

Urban Egyptian Women in the Informal Health Care Sector

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This chapter begins with the story of Siham,¹ an Egyptian women's healer who practices unofficially from her home in the crowded back alleys of a poor neighborhood in Alexandria. Siham is a plump, middle-aged woman who, dressed in black with a colorful kerchief tied around her head, looks like any one of the legions of poor women residing in the ancient city. But those who know Siham hold her in high esteem, for within her poor neighborhood she is known as a talented *daya* (traditional midwife), who not only delivers babies but also provides abortions and female circumcisions and helps infertile women overcome their plight through a wide range of folk remedies.

Siham's introduction to midwifery came when she moved into her husband's family's home as a bride. The multiple-story structure was known in the neighborhood as *bait id-dayat* (house of the midwives), for all of the women of Siham's husband's family, including his grandmother, great-aunt, mother, and married sisters, were practicing midwives. Indeed, Siham's mother-in-law was an "educated" *daya*, one who practiced midwifery "by certificate."

At first, Siham had no interest in the deliveries of infants that occurred in the family's compound and to which her female in-laws were constantly being called. But when she came to work as an all-purpose aide in a gynecologist's private clinic, Siham, an uneducated but highly intelligent woman, began observing the doctor and learning to "circumcise and deliver and do abortions and everything." Siham worked in the doctor's clinic for eight years, when her knowledge of obstetrics and gynecology grew tremendously. Thus, when her mother-in-law died, Siham decided to quit her

job at the doctor's clinic and take over the family midwifery business, where she introduced female circumcision and abortion into her practice.

Today, Siham, who is in her mid- to late forties, has a thriving practice because, as she claims, she "knows everything" about helping women overcome their reproductive problems. She is called upon to deliver two to three infants a day, although she is unable to assist all of the women who request her midwifery services. Furthermore, she sees at least two infertile women a day, having developed a reputation in her neighborhood and beyond as a highly skilled infertility specialist. Through physical manipulation of the reproductive organs, through herbal vaginal suppositories, cupping, and a wide range of therapeutic rituals (which make use of fresh placentas and miscarried fetuses, for example), Siham is able to cure her infertile patients. Their afflictions include malpositioned uteri, utero-ovarian *rutuba* (humidity), *dahr maftuh* (open back), *khadda* (shock), and *kabsa* (a.k.a. *mushahara*, or pollution leading to reproductive binding), all considered to be major causes of infertility by Siham and her clients.

Nevertheless, Siham knows that some infertile women and those with other gynecological complaints must be treated by physicians. She explains, "There are injections and lots of things from the pharmacy. Now, medicine is not like before. It is more enlightened." But she adds, "With doctors, you pay a lot and buy medicines and pay for operations. And some people are very poor, and they're scared of doctors. That's why they go to folk remedies. [Doctors'] treatments are surgical operations, like *nafq* (tubal insufflation) and *kaht* (dilatation and curettage) and *kawi* (cervical electrocautery). They just do *nafq* and such things to get money. Believe me, I'm frank. They get £E 500 or 600 [\$200–240]. The doctor I worked with did that, and the cure is from God. . . . There are lots of treatments from doctors, and there are some very good doctors. And there are doctors who only want money and don't help you. They ask for more and more money and nothing happens."

According to Siham, she sends her infertile patients to physicians only when all of her remedies fail to cause pregnancy. However, "thanks to God," she estimates her success rate to be 60 percent.

The "Invisible" Nature of Women's Health and Healing in Egypt

Siham is one of thousands of women healers practicing unofficially in the urban areas of Egypt. Their exact numbers are unknown, and their activities have been largely unaccounted for. Nevertheless, urban Egyptian women healers—primarily older, postmenopausal women with little for-

mal education—are meeting the reproductive health care needs of Egypt's poor urban female populace. They do so through an "informal economy of health care" that remains largely invisible to the authorities (scholarly ones included).

In Egypt, as in most other societies throughout the world, women are expected to assume responsibility for meeting the health care needs of their children and those close to them, often through the direct provision of remedies and other health services in the home.² Some women extend their domestic therapy management skills to nonkin, and they may eventually have paying clients and lucrative practices. Today in Egypt, large numbers of women seek the services of women healers, who are often more affordable, sympathetic, and understanding of women's health care beliefs and needs than the mostly male obstetrician-gynecologists (ob-gyns) who practice in urban areas.

Indeed, "modern" medicine itself serves as a major force of therapeutic diversification in Egypt. Because many female patients fail to obtain high-quality health care within the modern medical sector, they tend to fall back on the services available from women healers operating in the informal health care sector. Why do poor urban Egyptian women often prefer the services of healers such as Siham? The reasons lie in both the formal and informal health care sectors in urban Egypt, as well as the dynamic tension operating between them.

Following a brief methodological discussion, this chapter begins by characterizing the formal health care sector in Egypt, focusing on the colonial legacy of biologically based, Western medicine (so-called biomedicine) in Egypt and on some of biomedicine's contemporary deficiencies. The approach in this section is one of cultural critique,³ since I am interested in examining critically the ways in which the formal health care sector fails to meet the needs and expectations of Egyptian women as health care consumers.⁴ This chapter then characterizes the informal health care sector in urban Egypt, including a typology of female "ethnomedical" practitioners. Most important, I examine the reasons why so many poor Egyptian women patients choose healers such as Siham—who dedicate themselves to helping their fellow women but whose services go officially unrecognized—over treatment in the formal biomedical sector.

Methodology

The anthropological research upon which this chapter is based was carried out between October 1988 and December 1989 in Alexandria. This his-

toric seaport city, located on the northwestern tip of the Nile Delta where it meets the Mediterranean Sea, is today a markedly class-stratified city of an estimated 3 million to 5 million inhabitants, many of them poor migrants from rural areas of both Upper and Lower Egypt.

This research was carried out in Alexandria's poor urban and periurban neighborhoods. Women who participated in this study were first contacted at the University of Alexandria's Shatby Hospital, the public ob-gyn teaching hospital serving mostly lower- and lower-middle-class women from the Alexandria vicinity. Participant observation and semistructured interviews were conducted in the hospital with 190 reproductive-aged women, 90 of whom were fertile and 100 of whom were infertile. The vast majority were poor women from migrant families. Most were illiterate, uneducated, and unemployed (given the stigma surrounding women's nondomestic work in this population).⁵

It was through these women, many of whom invited me to their homes, that I gained a tremendous amount of information and insight about the nature of the formal and informal health care sectors in urban Egypt. Additionally, it was through these women that I met the informal-sector women healers who participated in this study. Over the course of the study, I interviewed and/or observed eleven women healers, only one of whom had any formal health care training. All of the healers, as middle-aged or older women of the lower class, were illiterate and uneducated. Seven women had acquired their midwifery or other healing skills from relatives, most often grandmothers, mothers, and aunts who were practicing *dayas*. All of them either practiced out of their own homes or visited the homes of their patients. None of them had clinics, shops, or even telephones, which meant that their patients (or emissaries from their patients' families) always contacted them in person.

Although these women were widely known for their obstetric and gynecological skills throughout their communities, they were nonetheless "invisible" on an official level, as they were not members of professional organizations, nor listed in directories of any kind, nor known to the governmental authorities or health care professionals in the area. Thus, I could meet these women healers only through an intermediary. Generally, once contacted, these healers were enthusiastic participants in this study, sharing freely, via tape recorder, information about their belief systems, *materia medica*, and healing practices, as well as their views on modern Egyptian medicine.

In addition to this informal-sector research, interviews with physicians were conducted in various formal-sector health care settings, including the

university teaching hospital, public maternal and child health (MCH) clinics, Islamic clinics associated with mosques, and physicians' private offices in the Alexandria vicinity. I conducted semistructured, tape-recorded interviews with seventeen ob-gyns, all but one of whom practiced in the Alexandria metropolitan area. I also conducted library research, in both Egypt and the United States, on the formal health sector in Egypt.

The Formal Health Care Sector in Egypt

Contemporary Egyptian biomedicine is, unfortunately, best characterized as the victim of its British colonial heritage. Despite health care reforms instituted under Nasser following the expulsion of the British from the country in the early 1950s, reforms have failed to transform the basic character of Egyptian biomedicine, which today bears the indelible mark of late-nineteenth-century colonization and anglicization.⁶ Perhaps most discouraging, contemporary critics charge that the British colonial legacy has thwarted the potential excellence of Egyptian biomedicine as a system responsive to the *needs of its own citizens*.⁷

What, exactly, are the colonially induced ills plaguing contemporary Egyptian biomedicine? And how do they relate to Egyptian women's health care?

First and perhaps most important, the British thoroughly privatized Egyptian medicine.⁸ Instead of encouraging health for all in Egypt, the British exported their own brand of fee-for-service, private medicine, practiced by physicians as a profession for financial gain. Excessive entrepreneurialism in biomedical practice was the result, and Egyptian physicians—"second-class citizens" to the European doctors imported by the British after they occupied Egypt in 1882—were forced to compete in sometimes unseemly ways in order to make a living. Furthermore, biomedical services were no longer accessible to the Egyptian masses under the private, fee-for-service system; thus, the public health of the Egyptian populace suffered dramatically during the period of British domination.⁹

Today, more than a century after British occupation, the foreign physicians are gone, and health care reforms have again brought public-sector medicine to the masses. However, the effects of colonial privatization have been profound in Egypt and have resulted in a major chasm between public and private health care services. To wit, purportedly "free" medical care is available to all Egyptians through Egyptian Ministry of Health hospitals (including university teaching hospitals) and clinics constructed under Nasser's aegis. Yet, as apparent in poor Egyptians' many complaints about

public health care, this system of free clinics and hospitals is “crumbling under the weight of the huge demand and lack of resources.”¹⁰ Public hospitals are in disrepair, and many patients’ stays are unnecessarily extended because physician manpower and crucial equipment and supplies are lacking.¹¹ Similar problems plague Ministry of Health outpatient clinics, including MCH clinics, where the hours of operation are short, the waiting lines are long, and drugs and other materials are often in short supply. The result is serious underutilization of public, primary health care services—underutilization fueled by the pervasive feeling among patients that it is wiser to spend hard-earned money on a visit to a private clinic.¹²

Private care is available only to those who can bear the full cost of medical intervention without the help of insurance. Yet, despite the economic hardships associated with seeking private medical care, many Egyptians, including the poor, prefer to seek out private clinics and hospitals, which have proliferated in Egypt in recent years. The reasons for this proliferation are considered to be threefold:

1. The significant glut of un- and underemployed Egyptian medical school graduates who, after completing mandatory government service in often remote rural areas, cannot find substantial, well-reimbursed positions in the more desirable (that is, urban) areas of the public-sector system;¹³

2. The significant numbers (75 to 80 percent) of active public-sector physicians, including university medical professors, who attempt to supplement their meager government salaries through afternoon and evening practice in their own private, fee-for-service clinics;¹⁴

3. Sadat’s capitalist call for “open investment” in Egypt, including targeting private “investment” hospitals, described as the “medical Hiltons and Sheratons” of Egypt but considered by some critics one of the most prominent “diseases” of the free-market economy.¹⁵

The result today is a schizophrenic medical landscape in which many Egyptian “biomedicines” are practiced according to patients’ abilities to pay. For most Egyptians, who despise the quality of service and treatment in the overtaxed, underequipped public medical sector, private medical care is the first choice, given sufficient out-of-pocket funds. Even private biomedicine is pluralistic, however, lacking uniform standards of quality. Thus, as it now stands, even patients who can afford to pay private physicians have no guarantee of appropriate care for what ails them.

Second, after privatization, the British, true to their heritage in industrializing Europe, exported to Egypt a brand of Western biomedicine enamored with technology for the “repair” of broken-down bodily “machines.” Instead of developing prevention-oriented public health care services, which were desperately needed throughout the disease-ravaged Egyptian countryside, the British promoted high-tech, curative, urban, hospital-based health care, which was frankly unresponsive to the pressing medical needs of Egypt’s largely rural populace.¹⁶

Today, the biomedical system in Egypt remains biased in similar directions. Namely, urban areas are favored over rural by health care personnel. Curative care is privileged over preventive services. And invasive high-tech medicine is often practiced at the expense of noninvasive lower-tech medicine, even though the standards of technological medicine in Egypt often lag far behind developments in Western medicine.¹⁷

Third, when the British took over medicine in Egypt, the quality of medical education deteriorated dramatically.¹⁸ Medical school admissions of Egyptian students were cut drastically to make room for the European physicians who were soon allowed free rein in the country. Furthermore, the cost of medical education, which had been free to any bright (male) Egyptian student, became prohibitively expensive under the British, who thus restricted medical education to the wealthy elite. Language became an additional barrier; Arabic, the original language of Egyptian biomedicine, was replaced by English, which became a prerequisite for medical school admission. Finally, in Egyptian medical schools the British quashed altogether critical scientific inquiry and innovative medical research, encouraging instead traditionalism in education based on the rote learning of imported materials.

In Egypt today, the state of medical education differs little from a century ago. Although Egyptian medical education has been opened up to the point of overextension, the quality of medical education is still seriously deficient.¹⁹ Classes are filled well beyond capacity, leading to a shortage of seats, textbooks, and opportunities for more individualized training, especially in critical clinical skills. Faculty are often absent and, when present, encourage students to adulate them as “demigods” in a system that is blatantly paternalistic, hierarchical, and authoritarian.²⁰ Furthermore, faculty encourage medical traditionalism by failing often to take their own research mandate seriously; by relaying sometimes outdated knowledge and standards of practice to their students, yet expecting unquestioning acceptance; and by failing to encourage the efforts of up-and-coming junior physicians who want to engage in biomedical innovation. The result is the

graduation of thousands of poorly trained physicians, who forget much of what they were forced to memorize for exams, who are not proficient in current clinical or research skills, who are underspecialized, and who may never be forced to update their knowledge or standards of practice, given the lack of continuing medical education requirements in the country.²¹

Furthermore, Egypt has no system of physician self-monitoring (for example, board exams or medical ethics review boards), and no system against medical malpractice. Physician graduates thus are essentially free to do as they please once they enter community practice, with little surveillance or scrutiny of their capabilities or services. Such deficiencies, according to critics, have led to poor-quality care in many instances and the lack of a well-developed medical morality in Egypt (which, in fact, can be traced to the British, who scuttled early ethical reforms).²² However, given the absence of health activist and consumer advocacy groups in Egypt today, individuals have little recourse when they feel their rights have been violated or their cases mishandled. The outcome is lack of trust in and ambivalence toward physicians, who as a group are often criticized by angry consumers for their incompetence, ineffectiveness, and avarice.

Lack of trust is perpetuated also by medical elitism of the worst kind, another byproduct of British medical domination. The British promoted the idea that everything European was superior to everything Egyptian, thus encouraging Egyptian physicians to speak only English and to look down upon the Egyptian masses, including the ethnomedical specialists who had practiced for centuries in their country.²³ Early efforts to train ethnomedical practitioners, such as *dayas*, as ancillary medical personnel were entirely suspended under the British,²⁴ and these healers were deemed “quacks” and “charlatans,” sought out only by “ignoramus” among the poor folk.

In this area, too, the situation in Egypt is little improved from a century ago. Attempts to incorporate ethnomedical practitioners into the biomedical system have been feeble at best and limited to *dayas*, whose services remain officially illicit. Furthermore, ancillary medical personnel of all kinds—nurses, medical technicians, paramedics, medical social workers, psychologists, and others—are undervalued, undertrained, and in chronically short supply.²⁵ Instead, only physicians are accorded professional prestige (although it often outstrips their real contributions), and their attitudes toward other health care personnel and toward their patients remain supercilious at best.²⁶ Indeed, the patronizing attitudes and lack of cultural sensitivity of many Egyptian physicians toward their patients—especially poor, uneducated patients presenting at public facilities—has been noted

by a number of scholars, who have described the untoward effects of medical paternalism on doctor-patient communication.²⁷

Today, most biomedical practitioners in Egypt lack the overt antipathy toward their ethnomedical counterparts displayed by many Egyptian physicians at the turn of the century. However, the reason is largely that most contemporary Egyptian physicians, especially those practicing in urban areas, have no idea of the extent to which ethnomedicine and ethnomedical practitioners continue to influence the actions of their patients. For example, urban ob-gyns tend to be wholly unfamiliar with all of the following: their patients' ethnomedical beliefs regarding the causes of women's health problems; the ethnomedical practices women engage in, including the types of ethnomedical practitioners from whom they seek help; and the significant degree to which poor urban Egyptian women participate in the ethnomedical world, claiming faith in its beliefs, practices, and practitioners.

Most urban ob-gyns admit that they possess no knowledge of ethnomedicine, given their lack of interest and resultant failure to inquire about “such superstitions” from their patients. However, others are adamant that such beliefs and practices have “disappeared” altogether in the urban areas of Egypt and are found only at a low level, if at all, among ignorant people living in the countryside of the Egyptian Delta or in Upper Egypt. Furthermore, those who dismiss the significance of ethnomedicine contend that only desperation would drive a woman to believe in and undertake ethnomedical practices—and then only after prior biomedical treatment had failed to provide a cure for her affliction.

Egyptian physicians who show little or no interest in the subject of ethnomedicine—deeming it irrelevant in the modern world—grossly underestimate the degree to which ethnomedicine is still present in urban Egypt in a vast informal health care system that parallels their own. Furthermore, little do they realize that the actual pervasiveness of ethnomedicine in urban Egypt is, in part, a reflection of the contemporary character of Egyptian biomedicine and its tendency to repel patients who might otherwise avail themselves of biomedicine exclusively.

To reiterate an earlier point, biomedicine itself serves as a force of therapeutic diversification, given the characteristics of biomedical practice that cause many patients to reject it. Such factors include economic and social class barriers to access and utilization of biomedical services; asymmetrical power relations between biomedical practitioners and their patients, which are maintained through physician authoritarianism, paternalism, and undermining of patients' self-esteem; utilization by physicians of purportedly

therapeutic, invasive procedures that are in reality biomedically unfounded, often health-demoting, and perceived by patients as profit-making ventures for physicians; and the resultant inability of many patients to find solutions within the biomedical system.

For some Egyptian women, ethnomedicine might be less appealing were biomedicine to offer more certain cures. However, given the deficiencies of Egyptian biomedicine described here, seeking solutions within the informal health care sector becomes compelling for many women, especially those who uphold ethnomedical notions of etiology, diagnosis, and treatment.

The Informal Health Care Sector in Egypt

Indeed, most poor urban Egyptian women accept the expertise of ethnomedical healers and the validity of their healing practices, which counterpose the formally legitimated, but nonetheless problematic, tenets of biomedicine as it is practiced in Egypt today. Women's acceptance is evident in many patients' serial or simultaneous utilization of both the formal and informal health care sectors. Egyptian women's tendency toward holistic health-seeking has been characterized as curative eclecticism and is regarded as a strategy for maximization of therapeutic benefits.²⁸

In fact, poor women seeking health care in Egypt now have a number of options from which to choose: (1) private, fee-for-service medicine administered by a physician; (2) public, purportedly "free" health care administered by a physician, nurse, or nurse-midwife in a government health care facility; (3) free or low-cost medicine administered by a physician in an Islamic clinic associated with a mosque;²⁹ (4) or ethnomedicine administered by one of an assortment of traditional healers, whose beliefs and practices derive in large part from three major literate medical traditions dating back approximately five thousand years in Egypt.³⁰

With respect to the last category, poor urban neighborhoods of Egypt are replete with ethnomedical practitioners who cater to the masses, promoting in many cases health care beliefs and practices that derive from Egypt's ancient medical traditions. Yet, because of shifting historical hegemones, unified "schools" of ethnomedicine rooted in ancient traditions are entirely absent in the country today. Rather, most contemporary ethnomedical practitioners offer services that can only be described as markedly eclectic in nature. Moreover, because they are not stringent adherents of any particular historical medical philosophy, most ethnomedical practitioners are not book-taught, learning instead by observation or apprentice-

ship. Furthermore, lacking professional associates and associations, they tend to operate independently.

Interestingly, subspecialization is just as common among ethnomedical healers as it is among Egyptian physicians. Ethno-obstetrics and gynecology is a particularly active area of ethnomedical practice. The reasons are Egypt's high total fertility rate, 4.6 births per woman;³¹ the maternal health problems that accompany such high fertility; the concern with fecundity among childless women; and the various barriers, both social and economic, that prevent Egyptian women from seeking biomedical care. In Egypt, the vast majority of poor rural and urban women consult an ethno-obstetrician or gynecologist, usually a *daya*, at least once in their lifetimes and usually much more often. However, ethnomedical specialists other than *dayas* also treat women's reproductive health problems.

Sittat kabiras

In fact, in urban areas of Egypt it is possible for women to visit healers who specialize in the treatment of only one or two specific "female conditions." These healers are typically postmenopausal women, or *sittat kabira* (literally, elderly women), who distinguish themselves from *dayas* because they do not perform deliveries or other roles traditionally associated with midwifery. Rather, these women perform various cures for miscarriage, infertility, excessive uterine bleeding, or other reproductive problems, especially cures requiring ritual healing objects. Because these objects are often difficult to obtain, originating as they normally do in Saudi Arabia, women who own them may begin to specialize in the treatments associated with them and become recognized for this specialized knowledge.

Dayas

In addition to *sittat kabiras*, Egypt is home to thousands of *dayas*, or lay midwives such as *Siham*, who throughout the centuries have delivered the infants and cared for the health of Egypt's women. In Egypt today, it is estimated that approximately ten thousand *dayas* are active practitioners of midwifery, conducting between 80 and 90 percent of all deliveries among the rural and urban poor.³²

Formal, six-to-twelve-month practical obstetrics training of *dayas* was initiated in the 1940s in Egypt. However, in 1969 the Egyptian Ministry of Health changed its policy by discontinuing all *daya* training; revoking all previously issued licenses; warning women by radio against the use of "ignorant, unskilled, and often dangerous" *dayas*; and encouraging women to

deliver with governmentally trained *hakimas*, or nurse-midwives, stationed at MCH clinics and rural health units throughout the country.³³ Because of this governmental effort to wipe out the position of the *daya*,³⁴ *dayas* were essentially forced underground, continuing their practices illicitly without the putative benefits of supervision, training, or hygienic supplies. Not until the 1980s, when the Ministry of Health realized that its program of health modernization had failed to bring about intended changes in the state of Egyptian obstetrics, did it reinstitute limited *daya* training programs in primarily rural governorates.³⁵

Yet, despite recent attempts by the Egyptian government and international health agencies such as the World Health Organization and UNICEF to regulate and professionalize the *obstetrical* practice of *dayas*,³⁶ little attention has been paid within the international health and scholarly communities to the *gynecological* services performed by *dayas* on thousands of Egyptian women. This neglect is serious because *dayas* are Egypt's truest "ethnogynecologists," performing the greatest variety of the most commonly employed ethnogynecological cures for pregnancy loss, infertility, and other types of gynecological problems.

In fact, it would not be overstating the case to suggest that *dayas* are perhaps the major force in the effort to treat infertility problems in Egypt. Many *dayas*, such as Siham, have gained wide recognition in their communities for their infertility services, thus silently but effectively competing with unwitting Egyptian gynecologists for infertile patients. However, to impute competitive motives to Egyptian *dayas* is unfair, given that the majority of them do not claim to treat the kinds of problems, such as "blocked tubes" and "weak ovaries," that only physicians are able to handle. Because *dayas* restrict themselves to the treatment of minor conditions, they generally charge their patients relatively little money for their services—usually £E 0.5–5.00 (\$0.20–2.00) and rarely more than £E 10 (\$4). Some *dayas*, in fact, refuse payment altogether, in the knowledge that if the infertile patient becomes pregnant, a gift will be forthcoming.

Munaggimas

The same is not true, however, of *munaggimas* (female spiritist healers), a distinct class of healers. Unlike *sittat kabiras* and *dayas*, they tend to charge high fees for their services (e.g., £E 10–250, or \$4–100). By far the most controversial class of urban Egyptian ethnogynecologists, *munaggimas* are widely known for specializing in diagnostic clairvoyance and the treatment of the more difficult, socially mediated causes of ill health, primarily those involving angered spirits. Despite cautionary mention of them in the

Qur'an, many *munaggimas* draw upon "the power of the Book" (the *Qur'an*) to help them diagnose and cure patients. Because of their professed religiosity, *munaggimas* are often addressed and referred to by the religious title *shaikha*. However, many Egyptians say that *munaggimas* do not deserve such a title of respect, given that they do not truly "know God," and they refer to *munaggimas* pejoratively instead as mere *sabharas* (sorcerers or magicians) or *daggalas* (quacks or charlatans).

Given the suspicion surrounding *munaggimas*, it is perhaps surprising that they make up significant numbers throughout the poorer areas of Egypt, claiming their fair share of reproductively troubled women. In fact, *munaggimas* are highly sought after for their ability to tell fortunes concerning matters of reproduction. For example, some *munaggimas* claim to divine whether or not an infertile woman is suffering from a biomedical problem, such as "weak ovaries," for which she should seek a physician's treatment, or an ethnomedical problem such as reproductive binding. Furthermore, some *munaggimas* claim to cure ethnomedical infertility problems through vaginal suppositories, herbal potables, cupping, and various healing rituals.

Unlike their male counterparts, female *munaggimas* generally do not traffic in malevolent sorcery—either its creation or its dissolution. However, they may be deeply involved in the spirit world, either as possessed individuals, who use their spirits to diagnose and treat other spirit-troubled women, or as skillful agents of spirit invocation, who make the wishes of others' spirits known. For women who are infertile or who repeatedly miscarry, female *munaggimas* communicate with the *akhawat taht il-ard* (spirit-sisters underground), who trouble their earthly sisters by preventing them from having children. However, because these spirit-sisters do not actually possess, or "wear," their earthly sisters, the female *munaggimas* who treat the infertile for spirit troubles rarely ask them to participate in the communal *zar* spirit placation ceremonies attended by the possessed. Instead, they may perform elaborate, private rituals that usually call for animal sacrifice and a variety of unusual and expensive items.

Because of the large amounts of money involved in undergoing a *munaggima's* healing rituals, *munaggimas* are regarded with a great deal of suspicion by most poor urban Egyptians, who view them as avaricious and potentially inauthentic in their claims. Furthermore, because the questions *munaggimas* ask patients are often indicative of prior knowledge of the patients, many Egyptians are suspicious of *munaggimas's* strategies of divination, believing that their knowledge must be based on illusive practices and trickery. Thus, *munaggimas* are often accused of being quacks, trick-

sters, liars, opportunists, and thieves who take advantage of gullible, desperate Egyptian patients and cheat them of large amounts of money. Even those individuals who complete a munaggima's suggested healing regimen are often unconvinced of its efficacy and may comment that the munaggima "stole my money for nothing."

This ambivalence toward a class of ethnogynecological healers appears to be restricted to munaggimas alone. It also appears to be increasing along with Egypt's contemporary Islamist movement and its attempt to eliminate all unorthodox religious elements, including spiritist healers and their practices. Sittat kabiras and dayas are generally viewed by the poor as being both honest and beneficent healers, even though many of their practices, too, are viewed with increasing skepticism by Egyptian Islamists.

Choosing the Informal Alternative

Despite growing Islamist concern over ethnomedical unorthodoxy, the utilization of ethnomedicine by poor urban Egyptian women continues unabated, for reasons having to do with the positive gender and class attributes of ethnomedical healers themselves, as well as issues of acceptability, accessibility, affordability, and appropriateness.

First, most ethnomedical healers who treat women for their reproductive health problems are also women, whereas most biomedical practitioners are not. Although Egyptian women, rich or poor, will generally seek the care of a male ob-gyn if necessary, the traditional preference for female reproductive health specialists (be they women physicians or healers) remains strong and appears to be increasing as a result of the Islamist movement in contemporary Egypt. Today, more women are refusing to expose their bodies—and especially their genitals—to male physicians, given their belief that this is immodest and *haram* (sinful in the religion). Yet because the biomedical practice of obstetrics and gynecology continues to be one of the most prestigious areas of specialization, it remains a bastion of male domination and frank intimidation of the poor, uneducated female patients who must deal in great discomfort with upper-class male physicians.

Ethno-obstetrics and gynecology, on the other hand, is a markedly gynocentric, female-dominated area of practice, with dayas and other women healers providing the bulk of the health care. "Gender comfort" is certainly one of the major reasons why most Egyptian babies are delivered by dayas. Furthermore, because many ethnomedical illness categories are perceived to be gender-specific, healing rituals are necessarily gynocentric, with women helping other women to effect cures.

Second, the class-based differences that often radically separate Egyptian doctors from their patients are essentially absent in the ethnomedical world. Most healers are themselves drawn from the lower classes and share their patients' social norms and expectations. In Egypt, male physicians tend to treat poor women patients as though they were ignorant: the physicians fail to divulge crucial diagnostic and therapeutic information, and they communicate in obscure and obfuscating medicalese. Women healers, on the other hand, tend to treat their female clients as equals: the healers share with patients their own beliefs and knowledge in familiar colloquialisms, and they bolster, if anything, clients' hopes and self-esteem. Thus, the haughtiness and patronizing attitudes that often typify physicians' care especially in public facilities, are essentially absent among the women healers, who are themselves poor, uneducated women occupying the same social world as their female clients.

Third, physicians and healers tend to differ fundamentally in their willingness to communicate with their patients. Whereas physicians tend to disclose very little, treating all diagnostic and therapeutic information as being akin to sacred knowledge, ethnomedical healers tend to share information freely with their patients. The process of sharing is largely how ethnomedical beliefs become disseminated and accepted within poor urban communities. Moreover, poor women know that their beliefs concerning reproductive binding, shock, humidity, angered spirits, and the other sources of gynecological trouble will be immediately accepted and likely remedied within the ethnomedical community. Physicians, on the other hand, are known to scoff at such views and attempt to eradicate them. Thus, poor women who visit ethnomedical healers, rather than or in addition to physicians, are in part seeking acceptance of their ideologies of health and illness, which are often at great odds with those of the biomedical system.

Fourth, in addition to compatibility of beliefs about etiology, diagnosis, and cure, poor urban Egyptian women have much easier access to ethnomedical healers, who live within the patients' own communities—perhaps only blocks or doors away. They can often be called upon day or night to assist with deliveries and other medical care in the patient's own home. A visit to a physician's clinic or a health facility, on the other hand, may require a long walk or a difficult and perhaps expensive journey by taxi or bus. Women may view such trips with great trepidation, and their husbands may even forbid them, begrudging the expense and fearing their wives' use of public transportation along with unknown men. Moreover, health clinic hours are usually short, waiting lines are typically long, and

time may run out before a patient is seen. Even when health facilities are conveniently located in or near poor neighborhoods, women may shun them because they view health facilities as breeding grounds for both biomedical and ethnomedical illnesses. Thus delivering a baby at home is considered much safer than in a hospital, but only dayas—not obstetricians or even government nurse-midwives—are willing to perform home deliveries.

Fifth, the poor urban woman's major reason for preferring women healers may be affordability. Most women healers (except for munaggimas) charge only nominal fees for services, or they may accept voluntary fees or gifts only if their remedies prove effective. Women who visit healers may be expected to purchase various ingredients of remedies. However, they are spared the expense of office visits, laboratory tests, prescriptions, medical procedures, surgeries, hospitalization, and tips to various health care personnel, which may apply even in public health facilities. For poor patients lacking health insurance, such costs are often overwhelming. Thus, ethnomedical care that is shown to provide relief is often considered a good investment, offering substantial savings to those who can afford little in order to stay healthy.

Finally, as noted by Siham in the introduction to this chapter, many poor patients suspect physicians of avarice—performing inappropriate medical procedures just to gain money. Indeed, the appropriateness of many of the ob-gyn interventions performed by Egyptian physicians has been called into serious question, given the health-demoting potential of the outdated, invasive procedures performed.³⁷ Furthermore, because ob-gyn is a surgical specialty, its practitioners' surgical bias leads to many unnecessary operations, which is especially frightening given the high postoperative infection rate in Egypt.³⁸ Thus, women avoid biomedical treatments, which often cause significant pain, prolonged recovery time, and complications without even curing the patient. Such treatments are seen as both financially and physically risky. Ethnomedical treatments, on the other hand, are rarely invasive and often employ familiar ingredients and household objects. Thus, even if they inflict pain, such treatments are usually viewed as more appropriate for a woman's body, given the known risks of high-technology medicine.

Conclusion

For all of these reasons, poor urban Egyptian women are often enthusiastic participants in the informal health care sector—relying on women healers of various types to deliver their babies and help them to overcome their

reproductive problems. Not only are women healers such as Siham inherently appealing in many ways, but their methods of health care delivery continue to counterpose those of the colonially molded formal health care sector, where the poor have come to feel unwelcome, silenced, and mistreated. Indeed, the very vitality of the informal health care sector in urban Egypt today is in many ways a direct reflection of the inability of “modern,” formal-sector biomedicine to treat the poor as patients needing health care and as human beings deserving of dignity and respect. Until the basic problems afflicting Egyptian formal-sector health care are recognized and reforms are achieved, it is quite likely that informal-sector healers such as Siham will continue to play a major role in caring for Egypt's poor women.

Notes

Parts of this chapter are adapted from Marcia C. Inhorn, *Quest for Conception: Gender, Infertility, and Egyptian Medical Traditions* (Philadelphia: University of Pennsylvania Press, 1994).

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14. El-Mehairy, *Medical Doctors*, 19; Institute of Medicine, *Health in Egypt*, 72.
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16. Kuhnke, *Lives at Risk*, 162-63; Sonbol, *Creation of a Medical Profession*, 135.
17. Inhorn, *Quest for Conception*, 301-17.
18. Sonbol, *Creation of a Medical Profession*, 108-20, 131-32.
19. El-Mehairy, *Medical Doctors*, 62-69; Institute of Medicine, *Health in Egypt*, 99-100.
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