

## TOWARDS A POLITICAL ECONOMY OF HEALTH: A CRITICAL NOTE ON THE MEDICAL ANTHROPOLOGY OF THE MIDDLE EAST

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**Abstract**—This paper critically reviews certain trends in the medical anthropological literature on the Middle East. It identifies and analyzes the dominant theoretical orientations found in the study of medical beliefs, folk illness, healing and competing medical systems. Data from an Egyptian village are used to illustrate some of the theoretical limitations which characterize the study of these dimensions of the indigenous Middle Eastern health system. The paper advocates a political economy perspective which undermines the idealist, reductionist and dualist approaches to the study of health and illness in the Middle East. Alternatively, it suggests that analysis of health systems requires their placement in their broader political-economic environment. Health and illness are thus conceptualized as results of historically specific social orders rather than the consequences of ideologies of obscure origins.

### INTRODUCTION

Anthropological studies of health systems in the Middle East have been extremely limited in number and in scope.\* Anthropological accounts of health and illness are with few exceptions confined to the present decade. Only a limited body of literature is available on the subject and, with the exception of some articles and a few unpublished dissertations on indigenous medicine in the area, few major published works are found. Anthropological accounts of health systems in the Middle East are scattered and often obscured in the midst of more general accounts of the area or confined to article length publications. Such accounts generally provide superficial descriptions of medical beliefs and practices from a relativistic perspective which stresses the functional utility of beliefs and practices while ignoring the basis of their existence and perpetuation.

The purpose of this paper is to provide a critical review of certain trends in the anthropological study of the contemporary indigenous Middle Eastern health system. It is not my intent to present an exhaustive survey of anthropological studies of health and illness in the Middle East. Instead, my attention is directed to the *analytical traditions* which have characterized the study of certain dimensions of the contemporary indigenous health system in the region. These analytical approaches are illustrated by selected

examples from the published works of anthropologists. Since culturally oriented psychiatrists, in particular, have shared anthropologists' interests in various aspects of the indigenous Middle Eastern health system, their works are also selected for illustrative purposes. In short, this paper focuses on ethnomedical studies, i.e. on studies which view illness, not simply as a biological deviation, but as a cultural category and as a set of culturally related events [2]. Additionally, it evaluates the analytical orientations of studies which are concerned with the effects of socio-cultural factors, particularly indigenous medical beliefs and practices, in conditioning Middle Eastern peoples' responsiveness to the introduction of modern health care. Certain limitations of the analytical orientations which have characterized the investigation of these topics are noted in light of data derived from a study of power, health and illness in the Egyptian village of FatiHa, where I conducted fieldwork during the period between August 1974 and July 1975.

### ETHNOMEDICAL STUDIES

Examination of the ethnomedical literature on the Middle East indicates primary concern with medical beliefs, culture-bound syndromes or folk illnesses and healing. Numerous investigators have given principal attention to indigenous beliefs and definitions of illness. This is illustrated in the early classical works (such as Walker's 1934 account of *Folk Medicine in Modern Egypt* and Westermarck's 1926 compilation of *Ritual and Belief in Morocco*) as well as in contemporary studies by psychiatrists [e.g. 3-8] and social scientists, particularly anthropologists [e.g. 9-16]. A number of these studies provide descriptions of indigenous conceptions of illness which contrast with biomedical interpretations of disease. In this regard, one notes the relative insignificance of the notion of body-mind duality in the Middle East. Unlike the biomedical dualistic orientation which differentiates "physical" and "mental" illness, the indigenous

\* Reviews of the general medical anthropological literature indicate that "... neither a widely shared definition of the field nor an agreement about its boundaries has emerged" [1: cf.2]. One notes the absence of a uniformly applied theoretical paradigm in the cross-cultural study of health systems. Similarly, for the Middle East, it is not possible to delineate a medical anthropology of the region on the basis of the consistent application of a set of theoretical models. Given the absence of a shared and conceptually based view of the medical anthropology of the Middle East (aside from the general tendency towards reductionism noted below), it is useful to follow earlier suggestions of turning to the criterion of content in identifying culturally oriented studies of health systems. [1].

Middle Eastern integrated view of sickness is characterized by a holistic orientation. Accordingly, all forms of illness are viewed as affecting the physical self, the patient's attitudes and moods, as well as his/her social relations. Sickness is regarded as both psychosocial and physical maladaptation [14; cf. 9, 13].

While some investigators have noted the indigenous holistic conception of illness, others have tended to impose the reductionist and dualistic ideology which permeates Western medicine on the study of illness in the Middle East. Thus indigenous multi-causal explanations of illness are reduced to single causes. Moreover, and in accordance with the dualistic tendency which distinguishes "physical" and "mental" illnesses, illness is described as "psychological", without reference to physical debility. Consequently, analysis of culturally significant illness states has often proceeded entirely at the psychocultural level [e.g. 12, 17, 18], although such illnesses may well represent expressions or ways of coping with structural bodily changes [19]. Regarding the tendency towards reductionism in the study of indigenous illness causation, this is reflected in investigators' emphasis on supernatural etiology [e.g. 5, 10, 12]. Contrary to this emphasis, data from the village of FatiHa indicate that illness causation is multidimensional and that it is necessary to distinguish different levels of causation [cf. 20]. In addition to efficient and instrumental causes (who causes illness, and how it is precipitated), analysis of local interpretations of illness discloses ultimate causes (*why* illness occurs) which involve the social dimension of the wordly environment. Extended case studies reveal that interpretation of illness is intimately linked to socially significant relations and events. Even in cases where illness is associated with supernatural beings and powers (e.g. spirit intrusion, sorcery and the evil eye), the *ultimate cause* of illness is social. Thus, while analysts of the Middle Eastern indigenous medical system continue to be fascinated by supernatural illness causation, the peasants of FatiHa themselves identify social conflict and asymmetrical power relations as the *ultimate causes* of sickness [14].

Further examination of the ethnomedical literature on the Middle East indicates concern with culture-bound syndromes or folk illness. Description and analyses of such illness, notably spirit possession in its various local forms, have been presented by both psychiatrists and anthropologists. For psychiatrists, the clearly elitist attitudes of some of these medical professionals prompts them to describe interpretations of sickness by folk healers and lay persons as reflecting the illiteracy of indigenous peoples, their irrationality, or their traditionalism [e.g. 4, 6, 21]. Additionally, one notes a tendency among these medical professionals of adopting a restricted, idealist "cultural" perspective which identifies local values and role expectations as the primary correlates of what El-Islam [21] refers to as Culture Bound Neurosis and to which Okasha [6] attaches the diagnostic labels "hysterical," "anxious," "obsessional," "demanding and demurring" and "schizoid". In short, psychiatrists have generally tended to view spirit possession as a manifestation of psychopathology which they correlate with narrowly defined "cultural" variables.

Unlike psychiatrists, anthropologists [e.g.

12, 17, 22], in typical cultural relativistic style, have focused on the functional utility of spirit intrusion in the Middle Eastern cultural context in which it occurs. The "safety valve" argument is illustrative of this tendency. Accordingly, spirit possession is linked to stressful social roles, and the resulting illness is described as a functional mechanism of social control. But no attempt, beyond reference to local role expectations, is made to explain why some roles are more stressful than others in the first place. Hence the emergence of a tautological argument. As indicated by the study of the illness of 'uzr, a local variant of spirit possession in FatiHa [23], what this functionalist explanation ignores is that it is the sociocultural *system* itself which defines the necessary functions of its elements (roles and illness, both). Functional considerations identify the rationality of the elements while ignoring the rationality of the broader structure within which such elements operate. It must be emphasized that these elements operate within certain structural constraints, namely specific systems of material production with associated socio-political and ideological elements which give continuity to stressful roles. In short, in order to explain the continued significance of certain roles, or stress associated with them, one must move, conceptually, outside the analytical boundaries of roles themselves to consider the structural elements which maintain these roles. Functionalist explanations of folk illness in the Middle East do not extend serious consideration to such structural constraints, i.e. to the political-economic conditions and asymmetrical power relations which underlie conditions of stressfulness associated with culturally significant afflictions such as spirit possession. Thus contrary to the emphasis on female *role* as a correlate of spirit possession [17, 21], the analysis of 'uzr cases in the village of FatiHa indicates that it is not simply gender role which is likely to precipitate the illness. When one focuses on power differentials and associated political-economic variables, rather than roles, it becomes evident that variation in the frequency of the affliction occurs *among* women (and among men) as well as *between* women and men [23].

Further scrutiny of the Middle Eastern literature on the indigenous health system shows that, in addition to concerning themselves with ethnomedical beliefs, investigators have focused their attention on healing. In this regard, one is often left with the impression that healing forms derive straightforwardly from medical beliefs, without regard for the dynamics of health care. The study of healing in the village of FatiHa leads to different conclusions. One notes the absence of perfect correspondence between expressed beliefs about illness, the reporting of definitive symptoms, and medical treatment [14, cf. 4, 9]. Selection of appropriate treatment is neither random, nor does it follow straightforwardly from an underlying logic of culturally shared categories of illness explanations [14]. Of particular significance, and in accordance with the political-economic orientation of the present critique, is the more fundamental question of social legitimation of the sick role, upon which initiation of treatment is contingent. Of additional, and related, significance is the differential allocation of valued resources for the treatment of persons of different

social identities. In fact, two persons may present identical symptoms and one would be denied the label "sick" while the other would be granted it readily. Neither is the severity of the symptomatic person's condition as perceived by him/herself a guarantee that the illness labelling would be granted and the necessary curative regimens pursued. In fact, it is evident that people whose contributions and social standing (as well as health) are highly valued may be granted the label "ill" even with the presentation of the slightest symptoms indicative of ill health. For example, since husbands are recognized as the primary "bread winners" of the family, they are urged to seek medical treatment at the slightest indication of illness. In contrast, powerless daughters-in-law in extended family households are often denied the legitimacy of the sick role, unless they have access to a significant power base (e.g. ownership of land, membership in a powerful family, education). When such legitimation is granted to relatively powerless persons, they are likely to receive the least costly form of illness treatment.

#### STUDIES OF COMPETING MEDICAL SYSTEMS

Over the past decade, the literature on health care in the Middle East indicates increased consideration, by international agencies, health care professionals and social scientists, of the health sector in relation to schemes of socio-economic development. Anthropologists with interest in the Middle East have begun to contribute to an area of study which has been of traditional concern to medical anthropology, namely the study of competing medical systems. In reviewing the relevant limited literature on this topic, it is evident that primary consideration is extended to the effect of indigenous values and health beliefs and practices in conditioning local populations' responsiveness to the introduction of modern health care [e.g. 16, 24, 25]. Guided by an idealist conception of culture, studies of health care have devoted primary attention to aspects of cognition and rationalizations related to health and illness. Such studies reason that since the indigenous Middle Eastern medical philosophy contradicts the underlying logic of modern medical treatment, this form of treatment may be rejected. In attending to this problem of what Kunststadter [26] has referred to as "cognitive dissonance" or "cultural conflict" (the assertion that conflicts exist between traditional illness classification and their associated causes and treatment, on the one hand and modern medical practice on the other), the anthropologist, as translator of indigenous philosophy, undertakes the task of identifying areas of possible blend and conflict and preaches tolerance of indigenous ideas and practices to biomedically oriented professionals [16].

There is no doubt that indigenous concepts of illness are relevant to problems of health care. In FatiHa where physicians' medical explanatory models differ from interpretations of sickness by lay persons and folk healers, these conceptual differences cause incompatible expectations of therapeutic regimens and may result in the patient (and his/her family's) non-compliance with the directives of health care professionals. Thus the proponents of the "cognitive dis-

sonance" argument are correct in considering the importance of indigenous concepts of illness. But these researchers must recognize, as none have to date, the dialectical relations between these beliefs people so firmly hold and the social conditions under which they live. The error of the literature is to isolate these belief systems from social conditions. In short, the limitation of studies of competing medical systems in the Middle East lies, not in their concern with indigenous medical beliefs, as such, but in their emphasis on such beliefs to the neglect of the political-economic context of health care. The village of FatiHa offers still another example of the importance of political-economic variables; in a survey of responses to illness over a one year period among the adult inhabitants of 100 households in the village, it was evident that in seeking medical care, beyond the family context, the physician was by far the first choice of the villagers [27]. But in spite of the fact that villagers value modern medical services and judge their utilization as important status symbols, such services are not always accessible. As peasants in a centralized state society with characteristic social stratification and associated power differentials, their health care needs are accorded low priority. Indeed, medical care for the peasants of FatiHa, like the rural inhabitants of other parts of Egypt and the underprivileged classes of the urban areas, cannot be divorced from the socio-political superordinate power relations which direct every facet of their lives. The peasants of FatiHa, like others in the Middle East, are part of a stratified sociopolitical system. Their subservient power status within the nation state precludes independent planning of their lives in their own best interest.

#### DISCUSSION

Review of studies of indigenous medical beliefs, folk illness, healing and competing medical systems in the Middle East indicates the predominance of a particularistic, reductionist orientation. Anthropologists who are guided by a functionalist orientation stress the utility of particular medical beliefs and practices. Psychiatrists, preoccupied with the identification of the Western diagnostic equivalents of culture-bound syndromes, and the narrowly defined "cultural" correlates of such afflictions, show minimal concern for the overall structures of societies where specific health problems occur.

Medical anthropological studies of the Middle East also espouse an idealist conception of culture. This idealist orientation of medical anthropological studies is not unique to the Middle East. It has been noted for other regions [28, 29]. The African anthropologist Omafume Onoge has referred to this idealist orientation as the "socio-culturalism" of anthropological studies of health care, a reductionist outlook which has tended to elevate the "cultural" component (narrowly defined as values, ideas and roles) into an omnibus explanation [29]. Guided by such a restricted "cultural" perspective, students of Middle Eastern health care systems have devoted much attention to investigating cognition and roles, while largely ignoring sociopolitical organization which transcends the boundaries of local institutions and beliefs. Thus,

reductionism replaces the search for institutional constraints which determine the "choice" of one form of medical treatment over another.

Because of the fundamentally idealist conception of culture which guides studies of health systems in the Middle East, one notes the neglect of class differences and their relation to access to medical care, susceptibility to illness, and their influence in the development of national health care policies. In short, there is a tendency to shun what Janzen has termed the macro-level of analysis which surpasses the context of the family and the local community [30]. The underprivileged people of the Middle East who are the subject of anthropological investigation do not simply live an isolated independent existence; they are part of stratified socio-political entities. Their subservient power status blocks independent planning of their lives and leaves them subject to the imposed planning and priorities of the ruling power elite. Moreover, awareness of the national context of anthropologists' study communities developed through macro-level conceptualizations cannot be presented in isolation from international domination, interventions and control. In this regard one notes the absence of a serious attempt by researchers to examine the impact of colonial domination, whether political or economic on the political economy of the Middle East and the relation of the latter to health. In contrast to Darity's [24] identification of "nationalism" as an impediment to the acceptance of modern health care, Jim Paul contends that medicine is absolutely inseparable from imperialism. He demonstrates how colonial doctors function as agents of imperialism while modern medical systems provide social control and reproduce a labour force to suit the requirements of colonial development [31].

In the foregoing critique of the medical anthropological literature on the Middle East, I have noted the overwhelming emphasis on local ideas and practices related to health and illness. This is not to say that material considerations which bear upon the issue of access to health care are *completely* ignored. In fact, some authors with concern for health care problems in the region make explicit reference to the limited availability of modern health care facilities, the necessity of travelling long distances in pursuit of modern medical treatment, and they even provide a sympathetic mention of the poverty of the rural people of the Middle East [24, 32, 33]. But reference to poverty does not entail identification of structural relations which perpetuate conditions of poverty. Reference to poverty is not a substitute for examining the structural constraints associated with particular productive systems and related exploitative relations and state imposed policies which foster ill-health and which limit access to health care. Moreover, poverty in the Middle East is not synonymous with the underdevelopment of the region. In examining the relationship between problems of health care and poverty, the latter should not be assumed to be an original condition. It is necessary to explain such problems in relation to developing historical systems of social production and the related *process* of underdevelopment in the Middle East. In short, amelioration of health problems requires the consideration of these problems in their specific historical and political-economic con-

texts. What is needed is the construction of analytical models which would *explain* cross-cultural variations in the provision of health care services and guide the formulation of realistic health care policies.

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