden desk and chair where the doctor sits and an examination table and some shelves and a trolley behind a curtain in a corner. There is a half torn poster about family planning on the wall.

Doctor Mahmoud used the examination table to examine the two cases of burns and he instructed the nurse on the application of the dressing. Otherwise the patients and the adults accompanying them were left standing in front of his desk and asked briefly to describe their symptoms. He examined three babies while they were held by their mothers. In one case he used the stethoscope and this is the case which he admitted to hospital. The baby was in severe bronchial distress. The other two he examined to ascertain their degree of dehydration.

He only asked the name of the child when prescribing and asked for no details other then the specifics of the particular episode of ill-health for which he was being consulted. Most consultations took only a few minutes. He was kind enough to explain to me each case, and comment on poverty and ignorance as precipitating factors for each condition.

After getting the coveted permit from the ministry of health, I had the opportunity to sit in on a few more such sessions. Save for a few emergency cases, many of which were scorpion or dog bites, the general picture was the same. Most days the clinic took a few hours, regardless of how busy it was. Throughout the morning Doctor Mahmoud would ask the nurse how many more patients there were and accordingly speed up his consultations. By twelve thirty in the afternoon, or one o'clock, maximum, his and the other clinics were finished.

The paediatrics ward is not as crowded as the out-patient clinic. Cases are normally discharged within three

or four days except if they have undergone surgery (see table 6.1).

Table 7.1: Cases in Paediatric Unit on 11/3/93

CONDITION	ADMISSION	DISCHARGE	COMMENT
Scorpion bite	9/3/93	11/3/93	recovered
Food Poisoning	8/3/93	11/3/93	recovered
ARI	6/3/93	11/3/93	recovered
Bronchial pneumonia	6/3/93		improving
nephrotic syndrome[5]	28/2		to be referred

Source: Abnube General Hospital Records

As we walked through the ward, Dr. Mahmoud showed me a young baby on an intra venous (IV) drip. The baby lay on a makeshift hospital bed which was actually a trolley meanwhile his mother was trying to help him suckle from her breast. Dr. Mahmoud shouted at the woman who started whimpering and apologizing and saying that she only meant to comfort and not actually feed the baby. He explained that the baby was too weak to feed and pointed to this incident as an example of why the general health of peasants' children is in such a sorry state. "The problem is one of ignorance as it is one of poverty" he said. On another occasion he referred back to this problem.

> If they knew that Ishal (diarrhoea) comes from their bad habits. You find that the bottle is not covered. The bottle is usually a medicine or coca cola bottle with a teat attached by part of the babies old underwear. These things are known. We say that the bottle should be boiled from one feed to the next and the remaining milk should be disposed of. No, she makes one bottle to last from morning to night. Of course the milk goes off and the teat becomes contaminated. If they understood these things. They

---

[5]. Nephrotic Syndrome is a combination of oedema, albuminuria (loss of albumin in urine) and an increase in blood cholesterol. This condition whereby the permeability of the kidney is increased may be due to kidney infection, diabetes, collagen disease or other unknown factors.

think that this is quite normal. If there was some awareness! But these are their habits. You find that she gives him vegetables or fruit for a child to eat without washing it first. This is normal. (18/3/93)

Dr. Mahmoud is talking about the cases that he sees who come from the region and not about people from Rihan in particular. It is therefore irrelevant to match this testimony against observed behaviour or the rationalization for it as it exists in Rihan. This point of view that Dr. Mahmoud holds illustrates his perceptions of the peasants amongst whom he lives and works. Dr. Mahmoud expressed a particular concern for the prevalence of malnutrition in the region of Abnube. He regularly sees cases of marasmus. He is of the opinion that marasmus is more prevalent than protein deficiency and blames this on the poverty of some small villages in the area as well as on "nutritional illiteracy", a phrase that he has coined.

For this area, like elsewhere the prevalent morbidities are; in the summer diarrhoeal diseases and cases of malnutrition such as marasmus even more than Kwashinkor. In the winter it is ARI and in January and February some infectious diseases such as measles and mumps, hepatitis and smallpox. But that is not all, we see many cases of severe respiratory infection. Because they are diagnosed late so we get cases in severe respiratory distress. Albeit no mortalities, but they take a long time to treat because they come late. Even concerning diarrhoea, people wait and say it will **yoqtob**[6] by itself or hold itself and you ask them how long has the child had diarrhoea and they say 5 or 6 days. By that time the child is severely dehydrated. There are cases like measles when people say a child should eat and not eat certain things and should not take medication so that the measles appear on him. This delays treatment and leads to complications like pneumonia. (1/4/93)

Even in the midst of his compassion, he still found room to, in a sense, blame the patient. But this does not

---

[6]. **Yoqtob** means to stop in Arabic. It is a vernacular word used by people in the region and not common Egyptian Arabic usage and has therefore been left untranslated in the text.

detract from his empathy for the people who experience such hardship.

> These children are now suffering from the effects of changes to the environment. I am not saying that one thing causes cancer but I just say to myself that these children suffer from the diseases caused by their environment like diarrhoea and from the problems of poverty and the ignorance of their families, and also are now suffering from the diseases that are common because of the modern way of life. (18/3/93)

Doctor Mahmoud explained that work pressure and the difficulty of communicating with rural women were the two reasons why he rarely elaborated on the cases that he sees and the diagnoses that he makes. On average he sees fifteen to twenty cases in out-patient clinic and up to sixty cases a day in summer. Usually it is the mother or the grandmother who accompanies the child. In his experience it is rare that a father comes with a case. He finds it pointless to explain too much to these women when he is convinced that they will not understand. He explains:

> They have their ideas. You have to tell them clearly that this is the medication and that they <u>must</u> buy it and give it to the child. You have to tell them in a way that they understand. When you ask them about symptoms they do not know how to be accurate and so sometimes when the condition is clear you sometimes do not ask anything. Many children come in with a **higab** on its chest. This is very common. Or a small child comes in wearing black so that the baby lives. Even the underwear is black. The gallabiya is black and they wrap him in one of their veils so that the baby lives. They do other things for treatment. They say they stung or cauterized him. I've seen cauterization on the back I do not know what it is for. They take the sun from his ear and so put water and salt. One here hears many of these things. When you know this you appreciate that it is difficult to communicate.(11/3/93)

When asked if by and large people complied with his directions and accepted his prescribed treatment , gave an emphatic yes explaining that people understand that medical advice cures children and do accept treatment,

"isn't this what they came for?!" he exclaimed.

Let me tell you, some children come and the breast-feeding is insufficient. The mother is anaemic. Yes we say that there is nothing better than the mothers milk but the mother comes and she is anaemic and her food cannot give enough milk for the child. We should then give something to help but the answer is no I give him caraway, anise and rice water. Of-course this creates malnutrition. Shall I prescribe a box of formula to help she says,no I cannot afford to get it, it is too expensive. This is of course because of poverty. Another thing that is common in the summer is food poisoning. Of course food is made at lunch time than they eat from it at night and again the next morning and so the child gets vomiting and diarrhoea and if the situation is left it can lead to death.
Also the mother may have to think of her whole household and family and give that priority over the health of one child. Let me tell you, some cases come and you tell the mother that the child needs to be admitted because he is sick. She refuses because in the house she has a water buffalo. She may prefer to tend the water buffalo than stay in the hospital with her sick child. She can get another child. This is very common because it is very easy for them to get another. They also have a thing concerning girls. She swears she only has him when she has eight or seven girls. This is another thing that you notice here. (11/3/93)

Since medication is a critical part of biomedicine, we discussed the misuse of drugs and their irrational use on the part of patients and physicians.

In my clinic if a child does not require medication, I do not prescribe it. Particularly antibiotics, I am not the kind who prescribes them for no cause. If a child comes with a flu, I do not prescribe them because it is a viral infection. I prescribe an anti-pyretic or anything for the symptoms. And I save the child from the consequences of antibiotics. But in villages people like medication. True they may not buy it but they like it to be prescribed. (18/3/93)

They go to the pharmacy and say el-tifl[7] has diarrhoea. There are many types of diarrhoea. It could be dysentery. If specific medication is not given, it will not do. It could be because of anything but he is

---

[7]. The infant

given **Entocid**[8] and it is considered enough and people keep buying and giving in this way and so the cases become complicated. (18/3/93)

Dr. Mahmoud added that he often sees complications resulting from the irrational use of drugs. He lamented this situation with reference to cases of dysentery:

If only it is prescribed right. Something like **Flagyl**[9] is all it needs. If taken for 10 days, that is the end of the problem but it enters into complications to the liver or chronic dysentery and the child can stay sick even if given **Flagyl** for ten days at a time because he has chronic dysentery. (18/3/93)

Yet he hesitated to censure colleagues or pharmacists insisting that these complications result either from patients "pressuring" physicians into writing long prescriptions, or are due to people prescribing medications for themselves or taking drugs that have been prescribed for others.

Dr Mahmoud feels that he knows about the poverty and suffering with which his patients and their families live. He is no stranger to their way of life: "Of-course we do not live like that but of-course I know about village life" he said. Yet he persistently gives weight to ignorance over problems of poverty and poor services when contemplating blame for various medical conditions.

He has not been in a villager's home for years because he undertakes home visits only in urban Assiut. But he has lived in this part of Egypt all of his life and so feels confident that he has accurate information about poor peasants. He triumphantly concluded one of our conversations by asserting that "I do not have to go into

---

[8]. The brand name of an oral synthetic antiprotozoal and antibacterial agent. It costs about 4 LE (less than £1) per 20 tablets.

[9]. A combination of Quinoline, Sulpha, and streptomycin commonly used to treat amoebic dysentery in Egypt. It costs about 3 LE (about £0.50) per 20 tablets.

their homes, I know **how they think!**" Consequently he feels secure in the knowledge that the families with whom he deals are to be blamed for their problems and that circumstances, services, and society are not the real culprits.

> They do not behave like educated mothers. No, here people say he will get better. They say he will grow like those before him have. If there is no milk they give him Caraway and anise. They make fenugreek or boil rice for rice water and call it **'irq roz**, they have such terms. This is natural for them. This is their nature. Of-course there are some children who pass through it and grow and that is why they take these things as being normal so they do not make the distinction between one case and another. (11/3/93)

B. 3 Another Physician

The physician favoured by families in **Rihan** is Dr. Salah, the physician at the health unit in **Arab Matteer**. He graduated in 1981 and worked in three other health units in Assiut before coming to work in this one. He has worked in **Arab Matteer** for two years. Dr. Salah always has a full clinic. His annual average is 50 cases a day (including both adults and children). His clinic is open from 8.30 to 2.00 pm and in Ramadan from 10 to 2.00 pm and he is on call for emergencies all day[10].

Doctor Salah lives in a Assiut city but since his clinic is in a village, he is of the opinion that he is quite aware of how peasant families live and behave. He believes that " Poverty is the main problem". They do not take the child to a clinic. If feverish they give an anti-pyretic and do not bring to a doctor except if he is **yekot**[11] or has become lax" he said. On reflection he distinguished between poverty and its consequences to **el-thaqafa el-**

---

[10]. However, on every single visit to the clinic after 12.30- 1.00 pm the clinic was closed.

[11]. Grunting or wheezing.

si'hiya (health education) [12]. This term is used in health campaigns in Egypt to imply medical awareness or knowledge. The term implies more than familiarity with facts concerning health. It resounds of a middle class bias for education and a certain type of **thaqafa** (culture).

Dr. Salah finds that people are receptive to biomedical knowledge and to the dictates of modern medicine. He questions the stereotypical assumption that peasants still rely on folk medicine. The following is an account of an interview with Dr. Salah in his clinic.

People rarely use folk medicine when it comes to children. It is more often used for adult cases. Some of the well known things are cauterization for pain. It has a scientific basis in that it creates counter action but I have never encountered any folk medicine for children.
Q- What other folk medical practices have you encountered besides cauterizing?
Just cauterizing and people stung by scorpions are put in empty graves.
Q- What about **el-riha** or **higab**.
I have seen children with beans hung around them like rosary beads or with amulets like little purses with old money with the hole in the middle and other things hung around their chest. I see these things but they are never mentioned in front of me.
Q- Do you think that this is done for prevention or for cure?
It is for prevention as people say that a child who has a **higab** will live and not die. I hear this but not often. (8/4/93)

He finds that people in the area of **Arab Matteer** and the inhabitants of **Rihan** are **Khawafeen** (fearful). They fear for their own health and that of their children so much that they are always rushing to the clinic with one complaint or another.

The strange thing in this area is anyone who has **imkaniyat** [13] goes to the doctor. Even people with tonsillitis. Tonsils, many people don't treat them but

---

[12]. **Thaqafa** (n.) in Arabic can mean culture and/or education. **Mothaqaf** (adj.) means intellectual.

[13]. The means to afford a certain luxury.

here, for the simplest thing, they seek a doctor. People who cannot afford it go to the pharmacy and say I have this, give me something for it. Any mother, even if a baby is just a late walker takes him to the doctor once, twice and three and four times and she brings him in and we try to explain to her that she must be patient and wait a little because medication takes time and too much of it is harmful in rickets cases.(8/4/93)

Most people do believe that biomedicine is efficacious, but many are not sure if it is the drug, the interaction with the doctor and the examination, or just the expense and effort which all this entails that does the trick. On one occasion he was asked to examine a young girl. He realized that he had just seen the child three days before and had given her grandmother who was accompanying her a long list of medicines. He asked the woman if the child had taken the medication as he had specified and she gave a hesitant "no!" commenting " You examined her and wrote for her a prescription; isn't that enough?"

Doctor Salah frequently mentioned this problem of lack of understanding and of the paucity of **el-thaqafa el-si'hiya**. He mentioned, for example, dominant theories of contagion and illness causation.

The prevalent notion is that illness comes from the air. You try to make them understand that it is a microbe and that this microbe found an ideal medium becomes of certain circumstances but they think and believe that it is in the air not from a specific thing. That is why the only way to reduce ill-health is through **el-thaqafa el-si'hiya**.
They are not to blame for this. Poor people have to work all the time and so have little time to listen to things like television. If a man is comfortable he can concentrate on what is on television and understand what is being said but because of the burdens of everyday life, people just think where will he work and other calculations but if he was not poor he would absorb **el-thaqafa el-sihiya** and medicine. But currently when a boy gets sick they take him to the doctor and think that the doctor can cure him.
You know, Malnutrition is rampant here. Marasmus and

Kwashinkor, rickets. People in el-reef[14] do not eat well. Their understanding of nutrition is wrong. I often tell a woman that an egg is very important for a child that beans and lentils are very important. They lack el-thaqafa el-si'hiya very much.
Q- What are their nutritional beliefs?
For them, meats have the highest nutritional content and cannot be substituted. They do not understand these things, what is the nutritional value of each food item. They do not know these things and they need thaqafa Sihiya. They eat cheese, bread, and onions, all things which are not nutritious. So all of the cases of rickets here comes from this malnutrition. (23/4/93)

He mentioned the extremes that can result from this state of ignorance. Some parents of children with congenital problems abandon their search for therapy in the belief that the sick child is destined to die anyway.

Some people dislike doctors, others have developed an addiction to them, but everyone has had some interaction with them. Dr. Salah reminisced on his days as a student. "Some of us went into medical school, not only because we got the grades, but because we wanted to help el-ghalaba [15]; others knew that a doctor practising in rural areas can make a lot of money if he can become popular and gets a private practice." In other words Dr. Salah was reiterating the common wisdom which says that peasants are poor enough to be the objects of charity and rich enough to enrich the do-gooder.

Both Dr. Mahmoud and Dr. Salah claim to understand their patients and to know of their living conditions and environment. But the most relevant aspect of this environment to health for them is the medical ignorance that it bestows on peasants. Both physicians appreciate poverty and its consequences. They both contest the hegemony of other medical traditions and affirm the popularity and supremacy of biomedicine. Yet they complain

---

[14]. The country-side or rural Egypt

[15]. Poor people

peasants "do not understand" and "do not play their part" and therefore they and their children suffer more than they need to.

Both assume that that which they do not see, does not happen, When asked about various popular forms of prevention, diagnosis, and therapy, they said that they knew of these practices but that these customs ultimately played a minor role in the determination of good health. Doctor Salah explained

> You may find this talk of **tamrees**[16] and **el-riha**[17] strange and interesting but it is not important. Especially when children are concerned, peasants here will run to the doctor. They may have tried some of these thing or may do them as well as taking our prescriptions but they know that modern medicine offers a good cure. They do not depend on these other things except in rare cases. These other things are common for women who want to become pregnant or who have other problems but they are rare for children.

This recognition of the significance of their roles does not necessarily translate into better communication between patient and physician. They realize that the modern medicine they provide has become a basic necessity and they know that patients take refuge in it even if they have referred to folk medical traditions before, after, or during their course of biomedical treatment.

B. 4 The Physician Working Privately

There is a clear consistency between the views of physicians working in the public sector and those who have private practices mainly because they are the same people working here and there. Physicians working in their own practices are doing so to make some profit. There are several venues to enrichment from rural practices. One is to become "the favourite family doctor". The first requirement for this favoured position is to down play the importance of specializations. The streets of Abnube, are

---

[16]. Massage

[17]. Diagnosis by divination

lined with boards advertising a physician's specialization as a specialist in internal medicine, gynaecology, obstetrics, and paediatrics. Another favourite mix of skills is 'Specialist in kidney problems, male and female infertility, and skin diseases'. Others favour 'specialist in female and male infertility and skin diseases and allergies'.

These practices hold a middle ground in terms of credibility and popularity. They are perceived by people in **Rihan** and in other villages, to be superior to the small village private practices but inferior to the clinics of the city of Assiut. Some of these practices are more successful than others. Many have a devout following of clients; whole families who consult the doctor when any member becomes ill. People in **Rihan** recognize the distinction between paediatrician and other doctors but may still prefer to take a child to the favoured family doctor for referral and advice.

The family of AwadAllah have such a doctor in Abnube. He is Coptic they stress, but a wonderful doctor. Going to see him is a treat in itself. Naggat, AwadAllah's oldest daughter who is in her late thirties and unmarried insisted that I go and see him because he is like a member of their family. She and I went together one afternoon under the pretext that her appendix was playing up on her again, although she had it removed three years earlier. We took with us some cleaned pigeons[18] and some **semn** (butter ghee) for the doctor.

We went up to the humble clinic situated in a run down block on the Abnube high street. The doctor was sitting in his dusty and ill-maintained office. There were no other patients and the doctor was chatting away with a man whom he introduced as his friend and colleague who has a clinic on the same landing as his own. Naggat gave him the basket

---

[18]. An expensive and much loved delicacy, pigeons are valued even more when slaughtered, plucked, and cleaned since this can be a tedious task most urban women dislike.

of goodies and he thanked her before turning to me and explaining that he and the AwadAllah family go back a long way. He is an internalist by training but he has been treating them and their children for all sorts of things. He works in the Abnube general Hospital by day and lives in the city of Assiut. "The competition is too much in Assiut so I thought that I would have my clinic where I have most of my patients and opened my practice here" he explained.[19]

Doctor 'Imad was not forthcoming about various aspects of medical practice in Abnube. He merely asserted that people in this area were good kind people and that he was happy with his clientele. On the way back from this visit Naggat indicated the many instances in which Dr. 'Imad had been of help to their family. He had proposed treating her brother Mohamed with electricity sessions to help him get better. Mohamed (family M) was a soldier in the 1973 war and had suffered a head injury which left him with a mental handicap and a speech impediment. Mohamed wanders around the villages in a disturbed condition and while he can perform some manual tasks his condition prevents him from pursuing a normal life.

Doctor 'Imad told the family that all Mohamed needed were a couple of electricity sessions to get the blood running in his head because "when people have accidents they do not eat so the blood in the head becomes weak and it stops but electricity can set it flowing again." Mohamed, who has a wife and daughter, cannot afford such sessions but upon the recommendations of the same physician, his mother is taking electricity sessions on her knee to get the blood flowing in them. She pays 20 LE a session and although her knees still hurts she has had to discontinue them since the summer is a difficult financial time of year. It is impossible to offer an educated guess as to how Doctor 'Imad decided on this suggested therapy for Mohamed. Particularly since no other doctor had

---

[19]. He means that most of his patients are the people whom he sees in the hospital.

mentioned the therapeutic potential of electricity to the family before!

Another doctor favoured by the families of **Rihan** is Doctor Mostafa who has a clinic just off the Abnube Market. Doctor Mostafa is reticent and polite. He is so polite that he says absolutely nothing to his patients except to ask them their symptoms. I accompanied Om Atef when she was bleeding due to her dysentery, 7 year old Sawsan who had a large abscess on her neck, 4 year old Saddam when he had a chest infection, and 12 year old Mona whose father took her to check on her previously broken arm. Each one of these consultations was marked by near total silence. "Yes", said Om Atef, "that is what he is like, but he writes good prescriptions". This was her response at my exasperation at Dr. Mostafa who only gave us a diagnosis and prognosis on my insistence.

Whether working for the government or for themselves the basic tenets which construct the relationship between physician and peasant clients are the same. This assumption of miscommunication and limited understanding permeates these relationships and indeed many doctors assume that it is one of the facts of their lives and is inconsequential to their work. "We do our best" said Dr. Mostafa in one of his rare utterances, "The rest is up to them, whether they take the medicine or not is not my responsibility".

Villagers from **Rihan** who frequent biomedical clinics are not uncritical of the services that they receive. Ni'mat once complained that "Doctors take from your mouth and give it back to you". Ni'mat was referring to the inability to diagnose without checking for symptoms. Part of the test of spiritual healers is their ability to diagnose without "cheating" from the patient. When one goes to a healer one is not supposed to say what their problem is. If it is a good healer he or she will be able to know without being told. It is in this vein that patients criticise the questions of physicians.

From the physicians point of view and their narrated

accounts several points are made explicit. The first is that physicians really do think that their biographic and personal experiences are irrelevant to their practise of medicine. All the physicians refused to relate their own personal experiences and circumstances to their profession. They only insisted that they know a lot about their patients but found that their professional role made their other roles in life irrelevant. That is part of their professionalism.

Secondly, physicians felt that they were delivering a good service and that any problems that existed had to do with patient intended disobedience due to ignorance or that which is unintended and is due to poverty. They could not fault their profession either in theory or in practise. They did wish that they had better **imkaniyat** (resources) meaning medication, machines, and other facilities. None felt a need for further research or for innovation.

The last point concerns their awareness of the impingement of their physical and cultural context. They only saw problems with this context, problems which interfere with ideal medical practise. The solution implied is the negation of this context. The corollary to this was the idealization of urban life and middle class attitudes and practises concerning child health care in particular.

Yet their rural patients seem to be oblivious of how these physicians perceive them and their village life. Kluzinger observed Upper Egyptians in the second half of the nineteenth century dealing with doctors in an assertive and critical manner. He says that they asked for medications they know, supervised how medications were mixed and were so suspicious that they were known to have asked the doctor to take it himself first (Kluzinger 1878: 82). A century later Upper Egyptians seem to have lost this cautious attitude. Patients do complain if they are snubbed by physicians or of the price of care. They are however no longer equipped to challenge or over-see the work of a doctor or nurse. But they have come under the sway of the

hegemonic discourse of the physicians and spend time, money, and energy on procuring their care and the drugs which they prescribe.

C . SPIRITUAL DIVINATION AND MEDICINE

Egypt has had a long tradition of spiritual divination and folk medicine in Egypt. Summarizing and theorizing such a huge stretch of human culture, knowledge and civilization is no easy matter. This tradition of medical thought implies religions, metaphysics, history and the history of science and scientific discovery, as well as other disciplines including astrology and mathematics. But these medical traditions have never been institutionalised or officially regulated. These medical traditions have become undermined to the extent that even those who practice them do so in near secrecy.

Spiritual divination and other folk medical specializations are the professionalised parts of folk medicine. Unlike biomedicine which offers therapy for a wide variety of ailments, from the common cold to cancers, these forms of folk medicine leave much of the primary health care and simple health problems to community care and only address certain complex or chronic cases.

Spiritual divination, for example, is sought out primarily for one or a mixture of the following conditions:-

- Unexplained/able chronic and/or recurring illnesses
- Indigenously constructed illnesses such as **Khar'a** (a susto-like illness), **mushahra** (a state of infertility), **uzr** (a depression – like malady), and other well known conditions.
- Cases which have coincided with social conflict or disruption.
- Cases which have failed to find comfort/cure with physicians.

In the case of children parents may consult a healer just

to make sure that recurrent bouts of diarrhoea, failure to thrive, and other serious conditions are not caused by more fundamental agents then the biological organisms and causes which physicians persist are the root of all evil.

Because initiation and education into spiritual healing is left to each individual healer there are many who malpractice this form of healing. This has further undermined spiritual healing as a domain for crooks and those stupid enough to trust them. It is true that many healers had been addressing physiological disorders without success and that these charlatans had been exhausting peoples trust and money. But this broad school of healing does supply a still existing need which biomedicine, as it is practised now, cannot supply.

This tradition dignifies peoples beliefs. A healer will respect a parent's view that a child is **batlan** and will take the child's circumstances and position into consideration when healing. This is the tradition that shares villagers' heightened sense of context and of history. As such it is the tradition that remains powerful in affecting peoples conceptualization of health and how to protect it[20].

C. 1 The Male Sheikh

In Arab Matteer there is a healer called El-Sheikh Hashem. He is a farmer who is also a **Khateeb** (A person who says the Friday sermon and who leads the prayer). He is not a government assigned **Khateeb** but a local one. He also "uses the word of God to diagnose and heal" explained a father who had just returned from consulting him. Men in particular insisted on the legitimacy of the powers of El-Sheikh Hashem. He is described as a man of God who just uses the words of the Quran to diagnose and heal. Abu Essam explained that he is not like the women and the crooks who have no religion.

---

[20].For an account of the philosophical and historical roots of these medical traditions see appendix 8.

Sheikh Hashem crumples the garment of his patient to diagnose their problems. He uses neither Quran nor Hadith but words of praise for the prophet and for his righteous teachings. By soliciting the blessings of the prophet, El-Sheikh Hashem creates an Islamic aura by which he differentiates himself from other healers.

El-sheikh Hashem also consults a book and prescribes herbal remedies to be burnt, diluted, swallowed, bathed with, or used in a combination of these four methods of use. He also writes out protective and curative amulets which are worn, slept on or buried, or all three in succession. His amulets usually contain only words and no substances such as animal parts or grains because he is a man of God and a Khateeb in a mosque. It is within these limits that he can heal and protect. The herbs that he prescribes are known to be medicinally potent and that is why he uses them. "There is nothing more potent than words; for words were/are the medium through which the miracle of the Quran was revealed to the prophet" he very often explains. As for the spirits themselves, el-Sheikh Hashem thinks that no one can take issue with their trifling and activities. The Quran confirms that the world is inhabited by **Ins wa jinn** (human beings and spirits) he explains. Some of these spirits are benign and they are called jinn, or Asyad (Masters) or **Sukan el-Ard** (those who dwell in the earth). Others are malevolent and they are known as either **jinn** or **'Afarit.**

El-Sheikh Hashem is the favourite choice for men from **Rihan.** They consult him when they have problems and recommend his consultation when a child or female in the family need help. Hashem Sewify is a good friend of el-Sheikh Hashem. They have entered into several business ventures together, selling produce and co-owning water buffaloes. When I asked to meet the Sheikh, Hashem insisted on fetching him from his home in **Arab Matteer.** Sheikh Hashem came to **Rihan** riding on the back of Hashem Sewify's motorbike one Friday morning and after breakfast, tea and

cigarettes he began to answer my questions.

Meanwhile, neighbours had heard that sheikh Hashem was in the house. Hussein and Qut, two of Hashem's friends came, and insisted that the sheikh give the Friday sermon that day in **Rihan** at the Sewify Mosque. He said that they would be waiting for him in **Arab Matteer** but Hashem refused this excuse saying that any other good man can take his place and that anyway his family knew that he was coming to **Rihan** and it would not be fitting if he did not stay to lunch.

Others came into the **mandara** asking to consult him concerning their own kin. Om Touba came with her daughter's scarf to ask for her **riha**, the girl is 15 years old but is weak and always angry or depressed. He wrote a **higab** for her and asked her mother to give her more to do so that the girl does not daydream and become sad. Farhana came to consult him concerning Abdouh's (8 months) hydrocele. He gave her a written amulet and told her to get an ointment from the pharmacy for inflammations. More women were coming in but Hashem put a stop to it. He stood at the door of the **mandara** and yelled at them saying that the sheikh was in his home on a private visit and so the small crowd reluctantly dispersed.

The sheikh asked Ni'mat about Osama's (13 years) foot. Osama had a **'adit ard** (literally a ground bite) or a foot boil that became badly infected when he was first treated with salt by his maternal aunt who massaged course salt on the boil and then wrapped it with a rag. He kept limping and could not walk. By the next day his ankle was swollen and he was in a lot of pain. A distant uncle and his father's best friend is known in the village for his surgical skills. He can make precision cuts to release pus, blood, or pressure. He cut the infected area and "rivers of pus" came out to use the words of poor Osama. He did not get any better and within a day, and upon my and his mother's insistence, he was taken by his older brother to the hospital in Abnube where he was given antibiotic. A

week later he had the abscess surgically removed. The sheikh had heard about the foot when he met Hashem in Abnube.

Osama's condition was one that did not necessitate the consultation of the sheikh. He explained that his work is to diagnose the cause and address this cause. His amulets and herbs deal with conditions which are in his power to cure. This does not preclude the therapy of modern medicine such as surgery and antibiotics of which he is an ardent admirer. He added:

> There are conditions that modern medicine cannot treat. Man knows very little of the Knowledge of God. and el-jinn are mentioned in the Quran. I only use words to cure and the herbs are well known in el-Tibb el-nabawi[21]. If a person needs a doctor, I am the first person to tell them to go to the clinic. But there are so many conditions that a doctor cannot understand and cannot provide therapy for.

One of his specialities is the treatment of bridegrooms who have a problem on their wedding night or on subsequent nights. The sheikh cured Salah of the Thokala family who became **mamsuk** (held) on his wedding night. Salah had wanted a modern wedding night and insisted that he enter his bride himself. When the time came he failed to penetrate her. The bride's mother and aunts entered the room and deflowered her manually, just to show the crowds outside the newly weds room that the bride was a virgin. The sheikh gave Salah some medications, some of which were pharmacy bought and the new groom was able to consummate his marriage after a few weeks[22].

Several months later, I accompanied Hussein and Hashem on a visit to sheikh Hashem at home. We were greeted by his

---

[21]. Prophetic medicine.

[22]. I am not sure what the exact medications and herbs used are because I heard the story from Salah's mother. Sheikh Hashem does not divulge the secrets of this therapy as he makes much money from treating male impotence.

elderly wife who showed us into a **mandara** (front room/parlour). Hussein wanted to consult him about his oldest son (14 years) who had suffered from bilharzia and who was urinating blood again. Hussein and I had discussed his condition and the boy was taking medication. But Hussein said that his wife was pressuring him to go and see if there wasn't some other contributing factor to the boy's condition. Sheikh Hashem took the item of clothing from Hussein and the 25pt($0.07) wrapped in it and after reciting words calling on the prophet consulted his book, said that the boy was fine, but made him a **higab** to protect and strengthen him anyway and prayed that God may take him by the hand and return his health and strength to him. Afterwards we stayed for another hour drinking tea and discussing the price of onions this year in comparison to last years when people became "millionaires", to quote Hashem, from their crops of onions.

Sheikh Hashem is a trusted and respected member of the community who has religious credentials which legitimate and inspire his healing practices as far as his patients are concerned. He practices one of the oldest traditions in diagnosis and healing known in Egypt. He recognizes the causative role of **el-jinn** in the generation of ill-health but he uses words and herbs to restore health and well-being. His mastery of these words and of the use of herbs sets him apart from spiritual healers who use spirits to heal or who cast spells. This is an essential distinction which elevates the sheikh from the position of a village quack, as are considered other healers in the area who do not have religious credentials, to that of a learned man of God.

C . 2 The Female Sheikh

Sheikh Eid is another favoured healer who lives on the outskirts of Arab el-Atawlla, 7 Km away from **Rihan**. This sheikh is however a woman who practices healing and who dabbles in something close to witchcraft. She is favoured

by many woman in **Rihan**. As Naggat explained:

> When a kid becomes sick and you go to several doctors and they do not know what is the matter. then you go to her and she tells you that he fell in such and such a place and is possessed as children do when they fall. So she gives you a **higab**[23] and the child becomes well. She tells you to return on such a day so that she sees how the child is.

She uses **el-riha** to diagnose a physical and/or psychological health problems. The consultation fee is fixed at 25pt($0.07) except if the patron is particularly wealthy then they may pay a whole pound. However, if the problem was particularly acute and if it was solved by the Sheikh's intercessions then a follow up payment is expected and is made either in cash or in kind.

I first met sheikh Eid, whose real name is Om Eid, when Naggat asked me to accompany her because she wanted to consult sheikh Eid concerning her inability to once more become pregnant. Hashem , my host, when hearing of this intended visit said "This is not a sheikh of God, this is a sheikh of the devil. It is only silly women who go to her, all of this nonsense!!" Naggat made me promise to consult her too and to say that we were going on my request and not to mention to anyone that Naggat also wanted to have her **riha** seen. Moreover, when she came by to pick me up one morning to go, she insisted that we pass by her own mother's house in **Arab Matteer** so that women in **Rihan** would think that we were going to visit her mother and not going to continue on our journey to see sheikh Eid.[24]

At the end of the visit myself, Naggat, and Naggat's (Naggat's mother) mother had been carefully diagnosed. Om AbdelHamid was told that her son is the object of envy, probably from his father's female kin who have resented him since birth. Om AbdelHamid said that she had suspected it all along. She

---

[23]. Amulet

[24]. For a detailed account of our first visit to sheikh Eid see appendix 9.

was given a **higab** for the boy and told not to worry and that he would be alright. "Of-course now that he is handicapped, there is nothing to envy" she sadly said as we left.

Sheikh Eid gave me three pills to take. They were pharmacy bought but she said that she had treated them with incantations. I could not tell what they were except that they are manufactured by Bayer, the Swiss pharmaceutical company. She gave me a folded up ribbon of paper with red writing on it and instructions on how to use it.

She also gave one to Naggat who forgot the instructions and asked me for them. Another strip of paper was to be passed on to Ni'mat who was to stain it with oil then sprinkle it with Henna and soak it in water with which I was to bathe myself. Then I was to soak myself in the vapours of some incense which she gave me. Next time she was to perform for me a ceremony with a red candle, a red rooster, seven loaves, an unlit match, henna, tea, salt, and sugar. Then both Naggat and myself will be given a **higab**.

Before we left she had taken me for an internal examination. She took me inside and asked me to take down my underwear and squat. She put her finger into my vagina and pronounced it to be dry and that is why it does not **la yelqot maa' el-ragel** (collect the man's water). She shouted at her disabled granddaughter who was looking on and trying to touch me. She then let me out and Naggat went in and she examined her internally (no hand washing). She told her **"Beit el-wild mayel we fih istilhabat. lazmek labayes odam we wara"** (Your womb is tilted and is inflamed, you need vaginal suppositories in the front and back). She explained that the internal examination helped her know what size and kind of vaginal suppositories she would make for us.

On the way Naggat had been saying, I hope she does not apply Kohl to us, then giggling and saying again, I hope that she does not make us up. I had not a clue what she meant. She later explained after the internal examination

that other women had told her that she sometimes uses a hot mirwed (the thin ivory, wooden, or metal stick with which Kohl is applied to the eyes) inside the vagina. Her mother explained that this is only done to women who need widening of the cervix/Os. She washed her hands after examining Naggat because she had let down water and took 1 LE($0.30) as an examination fee from her.

On the way back, Naggat told me that she had gone to Sheikh Eid some month ago because of her health problems. She had been feverish and her whole body ached and felt weak. Sheikh Eid had told her to eat honey and **semn** and to return. When she did she asked her for 30 LE($9) which Naggat refused to pay saying that she would rather spend it on medication. The reason for Naggat's health condition was a **khar'a** (shock). She had been inside the house one day when she heard her mother-in-law scream. She thought something had happened to her son and so ran out with her hair uncovered and her braids undone crying **ya waladi** (Oh my son)! It turned out to be the daughter of Obeid (who last year shot his wife by mistake) who had been run over by the harvester. Naggat saw her blood drenched body and felt faint. This **khar'a** caused her suffering and it took away her appetite.

On the three other days of visits to Sheikh Eid I witnessed her diagnosing small children, young married and single women and old grandmothers. Most of the children suffered from **khar'a** (shock) or **nazra** (envy). There was one boy who was being harmed by spirits which she explained as being the fault of his mother. All of these consultations were characterized by a lot of give and take between healer and patients and by the participation of everyone in the room in the process with analogies, criticisms, supporting evidence, and extra advice. Sheikh Eid speaks a language with which her visitors are familiar and suggests therapies with which they have experience. When Naggat said that she had never lost a baby and so could not be suffering from a bad **tabi'a** the woman sitting waiting for her turn suggested

that her tabi'a may be harming her in other ways and told her to look over her body for marks of pinches or bruises. Sheikh Eid agreed and Naggat said that it was true that she was black and blue all over even though her husband was away! This caused much merriment and stories of rough handling during intercourse and beatings ensued.

The words and therapy that sheikh Eid offers are antithetical to what we call medical. Her use of herbs is infrequent and she prefers pharmacy bought pills for their efficacy, specially the pills which bring on periods. This brand of spiritual diagnosis and the limited conditions which it can diagnose is perceived by people in Rihan as being somewhat illegitimate. Women clandestinely undertake their visits to her only to berate her diagnosis as nonsense amongst limited friends. Many later laud her publicly if they receive what they desire or rid themselves from their affliction or cause of vexation.

When Ni'mat heard of our visit she said "it is nonsense", then asked what she had recommended and insisted that I go through the ritual that she had suggested. She then told me that some women preferred the intercessions of a Coptic priest who lived by the Nile and who had cured many women and many children. However Aziza, Om Touba, Qut's wife, and Husseins' wife were all regular customers of Sheikh Eid. This healer has her hits and she has her misses. When she succeeds her popularity surges and when she doesn't her eminence goes into recession. "It is exactly like doctors who have private clinics" explained Ni'mat.

Perhaps physicians were correct in saying that not many children are taken to spiritual healers and that even fewer undergo healing ceremonies. Spiritual healers are commonly asked to diagnose the riha of a child and parents and villagers do heed this diagnosis but choose to treat it by their own means without the ritualised supplication of jinn. Indeed, here lies an essential distinction. Children are not taken to healers because so many of the common

childhood diseases are managed at the community level and not because physicians are supplying all the needs of parents and children. For example, and this will be the focus of the coming chapter, a child with diarrhoea is treated at home, then taken to one of the local masseurs who will attempt **tamrees** (massage). If the diarrhoea becomes chronic, there is distention and bleeding, or the child is dehydrated, parents may rush to the physician, and rush to the healer to diagnose through **el-Riha**. So it is arguable that although the observation of the physicians was correct, their analysis of the situation was not.

E. CONCLUSIONS

As laborious as these descriptions have been, they are necessary for the appreciation of the context in which villagers make their medical choices for themselves and their children. The traditions, structures and services of the medical system of **Rihan** coexist in a state of conflict and complementarity in which by and large biomedicine has the upper hand. Ammar tells us that even forty years ago modern medicine had succeeded in its challenge to folk medicine and that villagers in Silwa, the village he wrote of, going to the doctor was a sign of prestige although isolation in hospital was a sign of degradation (Ammar 1954: 79).

But biomedicine has established its supremacy in the curative sphere partially because of the degree to which it has taken on the garb of magical healing and healers. Doctors do not explain details to patients. "They would not understand" is the oft repeated explanation given by members of the medical establishment. Clinical encounters observed between friendly doctors and their familiar patients illustrate how doctors provide their private patients with simplistic explanations which assume that the patient actually does not understand a thing.

In Rihan, consulting a physician is symbolic of upward social and "educational" mobility. But isolation in

hospital is not only unpleasant because of the quality of comfort and care in the hospital, but also because it removes the afflicted from his/her community setting. In a sense, people bring into their world the knowledge of physicians when they wish to but they do not want to be taken out of this world and placed into the alienating, and often humiliating one, of the modern government or private hospital or clinic.

This chapter has described some health providers in some detail, but there are many others who have not been mentioned here. There is the barber who performs male and female circumcisions, the male nurses who undertake consultations and give medications, the pharmacists, the midwives, the bone setters, the dewormers, the cauterizers, and many others.

The healers described represent men and women who practise a tradition of medicine that has been greatly undermined but which centuries of dismissal have failed to destroy. They practise what could be described as an 'informal economy' medicine. It is commonly held to be illicit and inferior to the real thing. Yet it is to this medicine that people run when they cannot receive, have been failed by, or are otherwise dissatisfied with biomedicine. To avoid misplaced meanings, I have tried to describe events without censuring repetition, conflict, hesitation, jest, anger, or what I shall call for lack of a better word simple "nonsense".

Sheikh Eid knows that half of her mutterings are what she calls "ay kalam" (nonsense). This is not because she does not believe in what she is doing; but because she knows that her clients have certain expectations of healers and she does not like to disappoint them. She is quite flexible in asking for a black hen, or a black cockerel, or a white hen, before adding that any blood will do. She has her own worries and concerns and practises her medicine in the heart of a home blighted with divorce, mental handicap, and poverty. But her patients engage with her problems

lamenting that her handicapped granddaughter will never marry and telling her not to feign poverty since "we are all poor" as it was eloquently put by one vivacious client.

Sheikh Hashem is also a farmer, merchant, and a man of religion. He practices his form of divination to further these other professions as well as to help people attain their goals and become well. But he is conscious of the sanctity extended to his healing services by his knowledge and training in religion.

Both physicians and spiritual healers are prone to allegorizing readings as postulated by Taussig (1992: 10-11). Stereotyping is not a useful practise, nor is reading "too much meaning" into a relationship or event an advisable means to ethnographic interpretation. It is not the white coat, if worn, the spectacles, or the differences in language which structure the relationship between physician and patient. This relationship is subject to macro-level policy and economics, to a long history of a whole society, and to the needs and interests of individuals in search of better health and others in pursuit of a career. It is therefore necessary both to account for the general situation concerning medicine in Egypt and to describe encounters between physician and patient to better understand what kind of a choice biomedicine is for people in Rihan.

The intention of placing these health providers in some measure of a biographical context was to avoid allegorizing readings. Placing these healing traditions in a wider social and historical context was a way of retain the relationship of proportionality between the events described and their meaning and resonance in Rihan.

My second reason for a preference for a few detailed descriptions over a comprehensive list of concise profiles was to structure a sense of a medical system and not just its form and content.

Missing is the third medical resource mentioned in the introduction; that of the non-professionals. The exchange

of medical knowledge and practices does not necessitate the officiation of a paid professional. In Rihan, as elsewhere, people share their experiences of health and ill-health. Moreover there are individuals who have more medical knowledge than others but are not professional healers. Their roles will become clear in the next chapter on health management.

Plate 17

CHAPTER EIGHT

THE MANAGEMENT OF ILL-HEALTH

A. INTRODUCTION

The description of health services and health providers was a necessary introduction to the coming discussion on the management of conditions of ill-health in children. To understand how families manage their children's health problems, one must have acquired a thorough understanding of the material and intellectual conditions which produce their options of therapy and health care.

By management of ill-health I mean the processes, products, people, and practices which structure families' actions and reactions to a child's ill-health. Throughout my fieldwork in Rihan children I knew experienced episodes of ill-health; many of which were common childhood maladies. But some battled with the effects of fatal accidents, cancers, and serious infections. The differences in family management of such episodes and conditions depended on the age and sex of the child, the severity and endemicity of the condition, as well as on families' familiarity with the condition and with the child's health history.

Socio-economic and other factors such as education and perhaps ethnicity also play a role in decisions made concerning health care. But the differentiation effected by wealth and status are often ameliorated by ties of blood, and by other shared interests which draw families together and which detract from the significance of wealth and access to material resources per se (Abdel Fadil 1975, Abdel Mo'ti 1962; Fakhouri 1972; Hopkins 1988; Saad 1988). This discussion of disease and its management focuses on medical culture without denying the determinism of social, political, and economic

factors but also without falling into the trap of the over determinism of material factors (Young 1982, Morsy 1993).

Medical anthropologists of the 'Critical Medical Anthropology' school have pointed to the effects of structural disparities in wealth and power on the health of communities and individuals (Morsy 1993, Taussig 1980, Worseley 1982, Young 1982). Poverty and powerlessness can explain affliction and its causality such as malnutrition, poor sanitation, exposure to pollutants and toxins, as well as other conditions detrimental to health. But assuming that one can understand the health seeking behaviour of families in Rihan simply in accordance with their access to material wealth and to modern medical care would be a mistake. The use, or lack of, which people make of various medical resources reflects more than the ability of their pockets. It reflects their medical culture, the nature of their relationship with these medical care providers and the intellectual traditions which they represent, and their own critical commentaries and experiences of available quality of care.

The question of risk and disease implies that some health problems are more prevalent than others amongst children in Rihan. To record the geographical distribution of diseases and their intensity and casualties requires a credible epidemiological survey. The numbers involved in this study are too small to merit the qualification of a representative survey. Moreover the writer is neither an epidemiologist nor trying to be one.

This chapter will focus on morbidities which mothers, in particular, thought were common and to which children are particularly prone in Rihan. Age, as locally defined [1], is an important variable in the occurrence and the management of ill-health. Consequently, the medical problems

---

[1]. For an account of local defenitions of age, see appendix 10.

discussed in this chapter are organized in accordance with children's age.

This exposition relies on interviews and on observation. Interviews provide historical accounts and relay people's beliefs concerning sickness and disease. These testimonies do not always match observation but this does not mean that observation should be privileged. Being alone in the field meant that it was impossible to observe every single sickness event as it developed even when I tried to limit myself to my case studies. The course of a disease or sickness is erratic, as are adults' responses to it. Therefore, including interviews as basic sources for data became inescapable, and, indeed in some cases, preferable.

B. SALIENT MEDICAL PROBLEMS

B 1. The First Week of Life

Disease and health are subject to the hegemony of popular and/or dominant interpretations. Lay advice often rests on dominant ideas about sickness and about symptoms. A crying baby is assumed to be hungry. The first piece of wanted or unwanted advice given to often distraught mothers trying to cope with incessant crying is "feed him/her". Colic is another mysterious label dished out to frustrated parents to explain prolonged crying which may or may not be coupled with wind and other symptoms. This process of professional and lay explanation and prescription is echoed in Rihan. Here also the confluence of age, gender (not in all cases) and symptoms, conspire to promote a diagnosis.

In Rihan the explanation of serious illness of an infant who is less than seven days old rests on the concept of the qarina, more so if the baby is a boy. Severe sickness at this age which may result in death is related to the qarina and the baby's mother is said to be matbou'a. In Rihan the qarina is called the tabi'a. Both words mean the associate or follower

in Arabic. The **qarina** is the sister spirit of either the mother or the father. If either have a difficult sister spirit (the spirit is of the opposite sex to the human being that it is attached to) their newborn is at risk of death unless the spirit is somehow appeased or at least left untempted.

Blackman describes the sister spirit as being that of the infant itself. She says it is the child's evil brother or sister from the spirit realm that always makes its appearance and torments the poor child till it sickens and falls into convulsions (Blackman 1927). However it is clear in **Rihan**, and elsewhere, that it is the mother or father who are considered followed by evil kin spirits and that the children are taken and killed by these spirits out of spite and jealousy.

Kluzinger agrees with Blackman and writes that the **qarina** is born at the same time but is of the opposite gender to the new born. He tells us that even in physicians' registers, **qarina** was cited as a cause of death until the late 19th century. It loses its power as the child grows older (Kluzinger 1878: 382-3). One possible explanation of this controversy, and one made by several women in **Rihan**, is that the **qarina** gives birth at the same time as the mother. If she loses her baby or if she has a girl while the mother has a boy, she will express her jealousy by killing the human baby.

This uncertainty is important for understanding the **qarina**. It would be misleading to expect the clarity and the positivistic logic demanded by academic rationality to also apply to something as ancient and as precarious as the sister spirit. There remains, amongst many Egyptians, a 'folk' belief in a parallel universe. The inhabitants of this universe are the sister/brother spirits who from time to time cross over the boundary between worlds to affect the lives and health of their human siblings. The dissonance of various explanations and rationalisations of how and why the **qarina** harms or does not harm a baby is typical of any long surviving beliefs which have merged with and been submerged by successions of

dominating world views and religions.

Despite the uncertainty involved in rationalizing the parallel world of non-human beings, the way in which the **qarina** can harm a child is well known to all men and women in **Rihan**. A mother knows that it is the **qarina** by the way the infant falls into convulsions until its jaws are clamped together and it goes very stiff and dies. The description is surprisingly similar to **el_qazaz** (tetanus toxoid). The **qarina** may well be another name for tetanus toxoid poisoning. There is a clear consensus that neonatal death caused by convulsions is caused by the spirit choking the baby. Some women added that the spirit may cause a woman to accidentally suffocate her own baby by tossing herself on top of it as they both sleep. One woman in the village said that her daughter-in-law, who now lives in Cairo, had lost two boys in this way.

Although the sister spirit afflicts the child, it is the mother who needs the cure since it is either she or the father who are considered responsible. Some woman are known to be **matbou'a** (followed by a spirit). These women should know this themselves and be prepared before they give birth. They should go to a sheikh who writes them a **higab laban** (milk amulet). This is an amulet which both wards off the **qarina** and safeguards the mother's milk supply. Since it has this dual function, many women in **Rihan** have one made anyway.

For a woman who loses her newborn, this amulet should be made either with the **khalas** (placenta and umbilical cord) of a recently delivering donkey or with her own **khalas** which is salted and placed in her pillow. During my time in the village, I knew 10 women who gave birth. Seven had made a **higab laban** although only three had previously lost babies.

It is rare to find a newborn in **Rihan** who is taken to the doctor if he or she is in distress or is born with a health problem. During the first week of life ill-health is attributed to the **tabi'a**. Families differentiate between mild distress and the severe sickness brought on by the **tabi'a**. But

during those first few days, folk categories of affliction dominate when it comes to the definition and management of a newborn's ill-health. Although typically confined to the first seven days, the **tabi'a** may cause the affliction of an infant up until the fortieth day after birth. It is rare for a newborn to survive the blight of the **tabi'a**. Indeed **tabi'a** beliefs explain death more than they do sickness. But they are an important category of beliefs in that they explain how families manage the birth of a newborn and how they explicate his or her demise. 'Adila describes her experience with the **tabi'a**:

> I am **matbou'a**. The **tabi'a** would come in the night, bruise me and then strangle the baby. She even takes girls not just boys because she is so bad. I went to el-Hag Ni'man[2]. She is a young woman and she told me that I am **matbou'a** and that I must **ihagib**[3] with a Christian man. I did and since then I have not lost any children except Sayed[4].

To my knowledge, no woman who believes herself to be followed and therefore believes her children to be at risk has ever consulted a physician or any member of the biomedical establishment. This is a condition where physicians cannot be of assistance.

The **qarina** is not a remote survival from the past. Women do lose children to this spirit, or at least accept their loss on the basis of belief in the **tabi'a**. Om Mohammed has 6 children, the youngest of whom is 5 years old. She has delivered 23 times (see table 8.1 for details of other infants lost this way). She is unlucky because her **tabi'a** is particularly vicious. Other women like Ni'mat and many others have never had it happen to them. They simply have a benign **tabi'a** whom they do not tempt.

---

[2]. El-Hag Ni'man is a man's name.

[3]. Make a Higab or amulet

[4]. Sayed died of Cancer two years ago.

A woman beautifying herself excessively when pregnant or in the post partum period with Kohl and make-up is said to lure the **tabi'a** mischief by inspiring her jealousy. Letting the newborn sleep in the middle between father and mother is another foolish act. But the jealousy of the **tabi'a** can also come from the mere act of delivering a boy when the **tabi'a** has herself begotten a girl. Here the 'taken for granted' assumption is that the male newborn is cause for envy and the female spirit baby is a cause for lamentation and revenge.

Studies of the medical culture of rural Egypt have discussed the **qarin/qarina** without placing this belief in the context of the relationship between Woman/Man and spirit and the variability and outcome of this relationship (Blackman 1927, Inhorn 1994, Morsy 1993, Early 1988). Morsy refers to the **qarin/qarina,** as the **tabi'a** is called in the rural and urban north, as a sub-terranean being who causes illness. However, her quotes from peasants in **Fatiha** who have incurred the wrath of the **qarin/qarina** all refer to harm inflicted on children (Morsy 1993: 107-8). The sister and brother spirits do coexist with human siblings and may cross the boundary between the two worlds in an infinite number of instances and events. Yet this border crossing is most frequent and manifest in the case of children, and particularly newborns.

Spirits in general may attack the weak, the small ones left unattended, those who fall in rivers and wells, those wandering at night, and those who trespass on the spirit and so initiate aggression (Morsy 1993, Blackman 1927, Kluzinger 1878). But in the case of the newborn, it is the particular sister spirit of the mother or that of the father, according to some interpretations, who attacks, harms, or kills. According to this principle, death during the first week of life is linked to the **qarina** unless the baby was born with clear congenital problems or abnormalities.

During fieldwork, there was no incidence of neonatal mortality amongst the families with whom I worked. Yet a

number of women in the village had lost small babies by what they were very clear in calling **tabi'a** (table 8.1).

TABLE 8.1

NEONATAL DEATH AMONGST SOME WOMEN IN RIHAN

	NAME	SURVIVORS	BOYS LOST	GIRLS LOST
1	OM HUSSEIN	6 CHILDREN	1	4
2	Om HELMY	5 CHILDREN	11	2
3	OM MAHMOUD	4 CHILDREN	7	2
4	OM SHIHATA	2 CHILDREN	4	
5	GHALIA	4 CHILDREN	4	
6	MRS. AHMED	9 CHILDREN	2	
7	KARIMA	1 GIRL	1	
8	MRS. SALEM	4 CHILDREN	1	4
9	OM MOSTAFA	6 CHILDREN	10	7
10	ADILA	6 CHILDREN		4

Source: Interviews with women in Rihan

The ten women listed in the table above were all quite certain that their losses were caused by **el-tabi'a**. They reported that they had protected themselves and their newborns by making **higab laban**. The options of post natal and prenatal care were deemed irrelevant to the management of potential **tabi'a** affliction.

Tabi'a infringements on health and well being can also be a convenient excuse to stigmatise a woman. Om Laila who was divorced from her husband explains how the death of her baby was used as an excuse by her mother in law to get rid of her:

> I had Laila, then I had one boy who died. She claimed I was no good and **matbou'a** so he divorced me and sent me back with my daughter. My son was not taken by **el-tabi'a**. He died from a fever and he was beyond the first forty days but that woman insisted.

Case 1

When I first began visiting Gammalat, she was in the fifth months of her pregnancy. Her husband, Ahmed Abdel Nasser, and his brothers built their homes to the east of the village in an area that is now called **ezbet Nasser**. It is not a separate village but a row of 10 houses that overlooks the village of **Rihan**. Gammalat lives next door to her husband's second wife who was also pregnant and also in her 5th month.

Gammalat has 4 daughters who are married, a daughter in 5th primary who she is withdrawing from school because "education will do her no good", and another daughter in 4th primary. She lost 4 sons to the **tabi'a**. Her husband took a second wife when his youngest daughter was born. He had been a patient man and because of his love for his wife who is a distant cousin, he did not take the second wife before withstanding almost twenty years of lost sons and many daughters. His second wife has already given him a girl and now both wives are pregnant again.

Gammalat was very anxious about her pregnancy. "I have seen much " she lamented in reference to her dead sons. The daughter who is in 5th primary had a male twin. "**el-tabi'a** took him and left her" Gammalat told me in tears. Yet despite her despondency she is doing her best to insure that the new baby , if it is a boy, does survive. She believes that her problem is two-fold.

> I have a bad **tabi'a** but I am also the victim of the eye. Once we went to a doctor and he said that I lose the boys because of this sickness they call **el-Qazzaz**, you know the one that they give an injection for. Well, my husband said that sickness do not differentiate between boy and girl but the eye and the **tabi'a** do. Perhaps an eye causes me to get this sickness they call **el-Qazzaz** each time I am with a boy. But I know that my **tabi'a** is a bad one.

Her sons die within a week or so of birth. But she is a pious woman and she keeps trying to beget a healthy son for her husband. Gammalat dresses in sombre dark colours and makes

every effort to underplay her stunning natural beauty. She looks younger than her 36 years and speaks in very low hushed tones. Inside her house there is a tape playing the Quran most hours of the day.

> The Quran wards off the eye and any evil from the house. Now both I'm pregnant and my **dorra**[5] and many people have their eye on me to see if I shall get my husband a son like her or not. I pray and try to keep to myself so that no one even notices me. My black clothes hide my pregnancy and if he had not told her[6] no one would even know that I am carrying.

This was her explanation for her excessive modesty and sombreness. Towards the end of her fifth month she went to a Coptic priest to have a **higab laban** made using the **Khalas** of her own donkey. She also continuously burns incense made of flour, salt and **sheeh** and uses it to fumigate herself and her cow. For despite her problems she is not oblivious to the value of the cow (See Ghosh 1982).

Close to her time she insisted on being taken to hospital to deliver her child. "I feel that this child will live if I deliver in hospital where no one sees me" she often said. Gammalat had insisted on not taking the tetanus toxoid shots because she was convinced that her babies died because of the **tabi'a**. "They are no good" she said with reference to the vaccines. "My husband has gone to see the **khateeb**[7] and I have made a **tahweeta**[8] for the baby so that it lives. I made one for my youngest girl with the same priest" she explained. She refused any pre-natal care regardless of how many times I suggested it. "I have had children and the girls live so that means it is either an eye that won't leave me or a **tabi'a**, it

---

[5]. **Dorra** means the husbands' other wife.

[6].Meaning if her husband had not told his other wife.

[7]. The Sheikh

[8]. Protective amulet

cannot be anything else" she insisted on every occasion. Her wish to deliver in hospital was solely motivated by her belief that delivering away from the village and its women would save her unborn child.

When her time came Ahmed her husband ran out in the middle of the night to get her a car to take her to Abnube where she delivered their long awaited son. "If the other one had got him a boy he would not have bothered" some villagers said with sarcasm. She named the boy Shihata (begged one) so that he may live. She returned from hospital in the dead of night and celebrated his seventh day in utmost secrecy. The other wife soon followed suite and also delivered a son which she named Nasser after her husband's family. In all fairness this name should have belonged to Gammalat's son, but she preferred to give him a name that would protect him rather than to lay claim to her right of being the mother of Nasser.

Shihata lived, albeit under the stern security and protection of his mother. When I left the village he was two years old and in good health. Thus Gammalat had the satisfaction of giving her husband his first born son.

B 2. Ala bat-ha biyerda' (At Her Breast Feeding)

The afflictions suffered by babies who were still "breastfeeding at their mothers' armpit" can be classified into two categories. The first category of medical problems from which babies still receiving most of their nutrition from the mother often suffer is **nazla** a word that means bout or 'episode'. **nazla** can imply respiratory tract infection or gastro-enteritis and their complications. **nazla** can also imply fevers resulting from such infectious diseases as measles and meningitis. The second category covers afflictions caused by accidents or seemingly unknown or unclear causes whose symptomatology varies. This variation may call into question the use of the term 'category' to describe these afflictions

however the discussion which follows will attempt to justify this taxonomy.

A Stomach nazla (Diarrhoea and gastro-enteritis)

By far the most common afflictions in summer relate to digestion and to the mothers' milk (Hoodfar 1995, Reissland & Burghart 1988). The most common **nazla** that babies at this age get is a stomach one which results in fever, vomiting and diarrhoea. Although most mothers breastfeed, they do not do so exclusively. Besides breast milk, a new born is given Camomile (**sheeh**), Base gum (**liban dakr**), and sugar which are ground and put through a sieve (**yet halil-loh**) before being boiled in water and the extract given to the baby to sip from a spoon, or suck from a feeding bottle or the mothers'/carers' thumb. **"Kidah Yerda' w yeghlaz w yetkar' w yenam"** (In this way a baby feeds, gets chubby, burps and sleeps) Om Raggab explained. Nowadays they give Anise (**yansoon**) and gum (**Liban Mor**) instead of the camomile. These infusions may present an opportunity for infection and many babies do suffer their first **nazla** or bout of gastro-enteritis at this tender age. It is diagnosed when the baby has fever, refuses to feed and vomits what he or she are given.

To prevent this, most mothers are very careful in preparing herbal infusions. However, if a **nazla** does occur there are two simultaneous courses of action. The first is to send the **Riha** of the child and try to ward off the evil eye by putting a piece of white paper, some sheeh, some salt, and some flour in a plate and burning them. If the mother suspects a particular eye, she is to cut the paper in the shape of a doll and pierce its head with a needle mentioning the name of the suspect before burning it in flour and salt.

Almost at the same time, the baby is taken to the clinic for treatment. Zeinab lost her baby when he was thirty days old. He got a fever and was throwing up. By the time the morning came and she and her mother were taking him to the

clinic in Abnube, he was limp. There, he was put him on a drip but when he was brought back home a few days later, the same thing happened again to him and he died soon after.

The first forty days are also a time when the **tabi'a** may still be active and all that applies to the first seven days also applies to this period. The main difference however lies in the inclusion of natural as well as supernatural causes when sickness occurs. The possibility of cold, infection, and the ingestion of disagreeable substances are included as possible causes of a **nazla** as the case of Zeinab's baby illustrates.

These early days however are distinguished from the rest of the infants' first year by the remaining strong tie between mother and infant. **El-afia min labn el-om** means that well-being comes from the milk of the mother. Anger and grief can affect the quality of the milk. Om Kamel explained how she lost her first daughter:

> I had a daughter who died when she was 39 days old. She died of grief. She was born 14 days after the death of my own mother but I still gave her my milk but of course the milk was **madrour**[9] from my grief. She used to throw up **Siny**[10] but I thought that it was just my milk. Then I took her to the doctor but the bad milk and the grief made her neck limp like a slaughtered chicken. The doctor told me to take her to the hospital but by the morning she was dead.

That is not to say that bad milk necessarily leads to mortality. It is implicated in childhood morbidity as well. If a mother has a weak milk supply or suspects that she has bad milk because of a family problem she will supplement her supply by using boiled goat or cow milk or by using sweetened rice water. Buffalo milk is too heavy for a young child and so

---

[9] **Madrour** means spoiled or defected.

[10] Siny means China. There was a common porcelain or China which was coloured navy blue and so some people use the word Siny to mean the colour navy blue.

mothers buy cow milk if they do not have a cow of their own. Luckily there is a cow farm not too far from the village and so mothers have access to cow milk. Fake milk or rice water is used when there is no money and if there is no goat. 'Adila gives formula milk or rice water because she wants to keep her goats milk for the kids. "We sell them when they grow, I do not want to take all of their milk" she explained.

If a child becomes sick or is **batlan** (does not feed properly, throws up, has diarrhoea, is not putting on weight) it may be because the mother herself is upset. Fathers may cause the child's ill-health by picking a fight with the mother or saddening her in anyway. This is thought to be typical of men. **El-ab la ye'mil hisab lil 'ayel"** (the father does not take the child into consideration) complained Om Raggab. The golden rule is **La ahd yenakid ala el-om** (no one should upset the mother) . According to Om Khattab, these bad vibes (**el-za'al**) can be warded off and the baby's health can be restored if the mother becomes better. Physical well-being is also of extreme relevance to the health of the breast-fed child. Fatigue, malnutrition, and infections experienced by the breast-feeding mother have an immediate affect on the baby.

Case 2

Ferial for example was convinced that her baby, who was forty days old, was feverish because of her own **za'al** (grief/anger) due to her fight with her sister-in-law. Although she was still a **nafassa** (in her post partum period) she had gone up to the roof taking her newborn with her to stop her sister-in-law stealing the dry thatch reeds which form the roof of her home. "My in-laws steal the reeds to light their oven and my husband does not care because he cares about his sisters and mother more than he cares about me" she explained.

She had taken the baby up to the roof with her and put him on the ground when she was trying to physically prevent

the sister-in-law from snatching the reeds. A loud and aggressive exchange ensued and the neighbours interceded. When she calmed down and went down to her house the baby was crying hysterically. She breast-fed the baby so as to soothe him and satiate his thirst and hunger. By the evening the baby was feverish and would not accept to feed. She immediately knew her mistake; she had fed him when she was upset and the milk that he had taken had harmed him. She made some tisane for him with **sheeh** and sugar, and fed it to him drop by drop which she dripped into his mouth with her fingers.

When I went to visit her the next morning she said that the baby was **bihor** (had runny stools). Her husband was away and her in-laws were not on speaking terms with her.

> I want to take him to the doctor but I cannot leave the house and the animals and just leave. If I had any family or if they[11] would mind the house for me I would take him to Abnube. I do not want to lose him as I did his brother. I had two sons before him who died in their first year. My in-laws want to get rid of me and would like him to go from me too. At night I rubbed his head with salt to take away the sun. I thought that the fever could be from the sun because I took him up with me when she was stealing the **bouss** [12] but when he began to have runny stools I knew that it was the milk that I had given him which was full of **za'al** [13].

Ferial had been expressing her milk so as to keep up her supply and to empty her breasts of the milk contaminated with **za'al**. The baby was getting to be very thirsty and she kept giving him infusions. It was impossible to convince her to leave the house and go to a doctor. She was given some **garad** (a substance that grows on trees which when ground and given to a child, or adult will relieve diarrhoea) by a neighbour. She was going to grind it and infuse water with it to give to

---

[11]. She means her in-laws.

[12]. Reeds

[13] Grief/anger or woe

her son. I convinced her to give him some oral rehydration salts first and try to find a way to get her and the baby to a doctor. She was adamant in her refusal to leave the house.

Luckily the baby's diarrhoea started to get better by the evening and his fever went down. He started to feed again the next day. Ferial was relieved that he was saved. She had in fact given him the **garad** and said that this is what stopped his diarrhoea. A week later her husband returned and she made it up with her sisters-in-law. A few days after that she made the most of this temporary peace and asked them to mind the house for a morning during which she went to Arab Matteer and made a **higab** to protect her son from all and sundry dangers. "There is no **higab** to protect me from **za'al** if my husband does not stop preferring his mother and sisters, but the **khateeb** made one to protect the baby so that he does not fall sick easily" she said.

Chest nazla (Respiratory Tract Infections and Asthma

In winter small children often get a **nazla** which affects their chest. The Arabic phrase for this is **nazla ala sidroh (fem: sidraha)** which means a bout or episode on his or her chest. Families are alarmed if a baby develops a fever, refuses to eat, and/or begins to **yekot** (pant/wheeze).

There were three small children in **Rihan** whom I identified as asthmatics[14]. Their mothers said that they had **sharqa** (choke). Fits during which babies find it hard to breathe and may turn blue/ish are compared to choking and so the fits are called the choke or **sharqa**. One of these children is Mostafa who was one year old during fieldwork. His mother describes his case

Mostafa gets sick and gets a **sharqa**. He goes blue and coughs.

---

[14]. The other children who suffer asthma are Adam, son of Om Hassan who is 3 years old and the grandson of Om Khattab the midwife who is five year old.

The first time he got it he was 4 months old. He got a **sharqa** and was blue. I took him straight a way to the doctor in el-Arab who told me that he has **hassasiya fi qalboh** [15]. Afterwards he got it again and I took him to the doctor in the general hospital who told me that the first doctor is a donkey and gave me a prescription that cost 15LE and he said that he has to take these medicines all of the time. He still gets a **sharqa** sometimes but it is not as severe as the ones he used to get.

Case 3

Mohammed is another victim of chest problems this winter. He is an only son and his mother fears for him continuously. "I have been milking a goat for him for three month with the new moon because I want to protect him but he still got sick" she said. He could not take his breath easily and one night she found him going blue. "It is a sharqa (hiccup)" her mother in law said and told her to go straight to the doctor in Abnube. Her husband works abroad so two of his brothers came with her. The doctor gave the six-month-old baby vapours to inhale and antibiotic shots which she did her best to keep up with. They cost her 15LE($4.5) aside from the visitation fee. She said that no matter how much they protect the baby and let no one see him, he will still fall sick because the diarrhoea and cough are in the air. "They have nothing to do with our old cures, now children need medication and antibiotics to stay safe and well".

Severe respiratory tract infections are described as **nazla sho'abiya** (Bronchial **nazla**). This is the Arabic term for bronchitis. The medical term has wide currency in the village and is one medical term which has a significant meaning to families. **Nazla sho'abiya** is associated with cold, damp,

---

[15]. Sensitivity in his heart.

tiredness and poor nutrition. Acute Respiratory Tract infections are the most potent causes of childhood mortality and morbidity during the winter in Egypt. The diagnosis of these infections needs clinical tools. However chesty coughs, wheezing, fevers, lack of appetite, and wasting are indicators of the acuteness of respiratory tract infections. The management of these conditions varies according to how strong the child is. While coughing per se is never a cause for alarm, **el-khareef** or prolonged wheezing necessitates urgent action.

Mothers take respiratory tract infections very seriously because the air is perceived to be dry and clean in the village. "We are not like **el-bandar** (the city) where there are cars and where people live crammed together and where there is not enough air to breath. Here in **el-talq** (open air) children can run and play and smell clean air" explained Om Raggab in reference to the condition described above. She and Om Arafat are married to cousins and are neighbours. Mostafa, the son of Om 'Arafat has a chronic case of **el-khareef**. As we speculated about the cause of baby Mostafa's condition, Om Arafat filled me in on what she thought to be essential details.

She had made a **nadr** (promise) to Abu-Isaac (the Coptic holy man buried in the local church) after the death of an older son and had promised a he-goat if her next child was born alright. But before she could fulfill her promise to the shrine and slaughter the goat, her husband sold the goat because they needed the cash. Ever since she has been dreaming of snakes and now Mostafa who had been so well and healthy was sick. Om Raggab told her not to be silly since chest conditions and coughs were due to the cold and mostly came about if the child was prone to them because of **da'f** (weakness). "It is the snakes you should be worrying about!" Dreaming of snakes does not mean a child gets **Khareef**, it means other things that have nothing to do with children. She was implying the symbolic meaning of snakes as omens of

treachery and that she should fulfill her promise to Abu Isaac before so that her dream does not come true.

Om Kamel also has a son who has a weak chest. When I once met her at the Abnube general hospital, she had two tickets; One for herself to see the gynaecologist and one for her son. "I brought him with me because he has had this fever for days and I thought maybe the doctor can help. I was coming anyway because I keep fainting[16]." Her 4-year-old son had his head wrapped in a scarf and was coughing badly. "Last month they kept him here for three days on a drip and gave him antibiotics because he had **nazla 'ala sidroh** (a condition in his chest). He gets sick often even though he is not an only boy" she added.

After he was seen by the paediatrician we met again. "He has written more medicines and shots" she said in answer to my question concerning the doctor's advice. She said that the first time he had gotten a **nazla 'ala sidroh** was when he was still breastfeeding. Since those early days he has been getting a **nazla** every winter and each time means daily trips to el-Arab to find a nurse to give him the antibiotic shots.

Ahmed the son of Abdel-Lateef also got a **Nazla Sho'abiya** in the winter. "It is from cold and from weakness, this boy does not feed like other children" the father of the one-year-old said. When the boy got a high fever his father insisted on taking him to the private clinic of the doctor in Abnube. There the doctor told them to take the boy to hospital where he was put on a drip. "The hospital took 45LE($13.6), the doctor took from me 5LE($1.5) as his fee and then he asked for 12LE($3.6) worth of medications" recounted the father a week after his son's health had improved.

Case 4

---

[16]. She is pregnant but is observing the Ramadan fast even though she is due very soon. This is her third term.

Abdel-Basit had a **nazla sho'abiya** when he was a baby. His mother recalls that he had a fever and was yellow and was coughing very badly. Then he went yellow and became **hamdan** (tired) so she went to the general hospital and there they kept him for 4 days. Since then he gets one almost every winter and he has been hospitalised a second time. But otherwise the doctor gives him **modad** (antibiotics) and his health improves. "He gets it because he is **batlan**[17] and it is his nature to be sick" explained his father. Abdel Basit was three years old during fieldwork and has been getting all sorts of serious conditions since he was a baby. His father remembered.

> He goes yellow and weak and then gets something. When he was 6 month old he had urine retention and was kept in hospital. This time he has measles and **nazla sho'abiya.** He was kept in hospital where they were giving him antibiotics. I just run with him to Abnube, no matter what time of the day or night it is because I know that it is his nature and that he is going to get something. All my boys are like this. His older brothers also got **nazla sho'abiyah** many times. The girls are stronger and never get anything.

In retrospect Abdel-Basit's mother mentioned the eye and envy as possible reasons for Abdel-Basit's frequent illness but this did not in any way interfere with the family's decision to consult the physician. Likewise Om Mostafa wondered if his asthma or **hasasiya** (allergy) as she called it was not related to the quality of her milk or to his nutrition. However these were passing thoughts that did not have any significant impact on how Mostafa's **sharqa** was managed.

Khar'a (Sickness by Fright)

The second category of childhood afflictions at this age are those precipitated by **khar'a**. In other studies of Egyptian

---

[17]. Sickly

medical culture **khar'a** has been referred to as **tarba** (Morsy 1993) and **khada** (Early 1988). These are terms which describe illness by fright. This illness is similar to **susto** as described in the medical anthropology of Latin America (Bolton 1981, Foster 1994). Morsy and others have pondered the differentiation between natural and supernatural causes within Egyptian medical culture and have given **khar'a** (by whatever name) as an example of ill-health caused by a 'naturalised' supernatural cause. Meaning that it is an ill-health condition precipitated by a physical experience and is in that sense 'natural'. But this physical experience has health consequences because of a set of supernatural beliefs; most significant of which is that wells and rivers are inhabited by spirits and that is why people who fall in them become sick (Balckman 1927, Morsy 1993, Early 1988).

As far as small children are concerned their **khar'a** relates to their immobility. The most common cause for **khar'a** amongst small babies is a fall from a high place such as a bed or bench. Symptoms of **khra'a** in babies include lack of appetite, listlessness and diarrhoea. But **khar'a** can also cause an imbalance in a baby's health and cause him/her to suffer from other sicknesses. Early (1988) argues that **khar'a** indicates Egyptians' belief in balance as the key to good health. Fright caused by a fall or scare causes a temporary imbalance which is the opportunity through which sickness installs itself at the price of health. The literature on **Susto** also ties fright to humeral principles (Foster 1994). In **Rihan** sickness caused by **khar'a** is interpreted at more experiential and immediate levels.

Falls harm a baby physically. The small child may fall on its head or on a limb and be listless and unable to eat because of pain. But there is also the psychological effect of a fall which causes **khada** which literally means shock. Shock may bring on a dazed state which can temporarily incapacitate. Very small children rarely suffer from **khar'a** caused by actual

fright as they are too little to recognize what is frightening and what is not. **Khar'a** does cause imbalance in that a person's state is suddenly changed whether by falling down or by fright. But at a more immediate level **khar'a** is of concern for its physical as well as its metaphysical consequences.

In **Rihan** there is a clear rule which dictates that small babies must never ever be left alone. This serves to protect them both from **khar'a** and from natural and supernatural aggressors like insects and animals. Besides these creatures of the earth there are the inhabitants of the spiritual world to worry about. "A **tabi'a** takes advantage of the baby left alone" said Om Khattab. So to protect from both seen and unseen dangers and so as not to topple off a high place or somehow hit the ground, babies should never ever be left unattended during their waking and sleeping hours.

Khar'a is both an affliction and a root explanation for a variety of symptoms. There is little in terms of protection that families can do to prevent **khar'a** save for keeping the baby in the continuous company of competent carers. As for leaving a baby alone and the dangers which this involves other than **khar'a**, many mothers opt for making a protective **higab** called **el-'o'ed** (the knot) just in case circumstances forced the mother or other carers to leave the baby in a room for a few minutes. Om 'Arafat for example lost one of her sons when an ant got into his ear as she left him to see who was at the door. Since that tragedy she has made the protective higab for all of her children.

Case 5

Mohammed Hamed is a one year old boy. He is weak, listless, and forever coming down with all sorts of colds, flus, coughs, and diarrhoea. His mother explained that it was a **khar'a**. She had been carrying him and then put him down on the bench for a moment and he rolled over and fell. Since then he has been **Batlan** and in need of medical attention. The well

known cure for **Khar'a** is cauterization. But small children are exempt from the pain of the red hot nail. Families try other remedies such as giving them flour and water to take away the shock. But the best that can be done for them is the treatment of the symptoms of **khar'a** by taking them to the physician.

The **khar'a** of older children is treated more aggressively[18]. Adam, who is three years old was cauterized by Om Khattab the daya in my presence. His mother explained why she was having him cauterized.

> His father is in Saudi Arabia and we live alone. Last week I took him and his brothers and sister to their uncles in the fields. We stayed the night. When we slept one of his cousins lit a match and threw it in the hay and it caught fire. The whole house began to burn and we all had a fright. I took Adam in my arms and threw him into the neighbours house and went to help put out the fire. The very next day he was feverish and refused to eat. I tried to give him rice but then he passed out. I thought he was dead. When he came to he was like fire and he threw up the rice. My mother was with me and I told her "He is dead, let me take him to hospital". She said that the ticket time is over and so we waited till the private clinics began and I took him and my brother came with us. The medication they gave us was no good. I knew that it was **khar'a** from the night of the fire. I took him to Om Ghelmy and she heated a nail in the dung cake and cauterized him on his crown but **ma qawemsh m'ah**. It did not work with him.

Adham was **batlan** still but he had stopped throwing up. His mother was unsatisfied and thought that perhaps Om Khattab would do a better job. But Om Khattab refused to re-cauterize and told her that it could kill him. "He got **khar'a** yes, but you left it too late; now he needs a doctor" advised Om Khattab. Adam's mother took her advice and together we went to the general hospital where Adam was kept for three days. He has severe diarrhoea and food poisoning. His mother stayed

---

18. This section is about infants but since **khar'a** is under discussion it may make more sense to discuss its management amongst older age groups in this section.

with him sleeping under his bed at night. She had to pay for medications and since she had little money she sent word to his paternal uncles who sent her 15LE($4.5) with her own mother when she came during visiting hours.

In some cases mothers wait a few months and cauterize a child who has been exposed to **khar'a** but was too small to be cauterized when the fright occurred. Mostafa for example fell down the stairs when he was still crawling. He climbed upon his hands and knees and then toppled down again. He then started throwing up blood and his mother took him to hospital where he was treated. When he was two years old, and almost a year after his fall, she had him cauterized. She had been advised to rid the boy of the **khar'a** once and for all.

Hadas, who was two years old during fieldwork also had **khar'a** after he was attacked by a dog. His wounds were dressed in the clinic but his listlessness, diarrhoea, and poor appetite were put down to **khar'a**. His mother had him cauterized after she weaned him at the age of 30 months.

Cauterization is performed with a nail whose head is placed in a hot dung cake that is set alight. When the nail is red hot it is placed on the crown of the victim and then quickly removed and the mark is covered with a clean cloth. Noura (11 years old) the daughter of Ni'mat was cauterized after she nearly fell into the river. She was scared by her near fatal fall and was crying and shaking. Her mother gave her flour and water and wrapped her in a blanket and then sent for Salma, the children's grandaunt, who is good with the nail and they went into the animal yard and cauterized her. The next day she was well again. Hamada had the same therapy when he was accosted by a pack of dogs in the desert at night when he was returning from an errand to his grandfather's house.

Om Khattab, the local healer and midwife, is always reluctant to cauterize small children. She explained why

The child used to take **qarad**[19] and get better. Now if I tell a woman cauterize him and he dies, what will she do to me? She can do nothing to the doctor!

B 3. MAFTOUM (Weaned)

A child who is **maftoum** (weaned) is prone to all the afflictions discussed above. But the particular danger that is significant to this stage of a child's life is **mushahra.** Weaned children are in danger of **mushahra** until the lunar moon during which they have been weaned is over. From the moment they are taken off their mother's breast until the appearance of a new moon, the child can be afflicted by **mushahra** which in this case causes general poor health. Local myth has it that if an infertile woman sucks the thumb of a recently weaned child to rid herself of infertility this child will become very sick and may even die. But **Rihan** has yet to witness such a case and so this principle rests comfortably in the realm of inauspicious myth.

Weaning has a psychological and a physical effect on the child. The longing for the breast and the severing of the remaining bonds between mother and child are difficult for the child and must be handled with dexterity. To appease their longing for the comfort and security of the breast, children are compensated with sweets, and treats. They are taken to a relative's house when possible where they spend a few days so as to forget the breast. If this option does not exist, children are scared off the breast. Mothers apply blue or red tincture to frighten the child away or they apply **sabr** which is a bitter tasting substances and thus cause the child to shun the breast. Meanwhile all the member of the household try to help the child by offering treats, outings, or through play.

---

[19]. An often used medicinal leaf and berry/nut

But children also go through a nutritional transition which may cause them some health problems. By the time they are weaned, children have usually already started taking cow's milk. But for some the only milk they have ever had is the mother's. The introduction of other milks becomes a health risk since mothers do not go through the trouble of providing bottles. If there is a cow at home, the child is given its milk straight away without boiling and in a cup. Negative reactions result either from milk contamination or from intolerance to the new milk.

But **mushahra** which results in a child becoming **Batlan** and unable to feed or play is the most frequently reported cause of sickness of child who is **maftoum**. If a child who has just been weaned does become sick despite having been kept safely at bay from any woman or other child who could cause **mushahra**, families blame donkeys or dogs who have weaned or been weaned at the same time as the child.

The health of children is greatly affected if they have been force weaned due to the mothers' affliction with **mushahra** since this means that her milk supply dries up. Om Fayza got **mushahra** when she was breast-feeding her son Ahmed. She lost her milk, she suspected due to **mushahra**, and had to give him caraway and formula which she calls fake milk. Then her sister's husband's brother was shot. As she went with his mother and wife to collect the blood from under him, her **mushahra** was broken. She realized that she could breast-feed again. She knew her **mushahra** was broken because she discovered a few days later that she was pregnant. Unfortunately it was too late since she had been forced to wean Ahmed. She says that he was sickly and weak ever since his early weaning. He has also been hospitalised and put on a drip due to successive bouts of diarrhoea.

Case 6

Aziza was very careful on weaning 'Atef, her two year old son.

She sent him to his uncles' house in the fields and sent with him his older sister, Amina. She instructed her mother to give him sweets and to keep him occupied. Three days later she went to fetch him. That evening he became ill. He had diarrhoea and no appetite. She said that it was from **mushahra** and that probably her mother had not been careful enough to protect him from the animals in and around the house who may have caused his **mushahra**. Her sister Ni'mat advised her not to rely on all of this **baladi** (folk) talk and to consult a physician if 'Atef got worse. 'Aziza waited a couple of days during which his condition was stable. On the third he began to get better and Ni'mat admitted "It was **mushahra** or maybe just yearning for the breast" and what would the doctor have been able to do?". "Yearning and **mushahra** are the two things that can make a **maftoum** sick" later explained Om Khattab. The yearning for the breast, just like yearning for anything, can cause a child to be **batlan** for days on end. There is no cure for this state and doctors are rarely consulted.

B 4 BIYEHBI AND BIYEMSHI (Crawling and Walking)

When a child is at an age when he /she is crawling, accidents tend to be the main concern of mothers. Besides the **khar'a** that results from falls, there are the physical consequences of the accidents themselves. Burns are the most frequent and worrying consequences of accidents. Children toppling onto lighted stoves, stews and boiling water or onto the side of a lighted oven may be very badly scalded, burned or even killed. Luckily during my own research there were no deaths from burns. However Ni'mat's sister Layla did loose a baby girl five years before when the synthetic clothing that the baby was wearing caught fire, and the baby died before her mother could save her.

Case 7

Hind, who was 8 months old during fieldwork, had an

unfortunate run in with a cup of tea. I was there and the following are fieldnote excerpts.

As we talked Hind pulled herself up to the bench on which I was sitting and as she toppled back the glass of very hot tea that was on the tray on the bench went with her. The girl SCREAMED. There was hot sticky tea and lumps of tea leaves on her crotch and bare thighs. I suggested that they quickly get water to clean the scald but her mother snatched her up and wiped the tea leaves off with her hands. She tried to comfort the baby and told her daughter to go get some eggs. She complained that there was no milk in the house to soak up the heat. When her daughter brought the eggs she cracked one with her fist and smeared it all over the scalded skin.
Finally Hind settled down. Her mother gave her sips of water and kept her at her breast.
Later I saw Hind and noticed that her skin had become badly ulcerated. Under pressure, the mother consented to a visit to the physician. "I cannot run with them every time something happens" she complained. However even she could not deny that Hind was getting worse not better. At the clinic the doctor cleaned and dressed the burn and charged 12LE($3.6). He said that she needs dressing every three days and prescribed an ointment which cost 5LE($1.5) for the parts that he did not dress. Hind's mother was adamant that she could not afford the dressing and said that she would take one more time and buy the ointment but after that she would just dress the burn as they do in the village. Hind's burn improved dramatically when I next saw her. Her mother had not bought the ointment but had borrowed the left over ointment used by 'Amr, their neighbour's son. He had scalded his arm a few months earlier. She did not dress the burn again at the doctors but preferred to apply the ointment and wrap the burn with torn strips of one of her son's old galabiya's.[20]

When visiting the doctor with Hind and her mother I had asked him about his experience with burns. He said that slight burns are dressed at local clinics and only the severe ones are handled at the Abnube general hospital. He said that families always come in to dress the burns of children, specially small ones since they fear the cosmetic and physical consequences of burns. He added:

---

[20]. Traditional long gown worn by men and women in rural Egypt.

These people think about the marriageability of a girl since she is born and no one wants a son who has a **'agz**[21]. They are regular in coming in to dress burns specially after they have tried traditional things. Eggs are what they try first of all. Or they put tomatoes to soak the heat up. Some put milk or **kharwe'** leaves. And then if the burn stays because it is deep they come to the hospital we make him understand what the right thing is and we give the proper medication and dressing.

But for the families of **Rihan** the cost of dressing burns can present a very real financial problem. When 'Amr got scalded by tipping over some boiling water onto his arm his mother, Naggat, and grandmother had only 10LE($3) in the house. They tried to suck up the heat using milk but it was clear that the burn was severe to the extent that the boy could not move his arm and shoulder. His grandmother, Om Diab, borrowed 12LE($3.6) from the neighbours to add to the ten that they had, to cover the statutory 12LE($3.6) cost of burn dressing plus any drugs prescribed and transport. Three months later Diab sent 100LE($30) from Saudi Arabia to cover the expenses of **el-eid** (the feast). They repaid the debt, spent 80LE($24) on clothes for the festivities and on food, and borrowed another 30LE($9) from which Naggat took 10LE($3) since she needed to see the doctor herself.

B 5. TODDLERS AND PRE-SCHOOLERS

After weaning children begin their long life of independence from the mother and from afflictions linked with her health, her milk, and her watchful eye. Diarrhoea or **ishal** is a common health problem which can have dire consequences to the health and well being of children. It is not specific to any age and has been discussed above in relation to infants. However diarrhoea in the medical system of **Rihan** is a word which expresses a varied medical taxonomy. Older children who

---

[21]. Disability

are no longer breast-feeding and are still under the age of 5 years seem to be the victims of these varied types of diarrhoea.

In Egypt, as elsewhere, the under fivesare considered to be at higher risk of illness and death than older children. According to national statistics, the main causes of death amongst the under five (which stands at 81.9/1000 children who survive their first year) are diarrhoea, fever, and difficulties breathing (Capmas 1993: 219, 230). These are the symptoms most frequently reported by mothers during the two week period preceding death (Capmas 1993: 228-30)

While the stomach **nazla** of babies in **Rihan** is associated with problems in the mother's health and /or her milk supply, the diarrhoea of older children has a more complex causality[22].

Episodes of severe diarrhoea, chronic diarrhoea, and complications like fatal dehydration are familiar to families in **Rihan**. A mother knows the difference between a minor incidence of diarrhoea which she may relate to teething or to a change in the weather, and the dangers of life threatening dehydration. She also knows her child's **ttabi'a** (nature) and uses her instinct, the intimacy of her relationship with the child, and her socially and culturally constructed medical knowledge to judge severity and course of action.

The locally significant conditions such as **el-hagma, khar'a, el-warraniya, el-'amoud, tagg** and **el-sakta** describe health problems which implicate digestion and which cause diarrhoea. They are familiar conditions in **Rihan**. "They may have other names in the books of doctors" commented one sage to me "But this is what we know and because we know them we can treat them" she concluded. But the need for modern medicine cannot be denied. "Now **el-gaw**[23] is full of diseases

---

[22]. For a detailed taxonomy of diarrhoeal diseases as constructed by local medical discourse see appendix 11.

[23]. The air or the environment

and the chemicals for the agriculture' are all poisons" she added "so we need the doctors". (See plates 19-23 for diarrhoea massage called **Tamrees**).

B. 6 FEVERS AND MENINGITIS

High fevers amongst children in **Rihan** are sometimes caused by contagious diseases, such as meningitis. Fevers, described as heat in the head, are cause for alarm and if accompanied by other symptoms such as vomiting and delirium are cause for a quick visit to the nearest clinic or hospital.

When a child's fever first appears, mothers or other female relatives may attempt to "suck the heat" by rubbing a child's head with salt and by keeping the child indoors and away from direct sunlight. If salt does not work, some mothers try soap, milk, eggs or onions. If the fever persists and rises, then medical help is sought.

Of the many conditions which fever is a symptom, meningitis is the most serious and the most prevalent. During my period of fieldwork there was one small outbreak of meningitis in **Rihan**. The outbreak caused the death of one small baby and affected four other children who mercifully survived. Once reported, these cases were kept in the tropical diseases hospital in Assiut and after lumbar puncture and the administration of antibiotics, they were cured.

There is an annual winter outbreak of meningitis in the village. The year before my fieldwork, two boys were killed. The year after my departure a young girl died of the disease. Parents differentiate between **sekhouna** and **homa**. The first refers to normal fevers that eventually go down without causing too much damage and which are symptomatic of sun stroke, flu, **nazla**, or other infections. **Homa** means high fever and is synonymous with meningitis which is called **homa shawkiya** in Arabic.

Case 8

The first victim of the outbreak of meningitis was a five

year old boy who is the son of Mahmoud. He had become feverish the day before and had died the next morning. I went to pay my condolences with Ni'mat. We had to walk for almost an hour since the family lived out in the fields. There , his grieving father told us that the boy was well until in the afternoon he complained of a headache and was feverish. His mother rubbed his head with salt but by the morning he was dead. On our way back, Ni'mat said it was foolish of them not to have taken the boy to a clinic straight away as everyone knew how dangerous **sekhouna fi el-ras** (heat in the head) can be!

As we were having dinner that evening, Gamila from next door came by to borrow an aspirin. She said that her daughter Ahlam was unwell. She said that Ahlam (6 years) had a fever and headache and had thrown up. I was alarmed and beseeched her to take the girl to hospital immediately. Gammalat said that her husband, Salah, was not at home and she could not go out alone at night. I begged Ni'mat to convince her offering her my company but she said that all the men were out there paying their condolences and that for the time being nothing could be done. When I told Gamila that Ahlam could have the same disease that killed the son of Mahmoud, she said that she had heard that the boy died because his mother hit him on the head.

When Salah got home, he promised to take Ahlam to hospital the next day. Salah is the nephew of Hashem and his father owns a lot of land. Unfortunately he and his step mother (his own mother died many years ago) do not get along and he has to struggle to feed his wife, three daughters and son on his earnings as an agricultural labourer.

The girl survived the night and Salah set off with her the next morning to catch a ride off the main road. As they walked, Ahlam fainted. He rushed back with her to the village and to my door. He placed her on the ground and started beating his cheeks and weeping in lamentation. He thought her dead. We sent out for a taxi and took the girl straight to the

Assiut Hospital for Tropical Diseases where she was diagnosed with meningitis. They immediately began treatment.

Ahlam survived and remained in hospital for a week. The hospital also sent a team to the village to distribute antibiotics (Sulpha) to the family of Ahlam and to the neighbours. Meanwhile, three more cases appeared but all were treated and survived.

In hospital, Salah stayed with Ahlam sleeping on the floor next to her bed. Her mother stayed at home with the other children. On the first market day that came along after Ahlam was admitted to hospital, Gamila, her mother, sold all the ghee she had made that week and bought fruit for Ahlam and cigarettes for Salah. She told me that after my last visit to Ahlam, the doctor and nurses inquired who I was and when Salah said that I was their relative, they began to respect them and treat them well. They even brought an electrical heater in the room where Ahlam was staying. When I asked her how Ahlam was, she said that after they had drawn the spinal fluid from her back she had become well enough to even ask her mother for twenty five piasters to buy sweets.

C. THE COST OF MANAGEMENT

Managing conditions of ill-health is not only a question of causality, definitions, and beliefs. It is also a question of costs and expenditures. Often the decision to try out cures at home or seek a local healer are made with reference to considerations of money. Undoubtedly, families do not hesitate to spend and to borrow every piaster they have to cure a sick child. Once faced with a problem that can be solved by money, families do not hesitate. But the availability of money and of wealth also determine the course of therapy chosen for a child. Families who have children with chronic conditions cannot buy them medications all the time. They give them half doses or suspend medication and rely on alternative therapies until they can once again afford the medicines.

In so far as modern health care is concerned, families who could preferred private health care. But there were very few families who could really afford it. The cheapest visitation fee is 3LE($0.9) and prescriptions can cost up to 20LE($6). Private physicians tend to prescribe long lists of drugs despite their familiarity with peoples financial straits. It is difficult to judge the necessity of all the prescribed medications. Certainly the doctors prescribing them must be of the opinion that the drugs are essential. But one wonders what is the point of instructing patients to take drugs when one knows that their cost is beyond the capability of the patient. Perhaps a clue to this puzzle lies in the dominant belief held by poor and rich, urban and rural alike, that everyone is really much richer than they say or seem. The physicians who are the subjects of the preceding chapter were certainly of the conviction that most peasants had more money and more liquidity than they purported to have.

I worked out an average of the cost of all the medical prescriptions that I saw, or those which were prescribed by private physicians in my presence. The total number of 23 prescriptions averaged out to 8LE($2.4) per prescription. But this figure is actually meaningless. It could mean that the prescriptions were all for very sick children, that drugs are very expensive in Egypt, that children in Rihan happen to all get health problems that require expensive drugs, or that doctors seem to over prescribe or to ignore the financial situation of families. Moreover, this figure does not illustrate the financial burden that prescriptions and medications present to the families of Rihan. One expensive prescription a year is manageable but three a month would break anyone's back. If we assume that the wealthiest household in the village has a monthly income of 350LE($106), this means that one prescription costs 2% of income. The vast majority of families have no land, earn around 80LE($24) and such a prescription would consume 10% of their earnings.

The reality behind the average figure is an intriguing one. On the one hand, there has been a super-inflation in the price of medication. This is an issue that the Egyptian press has debated and illustrated over the past five years. Not only has government subsidy been removed from all except very few medications, but the pharmaceutical industry has given way to expensive imports marketed with the cooperation of physicians.

On the other hand, villagers go on frequenting private clinics and have no qualms with picking and choosing the medication to buy, often with the consultation of the pharmacist. Moreover, drugs are never wasted; once the health of the patient improves, medication is stopped and saved for later use. Although it is never resold, it is very often given, as a favour, to other siblings, relatives and/or neighbours.

This does not mean that villagers afford the prescribed medication with facility. "You need a complete twenty pounds in your hand before you can even think of a doctor" explained Ni'mat. We had been talking about poor Om Hamada.

Case 9

Om Hamada 's youngest son has been sick for a long time. Her husband died of kidney failure and she had nothing but the pittance payed to her by her husband's brothers who were farming her half feddan of land. When her 2 year old became sick with diarrhoea she took him to the midwife who said it was **el-waraniya**. She smeared it for him and took 2LE($o.6) but had to pierce his ear at the end and he got better. A few days later it started again. She thought the diarrhoea would go away but it did not so she took him to the government clinic who kept him in the hospital for three days and put him on a drip. They asked for 20LE($6) for medications and she had to pay for her transport as well. He came out and was sick again. His uncles insisted that she go to a private physician in Abnube or the boy would die. They gave her 5LE($1.5) for the visitation fee. She went to Arab Matteer instead because the doctor there is cheaper. She payed the visitation fee of 3LE($0.9) but the doctor gave him the following prescription: E-Max 250gm (antibiotic), Kapekt 120 ml (for diarrhoea), Cortigen B6 (usually given for

morning sickness and is to stop nausea and vomiting). When she went to the pharmacy, she was told that the medicines cost 8.50LE($2.5). She just bought one ampoule of the antibiotic and left. She had no money with her at all. The shot which the pharmacist gave to the boy made his body lax so she decided not to buy any more, even if she could borrow the money. But then he got worse again and she was at a loss. The boy became very ill and she took him to his uncles who in turn re-admitted him to Abnube general hospital where he finally became better. The uncles paid the hospital bills.

The ability to buy medications and get modern medical care is a question of luck for most families. Even those with the largest landholding in the village often do not have the liquid cash during some months of the year to buy expensive medical care. When Osama for example hurt his foot, he did so during the pre cotton harvest months when even his wealthy father could not afford to take him into town to have it dressed. When the foot was swollen, his father parted with the cash with difficulty to buy him prescribed antibiotics.

Local healers do not require much cash and will settle for payment in kind. They are also happy to defer payments since they know their customers and are from the same communities. This is often a major reason why some families prefer them to doctors. But this does not mean that their patients do not also believe in their ability to cure themselves and their children.

As is clear from the above arguments conditions of ill health are differentiated by their causes. Traditional and modern healers are sought for each condition in accordance with the way the condition is perceived. They are not really competing for patients. Consequently, men and women in Rihan need to have modern good quality and affordable medical care even if they persist in consulting various traditional healers. The cost of medicines and of doctors' fees is therefore a major cause of concern, even for those who rarely seek the advice of the doctor.

D. NUTRITION FOR UNWELL CHILD

Ill health means weakness and the need for special nutrition. For small babies who are too week to feed or who have been deprived of their mother's milk, because of the mother's ill-health or **mushahra**, substitute milks are given. Boiled goat's milk or cow/buffalo milk mixed with water are the usual substitutes. Sweetened rice water called "fake milk" is used when there is no money to buy animal milk and if the family have no goats or livestock in the house[24]. Formula milk is too expensive for the majority of mothers who do not breastfeed. Those who do buy it over-dilute it to make it an affordable alternative. Adila for example prefers to keep her goat's milk for the kids which she then sells for profit. For her feeding daughter she buys formula at 4LE($1.2) a tin and puts in half the amount advised by the manufacturers on her daughter's bottle. She also relies heavily on "fake milk" when cash is tight.

Children who are weaned and who are sick are given broth made with fowls or red meat and bones. This broth is considered to be a panacea for all forms of nutritional need. This is the food and drink of the weak and ill child, the recently delivered mother and the overworked and exhausted man. Broth has all the goodness of the meat but none of its taxing digestive requirements.

A child who is unwell needs plenty of broth. But that is rarely the diet that children who are unwell follow. Om Sha'ban explained sarcastically "Mine are sick all the time, should I be boiling a chicken or stuffing a pigeon everyday?!" Indeed the majority of people cannot afford to recreate this traditional and perhaps mythical ideal of feeding children broth and choice cuts of meat or of giving them **Foura**, a recipe that is supposed to be made with molasses, ghee, and

---

[24]. There is a cattle farm outside the village which sells milk.

cereals and which is, like broth, the nourishing first food given to a mother who has just delivered. In reality children are given either what they want or what is available. What they want is usually sweets, crisps, carbonated drinks, biscuits, and other locally made sweets sold by street vendors. If the parents can afford it, a sick child is provided with these items at great cost. If the child is too sick to want anything, they are given tiny spoonfuls of what ever is available and given plenty of sweetened herbal teas.

It would be too repetitive to go through case by case and analyse what children wanted and what they ate. 'Abdel Basit craved macaroni throughout his various bouts of ill-health. He also demanded Coca Cola. Ahmed Helmy ate his sisters' biscuits given to them in school in lieu of a lunch. The two sisters in school would save their biscuits and bring them home to him. Mayza's son demanded salty snacks sold under the brand name of **karate** and CocaCola. At home he craved sardines. Amr the son of Naggat has a passion for mud.

Case 10

Amr the son of Naggat had been unwell for days. He was wheezing noticeably and not his usual prankish self. His mother explained that it was because of his own doings. "This boy loves mud, so does his cousin. Together they can eat a wall. They keep breaking off from the oven and eating. A few nights ago he ate mud at night and then went to sleep in the open courtyard. He is 5 years old but I have no control over him. The mud went to his Maraweh (Lungs) and now he is pale and yellow and cannot take his breath". She did not take him to the doctor and he got better by himself eventually. He did spend a few days with his grandmother inside the house resting and she also wrapped his head for him.

But food can also be the cause of ill-health. **El-Marad** (sickness) and **Ishal** (diarrhoea) can come from **el-tabikh el-abyad** (white cooking) or mixing **zafar** (meat) and milk. This distinctly Talmudic taboo associated in most westerner's minds

with kosher Jewish traditions is very much a part of the principles of good housekeeping and nutrition in rural Egypt. It is not a religious principle nor a strict taboo that is sternly observed. It is merely part of local good wisdom and common sense. Fresh milk and meat, particularly red meat, should never be mixed.

In so far as principles of humeral medicine and nutrition are concerned **Rihan** and its villagers seem oblivious or un- . of these principles. Sukkary-Stolba has written on children's nutrition in rural Egypt and the persistence of food taxonomies constructed around humeral principles (Sukkary-Stolba 1989). The division of food stuffs into hot and cold is central to village food discourse. But this does not necessarily imply that humeral principles are instructive to village food consumption. Morsy (1993) says of her village that when villagers feel hot, ie from the hot weather, they consume cooling foods like cocacola or watermelon. These are foods that are actually cold. She points out that the relationship between excess body heat and the humour of the food concerned has more to with actual temperature than with Humeral medical principles.

Rihan is another case where the language of humours, particularly hot/cold exists and has wide currency in everyday speech and decisions concerning diet but the principles of humeral medicine are not as active and alive as one would assume from hearing this everyday speech. Foster (1994) argues that for his area of study in Mexico humeral medicine is used more for post hoc rationalization than for the making of real decisions.

The food and treatment of the un-well is idealized in village discourse but is, in reality, overwhelmed by material circumstances. Meat and **semn** can make a child healthy (chapter 5) but that is because they are a sign of wealth and not simply because of their nutritional value.

Rest for a sick child is important but sick children are

never kept in bed; because they have no beds to sleep in. They are not kept in doors because mothers rarely have enough control over them to prevent them from going out. Sick children are only confined by their own sickness (Hoodfar 1986). They stay put if they are too sick to move. They eat whatever is available and eat only when their appetite permits.

E. CONCLUSION

I do not want to give the impression that the afflictions of children in Rihan are necessarily different from those of children anywhere else in the world. Perhaps in this village, some children are more at risk because of their material circumstances and because of the inaccessibility of modern health care. Unfortunately they are also, like children everywhere at risk from fatal diseases and accidents which do not know national or class boundaries. Here children also suffer cancers and car accidents.

Adila has lost her 10-year-old son to cancer. The boy suffered for two years from a brain tumour during which time he and his mother had to make the 7 hour train journey to Cairo for chemo-therapy at least once every three months. In Cairo they often slept on the street because they had no-where else to sleep. During the final stages of his illness Adila used to place him at the front door after she bathed and perfumed him so that he could pass the time watching the passers by. They would in turn stare back at his large tumour ridden head.

During my fieldwork, Waleed, a 3-year-old, was hit by a harvesting machine. He had been inside his families **mandara** (front room or parlour) with his father who was smoking a **goza** (water pipe) with friends and favouring Waleed with a few puffs. Then men outside called to the father to come and drive the **darass** (harvester). The boy ran out to watch but the man driving did not see him and reversed the machine through his

body. The metal spikes when through the boy's neck right in front of the eyes of at least fifteen men including his own father. His father carried the bloody body through the village like a mad man and the boy was taken to hospital but he was already dead.

His family grieved for years. He had been a beautiful boy and his father was going to put him in school. The father still imagines seeing him around the house and often calls out his name. The family believes that the accident was precipitated by several factors. His father and uncles had been fighting over land and so there was za'al (anger) in the air which may have led to the boy's demise. They also say that because he was a beautiful and bright boy he had no chance of surviving the envy of others. Since his death, his mother has born another son whom she shows to no one for fear of another tragedy.

Indeed, not all the health problems in Rihan are related to poor environment, poor knowledge, or poor services. Many are due to the frail humanity of children and the precariousness of their health. In this chapter I have attempted to describe the strategies for survival employed by families to guard against such fragility and to ensure the survival of the members of the community who are deemed most precious and most at risk.

Plate 18

Plate 19

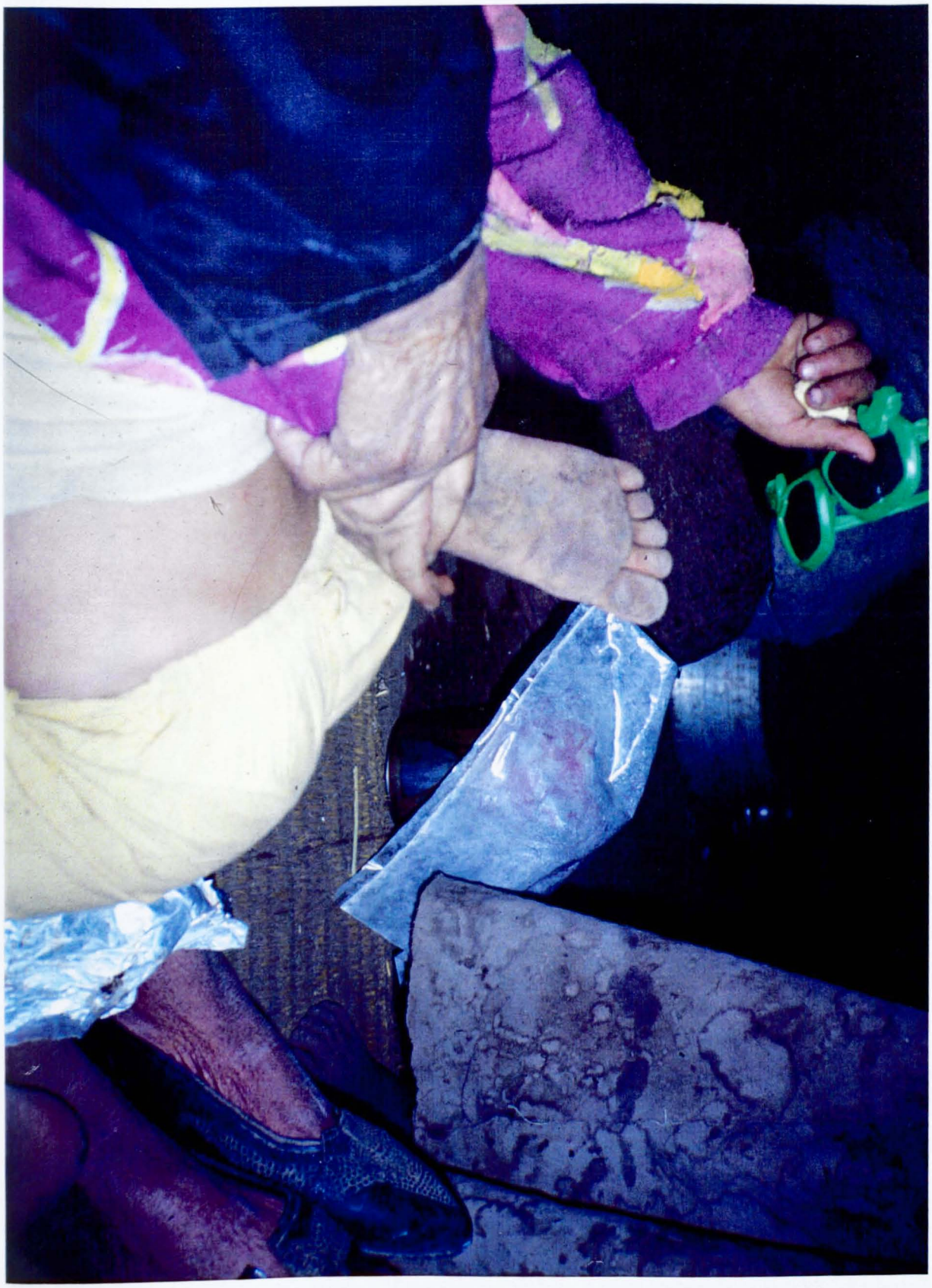


Plate 20

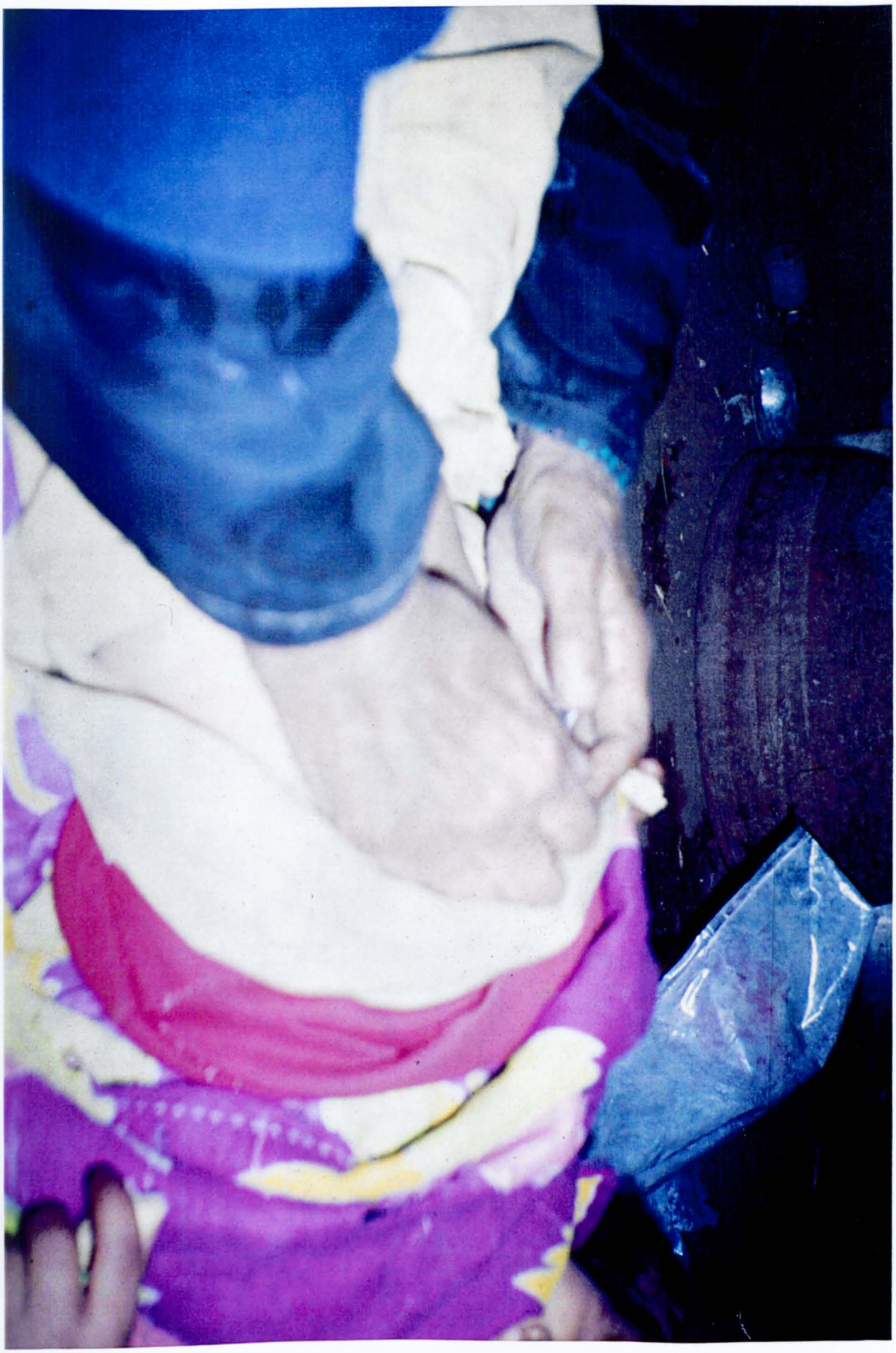


Plate 21

Plate 22

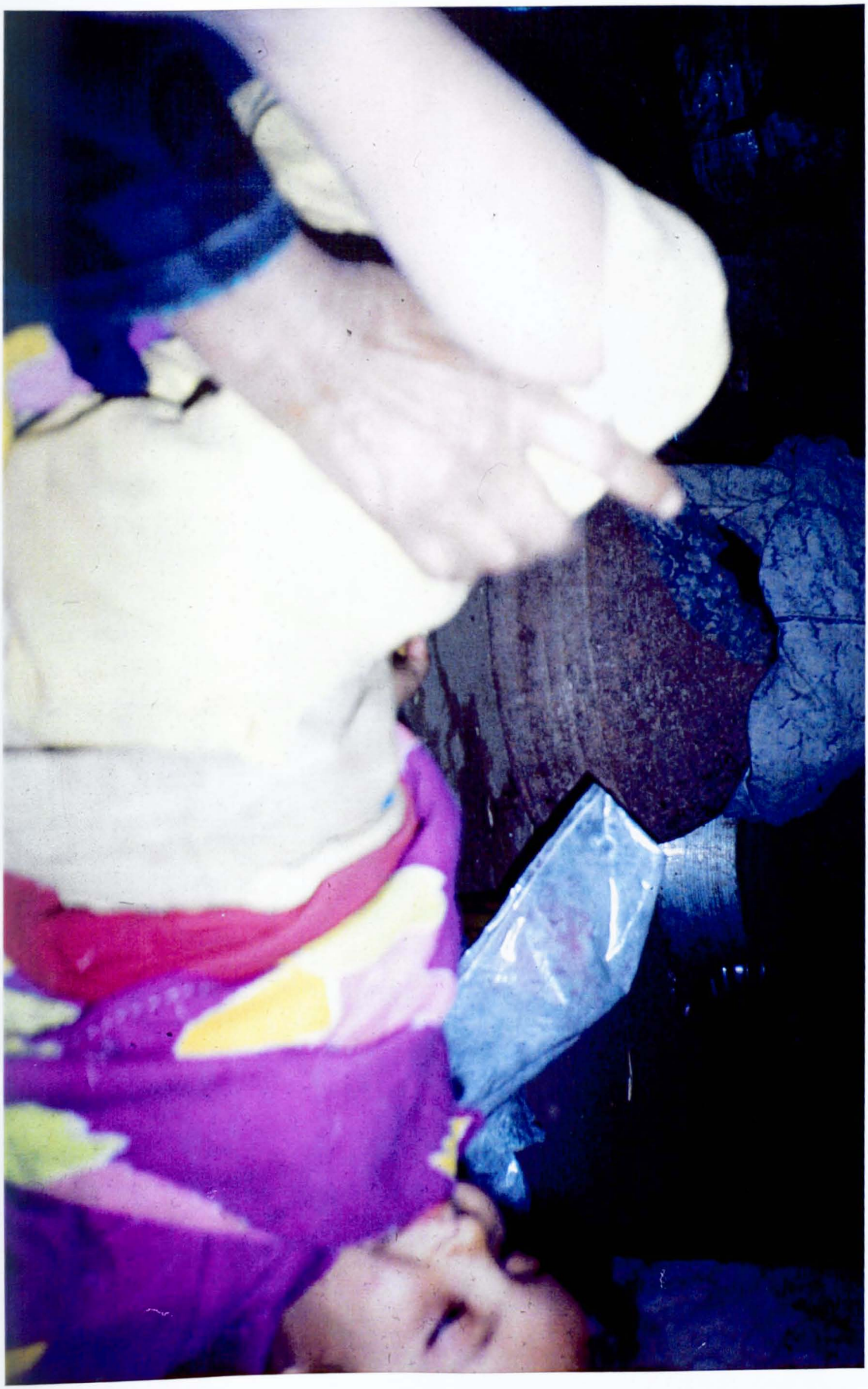


Plate 23

CHAPTER NINE
CONCLUSION

A. RECAPITULATING THE ARGUMENT

In the introduction to this thesis I proposed three areas of research and theory where the study of child health could make a significant contribution. First, I suggested that the study of medical anthropology could be enriched by a specific look at the health and ill-health of children. Secondly, I argued that child health, its protection, and management could contribute to a better understanding of the medical cultures of Egypt. Thirdly, I stated that the ethnography of rural Upper Egypt remains lacking in its scope and depth without a better appreciation of children, their significance, and place in society.

The body of this work has addressed these questions by employing a variety of methods, arguments, and ethnographic observations. In this conclusion, I shall try to succinctly draw the reader's attention to the main arguments of the thesis relating to the three areas of research, and to illustrate how the social basis for the construction of child health affects notions of health protection.

B. CHILD HEALTH AND MEDICAL ANTHROPOLOGY

B. 1 HEALTH

The conceptualization of children's ill-health demands an understanding of the social and cultural, as well as the phenomenological construction of health. This work has described how the health of children is conceptualized, restored and protected. In doing so it has drawn attention to the importance of families' world view and self perception as essential determinants of health.

The concept of **batlan** or sickly was shown to have direct consequences on how a child's health is managed. At times it leads to a continuous quest for therapy. At other times it leads to neglect. **Batlan** is not only defined by actual experiences of ill-health. The child's structural position in the family and the community can designate this label.

Girls are perceived to be healthier and stronger than boys. Consequently it is rare to find a girl who is **batlana**. She may be just ill but is rarely perceived to be in a structural position that can undermine the benefits of her gender and cause her to be sickly. A girl may just get frequent diarrhoea and may get the treatment she needs. A boy who displays the same symptoms is **batlan**. The natural conclusions from this statement are multiple and even contradictory. Does it mean that a boy is neglected because he is sickly and not expected to get well? Does it imply that girls receive better care than boys? Does it imply that boys get modern medical care and girls do not?

This work has tried to argue that structural definitions, like **batlan**, are important in themselves, regardless of the different practices they engender. They are significant because they illustrate what villagers take to be important determinants of health, and consequently of ill-health. In **Rihan** a healthy child is one who has many brothers and sisters and a fertile mother. If an only child or a boy with only sisters, this child can only be healthy if he is kept away from sight and far from envious eyes. For this reason it is misleading to argue that all children are alike. They are structurally differentiated. Once this becomes clear, the negative outcomes of such differential treatment can be better addressed and hopefully mitigated.

Health is also contingent on natural factors such as diet and pollution. But diet is esteemed for its symbolic not calorific content. Children who do not have red meat every week or two are not healthy, even if they are in good health.

They are not healthy because they are poor and are deprived of foodstuffs that extend energy and status. Adulterated foodstuffs, such as vegetable fat and bleached flower, lack this health giving power. Prepackaged snacks and sweets gladden a sick child's heart but they cannot extend health either.

Once recognized as a promising area in medical anthropology, child health could contribute to a better understanding of health, how it is instilled through child rearing practices, how it is perceived as a function of social structure, and how it is recognized as a symbolic capital that is negotiated in social and historical relationships.

B. 2 ILL-HEALTH

The focus on children can also contribute to studies of ill-health. Biomedicine and the medical culture that is native to rural Egypt both have sub-specializations specific to children. This is a recognition of the particular vulnerability of children as well as of their young and growing bodies, and their lack of agency when very young. Medical anthropology also needs to take account of the separate domain of child health and look at it on its own terms.

This work has tried to show how child ill-health is defined. The construction of risk and vulnerability are key to the conceptualization of children's ill-health and its management. Children are at risk everyday. They also come down with minor ailments all the time. Playing or working too long in the sun, colds and coughs, stomach upsets from too many sweets can become life threatening fevers, respiratory tract infections, and fatal dehydration in relatively short periods of time. Consequently health management in the case of children is a matter of everyday practices.

This work has tried to describe the everyday of children's lives and the everyday concerns of their families

to show this link and highlight the very short distance that exists between health and ill health.

Theory in medical anthropology has yet to account for this interrelatedness of health and ill-health and for the notion of everyday risk and vulnerability as defined by the nature of small children's health disposition. This work has tried to show the potential for using narratives as conceptual tools which show the linkages between health, ill-health, and the social and historical contexts in which they exist.

B. 3 MEDICAL PLURALISM

This work has shown how health is structured and defined in terms of one medical culture, that is a locally defined one which retains a heightened sense of social and political context, but is restored and managed through recourse to a variety of medical services and traditions. In describing families' use of biomedical services for their children, it becomes evident that they see the tradition of modern medicine as one that has the clout of modern science, the magic and mystery of drugs and medications , and the prestige of the urban middle class.

Families use biomedicine because it provides a short cut to relief from distressing symptoms. There are fewer people in Rihan, however, who are willing to adopt the principles of modern public health. There is not enough belief in these principles to warrant their adoption. As others have pointed out, medical pluralism does not mean that people uphold pluralistic beliefs. As the case of Rihan has shown, villagers are trying to buy the commodity that is called modern medicine but they rely on themselves and their own tradition to construct and protect their children's health. Both traditions are placed on a continuum where one pole represents therapy and the other meaning. Biomedicine is a technology. Local medical culture is an intellectual heritage and a system of meanings.

C. THE MEDICAL ANTHROPOLOGY OF EGYPT

In all of the works on Egypt, there is a doctor, clinic, or hospital lurking in the back ground. There is no denial of the accessibility and acceptance of biomedical health services. However, this ubiquitous presence has rarely been problematized. Inhorn is an exception to this observation since she writes on infertile women seeking in vitro fertilization and other forms of biomedical intervention. Yet even in this study, we learn very little about the doctors themselves (Inhorn 1994). Morsy's brief work on Islamic clinics raises issues concerning the nature, and politics of biomedical care and services (Morsy 1988).

This work has tried to diverge from this path by including physicians as healers and trying to socially situate their own experiences of being service providers to the villagers of Rihan. The problematic quality of care which villagers and their children receive is as much a part of their medical culture as are their own emic categories of health and ill-health.

A second general observation concerning the medical anthropology of Egypt is the domination of a limited number of culturally distinct root paradigms in the analysis of ethnographic observations from the field. Medical anthropologists, in general, have chosen the idioms of Islam, humeral medicine and/or spirit possession to analyse medical practices and beliefs.

Islam has been used as a broad meaning endowing framework with reference to which a variety of therapeutic and prophylactic practices have been 'intellectually' justified to the reading audience. An example of the analysis of

Mushahra/Kabsa (infertility spell) may illustrate the point[1]. The complex of activities and beliefs that constructs **mushahra** has been acknowledged by ethnographers and writers for over 100 years (Abu-Lughod 1993; Ammar 1954; Harrison 1993; Inhorn 1994; Ismael 1892; Kennedy 1978; Morsy 1980; 1993).

From various reports and accounts **mushahra** is clearly a set of practices that serve to preserve and restore fertility application for biomedical or religious intercession. It relies on the exchange of bodily substance between human being or human beings and animals. It also relies on the lunar calendar and on exposure to symbolic representations of blood and death. It is, one can safely argue, a secular belief since sufferers and officiates do not supplicate God or any religious intermediaries. Inhorn has supplied medical anthropology with the most elaborate explication of **mushahra** (Inhorn 1993; 1994). But her final analyses uses the idiom of Islam. She chooses a symbolic analysis that rests on concepts of pollution and purity to explain **mushahra** practices and beliefs and to justify the perceived potency of urine, blood, and death and their symbolic representation.

While this may be a plausible enough explanation, it does lead to two problems. The first is that it is essentialist in its reading of **mushahra** and in its employment of a huge body of faith, practices, law, and scholarship which is Islam. This explanation does away with historical contingency and context and with social significance and function[2] It basically tells us that **mushahra** survives because women partially believe in

---

[1]. For details of **mushahra** as constructed by my own field observation see appendix 4.

[2]. I realize that 'function' is not a word that anthropologists like to use due to a burden of historical and theoretical meaning, however there are functional aspects to **mushahra** but which do not imply it is a static or ahistorical practise.

its efficacy and that this belief is 'unconsciously' rationalized by Islam.

Secondly, this explanation isolates **mushahra** from other health related practices. In terms of Kleinman's notions of health systems as complete cultural systems, Inhorn creates a total model out of **mushahra** rather than seeing it as a component of an alternative therapeutic tradition; or at least investigating its connections to emic concepts of anatomy, illness causation, etiology, other idioms of distress and disease and choices of therapy.

In this work, I have tried to desist from 'using' Islam in this way. I have argued that while practices such as belief in **jinn** and in the efficacy of written charms are sanctioned by Islam, they are not a product of this faith. I have tried to show the friction that exists between belief in God as an omnipotent being who is the cause and the cure for all suffering and the belief in the agency of spirits and other human beings in precipitating disease and accident. The role of religion in this discourse has been to compete with, and not define or rationalize, medical traditions.

The medical ethnography of Egypt has also analysed practice in terms of the principles of humeral medicine. [3] The

---

[3]. Humeral medicine as elaborated by Hippocrates, Galen and Ibn Sinna (Avicenna) is now a 2 millennia old medical paradigm characterised by its simplicity and uniformity (Foster 1994: 2). It is a tradition which locates health in balance and equilibrium and which explains ill-health in terms of dis-equilibrium suggested by naturalistic not personalistic causes. It has been incorporated in what has become known in Egypt as **el-Tibb el-Nabawi** which is also distinguished by its naturalistic etiology. That is it locates the causes of dis-equilibrium in natural causes and not in personalistic ones. It also relies on significant knowledge of the nature of the afflicted individual, that is knowing the natural complexion of the patient (sanguine, phlegmatic, bilious, melancholic) as these complexions imply states of body and states of mind. Moreover seasonality and activity are crucial to diagnosis and therapy (Foster 1994: 7, 43).

There is an assumption that humeral medical beliefs survive in Egypt. Sukkary-Stolba, for example, in writing about food

language of humours is spoken by most village dwellers of Upper Egypt. Cautery is said to be effective in the cure of a variety of conditions. A person with a temper is described as having hot blood, and someone who is heartless or humourless is said to have cold blood. Lay medical diagnosis often refers to "cold in the stomach", "heat in the head". However these utterances and practices in themselves are not indicative of a humeral medical system.

Early has tried to analyse Cairene women's therapeutic choices in humeral terms. However, she transcends food and substance classification to examine the value of balance. She calls the health system which she is examining the **Baladi** system[4]. She locates the principles of this **Baladi** physiology in the ideal of the natural functioning of the body. Any irregularity, either in physiological sequence or in social relationships, assumes etiological significance. Balance is defined not in terms of humours but in terms of a conception of what is **tabi'i** or normal and which is concordant with the pragmatism of everyday life (Early 1988: 73-81).

This work argues that balance is a purely pragmatic construct. Newly delivering mothers must eat of everything because they are weak and have lost much blood. Shock or **khar'a** knocks the breath of life out of its victims so they need cautery to shock them into recovery. Too much sugar for children can make them sick. All these calculations rely on a

---

classifications and child diet chose to interpret the emic distinctions of light and heavy food as ones which correspond to categories of hot and cold as constructed by humeral food classifications (Greenwood 1981; 1992; Sukkary-Stolba 1987). But as Morsy notes, for rural Egypt, people's food classifications tend to correspond to actual properties of food relating to its thermal not metaphoric heat and digestibility (Morsy 1993: 297).

4. The term **Baladi** derives from the word **bald** which means country in Arabic. **Baladi** means 'my country' and denotes the urban authentic, un--westernized poor.

direct cause and effect rationale and not a symbolic one of humours and their interactions. However, yearning and jealousy can also damage health. Jealousy and fright, according to this concept of health determinants, are as real as chemicals and protein deficiency. All upset the body and leave it prone to disease[5].

Balance, both natural and social, is key to the medical system of Egypt. Indeed health cannot truly exist in the midst of excesses. Excesses of poverty and wealth, deprivation and privilege, infertility and fertility, child mortality and well-being upset the health of the individual or place that individual at risk. For example, the very poor are ill because of poverty, the very rich are at risk because of their wealth. Employment, opportunity and power also act as health determinants in the same way.

The third paradigm which figures in the analyses of health and healing in Egypt, as elsewhere, is that of spirit possession. The Zar cult is a familiar form of exorcism that persists in Egypt to day. It is expressive of a firm belief in the parallel and sometimes pernicious world of spirits. Spirit possession and exorcism has intrigued medical anthropology and has provided a root paradigm for analysing cosmology and health beliefs. In some studies, possession itself has been explicated in terms of gender relations of domination and patriarchy (Morsy 1991), as a means of escaping confinement and domination (Early 1988), and as an idiom of somatization that is of cultural essence to the Middle East (Nelson 1971) Exorcism has also been compared to "folk psychotherapy" (Boddy 1989: 353). In a rich symbolic analysis of the Zar cult in north Sudan, Boddy argues that it is a means by which women counter their cultural over-objectification whereby exorcism ceremonies become a means by which women "...step outside the

---

[5]. A notion legitimized by biomedicine once it discovered the function of the hypothalamus.

world and gain perspective on their lives." (Boddy 1989: 354).

But spirit possession is invariably isolated from other roles played by spirits in the lives of men, women, and children. For example, in Egypt, the prevalent belief in the powerful role of the qarina or sister spirit is not separate from the belief in domination by other spirits. The sister spirit is most active during the fist 40 days of an infant's life and is the potential cause for infant or neonatal mortality. But children are rarely possessed when older. This does not mean that the spirits exorcised by Zar and those which afflict children are unrelated or have no bearings on one another.

These various strands of analytical thinking leave many questions un-answered. Why are spirit possession beliefs and sister spirits belief un-articulated? Why does the literature mention an Egyptian equivalent of Susto (sickness by fright) without attempting to understand the emic physiology or anatomy on which it is based? Why don't children get possessed? Why can men resist their own sister spirits? In chapters six, seven, and eight I have addressed some of these unexplained aspects of the traditional medical knowledge of Egypt and tried to place my answers in a cultural as well as in a historical context.

This work has tried to locate a frame of reference that is detectable at the level of practise and in which various components of Egyptian medical culture have meaning. The most significant aspect of this medical culture is not its acknowledgement of a parallel spirit universe. This is a medical system that overwhelms this world of spirits by its concern for the relationships between human beings in this world. These relationships define health and ill-health and even use spirits to affect and structure these definition. Hasad, sister spirits, and mushahra, are all supernatural expressions of social relationships.

Zar is irrelevant to children because they are not

immersed in the kind of sexual relationships which are often related to spirit possession. Children don't get possessed because they are not in a social position that permits such possession. Disparate snatches of medical praxis can become varied dimensions of a medical culture if this essential generative role of social relationships is acknowledged.

I am not arguing for a totalizing theory of non biomedical Egyptian medical culture(s). I am not trying to construct an essentialist culturalist model either. I am trying to discern a logic of practise that people in Rihan find meaningful. This logic has been fragmented by the anthropological gaze itself.

The medical culture of child health and ill-health in Egypt is more than a product of the confluence of hardship and poverty. It is not structured by symbolic gestures alone. It is a cacophony of practices which have a contextualized coherence. This culture has a concept of health which is key to its analysis. The adoption of a notion of 'health construction' helps to restore coherence to medical practices and beliefs and show the purpose of practice not just their performance.

In therapeutic terms traditional medical culture has succumbed to the hegemony of biomedicine except in the case of female gynaecological health and some therapies relating to childhood diarrhoea. But it survives in its generative role in the conceptualization of health and its recommendations on prophylaxis.

D. THE LOGIC OF PROTECTION

In the clinic at the Abnube general hospital, Farhana, (who was waiting for the gynaecologist) and I saw one of the Dalalat [6] who comes often to Rihan. We greeted her and asked her why she had not been seen for so long. She pointed to a

---

[6]. The woman who travel from village to village selling cloths, and other items.

baby son who was seven months old and who had prevented her from travelling as far afield as **Rihan**. The boy was covered in grime and dust. She said that he has yet to have his first bath. He was wearing a scarf on his head to protect from head colds and so that no one sees his face properly. He also wore a **'o'ed** under his armpit, a **'higl hadad** (iron anklet) on his ankle, a **tahreeza** (an all purpose amulet for children) pinned to his clothes, a **higab** (amulet) encased in leather around his neck, and was playing with a black nylon veil with which his mother covered him completely when they were leaving. She explained that they were at the hospital to attend the paediatric out patient clinic for her toddler daughter who had a broken arm. She added "I have never felt my girls, it is the boy that I worry about!"[7]. Farhana later remarked that it was typical of peasants to do this to their children. "We the Arabs believe in God and his will. Of course we protect our children but not in that way!"

In discussing the conceptualisation of health and ill-health (chapter five), a child's structural position was presented as a major predisposing factor to risk. The logic of protection in **Rihan** is geared to these notions of predisposition and risk. Envy and envious agents are at the heart of this logic of protection. Diseases, accidents, loss of appetite, wasting and stunting, and other mishaps are recognised as dangers but are perceived to be manifestations of a much more serious danger, that is the envy and ill wishes of others.

Nazra (look/gaze) and **Nifs** (person) lead to sickness, weakness, or misfortune. "He got diarrhoea from underneath a gaze" is a common explanation given by parents. The diarrhoea is the visible condition but what really caused it? Why that child and not his sibling or neighbour are sick is a question whose answer necessitates a higher order of causation. This order of causation reflects that interconnectedness of the individual and the set of relations in which he or she exist. **Nazra** and nifs cannot exist outside of community. Bad intentions can only come from another human being who is in a

---

[7]. Never felt can be interpreted as having had an easy time with bringing up the girls.

position to comment and thus envy another. Parity is a prerequisite to envy (Ghosh 1982: 222). One can only be envied by another who perceives themselves to be equal in some respect and therefore entitled to the same good fortune as the person envied.

For example, Om Shihata (Chapter 8), who suspected both **tabi'a** and envy as the reasons behind her succession of miscarriages and her inability to bear a healthy son, made her husband swear that her next delivery would take place in a hospital "Where no one will see me or the baby" she explained to me. When in labour she screamed "Even if you throw me in the stream, I want to be taken to hospital"[8]. She had her wish and the boy lived. Thus her fears were confirmed. She was sure that giving birth amongst strangers who do not know her and cannot or would have no call to envy her was the only way to break the envious spell which had cost her so many beloved sons.

The example of Om Shihata is not an isolated one. Many other women firmly believe that strangers do not harm them. The exception are strangers who purposely want to inflict evil. Om Mohammed once had a visit right after her delivery from a woman she did not know but who came in the company of another neighbour. This woman was a relative of the neighbour who had come to visit from Cairo. When she looked at the new baby she said "Why is he clutching so tightly to the world?" in reference to his clutched hands. Within seven days, the boy died. Om Mohammed has no doubt that this woman had a very bad **Nifs** and she proved it by saying as an audacious thing as she said about the baby. A normal person says upon first seeing a baby either **bism Allah al-rahman al-raheem** (in the name of God the great and compassionate) or **bism Allahi ma sha'Allah** (in

---

[8]. Her exact words were "Inshallah fi el tir'a tirmouni bess 'al mustashfa wedouni". She was saying "even if you kill me in the process, I still want to be taken to hospital."

the name of God his will is done) or simply "what an ugly baby" or some other detracting remark so as to publicly disavow any wish to have a similar baby and so guarantee that they are not envious[9].

Ma ye'hsid el mal ila as'haboh No one envies money except its own owners is an oft used proverb. Besides the unintended envy of community members and the intended harm of others whether close or strangers, individuals can envy themselves or their own good fortune. That is why one must not gaze at one's own children or continuously think about one's own good fortune. To do so is not only to tempt fate. But it also implies that the lucky person is aware that the balance is tipped and that he/she are luckier than neighbours and friends. In this way one inflicts envy on one's own self.

Practices of prophylaxis are aimed at the involuntary envy of others. They do not target premeditated injury. There is a strong belief that much envy happens despite the envier. While in English the term "Evil Eye" is common, there is no linguistic equivalent in Arabic. Envy is called **'hassad** in Arabic and the instrument of this emotion is called **'ein el-'hassoud** or the eye of the envier. The significance of the eye as a symbol of envy, and as the protective charm to be worn to deflect a potentiality harmful is a well documented aspect of ancient and modern Egyptian beliefs (Blackman 1927, el-Aswad 1988, Kluzinger 1878; Ghosh 1983: 222).

But the eye is only a symbol and a medium. The underlying conceptualization of human relations in which the eye is instrumental is based on the principle of equality. The logic of envy is that people are or believe that they should be equal. A person's lot in life should be like everyone else. Consequently when blessed, a person must either hide the blessing or emphasize a problem so as to counteract the

---

9. All over rural and even urban Egypt such reactions and word are considered common etiquette.

imbalance caused by a blessing. Thus the family of a baby son will either shield him from view and de-emphasize his presence by denying his birth for days after the mother has delivered, or by saying that he is a girl and only letting the truth be known many days or even weeks after the birth. Alternatively the family may claim that the baby is weak, that the mother is very sick or that they have met with some calamity such as a bad harvest, lost a calf, or have been blighted with a parasite in the fields so as to shift attention from the baby to a problem and thus emphasise that their lot remains unchanged; that it is no more or less than that any other community member.

A true belief in the expectation of equality provides understanding for unwilling and unintended envy. It is understandable that a woman who herself has not been blessed with a child or with a son will, despite herself envy one who has. Evil people do exist and there are plenty who intend to inflict harm. However, protective practices do not address these people. These practices shield from those who are at a disadvantage and therefore can't help but seek, even if impetuously, to redress the imbalance. "The eye does not choose" as the saying goes, but the imperative of equality drives it to cause harm.

When a mother calls her son an ugly name it is to ward off the envy of any unfortunate man and woman. An ugly name preempts envy by instigating shock or displeasure at the name. So Om Hamada called her youngest **Touba** (stone in Arabic) after his older brother died. Om Ahmed let her son go by the name of **Matta** (a distinctively Coptic name) and Om Sewify called her new son by the name of **el-gassees** (the priest in Arabic) even though his given name was Ahmed.

The practice of giving a child a real name and a fake one by which the child is beckoned and which is given currency amongst people is another safeguard which protects against those who mean to do harm. To make a harmful charm or to ask

ill to befall a person, one must have the real name of the person and that of his mother. Giving currency to fake names is meant to confuse those who may go out of their way to try to cause harm.

The intellectual distance between biomedical prophylaxis and the protective practices connected with naming suggest that we are discussing separate worlds with separate concerns. This distance would seem to advance the stereotypical dichotomy between local beliefs as irrational ideas that are contingent on supernatural considerations and biomedical principles which are rational and scientific. But the difference between the two approaches to prevention can also be interpreted in terms of their concern for different levels of causation. Biomedicine's focus on immediate dangers to health contrasts with theories which attempt to explain the process by which these immediate dangers select certain individuals and not others.

The issue of the selective behaviour of many diseases is one which biomedicine has neither solved nor succeeded in dismissing. Indeed, it is one which is imposing itself on the biomedical research agenda. Currently it is accepted that many diseases are affected by genetic predisposition. Genetics are also pointing to the individualised nature of disease and affliction. In a sense, research on the 'cocktail' of genes which predisposes one person to obesity, another to hypertension and a third to specific kinds of cancer is also saying that while environmental factors matter, they impact some individual more than they do on others. It implies that diseases are selective because genes can catalyse the interaction and culminate in different results according to the genetic constitution of each person.

There is a similar argument at the heart of beliefs concerning personal disposition defining one's exposure to ill-health. Here as in modern theories of genetics, personal circumstances or constitution interact with environment to

render one healthy or unhealthy. The vitality of personhood and circumstance create a vernacular rendering of the biomedically constructed rationality of genetics. The remote similarity lies in the fact that these two sets of traditions and beliefs attempt to answer some of the same questions. The intellectual distance is not as vast as it would seem if one just compared the medical sophistication of the process of immunization to the practise of giving funny or fake names to newborns.

Rihan, like other villages, has witnessed dramatic changes in the recent past. Villagers have modernized themselves at a rapid pace, learning to cope with the change in their own lives and environment and with the upheavals going on in the world around them. But within this scene of change there are inter-community imbalances. Fortune, family, health, happiness, and power are overlapping arenas. The man who is rich but has no sons is like the man who has sons but is sick. Things eventually balance out. However if one is fortunate on all fronts, then this creates a fracture upon which envy can play.

This view of the world defines protection and provides an analytic framework by which events, specially unfortunate ones are interpreted. When misfortune does occur, parents recollect past events and determine whose envy it was that did the misdeed. Unlike **mushahra** (see chapter 3 & Appendix 4) which has become mainly an instrument of exegesis, **hassad** is still a belief which determines action and imperatives for protection. One of the short verses in the Quran, which is short enough for everyone to know by heart and which is the next verse that small children learn after the **Fat'ha**[10], mentions the envy of the envier [11]. I mention the Quran not in

---

[10]. The **Fat'ha** is the first and opening section of the Quran.

[11]. The verse is one of the short ones which list the main dangers from which the believer needs the protection of God. On

order to use Islam as a definitive root paradigm; Islam may condone **'hasad** but it is does not confirm **tabi'a** or **mushahra.**

Hassad is neither distinctively rural, nor Egyptian. It is not exclusively Islamic since beliefs in "Envidia" exists in many communities in South America. The importance of mentioning envy in the context of a discussion on prophylaxis and children in Rihan is its indication of the relationship between health, ill-health, and the principles which organize social and political life.

The old and wise say that ultimately all things, both good and bad, come from God. **"Rabina bi-yesabib"** (God creates reasons) affirms peoples complete belief in God as the only source of all initiative. The husband of Om Shihata went to a priest as well as a Muslim healer to make amulets to protect the baby his wife was about to deliver. Later he explained **"koloh bi 'amr Allah, el gasees bass el-sabab"** (It is all in the hands of God, the priest is only the reason/agent by which God chooses his will to be done".

However this belief does not translate into apathy, fatalism and a feeling of powerlessness as far as believers are concerned. That God is the ultimate source of all incidents, initiatives, and events is a belief which helps those who have lost loved ones or who have suffered to accept the tragic or difficult trial after it has taken place. However, until the 'deed has been done' believers are enjoined to try and strive to protect themselves and to seek remedies and redress. God as the ultimate source is a formula which helps ex post facto acceptance but is not one which precipitates an a priori fatalism. It is a tenet which leaves plenty of room for people to take initiative in defining, managing, and protecting their childrens' health and well being.

---

this list is <u>shar 'hasid iza 'hassad</u> (the evil of the envier if he envies).

E. THE ETHNOGRAPHY OF UPPER EGYPT

> Myths in our village sleeps across the door ways and above the surfaces of the mud ovens. It is in the waterwheel that are standing idle, in the animal yards and in the deserted dumps. Myth is on faces, under pillows and beds and around necks and waists. It is also to be found in cupboards, trunks and shelves, and in pigeon towers. Myth lies between two bricks in a wall and in the heart of a male date palm. Myths are everywhere and for every occasion and between every cause and its outcome. A bridge of myths connects each woman to the land and another of tradition connects the land to every man. For if tradition is the ideology of the male in upper Egypt then myth is the female's ideology. The space of tradition is the parlour, the playing field, the den where men smoke and in the field and mosque.... (Myths) are the harvest of the meeting of two opposites at a moment of urgency and not of desire. And so the land lies wide for the men who inherit it and becomes narrow for women for whom land can only be a shroud.
>
> (El-Kerdoussy 1996: 67)

One of the ambitions of this work has been to try to say as much about peasants, and Arabs, in Upper Egypt as has been said about children and their health. As argued above, health has an essential social context. Consequently the community, its daily life, its ideals , and the principles that govern its social organization, production, and reproduction came to form a major part of this work.

El-Kerdoussy talks of myth and the upper Egyptian. He eloquently describes how symbols and myths are everywhere in his village. They structure social, property, and gender relations. It is possible to argue the same thing for Rihan and indeed many other villages in upper Egypt. But I would qualify myths as meaning symbolic value. El-Kerdoussy is telling us that the culture of upper Egypt values certain symbols and bestows them with a meaning that pervades all aspects of life.

El-ard (the land) and el-'ard (honour) are the two commonly recognized essential values of rural life in upper Egypt and which have great symbolic significance in the

context of upper Egyptian culture. El-ard is the source of livelihood and identity for peasants. Those who were landless migrated to work in deprivation, not so as to break free from rural life and its hardships, but to further immerse themselves in it through the acquisition of even the smallest piece of land.

El-'ard is not really honour. It is the sexual integrity of one's women folk. This integrity is essential to the male peasant's well-being, pride, and self-respect. Only men have 'ard, women do not as they are 'ard itself. They have dignity and self-respect and modesty but not 'ard. The significance of 'ard which can be the sexual integrity of a man's wife, sister, mother, niece, cousin, or even aunt, is well known to observers of Upper Egypt. Land and female sexual integrity are the pervasive symbols about whom El-Kerdoussy is writing and which he describes as the source, or rather, the objects of myths.

The third important value, less commonly recognized is el-wild (children). Children mean as much to a man as does land and female sexual integrity. They mean even more to a woman. Their significant absence may be due to a male bias in ethnography, even that which focuses on women. In this work, I have tried to show how el-wild are key to the understanding of communities in Upper Egypt. They are important for the understanding of marriage, family life, economic production, inter village relationships, and to the relationship between village and the establishment. Children and their well-being are a priority for families. They are also the source of many of their anxieties and frustrations, specially when sick. Children are also the instrument of preference that the establishment uses to encroach on villagers daily lives. They are the subjects of an on-going discourse between peasants and state, each trying to assert their own view on how children should be brought up, educated, protected, and cured.

It is clear to villagers that children are definitive to

their way of life and to their life choices. This ethnography has tried to convey this clear vision and so provide both a feel and an understanding of life and community in an upper Egyptian village.

APPENDIX 1
MY PAST WORK IN RIHAN

I was neither accompanied by father, brother, or husband when introducing myself to the villagers (Abu-Lughod 1986). In 1988 I had been asked by the UNICEF Cairo office, along with a nutritionist and an anthropologist, to write three 'baseline' village studies in which the socio-cultural factors which affect diarrhoeal diseases were to be the main focus (Hadidi 1990; Oldham 1990; Sholkamy 1990). We were each asked to pick a governorate in which there were high levels of infant and child mortality and morbidity. I chose Assiut.

This UNICEF study was meant to provide 'culturally contextualized' information that would help UNICEF and the NCCDP devise effective interventions. The study had the blessings of the Ministry of Health who were the liaison between the researchers and the local authorities. Each one of us was taken on a preliminary tour of highly recommended villages in each governorate.

As a team we had decided to study one large village which is serviced with electricity, running or potable water, and a government presence such as a social services office, local village authority, police station, or school. We decided to choose a small satellite of each such 'mother village' where there were less or no services and to compare our findings between the two.

Upon deciding on the mother village we were given a guided tour by a high ranking Ministry of Health official who introduced each of us to local authorities and to the community. They did not bother about the satellite villages as I was later told, they were sure we would never work there. The ministry of health officials then disappeared and each one of us was left to do her work. We had decided to work for two three month periods, one in summer and one in the winter to capture the seasonality of childhood

diseases. In the end we spent over nine months in the field.

I worried about the nature of my official introduction and the effects of my warm relations with petty officialdom in the village. But after a few weeks, I realized that my novelty had worn off. Officials were not very interested in what I was doing and the village was big enough for me to still be a stranger to most. I knew that when seen in the market or walking on villages lanes, I was identified as the "Diarrhoea doctor".

After one months of fieldwork I decided to pick my satellite village. I had heard that 'the Arabs' are the worst people, the poorest people, the least refined, and the most marginalised. I was told 'the Arabs' are the inhabitants of the village I now call **Rihan**. I hitched a ride and went into **Rihan** on my own with my official letters of introduction. I stopped at a house and was asked by an old man what I wanted. I explained that I was doing research on children's diseases. After calling other men into his house they agreed that I could do my research in 'their' part of the village. I was told of the feud going on between the northeners and the southerners and advised against mixing with the 'enemy'. I had wandered into the south and this is where I stayed.

The men who had interviewed me asked about my village of origin, my family, my marital status (I was single at the time) but appreciated that I was there for 'work' and that I worked for a living. They were too courteous to ask about my religion but had realized that I am Muslim from my father's name[1]. It was clear that conduct was king and that they were willing to help as long as I was straightforward about my work. Later on I discovered that they had sent agents to ask about the truthfulness of my mission and to corroborate that I was who I said I was.

I am happy to have been able to keep a good enough

---

[1]. My father's name is Mohammed.

relationship with the people of **Rihan**, and write about them, to be able to contemplate going back. I did not visit the northeners until **'am Ibrahim**, the man in front of whose house I stayed and who remained my close friend until his death of dysentery after nine months, suggested that I should make a symbolic gesture and visit one or two houses there. I spent several periods of work in the village[2] and left on relatively good terms with most families.

When several years later I was in a position to undertake my doctoral fieldwork I chose **Rihan**. I took a Taxi from Assiut and drove in to the northern section. I remembered that there was one man there who had an extra room which he had wanted to rent out to a physician employed in a nearby government clinic. **Rihan** is a poor village where there are no extra houses or rooms to rent. Most houses are mud brick with mud floors and very few houses have latrines of any kind.

As the streets of **Rihan** are too narrow to drive through I had to walk to the house of **Ahmed el-Gasees** (Ahmed, the priest) as he is known. On my way, I was stopped by a woman who insisted that I enter her home. She said that she remembered me from three years back, she knew all my stories, she looked at my hand and said "thank God, now you are married, it has made you fill out, you look much better". I remembered that she was related to southerners and realized that she was the wife of the only official employee in the village. Her husband is an agricultural over-seer. They are neither rich nor urbanized. She had eight children at the time and was herself an illiterate women.

I explained that I wanted to do some more work in **Rihan** but this time I had to stay here not in Assiut. I

---

[2]. During this study I did not sleep in the villages, I used to commute back and forth from the ministry of health boarding house in Assiut city. It was a good thing that I 'went home' as sleeping among strangers before really knowing them and especially when single would have been considered eccentric if not immoral.

explained that my work demanded it and that because of the political troubles and frequent murders in Assiut my husband and family did not want me travelling to and fro like I used to[3]. She agreed but told me that I could not stay with **Ahmed** because he has grown sons who have a bad reputation and because he was a no-good scoundrel. She suggested that I stay in their house. They had built an annex of one room where they kept their animals. We waited for her husband to come to see about this arrangement. She added as we ate and had tea

Don't misunderstand me, stay where you please but I have been a stranger like you are now, when I first got married I went to Luxor with my husband as he was employed there. I was a stranger and I know how you will feel, I shall understand you because I too have been away from my family and home.

Ni'mat, for that is her name, was right. I did live with them and I did find comfort in her empathy and friendship. What I valued and still do most of all is that **Ni'mat** was not really interested in my work. She was a reluctant informant but a close confidante. She appreciated that I had to be doing what I was doing but thought it such a hard job. She pitied my frequent visits to the homes of **"Illy Yeswa we illy ma yeswash"** (those who are worth something and those who aren't). She knew that I missed my husband and family and would say that she could never ever do what I do. She also found it terrible that I had to talk and be with people all day and part of the night as well. As she once put it "Don't you get bored?!".

After I made the arrangements for the room, I went to visit old friends in the south. There were no hard feelings about my lodging in the north. "Hashem is a good man" most agreed referring to my landlord to be. More importantly, they could not find a single house where there was room to house me. Due to these specific circumstances, I was

---

[3]. I was in Assiut during the height of the government's bloody confrontation with Islamic radicals

finally granted access to both north and south.

If there is male member of my family who had the most impact on my fieldwork, it is my, then unborn, son. I was never viewed as a dutiful daughter by people in **Rihan**. They had first made my acquaintance as a working girl and now I was back amongst them as a married women. I had no children at the time, a calamity that many women were familiar with. Once at the end of a particularly tiring day and as we sat around the **kanoun** (hearth) warming ourselves from the late night chill, the subject of my unborn and unconceived children came up yet again. **Ni'mat** had many guests that night and I felt unable to cope with the questions, stories, prescriptions, and suggestions of all of the women present. So as we spoke, tears, of exhaustion, came to my eyes and I excused myself.

I had just wanted to be somewhere else but **Ni'mat** construed my reaction as a sign of my sadness at being childless. Her kind and generous reaction was to reassure me that I may well be fertile and that I should not worry. Meanwhile she and others, with whom I was close, began to share with me their view of the world as mothers and talk not only about the facts of children and childhood, but show me the existential aspects of motherhood and of the quality of the bond between mothers, daughters, and sons.

My emotional reaction prompted them to see me as a person with problems and feelings and not only as a sturdy stranger and a confident companion. This shift in affection and understanding established a shift in my own work. I began to see them as women and not villagers and to record and observe not only their action and utterances but also their imagination, fears , and affections. I also began to realize the extent to which I wanted children of my own.

After having my own son, my Fieldnotes stayed the same, but my understanding of them changed. MY points of interest and emphasis were different. I say this to establish the fact of this shift and of this difference. My son did not introduce me to the field, legitimate my

project, or guarantee the morality of my purpose. He has helped me to see things from more than one angle, appreciate the physical and emotional facts of motherhood, and observe the subtle but essential conceptualizations of family, community, and self which children create.

I make this long introduction to make a political point. Arab women in the Arab field seem to have aroused as much stereotypical analysis as Arab women have in general (Abu-Lughod 1987; 1989; Kandiyoti 1996). My own field experience is another illustration of the variability and diversity of Egyptian communities and of the ability of women to be seen as individuals and not as daughters or sisters or wives, even in the most conservative of communities. When discussing introduction to the field and rapport we are really explaining if people 'liked' us or not. 'Liking' is as yet un-theorized in anthropology, and so it should remain.

APPENDIX 2
SURVEY QUESTIONS

The questions I put to families in my village survey were the following:

1. Name of male head of household
2. Number of adult males in the household
3. Number of adult females
4. Total number of children
5. Total number of girls
6. Total number of boys
7. Total number of children under the age of 5 years
8. Number of married couples living in the household
9. Number of widows and/or divorcees
10. Presence of polygamous marriages
11. Total number of girls in school
12. Total number of boys in school
13. Total number of girls who had ever been in schools
14. Total number of boys who had never been in school
15. Occupation of male members of household
16. Education of adult males
17. Education of adult females
18. Present or previous labour migration of male members of the household

I relied on official records to estimate land ownership per household.

APPENDIX 3

PEASANTS, PARENTS, AND POLITICS.

Ill fares the land, to hast'ning
ills a prey
Where wealth accumulates, and men
decay;
Princes and lords may flourish, or
may fade;
A breath can make them, as a breath
has made;
But a bold peasantry, their
countries pride;
When once destroyed, can never be
supplied.
(Oliver Goldsmith)

1. INTRODUCTION

Peasants have long been the backbone of the Egyptian economy and still form an absolute majority of the populace today. The state however does not seem to acknowledge the value and rights of the peasantry. Modern developments in the region, namely labour migration, urbanization and confused government policies have resulted in the corrosion of the agricultural sector. Thus the predicament of the poem is about to be realized.

The numerical superiority of peasants is the only leverage that they have enjoyed vis-a-vis their urban and often foreign rulers for well over two thousand years (Ammar 1954, Brown 1990: 4). They have been subjects rather than citizens and yet have retained what has been seen as a distinctly separate and essentially peasant world-view. James Scott explains this situation in terms of the position of

villages vis-a-vis wider economic and social processes. "..(P)easant culture is not simply separate; it is frequently antithetical to the values of hegemonic institutions " because the latter represents little more than the appropriation of the peasant surplus product. Their cultural isolation is a result of their material exploitation. Combined together, they produce a hostile self-perpetuating outlook (Scott in Brown 1990: 16).

My aim is to scrutinize this peasant outlook in so far as it touches upon issues of childrearing and health choices concerning children. It becomes apparent however that an understanding of peasant historical experiences is a necessary context to understanding their present tribulations and their endeavours to secure their own continuity.

2. The Predicament of Peasants

> Virtually all contemporary writings on the Egyptian peasantry, whether by foreigners or Egyptians, indicate the existence of a distinct peasant outlook. They did not use terms such as political culture or alternative world view, for most were far too contemptuous of the peasant outlook to portray it in positive terms, much less in terms of modern social science. The one recurrent word in virtually all contemporary descriptions is ignorance. Indeed, ignorance forms the theme of most of these writings; the ignorance of the peasantry was obvious to all those who cared to look.
>
> (Brown 1990: 61)

As has been the case with peasant studies elsewhere, Egyptian peasants have been intellectually viewed as timeless

(to the extent that they became fascinating for Egyptologists interested in the social history of ancient Egyptians!), static both physically and intellectually, homogenous and passive. At the political and practical level they have remained subjugated but separate from the urban centre and government that dictated the "parameters" of their livelihood. They have been incorporated but not integrated into the national structure of Egypt (Brown 1990; El-Minoufy 1980; Hopkins 1988; Mitchell 1989; Saad 1988).

As recently as the eighteenth century, state power in village affairs was generally limited to the extraction of crops and labour. Villagers were left with-out interference in most of their daily affairs. This however was out of disdain on the part of the government rather than respect for the peasants' right to an autonomous existence (Brown 1990: 41).

Public political discourse initiated by the 1952 revolution incorporated the peasant as a political symbol of the new egalitarian order (Brown 1990: 10). Indeed much of the rhetoric of the revolution has centred around the abused, persecuted and oppressed peasant. The new order legislated for land reforms from which many previously landless peasants benefitted (Harik 1979, Hopkins 1988, Saad 1988). Basic services were extended to villages in the form of Wihdat mugama'a (Combined Units) which featured a clinic or hospital, a school, a veterinary clinic, a social services and pensions office and a local government and village administration bureau. Some of these were, it should be mentioned, vestiges of the philanthropic efforts of Egyptian notables and of the government that preceded the revolution. However, most of these institutions did not yield their expected results. They were either not frequented because they had nothing to offer, abused or completely subverted by village notables.

In 1954, Ammar rationalised the failure of these institutions by attributing it to the "..clash between the

(peasants') traditional views and practises and the new institutions, the purpose of which have never been explained or made comprehensible to the villagers." (Ammar 1954: 82). By 1987, these institutions and other interventions were still problematic and separate from peasant society and needs (Sholkamy 1988). Moreover the older negative image of the "fellah" as a submissive and ignorant victim remained (Brown 1990; El-Minoufy 1980; Saad 1988).[1]

The practical problems faced by state or other interventions; the resentment and silent disengagement that peasants practise is not merely caused by a collective retentive memory of past days of near serfdom. It is true that distrust of the state and experiences of corvee labour, imprisonment and eviction are enshrined in the odes and songs of Upper Egypt to this day. However, government resort to its own coercive and legislative powers to threaten the livelihood of the peasant has given sound basis to peasant suspicions of the state.

Scott argues that government claims on the peasantry that endanger its subsistence are perceived as more than economic threats. They are viewed as moral violations of peasant rights (Scott 1976: 7; Brown 1990: 17). Within the paradigmatic limits of "the moral economy" argument, peasant culture is not necessarily stagnant or unchanging. Peasants do not cling to tradition as such. Moral reactions and rejections need to be understood in terms of the precarious existence of peasants. Peasant/folk and state/modern world-views are misunderstood if seen as stages of unilinear development. These two poles in

---

[1]There have been debates in the official press about whether peasants should have electricity or not (Al-Ahram 1989). The President in his May Day speech of 1988 derided peasants for their "breeding" habits and excessive consumption of sugar. He quoted the national average for the consumption of foodstuffs and immediately blamed peasants, the poorest group in Egypt, as being the highest consumers. He claimed that ignorance and lack of patriotism were the cause.

fact represent the symbolic distance between the elite and the peasantry (Scott 1976: 238).

In Egypt, there is a constant struggle between village and city over the legitimacy of official definitions including that of education and health. To understand the relationship between peasants and the state, one needs to look at the domain where peasants can apply their own definitions and interpretations[2] "..since the freedom of peasants to elaborate and define their own culture is almost always greater than their capacity to remake their society" and see how they differ from the imposed ideals of the state (Brown 1990; El-Minoufy 1980; Scott 1976: 238-9).

My interest in childrearing arises from the political dimension of this cultural institution in so far as it is a domain where peasants are supposedly "free" to practise and create their culture. However, now that child health has been introduced to the arena of concern of national and international bureaucracies, the competition for legitimate definitions has entered even this "private" cultural life of

---

[2]In the public domain and the media, Upper Egyptian peasants have limited expression. Although many intellectuals and politicians came from these provinces, including President Nasser, most achieved their prestige by distancing themselves from their rural backgrounds. There is only one noted Egyptian writer who writes of his experiences as a peasant and who still lives in his village of birth. Like the Irish, Upper Egyptians were the subject matter of most jokes until the government banned such ridicule from the Media and the press. On television, Soap operas that are shot in Cairo studios but where the plot is supposed to take place in a village are very popular. However, villagers interviewed by the writer expressed great amusement at these television peasants. Women tend to try to imitate their television counterparts for fun. One anthropologist working in Fayyum noticed that villagers were naming their new-born with what city people think of as rural names as an effect of these soap opera; a case of life imitating very bad art!

villagers.

3 The Village and the Household

I have so far been talking in terms of peasants and the peasantry but it is necessary to make some distinctions. In Egypt, hierarchy and inequality permeate social relations in villages. Those who have access to the inputs of production also have social and political leverage. The hierarchy in the economic structure is mirrored in predominant cultural patterns which stress deference and which link people together in a continuing social system (Hopkins 1988: 180; Stauth 1990; Toth 1980).

However, it is commonly argued that peasants are not divided along class lines. Hopkins argues that class is present in work relations but is not evident at the cultural or symbolic level. He explains the absence of class consciousness by referring to the lack of political struggle between people of different strata. Conflict in most villages is acted out along clan, lineage, sufi or sectoral lines (Hopkins 1988: 181; c.f. Abdelmo'ti 1977 on class struggle in Egyptian villages). There is little doubt however, that villagers are differentiated according to their economic situation. What is yet to be understood is the function of family and gender in undermining the upward social mobility of male members of the household. One can argue that women prevent commitments to class positions taking a dominant role in household choices since they often enter social relationships in villages that run counter to class prescriptions (Beck & Keddie 1978; Stansworth 1984).[3]

---

[3]Men and women even if married may have different social and educational credentials. Educated men often marry uneducated cousins or relatives. Likewise, some government employees marry peasant women. These women socialise with and live the life of others who may have poorer backgrounds. It seems to many active in the area and engaged in research that women socialise in accordance with different principles to those of men.

Peasants derive their basic income from agriculture. Other activities include animal husbandry and incidental labour on government projects or nearby towns. The rates of government employment differ from one village to the next. They are determined by the productivity and availability of land. In villages that do not have access to fertile land, the rate of off-farm employment tends to go up (Sholkamy 1988).

Labour migration has had a huge impact on Egyptian villages. Iraq alone is said to have attracted over one million Egyptian workers before the second Gulf war. The push factor for migration was the fragmentation of land and the lack of opportunities presented by Egyptian towns. Migrants were pulled by the prospect of high pay in oil rich Arab countries. It is important to note that the overwhelming majority of migration was temporary and male. Migrants rarely took their families with them and mostly sent their pay back to Egypt. In fact remittances from migrant labour were one of the four basic sources of national income (Ibrahim 1982, Weyland 1993).

In terms of macro-economic structures, agrarian transition models based on the disappearance of the productive role of "peasant" and its replacement by that of the agricultural wage labourer do not apply to Egypt; despite the fragmentation of already small holdings rendering them too small for the subsistence of reliant families, consolidation of large land holdings by city dwellers and agribusiness and the predominance of cash crops imposed by the state and/or the market. The petty commodity producing small farmer household remains the corner stone of the agricultural sector and the most useful analytical tool for understanding village relations of production and of consumption (Hopkins 1988: 179; Stauth 1990; Glavanis & Glavanis 1990, Weyland 1993).

These households are integrated into a capitalist system in so far as land and machinery as well as profit are essential for their reproduction. They are however the locus

of the management of production and consumption. Here is the site where production inputs are articulated and managed by the head of the household. Within the household there is a major and traditional division of labour based on distinctions of gender and age. In this sense it is a structure outside capitalism.

Since each household develops its own survival strategy, one can understand why there is no "typical" peasant household despite the participation of all in a collective moral economy. Each group pursues its own efforts for survival in its own way and in accordance with material and cultural resources (Brown 1990: 35).

This situation of being engaged in state controlled macro-structures but still remaining outside them is reflected in most aspects of village life. Politically, villages have official and local political structures. Since the 1952 revolution and the rural reforms that it introduced, all villages have an elected village council as well as an appointed administrative body. Traditionally all villages had a "'Omdah" or village chief. now at the official level, the village has either a 'Omdah or a police station. Yet practically speaking all villages retain the practice of having a leader who is usually the resident with the largest landholding and who is consulted in disputes, marriages and marriage settlements and common affairs of the village. People tend to resort to the appointed administrative body only when they have grievances which by necessity involve the state. Even then, the "'Omdah" or an educated/knowledgable relative acts by proxy on behalf of the aggrieved villager. Most common folk prefer to have as little to do with government offices as possible (El-Minoufy 1980; Hopkins 1988).

Village notables encourage an Islam that is founded on family mosques and religious brotherhoods. Both of these cornerstones of village religiosity reinforce the patriarchal structure of family and kinship in the village. Mosques are

gathering places for members of family and lineage as well as their clients. The majority of mosques are built by affluent family members and become places for their congregation rather than public places of worship (Gilsenan 1973; Hopkins 1988).

Brotherhoods also incorporate a significant hierarchy that corresponds to that which structures the economic domain. Egalitarianism in brotherhoods is sometimes seen as an instance of the suspension rather than the negation of dominant structures (Hopkins 1988: 187; c.f. Hussein 1990). Charity is a form of distribution and reallocation which reinforces hierarchy. Giving tends to be a very public act and ingratitude is often severely punished with community condemnation and exclusion from future benefits.

Most villages have government services in one form or another. There are schools, clinics, agricultural and consumer cooperatives and social welfare offices in the majority of Egyptian villages. However the quality and utilization of these services is testimony to the distinctiveness and alienation of peasants from the state.

APPENDIX 4

MUSHAHRA

Mushahra provides an explanation and a toleration for female slow pregnancy and infertility. According to the dictionary of Egyptian Arabic **Mushahra** is "To put a spell of barrenness on a woman by entering into her presence during the daytime of the forty day period after her giving birth, carrying jewels, fresh meat, or the first fruits of the season" (Hinds & Badawi 1986).

Mushahra is a spell which afflicts girls and women by making them infertile or by affecting the milk supply of feeding mothers. It can also, by extension affect the young child of the afflicted woman. The word **Mushahra** is a conjugation of the word **Shahr** or month in Arabic. Literally **Mushahra** means monthing.

Girls and woman who are going through rites of passage which lead to life cycle transformations and which involve the letting of blood or milk are considered to be in a state of sacred vulnerability from the moment they experience these rites till the birth of the new moon which signals the end of their susceptibility. Life cycle transformation which thus jeopardize a woman's well-being are circumcision, de-flo ration and marriage, child birth, weaning, and miscarriage.

If during her period of vulnerability a woman or girl is entered upon by one who is also in jeopardy they may cause each other **Mushahra**. More likely, however, the female in confinement suffers and not the one who did the entering.

Blood and death can cause **Mushahra**, so can the extension and some symbolic representations of both. Black aubergines brought into a room where a vulnerable girl or woman are can cause **Mushahra**. Ismael writing in 1894 says that Indigo dye was believed to have the same affect. Both aubergines and indigo are black and are considered to be

symbolic representations of death. Moreover, aubergines are in some contexts considered symbolic representations of the placenta (Boddy 1989: 104-5). Raw meat bears similar potency. The fresh blood that meat contains is deemed to be the active ingredient. Visitors coming straight from the cemetery can afflict a woman. This is death by proxy that brings about the spell. Likewise, people coming from the market where fresh blood flows from weekly slaughters are dangerous for the same reason.

The elaborations on **Mushahra** inducing agents are infinite and most definitely prescribed by the local environment of women. Where Inhorn writing about Alexandrian women says cats who have delivered or who have lost their young (in-voluntary weaning) can effect **Mushahra**, in Upper Egypt dogs and donkeys are thought to possess the same capability. There are no cats in the village where I did my fieldwork (Inhorn 1994).

Mushahra-inducing persons and objects and their surrogates or substances are the self same substances and agents which can revoke the spell. **Mushahra** is deflected by a repeat interaction with **Mushahra**-inducing substances and objects or by substance sharing with a similarly afflicted woman. Instead of continuing with this generic account I shall use excerpts from my field notes to carry on with this account. But first I should say a few words about my fieldwork site.

During the course of my fieldwork I could not avoid **Mushahra**. Fertility per se was not a topic that I brought up but my own fertility was subject for much concern and seemed to impose itself due to the popular demand of my informants. To cut a long story short, I was considered to be perhaps afflicted with **Mushahra** and as such became privy to the experiences of others who had themselves somehow caused, cured or suffered from the spell. Following are a few summary excerpts from these conversations.

Fayza: She is a girl in her late teens or very early twenties. She is the eldest of 8 siblings.

Our neighbours daughter and I were circumcised together. We both wore Mashahir (5 or 7 palm reeds knotted together) and we became fine. Then she got married years ago and she waited for a child. She waited and waited but she could not get one. She saw a doctor but did not have the tests. My mother told her that she may be Mushohra (afflicted with **Mushahra**) since the time we were both circumcised. So I went over to her house and I peed on her pee and she took a bit of cloth and dipped it in the puddle and she wore it and a year later she had a boy.

Aziza: A woman in her late twenties and the mother of 5 children

I thought that I would not get pregnant. When I was weaning Atef I asked my niece Ola to enter the room. She was just circumcised and still wearing her Mashahir. I know that it could have harmed Atef but I was careful and did not let her get close to him. But now I am carrying again. I think maybe the **Mushahra** was undone by a parted Donkey or by one of the dogs. The dog of our neighbours in the fields had a litter and they kept one apart from the mother so that they could use it to undo their own daughters **Mushahra**. Maybe it is this bitch which crossed my path. Who knows it could be many things. Before when I had it and wanted children my aunt made me a **Kabsa** from the market (a mixture of vegetable peel, grains, and food stuffs mixed with the blood of a newly slaughtered animal and tied up in a piece of cloth) She told me to wear it but it was too big so I slept on it then on the first Friday of the new month I bathed in its water and I was cured.

Abu Hussein: A man in his early forties and the father of 12 children all from his third wife. He had no children from his first two marriages.

These women are so embarrassing. A son of a neighbour got shot in a feud. There he was lying bleeding and dying at the edge of the fields. The person who did it was running, some women were screaming, and what does my wife do? While running out screaming as if to accommodate the feelings of the dead man's family she hurries out to cross the corpse. Our women believe that this helps them carry (children). Don't you think that is an embarrassment. Everyone one knew what she was doing and there she was pretending to be crying when all she could think about was herself. Well, after that I gave her a good beating. Then after a while I went out to the desert to get her a local lizard that is so quick and difficult to catch but we know how to hunt for it. This lizard looks exactly

like a scared man. When you get it and slaughter it looks like a human corpse then women can cross it and it has the same effect.

Hosn: A woman in her early thirties and the mother of five discusses **Mushahra** with her mother as they wait in a private physicians waiting room.

"The railroads are best, imagine how many people have died on the tracks" said the daughter. She herself had suffered from Mushahra. She had cracked it by going to the hassinya (the place in the mosque where dead people are washed and prepared for burial) and had gone round the stone slab three times during the Friday prayers and then she was cured. "No " said the mother, "there is nothing like the milk of a bitch parted from her little ones. I was **Mushahra** many times and I used to make a doll with some of this milk and some flour and then step over it and then dissolve it in water and bathe with it on a Friday during prayer."

The above quotes exemplify a fraction of the ways by which one can enact or resolve **Mushahra**. They also relay an important aspect of this spell; that is its pervasiveness. I do not know of one woman in the village who did not voice an experience or opinion about the issue. More often than not the topic would be brought up in the following way. I would be visiting a woman I did not know in the company of another who was close, usually the wife of my host. I would be asked if I had children and when a sad no came usually from my companion, the immediate very empathetic response would be "walk her through the aubergines or is she using something?" the something being contraception. In this way the topic would be brought up and following would come the optimistic promises of all kinds of cures.

In this way, I also began to notice and realize the unsaid features of the spell. Palm reeds and Henna are characteristic of circumcisions and of weddings. Both are powerful prophylactics. Recently circumcised girls as mentioned wear palm reeds to protect them and to protect those whom they meet during their period of vulnerability. At any circumcision one can notice all the well wishers wearing Henna on their hands. As do the close family and

friends at weddings. Henna is perhaps a proxy for blood. A groom wears henna so that he cannot harm his bride and a bride wears henna so that she does not harm the groom. This blood look-alike creates a false **Mushahra** which deflects the effect of real blood.

Through interaction with some women who are trying to conceive I learnt that some aspects of **Mushahra** are professionalised. Women seek the professional help of a local healer to help them resolve the **Mushahra**. These are people who possess El-Mashhir. The word Mashahir implies the beings who cause the spell. It also implies the tools used by professionals to resolve it. These tools vary but always include a sea shell, a necklace with various coloured not precious or semi-precious stone and a human figurine that is pharaonic in style. These figurines are described as **Masakhit** or those who have been struck down. They are believed to be representations of the ancient Egyptians who were struck down by God because they were non-believers. Indeed one of the most potent of **Mushahra** breaking objects is the grave, corpse or skeleton of a non-believer.

One healer with whom I very often visited used an old metal ashtray that had a pharaonic figure as a stand. The beads, shell, and figurines are stepped upon, passed around the body (down the neckline, over the chest and out from underneath one's clothes), and they are dipped in water which is then drunk by the afflicted.

Mushahra explains much of the oft noted confinement of new brides and mothers. It also establishes days for weddings and when it is safe for a mother to wean. Those planning to abort keep **Mushahra** in mind. For example Farhana is a woman in her early Forties. Her 17 year old son died suddenly. She was heartbroken by her loss. She was also pregnant. As a sign of grief she decided to abort the baby. As this was under discussion as we sat paying condolences her cousin noted that it was the beginning of the month "What am I a young girl what do I care if I never

give birth again is there anything more to lose than the one that I have already lost". A couple of days later she buried her foetus in the wall of the house as is the practise. Some month later she offered it to a woman who was seeking pregnancy. Aborted Foetuses are another cure for the spell.

Out in the desert there is another object of great potency. It is an ancient structure which is now piled over with sand and resembles a small hill. It is built by El-Masakhit and believed to have their powers. Rolling down the side of it is thought to be a sure cure.

Mushahra is a familiar concept all over rural Egypt amongst both Copts and Muslims. Amongst well-to-do Cairenes, very few have been able to abandon Henna for brides and grooms despite a highly cosmopolitan self-image. The use of henna is similar to candles on birthday cakes and decorations on Christmas trees; vague in meaning but no one would dream of foregoing the ritual. In Cairo new mothers are strongly advised to wear their diamond jewellery to deflect **Mushahra**. Amongst Palestinians, Jordanians, Sudanese, and Moroccan educated women, the word **Mushahra** strikes a distant and familiar bell.

While the above are personal observations the literature on women and fertility in the Middle East concurs with these impressions. Under the heading of Fertility Rites, Blackman describes how peasant women in the province of Assiut cure their infertility and how they space their off-spring (Blackman 1927:97-108). Many of the rites that Blackman describes are still practised today in the villages of Assiut. It is surprising to read the descriptions that Blackman gives of practices which involve the use of pharaonic like amulets of cats, and figurines, skulls and deeply buried bones, and ritualised acts to counter barrenness including lying on the railway tracks. By and large and with infinite variations, these rites are still practised. However, **Mushahra** beliefs provide a meaning-endowing framework within which these prophylactic

and curative practices take place. This framework is missing from Blackman's work. But so is it from other ethnographies about Egypt and elsewhere where the visible practices are described but are not accounted for or explained.

In 1892 Abdel al-Rahman Ismail effendi included **Mushahra** beliefs in his catalogue of folk medical traditions called Tibb el-Rikka (the Medicine of Old Women) (Inhorn 1994). He describes **Mushahra** as a collection of gems/stones strung together along with human forms of silver and gold. These human forms are known as **Masakhit**; the term by which struck down infidels are known. The woman who owns these/this object has the power to cure barrenness and eye disease (Ismail 1892: 13-6). In another section of the book he describes barrenness (**Mushahra**) by indigo caused by a new mother being visited by another wearing a dress dyed with indigo (Ibid: 46). **Mushahra** by aubergines is also included in his index of deplorable practices. Under barrenness he mentions the crossing over of a dead body as a famous old practice (Ibid: 42).

Partial record of **Mushahra** can be found in the work of some anthropologists working in Egypt, (most notably those of Ammar 1966, Abu-Lughod 1993, el-Mehairy 1984, Harrison et al 1993, Morsy 1981b). In these texts the writers refer to the practices that infertile women resort to and to the taboos that women fearful for their well-being must uphold. One finds passing references to the auspiciousness of visitors coming from the graveyard and to the potent effects of railway tracks and red meat. At even less specific level one finds references to bridal and post-partum confinement in any text on the daily life of women in the region.

Kennedy who has written about **Mushahra** amongst the Nubians of the south of Egypt (1978) is one of the first scholars to attempt to make theoretical sense of the spell and to transcend simple description. In an article titled "**Mushahra**: A Nubian Concept of Supernatural Danger and the

Theory of Taboo" (1978) He puzzles at the diverse observances which come under the practice of **Mushahra**. He interprets the spell in terms of the prophylaxis from malevolent water and death spirits who threaten fertility during periods of sacred vulnerability. He stresses the observance of Taboos to please or neutralize spirits as the meaning endowing framework by which **Mushahra** is to be interpreted and intellectually represented (Kennedy 1978: 134, Inhorn 1994: 117).

Following similar reasoning, Boddy presents a more elaborate interpretation of **Mushahra** amongst North Sudanese rural women that also hinges around the concept of Spirit possession. Boddy mentions **Mushahra** as a kind of genital bleeding that is brought about by **Mushahra** afflicting substances and persons. She mentions gold jewellery as one such agent of the spell describing how one woman who was delivering but who had no gold on began to haemorrhage when her own daughter entered upon her while wearing a gold ring. She was cured when she was given the ring to wear. Placing these gold objects in water and looking at them can also cure an afflicted woman. This gold must be either Egyptian **Bondoqi** Gold (24-8 crt gold) or a Maria-Theresa coin (Boddy 1989:313-4).

In addition to the above noted substances Boddy includes Halaba (gypsies usually of fair skin) as **Mushahra** inducing regardless of their reproductive situation. They can afflict vulnerable women by their very presence. In Egypt Halaba are also feared and ostracized but they are not considered that dangerous.

Boddy explains **Mushahra** as a situation of violation of bodily integrity "Caused by visually mixing experiential domains and in turn, by spirits attracted to female genital blood" (Boddy 1989:106). Following the arguments of Mary Douglas on boundaries and the polluting potential of ambivalence, Boddy sees **Mushahra** as a process of violation and reconstitution of significant boundaries (Boddy 1989, Douglas 1966, Inhorn 1994).

Inhorn provides an elaborate, comprehensive and detailed account of what she calls the **Kabsa** complex. Her most significant contribution is that she shifts the focus from spirits to people. She posits the meaning of **Kabsa/Mushahra** in the polluting violation of Boundaries. Reiterating part of Boddy's argument, she makes the connection between rooms and wombs (Inhorn 1994: 122, Boddy 1989: 105). Both posit that when a woman's entrances are opened by the flow of circumcision blood, or defloration, or child-birth the substitute boundaries that are reconstituted for the protection of her inner well-being, that being her fertility are physical ones; they are walls that surround her. If these physical boundaries are transgressed while her own natural guards are temporarily in-operative, then the transgressors pollution reaches her. The only barrier for a woman who is vulnerable and defenceless are the physical, ritually re-constituted and socially maintained by the woman's community of protectors.

Only polluting transgression can thus violate a woman. Inhorn lists pollutants as pollution by blood, excreta, death, and pollution by wealth. The last is supposed to cover the effects that gold and jewellery are thought to have. In Alexandria she explains that women wear Gold coins with the image of George V on them and other human forms but this may be a representation of a different type of **Masakhit** or infidel (Inhorn 1994: 127-8).

By stressing pollution over violation Inhorn points to the sharing of **Kabsa** affliction and resolution amongst women. While women afflict each other they also need each others assistance in performing rituals of depolluting consubstantiality to effect a cure (Ibid: 132). She does mention rituals that preclude co-participants and which are performed with polluting substances or with a symbolic proxy. This is usually due to the inability of the afflicted women to find a willing co-participant. She then has to rely on an older officiant who advises her on how to perform the necessary rituals (Ibid: 144).

Inhorn's rich ritual analysis highlights the heterogeneous nature of the **Mushahra/Kabsa** complex. Women reproductively bound by the spell must overcome their binding by resort to numerous venues and cures which may involve peers or professionals.

APPENDIX 5
FAMILY PROFILES

FAMILY A

A family of nine children ranging from the age of 17 to 9 months. Their father is one of the few government employees in the village. He works as an agricultural overseer. He has a high school diploma and was in the army for several years. When he finished his army service he went to Iraq to work there. He then returned to the village where he is considered one of its most prominent inhabitants. He is married to his fathers brothers daughter who is uneducated and illiterate. They are a well-off family with an expanding land ownership. All the children have been educated but the girls are taken out of school once they finish primary school. The boys, on the other hand are encouraged to continue their education. Their eldest daughter is 16 years old. She has been at home for four years and is engaged to be married to her father's brother's son.

FAMILY B

They are a family of 4 boys and one girl. Their father is an illiterate peasant who worked in Saudi Arabia for several years. He is married to his father's brother's daughter. They are both cousins to the mother and father of family A. The boys range from the age of 13 years to 8 months. Their sister is the first born and is 14 years old. None of the children are in school and their parents do not regret their decision not to educate them. The family lives with the two younger and married brothers of the father.

FAMILY C

They are a family of two girls aged 6 years and 4 years who live with their mother in the father's extended household. The household includes the father's mother, two unmarried

sisters and little brother. The father has a primary school degree and works in Libya. Only their little uncle is educated, the rest of the family is illiterate. Their father and mother are second cousins. They are a middle class family by village standards. They have a small plot of land which the grandmother and unmarried aunts take care of. The mother has just had a third daughter.

FAMILY D

They are a family of 4 boys aged 13 years to 4 years. Their parents are landless peasants and none of the boys are educated. They all work as agricultural labourers, except for the youngest who is too small to work. Their parents are second cousins. They are very poor

FAMILY E

They are a family of two children. The girl has never been in school. Their parents are first cousins (FBD) but their mother is in very bad health and has had several miscarriages in the past couple of years. Their father is uneducated and works as a trader between the village and Cairo and is consequently very often absent from the village. The children spend most of their time in the home of their father's mother who lives next door. They are relatively well off.

FAMILY F

They are a family of two girls and three boys aged twelve to 3 months. Shadia has never been in school, neither has Arafat. Shadia works on her father's small plot of land but is also hired as an agricultural labourer by her relatives. Arafat is deaf due to measles. Their younger siblings are too young for school but their parents hope to educate them. Their parents are second cousins and both are illiterate. They live with their two unmarried uncles, one of whom is educated and works as a teacher in Yemen. They are a middle class family by village standards.

FAMILY G

They are a relatively well off family of one boy and one girl. The girl is not in school. The father works in Saudi Arabia as an agricultural labourer and has finished his primary school education. He wants to educate his daughter but her mother wants her to help around the house. They live with the father's mother and two unmarried younger brothers who take care of the family's jointly owned land. The father and mother are un-related but their families have been neighbours and that is how they got married.

FAMILY H

They are a relatively well-off family of two boys and two girls. Their mother and the mother of family G are half-sisters (the mother of one is married to the father of the other) and were brought up together. The father and his three brothers are all agricultural labourers in Saudi Arabia. The children are all in school except for Hussein who is too young. They live with their father's mother who is the matriarch of the house and who takes care of their land through the help of cousins and hired hands. The father has a middle level diploma. The father and mother are distant cousins.

FAMILY I

They are a middle class family of one boy and three girls. None of the girls are in school. Their parents are un-related and uneducated but the father is literate. They have a small plot of land which the father takes care of. The mother and three daughters are at home.

FAMILY J

The family is a large one of 11 children. The oldest five are girls who are married and no longer live in the house. Then there are three boys who work in Cairo and who dropped out of school at various stages, then there is one boy in primary school, a girl in the house who has never been in

school and little Tam Tam. Their father is a peasant but only takes care of his small ploy of land relying on the income of his sons. Their mother is a lively woman from one of the oldest families in the village. The family is in mourning due to the death by electrocution of one of the boys working in Cairo.

FAMILY K

They are a family of one daughter and two sons, one of whom is a newborn baby. They live with the parents, two married brothers and two unmarried sisters of their father. The father and uncles all work in Saudi Arabia. They are all educated with middle level diplomas. Their mother is a Cairene with whom the father fell in love and brought to the village. They are a well-off family benefitting from the remittances of the father and uncles and the income from their large land with is owned by the grandfather.

FAMILY L

They are a poor family from the people still known as slaves. They are a family of four girls and one son. The girls are uneducated. Abdel-Al had a brother who recently died of a brain tumour. Their mother is a peasant, not from Arab stock. She comes from a nearby village. They own no land and rely on the money sent by the father who works in Jordan. The mother and sisters work on a small plot of land that they rent to raise fodder for their sheep. Both the mother and father are illiterate.

FAMILY M

Are a very poor family. The father is the eldest brother of the father in family K. He is mentally disturbed as a result of a war injury to his head. He is married to his second cousin who is uneducated. They only have Ola who is slightly mentally handicapped and has a paralysed hand. They rely on the agricultural labour of the mother and the charity of the husband's family. Ola has never been in

school and has never been examined by a doctor or specialist.

APPENDIX 6
IMMUNIZATION SURVEY

House 1. The father is a peasant and has one wife. His mother lives with them and is a strong influence, she is the dominant female figure in the house. There are six children, all under the age of 11 years. They include two small boys and four girls who are older. None have birth certificates, none have ever had any immunizations ,and of the four who are at school age, none are in school.

House 2 The family have recently moved out of the extended family household to build their own house in the fields. The father is a peasant and he and his wife have two young boys of 4 years and 2 years who have birth certificates. Both have received the three DPT/Polio vaccinations. The older one received neither BCG or Measles. The young one received a Measles injection. The young was given the extra vaccination because he is very often sick and the mother believes it is **min taht nifs** (Ill wishes of another person). His older brother was well guarded out of sight in the fields but the young one was born in the village and seen by neighbours and strangers.

House 3 The father works as a guard and has some land. His wife bore eleven children of whom two died. One died of polio and the second from fever. They have two older daughter who are married. The remaining seven are between the age of 15 years and seven months. The four boys have certificates and the ones at school age are in school. They have received some vaccinations but they are not written in their certificates because the mother vaccinated them when the caravans came by and did not have the certificate at hand. She does not give them the 40 day one (the BCG) but gives them the others. Her baby daughter has a certificate and has received the three DPT/Polio vaccinations. The rest

of the girls do not have certificates. The baby girl was written up with her brother who is nearly three.

House 4 father is a peasant and a guard. He and his wife have one married daughter and two married sons. The sons live with them and they take care of the land. None of them have certificate. One son has a daughter in 3rd primary who has a certificate but who was given no vaccinations. They paid a 14LE fine once but have not had to pay again. They did not want to vaccinate her. He also has a son in 1st primary and a toddler (boy) who is 2 years old. The boys have certificates but have received only one vaccination each according to their certificates. The mother said that she just did not get round to it and that one was enough. However it seems that both have taken at least two if not the three DPT/Polio injections.

House 5 A single mother lives here with her four daughters. She is pregnant. Her husband married another woman and she did not get along with her so she asked to be moved out. As he still looks on her favourably he agreed. She has a small shop in her front room where she sells matches, sweets, salt..etc. Her daughters are 12 years, 8 years, 6 years and two years. She lost a baby boy 46 days old and his older brother, her first born when he was 6 years old. Her two older daughter are "written together" despite a four year difference. Both have dropped out of school. She has one in 1st primary and a two year old. The youngest does not have a certificate and she intends to "write her" with the coming baby. The older girls have not taken any vaccinations and the youngest have received "some". It was difficult to ascertain which since the certificates of the older ones were kept by the school. She has paid one fine per girl to the school but none for missing vaccinations.

House 6 Is inhabited by a peasant labourer who works for wages and owns no land but does rent a small plot to grow

fodder for his two water buffaloes. He and his wife have two boys age 13 years and 11 years, a girl who is mentally disabled and they had another one who died of polio[1]. None of the children have certificates and none go to school. The two boys work as agricultural labourers during harvest.

House 7 is an extended household in which the mother is the political authority of the household. This matriarch has 3 sons and a divorced daughter who all live in the house with her. Her daughter has a 5 year old son. Her eldest son has four sons age between 11 years and 2 years, her next son has a daughter who is 3 years old and her 3rd son has just got married. All the children have birth certificates. However her daughter and daughters in law said that they immunize only when the caravans come round. "When they come and the child is too old or too young for the vaccine or is sick we don't give it and they don't see the certificates or fine us" said the matriarch. The certificates of the children were denied so there is no way to ascertain the coverage of each child. All of the young mothers said that they had immunized against polio and had given the children BCG vaccines but when they were older than 40 days.

House 8 is the home of a mother who lives alone as her husband is in Saudi Arabia. She has two sons and three girls. Her eldest is a son in 2nd primary (age 8 years) and the rest are not yet in school. They are all registered. She says that she does not believe in immunization yet has taken her two sons for all of their injections at the clinic and has taken the girls for their DPT and polio injections. "You get what you can from the government!" she explained. She regrets that her daughters have birth certificates because she wants them to take only a few years of schooling before keeping them at home and does not want to pay a lot of money in fines to the authorities.

---

[1]. The deceased girl is mentioned above, and her father is quoted.

House 9 This is the home of another lone mother whose husband has been in Saudi Arabia for many years. She has one daughter and 4 boys age 13 years to 2 years. They all have birth certificates and most have been vaccinated at least once, depending on how they felt when the caravans came by and wether she could take them to the clinic or not. She has not given any of them a 40 day shot "They take it when their older" she said. She also has only given measles vaccination to her youngest son. Two of her sons are registered as twins but there is a 3 year difference between them.

House 10 Is that of another woman whose husband works in Saudi Arabia. She has 6 sons and one daughter. Her daughter is not registered neither are her two youngest sons who are toddlers. She doe intend to register them together. She has vaccinated the young ones when the caravans come by even though they do not have certificates. She says that when the older ones were little there was no vaccination. Her children range between the age of 15 years to 2 years.

APPENDIX 7
BIOMEDICINE IN EGYPT

1. The Old Tradition of Modern Medicine

Mohamed Ali Pasha was the ruler of Egypt (1808-1849) and the founder of a dynasty which was to rule Egypt until 1952. As a part of his plans for the military expansion of his would-be empire he introduced modern technology, education, and institutions, primarily to create a strong army and consolidate his power in Egypt. One of his innovations was the introduction of modern biomedicine as imported from Europe into Egypt and in the guise of a teaching institution at Abu Ze'bel. The school was later moved to Qasr el-Aini in Cairo in 1837 where it remains to this day (Kuhnke 1989, Sonbol 1991). In 1825 he set up the **Majlis el-Siha** (Health committee) and the **Idarit el-Khadamat el-Tibya** (health services administration) to safeguard his army and navy from disease epidemics and debilitating health problems (Salaam et al 1995: 15). These councils were staffed by foreigners.

Under the directorship of Clot bey, a French Physician employed in Mohamed Aly Pasha's army, the medical school of Egypt was organized in accordance to the principles of medical practice in Paris at the beginning of the nineteenth century (Sonbol 1991: 38). Since the 9th century, Egypt has had a long tradition of medicine commented on by travellers (Sonbol 1991: 1). The land was famous for the institution of the **maristan** (hospital) where the sick were tended (Sonbol 1991: 4-8)[1]. The decline and deterioration of medical and other institutions in the 16th to the 18th century were addressed by the reforms of Mohamed Ali at the turn of the nineteenth century. These

---

[1]. Such hospitals were known in Egypt since the ninth century (Sonbol 1991: 4).

reforms however were inspired by European, particularly French models. So despite the long and old medical tradition of Egypt which had been inspirational to what later became modern biomedicine, the medicine that Mohamed Ali brought to Egypt in the guise of hospitals and medical teaching and other institutions was European (Kuhnke 1989, Sonbol 1991).

In 1857 the **medrassit el hakimat** (the school of midwifery) which is the first teaching institution for women in the Middle East was established (Kuhnke 1974, 1989, Sonbol 1991). The graduates of the school provided public health and primary health care services for rural Egyptians. The school was created in recognition of the dire needs of the rural poor and of the importance of public health awareness and services (Kuhnke 1989).

These first students took midwifery and medicine courses in medical college. They were then distributed through the different provinces to treat women to whom male physicians had no access. They kept a register of the medication which they prescribed and which they distributed for free (see Kluzinger 1978: 81). These female graduates were employed in state run clinics and hospitals and were under the supervision of male physicians (Kuhnke 1989). They worked in the heart of Upper Egypt, amongst other places, providing care for women and children, vaccinations and Malaria medication, as well as overseeing sanitation and fumigation services in villages. Later the school closed in 1880 but these women had made an impact as the first agents of state orchestrated public health campaigns. Since then, the principles of state sponsored health services which contribute to state priorities of public health has continued to thrive all over Egypt (Gallagher 1990, Kuhnke 1974, 1989).

This link between state needs and health services was concretised by the establishment of the **Majlis el-Tibb el Khosousy** (Medical Privy Council) in 1857 which coordinated all health units and services in Egypt, save for those of the

quarantine. This council became the **Idarat Sihiya** (Health Administration) which was part of the ministry of Interior during the same year. Finally in 1937 and by Royal decree the **Idarat Sihiya** became the **Wizarat el-Siha** (the Ministry of Health MOH) (Salaam et al 1995: 17).

The relationship between medicine, particularly public health, and national politics has been investigated by medical historians working on Egyptian modern history (Gallagher 1990, Kuhnke 1989, Sonbol 1991). These works have focused on the political nature of public health campaigns, services and institutions but have payed less attention to the contribution of his long history of biomedical practise to the medical culture of Egyptians. On the other hand, anthropologists, travellers, and historians who have been writing about Egyptians, particularly Upper Egyptian peasants, have tended to focus on the practise of non-biomedical rituals and therapies and have disregarded the impact of these medical modernizers and the efforts of the state which controls their activities (see Ammar 1954, Ayrout 1963, Balckman 1927, Kluzinger 1869, Lane 1960).

Kluzinger who was sanitary physician at el-Kosair on the Red Sea from 1863 to 1864 tells of how Egypt was far ahead of Europe in its provision of free medical services and even medication in the provinces. But Kluzinger also notes that "...the peasant flies with horror from the offered hand and throws himself into the arms of the amulet writers, dealers in charms, soothsayers, saints, fumigators, spice mongers, and stroking women. " (Kluzinger 1878: 82). For despite the good quality of the services provided by the mid-wives and the public health authorities and physicians, peasants and the urban poor still seemed to place their faith in other non-biomedical therapeutic traditions.

This perceived preference does not undermine the claim that modern biomedicine has become an authentic part of Egyptian medical history and culture. Modern Biomedicine and

its practitioners have long been projected and accepted as saviours and heroes. When Taha Husayn in his biography, An Egyptian Childhood describes the death of his sister he has no doubts that if a doctor had been resent back then in the Upper Egypt of the early 1900's, she would have survived her sickness and lived (Husayn 1990). This assumption that biomedical knowledge can only be good and do good is shared by the Egyptian modernizers, by the foreign explorers and writers, and by the activists who have demanded better services for the peasants and the poor (Ammar 1954, Alport 1946 (in Gallagher), Blackmen 1927, Halim 1944, , Husayn 1990 & 1958 (al Mu'adhdhabun fi al-Ard) Hussein, a. 1951, Mahfouz 1935 & 1956, al-Raf'i 1951).

This positive attitude towards Biomedicine and and its practitioners is reinforced by the prestige attached to medical education and the uniquely high grades that entrance to medical schools requires[2]. There are now 14 medical schools in Egypt including one in Assiut opened in 1957 and incorporated in Assiut University in 1960. These schools have produced 100, 00's of graduates who work in almost all the towns, cities, and villages of Egypt (Saharty 1996: 30). Hence the availability of biomedical services, whether free, government or privately subsidized, private, or over-priced, is universal in Egypt.

The Structures and Present Condition of Medical Care

> (N)owhere are the notions of tactility and distraction more obviously important than in the need to critique ..... a dominant critical practice which could be called the 'allegorizing' mode of reading into events and artifacts, cockfights and carnivals, advertisements and film, private and public spaces, in which the surface

---

[2]. This bias towards medical education was complemented by an urban bias which made Cairo school of medicine accessible only to the very highest grades attainable. This situation was rectified by the introduction of geographical distribution of medical school applications.

> phenomenon, as in allegory, stands as a cipher for uncovering horizon after horizon of otherwise obscure systems of meanings.
> (Taussig 1992:12)

It is important to understand national medical structures, services, policies and debates so as to avoid uninformed symbolic interpretation. That is interpretation that not only misconstrues intended and other meanings, but also which distorts the proportionality of meanings. Taussig writes of the tactile eye as shorthand for collective distracted readings of symbols (Taussig 1992: 13). The concept is essential to the process of cultural interpretation which has indeed become burdened with the weight of profundity and the location of so many contemplative individuals (Ibid). The ethnography of Biomedicine in Rihan may be prone to such misreading if not situated in the context of national structures and policies of biomedical care. To grasp not only the meaning , but also the scope of this meaning of events, utterances, exchanges, and of action included in this discussion of Biomedicine, it is important to digress from ethnography and into this macro-level contextualization. The following section will therefore present an account of the structures of public health services, statistics on quality of care and national expenditure of health and an 'opinionated' reading of policy concerning health services for rural Egyptians.

2. Health For Poor Rural Egyptians: The Official Story

The extension of services to the Fellah remains as one of the most cherished achievements of the 1952 revolution and the Socialist regime that it brought into power. However, the issue of health services for rural Egyptians had been a pet cause of liberals and modernizers and had been a priority for the government before the revolution. In 1943 the Law for the Improvement of Rural Health came into effect and decreed the

establishment of a health unit for every 150,000 of the rural population.

But it was under the auspices of the 1952 revolution that the proliferation of health units and facilities became a reality in villages all over Egypt. The revolution extended the existing network of rural clinics which came to be operated by the ministry of health. Villagers were assured the right to free medical care and medication. Those who needed it were referred to government owned hospitals. Currently there are about 3000 rural clinics and polyclinics. Each serves approximately 11, 300 people (Al-Ahram 18/5/96). According to the Ministry of Health, the population per primary Health Care unit in rural Assiut is 11,742 (Ministry of Health; population estimates from CAPMAS Statistical Yearbook, 1988:38 in UNICEF 1989:69).

Aside from the ministry of health there are several other institutions which offer health care services but practically none of them do so to rural dwellers[1]. The complexities of the structures of health care provision in Egypt were confined to urban areas and to those who were in the employment of the government and public sector. For villagers, the MOH has been the sole supplier of free or subsidized health services[3].

Rural health clinics service 'mother villages' all over Egypt. Satellite villages rely on the services in the nearest mother village. These clinics vary in size and in the services that they provide. Some have the capacity to keep patients over night and/or have dentistry services. This type of larger clinic is called **Magmou'a Sihiya Rifeya** (Rural Health Group). But more common is the **Wihdah Rifeya** (health unit) which is a more limited outpatient clinic, dispensary, and a register to

---

[3]. International NGO's such as UNICEF work through the structures of the MOH. These NGO's and the programmes that they sponsor serve rural dwellers primarily. IN the recent past charitable, Islamic organizations have extended their services to many villages and rural towns.

keep relevant health statistics. In the past decade many rural health polyclinics have been transformed into rural hospitals by the addition of a limited general surgery facility, clinical pathology laboratory and an X-ray service. Rihan does not have access to such a hospital yet (Saharty 1996: 28).

The consultation fee in rural clinics and hospitals was a symbolic 25 piasters. This sum saw a 250% increase in 1992 when it was raised to 60 piasters. This fee is still affordable to most middle class peasants who still see government health care as a prized political gain which they are entitled to keep. Poor peasants are beginning to feel that even these government services are becoming too dear. More so since the price of medication has increased astronomically in the past decade. Where as in their hey day, medications were dispensed for free, now patients have to pay for them. This situation has been augmented by rapid inflation in the price of drugs most of which have showed a 200% increase in the past 3 years.

Since their inception, one of the often mentioned shortcomings of these rural clinics has been the disaffection of physicians who are assigned by the government to run them. Ammar writing about his own village in Upper Egypt reported that the health centre there, opened since 1936, was not functioning because the physician who was supposed to work there could not withstand village life (Ammar 1954: 79). The demoralisation of physicians due to disdain for poor people, poor pay, poor prospects, and poor training has become somewhat of a tradition in popular descriptions of Egyptian villages and their clinics[2].

To provide an incentive to physicians, government clinics in practise are often operated on a semi-public basis. Physicians are allowed to use them as premises for their private practices when they are not being used as public clinics. This is a common practise accepted by medical

authorities although it is hard to find a legal decree or administrative order allowing it.

From 8.30am to 10.30-11.30 am the patient pays 60 piaster for a ticket and is seen by the doctor. After that time, the doctor charges 3.00 LE and treats it as a private consultation. The difference between the two types of consultations is significant. For 60 piaster the consultation does not involve the use of a stethoscope. For 3.00 LE the stethoscope is used. In both cases, the patient buys the medications prescribed except for Sulpha tablets, aspirins, Oral Rehydration Salt, and contraceptive pills; although even these are often unavailable. Government dispensaries are rarely adequately stocked, in fact they are rarely stocked at all. Gauze and cotton for dressing wounds have been known to run out quite frequently. This license to operate publicly owned clinics on a private basis is difficult to locate at the official level. However in Rihan, Hammam, several other villages in Assiut and in other parts of Upper Egypt [4] the distinction between **kashf bisma'a** (examination with stethoscope) and **kashf magany** (free examination) is a fact of life.

Private health services have proliferated into even the most remote regions of Egypt[5]. Private medical care is a lucrative business venture for many physicians and has become a necessary alternative for most Egyptians. As with many other services, the bias is for urban rather than rural Egypt. The majority of clinics and private so called "Investment"

---

[4]. These are villages where I have undertaken fieldwork on health related issues.

[5]. The importance of privately operated medical services seems to only escape the Egyptian official authorities. Recently and in recognition of deteriorating health services, the government established a Medical Council to coordinate health services at the national level. This council however has no representatives from the private sector.

hospitals are in Cairo and Alexandria. The term "investment" hospital refers to a new brand of expensive hospitals that have come to be viewed as lucrative investment ventures [5].

Most Rural Towns also have General Hospitals to which patients are referred[6] . These hospitals have outpatient clinics with no rules that regulate access. These hospital outpatient clinics are more expensive than Rural clinics because the doctor one pays to see is a specialist in his field. The fee at Abnube General hospital is 1 LE. These hospitals include departments of surgery, paediatrics, gynaecology obstetrics, and internal medicine.

Other services offered and operated by the Ministry of Health are Ambulance units, Family Planning Units, and Mother and Child Health centres. In cities people also have access to University medical school teaching hospitals. The one in Assiut is one of the most highly regarded of such teaching hospitals and is nicknamed **El-Qasr**, in reference to the famous **Qasr el-Ainy** teaching hospital in Cairo. In Assiut there is also a Hospital for Endemic and Contagious Diseases and other specialized government operated hospitals[7].

Of relevance to an understanding of the 'Official' story of health in Egypt is the appreciation of the extent of urban bias that exists when it comes to health and health care.

According to the 1986 census 44% of Egyptians lived in Urban centres, but this does not justify why rural areas remain underprivileged and why rural Upper Egypt, in particular, is so badly served. According to the "number of beds" indicator, an indicator favoured by the ministry of

---

6. To qualify as a general hospital they have to have more than 16 patient beds (Saharty 1996: 7).

7. I have only mentioned the public medical services which exist within reach of Rihan. Cairo and other urban centres benefit from many other types of services such as Military hospitals, Health Insurance run hospitals and any other public and semi-public hospitals and clinics.

Health, Cairo has 27% of total number of beds, the delta (rural lower Egypt) has 36%, and the whole of Upper Egypt has only 27% of total number of beds (Salam et al 1995: 21). This bias in services has reflected on the vital statistics of the rural population of upper Egypt.

Perhaps the most obvious case of bias in medical services is that of the national health insurance scheme called **el-Ta'min el-Sihy** (the Health Insurance). This programme was initiated by presidential decree in 1964 to cover health care for government employees and those employed in local administration and in the public sector. This also extended to all state workers and was later opened to the participation of the private sector. Specifically excluded were those working in agriculture, domestic labour, and the self-employed. Pensioners and widowers of eligible workers were also covered.

The scheme is funded through the a 1.5% of monthly income of individual payed by the work place and another 0.5% is deducted from beneficiaries'salary. In addition, beneficiaries pay a symbolic fee to medical personnel and a third of the cost of medication. In 1975 these fees were increased and the instalments payed by work place rose to 3% of beneficiaries' salary and that payed by employee to 1% of salary (Salam 1995: 53-5, Saharty 1996: 55-60).

This scheme provides good quality care and choice. Beneficiaries are free to go to any participating physicians and hospital. Despite the poor fees many physicians favour participation because it gives them access to patients and the potential for establishing a name for themselves. In 1992 the scheme was extended to cover all school children. Their cover is financed by a 4 LE/student/year payed by the government and 12 LE/student/year payed as part of school fees (Ibid). In this way and for the first time rural agricultural workers and farmers gained access for their children to **el-Ta'min el-Sihy** (the health Insurance).

With the addition of the universe of school children,

this insurance scheme now covers 34% of the total population of which 24.9% are from the work force, 3.2% are pensioners and widowers, and 71.9% are school children (Ibid). This relatively limited coverage may soon change as discussion is currently under way to extended the scheme and make it a national one. This is thought to be a potential way of invigorating public health services in Egypt and providing better employment opportunities for physicians. It may also improve the quality of health care. However the current absence of coverage for peasants remains and so does its justification. This being that since they have access to government clinics, they do not need the luxury of choice offered by health insurance.

The realization that peasants do need choice, if only as a means of protest against limited care and its quality and that they are willing to finance their right to choose by going to private clinics is changing the state's views. It has recently come to light that 55% of total national health expenditure is out-of-pocket expenditure. It is the poor who, according to official figures, spend more than 10% of their income on health care, and who bear the brunt of most of this out-of-pocket expenditure (Bereman et al 1995: 4).

In the Egyptian Constitution of 1971, and as amended in March 1980, Item 16 reads as follows:

> The state undertakes to provide cultural, social, and health services, specially to the village with facility and so as to systematically upgrade it (author's translation).
> Salaam et al 1995: 12

The government of Egypt accepts the definition of desirable health services as postulated by the World Health Organization. Health services should be: Available, Accusable, Allowable, Acceptable, Equitable, Affordable, Continuous, Coordinated, and of good quality. The state and its authorities is meant to be striving towards this ideal (Ibid: 11-4).

There is a plan and a policy. But the government's new health project has not yet travelled to upper Egypt nor has it translated into improved quality of care. On the whole there is an extensive network of medical services but one which is by and large problematic. Statistics can tell many stories about the actual quality of care. They tell us that government expenditure on health has witnessed a decline since the 1930's. The percentage of public expenditure on health from annual public expenditure was 4.1% in 1936, became 5% in 1965, and fell to 1.9% for 1993/4. They tell us that life expectancy has been prolonged to 65 years, infant and under five mortality and morbidity sharply reduced and that diarrheal disease related mortality for the under 5 year old's has come down from 475/10,000 to 291/10,000, and that immunization coverage for children has increased under the effect of a successful national campaign (Salaam et al 1995: 18-20). But on the down side, statistics show that Infant mortality is still high at 45-53/1000 when compared to countries deemed to be developmentally similar to Egypt[8]. They also say that only 55% of all children under 5 years get any medical care of any kind (Ibid).

These cumulative figures however assess the official story but do not help us understand people's experiences and discourse with medical structures and services. The language of quantitative analysis is helpful in substantiating the intimations of bias which are notable of health services. Of significance is the in built in bias towards tertiary medical care and the significant disparities in investment and spending between urban and rural areas. As Dr. Hadidi, ex-minister of health explains:

> There are three lines of defence for the health of the Egyptian. The first line is the preliminary examination in clinics. The second is the general hospital. And the

---

[8]. Chile is a country to which Egypt compares itself.

third is the specialized hospitals. The first line deals with 85% of the population, the second with 12% of the population, and the third with 3% of the population (Saharty 1996: 72 authors own translation).

Yet despite this the main measure of performance for the Egyptian health authorities is that of "the hospital bed" (Ibid: 90). Moreover, the ministry of health devotes 22% of its annual expenditure on medical care to primary health care while hospitals and specialized health care consumes 61% of the said budget (Salam et al 1995: 21). It is also worth noting is the philosophy behind budget allocation in the MOH where 60.5% of the total budget of the ministry is spent on salaries and administration while only 25.5 % is spent on actual health care, medication, food, equipment...etc. The actual medical expenditure per person for the year 1993 was 4 LE/per person (Salam et al 1995: 21)[9].

The cost of medical care has come to form a substantial burden on most villagers in Upper Egypt. The difference in the quality of care and the notion that expensive is better has brought about a situation whereby patients feel that public service is no service. Nevertheless, many have no other option and they are the majority who still crowd the waiting rooms of government clinics. Few of those who do seek better ambulatory care in clinics can afford continuous private medical care (Bereman et al 1995: 4).

In general the quality of health care leaves much to be desired. As one report prepared for the government asserts:

> Along with poor quality, there is a common perception of waste and inefficiency in the government and public sector health services, especially in the Ministry of Health and the Health Insurance Organization. Some inputs such as physicians and hospitals, are provided in excess, while others may be lacking. Patients and families may be required to purchase essential inputs (e.g. drugs and

---

9. Percentage spent on health of total annual public expenditure is 1.9% only. In 1965 it was 5% of total annual public expenditure (Salam et al 1995: 21).

supplies. (Bereman et al 1995: 8).

But this crisis is a one that is injected with the dynamism of diversification and conflicting interests. The residents of Rihan and their children are not isolated from this vibrant discourse where private sector and public sector are battling over the little money that is in the pockets of farmers and civil servants alike.

It is therefore essential to recognize the history, depth, and breadth of this context in which health providers for the families in Rihan exist and work. Physicians and patients in Rihan are part of this national context. They are not isolated in an ethnographic bubble created by their words and deeds. They are part of a national discourse on health care and its problems and the specifics of their interactions and lives refer to national politics and economics as mwell as to local culture.

ENDNOTES

1. Public sector health care in Egypt is provided by
a- The ministry of Health
b- Public Authority for Hospitals and Education Institutes
c- Military Medical Services (reserved for military personnel and their families although some of their specialized hospitals accept civilian patients referred from hospitals).
d- University Hospitals managed by the Ministry for higher education
e- The Public Authority for Health Insurance
f- Hospitals Managed by other ministries for their own employees and their families (Ministry of Agriculture, Ministry of Interior, Ministry of transport)
g- Health Care institutions (These were hospitals which had been previously owned by charitable organizations and were confiscated by the government and are operated under this separate authority whereby they provide subsidized health acre for some public sector patients)
h- Other public sector authorities who may run clinics or hospitals.

2. This stereotype is common in novels, films, and in the press. IT is countered by the equally over generalized stereotype of the

dedicated politicized physician who is devoted to the village and villagers.

3. Total number of registered private clinics in Egypt is 12455. There are 450 private small hospitals and 265 hospitals (Saharty 1995: 30, 65, 90).

APPENDIX 8
CHARMS, WRITING, AND JINN

Spiritual healers were and still are at the forefront of medical practitioners who offer an alternative to biomedicine. These healers diagnose and cure through divination. Ideas about sickness and disease are still mixed with ritual and religious beliefs and the relationship between Man and spirit today as they have been for decades. This is the field of specialisation for healers (Ammar 1954: 78, Blackman 1927, Kluzinger 1878, Lane 1936).

This alternative medical tradition rests on two fundamental principles. The first concerns spiritual beings often called **jinn** (the word is sing and plural). The Egyptian belief in a parallel universe of spirits is distinct from other beliefs in spirit world common in Europe, Latin America and other parts of the world (see Finkler 1994). Jinn are not the spirits of dead people who once lived. They are beings who inhabit a parallel universe which is identical to the physical one we know. Jinn are male and female, Muslim and Coptic, young and old, good and bad, and are distinguished from human beings in that they are not made of flesh and blood. At one level, every human being is believed to have a twin who is a **jinn** born at the same time. The relationship between human and **jinn** can become tenuous due to jealousy and that is when a **jinn** lashes out at its human twin to harm him/her[1].

The **jinn** however are not always depicted as being twins to humans. There is consensus amongst those who believe in them that they do exist and the ultimate proof of that is that they are often mentioned in the Quran. **Jinn** are commonly believed to inhabit wells, deserted places, and high ground (Ammar 1954: 78). They are also thought to hang around fires and outside doorways and that this is why

---

[1]. This belief in a sister spirit or a **tabi'a** as the main reason for many neonatal death will be discussed in Chapter 7.

people must beg their pardon before putting out a fire or throwing water out of a doorway. Not pardoning oneself is considered an uncalled-for act of aggression which could start a feud in which the human being is always the loser unless a healer intercedes (Blackman 1927: 200-10).

Spirits of the human dead are called **arwah** (sin: **roh**) and do not really feature in rural magical, medical, or metaphysical beliefs. But the word **roh** meaning soul or life essence is very much part of Islamic and Egyptian religion and mythology respectively. The **roh** is that which passes away when the human body dies.

The second feature of Egyptian medical-magical traditions is the belief in written charms and in the power of writing and words. This belief precedes Islam since Ancient Egyptian religions relied on writing and hence the position of the scribe (Blackman 1927). But the magic of writing may have been strengthened by the miracle of the Quran and the centrality of the spoken, and later the written, word to the religion. Islam relies on the efficacy of the word not only as a vehicle of knowledge but as a powerful entity in itself. Hence the sanctity of the Quran and its untranslatability[2].

In most cases healers have mastered more than one healing specialization. They are also often versed in the heritage of **El-Tibb el-Nabawi** or old Arabic and Islamic medical practices. Arabic medicine relies on humoral principles in its construction of health and well-being. However the humoral medicine practised by healers confirms the personalistic over the naturalistic sources of disease and affliction. Many spiritual healers are herbalists inspired by humoral principles but they supplement the concoction with the recitation of spells. As was noted by Blackman, these healers stress that the efficacy of the cure comes from the spell and not the herbs themselves

---

[2]. The Quran is not translatable because it is a revealed miracle not a written text. Translations that exist are translations of "the meaning" of the Quran.

(Blackman 1927: 201).

Amulets and charms contain numbers intermingled with letters. These numbers are part of an astrologically related set of letters which have corresponding numerical values called the **Abged** [3]. The numbers and letters written in an amulet relate to this exercise in astrology. This form of healing also has a theory of astronomy. This theory depicts a structure of the skies which is divided into a hierarchy of heavens, each dominated by certain spirits. Their names are common in rituals of divination. The superlative spirit amongst these is said to smell the fumes of people burning incense and so he sends his servants to see who is supplicating him and why (Kluzinger 1878: 405). Therefore incense burning is a part of every healing ceremony performed by spiritual healers.

This science of magic/medicine relies on books one of which is called The Book of Adam as well as other books to undertake divination. These books contain recipes against sickness in general as well as ones for: "(H)eadache, restlessness, fever, stoppage of milk for both women and animals, against serpents, scorpions, bugs and other vermin, and for and against pregnancy (Kluzinger 1878: 385). This true magic is called **'ilm rawhany** or spiritual knowledge. It is distinct from the false science and harmful use of spells and drugs for deception and theft. True magic is divided into **'Elwy/Rahmany** (high and of God) and **sofli/shitany** (low and of the devil). The first is founded on the agency of God, the angels and the **jinn** and is practised mostly but not exclusively by men and for beneficial intercession, cure, and general good. The second is also true but uses the agency of the devil to perform

---

[3]. The **Abged** corresponds to the Hebrew Alphabet. It is a system which gives each letter a numerical value. It is used in divination by adding up the value of a person's first name with that of the person's mother and then deducting 1212. The remaining number determines the person's constellation. There are 12 constellations for men and 12 for women. The numbers and their meaning are similar to those of the Jewish Cabala (Kluzinger 1869: 406).

sihr (magic) to cause harm or cast spells and is practised by both men and women (Lane 1936: 341-3).

Lane, writing between 1822-35, notes that: "One of the most remarkable traits in modern Egyptian superstition is the belief in written charms. The composition of most of these amulets is founded upon magic...(T)hey are esteemed preservatives against disease, enchantment, the evil eye, and a variety of other evils" (Lane 1936: 318-9). But Lane also comments on the use of the **mos'haf** which is the text of the Quran often worn as an amulet[4]. Kluzinger (1869) also mentions the use of the verse of **al-kursi** (the chair) which is written out, folded and worn. The belief in the efficacy of this particular verse is universal amongst Muslim and it is widely available in gold and silver in all sizes to be bought by women as jewellery, each according to her means. It is also available as a key ring, side table ornament and wall hanging. This very common use of the **mos'haf** and the verse of **al-kursi** is indicative of the belief in the written word and its efficacy as protection and cure In rural Egypt this belief is associated but not limited to the text of the Quran[5].

There are many specializations within the domain of folk and spiritual healers. There are practitioners of geomancy, astrology, and specialists in Zar. Significantly all of these healers are not confined to curing cases of ill-health. They also 'cure' bad luck, bad marriages, family problems and other serious conditions.

Perhaps because of the prevalence of Zar cults in parts of Africa and in many Arab countries, Zar and its officiants and subjects have warranted such anthropological attention (Boddy 1989, Lewis 1989; Lewis et al 1991 ; Morsy

---

[4]. The **Mos'haf** is that which contains the collected Quran. Women may wear a Gold **mos'haf** meaning a gold case which could contain the written text inside or may just be worn empty as a symbol of the power of the Quran.

[5]. For an account of the origin of written charms and their place in the science of spiritual healing see appendix 8.

1991, Nelson 1978). But Zar rests on the same principles as do other spiritual healing rituals. Less elaborate and costly rituals such as the use of **el-riha** (the smell) to be explained later is much more common than Zar amongst the rural poor in and around **Rihan**. Zar officiants are rare to come by in this area and ceremonies have become a thing of the past due to their costs and their overtly syncretic nature which has made them the target of the counter propaganda and mobilization of Islamic and Coptic religious radicalism.

The relationship between Islam and spiritual healing rituals is a complex one[6]. Islam recognizes the contiguity between the human and spiritual world. Indeed there is a verse in the Quran called the verse of **el-jinn** in which the conversion of some of these beings to Islam is recounted and the heresy of others is admonished. In another verse the evils of **el-jinn** are discussed (verse of **El-Nas**) but this verse precedes the one in which **jinn** converted possibly meaning that **jinn** were abhorred till they converted to Islam (Abu Zeid 1994: 35-6).

Belief in **jinn** and sister/brother spirits was not only a feature of ancient Egyptian religion. They were also held in esteem by the Arabs of the **Jahiliya** (pre-Islam). Poetry, the most elevated of **jahiliya** intellectual activity was closely tied to a belief in **jinn** and the poetic muse was thought to be the brother spirit of the poet (Abu Zeid 1994: 34).

Islam also honours the 'word'. The words spoken by the angel Gabriel to the Prophet Mohamed were later collated and written to become the Quran. According to Abu-Zeid, the interaction between the Prophet and Gabriel was rationalized by the Arabs of Mecca as an instance of interaction with **jinn**. In this way the miracle was accepted and understood by the tribes of Mecca (Abu-Zeid 1994: 30-

---

[6]. Egypt does have a Christian/Coptic population but Rihan is populated by Muslims only and I shall therefore restrict this discussion to Islam.

5). It may be difficult to prove complete concurrence between Islam and the principles of spiritual divination. But there is little doubt that there is no conflict with regards to the efficacy of the word and the mediation and existence of jinn.

The divergence between the two intellectual traditions concerns agency and intent. Islam, particularly the popular orthodox sunni schools that predominate in rural upper Egypt, refuse any intercession save that of God. This intercession may be sought through established rituals such as the repetition of certain verses from the Quran for a certain number of times or through the interpretation of dreams. Supplications to saints, common to the faith of many Muslims, are rejected by this vigorous school of Islamic praxis (Gilsenan 1980).

Most healing rituals use the mediation of jinn to diagnose and heal. This is never done in outright rejection of the omnipotence of God. On the contrary the assumption is that God is almighty and that mediation, even if not addressed to God, is within his domains of power and creation. As most healers explain **Rabina biysabib** (God creates reasons) meaning that the jinn who they address and whose favours they seek to secure are parts of God's creation and are merely the 'reasons' or means that God presented. They are not outside the hegemony of God.

The relationship between forms of spiritual healing and Islam is tenuous only in cases where God is not addressed or beseeched. Examples are **mushahra** rituals. Also diagnosis by **el-riha** does not address God per se. There are those who resolve maladies which come about as a result of spirit afflictions by using some Quranic verses but as potent items of materia medica to be placed in amulets with seed, beads, other number and letters, and even bits of animals and so in this way engage in a kind of syncretism which they are loathe to discuss.

The Tibb el-Rokkah (The medicine of distaff) is a branch of healing as well as the title of a book. The book

written by Ismail (1892) provides some explanations of prevalent medical beliefs and practises. This lexicon of medical practices is judgemental and provides description solely for the sake of condemnation. However it is a valuable reference if only in the determination of the history and origin of some belief and a way of gauging the survival of some practices and the demise of others. The title implies that this is the medicine of women.

Lane mentions this branch of medicine as that which is not founded on religion or astrology and is therefore scorned by men who practise true magic/medicine (Lane 1936: 331). Practices listed are predominantly medicinal and fall under the rubric of **sofli/shitani** (evil) rituals. They are not addressed to God, place efficacy in items other than words and the Quran and supplicate **jinn** by name. They are rituals which women perform, usually for women. Many of these rituals survive in and around **Rihan**.

APPENDIX 9
IN THE HOUSE OF SHEIKH EID

Naggat and I left Rihan at 9.30 am. We took a car for 50 piaster to her mothers's home in El-Arab. The mother is the sister of Mohamed Abu Roussa and the divorcee of Zanaty. Her second husband is dead and she has 2 girls and a boy by him. She came to show us the way and to ask sheikh Eid about her son who had just accidentally shot himself in the hand. Om AbdelHamid, for that is her name, wanted to make sure that this accident was not precipitated by a spell. The 3 of us left and paid 2.00 to a taxi to take us to Arab el-Atawla. The Taxi cost 2.00 for the 3 of us. We got off on the main street and walked into the fields, crossing several streams and walked for a kilometre. Om AbdelHamid chatted happily, "The last time I came was with Farhana, then the Gaydee[1] was high "[2].

We arrived at a mud house and stopped. Two little girls told us that there were no dogs to be afraid of and asked us to go right in[3]. We entered into a courtyard lined with dried reeds. On our left was a single small mud room. On our right was a long house. On a **mastaba** (mud brick plateau) fronting the house sat Om Eid.

She is a dark woman well into her sixties with two skimpy braids dyed bright red. On her lap there was a regular lined exercise book and a worn and torn paperback book jammed with tight Arabic script. This turned out to be a famous **Kitab** (book) which people like herself consult to diagnose and prescribe for their patients. She held a pencil between her big and second toe. In her lap amongst

---

[1]. The local corn grown for its leaves and not for the grain.

[2]. In July/Aug

[3]. Houses built in the middle of the fields are usually guarded by ferocious dogs who keep strangers at bay, particularly at night.

the books was a red byro.

Hanging around were her granddaughters. They are her daughters girls. Sheikh Eid is the mother of two women one of whom is separated from her husband and lives with her. This daughter has five young daughters the oldest of whom is in her mid teens and is mentally handicapped. This girl was wearing a short tattered dress with no underwear despite her large frame (when she sat her pubic hair showed) and her hair was uncovered. The others were equally untidy but were properly covered. When I asked if the eldest was deaf I was told that she is **'abeeta** [4].

Eid lives in a house like the ones most villagers lived in before the building boom that came with the money of the mid and late seventies. Or as Naggat put it **"heya ga'da ala zamman"** (she has stayed as things were before). The house is comprised of small mud roms with a thatched roof and with the pots hanging from the ceiling. Sheikh Eid later explained that she owns no land and she is the breadwinner for her daughter and granddaughters. They have some animals and a few **Qirat's** of land which they rent to grow fodder for the animals. She only has her own profession from which to make money and that income is not enough for her to modernize her house.

Sheikh Eid welcomed us and asked us to sit down. Talking to her was a Coptic man in his early 30's accompanied by his mother[5]. He was telling her that he was unwell and did not know why. She told him that she could tell by his **Riha**, which she had already seen that he is not possessed. She suggested that he might be suffering from a **haleh nafsiya**[6] . She gave him a long strip of paper which

---

[4]. **'Abeeta** in Arabic means idiot and is used both as reference to individuals with mental handicaps and to people who do silly things.

[5]. The man had a cross tattooed on his wrist that is how we could tell on sight that he was Coptic. See Appendix B for a transcript of their conversation.

[6]. Nervous or psychiatric condition

she tore out of her exercise book and upon which she made several marks. She told him to put 3 pieces of bread, some salt, some Henna, and 3 five piaster coins in the marked ribbon of paper and place it under his pillow for 3 nights and then to come back for a proper Higab which she will make for him "And don't go to a doctor" she stressed.

He was not satisfied and kept telling her that she had not diagnosed him. She became angry and perplexed and told him within ten minutes "Look, you should go and see a psychiatrist because what you have is a nervous condition!" He refused her suggestion because as a yet unmarried man he cannot take sedatives because they "ye-shiloh min 'azmoh"(affect virility).

He then gave sheikh Eid a kerchief which belongs to his fiancée and asked her to tell him if she loved him or not. She said that the girl loved him but he was dissatisfied with her answer. They had a harsh exchange, quibbled over money and he and his mother left in a huff. "'Adwek 'adew deenek" (Your only enemy is the enemy of your religion) she said in exasperation and Naggat responded saying "Yes you mean the **Nosrani!**[7]" Then Eid explained that this is the second time this man comes to trick her. First time he said that he had the **Riha** of a man who is hated by his mother (Omoh karhah) but it was actually his own **Riha** and that his problem was that his brother's wife hated him and claimed that he had tried to sleep with her. Sheikh Eid told him that is not the case of this **Riha** and it does not have **Khwana** (betrayal). Then she laughed and said "Walaft 'aleeky" (I have become used to you) explaining why she was divulging such confidences.

Then it was our turn. Naggat insisted that I go first. So Eid then asked me for my head kerchief. I hesitated out of modesty and Naggat laughed saying "you're not bald, take it off". I was asked to wrap some money (1 LE) in a corner and give it to Eid. She took out the money and then began

---

[7]. **Nosrani** means Coptic man (Nasar: pl, Nosraniya: sing female)

using the kerchief to establish my ailment.

She asked me for my name and my mother's. Then she asked me if I was sick, or married, or newly married?[8] . I replied that I was not a newly wed aroussa and that I am married. Then the consultation proceeded.

Transcript of Tape

Sheikh Eid: Well, my mother please do not be offended but take off your shoes because if you do have something or are possessed by a genya[9] you must not be wearing a shoe. Will you be upset? I'm like your mother.
Sheikh Eid: Sickness or children
Naggat: For children
Sheikh Eid: For children well, may God give them to you. How many years have you spent without children?
Me: Three
Eid: Three years! But you have been to doctors?
Me: Yes
Naggat: She is not from here. She has not consulted anyone at all.
Eid: You have not been to the doctor? (in a high pitch probably in imitation of my own voice)
Me: No I'm fine thank-god. I am fine
Eid: You mean the doctor reassured you and said that the uterus is fine?
Me: Thanks to God
Eid: And your husband has had laboratory tests and is fine?
Me: Yes
Eid: Do you have his Riha?
Me: No he is abroad
Eid: Do you mind writing for me his name, maybe he has a Ginn related condition?
Naggat: She can write his name and his mother's
Eid: Yes so that I can reassure you
Eid: Will you do what I tell you?
Naggat: Oh yes, she will do everything you say, she never says no to anything!
Eid: (Chanting) 'Supplication for children and progeny for the one meaning men and the right of men, peace, may hardship/illness be removed and prevent betrayal. I have intended and by which/any prophet I have sworn and I have premeditated my intention by the right of

---

8. I shall repeat the same sentence used by sheikh Eid but translated without editing coherence or what we take to be common sense into them.

9. Genya is sing. female for jinn. I have used a spelling that relays the different pronunciation of the classical Arabic term jinn as it is used by this healer and others in the area.

the prophet to remove the hurt/illness condition if it is devilish. If it is a fall or a shock, Allah is great may the gift be given'.
No, Congratulations, you are fine.

Then she took my kerchief jiggled it around her book and gave a loud burp saying a loud "YES" signifying her success at locating a problem. Then she proceeded to chant some more.
Eid; Saviour of the sick and aid to the indebted, you head of the office, you who have a belt tied around you, extend your hand, you whose grandfather is the prophet, cleanse the skin from fear and thunder, the intended Hania requests progeny and release from harm and prevention of wrong/transgression. Safety is wanted you right of peace so that Hania will succeed with progeny. I have supplicated God for your pleasure. Harm or a step? Ginn or a wrongdoer? Blood or tabi'a? Earth dwellers.
Then another burp and another loud "YES"
Then she pronounced her verdict
Eid: Harm from defloration blood
Me: Harm from defloration blood?
Eid: Aha, yes. You of course were deflowered by the sunni method. So when the time came you were frightened when the entering was taking place and the blood flowed unto the ground so the earth dwellers took from it and the rest flowed back in again.
Me: Do I have **Mushahra**?
Eid: No the blood was taken by the earth dwellers, the sons of the red Genya. It is called **azwa damawiya**[10] that is what it is called, that is how it is known. You may need a red candle and a red rooster this of course you will supply.
Naggat's mother: We will help
Naggat: Yes she is not a stranger.
N's mother:
Naggat: Yes, I have a small one she can have.
Eid: She will need a red rooster and a red candle and seven single loaves and a bit of henna, and a bit of salt and a piece of soap and some matches that have never been used before.
Eid: You know ....
Naggat Mother: I know, I have come with several women before.
Eid: These are the things we need and she knows that we erect a stand with the candle in front and we slaughter the rooster and what do we take? We take the vaginal suppositories I shall make and smother them with the blood and if she says no to the vaginal suppositories I shall smother a bit of cotton wool.
Naggat's mother and Naggat: She will wear the vaginal suppositories but do examine her even though her

---

[10]. Harm by blood.

husband is away.
Eid: We will fix her up and when he comes
Naggat's mother: May God give her
Naggat: But open the book for her
Eid: Yes beloved, I'll give her my two eyes
Naggat: See the book for her and don't worry about the other things.
Eid: Alright but if you get any of the things from your homes, she pays for it the right price.
Naggat and her mother: Yes of-course she will pay us.
Eid: Yes I want to cost you so that the genya forgive you and you become pregnant.
Then Eid started chanting again
Eid: The servant has entered to the intended for the blood harm as you wish and order to obedience for belief in right to see you and to remove from you the harm and the infection. I have intended and by which prophet I have prayed and love and truth to believe in the intention for the one who seeks right and vision. May he give us and realize the gift with the hopes of the servant with the right utterances from the blood harm. Allah is the truth may the progeny be fixed by divine will. It shall occur if God is willing.
Me Naggat and her Mother: May Allah give you
Eid: Come back tomorrow and I shall have prepared things for you. But the three vaginal suppositories cost five pounds and I shall charge you a pound for the incense. Tomorrow I shall get the vaginal suppositories and prepare for you the higab.
Naggat and myself: You are welcome
Eid: I will give her three pills to take, one she shall take tonight and the other two with the vaginal suppositories. But daughter of my daughter do not be upset but it all cost money and if we agree on the price than we can proceed.
Naggat and her mother: You are welcome.
Eid: You will not later object
Me: Tomorrow we shall return
All in union: Inshallah

Then we exchanged places and Naggat gave her kerchief with twenty five pence note tied in it and was asked by Eid "sickness or children" and she answered "We want children!" and so Eid began to chant similar words to those cited above. During her chant she burped, zoomed, clicked and said in distress "Why? WHY OH NO NO NO" then continued to chant saying "Seeker of truth to our vision, prevent deception and prevent our mistakes. Touch us with blessing, Issa and Mohamed are brothers"[11]. Then after a long

---

[11]. Issa is one of the names of Jesus Christ

distressed silence she proclaimed that it is going to be a **Tabi'a**.

She then chanted "I seek the intention of the **tabi'a** mother of sons. She is a **tabi'a** sitting in my womb and depriving me of progeny." But sheikh Eid's diagnosis was hard to swallow for Naggat who has never lost baby nor even miscarried. She told Eid that her problem was that despite the 40 day holiday her husband had from his work in Saudi Arabia during which they had intercourse everyday except the two times she got her period, she has not conceived. Eid kept asking her if she was sure none of her children had died but Naggat and her mother assured the sheikh that no Tabi'a had taken foetus or babe.

Eid had to revise her diagnosis after looking in her book and said that the **tabi'a** had caused Naggat's womb evil with a **nazra** (look n. euphemism for envious wish or evil eye).

She recommended a **higab**, some vaginal suppositories which she would make, and sternly stipulated that when these things work, and Naggat does become pregnant, she should come back and make a **higab** for the baby. Eid emphasised that she was not going to put her through the expenditure of money for cloth or candles, items needed for rituals of resolution. She was going to make her **higab fardy** (single amulet) meaning that it does not extend its powers or protect either her foetus or husband. Indeed sheikh Eid was very clear that her therapy would not cure anyone but Naggat. If her husband had a problem or if his **Tabi'a** harmed the yet unborn baby, she would need further therapy. She reminded her that: "If you become pregnant and come back to make a **higab** for the baby, the **tabi'a** will not betray you in your womb and cause miscarriage or betray you on the seventh day".

APPENDIX 10
MILESTONES AND AGE

Childhood, medical, and developmental studies, have divided early infancy and childhood into commonly accepted stages. Rather than rely on these divisions of age and development, this discussion will be organized in accordance with the emic categories of Rihan[1]. Infancy and early childhood are broadly divided into the first week of life, the first forty days, the unweaned, the newly weaned, and pre-schoolers. Older children are categorized according to their education, capabilities, and physical development. These emic divisions of age groups do not always rely on fixed chronological time. They rely on socially and culturally structured time which is event related and not necessarily delineated by a calender of days and weeks. These stages are:

* Conception and the foetal stage. The woman is said to be carrying or **shalet** (present tense **Shayla**). The baby is in his/her mothers belly or **fi batn omoh**. A foetus is always referred to in the male gender.
* **Mawlood** (Newborn). The first seven days after birth are one stage of life. They are followed by the next stage which takes the baby up to his/her fortieth day. The baby is still **Mawlood** but mothers qualify this label by adding the phrase 'he has yet to reach his fortieth day' **Lissa ma rab'ansh** (female: **Rab'antsh**).
* **Ala bat-ha biyerda'** (at her armpit breastfeeding). The phrase refers to both feeding and motor development. It means that the baby still needs to be carried by its mother and that it is predominantly breastfed. In terms of the calender this means that the baby is under six month or so.
* **Biyoq'od** (sits). This stage is defined by the baby's ability to sit. The saying goes "**Bint arba'a qa'adouha we**

. I am not implying that **Rihan** is unique. This village is illustrative of many aspects of the culture and history of Upper Egypt in general.

in ma qa'adit libou-ha we ibn sittah qa'adouh we in ma qa'ad sanidouh " (Try to seat the four months old girl and if she does not sit, beat her and try to seat the six months old boy and if he does not sit prop him up).
Usually the baby is still predominantly breast feeding but has begun Talhees or licking. This means that the baby is enjoying the taste of solid foods licked off the mother's fingers.

* 'Ala el-ard biyehby (female: betheby) (on the ground crawling) beyshrab (female: betshrab) (drinking). This stage also refers to both feeding and motor development. This is when the baby is 'on the ground' and independently mobile. The reference to drink can mean drinking from the mother's breast, or clutching at the breast even when it is not offered; but more commonly refers to the ability to drink from a cup. This stage is a long one during which crawling develops into walking ' and drinking into eating. The child is beyakol (female: betakol) (eating) and beymshy (female: betimshy) (walking).

* Maftoum (female: Maftoumah) (weaned). This indicates the completion of weaning from the mother's breast which usually occurs earlier for girls than for boys. All women professed belief in equality between girls and boys, but amongst all children who were weaned by the mother and not due to circumstances such as sickness or a problem with the mother's milk supply, the girls were weaned earlier than the boys. Boys are breastfed for up to a year longer than girls. This means that amongst the weaned who are perceived as being of the same age, the boys are generally older.

* Ayel fi el-beit (a small child still in the house), Ayel ma dakhalsh el-Midrasa (a child not in school). This stage begins with weaning (around the age of two years) and lasts until children are of school age. At around the age of four years, children begin to help herd animals and carry siblings. This is the age when children are old enough to

go to a nursery[2]. At the age of six years children should go to school, but even those who don't are still described as being of school age.

* The next phases are marked by the school stage in which a child is. **Ibtida'y** (primary school) is from the age of six to 11 years. **I'dady** (preparatory school) is from the age of 11 years to the age of fifteen years. **Thanawy** (secondary school) is up to the age of 18 years.

* Children who are not in school are either **Sagheer** (female: **Sagheera**) of school age but little or **Kabeer** (female: **Kabeera**) meaning of school age but big. Age is also expressed by such phrases as **Balaghet** (matured), **Ala wish Gawaz** (about to be married) , **Mitahra** (circumcised), or **Ga'adet fi el-beit** (has been kept from school at home) for girls. Older boys may be described as **Zagnoh til'et** (his beard has come out) or **fi elgheit** (works in the fields).

Asma and her cousin Abdel-Rahman are described as being of each others age. They are both breast feeding and are still "on their mother's lap" since neither can walk despite the near year difference between them. Fatma is in the same age as her cousin Atef. They play, fight, kick each other out of their homes and flare up at each other in tears when they are vying for a third party's attention. Being the same age is reinforced if women breast feed each others babies[3], and if the children are left in one another's homes. Frequent visitation of say a common grandmother or aunt forms a same age bond as does co-habitation.

All of these stages vary in their length and timing from one child to another. A baby may be **maftoum** at the age

---

. Rihan does not have a nursery so all children at this age are at home.

. Acting as wet nurses for each other precludes the possibility of children ever intermarrying. It is most common if the two babies nursing are of the same sex or as a way of insuring the impossibility of marriage.

of one year if his or her mother looses her milk supply or becomes pregnant. Another child may reach the age of 3 years and still be breast feeding. Mothers do mark the passage of time with events and can explain a child's age in years. But the age in years is less significant to mothers within the village. The reasons for this lack of concern with chronological age may have to do with the irrelevance of age in years to child rearing in Rihan. Days months and years are the concerns of officialdom and of the medical establishment. For mothers and children themselves, capability and development count more.

These emic distinction of age are essential to a child's self perception. The **akhir el-'anqoud** (last born) has a much longer childhood than the first born. A four year old who has older siblings has the leisure to play out on the streets, while one who is the first born may be too busy tending animals or carrying younger siblings to have time to play. A ten year old girl who has an eleven year old sister may be spared household duties and kept in school, while her peer who is a single girl may be kept from school all together since every mother needs at least one extra female hand in the house. Such contingencies mean that the experiences of children cannot be grouped into age sets. They can only be understood in relationship to the child's specific circumstances and relationships.

APPENDIX 11
A TAXONOMY OF DIARRHOEAL DISEASES

BitHor (male: biyhor), Bitboz (male biyboz), Bit-Titmasha (male: Biyetmasha) are all synonymous descriptions of a female who has diarrhoea. The urban and commonly used word in the context of clinics and physicians is Is-hal. The locally significant terms describe frequency and consistency of defecation and faeces. Due to the recent campaigns concerning diarrhoeal diseases, there is a heightened consciousness of the symptoms and consequences of these diseases. Dehydration or Gafaf is well recognized as a childhood killer.

Despite this successful approach to the dissemination of knowledge on diarrhoeal diseases, there remains an emic perspective on these common ailments, one which has a sophisticated categorization which discriminates between different types of diarrhoea, their causation and their possible prophylactics and curative therapies. This taxonomy of diarrhoeal disease differentiates different diarrhoea by name, etiology, symptomatology, prognosis, and required therapy. The following passages will describe each distinct type of diarrhoeal disease as represented in the medical system of Rihan.

Types of Diarrhoeal Diseases for Children Under Five

a. Disease: El-Warraniya (the back one), also known as El-Wihsha (the bad one), el-Za'afa (the palm reed), or El-fouqaniya (the upper on).
Symptoms: Severe diarrhoea accompanied by vomiting, perhaps fever and listlessness. Some women insist that weaned children rarely get it. Babies who have it suck on their dry lips and may have yellow ears
Etiology: Caused by the evil eye or is wished upon a person through envy or witchcraft

Diagnosis: Skilled persons, usually the midwife or other older women, can easily diagnose **El-Warraniya**. They stroke the palate of the child and upon detecting a bump which is called a **Safeera** they can confirm the diagnosis. The **safeera** is usually shaped like a tiny date, that is it is like an oval lump.

Local Therapy: Massage palate with a cut garlic dipped in **homar** (red powdered clay) broken off from an inherited pot. The use of an old pot insures that the dust is not too coarse and so will not cut the palate. Elsewhere ground coffee is used (Sholkamy 1990). Lemon juice may be added to make the powder into a paste. When applying the paste with garlic no **Bism Allah El-Rahman el Rahim** (In the name of God the compassionate and merciful) is said because **El-Warraniya** is brought on by the evil eye and **min taht nifs** (as a result of the ill intentions of another human being). Some women say that the woman applying this paste should be **qata'a el-dem** (post menopausal). This therapy may be repeated more than once, often on six consecutive days and then once a week for three consecutive weeks or less if the child gets better straight away. The male child gets one ear pierced as a continuation therapy. Girls who have not had their ears pierced get both done. This is not a must but very often children with a chronic case of **El-Waraniya** wind up having one ear pierced whether they are boys or girls. Usually a red thread is threaded through the lobe.

Other Therapies: Use of Oral rehydration salts, and other prescriptions whether they are physician or self prescribed are also employed to "relieve the symptoms" as Om Khattab explained. Local therapy address the disease itself and its causes.

Medical significance: It is considered a very serious medical problem and one that merits immediate attention. It can be fatal and that is why it is referred to as **el-wihsha**.

CASE 1

Latifa is a widow. Her husband recently died of kidney failure. She has a three year old son who has been sick since his father died. He was a very weak child because he did not breast-feed. She was **Mushohra** by a dog and lost her milk. She therefore bottle fed him and still does. She has not weaned him off the bottle although he is old enough to carry it around and wander with it. The bottle teat has no cover and the little boy just drags it in to her when it is finished for a refill. He also has the same solid food as the adults in the household. His feed is half buffalo milk and half boiled caraway or anise as prescribed by the physician.

"He got **Gafaf** and I took him to the doctor along with my brother. He prescribed shots for him which cost us so much, but they made his body lax and that is why I stopped them, not because of the money. Right after that he got **El-Warraniya**. I took him to my maternal aunt, Halima, who felt the date in the ceiling of his mouth and told me that he had it. She did it with Garlic and **Homar** and when it did not go away and I was afraid that he would die, he was so sick and unable to eat and he became like a stick. She pierced his ear and now he is better. He got **El-Warraniya min taht nifs**. He is an orphan, and still women look at him".

b. Disease: **El-Amoud** (the column)

Symptoms: Diarrhoea that may be accompanied by slight fever and vomiting. Mothers say that if children defecate undigested food then they have a **'amoud mafrout** (broken column).

Etiology: Diarrhoea is caused by a break or a hernia in the column digestive tract as it is represented by an emically constructed anatomy of the body. A fall backwards or a severe fall can cause it.

Diagnosis: A Daya (midwife) can detect a break in the **'Amoud** where a young child is concerned. The **'Amoud** or column is the continuous passage between mouth and anus around which the body is constructed. If this passage is somehow obstructed or disconnected this can cause diarrhoea. A Daya feels the midriff and stomach of the patient. If she notices a bump right in the middle around the tummy button this signifies that the **'amoud** is not smooth or unobstructed but is either clogged or torn. This bulge is similar to what a physician would call an abdominal hernia. In this case the child is said to be **mi-'oumad** or to have a **'amoud mafrout** (broken 'amoud). Small babies are held on the upturned palm and arm if the rectus abdominous contracts then the **'amoud** is alright, if not then the **'amoud** is **mafrout.**

Local Therapy: **Tamrees** or massage (see plates 19-23) is the therapy usually employed. To mend the column, the child is massaged after being doused with oil, ghee, or with suds of soap to facilitate the massage. The child or infant is then placed on the outstretched legs of the masseuse and given a rub down, then turned on its back and the procedure is repeated, then each of the child's or infant's legs are brought up to cross the torso and reach to the neck and then the arms are brought to the back of the head and the child is given a good lift. If necessary the midriff is tied with a cloth for a few days. In this way the passageway or column is mended and the case is cured. **Tamrees** is very common and is experienced as an effective cure. It is the first option for children with diarrhoea. If no break in the **'Amoud** is detected then other alternatives are sought. Soap is a cooling substance and is used instead of oil or ghee when the patient also has a fever.

Other Therapies: If a child is weakened by diarrhoea or has been massaged but is still not responding, mothers may give some anti-diarrhoeal pills bought from the pharmacy to relieve the symptoms until the **'amoud** mends. Continuation

with massage presumes that a break in **el-amoud** was detected by a specialist. Other therapies are resorted to if the specialist says that the **'amoud** is fine. Then babies may be taken to a physician or have their **riha** seen. Physicians are quickly resorted to if **gafaf** (dehydration) has affected the child.

Medical significance: It is not an unusual occurrence and is not cause for alarm.

CASE: Since the **'amoud** is a pretty standard cause of diarrhoea it is treated summarily and is rarely cause for hesitation. A child is **Bi-hor** so he or she is sent or taken for their **'amoud** to be checked. If it is broken or obstructed then they are massaged and sent home. If they do not recover, they are either once more dispatched or other therapies are thought out in conjunction with massage.

Case 2

Mayza has an only son who is just over two years old. He is an only son of an only son, and so she spares no expenses in caring for his health. He was taken to the private clinic of Dr. Ahmed Hassan because he got feverish late in the evening. The doctor prescribed Diamycin dry suspension, Velosef and Novalgene tablets. Just a few weeks before that he was **Biyhor** for several days so Mayza took him to the government clinic in Abnube where there is a very good female doctor who is completely veiled. Before going she took him to Om Khattab to see if he is **Mi'Oumad**. She felt his torso and detected a tear which she massaged with ghee. At the time, he had no fever so she did not use soap which has a cooling effect. The tear may have been caused by a fall or when he was playing. He got a bit better but then his condition came back again and so she decided to go to the physician for fear that he may be getting **Gafaf**.

c. The Disease: **El-Hagma** (the attack)

Symptoms: Diarrhoea and weakness, lack of appetite, lax body. Irritation and continuous crying are signs of **el-hagma** amongst small babies. Older children wake up shivering and crying in the middle of the night which is when they are attacked. Very foul smelling excreta is another important indicator of the disease.

Etiology: It is caused by an attack by spirits especially

if a child is left alone. This attack can be inspired by another persons' ill intentions or by the special value of the child itself to his/her parents and family.

Diagnosis: **El-Hagma** is rarely diagnosed. It is a residual category of diarrhoea and it is something which children are protected rather than treated from.

Local Therapy: Since it occurs **min taht nifs** (from bad intentions of a human being), **El-Hagma** is specific to special children who are considered to be prone to envy. Such children may be protected with goats milk which at the beginning of the lunar month is milked right into the mouth of the child while the woman doing the milking says **sikhs, sikhs, sikhs** (Meaningless words in Arabic) with no **Bism Allah el-Rahman el-Rahim** since it comes from the bad intentions of human beings.

Other Therapies: More often than not therapy is employed to prevent **El-Hagma** and not in response to a specific condition. This therapy may be performed in conjunction with other protective actions which aim at guarding a child form the eyes and bad intention of others. The **'o'ed** (knot) is a **higab** made to protect children from attacks by spirits or insects, animals, or people if the child is left alone. It is also used to protect from **el-hagma.**

Since **el-Hagma** is associated with sleeping problems some mothers take a straw from the mat on which the afflicted child sleeps and burn it so as to drive the attacking spirits away and so the child sleeps safely and calmly.

Medical Significance: **El-Hagma** is the worst possible stomach **nazla** or what we may call gastro-enteritis. It is a condition which does not respond to medication and which can be fatal. It is very often used as an ex post facto interpretation of fatal cases of **nazla** which were accompanied by diarrhoea and vomiting.

CASE 3

Mohammed Helmy and his wife had 4 girls before they got Ahmed who is a year old but who has been sick since he was two weeks old. "I did not even have time

to protect him" said his mother. He began to shiver in the night and cry. He would not eat and so they took him straight to Assiut where he was kept in the General hospital (El-Kasr) for 4 days. They told her that he had a nervous condition. When he came out he was better but she feared for him. When the new moon was coming out, her mother in law milked goat's milk into his mouth for her. The next month they did the same thing. She got the goat ready while the young mother held her son and said "**sikhs sikhs sikhs** " as she milked without saying **bism-Allah al-rahman al-rahim**. He was fine for 40 days then he got the same condition again and again he was kept in hospital. Her mother and mother in law told her that it was not **El-Hagma** since he had no diarrhoea but that it may be a nervous condition as the doctors had said. At the hospital they had a brain and heart scan and gave him calcium to take. He should take two spoons a day but she gives him one spoon day in and day out because the calcium is expensive. "I have never seen anything similar to what he has" she said. The doctor has told her that he may never sit or walk if she is not careful in giving him the medication.

d. Disease: **el-Sakta** (Dysentery)

Symptoms: Chronic diarrhoea that comes in bouts which last for a few days, stools mixed with blood, wasting, and occasional fever.

Etiology: Dysentery is endemic to **Rihan**. Old and young know the name of the disease but refer to it as **el-sakta**. Long ago, Om Abdelwahab remembered, they used to think that it is brought about by disgust at seeing an ugly and smelly sight like rotting meat or a corpse or decomposed carcass. Dysentery is thought to be contagious only from mother to child through breast milk.

Diagnosis: **El-Sakta** is so common that children as young as the age of five years know by themselves when they get it.

Local Therapy: Children are taken off the breast if the mother has **el-sakta**. Infusions are given; usually made with cumin and fenugreek. Older children are given diarrhoea pills and not given heavy foods such as meat. The physician is usually consulted although not immediately since most families can recognize **el-sakta** and know when it is critical and when it is a mild attack. Pharmacists are

resorted to more often then physicians.

Other Therapies: For children there are rarely any other courses of therapy. Adults with **el-sakta** become alarmed when they have other conditions such as liver and kidney troubles. They then seek aggressive therapies and consult private physicians.

Medical significance: Dysentery is one of the most serious communal health problems. It is a major cause of death amongst older people when it is compounded with other health problems. Bouts of dysentery are endured and addressed in the most affordable and practical way but the problem itself remains.

Case: Out of a random sample of 20 households in the village who were observed and interviewed extensively, every single one had at least one family member who had or had had a case of el-sakta in the recent past. Moreover all households had at least one child who had had a case of **el-sakta** at one time or another. Following is the case of Sawsan and Racha, the granddaughters of Om Raggab

Case 4

A few days after our visit to the doctor in Abnube, I was enjoying the company of Sawsan and racha, the granddaughters of Om Raggab and their aunt Layla in the onion fields. The girls were doing a little bit of harvesting practise in the early morning and Layla was there to show them how to cut off the long shoots from the bulb. Sawsan went to the side and hid amongst some reeds and defecated. Layla asked her why she looked so tired and Sawsan who is five years old said that since yesterday she has **el-sakta**. She had just defecated slushy stools with ripples of blood. Her grandmother had gone with me to the doctor because of dysentery and Layla said that Aziza, her sister and their mother had it a few months ago. Layla suggested that we should all go home since Sawsan said that she felt sick and she seemed to be feverish. When 'Aziza saw sawsan she asked Arafat, the girls' uncle and her husband's brother to buy some medication from the pharmacy in el-Arab. His mother Om Raggab would not let him go all the way there. "See if any of the neighbours have any medication or give her half of one of my pills with sugar and water, it is **el-sakta** and it is not the first or last time she gets it" she said. Then she added " Tomorrow you take her to the

clinic if you want and get her some 'ilag[1] ".
Aziza took Sawsan after two days and she bought the pills prescribed for 5LE which she had to borrow from her sister Layla since she had no money and Raggab had gone away again[2]. Meanwhile Sawsan was eating dry bread and drinking infusions. When she started snatching food from her younger sister, they knew that the medication had worked. Meanwhile, Racha began to get runny stools and Aziza and Om Raggab waited to see what it was before deciding on who to take her to or what to give her.

e. Disease: **taqq** (child is **Tagiq**).

Symptoms: Itchy anus, worms, diarrhoea, wasting

Etiology: This disease is caused by the ingestion of worms but folk specialists who discussed it said that the child or adult ingest these worms by mistake. As with all diseases, this one can be a consequence of envy.

Diagnosis: A child is suspected of being **tagig** if they have a very itchy anus as well as persistent diarrhoea. Sometimes children cannot sit down because of the pain of a sore and itchy behind. One sure way of finding out if a person is **tagig** or not is to splash the anus with boiling hot water. "If lumps of fat and worms come out" said Om Khattab, "then he is **tagig**". All the other healers and other persons interviewed agreed with her.

Local Therapy: The anus is cleared with a **kherfet zeit** (oil wash) which is oil mixed with herbs and sometimes garlic and applied to the anus. This flushes out lumps of fat and worms. After that a **Kabsa** (dressing/mixture) is applied. I do not know what the **kabsa** is made of.

Other Therapies: Most women interviewed said that now clinics have cures for worms and that once it is locally diagnosed, people prefer to go to the clinic.

Medical Significance: Severe wasting and insanity were mentioned as possible outcomes if a child who is **tagig** does

---

[1]. Cure or medication.

[2]. Raggab is a construction worker in the red sea resorts to the east of Egypt. He also worked in Libya and is going back there soon.

not receive medical attention.

Cases: I did not come across a single case during my own fieldwork but during previous fieldwork in the area I saw several cases (Sholkamy 1990).

f. Disease: **Khar'a**

This disease was discussed in the preceding section. **Khar'a** can cause diarrhoea and is the sixth disease in the **Rihan** medical taxonomy of diarrhoeal diseases.

BIBLIOGRAPHY

Abaza, M. (1985)
La Paysanne Egyptienne et le "Feminisme Traditionnel". Peuples Mediterraneens. 41-42: 135-51.

------- (1987)
"The Changing Image of Women in Rural Egypt" Cairo Papers vol. 10 (3).

Abercrombie, N., Hill, S. & Turner, B. (1980)
The Dominant Ideology Thesis. London: George Allen & Unwin.

Abdel-Kader, M. & E. Afifi (1975)
"Turq el-Tarbiya el Muntashira fi El-Reef El-Misry".(The Prevalent Types of Socialisation in the Egyptian Countryside). The National Review of Social Sciences. 12(1): 3-61.

Abdel Mo'ti, A. (1977)
El-Sira' El-Tabaqi Fi El-Oariya El-Misriya. (Class Struggle in the Egyptian Village). Cairo: Dar El-Thaqafa El-Jidida.

Abdel Fadeel, M. (1975)
Development, Income Distribution, & Social Change in Rural Egypt 1952-1970). Cambridge: Cambridge University Press.

Abdouh, M. (1990)
El-Fatawa El-Islamiya (Islamic Legal Opinions/Fatwas). Vol. 26, 4. Cairo: Ministry of Awqaf.

Abu Lughod, L. (1987)
Veiled Sentiments: Honour and Poetry in a Bedouin Society. Cairo: American University Press.

------- (1989)
"Zones of Theory in the Anthropology of the Arab World." Annual Review of Anthropology 18:276-306.

------- (1990)
"The Romance of Resistance: Tracing Transformations of Power Through Bedouin Women." American Ethnologist 17:41-55

------- (1993a)

"Islam and the Gendered Discourse of Death." International Journal for Middle East Studies 25, 2:187-205.

------- (1993b)
Writing Women's Worlds. Bedouin Stories. Berkeley. LA. Oxford: University of Calfornia Press.

Abu El-Noor, M. (1992)
Nazret el-Islam fi el-Ingab (Islam's View of Reproduction). Cairo: Al-Azhar University Press.

Abu-Zahra, N. (1970)
"On the Modesty of Women in Arab Muslim Villages." American Anthropologist 72: 1079-1088.

Abu Zeid, H. (1994)
Mafhoum el-Nass: Dirasah fi 'Oloum Al-Our'an (The Meaning of the Text: A study in the Sciences of the Quran). 2nd ed. Beirut: The Arab Center for Culture and Publication.

Adams, R.H. (1986)
Development and Social Change Change in Rural Egypt.
Syracuse, N.Y.: Syracuse University Press.

Aijmer, G. (1992)
Coming into Existence: Birth and Metaphors of Birth. Gothenburg: IASSA.

Ainsworth, M.D.S. (1967)
Infancy in Uganda: Infant Care and the Growth of Love. Baltimore: Johns Hopkins Univ. Press.

Allsebrook, A. & Swift, A. (1989)
Broken Promise: The World of Endangered Children. London: Hodder & Stoughten.

Altorki, S. (1980)
"Milk Kinship in Arab Society: An Unexplained Problem in the Ethnography of Marriage". Ethnology, vol. XIX, 2: 233-44.

AlTorki, T. & El-Solh, C.F. eds., (1988)
Arab Women in the Field: Studying Your Own Society. Syracuse: Syracuse Univ. Press.

Ammar, H. (1954)
Growing Up in an Egyptian Village. London: Routledge & Kegan Paul.

Ammar, N. (1988)
An Egyptian Village Growing Up. PhD Dissertation. Univ. of Florida.

Anyinam, C. (1987)
"Traditional Medical Practice in Contemporary Ghana." Canadian Journal Of African Studies 21(3):315-36.

Appadurai, A. (1988)
"Putting Hierarchy in Its Place." Cultural Anthropology 3:36-49.

Aries, P. (1962)
Centuries of Childhood . Trans. Robert Baldick. London: Jonathan Cape.

Asad, T. (1979)
"Anthropology and The Analysis of Ideology." Man 14:607-27.

-------- (1986)
"The Idea of an Anthropology of Islam." Occasional Papers Series: Centre for Contemporary Arab Studies. Washington D.C.: Georgetown University Press.

el-Aswad, S. (1988)
"Patterns of Thought: An Anthropological Study of Rural Egyptian World Views." PhD Dissertation: The University of Michigan.

Auge, M. & Herzlich, C. (1995)
"Introduction". The Meaning of Illness. Trans. K.J. Durnin et al. Luxembourg: Harwood Academic Publishers. pp. 1-23.

Auge, M. (1995)
"Biological Order, Social Order, Illness, A Primary Form of Event." The Meaning of Illness. Trans. K.J. Durnin et al, pp. 23-71, Luxembourg: Harwood Academic Publishers.

Ayrout, H.H. (1963)
The Egyptian Peasant. Boston: Beacon Press.

Baer, H. (1982)
On The Political Economy of Health. Medical Anthropology Newsleter. 14, 1-2 & 13-7.

------ (1986)
"The Replication of the Medical Division of Labour in Medical Anthropology: Implications for

the Field." Medical Anthropology Quarterly. 17(3): 63-5.

------- (1987)
"Introduction." Encounters with Biomedicine. Case Studies in Medical Anthropology Hans Barr (ed.), New York: Gordon & Breach Science Publishers.

------- (1989)
"The American Dominative Medical System as a a Reflection of Social Relations in the Larger Society." Social Science and Medicine 28(11): 1103-1112.

Baer, A., Singer, M. & Johnson, J. (1986)
"Introduction: Towards a Critical medical Anthropology." Social Science and Medicine. 23(2):95-8.

Banerji, D. (1981)
The Place of Indigenous and Western Systems of Medicine in the Health Services of India. Social Science and Medicine. 15A: 109-14.

Barth, F. (1970)
"Father's Brother's Daughter Marriage in Kurdistan." in Peoples and Cultures of the Middle East L.E. Sweet (ed.), Vol. 1, pp. 127-37, Garden City, New York: The Natural History Press.

Beck, L. & Keddie, N., eds., (1978)
Women in the Muslim World. Cambridge, Mass. : Harvard Univ. Press.

Benedict, R. (1947)
The Chrysanthemum and the Sword: Patterns of Japanese Culture. London: Secker & Warburg.

Bentley, M. E. (1988)
"The Household Management of Childhood Diarrhoea in Rural North India." Social Science and Medicine 27(1):75-85.

Berger, M. (1970)
Islam in Egypt Today: Social and Political Aspects of Popular Religion. Cambridge: Cambridge University Press.

Berger, P. & Luckmann, T. (1966)
The Social Construction of Reality. New York: Doubleday & Company.

Berque, J. (1972)

Egypt: Imperialism and Revolution. London: Faber & Faber.

Bisharat, L. & Miles Doan, R. (1990)
"Female Autonomy and Child Nutritional Status: The Extended Family Residential Unit in Amman, Jordan." Social Science and Medicine. 31(7): 783-91.

Blackman, W. (1924)
"Some Beliefs Among the Egyptian Peasant with Regard to 'Afarit." Folklore 35:167-84.

Blackman, W. (1927)
The Fellaheen of Upper Egypt. London; George G. Harrap.

Blanchet, T. (1996)
Lost Innocence, Stolen Childhoods. Dhaka: University Press ltd.

Blaxter, M. & Paterson, E. (1982)
Mothers and Daughters: Studies in Deprivation and Disadvantage. London: Heinemann Educational Books.

Bloch, M. (1992)
"Birth and the Begining of Social Life among the Zafimaniry of Madagascar." Coming into Existence: Birth and Metaphors of Birth. G. Aijmer (ed.),pp. 70-91, Gothenburg: IASSA.

Blumhagen, D. (1980)
"Hypertension: A Folk Illness aith a Medical Name." Culture, Medicine, and Psychiatry 4(3):197-277.

Boddy, J. (1988)
"Spirits and Selves in North Sudan: The Cultural Therapeutics of Possession and Trance." American Ethnologist. 15(1): 4-28.

------- (1989)
Wombs and Alien Spirits: Women, Men, and the Zar Cult in Northern Sudan. Madison: University of Wisconsin Press.

------- (1992)
"Bucking the Agnatic System: Status and Strategies in Rural Northern Sudan." in In Her Prime: New Views of Middle Aged Women J. Brown & S. Vatuk (eds.),pp. 140-56, Urbana & Chicago: University Ilinois Press.

------- (1994)
"Spirit Possession Revisited: Beyond Instrumentality." Annual Review of Anthropology. 23:407-34.

Bogden, J. (1990)
"Childhood and the Policy Makers: A Comparative Perspective on the Globalization of Childhood." in Constructing and Reconstructing Childhood A. James & A. Prout (eds.),pp. 184-216, London: Falmer Press.

Bolton, R. (1981)
"Susto, Hostility, and Hypoglycimia." Ethnology XX, 4: 261-76.

Bolton, J. (1995)
"Medical Practise and Anthropoogical Bias." Social Science and Medicine . pp. 16[illegible]-1661.

Bouhdiba, A. (1984)
Sexuality in Islam. London: Routledge & Kegan Paul.

Bourdieu, P. (1977)
Outline of a Theory of Practise. Trans. R. Nice, Cambridge: Cambridge University Press.

Bourdieu, P. (1990)
The Logic of Practice Trans. R. Nice, Stanford: Stanford University Press.

Bourqia, R. (n.d.)
"Health and Healing Practices in Rural Morocco; Perceptions and Attitudes." Unpublished paper, Mohamed V University, Rabbat.

Boyden, J. & Hudson, A. (1985)
Children: Rights and Responsibilities. London: Minority Rights Group. no. 69.

------- (1990)
"Globalization and Childhood" in Children and the Politics of Culture S. Stephens ed., pp. 184-90. Princeton NJ: Princeton University Press.

Bourdieu, P. (1977)
Outline of a Theory of Practise. Cambridge: Cambridge Univ. Press.

Brown, N. J. (1990)
Peasant Politics in Modern Egypt. New Haven: Yale Univ. Press.

Browne, G. E. (1921)

Arabian Medicine. Cambridge: Cambridge University Press.

Browner, C. (1989)
Women, Household, and Health in Latin America. Social Science and Medicine 28(5): 461-73.

Browner, C. & Sargent, C. (1990)
"Anthropology and Studies of Human Reproduction." in Medical Anthropology: A Handbook for Theory and Method. C. Sargent & T. Jhonson (eds.), New York: Greenwood Press.

Bruner, E. M. & Turner V. (eds.), (1986)
The Anthropology of Experience. Urbana & Chicago: University of Illinois Press.

Bruner, E. M. (1986)
"Ethnography as Narrative" in The Anthropology of Experience. E. M. Bruner & V. Turner (eds.), pp. 139-157, Urbana & Chicago: University of Illinois Press.

Bruner, E. M. (1986)
"Experience and Its Expressions" in The Anthropology of Experience. E. M. Bruner & V. Turner (eds.), pp. 3-33, Urbana & Chicago: University of Illinois Press.

Burkit, I. (1991)
"Social Selves: Theories of the Social Formation of Personality." Current Sociology 39(3).

Burman, S. & Reynolds, P. (1986)
Growing Up in a Divided Society: The Contexts of Childhood in South Africa. SA: Ravan Press.

Capmas (1989)
The Statistical Yearbook. Cairo, Egypt.

------- (1993)
Egypt Maternal & Child Health Survey 1991. Cairo: Pan Arab Project for Children and Development, League of Arab States

Cavender, T. (1988)
The Professionalization of Traditional Medicine in Zimbabwe. Human Organization. 47(3): 251-4.

Chalmers, B. (1990)
African Birth: Childbirth and Cultural Transition. River Club, SA: Berev Publications.

Charles, V. & Charles, S.X. (1979)
Child Rearing Practises in an Indian Slum. Tropical and Geographical Medicine. 31(3): 459-65.

Chowing, A. (1989)
The Doctor and the Curer: Medical Theory and Practise in Kove. A Continuing Trial of Treatment. S. Frankel & G. Lewis eds., pp. 217-249, Dordrecht: Kulwer Academic Publications.

Chrisman, N. & Johnson, T. (1990)
"Clinically Applied Anthropology." in Medical Anthropology: A Handbook of Theory and Methods. C. Sargent & T. Johnson, (eds.), pp. 37. Connecticut: Greenwood Press

Ciaccio, N.V. (1979)
Child Development in Egypt. Cairo Papers in Social Sciences. American Univ. in Cairo. vol. 3, (2).

Clifford, J. (1986)
"Introduction: Partial Truths." in Writing Culture: The Poetics and Politics of Ethnography J. Clifford & G. Marcus (eds.), pp. 1-26. Berkeley and LA: University of California Press.

Colby, A. & Selby, K. (1974)
"Medical Anthropology" The Annual Review of Anthropology, 3:245-262

Cole, M, Gay, J. Glick, J. & Sharp, P. (1971)
The Cultural Context of Learning and Thinking. New York: Basic Books.

Coles, R. (1986)
The Political Life of Children . Boston: Atlantic Monthly Press.

Collier, J. & S. Yanagisako eds., (1987)
Gender and Kinship. Stanford: Stanford University Press.

Comaroff, J. (1978)
Medicine and Culture: Some Anthropological Perspectives. Social Science and Medicine. 12B: 247-54.

---------- (1981)
Healing and Cultural transformation: The Tswana of Southern Africa. Social Science and Medicine. 15B: 115-23.

---------- (1982)
"Medicine, Symbol, and Ideology." in The Problem of Medical Knowledge: Examining the Social Construction of Medicine. P. Wright & A. Treacher, (eds.), pp. 49-68. Edinburgh: Edinburgh University Press.

---------- (1993)
"The Diseased Heart of Africa: Medicine, Colonialism, and the Black Body." in Knowledge, Power, and Practise: The Anthropology of Medicine and Everyday Life. S. Lindenbaum & M. Lock (eds.), pp. 305-330, Berkeley, LA, London: University of California Press.

Cominsky, S. & Scrimshaw, M. (1980)
Medical Pluralism on a Guatemalan Plantation. Social Science and Medicine. 14B (4): 267-79.

Coreil, J. (1988)
Innovation Among Haitian Healers: The Adoption of ORT. Human Organization 47(1): 48-57.

Coreil, J. & Mull, J.D. (1988)
"Anthropological Studies of Diarrhoeal Diseases." Social Science and Medicine 27(1): 1-3.

Coreil, J. & Mull, J.D. (1990)
Anthropology and Primary Health Care. Boulder, Colo: Westview Press.

Crapanzano, V. & Garrison, V., eds., (1977)
Case Studies in Spirit Possession. New York: Wiley.

Crapanzano, V. (1980)
Tuhami: Portrait of a Moroccon. Chicago: University of Chicago Press.

Csordas, T. & Kleinman, A. (1990)
"The Therapeutic Process" in Medical Anthropology: A Handbook of Theory and Methods. C. Sargent & T. Johnson, (eds.),pp. 11-25 Connecticut: Greenwood Press.

Csordas, T. (1990)
"Embodiment as A Paradigm for Anthropology." Ethos 18:5-47.

Davis, J. (1987)
"Family and State in the Mediterranean." in Honour ans Shame and the Unity of the mediterranean D. Gilmore (ed.), pp. 22-34.

Washington DC: American Anthropological Association.

Davis, s. (1989)
"Convenience, Cost, and Courtsey: Factors Influencing Health Care Choice in Rural Morocco." in Modern and Traditional health Care in Developing Societies C.L. Zeichner (ed.), pp. 59-73. new York: University Press of America.

De Certeau, M. (1984)
The Practice of Everyday Life. Berkeley: University of California Press.

Delaney, C. (1991)
The Seed and the Soil: Gender and Cosmology in Turkish Village Society. Berkely, LA, Oxford: University of California Press.

DelVecchio-Good, M. (1980)
"Of Blood and Babies: The Relationship of Popular Islamic Physiology and Fertility." Social Science and Medicine 14B: 147-56.

DeMausse, L. ed, (1976)
The History of Childhood London: Souvenir Press.

De Watt, B.R. & Pelto, P. eds., (1985)
Micro and Macro Levels of Analysis in Anthropology: Issues in Theory and Research. Boulder, Colo. : Westview Press.

De Zoysa, I. et al (1984)
Perceptions of Childhood Diarrhoea and its Treatment in Rural Zimbabwe. Social Science and Medicine. 19(7): 727-34.

Desjarlais, R. (1992a)
Body and Emotion: The Aesthetics of Illness and Healing in the Nepal Himalayas. Philadelphia: University of Philadelphia Press.

---------- (1992b)
"Yolmo Aesthetics of Person, Health, and 'Soul Loss'." Social Science and Medicine 34: 1105-1117.

Dickerscheid, J. D. et al (1988)
"Gender Concept Development of Pre-School Aged Children in the USA and Egypt." Sex Roles vol. 18, 1-11: 669-677.

DiGiacomo, S. (1987)
"Biomedecine as a Culture System: An Anthropologist in the Kingdom of the Sick." in

Encounters with Biomedicine H. Baer (ed.), pp. 315-346. New York: Gordon and Breach Science Publishers.

--------- (1992)
"Metaphors as Illness: Postmodern Dilemmas in the representation of the Body, Mind, and Disorder." Medical Anthrpology. vol. 14: 109-137.

Douglas, M. (1986)
Risk Acceptability According to the Social Sciences. London: Routledge and Kegan Paul.

--------- (1994)
Risk and Blame: essays in Cultural Theory. London & new York: Routledge.

Dragadze, T. (1988)
Sex Roles and State Roles in Soviet Georgia: Two Styles of Infant Socialization. In Acquiring Culture. G. Jahoda & I. Lewis eds., pp. 288-307.

Duroch, L. (1990)
"Male Perceptions as Social Constructs." in Men, Masculinity, and Social Theory D. Morgan (ed.), pp. 120-70. London: Unwin Hyman.

Dwyer, D. & Bruce, J. (1988)
A Home Divided: Women and Income in the Third World. Stanford: Stanford Univ. Press.

Early, E.A. (1982)
The Logic of Well Being. Therapeutic Narratives in Cairo, Egypt. The Ethnography of Health Care Decisions. 16(16): 1491-7.

------- (1985)
"Catharsis and Creation: Informal Narrative of Baladi Women of Cairo." Anthropological Quarterly 58:172-81.

------- (1988)
"The Baladi Curative System of Cairo, Egypt." Culture, Medicine, and Psychiatry 12: 65-83.

------- (1992)
"Fertility and Fate: Medical Practices Among Baladi Women of Cairo." in Everyday Life in the Muslim Middle East D.L. Bowen E.A. Early (eds.), pp. 102-8. Bloomington: Indiana University Press.

Ehrenreich, J ed. (1978)
The Cultural Crisis of Modern Medecine . New York: Monthly Review Press.

Eickelman, C. (1993)
"Fertility and Social Change in Oman; Women's Perspectives." Middle East Journal 47(4):652-666.

Eicklman, D. (1989)
The Middle East: An Anthropological Approach 2nd ed. Englewood Cliff, NJ: Prentice Hall

Eisenberg, L. (1977)
Disease and Illness: Distinction Between Professional and Popular Ideas of Sickness. Culture, Medicine and Psychiatry 1:9-23.

Eisenberg ,L. & Kleinman, A., eds. (1981)
"Clinical Social Science. Is Medical Practice Impeded by 'too much science?'." in The Relevance of Social Science to Medicine. pp. 1-23. L. Eisenberg and A. Kleinman (eds.), Dordrecht, Holland: Reidel.

El-Islam, M. F. (1975)
"Culture Bound Neurosis in Qatari Women." Social Psychiatry 10-25-30.

Elling, R. (1981)
"Political Economy, Cult Hegemony, and Mixes of Traditional and Modern Medicine." Social Science and Medicine 15A:89-99.

El-Mehairy, T. (1984)
Medical Doctors: A Study of the Role Concept and Job Satisfaction , the Egyptian Case. Leiden: E.J. Brill.

El-Minoufy, K. (1980)
The Political Culture of Egyptian Peasants (in Arabic). Beirut; Dar Ibn Khaldun.

El-Mofty, M. (1979)
Reports on Child Rearing Practises: A Preliminary Study. Cairo Papers in The Social Sciences. 3(2): 75-88.

Evans-Pritchard, E. (1937)
Witchcraft, Oracles and Magic Among the Azande. Oxford: Clarendon.

Fabrega, H. (1971)
Medical Anthropology. Biennual Review of Anthropology. 1971: 167-229.

------ (1990)

"A Plea for a Broader Ethnomedicine." Culture, Medicine , and Psychiatry 14(1): 129-132.

Fabrega, H. & D. B. Silver, (1973)
Illness and Shamanistic Curing in Zincantan . Stanford: Stanford University Press.

Fahmy, K. (n.d.)
"Medicine and Power in 19th Century Egypt." Unpublished manuscript.

Fakhouri, h. (1968)
"The Zar Cult in an Egyptian Village." Anthropology Oaurterly, 41:49-56.

------- (1972)
Kafr El-Elow: An Egyptian Village in Transition. Holt, Rinehart and Winston inc.

Fakhr-el-Islam, M. et al (1988)
"Oral Contraceptives, Socio-cultural Beliefs, and Psychiatric Symptoms." Social Science and Medicine 27(9): 941-5.

Fassin, D. & Fassin, E. (1988)
Traditional Medicine and the Stakes of Legitimation in Senegal. Social Science and Medicine. 27(4): 353-7.

Favret-Saada, J. (1980)
Deadly Words: Wichcraft in the Bocage. Cambridge: Cambridge University Press.

Fernea, E. ed. (1995)
Children in the Muslim Middle East. Austin: Univ. of Texas Press.

Feierman, S. (1979)
Changes in African Therapeutic Systems. Social Science and Medicine. 13B(4): 277-85.

Feierman, S. & J. Janzen, eds. (1992)
The Social Basis of Health and Healing in Africa Berkeley, LA, Oxford: University of California Press.

Fergany, N. (1993)
"Social Development in Assiut". Report. Cairo: Unicef.

Finerman, R. (1987)
"Inside Out: Women's World View and Family Health in an Ecuadorian Indian Community." Social Science and Medicine 25(10): 1157-62.

Finkler, K. (1991)

Physicians at Work, Patients in Pain. Boulder CO.: Westview Press.

---------- (1994)
"Sacred Healing and Biomedicine Compared." Medical Anthropology Quarterly 8(2): 178-197

Firth, R. (1936)
We the Tikopia. London: Allen & Unwin.

Fortes, M. (1938)
Social and Psychological Aspects of Education in Taleland. In Time and Social Structure and Other Essays. by M. Fortes. London: Athlone Press. 1970.

Foster, G.M. & Anderson, B. (1978)
Medical Anthropology. N.Y. : Wiley.

Foster, G. (1994)
Hippocrates Latin Americal Legacy Pennsylvania. Gordon Breach Sciena Publiches

Foucault, M. (1973)
The Birth of the Clinic: An Archaeology of Medical Perception. London: Tavistock Publications.

-------- (1980)
Power/Knowledge: Selected Interviews and Other Writings 1872-77. C. Gordon. ed., New York: Pantheon Books.

Fox, R. (1991)
"Introduction." in Recapturing Anthropology, R. Fox, ed., pp. 1-6. Santa Fe, N.M.: School of American Research Press.

Frake, C. (1961)
The Diagnosis of Disease Among the Subanum of Mindanao. American Anthropologist. 63: 113-32.

Frankel, S. (1986)
The Huli Response to Illness. Cambridge Studies in Anthropology no. 62. Cambridge: Cambridge Univ. Press.

Frankel, S. & Lewis, G., eds., (1989)
A Continuing Trial of Treatment: Medical Pluralism in Papua New Guinea. Dordrecht, London, Boston: Kulwer Academic Pub.

Frankenberg, R. (1980)

Medical Anthropology and Development: A Theoretical Perspective. Social Science and Medicine. 14B: 197-207.

-------- (1988)
"Gramsci, Culture, and Medical Anthropology: Kundry and Parsifal? or Rat's Tail to Sea Serpent? Medical Anthropology Quarterly. 2:324-337.

-------- (1993)
"Risk: Anthropological and Epidemiological Narratives of Prevention." in Knowledge, Power, and Practice S. Lindenbaum & M. Lock eds., 219-245. Berkely, LA, London: California University Press.

Freeman, M. (1983)
The Rights and Wrongs of Children. London: Francis Pinter Publishers.

Franklin, S. (1997)
Embodied Progress: A Cultural accord of Assissted Conception. London, new York: Routledge.

Furnham, A. & Smith, C. (1988)
"Choosing Alternative Medicine: A Comparison of the Beliefs of Patients Visiting a General Practitioner and a Homeopath.". Social Science and Medicine. 26(7):685-691

Fyfe, A. (1989)
Child Labour. Cambridge: Polity Press.

Gallagher, N. (1990)
Egypt's Other Wars: Eoidemics and the Politics of Public Health. Syracuse, new York: Syracuse University Press.

Garbarino, J. Dubrow, K., Kestelny, C. & Pardo, C. (1992)
Children in Danger: Coping with the Consequences of Community Violence. San Fransisco: Jossey-Bass Publishers.

Geertz, C. (1973)
Thick Descriptions: Towards an Interpretive Theory of Culture." In The Interpretation of Culture by C. Geertz, pp. 3-30. New York: Basic books.

--------- (1983)
Local Knowledge New York: Basic Books.

---------- (1986)
"Making Experience, Authoring Selves." in The Anthropology of Experience. E. Bruner & V. Turner, eds., pp. 373-381. Urbana & Chicago: University of Illinois Press.

Ghosh, A (1982)
"Relations of Envy in an Egyptian Village" Ethnology vol XXII : 211-223

Giacman, R. (1988)
Life and health in Three Palestinian Villages. London: Ithaca Press.

Gilsenan, M. (1973)
Saint and Sufi in Modern Egypt. Oxford: Clarendon Press.

Ginsburg, F. & Rapp, R. (1991)
"The Politics of Reproduction." Annual Review of Anthropology. 20:311-343.

Glasser, M. (1988)
"Accountability of the Anthropologists, Indigenous Healers, and their Governements." Social Science and Medicine 27(12): 1461-64.

Glavanis, K. & Glavanis, P. (1983)
"The Sociology of Agrarian Relations in the Middle East: The Persistence of Household Production." Current Sociology 31(2): 1-109.

Glavanis, K. & Glavanis P., eds., (1990)
The Rural Middle East: Peasant Lives and Modes of Production. London: Birzeit Univ. & Zed Books Ltd.

Glavanis, K. (1984)
"Aspects of Non-Capitalist Social Relations in Rural Egypt. The Small Peasant Household in an Egyptian Delta Village." in Family and Work in Rural Societies N. Long ed., pp. 30-60. London: Tavistock.

Glick, L.B. (1967)
Medicine as an Ethnographic Category: The Gimi of the New Guinea Highlands. Ethnology. 6(1): 31-57.

Good, B.J. (1977)

The Heart of What's the Matter: The Semantics of Illness in Iran. Cultural & Medical Psychiatry. 1: 25-58.

Good, B. (1994)
Medicine, Rationality and Experience: An Anthropological Perspective. Cambridgge,: Cambridge University Press.

Good, B. & DelVecchio-Good, M. (1990)
"Learning Medicine: The Constructing of Medical Knowledge at Harvard Medical Schhol." in Knowledge, Power, and Practice S. Lindenbaum & M. Lock eds., pp. 81-108. Berkely, LA, London: California University Press.

Gordon, L. (1978)
"The Politics of Birth Control, 1920-1940: The Impact of Professionalization." in The Cultural Crisis of Modern Medicine J. Ehrenreich ed., pp. 144-84. New York: Monthly Review Press.

Gramsci, A. (1971)
Selections Frome the Prison Notebooks. London: Lawrence And Wishart.

Gran, P. (1979)
Medical Pluralism in Arab and Egyptian History: An Overview of Class Structures and Philosophies of the Main Phase. Social Science ad Medicine. 13B(4): 339-49.

Granqvist, H. (1947)
Birth and Childhood Among the Arabs: Studies in a Mohamadan Village in Palestine. Helsingfors: Soderstrom.

Gray, B. (1982)
"Enga Birth, Maturation and Survival: Physiological Characteristics of the Life Cycle in the New Guinea Highlands." in Ethnography of Fertility and Birth. C.P. MacCormack ed., pp. 75-115. London: Academic Press.

Greenwood, B. (1981)
Cold or Spirit? Choice and Ambiguity in Morocco's Pluralistic Medical System." Social Science and Medicine 15B: 219-35.

Grodos, D. & De Bethume, X. (1988)

Les Interventions Sanitaires Selectives: Un Piege Pour les Politiques de Sante du Tiers Monde. Social Science and Medicine. 26(9): 879-91.

Gruenbaum, E. (1981)
Medical Anthropology, Health Policy and the State. A case Study of Sudan. Political Studies Review. 1: 47-65.

Hadidi, H. (1990)
Socio-Cultural Factors Influencing the Prevalence of Diarrhoeal Diseases in Rural Uppper Egypt: An Ethnographic Study of Two Villages of Sohag. Cairo: Unicef.

Hahn, R. & Kleinman, A. (1983)
"Biomedical Practice and Anthropological Theory: Frameworks and Directions." Annual Review of Anthropology 12:305-33.

Hahn R. & Atwood, G. (1985)
Physicians of Western Medicine. Dordrecht, Holland: Kulwer Academic Publishers.

Hamamah, S. K. (1984)
Health Sciences in Early Islam 2 vol. Texas: Zahra Publishers.

Hana, M.S. (1974)
Dirasat Fi tarbiyat El-Atfal. (Studies in Child Rearing Practises). Cairo: Dar El-Sakafa.

Harik, I. (1974)
The Political Mobilization of Peasants: A Study of an Egyptian Community. Bloomington: Indiana Univ. Press.

Harker, R., Maher, C. & Wilkes, C. eds., (1990)
An Introduction to the Works of Pierre Bourdieu. London: Macmillan.

Harrison, G. et al (1993)
"Breastfeeding and Weaning in a Poor Urban neighborhood in Cairo, Egypt: Maternal beliefs and Perceptions." Social Science and Medicine 36(8):1063-9.

Hartman, B. (1987)
Reproductive Rights and Wrongs: The Global Politics of Population Control and Contraceptive Choice. New York: Harper & Row Publishers.

Hatem, M. (1987)

"Towards the Study of of the Psychodynamics of Mothering and gender in Egyptian Families. International Journal for Middle East Studies 19:287-306.

Heggenhougen, K. & Draper, A. (1990a)
Medical Anthropology and Primary health Care. London: EPC Publications, London School of Hygiene and Tropical Medicine.

-------- (1990b)
The Concept of Acceptability- The Role of Communication and the Social Sciences. in Prospects for Public health Benefits in Developing Countries from New vaccines against Enteric Infection D. Sack & L. Frei eds., pp. 180-9. Stokholm: SAREC.

Helman, C. (1990)
Culture, Health, and Illness. London: Wright

Henein, H. (1988)
Marie Girgis: Village De Haute-Egypte. Cairo: CEDEJ.

Herzlich, C. & Pierret, J. (1986)
Illness: From Causes to meaning. in Concepts of Health, Illness, and Disease: A Comparative Perspective. C. currer & M. Stacey (eds.), New York: Berg.

Hill, A. & Langsten, R. (1995)
"Treatment of Childhood Diarrhoea in Rural Egypt." Social Science and medicine 40(7):989-1003.

Hirschhorn, N. (1989)
Appropriate Health Technology in Egypt." Middle East Report vol. 19, no. 161:26-9.

Hodgson, M.S. (1988)
"A Hierarchical Location Allocation Model for Primary Health Care Delivery in a Developing Area." Social Science and Medicine 26(1):153-61.

Hoodfar, H. (19860
"Child Care and Child Survival in Low Income Neighberhoods of Cairo." Population Council Regional Papers, WANA Region. Cairo: The Population Council.

--------- (1988)

Household Budgeting and Financial Management in a Lower-Income Cairo Neighborhood. In A Home Divided. D. Dwyer & J. Bruce eds., pp: 120-142. Stanford: Stanford University Press.

------- (1991)
"Return to the Veil: Personal Strategy and Public Participation in Egypt." in Working Women: International Perspectives on Labour and Gender Ideology. N. Redclift & M. Sinclair eds., pp.104-24. New York: Routledge.

------- (1993)
"The Impact of Egyptian Labour Male Migration on Urban Families. Feminization of the Egyptian Family or a Reafirmation of Traditional Gender Roles?" Sociological Bulletin 42(1&2):113-135.

------- (1995)
"Child Care and Child Health in Low Income Neighberhoods of Cairo." in Children of the Muslim Middle East E. Fernea ed.,pp.146-67 Austin: University of Texas Press.

Hopkins, N.S. (1988)
Agrarian Transformation in Egypt. Cairo: The American Univ. in Cairo Press.

Houseman, M. (1988)
Towards a Complex Model of Parenthhod: Two African Tales." American Ethnologist 15(4):658-78.

Hussein, T. (1990)
An Egyptian Childhood. Cairo: American Univ. in Cairo Press.

Ibn- Battuta (1969)
Travels in Asia and Africa 1325-1354. New York: Augustus M. Kelly Publishers.

Ibrahim, S. (1982)
The New Arab Social Order. Boulder, Colo. : Westview.

Illich, I. (1976)
Limits To Medicine. Medical Nemesis: The Expropriation of Health. London: Penguin Books.

Illick, J. (1976)
"Child-Rearing in 17th cent. England and America." in The History of Childhood , L. DeMause (ed.). New York: Souvenir Press.

Imhof, A. E. (1985)

From the Old Mortality Pattern to the New: Implications of a Radical Change From the 16th to the 20th Century. Bulletin of the History of Medicine. 59: 1-29.

Inhorn, M. (1994)
Quest for Conception: Gender, Infertility, and Egyptian Medical Traditions. Philadelphis: University of Pennsylvania Press.

------- (1996)
Infertility and Patriarchy:The Cultural Politics of Gender and Family Life in Egypt. Philadelphia: University of Pennsylvania Press.

Ismael, A. (1892)
Tibb el-Rokkah (The Medicine of Distaff). Cairo: El-Matba'a El-Amiriya.

Ismail M.S. et al (1967)
Kayf Nurabi Atfaluna. (How We Raise our Children) (in Arabic). Cairo: Dar El-Nahda El-Arabiya.

Irvine, J., Miles, I. & Evans, J., eds., (1979)
Demystifying Social statistics. London: Pluto Press.

al-Jabarti, A. (1958)
'Aja'ib al-Athar fi al-Tarajim wa al-Akhbar (The Wonders of Influences in Books and News). Cairo.

Jackson, M. (1979)
"Knowledge of the Body." Man (N.S.) 18:327-345.

Jacobson-Widding, A. & Westerland, D., eds., (1989)
Culture, Experience and Pluralism: Essays on African Ideas of Illness and Healing. Uppsala: Uppsala Studies in Cultural Anthropology (13).

Jacobus, M., Keller, E. , Shuttleworth, S. (1990)
Body Politics, Women, and The Discourses of Science. New York: Routledge.

Jahoda, G. & Lewis, I. (1988)
Introduction; Child Development in Psychology and Anthropology. Acquiring Culture. G. Jahoda & I. Lewis eds., pp. 1-35. London: Croom Helm

Jahoda, G. & Lewis I., eds., (1988)
Acquiring Culture; Cross Cultural Studies in Child Development. London: Croom Helm.

James, A. & Prout, A. eds., (1990)

Constructing and Reconstructing Childhood: Contemporary Issues in the Sociologycal Study of Childhood. London: Falmer Press.

---------- (1990)
"A New Paradigm for the Sociology of Childhood? Provenance, Promise, and Problems." in Constructing and Reconstructing Childhood: Contemporary Issues in the Sociologycal Study of Childhood. A. James & A. Prout (eds.), pp. 7-35. London: Falmer Press.

James, A. (1993)
Childhood Identities: Self and Social Relationships in the Experiences of the Child. Edinburgh: Edinburgh University Press.

Janzen, J (1978a)
The Quest for Therapy in Lower Zaire. Berkeley: Univ. of California Press.

Janzen, J. (1978b)
The Comparative Study of Medical Systems as Changing Social Systems. Social Science and Medicine. 12(2B): 121-9.

Janzen, J. (1981)
The Need for a Taxonomy of Health in the Study of African Therapeutics. Social Science and Medicine. 15B: 185-94.

Johnson, T. & C. Sargent eds., (1990)
Medical Anthropology: A Textbook of Theory and Method. Westport, Connec.: Greenwood Press.

Jordan, B. (1983)
Birth in Four Cultures. Montreal: Eden Press.

Justice, J. (1986)
Policies, Plans and People: Culture and Health Development in Nepal. Berkeley: Univ. of California Press.

Justice, J. (1987)
The Bureaucratic Context of International Health: A Social Scientists' View. Social Science and Medicine 25(12): 1301-6.

Kaberry, P.M. (1939)
Aboriginal Women: Sacred & Profane. London: Routledge.

Kamal, M. (1994)
"A Qualitative Encounter with Quantative Research: The Case of Quality of Care." Ppaer prepared for Workshop on Qualitative Methodology, University of Bogazici, Istanbul, July 25-28, 1994.

Kandioty, D. ed., (1996)
Gendering the Middle East: Emmerging Perspectives. London & New York: I B Taurus.

Kapferer, B. (1986)
Performance and the Strycturing of Meaning and Experience. in The Anthropology of Experience E. Bruner & V. Turner eds., pp. 188-206. Urbana & Chicago: University of Illinois Press.

-------- (1988)
"Gramsci's Body and a Critical Medical Anthropology." Medical Anthropology Quarterly. (N.S.) 2(4): 426-32.

Kaufert, P. & O'neil, J. (1993)
"Analysis of a Dialogue. Risk in Childbirth: Clinicians, Epidemiologists and Inuit Women." in Knowledge, Power, and Practice S. Lindenbaum & M. Lock eds., 32-55. Berkely, LA, London: California University Press.

Kaufman, S. (1988)
"Towards a Phenomenology of Boundaries in Medicine: Chronic Illness Experience in the Case of Stroke. Medical Anthropology Quarterly (n.S.) 2(4):338-354.

Keesing, R. (1989)
"Exotic Readings of Cultural Texts." Current Anthropology 30(4): 459-0.

Keller, D., Hillier, S. eds., (1996)
Researching Cultural Difference in Health London, new York: Routledge.

Kendall, C., Foole, D. Martovell, R. (1984)
"Ethnomedicine and Oral Rehydration Therapy: A Case Study of Ethnomedical Investigation in Program Planning." Social Science and Medicine 19:253-260.

Kennedy, J. (1967)
"Nubian Zar ceremonies as Psychotherapy." in Culture, Disease, and Healing: Studies in Medical

Anthropology D. Landy ed., pp. 185-94. New York: Mc Pub Press.

------- (1978)
"Mushahra: A Nubian Concept of Supernatural Danger and the Theory of Taboo." in Nubian Ceremonial Life J. Kennedy ed., pp. 125-145. Berkeley: University of California Press.

Kerdoussey, M. (1996)
Mara Wa'hid Sa'eedy (Once and Upper Egyptian). Cairo : Madbouli Press.

Kerns, V. & Brown, J. (1992)
In Her Prime: New Views of Middle Aged Women. Urbana & Chicago: University of Illinois Press.

Kessel, F. & Seigel A. eds., (1983)
The Child and Other Cultural Inventions. New York: Praeger.

Keyser, J. (1974)
The Middle Eastern Case: Is There a Marriage Rule? Ethnology 8(3): 293-308.

Khatib-Chahidi, J. (1992)
"Milk Kinship in Shi'ite islamic Iran." in The Anthropology of Breastfeeding. V. Maher ed., pp. 133-151. Cross Cultural Perspectives on Women. Oxford/Providence: Berg.

Khuri, F. (1970)
"Parallel Cousin Marriage Reconsidered; A Middle Eastern Practice that Nullifies the Effects of Marriage on the Intensity of Family Relationships." Man (N.S.) 5(4):597-618.

Kim, Y. Norsigian, J. (1989)
"Contraception, Control, and Choice: International Perspectives." in Healing Technology: Femenist Perspectives. K.S. Retcliff et al eds., pp. 61-92. Ann Arbor: University of Michigan Press.

Kleinman, , A. et al, eds., (1975)
Medicine in Chinese Cultures: Comparative Studies of Health Care in Chinese and Other Societies. Washington: Fogarty Int. Cent.

Kleinman, A.(1978)
"Clinical Relevance of Anthropological and Cross-Cultural Research: Concepts and Strategies." Social Science and Medicine 12B:85-93

---------- (1980)

Patients and healers in the Context of Culture: An Exploration of the Borderland Between Anthropology, Medicine, and Psychiatry. Berkeley: Univ. of California Press.

--------- (1981)
"On Illness Meaning and Clinical Interpretation: Not rational man, but a Rational Approach to Man the Suffere/man the Healer.2 Culture, medicine, and Psychiatry 5:373-77.

--------- (19880
The Illness narrative, Suffering, Healing, and The Human Condition. new York: Basic Books.

-------- (1994)
"Pain and Resistance: The Deligitimation and Religitimation of Local Worlds. in Pain, Culture, and Experience: The Anthropology of Chronic Pain in American Society B. good, M. DelVechchio-Good, P. Bordwin, A. Kleinman eds.,. Berkeley : University of California press.

Kluzinger, C. (1878)
Upper Egypt: Its People and Its Products. (1st ed.) New York: Scribner, Armstrong, & Sons.

Konner, M. (1977)
Infancy Among the Kalahari Desert San. In Culture and Infancy: Variations in the Human Experience. P.H. Leiderman, A. Rosenfeld & S.R. Tulkin eds., pp. 287-329.

Kuhnke, L. (1974)
"The Doctor on a Donkey: Women health Officers in Ninteenth Century Egypt." Clio Medica 9(3): 199.

---------- (1990)
Lives at Risk: Public Health in Ninteenth Century Egypt. Berkeley: Univ. of Calif. Press.

Lane, E. (1936)
Manners and Customs of the Modern Ehyptians. vol. 1 & 2. London.

Lane, S. , Millar, M. (1987)
"The Hierarchy of Resort Reexamined: Status and Class Differentiation as Determinants of Therapy for Eye Disease in the Egyptian Delta." Urban Anthropology 16(2): 151-182.

Lane, S. & Millar, M.I. (1988)
Ethno-Ophthalmology in the Egyptian Delta: An Historical Systems Approach to Ethnomedicine in the Middle East. Social Science and Medicine. 26(6): 651-9.

Landy, D. (1990)
"Towards a Biocultural Medical Anthropology." Medical Anthropology Quarterly (N.S.) 4(3):358-69.

Last, M. (1981)
"The Importance of Knowing About not Knowing." Social Science and Medicine 15B:387-92.

Last, M. & G.L. Chavunduka (eds) (1986)
The Professionalization of African Medicine. Manchester: Manchester Univ. Press & Int. African Institute.

Leach, E. (1967)
An Anthropologist's Reflections on a Social Survey. In Anthropologists in the Field D.G. Jongmans and P.C.W. Gutkind eds., Assen: Van Gorcum.

Leiderman, P.H. & Leiderman, G.F. (1977)
Economic Change and Infant Care. In Culture and Infancy: Variations in the Human Experience. P.H. Leiderman, A. Rosenfeld, & S.R. Tulkin eds., pp. 405-38. New York, San Fransisco, London: Academic Press.

Leiderman, P.H., Rosenfeld, A. & Tulkin, S.R. (eds.) (1977)
Culture and Infancy: Variations in the Human Experience. New York: Acdemic Press.

Leslie, C., ed. (1976)
Asian Medical Systems: A Comparative Study. Berkeley: Univ. California Press.

Leslie, C., ed. (1980)
Special Issue on Medical Pluralism. Social Science and Medicine. 14B (4).

Levi-Straus, C. (1969)
The Elemetary Structures of Kinship. Boston: Beacon

Levine, R. (1977)

Child Rearing as Cultural Adaptation. In Culture and Infancy: Variations in the Human Experience. P.H. Leiderman, A. Rosenfeld & S.R. Tulkin eds., pp. 15-26.

-------- (1994)
Child Care and Culture: Lessons From Africa. Cambridge: Cambridge University Press.

Lewis, G. (1975)
Knowledge of Illness in Sepik Society. London; Athlone.

-------- (1981)
"Cultural Influences in Illness Behaviour: A Medical Anthropological Approach." in The Relevance of Social Science for Medicine L. Eisenberg & A. Kleinman (eds.,). Dordrecht, Holland:Kulwer Academic Publishers.

-------- (1993)
"Some Studies of Social Causes and Cultural Responses to Diseases." in The Anthropology of Disease. C.G.N. Macie-Taylor ed., pp.73-100. Oxford, New York, Tokyo: Oxford University Press.

Lewis, I. (1989)
Ecstatic Religion: A Study of Shamanism and Spirit Possession. (2nd Ed.) London: Routledge.

Lewis, I., A-Safi, A. & Hurreiz, S. eds., (1991)
Women's Medicine: The Zar-Bori Cult in Africa and Beyond. Edinburgh: Edinburgh University Press for The International African Institute.

Lindenbaum, S. & Lock, M. eds.,(1993)
Knowledge, Power, and Practice. Berkely, LA, London: California University Press.

Lloyd, G. E. R. (1990)
Demystying Mentalities. Cambridge: Cambridge University press.

Lock, M. (1985)
"Models and Practice in Medicine. Menopause as Syndrome or Life Transition." in Physicians of Western Medicine. R. hahn and A. Gaines eds., pp.115-39. Boston: Reidel.

------- (1993)

"Cultivating the Body: Anthropoogies and Epistemologies of Bodily Practice and Knowledge." Annual review of Anthropology 22:133-55.

Lock, M. & Gordon, D. (1988)
Biomedicine Examined. Dordrecht, Holland: Kulwer Academic Publishers.

Lock, M. , Scheper-Hughes, N. (1990)
"A Critical Interpretive Approach in Medical Anthropology: Rituals and Routines of Discipline and Dissent." in Medical Anthropology: A Handbbok of Theory and Method T. Johnson & C. Sargent eds., pp. 47-72. New York: Greenwood.

Lolas, (1994)
"Medical Praxis : An Interface between Ethics, Politics, and Technology' Social Science & Medicine. 39(1):1-5

Long, N. (1993)
"From Paradigms Lost to Paradigms Regained." in Battlefields of Knowledge N. Long and A. Long eds., pp. 16-43. London & new York: Routledge.

MacCormack, C.P. & Strathern, M., eds., (1980)
Nature, Culture and Gender. Cambridge: Cambridge Univ. Press.

MacCormack, C.P. (1980)
Proto-Social to Adult: A Sherbro Transformation. In Nature Culture and Gender. C.P. MacCormack & M. Strathern eds., pp. 95-119.

---------- (1981)
Health Care and The Concept of Legitimacy. Social Science and Medicine 15B: 423-8.

--------- (1982)
Biological, Cultural and Social Adaptation in Human Fertility and Birth: A Synthesis. The Ethnography of Fertility and Birth. C.P. MacCormack ed., pp. 1-25.

--------- (1982) ed.
The Ethnography of Fertility and Birth. London: Academic Press.

--------- (1986)
The Articulation of Western and Traditional Systems of Health Care. In The

Professionalization of African Medicine. M. Last & G.L. Chavunduka eds., pp. 151-62.

--------- (1988)
Health and the Social Power of Women. Social Science and Medicine. 26(7): 677-85.

--------- (1993)
"Medicine and Anthropology." in The Companion Encyclopeadia to the History of Medicine W. F. Byrum & R. Porter eds., vol. 2 pp. 1436-1448. London: Routledge.

Maher, V. (1992)
The Anthropology of Breastfeeding. Natural Law or Social Construction. Cross Cultural Studies on Women. Oxford/Providence: Berg.

Malinowski, B. (1966)
The Father in Primitive Psychology. New York: The Norton Library.

Marsh, C. (1982)
The Survey Method. London: Allen & Unwin.

Martin, E. (1989)
The Woman in the Body: A Cultural Analysis of Reproduction. Milton Keynes: Open University Press.

-------- (1990)
"Toward an Anthropology of Immunology and the Body as a Nation State." Medical Anthropology Quarterly 4:410-26.

Macie-Taylor, C.G.N. (1993)
The Anthropology of Disease. Oxford and New York: Oxford University Press.

Mayall, B. (1993)
"Keeping Children healthy: The Intermediate Domain." Social Science and Medicine 36(1):77-83.

--------- (1996)
Children, health, and the Social Order. Buckingham & Philadelphia: Open University Press.

Mayer, P. (1970)
Socialization: The Approach From Social Anthropology. London: Tavistock Publications.

Mayfield, J. (1971)
Rural Politics in Nasser's Egypt: A Quest for Legitimacy. Austin: Univ. of Texas Press.

M'Bokolo, E. (1995)
History of Diseases, History and Disease: Africa." in The Meaning of Illness. Trans. K.J. Durnin et al.M Auge & C Hezerlich eds., pp 123-151. Luxembourg: Harwood Academic Publishers.

McEwan, J.M.P., ed., (1979)
Parallel Medical Systems: Papers from a Workshop on the Healing Process. Special Issue. Social Science and Medicine. 13B (1).

McEwan, J.M.P., ed., (1988)
Anthropological Studies of Diarrhoeal Diseases. Special Issue. Social Science and Medicine. 27(1).

McEwan, J.M.P., ed., (1990)
Critical Perspectives in Clinically Applied Medical Anthropology. Special Issue. Social Science and Medicine. 30(9).

McEwan, J.M.P., ed., (1990)
Critical Medical Anthropology: Theory and Research. Special Issue. Social Science and Medicine. 30(2).

McKee, L. (1987)
Ethnomedical Treatment of Diarrhoeal Illness in the Highlands of Ecuador. Social Science and Medicine. 25(10): 1147-55.

Mead, M. (1928)
Coming of Age in samoa: A psychological Study of Primitive Youth for Western Civilization. London: Jonathan Cape.

Mead, M. & Wolfenstein, M (1963)
Childhood in Contemporary Cultures. Chicago, London: University of Chicago Pree.

Melrose, D. (1982)
Bitter Pills: Medicine and the Third World Poor. London: Oxfam.

Miller, P. , Hirschhorn, N. (1995)
"Effects of National Control of Diarrhoeal Diseases Program (NCDDP) on Mortality, Case of Egypt." Social Science and Medicine 40(10):5310536.

Mitchell, T. (1989)

Colonising Egypt. Cairo: American Univ. in Cairo Press.

el-Mofty, M. (1979)
"Children's Reports of Child-Rearing Practices: A Preliminary Study. Cairo Papers in Social Sciences 3(2):75-88.

Morgan, L. (1987)
"Dependency Theory in the Political Economy of Health: An Anthropological Critique." Medical Anthropology Quarterly 1(1):131-155.

Morsy, S. (1978)
Sex Roles, Power and Illness in an Egyptian Village. American Ethnologist. 5(1): 137-51.

--------- (1980)
Body Concepts and Health Care: Illustrations from an Egyptian Village. Human Organization. 39(1): 92-6.

--------- (1981a)
Towards a Political Economy of Health: A Critical Note on the Medical Anthropology of the Middle East. Social Science and Medicine. 15B (2): 159-63.

--------- (1981b)
"Childbirth in an Egyptian Village." in An Anthropology of Human Birth M. Kay ed., pp. 147-174. Philadelphia: F. A. Davis Company.

--------- (1988)
"Islamic Clinics in Egypt: The Cultural Elaboration of Biomedical Hegemony." Medical Anthropology Quarterly 2(4):355-369.

--------- (1990)
Political Economy in Medical Anthropology. A Handbook of Theory and Method in Medical Anthropology. J. Johnson & C. Sargent eds., Connec.:Greenwood Press. pp. 26-46.

------- (1993)
Gender, Sickness, and Healing in Rural Egypt. Boulder, San Fransisco, Oxford: westview Press.

Mull, J. D. & Mull, D. S. (1988)

"Mother's Concepts of Childhood Diarhoea in Rural Pakistan." Social Science and Medicine 27(1): 53-67.

Mull, J. D., Coreil, J. (1990)
Anthropology and Primary Health Care. Boulder: Westview Press.

Murray, C. Chen, L. (1992)
"Understanding Morbidity Change." Population and Development Review 18(3): 481-503.

Myntti, C. (1985)
Changing Attitudes Towards Health: Some Observations from the Hujariya. In Economy, Society and Culture in Contemporary Yemen. B.R. Pridham ed., London: Croom Helm. pp. 165-171.

Navarro, V. ed., (1981)
Imperialism, Health, and Medicine. Farmingdale, N.Y. :Baywood.

--------- (1984)
"Capitalism , Health and Illness." in issues in the Political Economy of Health Care J. McKinlay ed., New York: Tavistock Publications.

Navarro, V. (1986)
Crisis, Health, and Medicine: A Social Critique. London: Tavistock.

Nelson, C. (1971)
Self, Spirit Possession and World View: An Illustration from Egypt. Int. Journal of Psychiatry. 17(194).

Ngokwey, N. (1988)
Pluralistic Etiological systems in their Social Context: a Brazilian Case Study. Social Science and Medicine 26(8): 793-802.

Ngubane, H. (1977)
Body and Mind in Zulu Medicine; An Ethnography of Health and Disease in Nyuswala-Zulu Thought and Practise. New York: Acdemic Press.

Nichter, M. (1980)
The Layperson's Perception of Medicine as Perspective into the Utilization of Multiple Therapy Systems in the Indian Context. Social Science and Medicine. 14B: 225-33.

--------- (1981)
"Idioms of Distress." Culture, Medicine and Psychiatry 5:379-408.

--------- (1988)
"From Aralu to ORS, Sinhalese Perceptions od Digestion, Diarrhoea, and Dehydration." Social Science and Medicine 27(1):39-52.

--------- (1989)
Anthropology and International health: South Asian Case Studies. Dordrecht, Holland: Kulwer Academic Publications

-------- ed.,(1992)
Anthropological Aproaches to the Study of Ethnomedicine . Montreux, Switzerland: Gordon & Breach science Publications

--------- (1993)
"Social Science Lessons from Diarrhoea Research and their Application to ARI" Human Organization 52(1):53-67.

Nyamwaya, D. (1987)
A Case Study of the Interaction Between Indigenous and Western Medicine Among the Pokot of Kenya. Social Science and Medicine. 25(12): 1277-89.

Oakley, A. (1986)
The Captured Womb: A History of Medical Care and Pregant Women. 2nd ed., Oxford: Basil Blackwell.

Obeyesekere, G. (1981)
Medusa's Hair: An Essay on Personal Symbols and Religious Experience. Chicago: Univ. of Chicago Press.

Oldham, L (1990)
Socio-Cultural Factors Influencing the Prevalence of Diarrhoeal Diseases in Rural Uppper Egypt. Cairo: Unicef.

Onoge, O.F. (1975)
Capitalism and Public Health: A Neglected Theme in the Medical Anthropology of Africa. Topias and Utopias in Health. S.R. Ingman & A.E. Thomas eds., The Hague: Mouton. pp. 219-232.

Ortner, S. (1974)

"Is Female to Male as Nature to Culture?" in Women, Culture, and Society M. Rosaldo & L. Lamphere eds., pp. 67-87. Stanford: Stanford University Press.

Patel, V. L. , Eiseman, T. Arocha, J. (1988)
"Casual reasoning and the Treatment of Diarhoeal Disease by Mothers in Kenya." Social Science and Medicien 27(11): 1277-86.

Peletz, M. (1995)
"Kinship Studies in Late Twentieth Century Anthropology." Annual Review of Anthropology 24:343-372.

Pelto,P. & Pelto, G. (1978)
Anthropological Research. Cambridge: Cambridge Univ. Press.

Peters, E. (1978)
The Status of Women in Four Middle East Communities. In Women in the Muslim World L. Beck & N. Keddie eds., Cambridge, Mass. : Harvard Univ. Press.

Pierret, J. (1995)
"The Social Meaning of Health: Paris, The Essonne, and the Herault." in The Meaning of Illness. Trans. K.J. Durnin et al.M Auge & C Hezerlich eds., pp 175-207. Luxembourg: Harwood Academic Publishers.

Platt, K. (1988)
Cognitive Development and Sex Roles on the Kerkennah Islands of Tunisia. In Acquiring Culture. G. Jahoda & I. Lewis eds., pp. 271-87.

Pool, R. (1994)
Dialogue and the Interpretation of Illness: Conversation in a Cameroon Village. Oxford, Providence: Berg.

Ramzy, M. (1963)
Al-Oamus Al-Goghraphy Al Masry (The Egyptian Geographical Dictionary), Cairo: Dar el-Kutub.

Rapp, R. (1993)
"Accounting for Amniocentisis." in Knowledge, Power, and Practice S. Lindenbaum & M. Lock eds., pp. 55-79. Berkely, LA, London: California University Press.

Rashad, H. , El-Zeini, L. (1993)
"Measuring Mortality and Morbidity in Egypt." Unpublished Paper.

Ratcliff, K. et al (1989)
Healing Technology: Femenist Perspectives . Ann Arbor: University of Michigan Press.

Raum, O. (1940)
Chaga Childhood. London: Oxford Univ. Press.

Read. M. (1960)
Children of their Fathers: Growing Up Among the Ngoni of Nyasaland. New Haven: Yale Univ. Press.

Reynolds, P. (1986)
Children in Crossroads: Cognition and Society in South Africa. SA: David Philip; Erdmans.

-------- (1991)
Dance Civet Cat: Child Labour in the Zambezi Valley. Ohio: University Press.

Richards, A. (1939)
Land, Labour, and Diet in Northen Rhodesia: An Economic Study of the Bemba Tribe. London: Oxford Univ. Press.

Richards, A. (1970)
Socialization and Contemporary British Social Anthropology. Socialization: The Approach From Social Anthropology. P. Mayer ed., pp. 1-26.

Rivers, W.H.R. (1924)
Medicine, Magic, and Religion New York: Harcourt & Brace.

Roldan, M. (1988)
Renegotiating the Marital Contract: Intrahousehold Patterns of Money Allocation and Women's Subordination Among Domestic Outworkers in Mexico City. In A Home Divided D. Dwyer & J. Bruce (eds.), pp: 229-247.

Rosaldo, R. (1986)
"Ilongot Hunting as Story and Experience." in The Anthropology of Experience E. Bruner & V. Turner eds., pp. 97-139. Urbana & Chicago: University of Chicago Press.

Rubel, A. , Hass, M. (1990)
"Ethnomedicine" in Medical Anthropology: A Handbbok of Theory and Method T. Johnson & C.

Sargent eds., pp. 115-31. Westport, Connec.: Greenwood.

Rugh, A. (1988)
Family in Contemporary Egypt. Cairo: American University in Cairo Press.

Saad. R. (1988)
Social History of an Agrarian Reform Community. Cairo Papers in Social Sciences. 11(4).

Sabbah, F.(1984)
Women in the Muslim Unconscious. The Athene Series. New York: Pergamon Press.

Saharty, S. (1995)
Health in Egypt. Report. USAID. Cairo.

Salaam, I (1991)
The Future of Health in Egypt: A Study Prepared for the Shura Council, Cairo, Egypt.

Saltonstall, R. (1993)
"Healthy Bodies, Social Bodies: men's and Women's Concepts and Practices of Health in Everyday Life." Social Science and Medicine 36(1):7-39.

Sahlins, M. (1976)
Culture and Practical Reason Chicago and London: The University of Chicago Pres.

Sanjek, R., ed., (1990)
Fieldnotes: The Making of Anthropology. Ithaca, N.Y. : Cornell Univ. Press.

Sapir, E. (1949)
Culture, Language and Personality: Selcted Essays. D.G. Mandelbaum ed., Berkeley, California: University of California Press.

Sargent, C. (1982)
The Cultural Context of Therapeutic Choice. Dordecht: Reidel.

--------- (1986)
Prospects for the Professionalization of Indigenous Midwifery in Benin. In The Professionalization of African Medicine. M. Last & G.L. Chavunduka eds., pp. 137-50.

Scheper-Hughes, N. (1984)
Infant Mortality and Infant Care: Cultural and Economic Constraints on Nurturing in Northeast Brazil. Social Science and Medicine. 9(5): 535-47.

Scheper-Hughes, N., ed. (1987)
Child Survival. Anthropological Perspectives on the Treatment and Maltreatment of Children. Dordrecht, Holland: Reidel Pub. Company.

Scheper-Hughes, N. Lock, M. (1987)
"The Mindful Body: A Prolegomenon to Future Work in Medical Anthropology. Medical Anthropology Quarterly 1(1):6-41.

Scheper-Hughes, N. (1990)
"Three Propositions for a Critically Applied Medical Anthropology." Social Science and Medicine 30(2):189-97.

---------- (1992)
Death Without Weeping: The Violence of Everyday Life in Brazil Berkely, Oxford: University of California Press.

Scott, J.C. (1976)
The Moral Economy of the Peasant. New Haven & London: Yale Univ. Press.

Scott, J.C. (1985)
Weapons of the Weak. New Haven:ale Univ. Press.

Segalen, M. (1986)
Historical Anthropology of the Family. Trans. by J.C. Whitehouse & s. Mathews. Cambridge: Cambridge Univ. Press.

Seif-Al-Dawla, A. (1990)
The Ethnography of Child Rearing Practises in Egypt. UNICEF. Cairo Office Report.(unpublished).

Shanin, T. ed., (1987)
Peasants and Peasant Society 2nd ed. Oxford: Basil Blackwell.

Sholkamy, H.M. (1988)
They Are the Government: Bureaucracy and Development in an Upper Egyptian Village. MA Thesis. Cairo: American Univ. in Cairo.

--------- (1990)
Sociocultural Factors Influencing the Prevalence of Diarrheal Disease in Rural Upper Egypt: An Ethnographic Study in Two Villages of Assiut. Cairo: UNICEF.

--------- (1992)
Children in Especially Difficult Circumstances: War Victims in Khartoum, Nasir, Baghdad and

Suleymaniyah. Report Presnted to Unicef. Amman, Jordan: Unicef, Regional Office for Middle East and North Africa.

--------- (1994)
The Quest for Fertility. MESA Conference. Arizona, 1994.

Singer, M. (1989)
The Coming of Age of Critical Medical Anthropology. Social Science and Medicine. 28(11): 1193-1203.

---------- (1990)
"Reinventing Medical Anthropology. Towards a Critical realignment." Social Science and Medicine 30(2):179-187.

Singerman, D. Hoodfar, H. (1996)
Development, Change, and Gender in Cairo: A View From the Household. Bloomington and Indianopolis: Indiana University Press.

Sperber, D. (1984)
"Apparently Irrational Beliefs." in Rationality and Relativism M. Hollis and S. Lukes, eds., ambridge, MA: MIT Press.

Sonbol, A. (1981)
"The Creation of a Medical Profession in Egypt During the Ninteenth Century." Phd Dissertation, Geortown University.

Spiro, M.E. (1967)
Burmese Supernaturalism: A Study in the Explanation and Reduction of Suffering. Englewood Cliffs: Prentice-Hall.

Stafford, C. (1995)
The Roads of Chinese Childhood: Learning and Identification in Angang. Cambridge, New York: Cambridge University Press.

Stanworth, M. (1984)
Women and Class Analysis. Sociology. 18(2): 159-70.

Stauth, G. (1984)
"households, Modes of Living, and Production Systems.2 in Households and the World System J.

Smith, I. Wallerstein, H. Evers eds.,' Beverely Hills: sage.

--------- (1990)
Capitalist Farming and Small Peasant Households in Egypt. The Rural Middle East. K. Glavanis & P. Glavanis eds., London: Birzeit Univ. & Zed Books Ltd. pp. 122-38.

Stephens, S. (1993)
"Children at Risk: Constructing Social Problems and Policies." Childhood 1(4):246-51.

---------- ed.,(1993)
Children and the Politics of Culture. Princeton, NJ: Princeton University Press.

Strathern, A. (1989)
Health Care and Medical Pluralism: Cases from Mount Hagen. A Continuing Trial of Treatment. S. Frankel & G. Lewis eds., Dordrecht: Kulwer Academic Pub. pp. 141-54.

Sukkary-Stolba, S. (1985)
Changing Roles of Women in Egypt's Newly Reclaimed Lands. Anthropological Quarterly Washington, D.C. 58(4): 182-9.

Sukkary-Stolba, S. (1987)
Food Classifications and the Diets of Young Children in Rural Egypt. Social Science and Medicine 25(4): 401-5.

Taussig, M. (1980)
Reification and the Consciousness of the Patient. Social Science and Medicine 14B: 3-13.

------- (1992)
"Tacility and Distraction" in Reading Cultural Anthropology ed., G. E. Marcus. pp. 8-14. (Photocopy.

Tekce, B. (1990)
Households, Resources, and Child Health in a Self-Help Settlement in Cairo, Egypt. Social Science and Medicine. 30(8): 929-40.

Toren, C. (1988a)

Children's Perceptions of Gender and Hierarchy in Fiji. Acquiring Culture. G. Jahoda & I. Lewis eds., pp. 225-71.

Toren, C. (1988b)
Annotated Bibliography: Recent Studies on the Ethnography of Childhood. Acquiring Culture. G. Jahoda & I. Lewis eds., pp. 307-34.

Toren, C. (1990)
Making Sense of Hierarchy: Cognition as Social Process in Fiji. LSE Monographs in Social Anthropology no. 61. London: Athlone.

Toth, J. F. (1980)
Class Development in Rural Egypt, 1945-79. In Processes of the World System . T.K. Hopkins & I. Wallerstein eds., Beverly Hills: Sage. pp: 127-47.

--------- (1991)
"Pride, Purdah, or Paycheck. What Maintains the Gender Division of Labour in Rural Egypt?! International Journal for Middle East Studies 23:213-36.

Turner, B. (1991)
"Recent Developments in the Theory of the Body." in The Body, Social Process and Culture Theory. M. Featherstone, M. Hepworth,& B. Turner eds., pp. 1-37. London: Sage Publications.

Turner, V. (1967)
The Forest of Symbols. Ithaca: Cornell univ. Press.

--------- (1968)
The Drums of Affliction: A Study of Religious Processes Among the Ndembu of Zambia. Oxford: Clarendon; Buxton,J.

UNICEF (1989)
The State of the World's Children 1989. Oxford: Oxford Univ. Press.

------- (1993)
Egypt: Situation Analysis ?/. Cairo: Unicef.

Unschuld, P.U. (1976)
The Social Organization and Ecology of Medical Practise in Taiwan. In Asian Medical Systems: A Comparative Study. C.M. Leslie (ed.) pp. 300-21.

Unschuld, P.U. (1985)
Medicine in China: A History of Ideas. Berkeley: Univ. of Calif. Press.

Vasina, J. (1985)
Oral Tradition as History. London: James Currey.

Vom Bruck, G. (1994)
"Down Playing Gender: Hatm Rituals in San'a." Quaderni Di Studi Arab 12, pp. 161-82.

Wahba, S. (1996)
"gender Difference in School Enrollment for Migrant Households. Unpublished paper. Harvard University.

Wartovsky, M.W. (1976)
Editorial. Journal of Medical Philosophy. 1: 289-300.

Wee, V. (1995)
"Children, Population Policy, and The State in Singapore." in Children and the Politics of Culture S. Stephens ed., pp. 184-217. Princeton, NJ: Princeton University Press.

Werner, D. (1977)
The Village Health Worker: Lackey or Liberator. Palo Alto: Hesperian Foundation.

Werner,D. (1979)
Where There is No Doctor. London: Macmillan.

Weyland, P. (1993)
Inside the Third World Village. London & new York: Routledge.

Whiting, J.W.M. & I.L. Child (1966)
Field Guide for the Study of Socialization. N.Y. : Wiley.

Whiting, B.B. & Whiting, J.W.M. (1975)
Children of Six Culture. Cambridge, Mass.: Harvard Univ. Press.

Whiting, B. (1988)

Children of Diffrent Worlds: The Formation of Social behaviour. Cambridge, Mass. London: Harvard University Press.

Wikan, U. (1996)
Tomorrow God Willing. Self Made Destinies in Cairo. Chicago & London: the University of Chicago press.

Winn, M. (1984)
Children Without Childhood. Harmondsworth, Penguin.

Wissa, H. (1994)
Assiout: The Saga of an Egyptian Family. Sussex, England: The Book Guild.

Worsley, P. (1982)
Non-Western Medical Systems. Annual Review of Anthropology. vol. 11 pp. 315-48.

-------(1984)
The Three Worlds: Culture and World Development. Chicago: University of Chicago Press.

Young, A. (1975)
Why Amhara Get Kureynya: Sickness and Possession in an Ethiopian Zar Cult. American Ethnologist. 2: 567-84.

--------- (1976)
Some Implications of Medical Beliefs and Practises for Social Anthropology. American Anthropologist. 78: 5-24.

--------- (1982)
The Anthropologies of Illness and Sickness. Annual Review of Anthropology. 11: 257-85.

--------- (1993)
"A Description of How Ideology Shapes Knowledge and mental Disorder (Posttraumatic Stress Disorder)." in Knowledge, Power, and Practice S. Lindenbaum & M. Lock eds., pp. 108-129. Berkely, LA, London: California University Press.

Young, J.C. (1981)
Non-Use of Physicians: Methodological Approaches, Policy Implications, and the Utility of Decision

Models. Social Science and Medicine. 15B: 499-507.

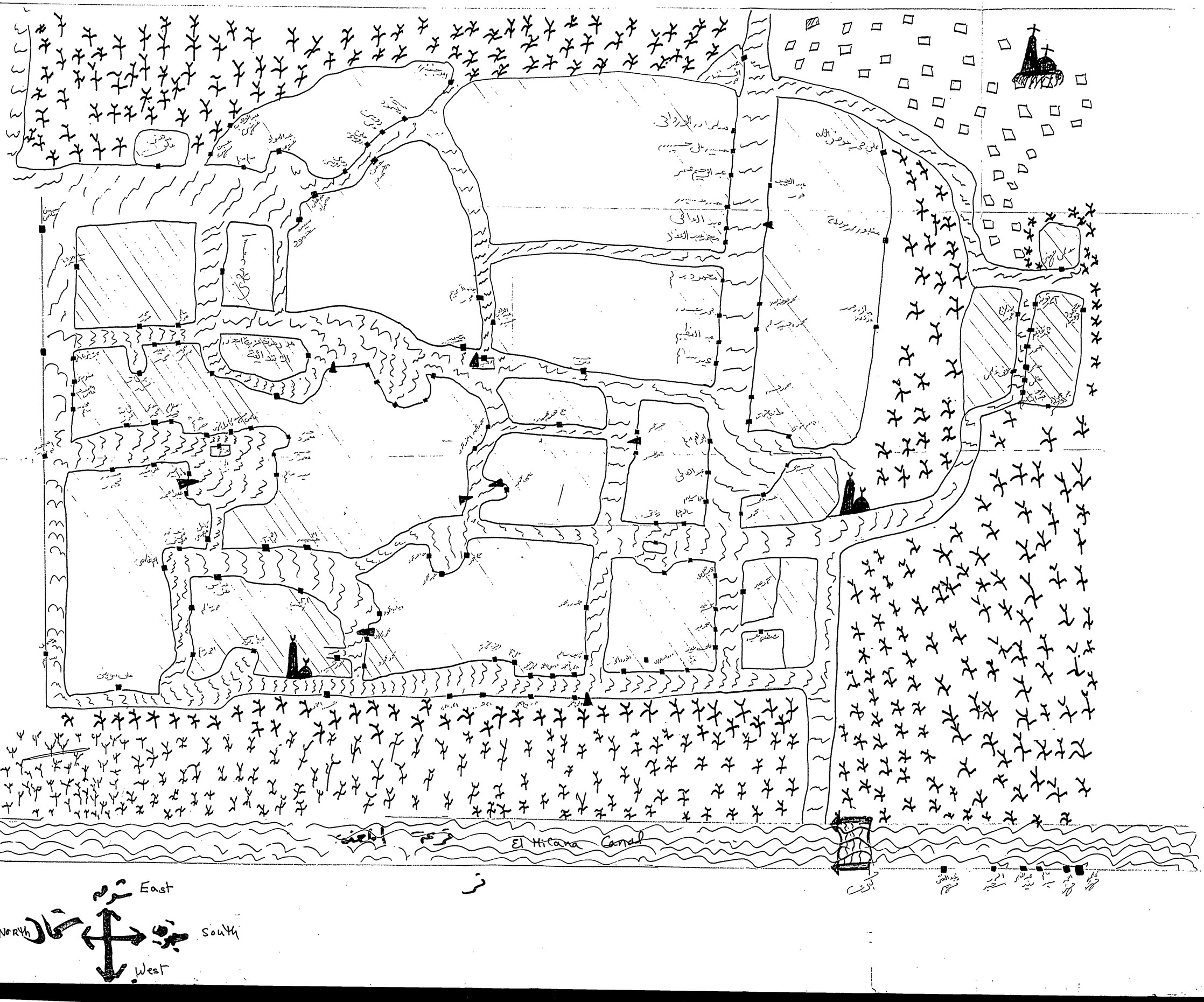
Young, J.C. (1981)
Medical Choices in a Mexican Village. N.J.: Rutgers Univ. Press.

Zeliger, V. (1985)
Pricing the Priceless Child. The Changing Social Value of Children. N.Y: Basic books.

Zenie-Ziegler, W. (1988)
In Search of Shadows; Conversations with Egyptian Women. London: Zed Books Ltd.

Zimmermann, S. (1982)
The Women of Kafr el-Bahr. A Research into the Working Conditions of Women in an Egyptian Village. Cairo & Leiden: State University of Leiden, Institute for Social Studies.

Map 3 RI HAN


El Hicana Canal
streets
houses
shops
buildings
agriculture
East
NORTH
South
West