TUNISIAN MEDICINE IN EVERYDAY LIFE

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ABSTRACT

In identifying symptoms and causes of illness, and in pursuing their prevention or cure, Tunisians in the town of Mahdia draw upon a variety of medical alternatives. Contemporary Tunisian medicine represents the juxtaposition of formerly disparate healing traditions, including ancient beliefs in the evil eye and jnun (spirits), Sufism, the humoral Arab medical system adopted in the eighth century A.D. and biomedical practices. Most individuals use the wide range of therapies available, often emphasizing certain kinds of treatment for particular problems. Syncretism is evident in the behavior of those who make health care decisions and administer therapy as well as in the explanations of the pathology and causation of illness. The tenacity of the medical system is attributable to the fact that some of its underlying themes are reflected in semiotic structures of the Tunisian culture as a whole.

RESUME

Les habitants de la ville de Mahdia en Tunisie, ont recours à une variété d'alternatives dans le but d'identifier les symptômes et les causes des maladies et pour déterminer des mesures préventives et des remèdes. La médecine tunisienne contemporaine présente une juxtaposition d'anciennes traditions disparates pour trouver des traitements incluant les anciennes croyances dans l'oeil malfaiteur et les jnuns (esprits), le sufisme, le système humoral de la médecine arabe adopté durant le huitième siècle A.D., et des pratiques biomédicales. La majorité des individus utilise la grande gamme de thérapies disponibles souvent mettant de l'emphase sur certains types de traitement pour des problèmes particuliers. Le syncrétisme est évident dans la conduite de ceux qui prennent les décisions relatives aux soins médicaux et administrent la thérapie, aussi bien que dans les explications dans la pathologie et la cause des maladies. La ténacité du système médical est attribuable au fait que certains de ses thèmes de base sont reflétés dans la sémiotique des structures de la culture globale tunisienne.

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FORWARD

Most Arabic words appearing in the text are transliterations of terms used in the Tunisian dialect. With some modifications the system of transliteration used is based on a language workbook written by Noury Al-Khaledy. English phonetics are used to indicate vowel sounds. The 'ayn is presented by an apostrophe (') and the emphatic consonants are written as follows: ḅ, ḍ, ṭ, ṣ, and q. ḴḴ is pronounced as in Bach.

Had it not been for the generosity and helpfulness of my in-laws and friends living in Mahdia, this research project would have been exceedingly difficult, if not impossible , to carry out. I am very grateful to them for accepting me into their lives and allowing me to share their work, interests, concerns and joys. Through their efforts I was introduced to various people in Mahdia including women knowledgeable in Tunisian ethnomedicine. These women were kind enough to work with me as informants. I particularly want to thank Samia who assisted me during numerous hours of interviewing. In order to insure the privacy of my family and informants fictitious names have been used in the text. Place names, however, were not changed.

I want to express my gratitude for the continued support and helpful advice given to me by Dr. Margaret Lock, Dr. John Galaty and particularly my superviser Dr. Philip Salzman. I am thankful for the time they spent with me discussing my research and carefully reading my thesis during its

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INTRODUCTION

Casual observations made during previous visits to Tunisia suggested that three medical traditions co-existed there. In addition to Western medicine (called dwa suri meaning European remedies) two other medical systems appeared to be operative: 1) a humoral medical tradition employing herbal remedies and minor surgery (called dwa 'arbi meaning Arab remedies) and 2) spirit mediumship. Based on the behavior of my Tunisian acquaintances I concluded that each of these medical alternatives was institutionalized through its practitioners and validated by patients' health seeking behavior.

Subsequent perusal of the literature revealed that although remnants of Tibb al-'Arbi (Arab medicine dating back to 750 A.D.) had been observed in some contemporary Middle Eastern societies, the subject had not been investigated thoroughly. That is, no attempt had been made to correlate the popular medical beliefs with the ancient medical tradition. Furthermore, research conducted on spirit mediumship had, for the most part, been studied as a single phenomenon and not as part of a wider medical system.

Armed with the knowledge that little data on "old recipes" (as they have been referred to by some researchers) had been collected in Tunisia or elsewhere in the Maghreb (North Africa), I began my investigation of Tunisian medicine by collecting data on the etiology and ethnomedicine of dwa 'arbi - a medicine I knew was widely utilized and highly

respected by Tunisians with whom I had contact. In the early stages of data collection the importance of spirit mediumship and biomedical therapy became evident and thus the research project was expanded to include an analysis of the utilization of the other two medical traditions. Finally, starting with the assumption that medical situations do not exist in isolation but rather within a cultural context, an attempt was made to interpret the data in light of more general cultural norms and values. Thus the primary objectives of the research effort were as follows: 1) to analyze the data collected on the etiology and ethnomedical practices of the humoral and spiritual healing alternatives; 2) to ascertain the meanings in the three co-existing medical ideologies; 3) to analyze the juxtaposition of the medical traditions in terms of cognition and practical usage; and 4) to determine the congruence of behavior and meanings inherent in the medical domain with those found in the culture as a whole.

Fieldwork was conducted in Mahdia, Tunisia - a coastal town with a population of approximately 45,000. Because of my personal relationship with inhabitants of Mahdia, accommodations and access to informants were readily available. Thus this town became an obvious choice as a research site. Data was collected by means of participant observation, informal conversations and taped interviews.

An analysis of the information gained during fieldwork follows. In Part One the theories and methods used in this

project are explained. A description of Mahdia is also provided, including a discussion of the social dynamics of neighborhoods (zneg). In Part Two the etiologies and ethnomedicines of the medical traditions are first described and then analyzed in terms of their relationship to one another and to the culture as a whole. In the final analysis I conclude that: 1) the Tunisian medical domain is a syncretic system incorporating dwa 'arbi, dwa suri and spirit mediumship not only in the health seeking process but cognitively as well, and 2) the cognitive structure inherent in the medical domain is part of the fabric of everyday life in Tunisia and is thus reflected in the semiotic patterns of the culture as a whole.

PART ONE

CHAPTER ONE

CONCEPTUAL FRAMEWORK

The theoretical and methodological orientation of this research project is derived from theories developed in medical, cognitive and symbolic anthropology. The latter two fields, according to Colby, Fernandez and Kronenfeld (1981), are at the point of convergence. They explain that the convergence of these fields is the result of an evolutionary process wherein the methodology of cognitive anthropology has merged with the search for meaning in social action - the latter being the concern of symbolic anthropology. They state:

> Essentially, the convergence we detect and envision lies in the fact that cognitive anthropology has been seeking to move away from the highly formal, methodologically logical, but so often trivial analyses of early ethnoscience, and towards analyses of behavior in contexts where the participant's encyclopedic (that is, cultural) knowledge is at play. Of course, in its concern with the meaningfulness of human action, symbolic anthropology has directed itself characteristically to this question of behavior in the full context of associated cultural knowledge. Thus, cognitive anthropology has been moving towards the level of analysis characteristic of symbolic anthropology. At the same time, there has been a worrisome idiosyncrasy in symbolic interpretation: the hermenuetic circle, to put it in symbolic terms, has been too tight. Consequently, there has been a desire for greater validity of method and a greater constancy and generality of theoretical perspective. These are precisely those strengths present in cognitive anthropology: the strength of emphasis upon verifiability of procedure and the strength of constant reference to the logical structures present in human thought and action. . . This high-level convergence towards the analysis of meaningful content by valid methods revealing logical structures we have called <u>microanthropology</u>.
>
> Above all, microanthropology represents a

> general movement from a static structural picture to an interest in process. . . . (Colby, Fernandez and Kronenfeld, 1981,p. 440)

This research endeavor, in the terms of Colby, Fernandez and Kronenfeld then, is an example of "microanthropology" in as much as its formulation has been based on ideas developed in those two areas. As a result, some basic assumptions underlie the data collection and subsequent analysis. First, culture is perceived as a system (1), consisting of discernible subsystems, referred to as "domains" by C. Frake (1961) and J. Spradley (1970), "cultural units" by D. Schneider (1976) and "categories" by P. Bock (1969).

Second, I maintain that culture is in Clifford Geertz's sense "a system of meanings which are embodied in symbols" (Feinberg, 1979, p. 542). Thus I observed and recorded the behavior of participants in the medical domain, with the conviction that in doing so, "core symbols" (Schneider, 1976) or "collective representations" (Durkheim, 1915) or "themes" (Opler, 1946) that underly and give meaning to participants' behavior and ideas could be discerned. Third, keeping in mind the criticisms directed towards interpretive studies, I attempted to ground my analysis in social action and not in the symbols themselves. (Ibid.)

Thus my goal has been to understand the cognitive constructs of one particular domain in Tunisian culture - the medical domain. An analysis of the various medical traditions that subsume that domain was required. To this end information was elicited in a systematic fashion to ascertain what people <u>think</u> about health, illness and therapy. Then

attention was given to the way in which the logical structures are transformed into action (behavior). What do people do in medical situations? How is behavior reflected in the utilization of the "cognitive map". In this regard I was concerned with process - in the selection of health care and the implementation of therapy. Finally, an attempt was made to correlate the themes (cognitive structures) and behavioral patterns found in the medical domain with those identified in other domains. Did the medical cognitive structures permeate other aspects of culture?

"Folk Medicine" versus "Biomedicine"

The terms "folk medicine" and "biomedicine" are used frequently in the literature of medical anthropology. The dialectic between these two entities, as it occurs in the Tunisian domain, will be discussed in this work as well. Therefore it is useful to define these terms from the beginning.

Irwin Press and Arthur Kleinman, as well as others, have used the terms "professional", "folk" and "popular" medicine to explain the variation that occurs in societies that have medical pluralism. Professional medicine is the type of medicine that is considered the orthodox legitimate medical system.(2) Press states, "In anthropology, as in sociology and economics, we have come to equate "professional medicine" with -- and thereby conceptually divorce the lay populace from -- control, legitimacy, and orthodoxy of health beliefs and practice." (Press, 1980, p.48) Whereas folk medicine, he

explains,

> ... should be strictly limited to describing systems or practices of medicine based upon paradigms which differ from those of a dominant medical system of the same community or society. (Ibid.)

And finally, Press defines popular medicine as

> ... all medical practices performed by other than officially sanctioned professionals of a medical system, and which do not directly contradict the paradigm of the system. (Ibid.)

Using these definitions biomedicine represents the professional medical tradition in Tunisia. This is the medical alternative sanctioned by the government. Immunization programs are organized and executed by government agencies. Hospitals and clinics dispense health care free of charge or at a minimal cost. The education of medical and nursing students is subsidized by the Ministry of Health. Thus biomedicine clearly is perceived by government officials as the orthodox legitimate medicine of the country.

Folk medicine is represented by spirit mediumship and dwa 'arbi. Specialists in each of these traditions definitely draw from a cognitive framework different from that of biomedicine. Whether or not these two traditions represent one or two folk medicines and whether or not they represent popular medicine as well is one of the concerns of this work.

Biomedicine within Pluralistic Medical Domains

Ethnomedicine developed in Euro-American countries and distributed world-wide under various auspices is sometimes referred to as "western medicine", "modern medicine" or

"cosmopolitan medicine". But increasingly the term "biomedicine" is being used instead. Robert Hahn and Arthur Kleinman remind us that biomedicine includes more than just medical theories and practices. It is, in fact, a sociocultural system derived from a cultural framework based on specific values and ideologies. What is being diffused is biomedical theory, practice and institutional organization. (Hahn and Kleinman, 1983)

Biomedical therapy is based on molecular biology. Its focus is on the identification, treatment and/or eradication of diseases. According to Horacio Fabrega, "In . . . a biologistic perspective, the term disease signifies a medical concept whose meaning or intention involves an abnormality in function and/or structure of any part, process, or system of the organism." (Fabrega, 1974, p. 132) Thus the goal of diagnosis is to discover the abnormality in the bodily processes or structure. The characteristics that identify a particular disease refer to biological processes. The scientific method is used to identify diseases. Fabrega states,

> According to the medical model, a human illness does not become specific disease all at once and is not equivalent to it. The medical model of an illness is a process that moves from the recognition and palliation of symptoms to the characterization of a specific disease in which the etiology and pathogenesis are known and treatment is rational and specific. (Fabrega as quoted in Engle, 1977,p.131)

George Engle adds,

> Thus taxonomy progresses from symptoms, to clusters of symptoms, to syndromes, and finally to disease with specific pathogenesis and pathology. This sequence accurately describes the successful

> application of the scientific method to the elucidation and the classification into discrete entities of disease in its generic sense. (Ibid.)

Fabrega explains "The necessary and/or sufficient conditions that allow inferring the presence of disease are expressed in information pertaining to such things as blood sugar levels, electrographic patterns, chest x-rays or microscopic specimens of tissues." (Fabrega, 1974,p.134) Just as medical technology is used to ascertain the disease, medical technology is used to treat the disease. Treatment is aimed at adjusting the processes or structure in an attempt to regain a normal state.

In discussing the biomedical model, George Engel suggests that it has become too reductionistic. Although he acknowledges the fact that biomedicine has made tremendous progress in diagnostic, therapeutic and curative practices, he as well as others point out that the approach taken by biomedicine is too narrowly defined. He states,

> The dominant model of disease today is biomedical, with molecular biology its basic scientific discipline. It assumes disease to be fully accounted for by deviations from the norm of measurable biological (somatic) variables. It leaves no room within its framework for the social, psychological, and behavioral dimensions of illness. The biomedical model not only requires that disease be dealt with as an entity independent of social behavior, it also demands that behavioral aberrations be explained on the basis of disordered somatic (biochemical or neurophysiological) processes. Thus the biomedical model embraces both reductionism, the philosophic view that complex phenomena are ultimately derived from a single primary principle, and mind-body dualism, the doctrine that separates the mental from the somatic. Here the reductionistic primary principle is physicalistic; that is, it assumes that the language of chemistry and physics will ultimately suffice to

> explain biological phenomena. From the reductionist viewpoint, the only conceptual tools available to characterize and experimental tools to study biological systems are physical in nature. (Engle, 1977, p. 136)

Due to the efforts of Christian missionaries, national governments and the World Health Organization, biomedicine is practiced universally. The ramifications of its adoption into nonwestern culture varies. However most often medical pluralism is the result. (It should be noted that medical pluralism in many cultures exists prior to the introduction of biomedicine.) Medical anthropologists studying pluralistic medical "configurations" (as opposed to pluralistic systems) (Press, 1980) find that the traditional ethnomedicines remain tenacious despite the infusion of biomedicine. It has been suggested that this tenacity is due to the fact that some traditional medical systems are based on multifactorial etiologies (as opposed to a specific etiology as is biomedicine) and thus are better suited to deal with chronic, psychogenic and incurable illnesses. Thus such medical treatment is concerned with healing illnesses (defined by Eisenberg as "experiences of disvalued changes in states of being and in social function") rather than curing diseases ("abnormalities in the structure and function of body organs and systems"). (Eisenberg, 1977, p. 11)

It is often assumed that the etiology and ethnomedicine of traditional health care will finally collapse in the face of the introduction of biomedicine. This assumption, however, seriously underestimates the medical (and cultural) processes. As Margaret Lock explains,

> There is, nevertheless, a tendency to accept the 'convergence' hypothesis frequently applied to the process of industrialization and modernization. That is, it is assumed that traditional medicine will be rendered useless or very peripheral once economic development reaches such a level that cosmopolitan medicine is established as the primary source of health care.... The convergence hypothesis fails to take into account the fact that all medical systems, including cosmopolitan medicine, undergo a constant process of reevaluation and adjustment in light of changing health problems with which the system is confronted. (Lock, 1980, p. 259)

Semiotic Approaches in the Study of Medical Systems

I found the theoretical approaches developed by Allan Young and Arthur Kleinman very useful in formulating my ideas. Their approach is to view illness episodes and their subsequent treatment as processual events which involve the interplay of social behavior with cognitive structures.

Allan Young, in his article "Some Implications of Medical Beliefs and Practices for Social Anthropology" (1976), makes two principal points: 1) that medical traditions persist because they are effective (they "work") - in dealing with the biological and social disruptions that occur during sickness episodes, and 2) that the sickness episode serves an ontological role in as far as the episode calls forth explanations that give meaning to the real world.

Young (1976) suggests that by looking at the "motives of the sick persons and other interested people" (p.6) one finds that the sick person is responding to two imperatives. The first is the practical one, the need to prevent or cure a particular illness. The second is the social one, the need to

establish himself, at least temporarily, in a sick role. This is legitimized by society and different behavioral patterns and attitudes are called into play.

Illness begins with "signs" which are conceptualized by the patient and relatives as "symptoms". These symptoms are presented to the healer, who will make a diagnosis drawing upon his understanding of illness causation. If the diagnosis concurs with the preliminary diagnosis of the patient and family, it legitimizes the individual's sick role and at the same time confirms the belief in the etiology. Likewise, therapy is efficacious if there is agreement between patient and practitioner. This is true for a number of reasons. In a sickness episode various changes take place. That is, the symptoms may change or disappear. This is especially true with self-limiting ailments and illnesses that have transient symptoms. Change is often verification that the treatment is working. More to the point, however, Young states that "Therapies are not only a means for curing sickness but, equally important, they are a means by which specific, named kinds of sicknesses are defined and given culturally recognized forms . . . . What people get during sickness episodes, then, are medical proofs consistent with their expectations." (Ibid., pp. 8-9)

In choosing practitioners, patients and/or relatives will base their choice on their etiological system. Thus, in Euro-American societies one will decide whether or not to go to a chiropractor, faith healer, psychiatrist, gynecologist or orthodontist based on the symptoms and corresponding etiology.

These are practical concerns.

In the social sphere, the community must also deal with a sickness episode. In as much as the sick person withdraws from social and economic activity, he is seen as deviant. Young states,

> The more 'serious' is the sickness, the greater is the deviance. What distinguishes sickness from other kinds of deviant behavior are the special techniques by which society offers to exculpate the sick person, and the fact that social accountability for his behavior can always be transferred onto some agency beyond the sick person's will. These agencies can be in some sense external to the sick person (a witch or a virus, perhaps), within his own body (a morbid physiological process, for example), or most often, a combination of both. Indeed, recognizing that sickness roles (at least those that involve serious sickness) and ritual behavior are distinguished from everyday behavior in many of the same ways, it would be more appropriate to label them extraordinary than deviant.
> (Ibid., p.11) (emphasis in original)

It is the therapist's job to pinpoint the source of the illness and prescribe treatment. In doing so he legitimizes the sickness episode and exculpates the individual. Young finally says, "To transfer accountability means to translate 'sign' (behavioral or biophysical expressions of the sick person) into 'symptom' (recognizable indicators of sickness)." (Ibid., p. 15)

There are what Young calls "ontological consequences" of sickness episodes. A sickness episode forces the community to take stock of various factors, such as: a) the fact that illness can occur at anytime to anyone, b) the responsibilities of the community to the sick person, and c) the reaffirmation of the etiology of illness held by the

culture. In short, the society reaffirms the fact that their medical practices "work". Young explains,

> In practical explanations, 'work' means the ability to purposively affect the real world in some observable way, to bring about the kinds of results which the actors anticipate will be brought about. On the one hand, it can mean what people hope will happen, what should happen. On the other hand, 'work' can also mean what people hope will happen, what people expect will happen, what will happen regardless of whether or not the sick person's situation has been improved by the healer's activities. (Ibid.,p.7) (emphasis in the original)

Thus a person's sense of reality is put to the test, so to speak, and if the medical practices prove to "work", then one's sense of reality is reconfirmed. Etiological explanations of disease causation and therapeutic practices related to that etiology become in Geertz's terms a "model of" and a "model for" interpreting reality. As Young states,

> . . . it should become clear that the notion of "work" which is central to understanding the meaning of medical beliefs and behavior is, if understood from an ontological point of view, a way of describing praxis. There are several reasons why sickness episodes are ontologically important settings. (Ibid., p.17) (emphasis in the original)

Medical etiologies provide a construct of reality - a rationale for action (praxis). The action in turn verifies the legitimacy of the etiology. He concludes:

> Medical beliefs and practices can never explain away sickness or death. Why, then, when they fail to produce a cure, can it be said that they make suffering sufferable? I have argued in this section that while serious sickness is an event that challenges meaning in this world, medical beliefs and practices organize the event into an episode that gives it form and meaning. (Ibid., p. 19) (emphasis in the original)

Arthur Kleinman, like Young, focuses on the sickness episode as a starting point for gaining information on the

semiotics of medicine. He focuses on the interaction that takes place in a clinical situation. He argues that much of the research that has been done in ethnomedicine has been practitioner-oriented or patient-oriented, but very little work has focused on the transaction (exchange of information) that takes place between patient, practitioner and the family. Such transactions, he suggests, take place in a specific setting and under given conditions, which he refers to as "clinical".

Kleinman insists that such transactions be studied within the cultural contexts. That is, one must be aware of the fact that the medical domain (which Kleinman refers to as a "health care system") is part of the larger culture which usually includes a diverse population in terms of residence, occupation, ethnicity, socio-economic level, education, etc. Thus even though the cognitive basis (or bases) of the medical domain is held collectively, the medical systems may be used differently according to the individual's position in society. (Kleinman, 1980)

Kleinman reiterates a point made by others, that the function of clinical activity is to heal the illness and not necessarily cure the disease. A "cure" for the patient is usually relief from the symptoms and an explanation for the illness that is meaningful to him and his peers. More specifically, Kleinman offers five "core clinical functions" that are served in a clinical situation:

1) the construction of the illness experience (lay diagnosis of symptoms);

2) the establishment of general strategies and criteria for choosing and evaluating health care alternatives (selecting practitioners);
3) the management of particular illness episodes through communicative operations such as labeling and explaining (practitioner's diagnosis);
4) healing activities per se (treatment);
5) the management of the therapeutic outcomes (death, reoccurrence, failure).(Ibid., pp. 72-85)

The success of clinical transactions depends upon whether or not the patient's and practitioner's cognitive structures are in agreement. The patient, family and practitioner will come to a clinical situation with a given "explanatory model" (EM). Explanatory models provide explanations for etiology, time and mode of onset, pathopsychology, course of sickness (acute, chronic, temporary) and treatment. Having said that, however, Kleinman adds that "To analyze popular EMs into the five categories enumerated above is to attribute more formal organization and specificity to them than they usually possess. Vagueness, multiplicity of meanings, frequent changes, and lack of sharp boundries between ideas and experiences are characteristic of lay EMs." (Ibid., p. 107)

Kleinman also states that

> Explanatory models need to be distinguished from general beliefs about sickness and health care. As we have seen, such general beliefs belong to the health ideology of the different health care sectors (popular, professional and folk) and exist independent of and prior to given episodes of sickness. EMs, even though they draw upon these belief systems, are marshalled in response to particular illness episodes." (Ibid., p. 106) (In dealing with particular illnesses) "individuals strain to integrate views in part idiosyncratic and in part acquired from the health ideology of the popular culture." (Ibid., p. 109)

What transpires in a given transaction between patient,

practitioner and family is an elicitation and evaluation of the others' EM. In short, Kleinman hypothesizes that when there is agreement the chances of the individual being "healed" are higher. When the EMs do not concur, either the practitioner will convince the patient and family of the efficacy of his EM (often successfully because his EM is much more thorough and better articulated than is the lay person's) or the patient will maintain his EM and search for another practitioner that shares the same EM.

Both Young and Kleinman have provided an approach useful to the researcher who wants to discover what illness and treatment mean to the patient, healer and family. They seek ways of discovering the symbols that are called upon to make sense of the disruption that has occurred physically and socially. They are neither concerned with trying to describe and/or categorize concepts of disease, as have other medical anthropologists (Frake, 1961, Foster, 1976) nor are they interested in a functional explanation as to the endurance of indigenous medical systems as has been the concern of researchers such as Press (1978). Rather Kleinman's and Young's approach is a semiotic one. They are operating on the premise that notions of health care are rooted in an overall cognitive construct which pervades the cultural system in general and the medical domain in particular.

Combining the theories of Young and Kleinman one concludes that to understand the practical activity witnessed in illness episodes one must do the following: 1) discover

the 'motives' of the sick person, healer and family, 2) analyze the effects of an illness in the community, 3) understand how the treatment in itself legitimizes and thus gives meaning to the etiology, 4) assume that there are variable "explanatory models" held in a given culture, and 5) assume that only in a clinical situation, wherein patient and practitioner are interacting, do these "explanatory models" come into contact with one another, often testing their tenacity.

Research in Medical Traditions in the Maghreb and Middle East

During the first part of this century ethnographers painstakingly recorded descriptive material in minute detail and thus provided us with a rich source of reference data. Edward Westermarck (1926) in particular compiled a lengthy and detailed treatise on what he termed "magical and ritual beliefs and practices" in Morocco. From this work as well as from Blackman's (1926) and Lane's (1908), one can ferret out those beliefs regarding illness etiology and ethnomedical practices. (In Chapter Five, these works are used to describe the historical context from which current Tunisian medical ideology is derived.)

Writing at the same time, Hilton-Simpson (1922) published his ethnography on the Shawiya, a Berber tribe living in the Aures region of Algeria. He was struck by the effectiveness of the local healers who administered various treatments such as trepanning, removal of limb bones, bone substitution, bone setting, eye surgery, cautery, styptics,

cupping, lithotomy and dentistry, and who were extremely well versed in the collection and use of herbs. He described the herbal treatment (noting the Latin term for each herb) for 35 ailments. Many of the techniques and herbs used in Algeria are similar to those used in dwa 'arbi, described in Chapter Six.

It would appear that neither Westermarck nor Hilton-Simpson was aware of one another's work. Even if they were, I suspect that they would have concluded that they were looking at mutually exclusive topics. Westermarck did not describe any instrumental modes of treating illnesses, and Hilton-Simpson made no mention of "magical practices" other than to say that the Shawiya healers did not use magic.

Historians such as Edward Browne (1921) and Amin Khairallah (1946) documented the basic tenets and development of Islamic medicine. More recent historians have focused on particular aspects of Islamic medicine, demonstrating the influence that Islamic medicine had on medieval medical traditions leading eventually to modern medical practice. Martin Plessner (1974) for example explains that Materia medica compiled by Arab doctors and Ibn Sina's (Avicenna) Qanun (Canon) were major contributions made to European medicine. These works, as well as others, became "a kind of bible of medieval medicine . . ." (Plessner, p. 449) The materia medica remained an authority in pharmaceutics in Europe until the 19th century.

Manfred Ullman (1976), in his book Islamic Medicine presents a detailed explanation of the concepts of physiology,

anatomy and pathology in the Islamic medical system, illustrating how these concepts were derived from Greek, Syrian, Indian and Persian cultures. Interestingly he also addresses the existence of magical beliefs and practices during pre-Islamic times and how these beliefs and practices continued to persist during the height of Islamic civilization. Even so, Ullman sees the belief and practice of magic as something that was competing with the secular medical system rather than co-existing in an integrated medical system.

The fact that prevention is a predominant feature of Middle Eastern medical systems was noted by Ailon Shiloh (1968). In his comparison of "Middle Eastern medicine" (by which he is referring only to magic and spirtualism) with Western medicine, he depicts two kinds of preventative medicine - those that are aimed at preventing internal disorders and those designed to protect against external disorders. He describes Middle Eastern preventative medicine as including amulets, religious artifacts and the practice of repeating the name of Allah. He claims that neither Western medicine nor Middle Eastern medicine is concerned with the latter. However, Shiloh exlains that Middle Eastern medicine puts the highest priority on preventing internal disorders.

Although this description is valid, Shiloh omitted any reference to Islamic medicine. This would lead the reader to assume that the basic tenets of Islamic medicine were lost in antiquity. In fact, as will be discussed in Chapters Five,

Six and Eight, various preventative measures are taken which are derived from Islamic medicine - a humoral medical system.

There is a substantial amount of literature written on maraboutism. The role of North African saints, who are known to be endowed with the power of baraka, has been researched from various points of view. A distinction must be made between marabouts and oulaya (Tunisian term for saints). Marabouts are believed to be living saints, whereas oulaya are immortal. (In Tunisia, promises are made to oulaya and occasionally diviners. Those thought to be possessed by jnun are taken to a human intermediary who may or may not be a descendent of a saint. Marabouts do not have the same prominence as they do in Morocco and Algeria. Communication is directed toward the immortal oulaya, not his descendents.)

Some studies have looked at the socio-political dynamics of maraboutism ("cult of living 'holy men'" according to H.A.R. Gibb (1962 p. 158)) in North Africa. Thus Ernest Gellner, in Saints of the Atlas (1969), demonstrates the way in which marabouts mediate disputes between individuals and social groups. The marabouts' power of baraka is used to transcend conflicts and to help arbitrate a solution. In addition the marabouts act as mediators with God regarding harvest and illnesses (but relatively little was said in the book about these activities).

Dale Eickelman (1976) presents the evolution and ideology of maraboutism in Morocco. He notes that some marabouts specialize in healing particular illnesses but that their importance lies in the fact that they are "concrete

symbols" of the supernatural world. Baraka, he explains, is "a concrete manifestation of God's will". Likewise Paul Rabinow (1975) analyzed the symbolic meaning embodied in the social status acquired by the saint's descendents in two villages in Morocco.

As edifying as these works are, they do not really focus on the marabouts as healers but rather analyze their role as mediators or as symbols of the existence of the supernatural. Vincent Crapanzano (1973), however, looked at the activities of one particular brotherhood, the Hamadasha. The leaders utilized their baraka to enact cures. His book, The Hamadasha: A Study in Moroccan Ethnopsychiatry, stands out in the literature on maraboutism for it addresses not only the marabout tradition and how it relates to Sufism but also analyzes the jnun-oulaya tradition. Crapanzano describes the types of illnesses that are treated at the Hamadasha hadrat and offers a psychological explanation for participation in the hadrat. In a similar vein, Hasan El-Shamy (1971) explains that preventative practices of the Egyptians (which include singing folk songs, zikr (hizb in Tunisia)) and therapeutic practices (such as visiting local "shamans" and religious specialists or participating in a spirit possession cult (zar cult)) alleviate anxiety and dissipate feelings of shame and guilt, the latter being projected on the "world", "fate" and "satan".

Finally, Soheir Morsy (1980a), who surveyed 186 subjects, compared the ways in which sex roles were

manifested in illness episodes. Similar to Ioan Lewis (1971) she argues that powerlessness is the most important factor in determining who will fall victim to spirit possession. Thus because of their lack of economic and political power women tend to fall into this category most often. Yet so do the poor and so do those who are in a position of little authority within a family, for example a brother of the head of household. Likewise, not all women are powerless. For example, women who have an independent source of income via a trade, job or inheritance wield a considerable amount of power within their families. Likewise women with sons have more status and influence than those without. In both cases, possession experiences occur less frequently. Morsy's conclusions actually bear out those made by Lewis as well as others.

Analyses of maraboutism, have been either socio-political (Gellner, Morsy), semiotic (Eickleman, Rabinow) or psychological (Crapanzano, El-Shamy) in orientation. None of the authors mentioned have looked at the interrelationships or the common denominator that link maraboutism with other healing activities.

Joel Teitelbaum (1975, 1976a and 1976b) chose not to study the jnun-oulaya system but instead conducted a sociological study on the way in which illness is perceived and acted upon within Tunisian coastal villages. He describes the humoral etiology of illness which, with some exceptions, corresponds with my findings. He focuses on sickness episodes as events which are used as a device to gain recognition in

the social situation and to manipulate family members. The patients, he argues, expects apologies to be extended to them in order to regain their health, and in doing so strengthens their status. (I found no evidence of this happening in Mahdia. Usually the situations that induce anxiety and anger are those that cannot be changed. An apology from a relative would do little to correct the basic situation.) In reference to visits to shrines, Teitlebaum only states that:

> Visits to religious shrines such as marabouts (saint's tombs) and watering places widely known for their curative properties afford physical and emotional relief and also serve to communicate the immedicacy of the problem to kin and friends in the community. These visitations are social acts which correspond to the value system of the community. Thus the tendency to expend time and money by leaving the village for treatment reflects the seriousness of the social breach which is thought to have caused the affliction and weighs the standing and other status components of the invalid and the person (or persons) who has wronged him on the scale of communal values. (Teitlebaum, 1975, p. 405)

Furthermore, Teitlebaum places little importance on the "traditional treatments" indicating that they include "mystical acts and magic foods". Thus dwa 'arbi is not dealt with in any context.

In another study Teitlebaum analyzes the economic effects of the evil eye belief amoung handloom weavers in a Tunisian village. He found that workers who attempted to weave more pieces of cloth than the agreed upon daily quota were believed to be more vulnerable to an evil eye curse. Teitlebaum explains, "This ceiling on cloth production functions to preserve economic parity among weavers as well as

to prevent supplies of cloth from outstripping market demand, thus maintaining profit margins for all." (Teitlebaum, 1976, p. 69) He explains that those wishing to produce more were forced to do their weaving at home rather than in communal shops with other weavers. At home the usual division of labor changed as women began to assist in the weaving production.

Although Teitlebaum's description of the effects of belief in the evil eye is an excellent sociological analysis, it makes no attempt to link belief in the evil eye with the medical domain as a whole.

Some research concerning health seeking behavior has been conducted in Tunisia. Liesa Auerbach (1982) collected data on childbirth decsion-making in Ksar-Hellel; Christina Hermanson-Klein (1976) examined the health seeking patterns of the women in El-Halfawin, a suberb of Tunis; and Amor Benyoussef and Albert Wessen (1974) compared the utilization of government health services in rural and urban areas. Working separately, these researchers found that biomedical facilities were chosen as a first alternative in cases involving acute, serious ailments. Chronic illnesses or those believed to be caused by the supernatural, however, were treated by the informal health care sector. (This conclusion is corroborated by my findings as well.) These studies are important in as much as they provide us with information about the utilization of available health care options in Tunisia. Like Teitlebaum, however, they do not go far enough in their analysis of the cognitive bases upon which decisions are made.

Byron Good (1977) and Soheir Morsy (1980a, 1980b)

working separately, have in my opinion made the most important contributions to the understanding of Middle Eastern folk medicine. Using a semiotic approach they have analyzed the medical domain in a holistic way. This represents an exciting line of research, one which I have found very useful in formulating my own ideas.

Good suggests that the semantic network used by the society be analyzed. He argues that a semantic network incorporates not only the physiological symptoms and pathology used to describe an illness but it also covers psychological, sociological and cultural factors as well. Concentrating on the semantics, Good analyses various explanations given by Iranians when describing "heart distress". The experience of "heart distress" is linked to various psychological and social aspects involved in the individual's lifestyle. Notwithstanding particular Iranian expressions, the general perception revealed in the explanatory model of the Iranians, as described by Good, is similar to what I found in the Mahdian data. In particular, in both cases there is the notion that emotional distress (caused by quarrelling, sadness, anxiety and worry) is the cause of "bad blood" leading to physical ailments.

Morsy (1980b) looked at the etiology of illness held by Egyptians living in FatiHa. Her conclusions reflect some of the concepts I have found in Tunisia as well. She states "Illness causation, which is given primary emphasis in diagnosis, is defined in terms of body-environment

interactions." (p.93) The environment, she explains, is thought to consist of natural, supernatural and social factors.

Finally, in an article entitled "Communication between Peasant and Doctor in Tunisia" (1979) Marielouise Chreyghton describes a clinical situation in Djebel Khroumir. Similar to Good and Morsy, she stresses the importance of studying the semantics of illness, and how confusion is fostered in situations wherein the doctor and patient possess different explanatory models.

After surveying the literature cited above I was better able to focus my research efforts. Certain types of information and methodological stratagems were gleaned. At the same time, a number of questions came to mind. The research project was launched in hopes of answering those questions.

To summarize, my early training in cognitive anthropology sensitized me to the importance of collecting detailed terminologies in a format that could easily be repeated and verified at a later date. However this methodological concern was tempered in this research project with an interest in discovering the meanings that underlie the semantics and behavior related to medical situations. More specifically, I wanted to discover the boundaries of each of the medical traditions referred to in the literature and then to investigate how they articulated with one another cognitively and behaviorally. Interview questions were

designed to elicit descriptions of illness-episodes including explanations as to the causes of illness, health care seeking behavior and therapy. At the same time observations were made in homes and in local shrines. From this data I was able to ascertain some of the meaningful threads that underpin each medical tradition, the medical domain, and the larger cultural system as well.

FOOTNOTES

1) Irwin Press (1980, p.46) defines a system as "a functionally integrated entity with intercommunicating parts. Change in one sector will require changes in others so that equilibrium is maintained."

2) Press (Ibid., p.47) further defines a medical system as "A patterned, interrelated body of values and deliberate practices, governed by a single paradigm of the meaning, identification, prevention and treatment of sickness." (Ibid.,p.47)

CHAPTER TWO

ETHNOGRAPHIC FRAMEWORK: A SKETCH OF TUNISIA AND MAHDIA

TUNISIA

In this chapter the history and social organization of Tunisia in general and Mahdia in particular will be described. It is within this context that medical beliefs and practices have evolved.

The Berbers were the original inhabitants of the Maghreb (North Africa). Their precise origin is yet unknown. However since their language is classified as Hamitic it is assumed that they came from the area of Egypt. According to Richard Brace (1964) they immigrated to the Maghreb approximately 4000 years ago.

The Berbers were ruled first by the Phoenicians, who built the port of Carthage during the 9th century B.C., and then by the Romans from 200 B.C. to 650 A.D., who used the area to supply the empire with cultivated grains.

In the 7th century the Arabs founded a new city in Kairouan and from this base spread the Islamic religion throughout the country and the rest of the Maghreb. The Berber population adopted the new religion readily and eventually adopted the Arabic language as well. Today Berber speakers constitute a small minority - perhaps 5% to 10% of the country's population.

The Sunni tradition, since its introduction in 647 A.D., has continued to be the most prevalent form of Islam in Tunisia. Nevertheless, during the 10th and 11th centuries a

Shiite faction called the Fatimids, originating in Mahdia, reigned over the Islamic world. (1) The Fatimid rule in Tunisia was usurped by the Zirids (a Berber tribe). The Hilal invasion of 1053 A.D. occurred under their reign. The Zirid period was followed by the Normand conquest, the Tunisian Hafcid dynasty, a brief Spanish occupation and finally the establishment of Turkish (Sunni) rule in 1574 A.D.

During the reign of Ahmed Bey (1837-1855) Tunisia became heavily indebted to various European powers, in particular to France. This indebtedness eventually led to Tunisia becoming a French protectorate in 1881. Tunisia finally won its independence in 1956, primarily through negotiations.

Throughout the precolonial and colonial periods the hub of economic and political development took place in the coastal town and cities. This pattern is still evident today, even though there have been recent attempts to stimulate agricultural and industrial growth in central and southern Tunisia. (Findlay et.al., 1982) The port cities such as Mahdia, Sousse and Sfax continue to be the locus of market activity and have stimulated growth in the local economies surrounding such cities.

Since Independence the rural-urban migration has accelerated. As labor-intensive industries (2) are established in the port cities, and particularly in Tunis, the decision to leave the rural area is one made by many peasants. An increase in population, coupled with the traditional land inheritance pattern (which dictates that all sons inherit equal parts and daughters inherit half parts), has left

peasants with very small land plots from which to make a living. Thus jobs in the cities begin to look attractive.

Over 76% of jobs created during the period between 1973 and 1978 were located in Tunis and the Sahel (coastal area). This factor tends to encourage the ever prevalent rural-urban migration. The effects of this migration can be felt in Tunis. As of 1982 20% of the population of Tunisia lived in Tunis. In 1921 only 8.1% of Tunisian population resided in the capital. (Ibid.)

Economic Development and Political Organization

An attempt was made to socialize the industrial and agricultural sectors in Tunisia during the 1960's. For the most part this attempt failed miserably resulting in the ousting of Ahmed Ben Salah, who conceived and implemented the plan. Since then the government has encouraged domestic and foreign investment in the industrial sector. Foreign investors in particular have been lured by liberal tax regulations extended to them since 1974.

As a result of Ben Salah's development program, one third of all agricultural land was in cooperatives in 1969. By 1980, however, almost all of the land had been returned to the private sector. Nevertheless the government continues to excercise considerable control by maintaining strict pricing of primary products such as cereals, olives and grapes.

If one looks at the indicators of economic growth one finds that Tunisia has prospered. To give some examples - the GNP per capita has grown reaching $1,590 in 1979; the annual

growth rate of production has increased steadily from 1960-1979 in all sectors of the economy - agriculture, industry, manufacturing and services; exports in hydrocarbons and phosphates have increased; and exports in manufactured goods have increased substantially with one fourth of all the nations export earnings coming from manufactured goods.(Nellis,1983)

Statistics compiled on the consumption figures for 1966 and 1975 (presented in the Tunisian Five Year Plan of 1977-1981) led Annette Binnendijh of AID to conclude that although there had been considerable economic growth during that 10 year span, the benefits of such growth were not enjoyed by all Tunisians. It appears that the poorest 20% of the population actually was able to purchase fewer goods (a decrease from 6% total consumption in 1966 to 5% in 1975) while the richest 5% of the population were able to purchase more goods (increasing their total consumption from 18% to 22% in 1966 and 1975 respectively). (Ibid.) (Interestingly, these statistics substantiate the observations I have made over the past 20 years. That is, it is clear that the rich are getting richer and the middle class is becoming more affluent while at the same time the living standards of the poor remain the same).

Tunisia has a one-party political system with Habib Bourguiba, a social democrat, at its helm. Bourguiba led his country to Independence and has formulated and implemented all changes since that time. Ostensibly there are elections, but up until 1981 these elections have served only to ratify the

election slate. However in response to recent internal pressure to democratise the political system some opposition parties are beginning to emerge. What happens after the president's death will be very interesting.

Tunisia is divided into 24 provinces, each of which is governed by a governor. The governor has authority over the Mutamads (city chiefs) who represent the people in their district. Thus the political organization is an hierarchical one, where orders are transmitted downwards and requests and/or problems are referred to the next highest level of authority. This organization has been very effectively used by the Neo-Destourian party when implementing new policies.

National Health Care

In addition to providing infrastructures such as roads, trains, and ports, France during the colonial period also established some of Tunisia's fundamental institutions. These include the University of Tunis, some elementary and secondary schools, and some urban hospitals. These institutions have been developed further on the basis of the country's means and perceived needs.

With the help of the World Health Organization the delivery system was organized as follows. Today each province has a range of facilities:

1) A Regional Hospital - with 150-200 beds. Various biomedical specialists can be found here. Located in the provincial capital, it receives referrals from the auxillary hospitals and dispensaries.

2) Auxillary Hospitals - usually found in towns of approximately 10,000 population. They have 50-100 beds and provide basic medical, surgical and obstetrical care. They are staffed with one to two full-time physicians.

3) Dispensaries with obstetrical service - usually found in smaller towns. They are staffed with one full-time physician and full-time midwives, providing prenatal, postnatal and early child health care.

4) Dispensaries with full-time care - the same as above without the obstetrical services.

5) Rural dispensaries - with a full-time nurse and visiting physician (2-3 times/week) coming from his permanent station at either a dispensary or a hospital.

Health care is given free of charge to persons having a "Carte de Soins" (certificate of poverty) or "Cartes Nationales de Securite Sociale" (national insurance plan). Families not having either of these cards must pay a flat rate of five dinars if hospitalization is required. Probably less than 10% of the population do not possess either of the two cards mentioned.

The Tunisian Ministry of Public Health has attempted to provide health care to the whole population. They estimate that they are reaching 71.2% of the population. However a study conducted by Benyousseff and Wessen (1974) in the Province of Nabeul found that actually only 50.5% of the population (49.2% in the rural sample and 56.3% in the urban sample) utilize the government medical services within any

given year.

Furthermore, this same study revealed that most visits are one-service visits. Only 8% of all illness episodes included repeat visits. As Benyousseff and Wessen (1974, p. 294 and p. 298) concluded, "Apparently, patients are either satisfied with the attention and advice given at the first visit or do not return for further treatment for other reasons." (It is these "other reasons" that interest me. They go on to state that the "low-user households" admitted to using some "old recipes" and suggest that the use of traditional medicine is quite high.)

MAHDIA

The town of Mahdia was founded in the beginning of the 10th century when the Fatmid Caliph, Ubayd Allah Ali Mahdi, usurped the Aghlabid dynasty and then moved his Shiite religious/political capital to Mahdia. From Mahdia expeditions were launched in an attempt to conquer the Sunni rulers in Egypt. Eventually the Fatimids were successful and the seat of power shifted to Cairo. Ironically once the Fatimids had secured their postion in Egypt they sent Arab armies to invade Tunisia once again. Thus during the 11th century the Beni Hilalal and Beni Sulaim tribes inflicted considerable destruction on the area.

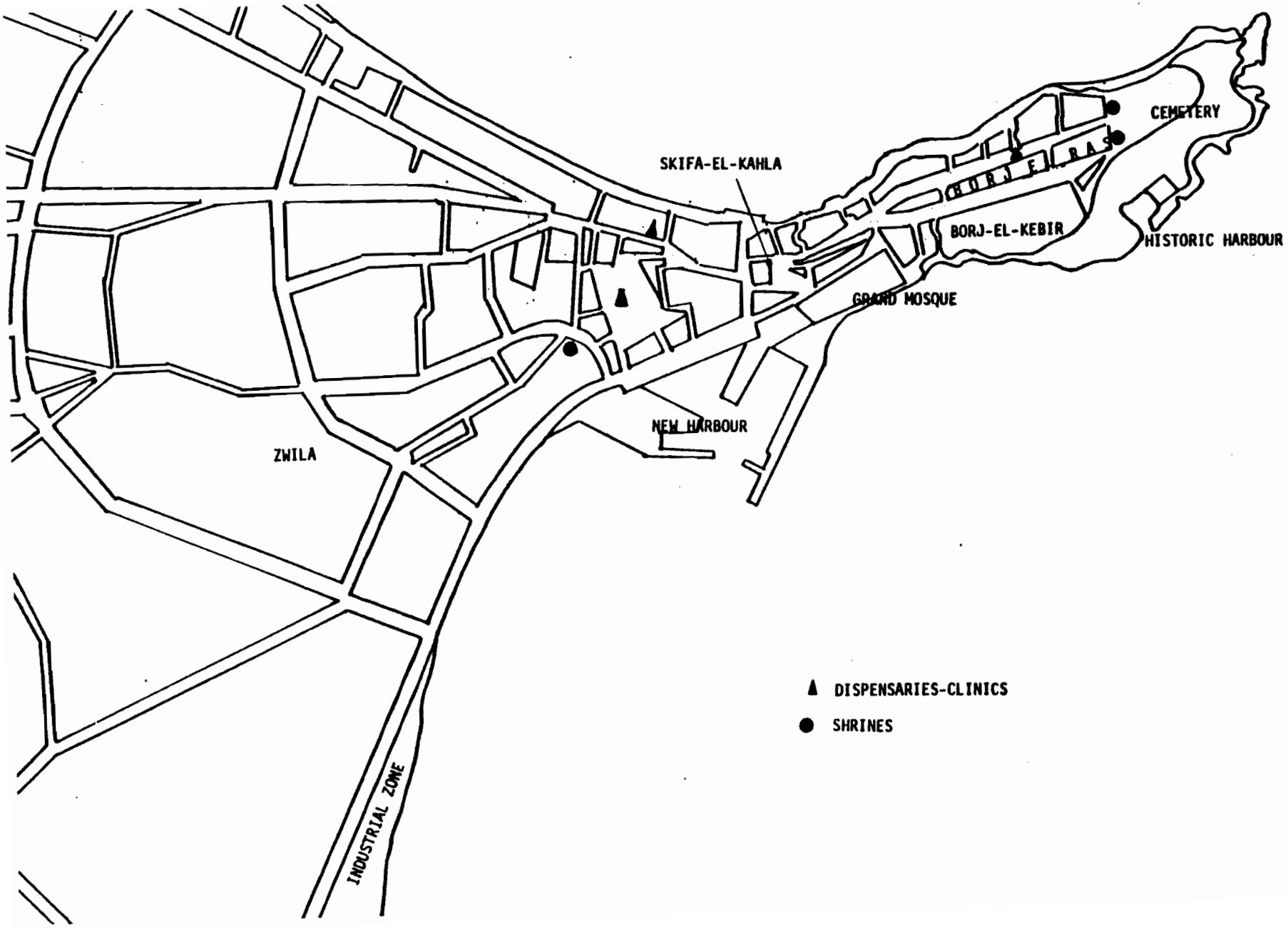
Mahdia, which is approximately 100 kilometers south of Tunis, is situated on a peninsula that looks like a man's outstreched arm, according to Tunisian school books. The peninsula is lined with sandy beaches on the northern and

southern coasts and a rocky coast along the most eastern tip. Today the municipality of Mahdia covers an area of 5.5 kilometers in length, with its width varying from 250 meters (at its narrowest point) to 3 kilometers. The Mahdian municipality includes the "old city", referred to as Borj el-ras by the residents, the "new city", and various hamlets and gardens located in the Zwila - the area on the outskirts of the two cities. Zwila was the site of some of the earliest residences in the Mahdian area. Apparently this was the place where the families of the Fatimids built their homes and gardens. Remains of homes built as early as 930 A.D. have been found - 10 years after the founding of Mahdia itself.(Refer to the map.)

As of 1975 the population for the municipality was 45,000, with 35,000 inhabiting the "old" and "new" cities. The area of greatest expansion has been the Zwila, where new houses, factories, schools and the new hospital have been erected.

Today in the "old city" one can see the remains of the original harbor and fragments of what was once a wall encircling the former fortress. Also one finds the Great Mosque and the Sqifa al-Kabla, both of which were built by Caliph Mahdi. Finally the Borj el-Kebir, built in 1595 by the Turkish rulers and recently reconstructed, can be found within the former coastal walls.

Coming inland from the Borj (fort) one finds the Muslim cemetery whose tombstones are facing eastwards towards Mecca.


SKIFA-EL-KAHLA
CEMETERY
BORJ EL RAS
BORJ-EL-KEBIR
HISTORIC HARBOUR
GRAND MOSQUE
NEW HARBOUR
ZWILA
INDUSTRIAL ZONE
DISPENSARIES-CLINICS
SHRINES

The dates on the tombstones range from 1987 back to the Turkish occupation in the 16th century. Beneath the cemetary are the ruins of buildings occupied by the early Fatimids and perhaps by the Romans.

The residential area of the "old city" begins as the cemetery ends. This section of Mahdia consists of some of the oldest homes in the area. Although a cross-section of society can be found in this residence, it is primarily occupied by fishermen and artisans. Prior to the 1950's the Jewish community resided in this area as well. Today one only finds abandoned houses and a synagogue that attest to their earlier presence. (As of 1980 there were only 20,000 Jews left in Tunisia, as compared to 70,000 in 1956. (Findlay, et. al., 1982)).

The Sqifa al-Kabla (meaning "dark hallway") was built in the late 900's and later rebuilt by the Turks. It is a three story building which separates the "old city" from the "new city". When it was built it was located at the entrance of the town and thus served as a gateway as well as a watch tower for the city. The walls that extended out from the Sqifa have long since disappeared. However a few remains of the walls can be seen on the coastal shores.

As one leaves the "old city", passing through the ground floor of the Sqifa, one enters the business and administrative center of Mahdia. Here one of the two roads that penetrate the penisula terminates. The other road goes along the southern coast near the new harbor and into the "old city" along the cemetery.

Mahdia is primarily a fishing city. Its annual fish production is as much as 40% of the total fish production for the nation.(Lezine, 1968) Fish caught in Mahdia is distributed within coastal markets along the Sahel, exported to other countries, or processed locally for national and international markets.

There are now five fish canneries processing tuna, sardines and anchovies. One of the canneries employs workers year round. The other four canneries employ primarily bedouins/Berbers for six months of the year.

In addition to the canneries there exist one soap factory, one textile factory (financed by a Danish company), and several olive presses. These along with the shops, grocery stores and government agencies provide the bulk of the wage paying jobs in Mahdia.

Mahdia is also a regional marketplace where peasants bring their produce to sell. Here there are permanent markets, but more important is the weekly market that is held every Friday. The produce sold at the market varies according to the season, but includes vegetables, fruits, chickens, sheep and draft animals (camels and donkeys). At the marketplace one finds a variety of non-edible commodities as well, including dishes, clothing, electronic goods, etc. These are brought in by entrepreneurs living in Tunis, Sousse or Sfax.

Despite the steady emigration to Tunis and Europe, Mahdia's population is rapidly expanding. This is due to an

increased birth rate, an immigration from the rural areas (which include peasants, bedouins and Berbers from the south) and some immigration of professionals from the capital. As mentioned above the increase in population is being absorbed in Zwila.

Because of the government's priority of providing general education to all young Tunisians, the number of schools in Mahdia (and not including those in Zwila) have increased from four to thirteen since 1956. There are six elementary schools, four secondary schools (three public and one private), and three vocational schools.

Social Hierarchy in Mahdia

At one time the social classes in Mahdia were pyramidal in structure with a very small elite at the top, a slightly larger middle class and a substantially larger lower class. But today this is no longer the case. Tunisia's economy has prospered over the last few years. As the Tunisian economy has developed, educational and business opportunities have risen. These factors have helped change the social hierarchy in Mahdia.

In an attempt to classify my informants by socio-economic criteria, I used a technique similar to the one used by Sydel Silverman (1966). In going through this exercise I was able to develop a general picture of the social classes as conceived by the Mahdians themselves. They began by explaining that there are three classes: the "poor", the "elite" and the "middle class". After further discussion they

were able to break down the "middle class" based on occupation and wages/month. Based on this information, I formulated the social hierarchy depicted on the following page.

Determining the criteria for membership in the two extremities of the hierarchy was relatively easy. A family is considered "poor" if 1) they do not own their own home or own land, and 2) if the women in the family are required to work. The poor include long term residents of Mahdia as well as bedouins of Berber descent who pass through Mahdia as migrant laborers.

The highest class, on the other hand, is composed of the elite families in Mahdia. Their status has remained relatively unchanged since the colonial period. They are large landowners owning farm property in and around Mahdia as well as in other parts of Tunisia. Members of these families invest in the fishing industry and/or follow professional careers in law, medicine, etc.

Next we come to the largest grouping - the middle class. Again what differentiates the "lower" middle class from the "poor" class is the acquisition of a house.(3) Minimum wage is three dinars/day. If a family can earn this amount or more on an annual basis they may - with help from the extended family - be able to ascend into the middle class. Today some peasants, factory workers and even fishermen are on the verge of stepping into this class.

There is a very large group of people who fall into the "middle" of the middle class. These are people who are at least literate and have in some cases acquired a secondary

SOCIAL CLASSES IN MAHDIA

CLASSES	DINARS/MONTH (ANNUAL AVERAGE)	LEVEL OF EDUCATION	OCCUPATION OF MALE HEAD
ELITE	500-more	secondary/ university	large land-owners, big businessmen, professionals
MIDDLE CLASS	300-500	secondary/ university	professionals small business men, gov't jobs
	120-300	primary/ secondary	teachers, nurses, gov't jobs, foremen shopkeepers, artisans, small land-owners
	90-120	primary/ none	small land-owners, fishermen, factory jobs
POOR	0-90	none	landless, homeless, seasonal laborers, semi-employed

level of education.

Finally, there is a small number of people who can be classified as belonging to an "upper" middle class. They include government officials or professional men. These are people whose parents came from rather humble origins. They were encouraged to take advantage of the educational opportunities that were not open to their parents during the colonial period. Today they earn rather high salaries. Even so, they cannot penetrate the long standing elite class unless through marriage.

Health Care Facilities in Mahdia

Within the municipality of Mahdia there are eight doctors. Five of these doctors operate their own clinics. By law, however, they must spend 50% of their time in the hospitals serving the public clientele. The remaining three doctors work full-time in the hospital. A new hospital has just recently been constructed. As of August 1984 only the first floor was fully operational - admitting patients for emergency treatment or for psychiatric care. It is expected that the hospital will be completed by 1987. At that time it will serve as a Regional Hospital with 250 beds. Eventually Mahdia's hospital will be a primary training center for interns, nurses and primary health care workers. It will employ 38 doctors and 220 nurses who will work in the hospital and the satellite dispensaries. (Existing dispensaries will, I assume become auxillary hospitals.) Finally, plans are being made to provide visiting medical instructors to train 70

primary health care workers each year.

In addition to the hospital and private clinics, the area also has 10 government sponsored dispensaries already. Two of these employ a nurse whose training consists of 10 years primary and secondary education plus three years of nurses' training.

As explained earlier, health care is free to all Tunisians who are unable to pay. Only families that have neither a "certificate of poverty" or "health insurance" card are required to pay. Furthermore all medication distributed at dispensaries and hospitals is free of charge.

According to my sources (mainly from the "middle class") there is a general feeling that health care in the private clinics is superior to the care received at the hospital. I was told that the hospital and dispensaries are both understaffed and suffer from a shortage of medicine to be distributed. Thus a family that can afford it will take their sick relative to see a doctor in a private clinic. More affluent families might even travel to Sousse or Tunis to visit a larger private clinic. The less affluent will go to one of the dispensaries or to the hospital depending on the seriousness of the illness. What one finds, then, is a two tier structure in biomedical health care.

As will be described more fully in Chapters Six through Nine, Mahdians (as well as Tunisians in general) have other health care options from which to choose. These medical alternatives operate in an informal, less structured fashion than biomedical institutions due to the fact that they are not

government supported or approved. Specialists in dwa 'arbi and dwarish (diviners) are found throughout Mahdia. Patients will go to visit the specialist at his or her home unless they cannot be moved. Patients can also be taken to shrines where a saint's medium will administer treatment. In later chapters these medical alternatives will be discussed more thoroughly.

The following chapter will focus on the zneq (neighborhoods) within Mahdia. It is within the zneq that the dynamics of social interaction can best be observed. The zneq are home for Mahdians. Within the zanqa one resides with family members as well as one's most intimate friends. Since illness-episodes play themselves out in the home setting, it is important to describe this environment.

FOOTNOTES

1. There are two major traditions in Islam, the Sunni and the Shiite. The Shiites originated as a political movement soon after the founding of the religion. The political dispute occurred after the Prophet's death and centered on the succession of caliphs, or religious leaders.

2. Foreign owned labor-intensive industries have helped ease the overall unemployment situation. However they tend to employ women and thus do not meet the perceived needs of the society - that is, full employment for the male heads of households. (Findlay, et.al., 1982)

3. One family who was renting a very old house in one of the zneq I observed was making a concerted effort to purchase land and build a house. The grandmother (a bedouin) worked in the cannery. The son was a house painter most of the time but took other jobs as well. The daughter-in-law also worked at odd jobs, albeit jobs that allowed her to look after her two small children at the same time. This included doing domestic work and processing food at harvest time. The family lived as meagerly as possible to obtain their goal. As of 1984 they had purchased land and were on their way to constructing the structural foundation of their new home.

CHAPTER THREE

ZNEQ: THE NEXUS OF SOCIAL INTERACTION

Every village, town and city in Tunisia is composed of neighborhoods called zneg (plural). (1) Zneg are blocks of houses whose walls are shared with one another. Each house has an entrance onto a common path. These paths create a mazeway that inevitably terminates in a dead end. The width of the path indicates the age of the neighborhood, with more recently constructed zneg possessing streets wide enough to accomodate automobiles and older zneg wide enough for three or four people to walk abreast. Paths are paved by the municipality, but only if two or more famlies have built along the path and have remained there for 10 years. Once paved paths are rarely maintained by the city. When it is necessary zanqa (singular) members do their own repairs on that section of the path in front of their homes.

Zneg constitute the basic units of all neighborhoods - poor, middle-class and wealthy. Some zneg (particularly new zneg) are homogenous in terms of the socio-economic status of their residents, but most zneg are heterogenous. This is the case of Zanqa Turki and Zanqa Sfar, the two zneg within which I resided while doing fieldwork. The constituency of both zneg reflect typical Mahdian zneg. Likewise the social interaction I observed in Zanqa Sfar and Zanqa Turki is similar to that which takes place in other zneg I have visited in Mahdia. The following description of the social organization and daily life in the zneg, provides the reader with a background in which this research was conducted.

Zneq vary in size. Some are as small as three houses, others may include 12 or more households. Each zanqa is named unofficially after the largest patrilocal household, which can include two or three brothers and their families.

Fishermen, teachers, factory workers, government employees, small businessmen and lawyers may all own houses (or part of a house) in the same zanqa. Bedouins may rent rooms or a house in the zanqa during part of the year when they come to town to work at seasonal jobs. Despite the differences in socio-economic status, people who own a house in a zanqa (and thus renters are excluded) form a close bond. The bond is enhanced by the close relationship of the women and their children, all of whom spend most of their time together. Some of the children (males especially) inherit - if not an entire house, at least part of one. They remain in the zanqa and bring in brides who then begin to develop friendships amongst the women. And so the bond is strengthened.

Seclusion of the women varies from household to household. (2) But for the most part women have easy access to the homes, pathways and rooftops within their zneq - provided their arrival is timed during the period of the day when the men are out of the house. Thus the necessity of wearing a veil is relaxed in the zanqa. This is true for a couple of reasons. First of all many of the women's neighbors are in fact kinsmen or affinals. Secondly, the men are absent for the majority of the day.

The daily routine is more or less the same in all zneg. The adult men and women arise at the first call to prayer. After the prayer is said the male head of household leaves the zanga for the market. Here he purchases the food for the day and returns it to his wife. Upon his return the family has a light breakfast of cafe au lait and bread. (Families that cannot afford milk will eat bisissa, a cereal made out of barley.) The men leave for work and women begin their household chores. School children are sent off to school and smaller children are encouraged to amuse themselves - outside if possible. There may be brief exchanges among the women in the zanga but these are perfunctory bits of conversation as there is much work to do - food preparation, laundry, daily scrubbing of the floors, etc.

The main meal of the day is ready by 1:00p.m. The men return (one by one) around this time. The family eats together unless there are visitors. If so, the men and visitors eat separately from the women and children. The young girls then clear the table, wash the dishes and sweep the floor. For about two hours the family rests. In the summer most everyone sleeps because of the intense heat. In winter the family rests while chatting, listening to the radio, and more recently watching television.

By 3:00 p.m. everyone is ready to start the second cycle of the day. The men return to their place of work or in the summer, go to the coffee shops. The women prepare for what I call the "visiting hours". Sometimes women will choose to use this time to stay home and sew or do handiwork such as

mending, crocheting, knitting or embroidery. But one knows that her house is open for visits from women in the zanqa. Often arrangements will be made to visit or receive women friends or kinsmen from other parts of the city. These arrangements are usually made in the morning via the children.

Visiting hours last from approximately 4:00 p.m. to 8:00 p.m. At 8:00 p.m. preparation for the evening meal begins. When the men return home the family will reassemble to eat a light meal. Again the eldest daughter(s) will clear the dishes and sweep the floor. After dinner the family spends time conversing as the smaller children fall off to sleep. Finally the adults go to bed as well. In the summer months it will be quite late before it is cool enough to sleep. And so during that season the evening hours are extended.

ZANQA SFAR AND ZANQA TURKI

While in the field I, along with my husband Tarik and children, lived in two zneq. During my earlier visits we lived in my father-in-law's house (Dar Souissi) in Zanqa Sfar. I came to know this neighborhood quite well. Later we lived in Zanqa Turki, the zanqa of Tarik's mother's patrilineage. This change of residence occurred after my father-in-law constructed a second house on land that he had purchased from his brother who had previously bought it from Si Turki. Although my in-laws maintained the house in Zanqa Sfar, living there most of the year, Tarik's father insisted that we live in the new house on our return summer visits. We abided by his wishes, but made regular vists to Zanqa Sfar.

Zneq develop their own character or atmosphere which is often a reflection of their history and the personality of their residents. Thus Zanqa Sfar and Zanqa Turki are differnt from one another in many respects. First of all, Zanqa Turki is a newer neighborhood and as such is not as close-knit as Zanqa Sfar, which has a long and intricate history. Secondly, the population density is less in Zanqa Turki than in Zanqa Sfar (see Tables 1, 2 and 3 at the end of the chapter). One can sense this difference when moving from one zanqa to the other. The crowding and noise level increases radically when one enters Zanqa Sfar.

The Founding of Zanqa Sfar and Zanqa Turki

Zanqa Sfar was established two hundred years ago. Originally four families built in this zanqa: the Sfars, the Souissis, the Bendalys and the Gaiebs. (See Diagram A) Each builder walled in his property. Within each walled area he and his family built their homes and left open spaces for gardens and fruit trees. The homes were built in the traditional style with a square courtyard at the center surrounded by rooms (for sleeping, cooking, storing food and household equipment) and a hall where guests were entertained.

Either as a consequence of a sale to an outsider or to accomodate the needs of the originator's descendents, the original houses have been expanded, rejuvenated or subdivided. (See Diagram B) Within the walls additional homes have been constructed in the open areas as well. The Gaiebs' property was sold to the Hannefis, the Tounsis, and to Si Souissi who

DIAGRAM A
ZANQA SFAR
1800

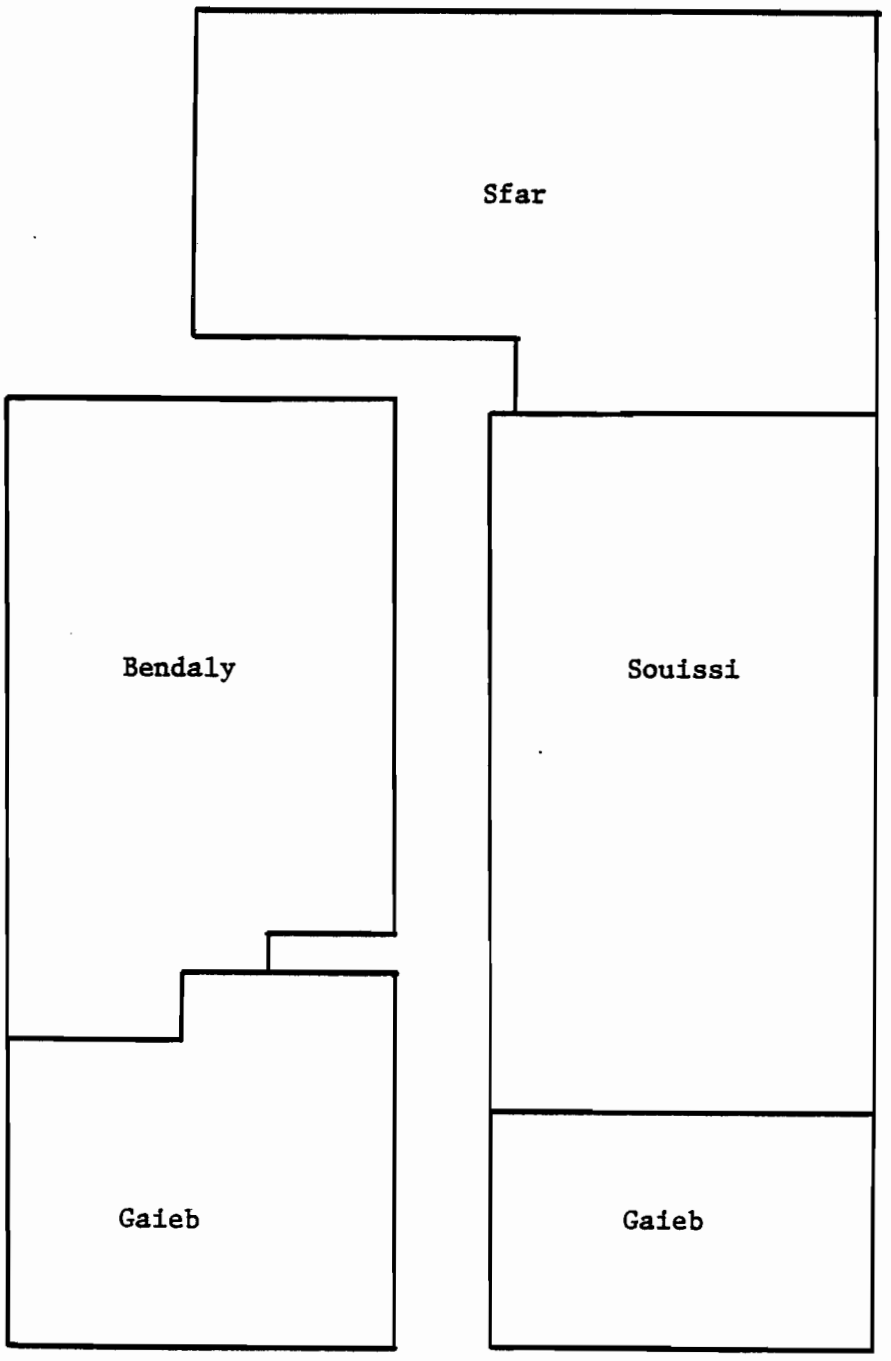
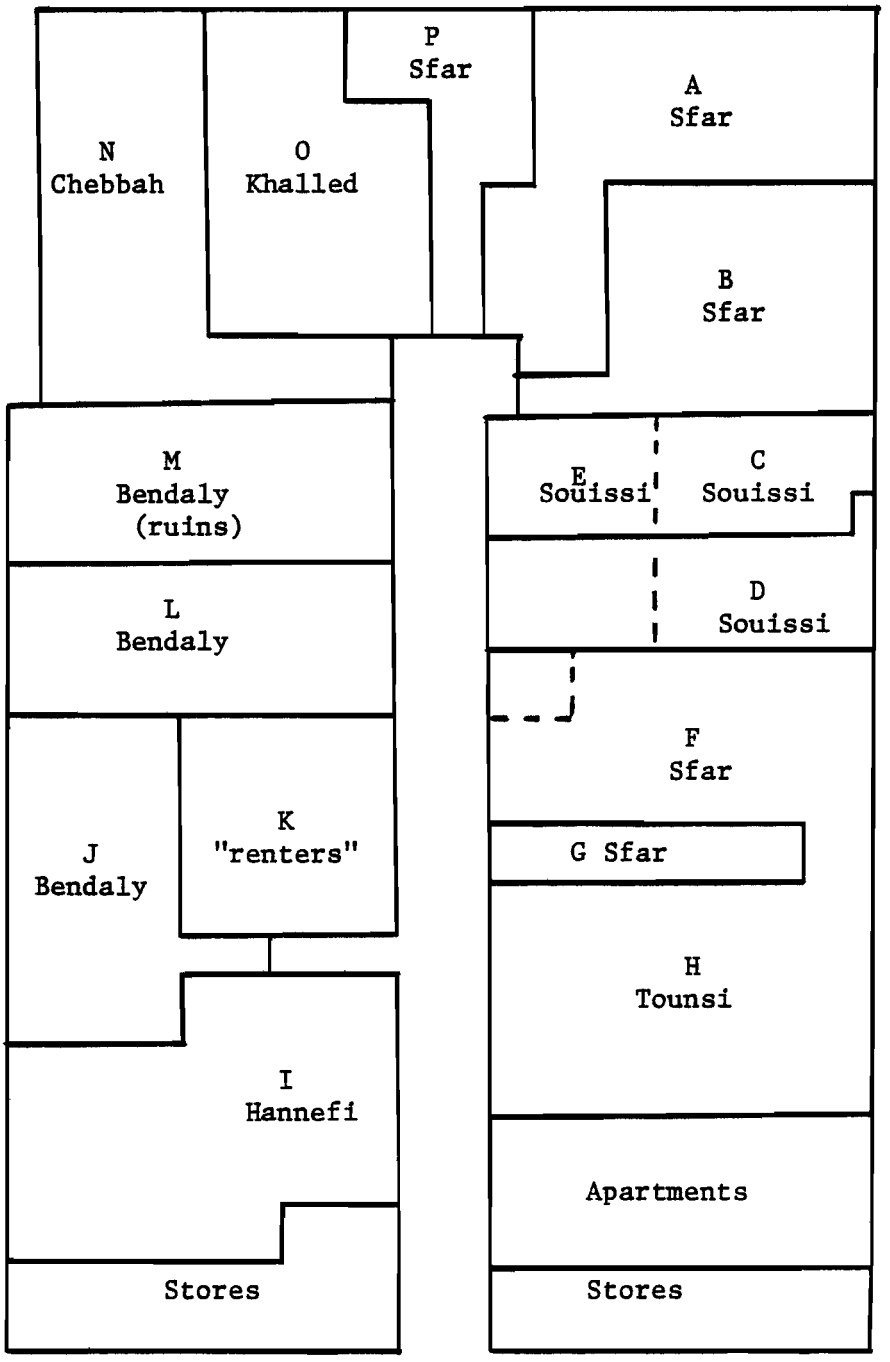


DIAGRAM B
ZANOA SFAR
1980



built a store facing both the zanqa and the outside street. The Souissi household was halved, with one half being sold to Hedi Sfar's wife's family (Household G/F) and Bashir Tounsi (Household H). The other half was rebuilt and subidvided by the three Souissi brothers. (The Sfars in Households F and G are not related to the Sfars in Households P, A and B.) The Bendaly house was subdivided into four parts, one of which was transferred to Bendaly's wife while the other three divisions were inherited by members of the Bendaly patrilineage. The largest house, that of Mehdi Sfar, was subdivided into three parts -- between two brothers and a cousin. The sons of the two brothers inherited each of the divisions (Households A and B on Diagram B), and the cousin sold her part to Ferid Khalled (Household O). Recently Kamel Sfar purchased Household P from his father, Mehdi Sfar (Household A). Si Chebbah (Household N) built in the area once uninhabited, closing the zanqa at the rear.

Obviously, even with the expansion, not all of the descendents of the original four houses could be accommodated and thus some of the Bendalys, Hannefis and Souissis have had to move to new zneq. Family ties thus bind Zanqa Sfar with other zneq, including Zanqa Turki.

Zanqa Sfar is named after the Sfars who constitute the largest part of the neighborhood. Even so, this matter has been the subject of debate over the years. The Souissis have argued that they are the oldest family in the zanqa and that the Sfars in Households F and G are relatively newcomers.

When Zanqa Sfar was being built the area where Zanqa Turki exists today was part of the country-side. Zanqa Turki only became established as part of Mahdia at the turn of the century. Si Turki and Si Nassar were one of the first to buy land in that area. As custom dictated, they walled their property which included a house, orchards and gardens. Later Si Ayed bought a plot of land adjacent to that of Si Turki.(See Diagram C) These men were owners of olive and almond groves east of Mahdia and were relatively wealthy at that time.

Si Turki was reknowned in Mahdia for his active role in establishing the original independence movement (Destour Party). In fact during the 1960's President Bourguiba delivered "The Order of Tunisia", the highest citizen's award given in Tunisia, to Si Turki in his home in Zanqa Turki. Undoubtedly this is why the zanqa is named after him.

The original plots of Zanqa Turki have been subdivided by Si Turki's and Si Nassar's descendents or sold to non-family members (See Diagram D). Furthermore, the zanqa has been expanded to include homes to the south that were built in the 1940's (Households G and F) and homes to the west that were built in the 1950's (Households D and E). Thus, today we find that Si Turki's original plot has been divided into four smaller lots. Today his daughter (who purchased the original house built in 1900) occupies Household A. Three of his grandsons inherited Household B, which had been built by Si Turki himself. Three of Si Souissi's sons (from Zanqa Sfar) own Household J. One of these sons (Tarik) is Si Turki's

DIAGRAM C
ZANQA TURKI
1900

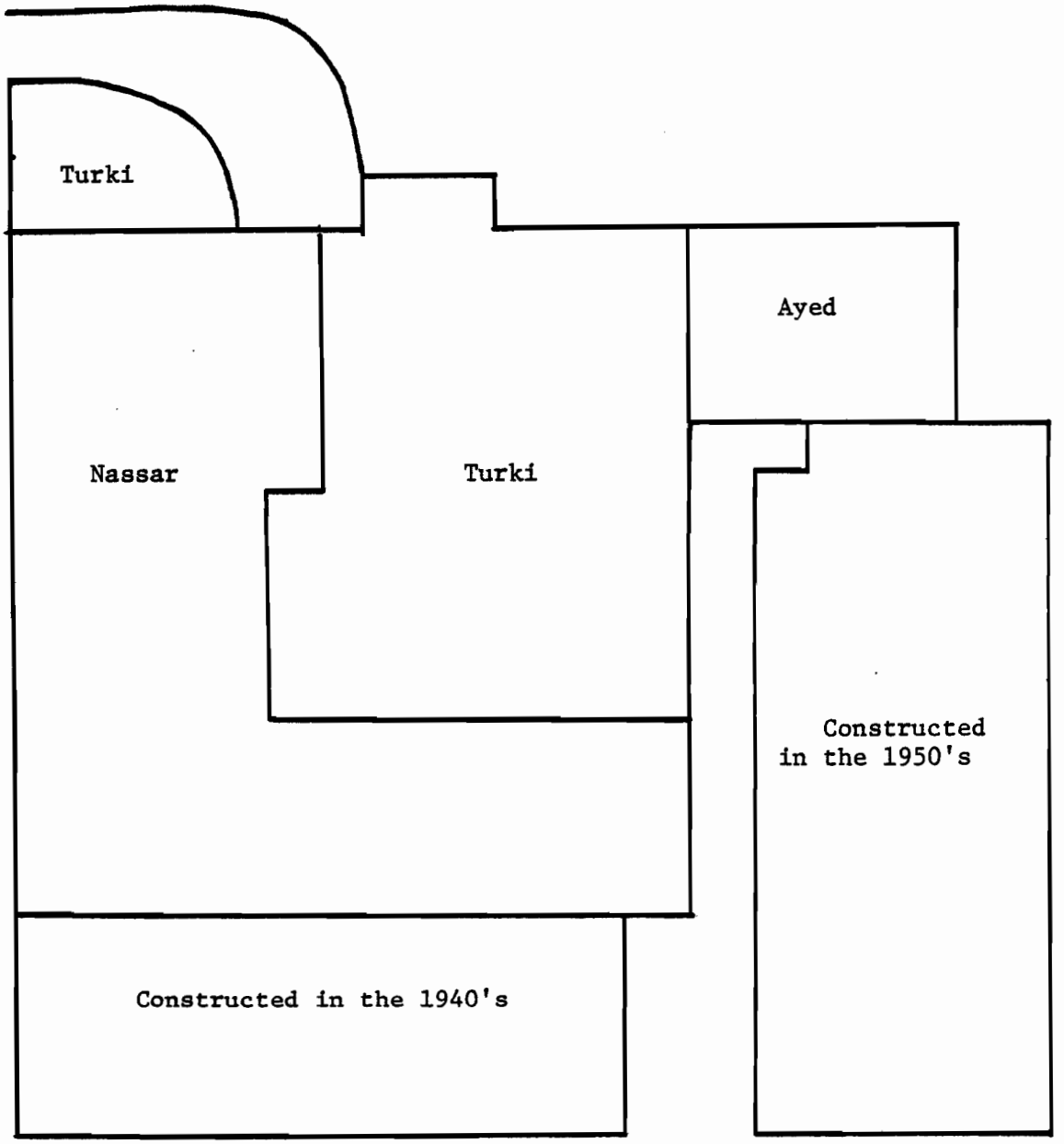
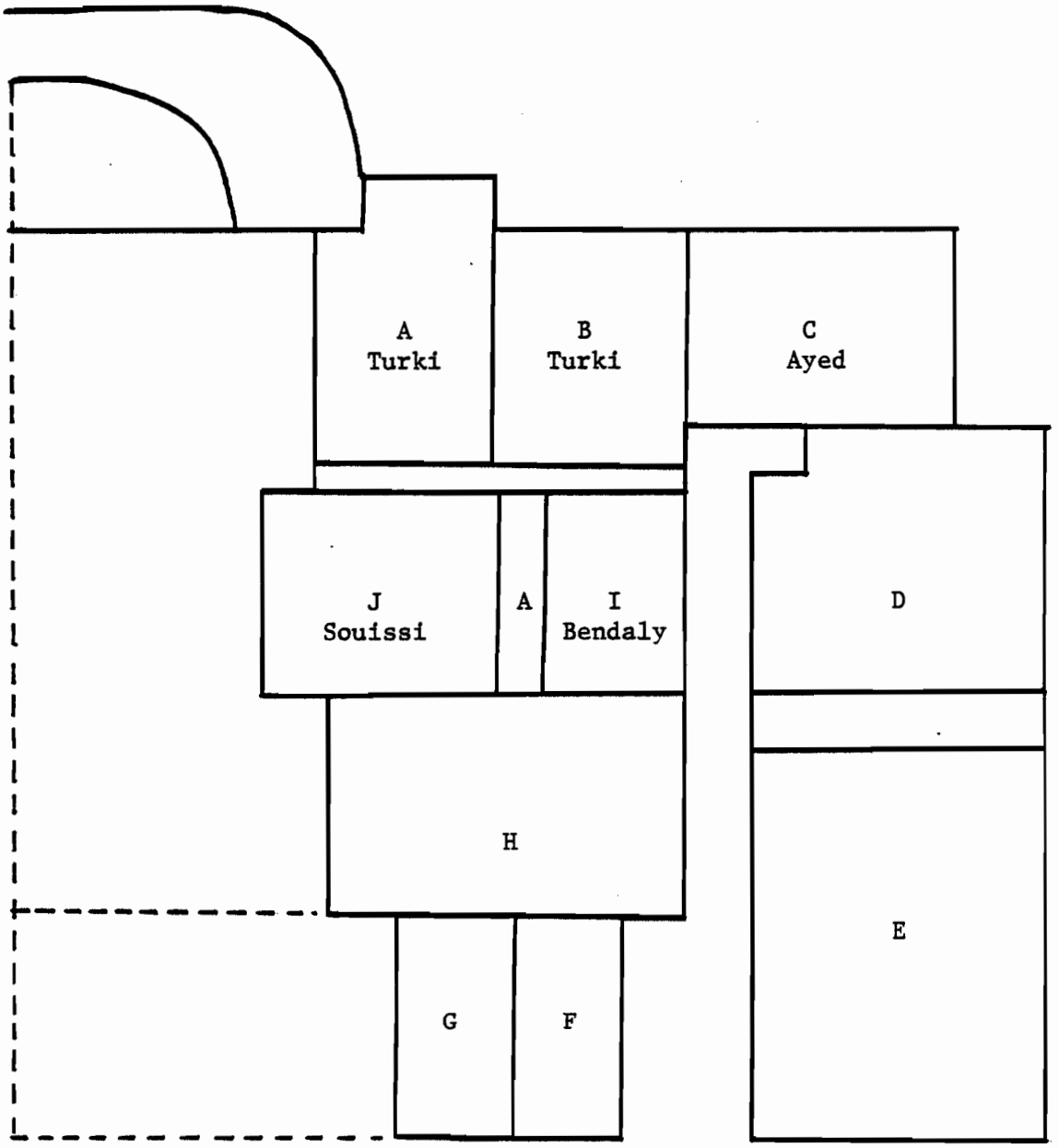


DIAGRAM D
ZANOA TURKI
1980



grandson. (Si Turki's daughter was Si Souissi's first wife. She died when she was about 30 years of age, leaving two children.) And a fourth lot was sold to the son of Si Bendaly, also of Zanqa Sfar (Household I). Si Nassar's property was divided as well, leaving only household H in Zanqa Turki. Homes built in Si Nassar's original plot now all face onto another path, and thus form part of another zanqa. The Ayed household (Household C) remained undivided.

Because of the fact that Zanqa Turki was established during this century, most of the descendants of its founders have inherited sufficient property in which to live and raise their families. In time, however, when the present heads of household die, their offspring will find it necessary to subdivide the existing houses. This will force many to leave the zanqa. Those that remain will be obligated to subdivide their parents home, thus creating a smaller living space than that in which they were reared. This has already occurred in Zanqa Sfar.

Residents of Zanqa Sfar and Zanqa Turki

Today one finds 15 households in Zanqa Sfar. On average, the houses have about five rooms and most have ready access to a courtyard and/or rooftop. (See Tables 1 and 2) Twelve are occupied year round and three are occupied two or three months a year when their owners return for a visit. Among the 12 permanently occupied households, two are rented to long-term renters - one to a construction company and another to a family of six who have been there for 10 years.

In addition to these 15 households, there are three stores and an apartment building at the entrance of the zanqa. Although they are considered part of the zanqa (because they have an entrance from the zanqa street), these are not permanent households. They are either a place of business or are occupied by transient renters - i.e. school teachers, nurses and others from elsewhere in Tunisia. Therefore, I have chosen not to include them in the census data.

Despite the fact that Zanqa Turki is larger spatially than Zanqa Sfar, Zanqa Turki consists of only 10 households. One house is rented. Two of the homes are only occupied during the summer months and holiday seasons. Seven of the homes are occupied year-round. Homes in Zanqa Turki generally have a larger number of rooms per house (6.5 rooms in Zanqa Turki versus 5.0 rooms in Zanqa Sfar) and the rooms in Zanqa Turki are larger.

In total the 15 heads of household in Zanqa Sfar sired 89 children that survived - 48 males and 41 females. The average birth rate/household is 6.36. (See Table 3) The number of children born (and survived) to the eight permanently occupied households in Zanqa Turki is 41 - 22 males and 19 females. The average birthrate/household is 5.12.

Forty-two (47%) of the children born in Zanqa Sfar and 26 (63.4%) of the children born in Zanqa Turki continue to reside in their natal zneg. Their ages range from infancy to 48 years in Zanqa Sfar, and infancy to 49 years in Zanqa Turki. Depending on their stage in the life cycle, these

children/offspring live with either their spouse and children, or their parents.

The fact that Zanqa Sfar is over-populated is obvious. In Zanqa Sfar the birth rate is higher. The households are older, thus experiencing at least one, if not two, subdivisions as a means of settling inheritance. As a result the homes are relatively small and crowded.

Not too surprisingly the emigration rate has been higher from Zanqa Sfar as compared to Zanqa Turki. The following chart depicts the emigration patterns from both zneg:

EMIGRATION PATTERNS

	Zanqa Sfar				Zanqa Turki			
Emigrated to	M	F	Total	%	M	F	Total	%
zanqa in Mahdia	8	20	28	31.5	4	3	7	17.0
town in Tunisia	5	3	8	8.9	6	2	8	19.6
foreign country	10	1	11	12.4	0	0	0	0
Totals	23	24	47	52.8	10	5	15	36.6

In looking at the emigration patterns we find that they are quite different in each zanqa. Nearly 53% of those born in Zanqa Sfar have taken up residence elsewhere, as opposed to 36.6% of the offspring born in Zanqa Turki. Those who have left Zanqa Turki have either moved to another zanqa in Mahdia or moved to Tunis. However emigrants from Zanqa Sfar were more apt to leave the country than to move to another town.

In comparing the average years of education completed by

members of the two zneq (Table 6), we find that: 1) females have received less education as a whole, but females in Zanqa Turki have gone to school longer than their female counterparts in Zanqa Sfar; 2) in both zneq residents have a lower level of education than non-residents. Education, especially in Zanqa Sfar, has been used as a vehicle out of the zanqa. Generally (but certainly not in all cases) those who did not advance in school were more or less forced to remain in Zanqa Sfar, either for economic reasons or due to academic failure.

In 1984 there were 65 permanent residents of Zanqa Sfar and 41 in Zanqa Turki. The average age in the zneq was 30.8 and 33.9 respectively. Looking at the population statistics illustrated in Table 4 one finds that: 1) in Zanqa Sfar and Zanqa Turki over 50% of the population is under the age of 29; 2) approximately one third of the population is under the age of 19 in both zneq; 3) the largest single category of persons is the 20-29 age group. In this group in Zanqa Sfar there are only three females. One of them is married into the zanqa and the other two are not yet married. The remaining 11 within this group are single males.

In Zanqa Turki, on the other hand, the situation is reversed. The number of single women between the ages of 20-29 exceeds the number of males in the same age group. There are six single women, three single men and one married woman.

Due to their economic circumstances the men aged 20-29 living in both zneq are essentially trapped. Most of the

young men in Zanqa Sfar have not emigrated because they haven't any marketable skills. They are either unemployed or are working at low-paying jobs in Mahdia. If they were to marry they would be forced to bring their brides into an already crowded house. They must continue working at their low paying jobs until they have accumulated enough money to buy a house of their own. This means they must delay any plans of marriage until they are well into their 30's. (According to the norm, young men should marry between the ages of 25-30 years. Young women should be married no later than 21 - 25 years.)

Most of the unmarried women in Zanqa Turki are unmarried by choice. That is, with the exception of one woman who is mentally retarded, the other five women have continued their studies, thus delaying any plans for marriage.

Occupations and income levels vary in Zanqa Sfar and Zanqa Turki, but all households fall within the "middle class" described in the preceding chapter. Occupations held by residents of Zanqa Turki require at least a primary education. This is not the case for those residing in Zanqa Sfar. (See Table 5) Some of the children of the household heads have followed the same type of work as their fathers, but many have received better educations and are qualified for better paying positions.

Thirty years ago the only schools available were coeducational. Most families did not want to send their girls to such a school. Consequently women in their 40's and over received no education. Since that time, however, girls'

schools have been established and that, coupled with greater affluence, has enabled families to send their daughters at least to primary school. Today an educated girl is a more attractive marriage partner, and thus it is felt important to give one's daughter some education. In Zanqa Sfar the average education for women is 2.8 years. In Zanqa Turki the average is somewhat higher - 4.3 years. (See Table 6) Again these statistics reflect the relative age of the two zneq, wherein older, uneducated women are more commonly found in Zanqa Sfar.

Men have always had access to schools - either Koranic or public schools. In the past finances prevented men from attending school, especially when they reached an age when their labor was required either in the fields or in a family business. Even so there are a number of older men in both zneq who learned to read Arabic with as little as one or two years of schooling. In some cases men achieved literacy without attending school at all. The educational level of males in both zneq has improved with time.

Generally, the average years of schooling for those who have left the zanqa is higher both for males and females. It is the sons and daughters of the older household heads that left. They had greater opportunities to obtain an education. Those that did well in school were offered government scholarships during the 1950's and 1960's when the government was committed to education as a means to modernization. Males were more likely to take advantage of these educational opportunities than were women, for to do so meant leaving

Mahdia. Those who attended university - both men and women - have never returned to live in either of the znega. They live either in Tunis or abroad.

HEADS OF HOUSEHOLD AND OWNERSHIP

Each household is named after its builder. For example, a house is known as Dar ("house of") Walid Souissi because Walid built an addition to the original Souissi house. It remains Dar Walid Souissi. It does not change names even if there is a new owner, only when the new owner makes major renovations. Thus a house is a monument to the builder and is considered an important achievement in one's lifetime.

Heads of households are almost always men. However there are exceptions to that rule. In Zanqa Sfar there is one elderly woman who is considered the head of her household because she used her own money to renovate her house. This house had been transferred to her before her father's death. Had she simply inherited the house after his death and made no renovations the house would still be named after her father. (In Zanqa Turki Household A is owned by Si Turki's daughter who purchased the house from her father. Since she did not make renovations the house is still called Dar Turki.)

Usually the house remains the property of the builder until after he dies at which time his surviving wife and children inherit the house along with all of his other property. The division is based on Koranic law. (These laws will be explained later in this chapter when describing a particular inheritance case.) There are three exceptions to

this rule in Zanqa Sfar and Zanqa Turki. In each case the elderly head of household has transferred ownership of the house to his wife, postponing the eventual subdivision and insuring her a place to live after his death. (Traditionally the mother continues to live in the house even after ownership has transferred to her children. But a man may transfer complete ownership to his wife prior to his death if he suspects that his children, perhaps from a previous marriage, will sell it when he dies.) (See Table 7)

There are five houses in Zanqa Sfar and six houses in Zanqa Turki which are owned by more than one person. Multiple-ownership occurred after the death of the head of household. The remaining houses are owned by only one person.

Obtaining a place to build or obtaining resources to expand an existing residence is extremely important to most Tunisians as reflected in the attitudes of Mahdians living in Zanqa Sfar and Zanqa Turki. Inheriting from one's parents (usually from one's father) is considered a critical windfall. One particular inheritance case was a subject for conversation in both Zanqa Sfar and Zanqa Turki. This was particularly so because the dispute involved a cousin common to families living in both zneq. The dispute involved the division of Dar Ali in Zanqa Hamrouni.

Dar Ali in Zanqa Hamrouni: A case of disputed inheritance

Around the turn of the century Si Ali built a house on a large plot of land. He then enclosed a space for a garden and orchard. According to the patrilocal residence rule utilized

in Mahdia, his married daughters left home to live with their husbands' families. When his three sons married they brought their wives home to live in the extended household. Each nuclear family had a room which included two beds - one for the parents and one for the children. The courtyard, bathroom, kitchen and garden were used communally by Si Ali and his wife, three sons, their wives and children. This was the typical family arrangement then and is still prevalent today in older neighborhoods, including Zanqa Sfar.

When Si Ali died his children inherited his property and disposable assets according to the Koranic tradition. This states that the inheritance will be divided in such a way as the remaining spouse receives 1/8; parents of the deceased receives 1/8; and the rest is to be divided by the children, with sons receiving two parts and daughters receiving one part. When Si Ali died his wife and parents were no longer living. Thus his children were his only beneficiaries. The daughters were given a cash settlement. The house was then passed on to the three sons who were living there at the time. Two of the sons, Chedli and Ferid had children of their own. The third son (Osman) married but did not have any children. (Refer to Diagram E) The three brothers did not divide their property but continued to live corporately as they had prior to their father's death. Had the property been divided at the time of Ali's death the dispute that is going on today would never have begun. This will become apparent as the account continues.

KEY FOR DIAGRAM E

Persons mentioned in the text are indicated on the diagram. They are:

1. Si Souissi
2. Si Turki
3. Si Ali
4. Walid Souissi
5. Chedli Ali
6. Ferid Ali
7. Osman Ali
8. Moniya Souissi
9. Tarik Souissi
10. Kamel Ali
11. Ziyad Ali
12. Rachid Ali
13. Jalika Ali
14. Rafik Ali

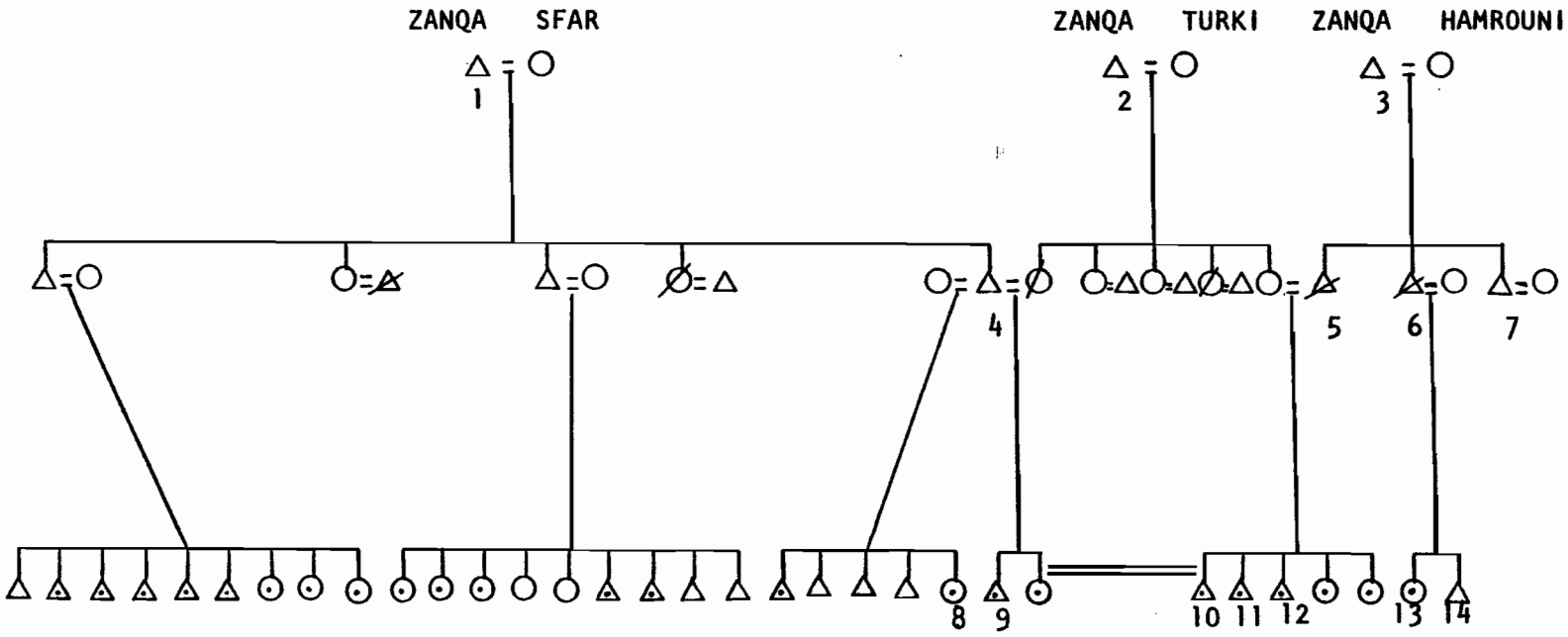
Notes:

1) The families of the women who married out are not indicated in the diagram. They live in other zneg.

2) The diagram includes children for whom Zneq Sfar, Turki and Hamrouni represent their natal home. Some continue to live there permanently while some reside elsewhere. Nevertheless, males, in particular, usually inherit at least part of their father's house and therefore use that part of the house on various occasions despite the fact that they have a home of their own elsewhere.

3) For simplification affins in the third generation are not indicated. A dot in the middle of a triangle or circle indicates that that individual is married. Likewise, children in the fourth generation are not indicated.

DIAGRAM E



. Married

In time Ferid and Chedli died. Chedli's wife returned to her natal home in Zanqa Turki which she had purchased from her father, Si Turki. Ferid's wife continued to live in Dar Ali with her brother-in-law (Osman) and his wife.

According to the Koran, children have a right to their inheritence soon after the death of their father. Thus the children of Chedli and Ferid have rights to a portion of their father's portion of Dar Ali. But since the property had never been divided, the exact nature of the division was undefined. Upon Chedli's death his wife and daughters were given their share of his inheritance without involving Dar Ali. Chedli's portion of Dar Ali was inherited by his three sons - Kamel, Ziyad and Rachid. Likewise Ferid's children inherited their father's portion of the house with the son (Rafik) receiving two parts and the daughter (Jalika) receiving one part. The transferal of inheritance, however, has not been realized for reasons to be explained below.

Chedli's sons each have acquired land of their own and are not particularly interested in the Dar Ali inheritance. Rafik is a student living with relatives in Tunis and is not actively involved in the dispute. The only cousin adamantly concerned with this matter is Jalika, Rafik's sister.

Jalika is married to a man who has a management position in Tunis. They have seven children and live comfortably on his salary and on the money she makes selling bolts of imported cloth. But as the children reach school age greater demands are placed on the household funds. For this reason Jalika has become impatient to obtain her inheritance.

Because none of the grandchildren are interested in living in the house, she wants Dar Ali to be sold. She then would receive her part of the inheritance in cash. This has not taken place because Osman and his wife, who have always lived in Dar Ali and who have maintained it since the death of his brothers, refuse to sell.

Jalika has urged them to settle the inheritance by selling Dar Ali. She feels strongly that her inheritance is due to her now. She asks, "Must I wait for my father's brother to die to receive my inheritance? This is not right." At one point, probably due to her constant badgering, the uncle and wife agreed to sell. At that point Kamel, one of the cousins, came up with a solution. He agreed to buy the property and settle with each of the inheritors (giving Osman one third and then dividing the remaining two thirds with males receiving two parts and females receiving one part. He would then allow Osman to live there until the uncle died, after which he would sell it himself and recuperate his investment.

The elderly couple agreed to this plan verbally, and thus Jalika thought the problem was solved. For 50 dinars she hired a licensed notary to come to the house to witness the agreed upon settlement. In front of the notary, however, Osman's wife protested. She refused to let her husband sell the house.

After this aborted attempt to settle the inheritance Jalika took more drastic steps. She hired two notaries to

come to the house and divide up the property, outlining the portions to be inherited. In the process Osman and his wife were told the quarters to which they were confined. They were outraged! For all practical purposes they were the sole occupants of the house and now they were being told not to enter some of the rooms. The argument that ensued between Jalika and Osman escalated to the point that Osman slapped Jalika across the face. (Although children are given physical punishment, physical aggression between adults is extremely rare. When one reaches maturity it is expected that one has control over his/her emotions.) This assault was considered a serious affront. Jalika left along with the notaries.

Finally Jalika took the case to court. Here the case was heard. Jalika and Osman presented their cases. Jalika was claiming she had the right to immediate settlement. Osman was refusing to sell Dar Ali on the basis of two principles: 1) his right of occupancy, and 2) the male heirs (nephews) were not asking for a settlement. The judge took no action, conceding the case to Osman.

As mentioned above, Osman and his wife had maintained the house for many years, including the period after his brothers died. Since they did not have children they felt that they had nowhere else to move. If they agreed to a cash settlement it would not be enough to purchase another house. Furthermore, they were attached to Dar Ali. It was their home and that is where they wanted to stay. Osman's wife felt particularly vulnerable. She is much younger than her husband and will undoubtedly be widowed at an early age. If they

agreed upon a cash settlement now she would later only receive 1/12 of it. (A childless man's assests are inherited by his wife who receives one quarter of the inheritance and the remainder of his belongings are divided amongst his nieces and nephews. On the other hand if they remain in the house, Osman's wife will have a traditional right to stay in the house until her death, even after he dies. Knowing this, Jalika is anxious to make a settlement - prior to Osman's death!

People in Zanqa Sfar and Zanqa Turki who are acquainted with the case agree that the situation poses a serious dilemma. There is sympathy for the elderly childless couple, and particularly for the wife. On the other hand they feel that Jalika is right in wanting her share of the inheritance now. As mentioned earlier, it is felt that inheritance matters should be settled soon after a person's death. The inheritors must not be made to wait for others to die as well. All agreed that had Dar Ali been divided after Si Ali died the dispute would never have started.

SOCIAL COHESION

There is a certain amount of quarrelling that goes on within any zanqa, but on the whole a feeling of closeness exists. This closeness is particularly evident in Zanqa Sfar. No doubt their sense of corporate identity has evolved over the years through day to day contact and as they have watched their children grow up, marry and have children of their own. Factors that insure this cohesion are the bonds created by

consanguineal ties and friendships that have developed over the years. Corporate activity within the zanqa is based on these bonds.

Consanguineal Bonds

Many of the households within a zanqa are related consanguineally due to the fact that their households were created by the subdivision of the original house. Referring to Zanqa Sfar (Diagram B) the following households are consanguineally related: Households G and F (father and son); C, D, E, and N (brothers and their sister's son); J and L (siblings); and O, P, A and B (patrilateral cousins). In Zanqa Turki (Diagram D) the following households are consanguineally related: Households A, B and J (matrilateral cousins (B and J), mother and sons (A and B), matrilateral aunt and nephews (A and J)); Households D and E (brothers).

Certainly the closest bond that an individual has outside of his nuclear family and household is with the individuals within consanguineally related households. Children run freely into one another's homes; support is given during family crises; loans are extended; and sometimes business ventures are launched by patrilineal heads of households. For example, in the Souissi family one uncle loaned his nephew enough money to start an electrical supply shop. In household B (in Zanqa Sfar), two of the Sfar brothers pooled their money to start a cafe. One's duty to family is extended to include all consanguineal relatives, but especially to those living in one's zanqa because they are

seen daily and their needs are known.

The closeness of members within a patrilineage can be observed when members of an extended family go to an extra-zanga activity such as a wedding, circumcision or visit to a shrine. Family members and zanga members sit together. I have seen women align themselves with a cousin, aunt or a relative without a moment's hesitation regardless of the incident. I was involved in a trivial episode that brought this to my attention. It occurred when attending a w'ada (a festivity in honor of a saint) at a local shrine. The women of our family were invited to a w'ada held by Tarik's father's sister and her daughter-in-law. The women and children from the two families made up a gathering of about 50. My four year old daughter had brought a small stuffed animal. Another little girl (from the other family - the relatives of the daughter-in-law) had been eyeing this toy for some time. When my daughter fell asleep, the little girl seized the opportunity to take it. Rather than just letting the matter slip by, as I was prepared to do, Tarik's cousins made an issue over this. This was our property, not theirs. The little girl had no right to take the toy and one of Tarik's cousins simply took the toy away. The matter was over quickly. I was embarrassed to have been the center of attention over such a trivial matter and yet pleased that we were considered worth defending.

Friendship Bonds

Men have contacts both within and outside of the zneg,

and thus have an opportunity to establish friendships in different settings. Boys are liberated from the confines of the zanka at about the age of eight. They accompany their older brothers, cousins or fathers into the city, run errands and are generally free to run around in the city and to visit friends.

Women, on the other hand, are confined most of their lives to either their natal zanga or their husband's zanga. It is here that they must develop their friendships. Usually a young girl's friends are her cousins and zanga members. After she marries she makes friends with women in her husband's family and zanga. (Friends are also made at school, but whether or not a girl will be allowed to associate with them after school depends on the conservatism of her family.) Generally girls and women do not leave the zanga unless very specific business takes them out to the city - such as attending school, going to the doctor, visiting relatives in another zanga, etc. On these occasions, depending on the family, girls are usually accompanied by a brother, father or older woman.

Cooperative Efforts

All members of the zanga join together to celebrate the rites of passage of each person in the zanga. These include weddings, circumcisions and funerals. Also during the 'Id al-Kabir (the Islamic holy day that celebrates Abraham's sacrifice to God) all members of the zanga visit one another wishing each other a happy 'Id. Before such events the women

work in groups to prepare the food required to serve those attending.

In addition to such occasions, two or three households will often unite in order to make major repairs on one of the households. For example, because the job must be completed in one day, the construction of a roof requires the work of several men. Men in the zanga can be counted on to help in this job. It is understood, of course, that this help will be reciprocated when needed.

At harvest time some foods need to be prepared for winter storage. Women from two or three households will help one another with the preparation of couscous, almonds, olives, etc.

Kitchen utensils and occasionally chairs are borrowed within a zanga. The only tools found within the home are those used in whatever trade the man or woman is involved. These tools are never loaned. With the exception of perhaps a ladder, homes have few if any tools. Repairs that are required can be readily obtained by local repair shops (bicycle, jewelry, electrical). Such repairs are relatively inexpensive.

Zneg are apolitical. That is, they are essentially free of political discussions and certainly of any political activity. Political discussions take place outside of the zanga within the male domain. Men discuss politics in the cafes or in the streets with their friends and/or relatives but rarely at home. The family may watch President

Bourguiba's daily speech on television but this rarely sparks a political discussion. If there are any comments made it is in regard to the health of the president and his family. Women are not interested in politics and children are unaware of the issues. Thus only if a man has another man to talk with in the home will there be any reference made to politics. But even that is rare. At most they will grumble about a recent tax or government change that effects them personally.

Newspapers are read in the cafes. Radios and televisions are also often played there. It is here that men gather to discuss events of the day and to debate the issues. Some cafes in particular are known to play host to more radical clients and they are occasionally scrutinized by government authorities. As proof of the fact that the government considers cafes to be influential, cafes are legally obliged to close on election days.

SOCIAL CONFLICT WITHIN THE ZANQA

Conflicts are often initiated by children who, for example, speak disrespectfully to an elder neighbor. This then creates a flurry of accusations thrown at the young person and in turn at their parents. Adults try to avoid getting involved in the children's squabbles but sometimes a parent (usually a mother or grandmother) is brought into a conflict. Once one adult is pulled in another will follow to counterbalance the sides. Then the conflict escalates to include more adult members from each household. Discord is usually expressed through shouting and yelling, but I am told

that occasionally it can lead to physical aggression among the women. For several days or weeks the women will not be on speaking terms. Ironically, of course, the children whose fight started the problem are soon back to being friends again.

Sometimes rifts will occur between adolescent and young women who have shared confidences with girlfriends, only to find out that a trusted secret has been revealed to others in the zanqa. This leads to heated arguments.

Whatever the disputes, be they minor or rather significant, social conflicts are always public and open to everyone within earshot. Arguments may begin within a house but usually spill into the street where everyone becomes a participant - either as a listener, a discussant or an adversary.

THE SOCIAL NETWORK OF THE ZNEQ

Zneq are interlinked through consanguineal and affinal ties. (Note the case of the Souissis and Bendalys whose extended family members reside in Zanqa Sfar and Zanqa Turki.) A person born into the patrilocal household of one zanqa will also have regular contact with their mother's patrilocal zanqa. Furthermore, one is likely to know uncles, cousins or brothers who left the patrilocal zanqa and established themselves in another neighborhood. By association one is introduced into this new zanqa. As well, when one marries people in the spouse's zanqa become new contacts for the

individual and his/her family. In this way the zanka network is ever expanding.

Marriage as a Catalyst for Networking

Marriage in Mahdia is an important factor in creating and maintaining inter-zanqa relations. First marriages in Mahdia are usually arranged by the parents. The few exceptions to this general rule are those of men (and the very few women) who move to Tunis or travel abroad. For example, only three first marriages in Zanqa Sfar were not arranged, and those were of men to foreign wives. (Second marriages may use intermediaries, but not necessarily.) Mahdians observe zanqa exogamy and express a strong preference for Mahdia endogamy. These are the parameters within which parents usually operate when arranging marriages. Although the patrilateral parallel cousin marriage is still valued as it is in other parts of the Arab world, and male ego's "bent ami" (father's brother's daughter) is considered as an alternative when marriages are being discussed, it is not widely practiced. Out of the 61 marriages occurring in Zanqa Sfar between 1920 and 1980 only five were between cousins, two of which involved patrilateral parallel cousins. In Zanqa Turki there are no instances of cousin marriages. (See Table 8) (3)

Neither in Zanqa Sfar nor in Zanqa Turki are there cases of zanqa intra-marriage. I was told that it is not considered "good" to marry someone within your own zanqa; the ties are too close. Zanqa playmates are not preceived as appropriate marriage partners - they are like sisters or brothers.

Before the age of puberty boys and girls play together freely on the streets and in the homes of the zanga. A girl after the age of eight begins to have more household duties, but even so she is allowed to play with children when she is not needed by her mother. However once a girl reaches menarch (or shortly before) she begins to associate more with her female peers and has limited contact with males in the zanga. She is expected to act with modesty. This symbolizes sexual purity in a young woman. Thus her behavior with male peers is altered. The interaction that does take place is strictly verbal and not physical, as it may have been when they were younger. Likewise, as boys reach puberty they are expected to behave more respectfully and less familiarly to their former female playmates. For example, as a boy approaches manhood he refrains from walking into the interior of the homes (as he once did) of nonkinsmen. Instead he goes no further than the entrance hall as is appropriate for men visiting nonkinsmen.

An analysis of Arabic songs, stories told on radio and dramas presented on television and on film reveals the importance placed on romantic love. The scenario of "love at first sight" is told over and over again as an ideal. This becomes the basis of fantasies. And in fact it is often the basis of a young man's pursuit of a woman he thinks he wants to marry. The idea of marriage with someone you have seen every day of your life falls short of the ideal. Thus ex-playmates do not consider one another as potential marriage partners.

I was told that on rare occassions zanga in-marriage

does occur. In these instances there is a considerable amount of gossip about the couple. It is assumed that premarital sex must have occurred and that the couple having been discovered, were forced to marry one another. Thus only if one is obliged to do so would one marry an ex-playmate. (4)

If one's "bent ami" (partilateral parallel cousin) is also a zanqa member (which is often the case) then the exogamous rule comes in direct conflict with a traditional Arab marriage preference. Most households have had to deal with this problem. This was the case for Tarik's sister, Moniya Souissi.

Moniya had reached marriageable age and her father was anxious to have her engaged, if not married, before she got older. While she was attending university he received two offers from families whose sons were interested in marrying Moniya. The offers occurred at about the same time. Even though both of the young men lived in Zanqa Sfar (as did Moniya) their offers were considered. One of the suitors was her patrilineal parallel cousin who lived in the household next door. The other young man was the brother of Moniya's best friend.

This situation provoked discussion in the neighborhood. Arguments were made for each choice. Some held that Moniya's cousin (she was his "bent ami") was the obvious choice for all the reasons usually put forth. First, one should marry one's daughter into an honorable family. What could be better than your own family? Second, such bonds strengthen family unity.

Third, one's daughter would not have to move away after she married. She would always be close by. Fourth, the chance of a divorce is reduced. Fifth, matters of inheritance are simplified. The wealth accumulated by the grandparents and parents would be kept in the family.

On the other hand, arguments were raised on behalf of the other young man. The strong point in his favor was his education. He, like Moniya, had reached a university level of education, whereas the cousin in question has much less education. A second point was the friendship of Moniya and his sister. An important consideration in any marriage arrangement is the compatibility of the bride and the women in her husband's family.

Despite the discussions surrounding her, Moniya herself was not really interested in either one of her suitors. Although the men were both older than Moniya , she had known them since childhood. Her family, in keeping with her wishes which corresponded to the zanqa exogamous pattern, declined both offers.

Zanqa exogamy increases the social network that criss-crosses the city of Mahdia. Sometimes the bonds between two zneq are strengthened by multiple marriages between the two. In Zanqa Sfar, for example, there are two families that marry regularly into two other families living elsewhere in Mahdia. The social network that is created through intra-zanqa relations thus becomes the context within which life is spent, especially for women and children.

Weddings

Marriage arrangements are made through a series of incremental steps. The arrangements begin in the woman's domain. These arrangements can be initiated by either the family of the man or the woman. A common scenario goes as follows. A young man (we will call him Mohammed) comes to his mother (we will call her Fatima) and tells her about a girl he finds attractive. Perhaps he has seen her at school, at the marketplace or at a friend's house. Mohammed wants to know more about her and her family and asks his mother to make inquiries. Fatima will go to visit the girl's mother for a casual conversation. This initiates the first stage, the khautba. The intent of this meeting is to ascertain the availability of the girl and the suitability of such a match. If the girl has not already been spoken for and the family is deemed a "good" family Fatima will organize a second visit. On the second visit Mohammed's mother is accompanied by other adult females in the family, i.e. his aunt or sisters. This gives women in both families a chance to assess one another. On the second or third visit Fatima will officially ask if Mohammed could marry the girl. The request does not come as a surprise. The girl's mother has been waiting for this. In the meantime the matter has been discussed amongst the family members, in particular the daughter and the father. Collectively they have reached a decision. Once the proposal has been made the girl's mother replies positively or negatively. The decision is dependent upon many factors - the girl's age, the educational aspirations of the girl, the

economic standing and reputation of the suitor's family, whether or not her older sisters have been married yet, and the girl's interest in the young man.

If the answer to the perspective groom's family is "yes" then the khautba is completed. After the khautba, the perspective groom will send gifts (gouffa) to the young woman, particularly on religious holidays. These gifts will include gold jewelry, money, clothing, etc. Negotiations as to how much will be contributed by each family are conducted during this stage. It is customary for the groom to provide housing - either a house, apartment or a room of his father's house. The new home should be completely furnished. Furthermore, at the time of marriage the groom should provide at least some, if not all, of the food for the wedding festivities. This is called t'am and can be either food or money given for refreshments. The type of house, the amount of furniture, jewelry, clothing and food to be provided by the groom is determined in the negotiations. Likewise, the amount of bedding, towels and kitchenware the bride will provide is also specified in the khautba discussions.

Direct participation of the men begins in the next stage when a fetha (a prayer) is read. A fetha is held after some gifts have already been given to the girl and a verbal settlement has been reached as to how much each family will give to the marriage. At this point the men from both families assemble in a home (usually the home of the bride) and a prayer is said. The meeting is short, lasting only ten

or fifteen minutes. With the performance of the fetha the commitment to the union is even more pronounced. Marriage arrangements can be broken during the khautba and during the negotiations with little loss of face. However this is not the case once the fetha has been performed. After the fetha the marriage plans are made known publicly. This represents a statement of intention. During the period after the fetha the gifts continue to be given to the bride. This period lasts perhaps one to three years. It is possible to back out of the marriage arrangment after saying the fetha but it is not looked upon favorably. To break away from the agreement at this point would be to go against one's word. Families who change their mind and decide to back out of the deal may have difficulties making another marriage arrangement. Their resolve may be doubted.

The third stage, the zdag, is the most important stage from a legal point of view. The zdag is the signing of the marriage contract. It is signed by the groom, bride's father (or in some cases the bride herself) and two male witnesses in the presence of a notary and attending males of both families. (The witnesses are respected elders in the the community and can be an uncle of either the bride or groom.) The zdag is legally binding. From a legal point of view the couple are married after the zdag has been signed. For example, if either of the marriage partners should die prior to the marriage festivities and consummation the inheritiance statutes would still be applicable. The period following the zdag can last up to three years. Sometimes it takes that long

for the groom to accumulate the funds to satisfy the terms of the marriage agreement. However it is generally felt that the zdag should be short and the marriage festivities should begin very soon after the signing. It is argued that the couple will want to get together to consummate the marriage since legally they are married. Should consummation happen before the wedding festivities the couple would be frowned on. As with all rites of passage the ceremonies mark a change in status of the individuals involved. Not to celebrate the event would lessen the value of the union in the eyes of both the couple and the community. So before the wedding festivities begin the fiance is allowed to visit his future bride, but only if she is chaperoned.

Due to varying individual personalities and circumstances each marriage arrangement is different. For example, if the girl is young the parents may not want to commit themselves so early. They may wish to hold out for a better offer. In another case, the bride's family may want to postpone the zdag until the last moment if, for example, there is doubt as to whether or not the groom or his family will be able to meet the financial responsibilites spelled out in the negotiations. On the other hand, if the family is poor or if the girl is in her late 20's (and thus reaching an age considered "too old" for marriage and childbearing), physically handicapped or not beautiful, the parents will be anxious to move the arrangements along, culminating in the signing of the zdag at the earliest date possible. (It should be noted that a young

man that is physically handicapped or considered unattractive must be able to provide a sizeable endowment if he expects to convince a girl's parents to allow the marriage.)

Traditionally marriage festivities last five days, beginning with the first Henna (women's ceremony) on Monday and ending with the Jilwa on Friday. (The Jilwa is the ritual wherein the groom comes to the bride who is waiting for him in his father's house. The marriage is consummated there that evening.) Today, however, the marriage festivities are often curtailed to two or three days. There is considerable variation from one wedding to another. The variation depends on the finances of the families involved, the relationship between the two families, and whether or not the marriage is between families within the same town or from different towns. Below is the itinerary for a traditional wedding:

	Women of Both Families	Men of Both Families
Day 1	Henna	
Day 2	Henna	
Day 3	Sbah	Sbah
Day 4	Henna	Ftour
Day 5	Jilwa	Kharja

Hennani (plural of Henna) are ceremonies held for women only. The mood is joyous with singing and dancing accompanied usually by a group of hired musicians. Pastries and beverages are served throughout the evening. The sbah (which is becoming less frequently practiced today) is held in the home of the bride's parents. Immediate relatives of the groom and the bride gather to visit informally. As in all visits, refreshments are served. The couple themselves are absent.

At some weddings the groom's friends and male kinsmen will be invited to his house for a dinner (ftour). At this time his friends and kinsmen will give him gifts of perfume, cigarettes or money. Someone, perhaps a brother, will take note of who gave gifts and exactly what they were. The groom will be expected to repay this gift in the event of the giver's wedding. The ftour may occur either the day before or the day of the Jilwa.

Finally, on the last day the bride is dressed and brought to the groom's father's house by her family. This is called the Jilwa. Her departure from her home initiates a procession of cars filled with her family and friends. The procession takes her to her husband's patrilocal residence. Soon after her arrival the groom arrives in a similar procession (called Kharja) of family and friends. Kharjas usually include a band of musicians. When the male procession reaches the groom's house a prayer (fetha) is read. Then the groom enters the house alone.

The marriage will be consummated that evening. The couple will reside there for seven days during which time neither of them will be required to perform regular duties. After seven days if they plan to live outside of the groom's father's residence they will move to their own home.

To illustrate these customs more fully Moniya Souissi's marriage arrangements and wedding will be discussed. Moniya (whose proposals were described earlier) is the second daughter of Si Soussi of Zanqa Sfar. Moniya is the only

daughter amongst five children born to Si Soussi's second wife. (As mentioned earlier Si Soussi's first wife died leaving one son and one daughter. A span of approximately 10 years separates the two sets of children.)

Despite the fact that Moniya was required to perform many household duties she was a very good student in school. She successfully completed primary and secondary school and passed the entrance exams for university. After some hesitation on the part of Si Soussi, Moniya was permitted to move to Tunis and live with her stepsister while attending university. She completed a three year teacher training program and began teaching in a primary school in Tunis. At this point her parents were becoming anxious for their 24 year old daughter to marry. As explained earlier, two young men had already expressed an interest in marrying her. But she had refused their offers. Si Souissi felt that she was rapidly growing "too old to marry" and he feared she would become a spinster.

Moniya had become friends with one of the teachers at the school where she was employed. She was invited to her friend's home where she met her friend's mother and sister. In time the women reached the conclusion that Moniya would be a good marriage partner for the brother (Ahmed). Ahmed was working as an accountant in the civl services. When she expressed her interest in marrying a colleague's brother the Souissis were happy. They would have preferred she marry someone from Mahdia but they decided to give this arrangement serious thought.

A hautba was initiated by Ahmed's mother and sisters. During the hautba gifts were given to Moniya. Si Souissi began to make inquiries about the family via established connections he had previously cultivated in Tunis. Moniya and Ahmed actually saw each other on two occasions, and then only in the presence of his and her immediate relatives.

Negotiations did not go smoothly. There was some question as to where the wedding would be held, Mahida or Tunis. Si Souissi felt that the groom should have purchased a house rather than rented one. The kind and amount of furniture to be provided was debated. Eventually compromises were made and the fetha was held in Tunis, in Moniya's stepsister's home.

A date was set for the signing of the zdag and wedding festivities. A house was rented, furniture purchased, and Moniya busily prepared her trousseau. Arrangements were made to host the groom and his family in Mahdia. Six months later the wedding festivities began.

Day One - Signing the Zdag

Ahmed, his parents, two sisters and brother-in-law and various nieces and nephews drove from Tunis to Mahdia on the morning of Day One. They were shown to their rooms above Si Souissi's store. Then they were served the mid-day meal. A few hours later the men from both families gathered in Si Souissi's house for the signing of the zdag. (Due to the fact that there was some apprehension about marrying "outsiders" Si Souissi insisted that the zdag only be signed when the wedding

commenced.) Most of the men were dressed in the traditional dress, a white jeba. (Jebaib (plural of jeba) are loose garments resembling nightshirts. Beneath the jebaib white dress shirts and white bloomers are worn. For special occasions the jebaib are made of white cloth and richly embroidered.) Chairs had been rented and placed in the open courtyard. They were arranged in front of the table where the signing would take place. As the men arrived they sat with their friends and visited, waiting for the main event. In the meantime small children (of both sexes) were playing amongst the men - running around and through the lines of chairs. The bride, her mother, sister, and female in-laws stayed within the house. They could be seen peeping out of the windows of the rooms. Women who were not secluded in the rooms of the house veiled and positioned themselves on the rooftops surrounding the open courtyard. (5)

Once the notary and witnesses arrived the informality of the gathering changed to one of solemnity. Everyone became quiet. The children were ushered into the house or on to a chair. Prayers were said. Recitations from the Koran were repeated in unison. The zdag was placed on the table. The groom stepped forward and placed his signature on the marriage contract. Then the two witnesses signed. Normally the father of the bride would sign as well. However this was not to be in this zdag. Moniya had insisted for weeks prior to the wedding that she would only marry Ahmed if she could sign the zdag herself. She argued that she was of legal age and that it was

her right to sign the marriage contract. Si Soussi did not want to concede his traditional role, but he gave in to his daughter's wishes in the end. Even so, Moniya did not sign the contract until after most of the men had left.

After the signing, baklawa and bottled soft drinks were served to all the men. They continued to visit, leaving one by one or in groups of two or three. The ceremony was over in approximately 90 minutes. Before the notary departed Moniya came out of the house and signed the zdag. At this point Si Soussi clapped his hands together with obvious delight. Now it was done! "He can take her now", he said. His wife and his sister became angry with him for making such a statement. "What do you mean, 'he can take her'?", they asked. "There is still the Henna." He replied, "Oh, it doesnt't matter now. We can save ourselves some money by not having the Henna. They are married now. That's all." There were a few more heated exchanges, but everyone knew that it was too late to cancel the Henna. Not only had preparations been made, but to cancel the Henna was unthinkable.

In the evening Moniya's cousins, aunts and friends from the zanga gathered at her house. Two drums and a tambourine were brought out and warmed over the kanun (a clay burner used regularly to prepare tea). The women gossiped about their peers who had recently married. They talked about their past, their future and the wedding being celebrated. As the drums warmed up they began to play them and sing favorite songs. One by one they got up and danced. Each dancer in turn was watched and urged to continue. They mimiced one another and

sometimes made fun of one another. The mood was light and gay. Eventually it was time to apply henna on the feet and hands of the bride and to apply it on each other as well. (Henna is a red dye that is rubbed on the palms, soles and around the edges of the feet. When applied on the edges of the foot a decorative style is made. Once applied a person must avoid walking or using their hands until it dries. The design will be smudged if this precaution is not taken.) The mashta arrived and applied the henna. The mashta is the woman who provides the entertainment for the Henna evening. She is the lead singer of a group of four women, all of whom play drums and tambourines. Satin embroidered mittens, which had been made for this occasion, were then placed on the bride's hands. (These would be used later in the wedding festivities.) Moniya was carried to bed. Her friends went home and everyone went to bed.

Day Two - The Henna

Day Two was the day of the Henna - from a woman's perspective this is the most important event during the wedding. Moniya's aunts (her father's sisters) arrived early to assist in the bathing of the bride. They shampooed her hair and bathed her, rubbing her skin until it became reddish. After her bath her aunt began the long process of removing all of Moniya's body hair, with the exception of the hair on her head and eyebrows. Not only is this a tedious undertaking, it is also painful, for the technique requires uprooting the hair follicles. Honey, sugar and water are boiled down to a paste.

The paste is placed on a small area of the skin and then after a few minutes the paste is ripped off, pulling the hair with it. This is done because it is believed that a woman's body is most beautiful when devoid of body hair. Thus this preparation is done to seduce her husbond on the night of the Jilwa. (6)

After the mid-day meal the mashta returned to complete the henna decoration. She applied the hargous (a black dye) over the henna design on the feet and hands. Unlike henna, however, hargous dries within two to three hours.

After the mashta left Moniya rested for the remainder of the afternoon, visiting with her cousins and friends from the zanga. Her older sister, her aunts (including her father's sisters and father's brother's wife) and her mother spent the afternoon completing the preparations for the Henna to be held that evening. Si Souissi and his sons arranged the chairs in the courtyard once again. A special chair was draped with a wedding cloth for the bride. Decorative lights were strung around the courtyard floor. Cases of soft drinks were purchased and delivered to the house.

After a light meal the women of the household prepared themselves for the Henna. Married women dressed in their own wedding dresses and unmarried women wore their better dresses made of nylon, jersey or satin. The bride's wedding outfit was typical of the traditional Mahdian wedding dress. It consisted of layers of clothing. Starting from the undergarments the layers included a cotton white slip and

bloomers, a white and red cotton sheath with a green and black fringe, a satin vest decorated with gold embroidery, a cloth draped over the body pinned in strategic places, and a headdress made of gold coins. On top of all of this several gold necklaces were draped around the bride's neck. She also wore gold earrings and ankle and arm bracelets. On her embellished feet she wore a pair of wedding "kob-kobs"- wooden shoes.

As mentioned earlier women keep their wedding dresses and wear them when going to other Hennani. Thus at one Henna one can look around the room and see the stylistic changes that have taken place over the last 50 years. The change has not been great, but variation in the types of cloth and styles of jewelry can be seen. The most notable contrast between an older woman's attire and that of a younger woman's is the amount of jewelry worn. The younger woman has much more. Most of the older women have had to hock or sell their jewelry over the years as their families needed financial contributions in years of crises. The jewelry amassed during her young adulthood (mostly through marriage gifts, but also through inheritance) is the woman's savings account. Unless she has another means of raising money (through a craft, orchards, or a job), this may be all the money she will ever have.

Much of the jewelry, as well as the henna and hargous application, include motifs that are aimed at casting off the evil eye and jnun, thus insuring good health. For example, silver amulets are designed to repulse jnun. Fatima's hand

and a fish motif are believed to protect one from the evil eye. (Belief in the jnun and the evil eye will be discussed in later chapters.)

At Moniya's Henna women began to arrive around 8:30 p.m. They came in groups of three to five, some being escorted to the door by a husband, brother or adult son. Infants and toddlers were left at home with their fathers. Some women came with their children above the age of four or five. Boys over the age of approximately eight years, however, did not come. By this age they prefer the company of men.

As the courtyard began to fill with guests, the noise became greater and greater. As they arrived groups of women sat together with other groups, forming discernable cliques around the courtyard. Some groups were laughing and talking and obviously enjoying themselves, whereas other goups were more somber and watchful of the guests that were arriving. In time the mashta and her entourage arrived. Kwanin (plural of kanun), already lit were brought to the women, who sat themselves down on the ground in front of the ornately decorated "bride's chair". They formed a circle with the mashta facing the bride's chair and the kanun and an empty space in the middle. The empty space was reserved for dancers. While warming up the drums over the heat of the kanun, the mashta and musicians were served tea. Now everyone was waiting for Moniya to appear. Guests, especially those who had arrived at 8:30p.m., were becoming impatient and some were getting irritable. The complaints which were first

expressed through whispers were becoming audible. Finally, 30 minutes after the musicians had arrived and one hour after the guests had began to arrive, Moniya was led by her aunts and mother out from the bedroom and to the bride's chair where she was seated. Once she came into the courtyard the musicians began to beat the drums loudly and sing. Women in the audience gave the shrill cry so common throughout the Arab world - an utterance that is made as a display of joy. And then the Henna got underway. Song after song was sung by the mashta and her group. Individual women would step into the dancing circle, toss some millimes into a basket next to the mashta, and begin to dance. Young women and adolescent girls were the first to dance, but through the night almost all of the women would dance a noba (a dance to a song). Family and friends "dance for the bride". The money collected in the basket would be taken by the mashta at the end of the Henna. She in turn would divide it up amongst her musicians.

Throughout the night women were watching each other. In particular, young women were observed by women with eligible sons. Those being observed were conscious of this fact as was reflected in their self-conscious manner. Gossip was flying around the room as women assessed the amount of gold adorning one woman or the beauty of another, etc. At times it appeared that the bride, Moniya, had been forgotten. Her chair was separate from the crowd. She sat alone, distanced from the others. Occasionally one of her female relatives stood by her side for a few moments or a well-wisher would come up and say a few words to her. But for the most part she remained alone

and looking mournful.

Despite the fact that Moniya has lived away from Mahdia for several years, she considers Zanqa Sfar her home. (In Tunis her social contacts were limited to her sister's family with whom she lived and with other teachers in the school where she was employed. She spent her holidays in Zanqa Sfar.) Moniya looks sad as is expected of a bride. This is the last night that she will spend with her family and zanga members as a permanent member. Tomorrow her status will change. She will be living in new circumstances and with people she barely knows. She is frightened and wary of many things - leaving her natal home and zanga, entering a new extended family, and the anxiety associated with adopting a new role - that of wife. The bride is anxious due to the uncertainity of the situation, plus her fear of having sexual intercourse for the first time. Her fear and anxiety are visible. Married women try to console her by saying that soon whe will have children of her own and her situation within her husband's family will improve.

Periodically during the Henna lewd remarks or gestures were made by older women. They were made in an attempt to convince the bride that she would come to enjoy sexual intercourse. (This lewdness provoked laughter among some, but at the same time was not appreciated by others who found such behavior impolite.) Girls younger than the bride appeared to empathize with the bride and were appprehensive for her, no doubt contemplating their own futures.

About 11:00 p.m. Moniya's older sister (Najeeba) came up

to the bride's chair and announced that it was time for the rashg (gifts of money given to the bride's family). Najeeba gave one basket, lined with satin, to the groom's mother and she kept one for herself. At this point people began to drop money into the baskets, calling out their family name. Each woman holding the basket took a mental note of who contributed and perhaps how much. Some friendly bantering began between the two women holding the money baskets. However Moniya's sister was collecting more than the groom's mother. This, of course, was due to the fact that there was a disproportionate amount of Moniya's family and friends in attendance. Only the groom's immediate family came from Tunis.

Once everyone had contributed the rashg the women retired and counted the money collected. As tradition dictated Moniya's sister turned the money over to Moniya's mother as a form of recompensation for losing her daughter. The amount of money collected came to about $300.00. (On the following day this money fell into the hands of Si Souissa, which led to a family quarrel.)

After the money collection the music started up again and the singing and dancing continued until the early hours of the morning. Women began to leave around midnight as their husbands or other male relatives arrived to escort them home. At 4:00 a.m. everyone had left and a very tired bride and her family went to bed.

Day Three - The Jilwa and Kharja

Because Ahmed and his family were guests in Mahdia, they were unable to host a dinner for Ahmed. Likewise, due to the circumstances, the Kharja consisted of a relatively small group of Ahmed's male family members. It was augmented by the bride's male cousins, brothers and their friends. A band was not hired for the procession.

On the day of the Jilwa the women in Moniya's house (who by this time were exhausted from the massive amounts of labor required in preparing food for two extended families plus the demanding schedule of the wedding) helped Moniya dress for the Jilwa. Throughout the afternoon her cousins, aunts and friends in the zanga came to visit her.

Moniya dressed in the wedding dress she wore the night before and then an overdress was placed on top. The overdress included another vest heavy with gold coins and gold thread. Another veil of cloth also laden with gold was placed on top of it all, as was additional jewelry. The vest, outer veil and extra jewelry had been rented for the day. (It was worth approximatley $10,000. Moniya's wedding dress and jewelry was worth about $5,000. The majority of families rent the outer garment and borrow extra jewelry. Those who are more affluent are able to purchase the entire wedding garb.) When Moniya was finally dressed she looked spectacular. She was so laden with heavy cloth and gold that she was unable to stand or walk by herself.

Normally Moniya would have been taken to the groom's house, but in this case she was escorted to a small platform

in the courtyard. There she stood while her friends and female relatives admired her. While waiting for the arrival of the groom pictures were taken.

Moniya, standing for 30-40 minutes, looked dreadfully hot. The perspiration was running down her face. As family and friends came up to stand by her she remained silent. If Moniya looked miserable, her mother looked grief stricken. She had been crying most of the morning, and now that the Jilwa had begun she was weeping openly. She was losing her daughter - a girl who had been her companion in a household of males. Not only was her daughter leaving her natal home, she would be leaving Mahdia. She would be moving to a city and family unknown to her mother.

Finally the men arrived. Upon their arrival a prayer (fetha) was said. The door to the courtyard was opened and the men, led by Ahmed entered and walked up to the bride. (At this point the women were wild with enthusiasm and merriment - all except for Moniya's mother who reached up to her face and scratched her cheeks deeply - making blood run down her face. (This is the same gesture made at the death of a loved one. The symbolism is obvious.) The women gave their shrill cry as the groom reached the bride who was looking stone- faced. Her gloved hands were held up in front of her in the traditional manner, symbolizing her readiness to submit to him as her husband. (The same gloves are to be used when the marriage is consummated to protect the man from being scratched!) All but the immediate relatives went home. The bride changed out

of her wedding dress and the two families visited, drank tea and posed for more pictures. Moniya and Ahmed remained side by side throughout the photo session but said little to one another. Soon the couple retired to Si Souissi's bedroom for the evening, not leaving until morning when they departed for Tunis.

Traditionally "haloo" (sweets) are sent by the bride's family to the groom's family on the morning after the Jilwa. These include pastries such as baklawa and sweet couscous dishes. In Moniya's case, pastries were sent with her when she left for Tunis.

Debts and Credits Used to Solidify Relationships

Marriages create bonds between families and thus promote a network of relationships useful (and sometimes troublesome) to the individual. Once relationships are formed they are strengthened or concretized by a system of debts and credits. Debts or credits are usually accrued during rites of passage, in particular, during marriages and circumcisions. These ceremonies are relatively expensive and thus most families must rely on the help of family members and friends (usually in the zanga) to amass enough money to pay for them. This is done in two ways: 1) through an obligatory gift of money (rashg) made by kinsmen, and 2) through voluntary loans extended by a non-relative.

Rashg are collected by the woman of a household. They are given to the mother of the bride at Hennani and to the mother of the son to be circumcised at thourat. Parties are

held the night before the boy is to be circumcised. They are similar to Hennani in that they are exclusively attended by women, music is played and refreshments are served. The only role the boy plays is to stay seated on a chair for the evening, to be admired by the women.

Hennani and thourat are usually held in private homes. Sometimes they are held in a shrine if a family does not have enough space in their home. If invited to a Henna or thour one is obliged to pay a rashq. A rashq is a small donation of 100 to 500 milliemes (less than one Canadian dollar) that is paid to "admire the bride or boy". All women attending these ceremonies pay a rashq and sometimes men send a rashq with a woman attending the ceremony. To attend a ceremony and not give a rashq would be an insult to the family of the bride or boy. However, if one chooses not to enter into the obligatory relationship one simply does not attend the festivity.

Rashq help offset the costs of weddings and circumcisions. However it isn't always sufficient. In addition, loans are extended and thereby debts initiated through gift giving at rites of passages. These credits and debts are only accumulated between non-relatives. For example, at the time of a girl's wedding a neighbor may donate a gift of maybe two dinars to the girl's mother. When men give gifts they are always larger items, such as a sheep, ten liters of oil, etc. The parents of the bride are then indebted to the neighbor. When the neighbor's daughter marries a gift of the same value is expected. If it is not paid the neighbor will go to them and demand it. Certainly

the matter will be discussed thoroughly and publicly!

In summary, familial and non-familial social relationships within zneg and with external zneg are predicated on exchanges that result in a set of obligations and responsibilities. Within and between families marriages are arranged gifts are given and favours are extended. Such exchanges provide the nexus of the inter- and intra-zanga social network.

It is within the context of the zanga that illness episodes occur. Symptoms are analyzed not only by family members but often by neighbors as well. This is particularly true if the illness is acute or if it lasts more than three or four days. Dwa 'arbi remedies are usually administered as the first step. Within most zneg there is at least one senior man or woman who is considered a dwa 'arbi specialist. These individuals (whose age may range from 40 to 80) have developed an expertise in diagnosing illnesses and in preparing and administering various remedies. (The principles upon which these remedies are based is described in Chapter Six.) The reputation of some dwa 'arbi specialists go beyond the zanga. In these cases their advice will be sought by various outsiders.

Alternative health care options are discussed within the zanga. Often whether or not the patient should be taken to a derwish, a clinic, or a shrine will be determined only after weighing the advice of neighbors. In Chapter Nine I explain the significant role that family and friends in the zanga play

in the selection of a particular health care alternative.

In Chapters Five, Six, Seven and Eight the cognitive basis of the Tunisian folk medicine is described. Before moving on to that analysis, however, I think it is important to explain the methodology used in the collection of data.

FOOTNOTES

1. In Morocco such neighborhoods are called derbs. (Geertz, Geertz, and Rosen, 1979)

2. The degree to which women are expected to wear veils and move around the city freely varies greatly from family to family. This matter is in flux at the moment. There was a steady trend towards "emancipation" which was encouraged by Bourguiba from the very beginning of his presidency. Thus middle class and elite women under the age of 40 generally do not wear veils in Mahdia. But in recent years the revival of Islamic fundamentalism has reached Tunisia and, of course Mahdia as well. Now one sees an increasing number of young women wearing veils.

3. There is one elite extended family in Mahdia who marry only within their own family, never an outsider. They are one of the oldest, most wealthy and prestigious families in Mahdia. They are considered handsome looking because of their fairness and are also known to be honorable in their dealings with non-family members.

4. Zanga exogamy substantiates the position held by E. Westermarck who argued that one feels no erotic attraction for a person with whom one is reared. (Westermarck, 1922)

5. Having been previously trapped in hot, secluded rooms on similar occasions I arranged to go onto the rooftop with some of the women in the zanga. The vantage point was much better. I might note that only on these occasions was I asked to put on a veil. Men complain about women who peer over the rooftops. Thus, to defract criticism and to uphold the family's good name, women cover themselves with veils.

6. Girls prior to marriage do not remove the hair on their legs or anywhere else. To do so would be immodest and not acceptable behavior. But after marriage women periodically remove the hair on their legs, arms and underarms as part of their personal grooming.

CENSUS DATA

TABLE 1

	Zanqa Sfar	Zanqa Turki
Population of Permanent Residents	65	41
Number of Households	15	10
Number of households occupied year-round by owners	10	7
Number of households occupied occasionally	3	2
Number of houses rented	2	1

TABLE 2

Number of Rooms*

Number of rooms	No. of households in Zanqa Sfar	No. of households in Zanqa Turki
10	0	2
8	1	0
7	3	0
6	1	5
5	6	3
4	2	0
2	2	0
Average No. of Rooms/ House	5.0	6.5

	Zanqa Sfar	Zanqa Turki
Additional Space		
Houses with access to courtyard and roof	12	3
Houses with easy access to roof only	3	4
Houses with access to courtyard only	0	3

*Spaces smaller than 8 x 6 feet were not considered rooms. Generally, Mahdians arrange their homes to maximize space. Thus it is unusual to find rooms smaller than 12 x 12 feet.

TABLE 3

Number of Children Born to Each Household (Surviving) in Zanqa Sfar

Household	Male	Female	Total
A	5	3	8
B	7	5	12
C	4	5	9
D	6	3	9
E	5	2	7
F	3	3	6
G	5	4	9
H	0	1	1
I (moved)	3	4	7
J	1	1	2
K (renters)	3	1	4
L	1	2	3
M (vacant)	0	0	0
N	2	1	3
O	3	6	9
P (vacant)	0	0	0
	48	41	89

Average Number of Surviving Children Per House: 6.36

Number of Children Born to Each Household (Surviving) in Zanqa Turki

Household	Male	Female	Total
A	3	2	5
B (vacant)	0	0	0
C	2	1	3
D	4	2	6
E	2	2	4
F	2	2	4
G	3	1	4
H	4	6	10
I	2	3	5
J (vacant)	0	0	0
	22	19	41

Average Number of Surviving Children Per House: 5.12

TABLE 4

Age Groups in Zanqa Sfar

Age	Male	Female	Total
80-89	1	0	1
70-79	1	3	4
60-69	2	3	5
50-59	0	2	2
40-49	5	2	7
30-39	2	6	8
20-29	11	3	14
10-19	4	8	12
0-9	6	6	12
	32	33	65

Average Age of Population - 30.8

Age Groups in Zanqa Turki

Age	Male	Female	Total
90-100	0	1	1
80-89	1	0	1
70-79	0	2	2
60-69	1	1	2
50-59	1	3	4
40-49	2	2	4
30-39	3	1	4
20-29	3	7	10
10-19	3	3	6
0-9	4	3	7
	16	22	41

Average Age of Population - 33.9

TABLE 5

Occupations of Permanent Residents (including renters)

	Zanqa Sfar		Zanqa Turki
1	owner of large fishing boat	1	landowner
1	owner of small fishing boat	2	fishermen
3	blanket weavers *	1	accountant
2	cafe owners *	2	bank tellers
1	manager of cafe	1	owner of small fishing boat
2	bicycle repairmen *	1	primary school teacher
1	taxi driver	1	chauffeur
1	electrician	1	secretary
1	truck driver	---	
1	saleswoman **	10	
1	factory worker		
1	cashier on bus		
2	retired		

18			

* men belong to same household
** only female wage-earner in either zanqa

TABLE 6

Levels of Education

ZANQA SFAR

Education	Residents Males	Residents Females	Non-residents Males	Non-residents Females
**22	0	0	2	0
19	0	0	2	0
18	0	0	0	0
17	0	0	2	0
16	0	0	0	0
15	0	0	0	1
14	0	0	1	0
*13	1	0	2	1
12	1	0	0	0
11	1	0	2	1
10	0	0	2	0
9	0	2	0	1
8	0	1	0	0
7	2	0	0	0
6	9	4	4	10
5	0	0	4	0
4	2	0	2	0
3	1	1	2	0
2	0	0	0	0
1	0	0	0	0
0	5	11	1	7
?	0	2	0	0
in school	8	8	0	0

*Baccalaureate
**Doctorate

ZANQA TURKI

Education	Residents Males	Residents Females	Non-Residents Males	Non-Residents Females
**22	0	0	1	0
19	0	0	0	0
18	0	0	0	0
17	0	0	0	0
16	0	0	0	0
15	0	0	0	0
14	0	0	0	0
*13	2	1	3	1
12	1	0	3	1
11	2	0	1	0
10	0	1	1	1
9	0	1	0	0
8	0	1	0	0
7	0	0	0	0
6	2	1	0	2
5	0	0	0	0
4	0	0	0	0
3	0	0	0	0
2	0	0	0	0
1	4	1	0	0
0	0	5	0	0
?	1	2	1	1
in school	4	5	0	0

Comparison of Educational Levels

Average Years of Education Completed

	Zanqa Sfar	Zanqa Turki
Female residents	2.8	4.3
Male residents	4.4	6.9
Female non-residents	5.1	9.4
Male non-residents	9.9	13.1

*Baccalaureate
**Doctorate

TABLE 7

	Zanqa Sfar	Zanqa Turki
Number of Single Owners	10	4
living head of household	*7	4
wives of living head of households	2	0
son of deceased head of household	1	0
Number of Multiple-Owned Households	5	6
10 owners (wife and children)	1	0
9 owners (wife and children)	1	0
7 owners (sons and daughters)	0	1
3 owners (sons)	0	2
4 owners (children) (wife • children)	1	1
2 owners (wife and grandson) (son and daughter) (two sons) (mother • daughter)	2	2

*1 woman and 6 men

TABLE 8

Marriage Patterns

	Zanqa Sfar	Zanqa Turki
Number of Marriages	61	23
Marriage of zanqa member with someone in Mahdia vicinity	51	22
Marriage of zanqa member with Tunisian, not from Mahdia	6	0
Marriage of zanqa member with foreigner	4	1
**Number of Cousin Marriages	5	0
Number of Divorces	5	0

**Types of cousin marriages are presented on the following page.

Types of Cousin Marriage in Zanqa Sfar:

F - patrilateral parallel cousins
E - matrilateral parallel cousins
C - patrilateral cross cousins
D - patrilateral cross cousins
L - patrilateral parallel cousins

CHAPTER FOUR

METHODOLOGY

In 1965 Tarik and I were married in Mahdia. Our wedding was celebrated in Zanqa Sfar with all of his family and zanqa members in attendance. From this point on I have been immersed in Tunisian culture. During the past 20 years we have maintained constant communication with his family through letters, phone calls and frequent visits. In particular, we have been informed of deaths, births, and marriages, as well as educational and business successes and failures of all who were born into Zanqa Sfar, in particular.

Our trips to Tunisia were never longer than six weeks at a time. Longer stays were impossible due to financial, career and family obligations in both Tunisia and in Canada. In total I have spent five months living either at Zanqa Sfar or Zanqa Turki. The idea of staying in the field longer by myself was never seriously considered. This would have been unacceptable behavior and I think would have jeapordized my standing in the zneg. A married woman with young children is expected to remain with the family.

Data collected for the purposes of this thesis was collected during three summers: in 1978, 1983 and 1984. In 1978 a preliminary investigation was done on the possibility of researching medical systems. It was at this time that I began to hear about home remedies in particular. On the basis of this information, along with knowledge I had attained over the years, I formulated my research proposal. In 1983 and 1984 formal interviews were conducted on dwa 'arbi, spirit

mediumship, and the evil eye. (The results of these interviews are discussed in Part Two.)

Between visits I had an opportunity to process and think about the material collected. I also had time to follow up ideas I had while in the field and to compare my preliminary findings with data collected elsewhere in the Middle East. This is one benefit of doing fieldwork intermittently. I have an extra advantage as well. At home in Montreal I have access to "captive informants" - my husband and two of his younger brothers, one of whom resides with us. I used these sources for clarification and validation of Tunisian concepts, ideas and Arabic terms.

ORIENTATION

As my relationship with Mahdians has developed, my knowledge of that culture has evolved. At first I was eager to learn "everything" that I could about marriage/residence patterns, division of labor, belief systems, etc. - the standard anthropological categories of investigation. My interest in the beginning was quite general and unfocused. However in time, due to the long-term relationship coupled with familiarity with the literature, I was ready to move from a child-learner to at least an adolescent -learner who began to pose probing and sometimes menacing questions. I started to focus in on specific areas of interest and to formulate questions regarding these areas. My approach has been, to use Michael Agar's term, a "funnel approach". (Agar, 1980) Using this strategy the investigator begins by looking at a broad

spectrum of cultural activity. Only later, after the cultural categories are more defined to the researcher, does he/she begin to narrow in on specific topics of interest.

The "funnel approach" appealed to me perhaps because of an early training in ethnosemantics and ethnoscience. Works done by anthropologists such as James Spradley, Charles Frake and Ward H. Goodenough, and lectures by David McCurdy influenced my way of thinking about how data should be collected. In essence the approach is to ask open-ended questions, encouraging the informant to give as much information as possible and in the structure he/she thinks is appropriate - thus avoiding superimpositions of ideas that can occur in a structured line of questioning. Thus, in general, my approach has been to obtain a great deal of general background information, and then, after coming to grips with this information to focus in on more detailed data - using the structural framework of the informants.

This same approach was used on a smaller scale when structuring interview questions. After obtaining census data on the informant, the interview began with an open-ended question followed by questions that focused on specific topics. Below I discuss the interview format in greater detail.

In general I, like many other ehtnographers, go from general to specific while investigating a subject. As much as possible I try to ensure that the "specific" is within the cultural context of the informant and not predetermined by

suppositions I may have developed while designing the research project.

HOUSEHOLD ROUTINE

Time of Year

Each field visit took place in July and August. The average mean temperature during this time is approximately 30 degrees Celsius, with the noon hour high reaching as much as 37 degrees Celsius. Nights cool off to a low of 20 degrees Celsius. Fortunately Mahdia, being surrounded by the sea, is blessed with a continuous breeze which makes the heat bearable.

During this time of year food is very plentiful. There is a diversified selection of fruits and vegetables, sheep are ready for slaughter, and almonds and wheat are being harvested and prepared for the year. All of these products supplement the steady supply of fish caught locally.

It is during this period of the year that Mahdia is inundated with people. There are a few tourists that come through, but most stay in the hotels outside of the city near the beaches. Secondly, and more importantly, are the migrant workers that come to work in the canneries and the almond groves. Thirdly there are the Mahdians who have immigrated to other parts of Tunisia or Europe and return home for the summer months. The former stay in temporary shelters in the countryside or rent accomodations in the city, while the latter usually stay in their own homes, often occupying one or two bedrooms inherited from the division of the patrilineal

household. Permanent residents of Mahdia have mixed reactions to this "invasion". Shopkeepers increase their sales at the same time the cost of food at the market skyrockets to reach the prices the "outsiders" are willing to pay.

For obvious reasons - the reunion of the family, the good weather and the plentiful food - this is the season for large social gatherings. Weddings, engagement ceremonies, circumcision ceremonies, soulayimiat, w'adat, and msawid are held during this time period.(1) Thus I have been fortunate enough to be a participant observer in all of these events.

Daily Schedule

My schedule, for obvious reasons, had to coincide with the regular activities of the zanga, as described in an earlier chapter. During previous visits my status was more of a "guest". My mother-in-law was in charge of the cooking, laundry, etc. I was given little to do. However, since my father-in-law's death his wife has stepped down from her primary position as housekeeper. (In Tunisian families parents gradually relinquish their authoritarian position as heads of household. This is particularly true if the eldest son(s) is making a substantial financial contribution to the family. However this process is accelerated by the death of either of the parents. This is true because in either case, the surviving parent becomes a dependent. In the case of a widow, she usually needs financial support. Widowers in some cases need financial assistance, but they also require domestic services. These are usually provided by either a

daughter or a daughter-in-law.) Thus it was only after the death of my father-in-law that I was able to participate fully in household activities. My mother-in-law assumed a dependent role and left the decision-making to Tarik and myself.

As of 1978, when we are in Tunisia we reside in a house located in Zanqa Turki. This house is adjacent to Tarik's aunt's house. This change of residence was dictated by Tarik's father when he was alive and by the fact that Tarik inherited one third of the house after his father's death. Nevertheless, we make return visits to Zanqa Sfar almost daily to see relatives and friends.

Our house, which includes five rooms (two bedrooms, a living room that doubles as the children's bedroom, a kitchen, a small dining room and large courtyard) accommodates 10 people. Six additional relatives live in the adjacent house. Thus there are 16 extended family members who share accommodations, taking their meals together in our courtyard. In addition two of Tarik's brothers, who live in Zanqa Sfar, would come for meals. Altogether we cook daily for 18 people and sometimes more if visitors came.

My sister-in-law and I did the cooking every morning. Each morning I would bake a cake to be distributed later during my interviews. Then we would begin cooking for the household. Each of us prepared a (Tunisian) dish while one of the two older women - my mother-in-law and an aunt - would make a side dish, i.e. a vegetable or hot sauce. We had to prepare enough food to feed 18 people twice - at the noonday meal and in the evening. Throughout the morning we talked a

great deal. I was able to converse through a mixture of rudimentary Arabic and French. Through this means I learned a great deal about the neighborhood, the women's concerns, values and interests.

After the dinner dishes were finished everyone would rest. Most took a two hour nap. Some of the men and sometimes the teenagers played cards. I used this time to take down notes about what was discussed in the kitchen.

"Visiting hours" (described in a preceding chapter) begin about 4:00 p.m. If we ourselves did not go out visiting or interviewing, we were sure to recieve someone making a call. Women usually go to visit one another in groups. A woman will go with her daughter, daughter-in-law, mother, etc. Upon arrival a box of sugar cubes is given to the woman host. Drinks and cookies are always provided to the visitors. If the visit is long there will be several rounds of drinks and snacks (almonds, sunflower seeds, cakes, soft drinks, and tea).

Men are visiting during this time also, but in the coffee shops or at the storefront of a relative's or a friend's establishment.

Most interviews were conducted during the "visiting hours". This was the time most suitable to all women. In some cases, however, interviews took place in the mornings or evenings. This occurred when a woman couldn't fit us into her "visiting hours".

Members of our two households would reassemble for the

evening meal. This usually consisted of left-overs from the noonday meal or fried eggs and potatoes. Then the family - men, women and children of all ages - would settle down on mats in the open air courtyard for the evening. Conversations on a multiplicity of topics took place until midnight or so. When the house was cool enough for sleeping, everyone retired for the night.

Evening chats were very enjoyable and at the same time quite valuable to my investigation. It was here that I had an opportunity to hear the men's points of view on subjects I had heard discussed earlier by the women. (I feel privileged to have been part of such discussions, for an "outside" investigator would never have access to this forum that included both sexes at the same time.) During this time I was also able to cross-check and verify the data collected during the interviews. For example, I might ask, "Fatuma said such and such today in the interview. Is this true?" Or, "Do you remember if this happened?"

Occasionally the evening routine was broken when we (the women and/or men) were invited to attend various social gatherings. These events usually begin around 9:00 p.m. and often continue until 4:00 a.m. The days following such events were gruesome, for there was always work to be done starting early in the morning.

MY ROLE IN THE SOCIAL NETWORK

In both Zanqa Sfar and Zanqa Turki I am a member of a specific household. This membership defines the social

network of which I am a part. My kinship status is a given and my roles are well defined. Unlike most ethnographers, I do not have difficulties explaining my presence. I am simply Tarik's wife, Salha's foreign daughter-in-law who executes the household chores adequately and participates in all the social activities. Even so, once the notebooks and taperecorders are brought out explanations are in order.

The concept of studying for a doctorate is not a new one in Mahdia. Men from Zanqa Sfar have gone to France, Italy, and the U.S. to pursue doctoral degrees. (Probably the idea of a greying mother of teenage sons taking on this task seems rather odd. But no one expressed this openly.) There was minimal interest in my personal motivations for doing research. But there was genuine interest in discussing the topics once the conversations/interviews were underway. I think that my presence livened up the summers' "visiting hours", for I asked questions that stimulated thought. Memories were revived. Convictions were expressed. And all of this occurred in the presence of younger family members and friends who could learn from such discussions. The conversations captured the interest of all - men and women, young and old.

Tarik has proven to be a dutiful eldest son, providing emotional and financial support over the years. Letters and phone calls are exchanged on a regular basis. Furthermore, we have hosted two younger brothers who have lived with us for extended lengths of time here in Canada. Such things, of course, are known to the entire extended family and to those

living in both Zanqa Sfar and Zanqa Turki. This reflects well on me. I think it is safe to say that I am considered a "good" wife (at least not a troublesome one), for I have not interfered with Tarik's familial duties.(2)

Friendship, as explained in the preceding chapter, is built upon a series of favours and shared life-experiences, either with members of one's extended family, affinals, or with zanqa members. Through my association with people living in Zanqa Sfar and Zanqa Turki I have developed some good friendships. I knew some of the women when they were children. I've seen them grow up and marry and have children of their own. Some of the women and I were married about the same time and have children about the same age. If nothing else, our similar status in life creates a common bond. We have common recollections of a wedding we've attended together or a circumcision or of times spent visiting. It is with these women that fieldwork was conducted. Some of them were interviewed. Some of them introduced me to other women in other zneq.

Interviews were granted to me for a variety of reasons. Some women were being kind and hospitable to a visitor to her home. Some were curious about me. Others agreed to the interview perhaps out of a sense of obligation. I had visited some of them previously and I had attended some of their ceremonies and paid the rashq. I had also given some of the women small gifts from Canada. But these favors were considered very minor. In reality I was quite aware that I

was pulling on strands of webbing that formed the system of debts and credits that had been built up over the years. Interviews were given to me more as a favor to my affines. As one woman from Zanqa Sfar explained, "I do this because of Tarik. Even as a boy, Tarik was always very nice. And I remember your wedding. . . ." Another woman had been close to Tarik's mother (who died in her early 30's), and did it in memory of her.

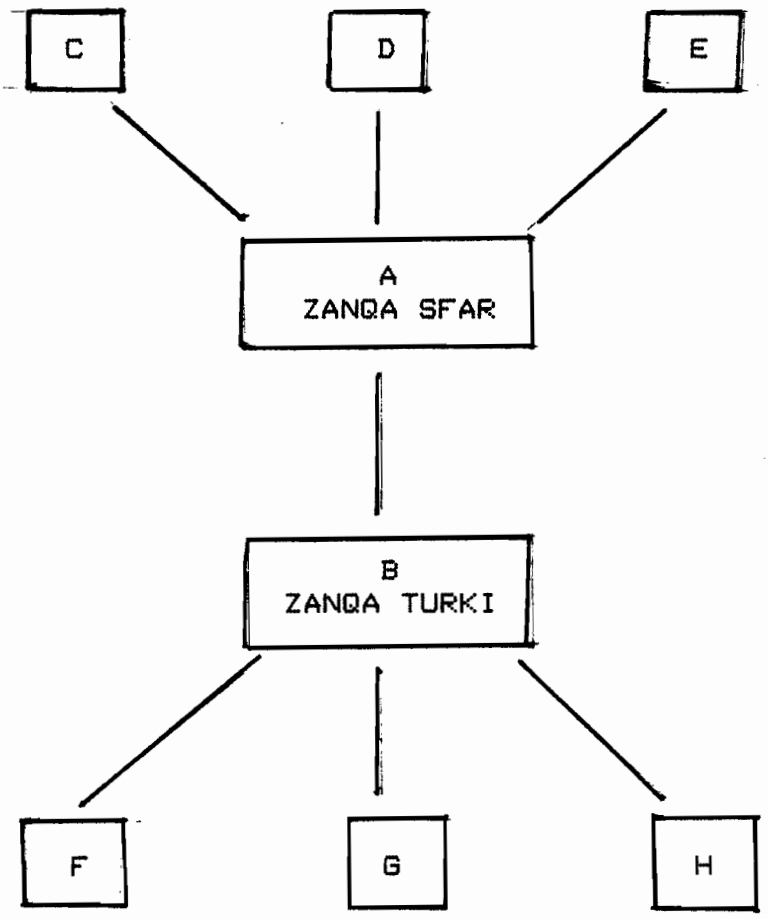
I had not fully appreciated the intra-zanqa social structure in which I was embedded until it was time to arrange for interviews. Relatives living in Zanqa Sfar had relatives in other zneq. Members of Tarik's mother's patrilineage mostly include women who through marriage are scattered around in various zneq. These encompass not only the "contact relative" but neighbors of that relative as well. All together my informants came from 24 extended households spread throughout eight zneq. Diagram A illustrates the way in which Zanqa Sfar and Zanqa Turki are interrelated and in turn how they are linked with other zneq.

DATA COLLECTION

Data was collected by the following means: 1) reading the literature on local history, 2) informal conversations, 3) participant observation, and 4) taped interviews. Much of the findings from the first two means of data collection have been presented already in the chapters describing Mahdia and the zneq. I will now elaborate on the remaining two methods of investigation, including sampling procedures.

DIAGRAM A

INTRA-ZANQA NETWORK



A - B consanguineal and affinal ties
A - C consanguineal ties
A - D affinal ties
A - E affinal ties
B - F consanguineal ties
B - G adoptive "consanguineal" ties (through second marriage)
B - H adoptive "consanguineal" ties (through second marriage)

Participant Observation

From the preceding pages it is obvious that participant observation is a method I used continuously -- almost every waking hour. I participated in the daily routine of cooking, doing the laundry and child care. (Housecleaning is not usually the task of a married woman if there is a young girl available to perform that task. A young girl starts assuming the responsibility for washing the dishes, cleaning the floors and dusting the furniture as early as 8 years of age. This will remain her responsiblity (aided by sisters and perhaps new daughter-in-laws) until she marries and has a young girl of her own.) Although I tried numerous times to help in cleaning, everyone in the household was adamant that this was not necessary because we had someone in the house to do those things. This was Samia (Tarik's niece) and occasionally her unmarried aunt, when she wasn't busy preparing for her trouseau.

Within the household and at social gatherings outside of the house I was a participant observer. Most of my time was spent observing, asking questions as well as working, dancing, singing, eating or doing whatever was expected of me.

Sampling

In preparing for the research project I had initially wanted to use a quota sample. By this means I had hoped to ascertain not only the beliefs about illness and healing but also patterns of health seeking behavior according to differences in age, sex and economic standing. However

getting a quota sample turned out to be more difficult than I thought.

The majority of my informants came from the rather extensive social network I have already described. At first I feared that this sample would be too limited, but I soon realized that within the network there was considerable diversity. This was due to the fact that each of the zneg sampled were heterogenous populations in terms of age, educational backgrounds and occupations. As such I feel that the data collected is representative of a substantial proportion of the Mahdian population. To have stuck with my original idea of obtaining a quota sample would have meant going outside of the social network. This would have been untenable for my female in-laws. An alternative would have been to go door to door on my own, but this would have disgraced my family.

In John Honigman's (1970) terms, I utilized two types of samples: 1) an opportunistic sample - those drawn from the network in which I had solid connections, and 2) a judgemental sample - those individuals who were considered to have specialized knowledge within the network and, in five cases, outside of the network.

The few outside informants contacted posed a great deal of difficulty for my female relatives (mother-in-law, sister-in-laws, and niece). Interviews with external informants were time-consuming to arrange, for they required go-betweens and several trips to explain why the contact was being initiated.

It meant traveling to "foreign" zneg. This usually meant some involvement with our household men, who would be obliged to accompany us and provide transportation if necessary. It meant determining a payment for these informants to whom no social obligations were owed. This was an awkward point because with the exception of hafidet (caretakers of shrines), a standard fee does not exist for talking with a derwish (those who communicate with the supernatural) or an expert on dwa 'arbi. One risks underpaying and then insulting the informant, or overpaying and being ridiculed by family members. The discussion of an appropriate payment took place before and after such interviews. If I had been acting on my own I would have been free to make an inappropriate payment. But in my situation my females relatives, in particular, were responsible for my actions. What I did or didn't do was to some extent a reflection on them.

We did pursue eight individuals in hope of obtaining an interview with them. However we were only successful in getting interviews with five: two hafidet and three dwarish (two males and one female). The three people who refused an interview with us included one specialist in dwa 'arbi (male) and two other dwarish (one male and one female).

There were obvious sample biases, some of which I anticipated from the beginning. First of all males in my sample of interviewees were greatly underrepresented - 4 men as opposed to 35 women were formally interviewed. (All four of them were interviewed by men, in my presence. It would not have been appropriate for a woman to interview a man.) Men

outside of the household were simply inaccessible to me or my female relatives. Occasionally when I was interviewing a woman, her husband would come in, listen to the discussion and add a few points, for example, about a treatment for sore throats or an account of his trip to a shrine. But after he had spoken he quickly left. Even these few instances took place in the homes of Tarik's consanguineal relatives. They knew of my research interests and wanted to contribute. (Sometimes I felt that it was a gesture of support more than anything else.)

The underrepresentation of males in my sample certainly does not mean that men are not knowledgeable or are non-participants in dwa 'arbi or spiritualism. This simply is not the case. I had ample opportunity to discuss dwa 'arbi and hadrat (gatherings where a specific drum beat is played that is intended to induce trances) with men living within my extended household on an informal basis and their interest was obvious. Furthermore, during the interviews detailed accounts of a number of cases that involved the active participation of men -- either as patients, healers or as a parent -- were elicited.

The second bias in the sampling was an overrepresentation of women over the age of 40. At first this was a concern of mine, but as time progressed I came to realize that in fact just such women made the best informants. I had hoped to interview women from different age groups and in different parts of the life cycle. Although I was able

to do this, most of the informants (over 50%) were over the age of 40. There is a good reason for this. Women who have raised a family, experienced the trials of living, and have suffered the loss of loved ones are respected by the young. It is inappropriate and impolite for a younger woman - a daughter, a granddaughter or a niece to speak out authoritatively on a topic on which the older woman is knowledgeable. Younger women were participants in interviews --listening, giving supplementary examples of case studies, etc.-- but clearly their role was secondary. In an attempt to get the younger women's point of view, I approached them when they were alone. But almost always I would be told to talk to their mothers or aunts or grandmothers. They would always tell me that older women could tell me more about these things. (Sometimes I wondered if this was not a gesture of deferrence to me given that I was their senior as well. But this idea had to be counterbalanced by the fact that Samia, my interpreter, was young herself and thus this should not have affected their behavior.) There was only one exception to this pattern, and that was a young woman in her 20's who (while older women were out of the room) discussed at length various cases of the evil eye.

Older women have another advantage that younger women do not, and that is their ability to move more freely throughout the town. They have fewer household chores; often their role is much more supervisory. Their teenage daughters and their daughters-in-law, if they live with them, are available to do more of the work. Not only did older women have more time to

talk with me, but they were also free to go with me to shrines or to seek out other women.

I feel confident that even though my sample draws heavily from women above the age of 40, it is just these women who made the best informants. They were more knowledgeable, more widely traveled (going to different shrines in and around Mahdia), and simply had more experience to draw upon.

The socio-economic status of the informants vary greatly. Some are living as dependents in their son's home, while others own rental properties or orchards. However, the majority of the informants (35 out of 39) live in households that would be considered "middle class" as described in the preceding chapter.

A woman, if she does not work outside of the home, has only a few ways to obtain personal assets: 1) inheritance from her mother, usually in the form of jewelry), 2) inheritance from her father (usually a fraction of his property - either of orchards or a house or a cash settlement), 3) inheritance from her husband if she is a widow, and 4) cash from the sale of handicrafts made at home or money collected at Hennani or thourat. By the time a woman is in her 60's she has quite often had to dip into her assets to pay for her children's education, weddings or illnesses that require additional expenses. Often she sells a parcel of land to her husband or brother or sons, who then promise to always provide a place for her to reside. Clearly women become poorer as they age (as in most parts of the world),

especially after the death of their husbands. At that time the majority of the man's assets go to his grown children. This is not always the case, as explained in the previous chapter. In the end the widow lives with her son(s) and his family. She is well taken care of, but has little or no money of her own. Many of my informants, if not now, will be in this siutation within the next 10 to 15 years.

Interviewing

Taking into account my previous experiences in Mahdia, and after reading the literature, I prepared interview questions that I felt were adequate for obtaining qualitative data on dwa 'arbi (in 1983), and spirit mediumship (in 1984). Upon my arrival in Mahdia (in 1983) my first task was to try these questions out on a small group of women. Questions that were meaningful were used in the final interviews, questions that seemed puzzling were discarded or rewritten. New questions were designed as a result of the discussion that ensued after critiquing the questions and talking about the research project in general.

I brought a copy of Lonnele Aikman's Nature's Healing Arts published by National Geographic. This book illustrates Americans, Chinese, Turks, and others collecting herbs in fields, processing them in kitchens etc. I used this to show the women the sort of thing I was investigating. They seemed pleased to know I was studying this subject, for they wanted me to learn about the efficacy of dwa 'arbi. To do so they had me talk with women who were known for their ability to heal

ailments. I found that in almost every zanqa there were women who had this status. There are some male specialists in dwa 'arbi as well, but they are more difficult to interview. This is true not only because of the separation of males and females, but also because men are more secretive about their knowledge in dwa 'arbi, and they do not give their services free. One such specialist refused to be interviewed by either a male or female.

In 1984, when I returned to the field, I explained that this time I wanted to learn about the healing that takes place in shrines (zawiat). These interviews began a little differently than those on dwa 'arbi. I was asked questions such as the following: "Are you studying to become a Muslim?"; "Are you converting to Islam?"; "When you pray, who do you pray to? God or Jesus or someone else?" Only after they had settled in their mind what this was all about did they begin the interview. (The women whom I interviewed both for dwa 'arbi and spiritualism saw a continuity in the topic and quizzed me less.)

Procedures

As long as the conversations were about home and family matters, I was able to communicate rather effectively within the household and zanqa. But when conversations began to escalate to a higher, more abstract level I experienced more difficulty. For that reason I decided to use a research assistant to translate for me during the interviews. I knew that this would insure a smooth interchange. Fortunately

Samia, Tarik's 19 year old niece, was more than willing to work with me on the project. Samia is majoring in natural science at the University of Tunis and is trilingual in Arabic, French and English. She proved to be an excellent interrogator. She not only posed the questions previously prepared, but in addition she prodded the informants a bit for further information and cross-checked for internal consistency. Of course she was familiar with the various styles of speech and nuances that I would not have been able to "read" had I been conducting the interviews. One style of speech would have probably led me to abandon a number of interviews. That is a common tendency for people to answer initially in the negative. We would ask "What can you tell me about Sidi 'Akmer?" The response might be, "Oh, I don't know much about him . . . . except when I went to see him once when . . . . Another time my brother went to him . . ." The informant may spend 30 minutes talking on this subject even though she started off saying she knew very little. My best informant, a woman living in Zanqa Sfar, had to be coaxed into talking with us. The neighborhood had told us that she was very knowledgeable in dwa arbi, and indeed this was true. But her first response was to say that she knew just a little bit - not too much.

In total 39 people were interviewed on either dwa 'arbi or spiritualism. Five of the 39 were interviewed on both topics. I was present at all of the interviews. I listened attentatively to the informants' discourse and interjected a point now and then and made clarifications if necessary. All

interviews were tape-recorded and normally lasted 90 minutes. Some were as short as 45 minutes and others as long as three hours. As indicated earlier, interviews were scheduled for the "visiting hours" (4:00-8:00p.m.), but sometimes a morning or evening interview was conducted as well. Some interviews were held in my courtyard or in the guest hall in the house adjacent to ours in Zanqa Turki. Others were conducted at the informant's place of residence.

Once an interview was underway one never knew when a visitor might drop in. This happened regularly. When it did the interview continued but with the extra person(s) joining in, contributing their experiences and knowledge. At first I found this situation frustrating, but after the first interview I concluded that the additional women in the room actually enhanced the responses - for one person's experience or knowledge triggered the other person's memory and the interview evolved into a lively discussion to the enjoyment of all. An added benefit to this approach is that any temptation to fabricate or exaggerate was stultified for the other women in the room would be quick to point this out. I am convinced that the amount and quality of the information ascertained through this method was greater than had we interviewed the women individually.

At the end of an interview it became clear that there was usually a dominant (sometimes two) speaker in the interview. These I have designated as primary informants. In most cases these are the women we arranged to see originally

because of their reknown on a particular subject - either dwa 'arbi or the workings of the saints and jnun(spirits that live underground). Visitors or younger female relatives became secondary informants - adding extra information and describing cases unique to them.

There were no objections to me taping the interviews. It was understood that these tapes would be translated later. I made a point of asking each informant if she wanted to hear the tapes replayed. Some did and found hearing their voice amusing. One woman wondered if her interview would be aired on radio. The tapes were later translated into English and transcribed.

I think that this is a valuable means of collecting data. One can never get all the information when listening first hand. One's attention is often drawn elsewhere -- to other sounds, visual diversions, etc. But later upon listening to the tapes or reading the transcribed texts one has the opportunity to review what was said several times if necessary.

Objective

The purpose of conducting interviews was twofold. Primarily I was interested in collecting qualitative data on people's etiology of illnesses, their ethnomedical practices, and the cognitive bases of those practices. Secondarily I hoped to ascertain some quantitative data on the health seeking strategies used in sickness episodes. To this end I obtained a substantial amount of case material with which to

work.

The framework for my interviews was basically the same for both topics. The interviews on dwa 'arbi stayed within the limits I had anticipated. Interviews on spiritual healing were more diffuse. A number of case studies involving healings via the saints were obtained. Also additional information was elicited on divinatory powers of intermediaries (living and dead). And finally a substantial amount of data was collected on the evil eye.

Interviews began with a short set of questions regarding the informant's age, residence, amount of schooling, personal income, and number of children. Then the informant was asked an open-ended question - a question designed to elicit a rather lengthy response. Here it is important to note the direction the informant chose to pursue. This in itself I think is revealing and worthy of analysis. Thus in the dwa 'arbi interviews the first question would be: "Can you tell me about any illnesses that you or your family have had that you treated at home?" The informants would respond by naming specific illness episodes. They would then be encouraged to expand on each of those episodes regarding the treatment procedure, whether or not an external specialist was consulted, the outcome, and the probable cause(s) of the illness.

In the case of interviews dealing with saints and evil eye the opening question would be: "Do you ever attend hadrat (gatherings wherein music is played and trance behavior may occur) at zawiyat (shrines)?" "Do you go to zawiyat for other

reasons?" To this opening question informants would describe their visits to zawiyat explaining which ones they usually go to, on what occasion they go there and with whom.

In all interviews the informants were encouraged to discuss actual cases rather than hypothetical ones. In this way I felt I was getting more concrete data and also data that could be verified with other informants.

After this initial unstructured beginning, which would take up about one third of the interview, the line of questioning would focus in on more specific types of inquiry. For example, dwa 'arbi informants were asked to talk about specific illnesses that they hadn't already mentioned. In interviews regarding saints, jnun and the evil eye, more detailed questions were posed such as "who is most likely to be attacked by jnun or the evil eye?"; "do hadrat always have to be held at a zawiya, can they be held at home?," etc. In some cases the informant had already answered these questions in the preceding discourse. Sometimes new areas were pursued on the basis of something the informant had mentioned in the first part of the interview.

A FINAL NOTE

My fieldwork took place under the umbrella of male domination. This factor always had to be reckoned with. Generally interviews went pretty smoothly, but there were instances where interviews were severed abruptly because the patriarch of the house had something for the woman to do. These interviews were continued on another day.

Within my household the entire family was sympathetic to my research endeavors and helped me in numerous ways - both the women and the men. Even so, routine tasks performed by the women always took precedence.

One evening there was a lengthy discussion as to whether or not I should be allowed to attend a _hadra_ at Sidi 'Akmer (a _zawiya_ about 50 kilometers from Mahdia)on the eve of 'Id al-Kabir. (3) (This was a hypothetical question in 1984 for it did not fall within the summer months. But within the next few years it will.) Tarik's aunt argued vehemently on my behalf. She declared that since I want to learn about these matters I should go. I am a Muslim, she said, by virtue of being married to Tarik. She said that she would stay with me and take care of me. The men (two cousins) said absolutely not! It wasn't a safe place for any woman, and especially not a foreign one. For sure Samia, being a young unmarried woman, would not be allowed to accompany me. Tarik could go to Sidi 'Akmer with me, but once there we could not stay together. Men and women eat and sleep in different areas, and during the _hadra_ itself the women stand to one side. One thing everyone agreed upon - the decision would be made by the men in the household.

PRELIMINARY DATA ANALYSIS

Analysis of the data has been continual. While in the field I kept careful notes on what was happening around me. My notes consisted mostly of questions, the answers to which I

have tried to obtain. Particularly interesting interviews were discussed with family members, as mentioned earlier. This was quite valuable in bringing the data into better focus.

Once home the translating and transcribing began. I was pleasantly surprised to find the immense amount of data compiled. Much of it was repetitive, but such repetitiveness is indicative, as far as I am concerned, of a normative pattern. In addition I have sufficient data to pinpoint variation from the norm - an important contribution to a comprehensive study.

Topics raised in the interviews were coded and categorized. During this process cognitive patterns began to emerge that appear to underly actual behavior -- both stated and observed. We shall now turn our attention to those symbolic and behavioral patterns.

FOOTNOTES

1) Soulayimiat are socio-religious meetings that are attended by both men and women, but men are the only participants. Women remain in the inner rooms listening and peeping through curtains at the activities. Professional singers are brought in and they spend the evening singing religious songs.

W'adat are socio-spiritual gatherings. They may be attended by both males and females (although they are separated in different rooms) or they may be attended by just women. The latter is probably more common. W'adas are held at shrines (zawiyas) in honour of the saint who granted a wish. (In the next chapter, this will be discussed at length.)

Msawid are gatherings primarily for men, but occasionally women are invited as well. The inclusion of women is a more recent trend. Unlike the soulayimiat, msawid are a purely social occasion where songs are sung by both

professional singers and the participants. The songs are about love, about funny tales, folklore, etc. Men will dance, one or two at a time, for the audience's enjoyment.

2) It is difficult to know exactly how I am perceived by my family in Mahdia. My in-laws are extremely nice to me and the children. But I am sure that I am considered "different" - different in a number of ways. Relative to Tunisian women I am probably perceived as rather dull. My clothes are plain and I wear little, if any, jewelry or make-up. (This has been pointed out to me.) Furthermore my demeanor is relatively quiet. One woman said to me once, "You are not like me, you never scream and shout at your children when they have been bad - you just send them to bed. I get too angry." (Of course, she wasn't privy to my quiet lectures and threats that accompany this type of punishment. If she had been she might have had a different picture of my "gentleness".

Ideally women, especially in public, are expected to be quiet and reserved. This speaks well of their family. Young women who before and after marriage behave in this way receive approval from observers. Thus my behavior 20 years ago (by chance) was appropriate and noted as such. But as a woman gets older and has several children, and has perhaps acquired some financial independence as well, her quiet demeanor changes. (I have noted the change in individuals over time.) Most middle aged and older women are far from quiet, especially when in the privacy of their own homes. In the zanqa street and at social gatherings these women are the ones who provide the excitement, the drama, the fun. I am afraid I myself haven't been able to change that radically.

3) The possessed are brought to the hadra that is held at Sidi 'Akmer. Families bring their "sick" relatives here in search of a cure. Many of the possessed (and unpossessed as well) go beserk. Their behavior is often violent and unpredictable. For this reason it is considered unsafe, and generally women are not allowed, by either their fathers or their husbands, to go there. However once a woman is widowed and is free of any responsibilites towards her children she is able to do as she pleases - and that often includes going to various zawiat throughout the country.

PART TWO

CHAPTER FIVE
THE NATURAL AND SUPERNATURAL SPHERES IN HISTORICAL CONTEXT

INTRODUCTION

Tunisian folk medicine treats three categories of illness: 1) marḍ rabeni, natural illnesses which "God permits", 2) marḍ min tebt idihum, illnesses caused by the jnun, and 3) yakhuda bin nufs, illnesses caused by the evil eye. (Foster, 1977) Thus the etiological framework includes two spheres - the "natural" sphere which includes God-approved illnesses (or sometimes expressed as God-given illnesses) and the "supernatural" sphere which includes illnesses caused by spirits or the evil eye. The delineation between these two spheres was clearly articulated by those interviewed in Mahdia.

In Chapters Six and Seven I have taken the liberty of further subdividing each sphere into categories which are implicit in the informants' responses. Within the natural sphere, for example, one finds illnesses caused either by physical injury and disorder, God specifically or by an imbalance in bodily elements (blood, air, food, dirt). In the supernatural sphere illnesses are attributed to spirits or to a malevolent force emanating from people possessing the evil eye. The meaning of the illness categories and the ethnomedical practices obtained from data collected in 1983-84 will be discussed in those chapters. However, before moving on to that analysis it is useful to provide the historical context within which Tunisian folk medicine emerged. In this chapter the ideological and institutional precedents that have

been influential in structuring the cognitive bases of Tunisian folk medicine will be documented.

ANTECEDENT TO THE NATURAL SPHERE - ARAB MEDICINE

The Origin and Development of Tibb al-'Arbi

Tibb al-'Arbi (Arab Medicine) (1) evolved from a synthesis of the humoral medical traditions of ancient Greece (primarily), Persia, India and China and to a certain extent, the Prophet's medicine (tibb annabi) collected in the hadith (traditions and sayings of the Prophet Mohammed). These traditions culminated during the Abbasid Period (750-850 A.D.) at the school of Jundi-Shapur.

The school was founded during the Sasanian rule prior to the time of Mohammed's birth. (Browne, 1921) During that time Greek, Syrian and Persian scholars gathered to translate the medical texts developed in each of their homelands. The school continued to exist during the Arab conquest and became quite prominent during the Abbasid Period. During the "Age of Translations" Greek treatises by Galen and Hippocrates were translated into Arabic (sometimes via Syriac or Persian) as was the Araka-Samrhita, written by the Indian scholar Susruta who lived about 400 A.D. (Ullman, pp. 19-20) These works provided the basic theories of physiology, anatomy and pathology of Arabic medicine. The pharmacology of tibb al-'arbi was particularly influenced by Persian medicine and, to a lesser extent, by Indian and Chinese traditions. (Browne, pp. 19-32;106-109)

It would appear that the influx of various medical

practices did not stop at translating the ancient texts. According to letters written by Rashid the Physician (Rashidu'd Din Fadlu'llah, born 1247 A.D.), practitioners from different regions were drawn to Tabriz. In a description of the city Rashid states,

> Fifty skilful physicians had been attracted thither from India, China, Egypt, Syria and other countries, to each of whom were assigned ten enthusiastic students with definite duties in the hospital, to which were also attached surgeons, oculists and bone-setters, each of whom had the charge of five students. All these dwelt back of the hospital, near the gardens and orchards of Rashidabad. (paraphrased by Browne,p.109)

Simultaneous to the translating activity during the 8th and 9th centuries, the teachings of the Prophet Mohammed, which had been part of the oral tradition for approximately 100 years, were being written down and canonized into the hadith. Al-Bukhari (died 879 A.D.) amassed many of these sayings into a collection called Sahih. Some of the passages deal specifically with health care. The Prophet's medicine (tibb annabi) reflected the bedouin culture of Saudi Arabia. For the most part, the sayings deal with preventative medicine. Attention to diet is particularly important, not only in preventing illness but in curing certain ailments. (Burgel,1976; Said,1976)

Arab medicine evolved from the amalgam of humoral medicine (diffused from various cultures) and the Prophet's medicine. This amalgam was spread throughout the Islamic empire, which at its height extended from southern Spain to Indonesia. The degree to which these two medicines were

incorporated into one is debated by some historians. For example, Burgel (1976) is convinced that a dualistic medical system was perpetuated by scientists and religious zealots. Said (1976) and Gallager (1983), on the other hand, suggest that the Prophet's medicine and humoral medicine complemented one another, eventually fusing into one medical system.

I would argue, however, that unique medical systems emerged in various regions once ruled by the Islamic caliphs. In India, for example, the Unani tradition ("unani" being derived from the Arab word meaning Greek) has continued to exist up until the present. Its emphasis is on the humoral etiology. In other areas tibb annabi continued to be revered as the only medical system sanctioned by God. More often than not a certain degree of diffusion between the two systems must have occurred. (I have arrived at this position after analyzing the data collected on dwa 'arbi.) Burgel himself states that,

> The basic theory of Bedouin pathology was evidently all diseases were ultimately caused by a disorder in the stomach, by wrong nutrition or indigestion. Reasonable nutrition was therefore the chief prophylactic against falling ill, and diet the best remedy for sickness. However, the leading role this saying came to play in medical literature might be based on the fact that it was closely related to the central Greek idea of symmetry. The same relation could have helped a verse of the Koran to a similar importance. It was, 'Eat and drink, but do not yield to excess!' (surah 7,31)(Burgel, 1976, p. 57)

In any situation of acculturation, compatible ideas, patterns of behavior or material goods are readily diffused. Both tibb annabi and tibb al-'arbi are concerned with

maintaining a balance through the ingestion or exculpation of various substances. Thus each medical tradition could be adapted by the other. Furthermore, as indicated in the Tunisian case described below, schools of medicine were usually an extension of mosques where relgious study took place. Thus, Arab medicine would undoubtedly draw from both tibb annabi and tibb al-'arbi. In the description of dwa 'arbi in Chapter Six, it is evident that remnants of both tibb al-'arbi and tibb annabi have fused. For example, one finds an emphasis on dietary means of preventing illnesses (coming from the hadith) as well as reference to humours, such as blood and yellow bile.

The contributions made to medicine during the florescence of the Islamic Empire would be felt in Europe and elsewhere for centuries after the Empire's demise. This is due to the vast literature that was written during this period and its dissemination into Europe. The first major book written on Arabian medicine was entitled Firdawsu'l-Hikmat (Paradise of Wisdom) by Ali ibn Rabban in 850 A.D. Physicians who authored texts following Rabban included: al-Razi (author of al-Hawi) who is known for his detailed clinical notes describing symptoms, treatment and results; al-Majusi (author of Kitabu l-maliki) who criticized Hippocrates and Galen and provided an etiology of disease causation; and, the most famous, Ibn Sina, known as Avicenna in Europe (author of Qanun), who compiled earlier works into organized treatises. (Browne, 1921)

The Qanun was translated into Latin and printed in Rome

in 1593. It became the primary medical text for medieval European medicine. Along with the Qanun, the Materia medica of Dioscurides, also based on Arabic medicine, was the authority for pharmacology in Europe up until the 19th century. (Plessner, 1974)

Basic Tenets of Tibb al-'Arbi

Arab medicine is based on the principle that the universe is composed of four primary elements: fire, air, water and earth. Primary elements can be found in all things, although not in their pure form. For example, fire is found in hot substances. Humans have a mixture of these elements within their bodies. The mixtures (humours) are manifested in yellow bile (which is formed in the gall-bladder), black bile (which is formed in the spleen), phlegm (which is formed in the veins), and blood (which is formed in the liver).

Although everyone possesses the four humours, usually one dominates, resulting in a particular personality or temperament. Thus a person with a sanguine temperament is said to have a dominant blood humour which is a blend of wet and hot elemental substances.

Browne (191, p. 119) explains that "mizaj" is a word used in Arabic, Persian and Turkish meaning "health". It is derived from a common root, meaning "to mix". Thus if there is an equal mixture of the natural humours within the body there will be good health. Illnesses are attributed to humoural imbalances, or inhinafu' l-mizaj meaning "deflection of the tempermental equilibrium" that may be caused by

inappropriate diet, exercise, anxiety, fear, anger, etc. Treatment is based on an oppositional principle. The purpose of treatment is to exculpate excess humours (via vomiting, excretion or surgery) or to ingest a counteracting substance (i.e. "hot" substances if the imbalance is due to an excess of "cold" substances). In prescribing treatment, however, the healer must consider a number of variables reflecting concern with cosmic influences. Amin Khariallah, an Arabic historian, points out that "The temperaments differ in the different seasons, regions, ages, individuals and organs. Hence, in the treatment of disease the physician should take into consideration the age of the patient, the organs affected, the season of the year, and the region where the patient lives." (Khairallah, 1946,p.78)

Melancholy, for example, in tibb al-'arbi is seen as a manifestation of an excess in the production of black bile. People born with that dominant humour are characteristically melancholic. Others, however, who are temporarily suffering from melancholy are producing an excess of black bile caused by over-eating, lack of exercise, uncleanliness, fear, annoyance or anger. (Ullman, 1978)

One was advised to keep a balanced lifestyle. In order to do this al-Majusi, a reknowned Arab doctor of the ninth century, claimed that the quality of six essential "non-natural things" must be maintained: 1) the air around us, 2) movement and rest, 3) eating and drinking, 4) sleeping and waking, 5) natural excretion and retention (this includes

bathing and coitus), and 6) the soul's moods - joy, anger, sadness, etc. If these "non-natural things" were used in the right way, according to al-Majusi, they would preserve the humours and pneumata. (The pneumata is that which "organizes and breaks down the material". (Ullman, p. 62-63)) If these "things" were not used properly they would drive the body out of its natural (balanced) condition. Ibn Ridwan's (998-1067a.d.) major treatise, On the Prevention of Bodily Ills in Egypt, reaffirmed that there were six "causes determining health and illness", and he elaborated upon the six identified by al-Majusi. In particular, he explained how Egyptians could best prevent illnesses by counterbalancing harmful "bad air" and being careful about consumption patterns, exercise, etc. (Dohls, 1984, pp. 89-98)

"Innate heat", the essence of life, was believed to come from the heart. It was believed that if proper behavior was not observed one could set the "innate heat" in motion, creating an excess of humours and/or vapours - vapours coming from the humoural excesses. Illness (the "extra-natural things") would be the expected result. (Ibid., pp.72-75)

The Decline of Tibb al-'Arbi

The decline of Arab medicine as practiced by al-Razi, Ibn Sina and others coincided with the political events of the 13th to 17th centuries.(2) During that time the Islamic Empire itself collapsed due to a variety of reasons. There were number of factors that contributed to the fall of the Empire. First, the Mongol invasion, which was particulary

devastating to the centers of learning in Iraq, Iran and Syria. In their siege the Mongols destroyed hospitals, libraries and schools. Second, the Mongol invasion was followed by Mamluk and Turkish rule. This led to the decentralization and regional independence of those areas remote from the Levant-Egypt area. This disunity discouraged the flow of information that existed during the earlier years of the Islamic Empire. Third, the economy which had been based on an active commerce fell into a feudal economy based on subsistence agriculture. Again this change resulted in regional differentiation. (Lewis, 1966)

Tibb al-'Arbi in Tunisia

Dr. Ahmed Milad's book entitled The History of Tunisian Arab Medicine (1980) outlines the development of Arab medicine in Tunisia. The author explains that there were three periods in Tunisian history where advances were made in medicine: 1) The Kairouan Period (900-1057 A.D.), 2) The Tunis Period (1350-1553 A.D.), and 3) The French and Post - Independence Period (1881 - 1980 A.D.) Tunisia was the scene of warfare between the Kairouan and Tunis Periods and was occupied by the Turks from 1553 to 1881. During these hiatuses Arab medicine was in a state of abeyance.

Kairouan was founded in 670 A.D. during the Arab conquests. It was a military outpost at first but soon became a religious center to which many scholars migrated. By 900 A.D. there were two schools - the Maliki (a religious school) and the School of Medicine. In the founding years the School

of Medicine was staffed by Muslim and Jewish doctors who had immigrated from Bagdad and elsewhere in the Middle East. They brought with them the translated Greek, Syrian and Persian texts. In time Tunisians were trained in medicine and they made their own contributions. Doctors at the School of Medicine tended patients at a hospital in Kairouan, and collaborated with doctors establishing themselves in Tunis (at the al-Zaytuna mosque).

During the Kairouan period a number of books were written. Those that became reknown were written by Omarin, Soulamin, El-Jazzar, to mention a few. Isaac Ibn Omarin wrote a book describing the causes of melancholy and anxiety. He gave advice on how to avoid those conditions. Isaac Ibn Soulamin (died 953 A.D.) wrote a three volume treatise on the importance of diet, in particular the benefits of nuts, meats, grains, fruits, flowers and herbs. He also wrote two diagnostic books, one explaining the way in which urine could be used in diagnosis and another describing the diseases characterized by fevers. A Tunisian born doctor, Ahmed Ibn El-Jazzar (died 979 A.D.) wrote The Package of the Traveler, which was translated into Greek and Italian during the 11th century. (One chapter in Ibn Ridwan's On the Prevention of Bodily Ills in Egypt is a critique of El-Jazzar's assessment of Egyptian health conditions. (Dohls, 1984) This indicates the degree to which there was communication between medical scholars of the day.)

In El-Jazzar's works, as well as others, the Tunisian influence can be gleaned. Scholars during this period studied

the indigenous medical system. They discovered that much of the tibb arrani (folk medicine) had already been infused with the humoral etiology of the Greeks. This was the result of earlier contacts with the Romans. It appears, however, that the pharmacopoeia used by the Tunisian practitioners reflected the North African floral and faunal environment. The Kairouan scholars of this era collected the medicines and therapeutic practices used in tibb arrani and compiled them in a number of books. Some of the indigenous medicine was incorporated into the Arab medicine eventually. Thus, Milad argues, a Tunisian variety of Arab medicine was born. (Ibid.)

Milad explains that after the invasion of the Beni Hilal tribe (1057 A.D.), followed by the Norman conquest (1091 A.D.), Kairouan became isolated from the coastal areas and thus lost its influence on the outside world. Some medical schools continued their work, for example in Tunis and in Mahdia. But the period of growth had ended.

There was a resurgence in Arab Medicine during the period from 1350 to 1553. Tunisia acquired international fame for its contributions to sciences and, in particular, to medicine. The learning center was the al-Zaytuna Mosque, where conferences and lectures were held regularly. It was here that famous people such as Ibn Khaldun, Dr. Ibn Arafat and Dr. Ahmed Skelly gave lectures to their students.

During this period health care was widely available. Dispensaries were located in various towns. Hospitals were established in Sousse, Sfax and Tunis. (The hospital in El-

Hafsi (Tunis) still exists. It is said that Dr. Ahmed Skelly practiced there.) Quarantines were built in Tunis. In addition to these facilities, 35 health spas existed in Tunis - the most notable being Hammim Leaf and Hammin Korbous. (Ibid.)

In 1553 Tunisia became part of the Turkish empire. This led to a decline in the health care delivery system. At the beginning of the Turkish rule all dispensaries and hospitals outside of Tunis were closed. Most of the hospitals in Tunis were transformed into military institutions. Medical training fell into an apprenticeship arrangement whereby young practitioners would learn from doctors who had had formal educational training. Even so, Arab medicine remained the prominent medical system until the mid-1800s. Its legitimacy was insured by the fact that the bey (the Turkish ruler of Tunisia) always kept a doctor trained in Arab medicine in his court. 'Ali Bey in 1754 summoned the services of an Italian doctor, Joseph Curillo. He stayed and apparently began the precedent of having two physicians within the bey's court - one European-trained and one trained in Arab medicine. (Gallagher, 1983)

Some hospitals were built by the Turks. El-Aselfein Hospital, erected in 1661, was built as a military hospital. It later became a public facility. Corstan Hospital, built in 1759 A.D., was transformed into a military barrack in 1846. Finally, El-Sadiki Hosital was completed in 1879. This 100 bed hospital was well equipped and served the needs of the local people. These hospitals were built in Tunis, and thus

what health care was available was limited to the capital.

The chief doctors (amin al-atibba) of Tunisia were established in hospitals in Tunis. They maintained a close liaison with the bey and his administrators. It was through these connections that funds were made available for the maintenance of the few hospitals remaining. Funds were also obtained through private wagfs (religious endowments).

The amin al-attiba issued ijazet (certificates of competence) to practitioners who could demonstrate their ability. In some cases practitioners presented signatures of patients treated. In other cases the applicants were given tests. Apprentice-trained practitioners continued to be issued ijazet through the 1860s. During that decade, however, the first European - trained doctor (Dr. Lambroso from Italy) to replace the amin al-atibba as medical licensor. This symbolized the growing acceptance of the European medical system by the ruling authorities. (Ibid.)

As a result of a border dispute between Algeria and Tunisia, the French took control of Tunisia in the late 1870s. By 1881 Tunisia officially became a protectorate. French missionaries and hospitals were already established. Through these institutions biomedicine was introduced into the country. By 1888 the colonial government articulated its policy regarding tibb al-'arbi practitioners. Nancy Gallagher (1983 p.93-94) states,

> Indigenous and European empirical medicine was legally curtailed by the decree of 15 June 1888, which regulated medicine, surgery, and obstetrics. It declared that all persons who had

practiced medicine for five years or less in Tunisia had to prove that they had completed at least three years of medical school. Each additional year was equivalent to a year of practice. Indigenous practitioners under sixty years of age who had practiced for at least twenty years were allowed to continue without an ijaza, but could not perform surgery.

The days when European doctors sought to stay on good terms with the amin al-atibba' to avoid trouble were gone. Now, indigenous doctors such as Hamda b. Kilani, son of the former amin, were classed as medecins toleres. Members of the new medical elite were licensed only in Europe. Italian doctors continued to predominate until the early twentieth century, when there were about twenty French doctors. By 1928 there were only ten French-trained Tunisian doctors in Tunisia. The majority of the licensed French, Italian and Tunisian doctors practiced in Tunis.

Health care for the most part, then, was left to the informal sector of society. This situation continued well into this century. This fact certainly is corroborated by my informants, who recall a time when there were no doctors available, and thus dwa 'arbi was the medical option for natural illnesses (mard rabeni).

As pointed out by Nancy Gallagher, up until the last half of the 19th century neither Arab medicine nor European medicine (which was, in fact, derived from Arab medicine originally) was able to successfully treat the epidemics of plague, cholera and typhus that swept the Mediterranean area. Notions of contagion and the importance of sanitation were shared by both medical systems. (Quarantines were utilized throughout the Arab and European world. However, when quarantines began to interfere with trade, Europeans coerced the Tunisian beys to ease their quarantine requirements of

incoming merchants.)

European medicine did have something new to offer after the germ theory became an accepted theory of disease causation. This concept revolutionized European thinking about medical problems and the way in which it was practiced. The efficacy of European medicine was eventually acknowledged by the Arab doctors in Tunisia. The best example of this is Khayr al-Din's book, The Surest Path, wherein he designs a sanitary program for the city of Tunis. In this work he cites numerous achievements accomplished by the European medical community. (Ibid., p. 90)

Nancy Gallagher, however, argues that European medicine was not simply accepted on its own merit. More important, medicine was used by the French to gain political control of Tunisia. She states,

> European medicine became an integral part of the French mission civilisatrice as it had earlier been a part of foreign policy, facilitating political influence and economic expansion. The Revue tunisienne (1905) observed that 'the doctor is the true conqueror, the peaceful conqueror .... It follows that if we wish to penetrate their hearts, to win the confidence of the Muslims, it is in multiplying the services of medical assistance that we will arrive at it most surely.' A 1904 essay on French medical assistance in Tunisia claimed that 'nothing serves better our influence than the medical institutions and with the aid of doctors, one does a good work for humanity which is also good for France; it is double profit.'. . . .
>
> By the beginning of the twentieth century two myths had become cornerstones of colonial history: the myth of Muslim fatalism and the myth of European medicine coming to the rescue. Actually, in Tunisia the beys and Muslim reformers had tried to follow those procedures they thought most apt to succeed in disease defense, regardless of their cultural or national origin. The Tunisian authorities hoped to learn from the European medical expertise how better to deal with epidemics, the consequences of which

> were, ironically, exacerbated by the European impact. They did not intend to lose their power to foreign occupation as part of Europeanization. Following the occupation, however, the French government was able to legislate medical reform on its own terms and to propagate its own ideology of the role of medicine in the colonial process.(Ibid.,p.95-96)

The French government established biomedical institutions such as hospitals, pharmaceutical manufacturing, the Pasteur Research Institute and the School of Medicine at the University of Tunis. Through this process biomedicine became the professional medical system. Without financial support from the government to maintain the Arab hospitals or any mechanism to train new practitioners, tibb al-'arbi lost its status as a professional medical system. It was considered folk medicine by the colonizers.

Evidence Revealing the Tenacity of Tibb al-'Arbi

There is not a great deal of literature on the practice of Arab medicine during the 20th century. Much of what is available comes from works written at the turn of the century or shortly after. For example, Edward Browne observed in 1887 that the majority of physicians in Tehran were practicing "Tibb-i-Yuanani". By the early 1920's the practices of tibb al-'arbi was still in evidience. (Browne, 1921)

Writing at the same time, Hilton-Simpson investigated the medical practices of the Shawiya in the Aures of Algeria. Here he found evidence of practices that drew from the principles of Arab medicine. This was particularly true in terms of disease etiology and treatments including drugs, herbs and prescriptive diets. Herbs were prescribed in

reference to the hot, cold, wet and dry elements. Furthermore, many of the healers possessed medical reference books handed down over the generations that outlined the basic tenets of Arab medicine. Hilton-Simpson did note, however, that the surgical practices which included removing bones from limbs, trepanning, bone implants and many others could not be found in the medical literature of Arab medicine and thus reflected an aboriginal medical practice.

More recent works by Good (1977) and Morsy (1980b) reflect the perpetuation of the Arab tradition, not in specific practices but rather in the cognitive perception of illness and health. Morsy (1980b) reports, for example, that notions of conception, "good eating", and illness causation are defined by body-environment interactions in the village of FatiHa in Egypt.

Byron Good, while analyzing the semantics of illness in Iran, also found that Western medicine exists alongside what he called the "Galenic-Islamic" medical tradition and the sacred medical tradition (which refers to curative Koranic prayers given to the patient by mullahs). He states that "traditional medicine continues to flourish in the popular sector, (but) traditional health specialists constantly fear suppression of their practice." (Good, 1977, p.29) He suggests that the three systems constitute a popular medicine that "provides a language, passed on from generation to generation, in which people voice their experience of disease". (Ibid., p. 30) He is particularly interested in

showing the relationship between "medical language and disease". For example, he brilliantly analyzed the multiple meanings of "heart distress" and demonstrated how such references interrelated with sociocultural factors. The heart, it should be noted, is of prime importance in tibb al-'arbi being considered as the machine of the body. (The heart among FatiHa villagers in Egypt was also conceived of being the most important center of the body. (Morsy, 1980b))

It must be concluded, then, that the etiology of tibb al-'arbi operates at various levels within the popular sector in Islamic societies. Based on the data collected in Mahdia, I feel there is strong evidence indicating that the folk medicine being practiced in Mahdian (as well as other Tunisian) homes is based on the tenets of tibb al-'arbi. Despite the fact that it is not formally institutionalized, it plays an important role in the diagnosis and treatment of illnesses that occur within the family setting. It was on this assumption that I began to investigate the treatment practices and etiology of dwa 'arbi, which incorporates the natural sphere of Tunisian folk medicine. (This will be discussed in the following chapter.)

ANTECEDENTS TO THE SUPERNATURAL SPHERE

Two types of illnesses are attributed to supernatural causes -- illnesses caused by the evil eye and jnun-related illnesses. Beliefs about jnun (spirits who live underground) and the evil eye have a long and well-established tradition throughout the Mahgreb as well as elsewhere in the Middle East

and parts of Europe. These beliefs predate the emergence of Islam and have been absorbed, if not into the religion itself, at least into the daily life of its adherents.

In this section early beliefs regarding the evil eye and the jnun will be described. In addition North African Sufism, a mystical tradition in Islam, will be discussed. Each of these beliefs has influenced the cognitive structure of the supernatural sphere that exists in today's Tunisian folk medicine. They are presented in the same chronological order in which they are believed to have first appeared. An analysis of how these beliefs are utilized in illness episodes will follow in subsequent chapters.

The Evil Eye

An evil eye is an envious eye. People possessing the power of the evil eye have only to look at a person or object with envy and, in doing so, cause harm to the focus of envy. If they should accompany their gaze with words of praise the effects can be more serious. Thus the evil eye is an ominous malevolent force that can strike at anytime.

The evil eye belief system is unlike sorcery/witchcraft (3) in two important ways. First of all, the possessor of the evil eye does not willingly cast his/her spell. Simply an envious look can effect a curse - a curse that may, in fact, not be consciously wished by the person with the evil eye. Secondly, the person with the evil eye does not require any paraphenalia to unleash his/her evil power. It is believed that the power is, in fact, innate.

Belief in the evil eye has considerable depth historically and breadth cross-culturally. According to Leonard Moss and Stephen Cappanari, this belief can be traced back to ancient Babylon and ancient Egypt wherein the eye was symbolic of deities: "Eye of Ra, Eye of Atum, Eye of Osiris, Eye of Horus, et." (Moss and Cappanari, p.2) They go on to say that "The innovation of the eye of God, in the form of an amulet affords protection from known and unknown evils. The homeopathic use of the eye was practiced by ancient Egyptians, Etruscans, Greeks and Jews. Such amulets are frequently found in contemporary Mediterranean cultures." (Ibid. p.3)

The belief has diffused widely spanning societies from Scandinavia to the Philipines, all having different cultural and religious orientations. Its greatest concentration is in the Mediterannean area. Moss and Cappanari conclude that "the evil eye is probably one of the oldest continuous religious constructs in the Mediterranean basin." (Ibid.,p.13)

A cross-cultural analysis of belief in the evil eye is striking in its consistency. In Maloney's The Evil Eye, twelve cultures having the evil eye ideology were compared. From these, seven common feaures could be discerned:

1) power emanates from the eye (or mouth) and strikes some object or person,

2) the stricken object is of value, and its destruction or injury is sudden,

3) the one casting the evil eye may not know he has the power,

4) the one affected may not be able to identify the source of the power,

5) the evil eye can be deflected or its effects modified or cured by particular devices, rituals, and symbols,

6) the belief helps to explain or rationalize sickness, misfortune, or loss of possessions such as animals or crops,

7) envy is often a factor.

Focusing on North Africa, one finds each of these factors, both in the historical literature and in the present day context. For example, Westermarck (1926), Lane (1908) and Blackman (1926) described various protective magical objects such as blue beads, blue amulets, Koranic charms, red henna, jewelry with eye-like designs, and a representation of the hand - all of which were used to reflect the effect of the evil eye. Likewise, protective rituals such as repeating utterances from the Koran, burning incense and breaking a piece of pottery in the presence of a person suspected of having the evil eye or in large social gatherings (where some of the guests were strangers) were reported at the turn of the century.

Whether or not the evil eye is mentioned in the Koran is debated by Islamic scholars. (Spooner, 1976) Some use the following passage from the Koran to support their position that belief in the evil eye is part of the Islamic tradition:

> In the Name of God, the Merciful, the Compassionate Say: "I take refue with the Lord of the Daybreak, from the evil of what he has created, from the evil of darkness when it gathers, from the evil of women who blow on knots, from the evil of an envier when he envies. (Sura 113)

In Mahdia many told me that the evil eye was discussed by the Prophet himself. They state that in the Hadith

Mohammed said that "the evil eye is real, but the bird of doom is not." (I will discuss this proverb later.) This proverb was repeated to me often with the conviction that the evil eye is the source of many ailments.

For the most part, the evil eye belief system has been treated in the literature as an exclusive unit of culture. Thus the belief in the evil eye and the precautions taken to prevent an evil eye curse have been described variously. Michael Herzfeld argues that studies of the evil eye belief system have failed to place the belief system in context. He suggests that through a semiotic approach the phenomenon of belief in the evil eye can be better understood. In his analysis of the Greek community of Pefko he concluded that being accused of having the power of the evil eye was a condition, not a role. Furthermore, this condition symbolized the degree to which that person violates the social bounderies of social interaction and morality. (Herzfeld, 1981) (In Chapter Eight, cases collected in Mahdia during 1983-84 involving the evil eye are presented. An attempt is made to analyze these cases in their social and medical context.)

The Jnun

In the rich oral tradition of the pre-Islamic Arabian bedouin culture legends developed that included tales of invisible spirits that possessed human-like characteristics and lived amongst man. (Jeffery, 1958) Belief in these spirits was prevalent during the founding of Islam and thus it is not surprising to find mention of them in the Koran. (Suras: XV, 26-27; VI 128-30; LI 56-57; LXII 1-13).

There are several references to the jnun in the literature. However, there are two classic sources that remain the most authoritative: Manners and Customs of the Modern Egyptians (1908), by E.W. Lane and Ritual and Belief in Morocco (1926) by Edward Westermarck. These works scrupulously document the beliefs and practices of North Africans. Relying on these sources and the Koran, I will describe beliefs in the jnun as they were some 60 years ago. (Jnun is the plural form, jinn is masculine singular and jinnya is feminine singular.) Later we will find that such beliefs have remained the same even today. (Note that I have chosen to use the ethnographic present tense because the earlier beliefs are practically the same as those expressed during fieldwork in 1983-84.)

The Koran explains that the jnun were created intermediate between angels and men. Thus God first created angels out of light. Then he created the jnun out of fire. And finally he created Adam out of the earth. Thus the jnun are believed to have inhabited the earth before man was created. Only after the creation of Adam were they forced to

live underground.

It is believed that God created seven levels of existence on earth. We, who inhabit the top of the earth, occupy the first level. The jnun occupy the second level, which is below the earth's surface. The rest of the levels are located on successive levels below the earth. Unlike man, the jnun can visit each of these levels at will. They are also able to travel to the walls of heaven. They often listen to God and the angels from outside the walls. This is how they come to know the future and are thus able to help human magicians. In fact a falling star is explained as being a star that was hurled by God toward the jnun whom he caught eavesdropping outside the gates of heaven. (Sura LXXII 1-130) When visiting earth jnun and jnun families often take up residence in places like rivers, wells, abandoned houses, public baths, ovens and toilets.

Although jnun have no bodies as such, they are very much like humans in the fact that they have a language and live in villages and towns and belong to tribes and nations, each of which has its own sultan. They eat and drink as do humans, but they drink blood rather than water and eat foods inedible to man. They propogate themselves, although not like humans. Males and females copulate by rubbing their thighs together, at which time many young jnun are born.

In Egypt it is believed that there are Christian and Jewish jnun whose symbolic color is black, and there are Muslim jnun whose colors are white, green and yellow. Finally

there are infidel jnun whose color is red. The infidel jnun, who are believed to be the most wicked, are called sheyateen (devils) and their chief is Iblis (satan). (Lane, 1908, p. 228)

Jnun are generally invisible to the human eye. However they are able to assume various forms. Very frequently they disguise themselves as animals. At times these transformations are seen by all. Westermarck remarks,

> In many cases a jinn can be seen by certain individuals only. Persons who are ill may see jnun that are not visible to others, and animals sometimes see jnun that are not seen by men. There are also methods of making jnun visible. A scribe from Glawi told me that if a person wants to see jnun he simply goes to a slaughtering place, dips his finger in the blood of the animal which was first killed and smears the blood on his forehead above the nose. (Westermarck, 1926,p.269)

Sometimes jnun assume human form for brief periods. Other times they remain in human form for years, often marrying a human.

Jnun will cause one harm, it is believed, if one hurts them or makes them angry. Hence they are revengeful. Knowing this one must be very careful not to injure a jinn. One must be careful when near places that are known to be inhabited by jnun. When throwing out hot water into the street one should say "Bismillah r-rahman r-rahim" ("In the name of God, the merciful and compassionate.") This will protect people from harm in case they happen to have hit a jinn that was passing by at the time. Likewise, the same utterance is made upon dropping a bucket into a well, for fear that the bucket may hit a jinn living there. These are just a few of the

preventions people observe in order to protect themselves against the jnun's' evil acts.

The jnun cause illness as retribution for the harm that is done to them. A person who is bleeding is especially vulnerable to an attack by the jnun. Thus newborn infants, boys during circumcision and bridal couples are in great danger of attack by jnun. In these circumstances individuals are protected in various ways from being attacked by the jnun.

Jnun have certain dislikes and fears. Knowing this, mortals can protect themselves from their evilness by surrounding themselves with things usually avoided by jnun. For example, jnun avoid the smell of tar, alum, harmel, rue, rosemary, coriander seed, agalwood, gum-ammoniac, gum-lemon, and benzoin. Westermarck explains that, "Among the Ulad Buaziz, for forty days after the birth of the child, when it is in threat of danger of being hurt by jnun, alum, harmel, and coriander seed are in the afternoon or evening burned in the tent, and the child is held over the smoke; and the same is also done after the end of this period, when the child is crying." (Westermarck, 1926,p.308)

Jnun dislike henna, which is a dye made from leaves of a particular plant. They also dislike loud noises. At various rites of passage both henna and loud noises are evident. Henna is used by women to decorate their face, hands, feet, and hair. Music and singing is always a part of the celebration.

Jnun are afraid of items made out of iron, steel or silver. Thus men often wear rings and women wear silver

jewelry to protect themselves from the jnun. Westermarck comments,

> A very effective method of driving away the jnun from a desert place at night is to strike a piece of steel against a flint. An article of steel is sometimes put with money which is buried in the ground .... There are persons who put a dagger or knife close to their pillow before they go to bed ....Daggers, swords, and needles are in frequent use as weddings a safeguards against jnun." (Ibid, pp.305-306)

Salt is by far the most potent substance that one can use against the jnun. Salt is frequently strewn on the floor of one's tent or house. Many people place bits of salt under their pillow at night. Still others will take a handful of salt with them if they should happen to go out in the evening. Also, salt is placed with buried money to keep the jnun from stealing it. (Ibid., pp. 303-304)

The most powerful of all preventatives against jnun, however, are passages from the Koran. All jnun fear the Holy words from the Koran. Because of its potency, this device is used more commonly than any other preventative measure. The passages can be either written on charms or spoken. Thus whenever one fears the presence of jnun various formulas or excerpts from the Koran are uttered.

Materials that are used to ward off the jnun are also used to cure illnesses caused by jnun. Thus the victim is often made to inhale fumes from burning tar, alum or harmel. Or the patient may be served foods that contain rosemary, coriander seed or saffron, all of which the jnun dislike. Silver, lead or steel items are often placed underneath the

pillow of the person who has been attacked or harmed by a jinn.

If members of the family or neighborhood cannot heal the patient struck by the jnun exorcists are sought. Some exorcists are the mediums of saints, as is the case in Tunisia. But according to Westermarck, sometimes the school master, or fqi, is called in to prescribe a cure. He is able to do this because he is literate and thus can recite or write Koranic passages or magical formulas.

Because of the jnun's fear of God, the most powerful curing device is the use of the sacred words of the Koran. A reading of the Koran may go on continuously for days until the patient recovers. Other uses of the Holy words are used too. Westermarck reports that, "In Fez, if a person is affected by le-rvah (harmed by a jinn), a scribe writes something from the Koran on a paper which has the colour of the spirits troubling him, after which the paper is burned and the smoke inhaled by the patient." (Ibid., pp.327-8)

Another remedy is reported by Lane in Egypt. He states, "The most approved mode of charming away sickness or disease is to write certain passages of the Koran on the inner surface of an earthenware cup or bowl; then to pour in some water, and stir it until the writing is quite washed off; when the water, with the sacred words thus infused in it, is to be drunk by the patient." (Lane, 1908, p.260)

Finally, sacrifices may be offered to jnun in order that they stay away from a place or person. Sacrifices are often made, according to Westermarck, when a house is being built or

when a person is being treated for an illness. The following passage is one of the many examples Westermarck gives of sacrificial techniques for curing the ill. He reports,

> An old woman brings a yellow hen. A scribe kills it over a bowl or plate which is held upon the patient's head, and rubs his forehead and the joints of his arms and legs with the blood. The old woman boils the hen without salt in a new pipkin, fumigates it with white benzoin, and gives it to the patient to eat off. After he has eaten she puts anything which is left of the hen, even its entrails and feathers, as also the pipkin, into a basket, which she carries away to a haunted place. On her way there and back she has a silver coin in her mouth, and must neither speak to anybody nor look behind until she has re-entered the sick man's house. (Westermarck, p.333)

Sorcerers obtain their power, it is believed, through their association with the jnun. They are able to summon up a jinn and ask it to do the sorcerer's bidding. In return the jinn is given a blood offering or something else of value to the jinn.

Jnun are usually summoned by burning pieces of paper with magical writings on them. Thus the sorcerer may write the name of the jinn he wishes to contact on a piece of paper, and then burn it in a fire made of various materials, for example coriander seed. While the paper is burning the sorcerer recites passages from the Koran, substituting the name of God with that of Satan. This continues until the jinn comes and possesses the sorcerer. A jnun may be summoned by a charm which contains a formula that only the sorcerer knows. These charms often include numbers arranged in various ways, each arrangement having significance. Again these charms are

burnt in a fire made from coriander or frankincense. Sometimes these charms are written with blood, which attracts jnun, or a special type of ink. (Ibid.,p.360)

Once summoned the sorcerer may ask the jnun to make someone ill, to bring him a certain person from a long distance, to induce love between two people or to cause the death of a victim. The requests vary. (Westermarck, Lane, Blackman)

To summarize, belief in jnun is a longstanding belief throughout the Middle East that predates Islam. Reports of the practices related to preventing the attack of a jnun and curing illnesses caused by jnun are remarkably consistent throughout North Africa and have changed little during this century. In Chapters Seven and Eight illness episodes involving jnun in Mahdia are described. Their role as an agent of illness causation and misfortune will be analyzed.

Sufism and North African Saints

Sufism represents the mystical side of Islam. Both Sunni and Shi'a sects have Sufi adherents. (Often it is incorrectly assumed that Sufism is a separate sect.) This movement originated soon after Mohammed's death by individual ascetics who rejected the materialistic and pragmatic lifestyle of their fellow Muslims. As Gibb states "There was in their view, but one way to knowledge -- not the rational and second-hand 'knowledge' ('ilm) of the schools,, but direct and personnal 'experience' (ma'rifa) culminating in momentary union or absorption into the Godhead." (Gibb, p. 137) Thus

the Sufis sought unity with God through self-realization.

The early Sufis wore only plain undyed clothes made of wool (suf), hence their name. (Martin, p. 64) They meditated on God and did good deeds in the community aspiring to become one with Him. Followers would try to simulate the Sufi's devotional life in order to experience a union with God themselves. In time Sufi orders developed, first in the Middle Eastern region and later in North Africa. Congregations would erect zawiat as places to meet and perform sama (spiritual concerts) and dhikr (spiritual litanies). The dhikr evolved into exercises that included repeating the word "Allah" many times. Singing and repeating litanies were intended to draw one close to God.

If not before his death, certainly after, a Sufi leader would become known as a saint, or wali, "friend of God." In litanies performed after the leader's death, hommage would then be made to Allah, Mohammed and, in addition, to the founding saint.

Thus throughout the Middle East and particularly in North Africa, one finds shrines, called zawiat, that include the tomb of a saint. During their lives these men or women were known to be devout and pious, performing generous acts and sometimes miraculous deeds in the locality. Not all such men and women were the founders of Sufi orders, but they were all well-known for their piety and devotion to God. After their deaths they were perceived as having at last achieved union with God.

Sufi orders developed differently according to the

founder's teachings, the locality, and the social and political setting of the time and place. Often these orders were seen as heretical to the majority of Muslims and thus, in Lewis's (1971) terms, would be considered "peripheral" to mainstream Islam. In Berber areas of Morocco and Algeria, in particular, Sufism evolved into what is called maraboutism. Marabouts (Arabic "murabitun") are living holy men who possess baraka. They are the descendents of a saint, and thus have baraka through inheritance. Maraboutism has been well documented by Eickelman (1976), Gellner (1969) and Rabinow (1975).

A primary criticism of Sufism in the past, as well as today, is centered on the role of the founders -- the saints. It is feared that they, and not God, become the focus of the devotional life. This is anathema to an orthodox Muslim for whom the message of Mohammed was "There is No Other God but Allah, and Mohammed is His Prophet". Thus Sufism is condemned as the antithesis of Islam by conservative believers. Nevertheless Sufi scholars claim that their ideologies are rooted in the Koran, and in the exemplary life of the Prophet himself.

In North Africa today there are remnants of older Sufi orders, such as the Tijanniya order (to be described below). Such orders provide the philosophical and institutional backdrop for the development of saint-worship that exists in the Mahgreb today. It is in this context that people seek the aid of saints ("friends of God") to help them with their

problems and to cure their illnesses. To better understand Mahdians' belief in, and relationship to, saints (discussed in Chapter Seven), it is useful to review the beliefs and practices of one particular Sufi order that has been influential in Tunisia.

The Tijaniyya Order

Sufism was introduced into the Maghreb during the 11th century by Abu 'Imran Musa b. 'Isa, a Moroccan Muslim who had studied the teachings of al-Junaid in Baghdad. After this initial introduction many Sufi orders arose. Some expanded from the Middle East itself, such as the Qadiriyya, which was founded in Bagdad in the 12th century. Some were indigenous to the Maghreb, such as the Tijaniyya order founded in the late 1700's.

The Tijaniyya order, like other Sufi orders, gained their major support from people inhabiting villages and oases in the rural areas. This was probably achieved because such areas were relatively untouched by orthodoxy. Suni orthodoxy was practiced and perpetuated in the urban centers of the Maghreb, since it was in such centers that Islamic universities were established.

Drawing from primary sources stored at the Tijani zawiya at Bab Al-Manara in Tunis, Jamil Abun-Nasr gathered material for his historical account of the Tijanniya order presented in his book The Tijanniya order: a sufi order in the modern world. The founding, expansion and doctrines of the order described below is based on Abun-Nasr's account. I

believe a knowledge of this order, which flourished at the turn of the 19th century, is important to understanding present shrine participation and its relationship to the supernatural sphere in Tunisian folk medicine.

Ahmad al-Tijani - The Founder

Ahmad al-Tijani, born in 1737, founded the Tijaniyya order in 1781. Based on the tenets presented by al-Tijani, which were said to come directly from the Prophet, the order grew rapidly during his lifetime and remnants of the order can still be found in North Africa today.

Ahmad al-Tijani was born in an oasis called 'Ain Madi in Algeria. 'Ain Madi had been built in the 11th century and by the 18th century it was a relatively affluent oasis. It served as a trading center for the neighboring bedouin tribes.

The father of al-Tijani was a venerated member of the community. He was a man of learning and taught in 'Ain Madi. His mother belonged to the original Tijani tribe of 'Ain Madi and sources indicate that she was probably black. Al-Tijani's father had taught his son in the Maliki school of Sunni law, and from an early age the boy showed a deep concern for his religious faith.

At the age of 16 both of his parents died during the plague of 1752-53. He was married at that time but soon divorced his wife after he began his preoccupation with the Sufi calling. Later he married two slaves whom he had purchased. Each of these wives bore him a son, the oldest of which died in the 1827 uprising against the Turkish rulers.

The second son became the chief of the order from 1844-1853. (Abun-Nasr, pp.15-17)

At the age of 21 al-Tijanni left 'Ain Madi and traveled to Fez in order to further his religious training. It was in Fez that al-Tijani became familiar with the Sufi orders that existed at that time. In fact, he became a member of three Sufi brotherhoods: Qadiriyya, Nasiriyya, and the Tariqa. It was prophesied by a seer in one of these orders that al-Tijani would achieve "spiritual realization" if he would return to the desert. With that inspiration al-Tijani left Fez immediately and settled in a village called al-Abiad, located in the outskirts of the Sahara. Here he spent five years teaching and meditating. He did not, however, obtain "spiritual realization" and thus decided to make a pilgrimage to Mecca.

It was on his first pilgrimage to Mecca in 1772 that he became sure of his Sufi calling. On his journey he spent one year in Tunisia, teaching in Tunis and Sousse. He became so well known as a teacher there that the ruling Turkish Bey invited him to remain in Tunis and to teach in the al-Zaytuna mosque-university. He declined the offer and resumed his pilgrimage.

He reached Mecca by December 1773. There he came to know Ahmad b. 'Abdullah, an Indian Sufi shaikh, whose teachings had a profound influence on al-Tijani. Shortly after the meeting the Indian shaikh died and al-Tijani adopted the shaikh's "occult mystical learning". It was also at Mecca that a shaikh of the Khalwatiyya Sufi order (of which he was

already a member) told him that he was destined to become the "dominant qutb"(pole of the universe) or spiritual head of Sufi shaikhs. On his return trip from Mecca he stopped in Egypt, where he was authorized to teach the Khalwatiyya Sufi order in the Maghreb.

Upon his return to the Maghreb al-Tijani settled in Tlemsen from 1772-1782, still seeking a spiritual revelation. He left Tlemsen and finally settled in Sidi Abi Samghun. It was here that at last he had a vision of seeking and talking with the Prophet. Mohammed told him, according to Abun-Nasr, "to start his work of spiritual guidance, and assigned him the wirds (litanies) of his order." (Ibid.p.17-19) In 1789 al-Tijani left Abi Samghun for Fez, where he would remain until his death in 1815. This emigration was to become a turning point in the history of the Tijaniyya order. The order which had originally been ascetic became dogmatic and political in its orientation.

Al-Tijani's order was for the most part rejected by the general population of Fez. However he did win converts in some sectors of the city. Abun-Nasr says "His residence in this town put him in the most important centre of religious and cultural life in the Maghrib; and his arrival seems to have been noted by the religious and learned circles, as well as by the government authorities." (Ibid., p. 20) Fortunately, he was able to gain the favor of the Sultan, Mawlay Sulaiman, who provided him with a house in which to reside and built him his own zawiya in Hawmat al-Dardas in 1800. After Al-Tijani's

death a mausoleum was built for him there and the zawiya was expanded. This zawiya can still be found in Hawmat al-Dardas today.

The Expansion of the Tijaniyya Order

During his lifetime al-Tijani established missionaries that were staffed by his followers. Missionaries were dispersed throughout North Africa with the goal of converting Muslims to the order. Each time a town was won over to the order al-Tijani would appoint a trustworthy man of that community to act as muqaddam of the order and to preach in that area.

The Tijaniyya order reached Tunisia during the Turkish occupation by two different routes - via the north and via the south. The person responsible for first bringing the Tijaniyya order to Tunisia and giving it much of its prestige was al-Riyah. He had met al-Tijani in Fez. Born in Testour, about 70 miles southwest of Tunis, al-Riyah studied at the al-Zaytuna mosque-university. He had formerly been initiated into the Shadhiliyah order. However after meeting Ali Harazim, al-Tijani's lieutenant, while on his way to Mecca, he decided to give up his membership in the Shadhikiya order and become a member of the Tijaniyya order. On an assignment for the Bey of Tunisia al-Riya met al-Tijani. (He had been sent to Morocco to ask for a wheat supply to relieve a famine that was sweeping Tunisia.) During his stay in Fez he came to know al-Tijani who made him muqaddam of Tunisia in 1804.

Tijaniyya teachings entered southern Tunisia only after

al-Tijani's death.. The order disseminated out of Tammasin, the home of Ali al-Tammasini, the successor of al-Tijani. (Not only did it penetrate Tunisia, but it also diffused into the Sahara where some of the Tuareg are believed to have converted.) Although the Tijaniyya order had competition, as it entered Tunisia, from older more established orders, the Tijaniyya order spread quickly during the 1800's. By 1826 the first mugaddam was appointed out of Tammasin and zawiat were reported through the area, including the one at Gasfa built in 1870. (Abun-Nasr, pp. 82-93)

The Doctrines and Practices of the Tijaniyya

By the 18th century, the Sufi orders had each incorporated, as Abun-Nasr explains,

> the belief that their shaikhs were organized in a spiritual hierarchy, and that the holder of each rank in it had his own functions and responsibilities . . . . The head of the heirarchy, the Qutb (the Pole of the Universe) is unique; the other ranks on the other hand have more than one holder at the same time, but the number in each rank is also fixed. (Abun-Nasr, pp.27-28)

At the time of the emergence of al-Tijani's order it was common practice for a Sufi shaikh who had gained a good reputation for himself as a spiritual leader and a learned man to proclaim that he had attained a certain rank in the hierarchy described above. Accordingly, al-Tijani prolaimed that he occupied two ranks: 1) Qutb al-Aqtab (the pole of poles) and Khatm al-Wilaya al-Muhammadiyya (the seal of Mohammaden sainthood, i.e. the Last). By ascribing to himself the rank of "pole of poles" al-Tijani was indicating that he was not merely another qutb, as many Sufi shaikhs had claimed

to be, but that he was their chief. (Ibid.,p.28)

The founder's proclamation of his ranks engendered a great deal of criticism among the Sufi denominations. However the Tijani remained convinced that al-Tijani held each of the ranks, for after all, had not the Prophet himself appeared to al-Tijani assuring him of this fact?

It was in fact the belief in al-Tijani's visions of the Prophet that made Muslims either reject him with utter disgust for having the audacity to make such a claim, or to convert to the order, believing that al-Tijani had been chosen by Mohammed himself. As he dictated to his scribe, Ali Harazim (who wrote al-Tijani's autobiography), he was pre-eminent over all oulaya whoever lived in the past or will live in the future, and that his order was superior to all other Sufi orders.

The Tijani believed that just as Mohammed is the Khatm (last) of the prophets, al-Tijani was the Khatm of the oulaya. However in time that pronouncement was amended. Later Tijanis stated that there might be other oulaya after al-Tijani, but none that would supersede him. Thus oulaya and followers of these later oulaya would eventually join the Tijaniyya. Even the Mehdi, once revealed, would belong to the Tijaniyya order. (Abun-Nsar, pp.32-33)

In addition to the standard religious obligations of all Muslims, that is the observance of the five pillars of faith, the Tijaniyya have three additional rites to perform. The first rite consists of the recitation of the wirds

(litanies) of the order. They are performed twice everyday, in the evening and in the morning, and consist of the following: "1) recitation of the formula of penitence Astaghfiru Allah (I beg forgiveness of God) 100 times;(presented below), 2) saying a prayer for the Prophet, preferably in the form of the Tijani prayer Salat al-Fatih, 100 times; 3) reciting the formula La ilahia illa Allah (There is not God but Allah) 100 times." (Ibid. p. 51)

Below is the text of the Salat al-Fatih. Interestingly enough, the Salat al-Fatih was the only litany not delivered from the Prophet, as were all the others. It was revealed to a Tijani follower who then related it to al-Tijani. At first al-Tijani did not believe him, but later the Prophet confirmed the follower's statement to al-Tijani. It reads,

> O God, bless our master Muhammad, who opened what had been closed, and who is the seal of what had gone before; he who makes the Truth victorious by the Truth, the guide to Thy straight path, and bless his household as is the due of his immense position and grandeur. (Ibid., p.51)

The second rite is the wazifa. It is performed at least once everyday. This includes a repetition of the penitence formula (30 times) and the affirmation of faith, the Hailalah, (100 times), plus saying the Jawharat al-Kamal twelve times. (Ibid.,p.52) The following is the text of the Jawharat al-Kamal:

> O God, send benediction upon and salute the source of divine mercy, a true ruby which encompasses the centre of comprehensions and meanings, the son of Adam, the possessor of divine Truth; the most luminous lightning in the profitable rain-clouds which fill all the intervening seas and receptacles; Thy bright light with which Thou has filled. Thy universe and which surrounds the places

of existence.

O God, bless and salute the source of Truth from which are manifested the tabernacles of realities; the source of knowledge, the most upright; they complete and most straight path.

O God, bless and salute the advent of the Truth by the Truth; the greatest treasure, Thy mysterious Light. May God bless the Prophet and his household, a prayer which brings us to knowledge of him. (Ibid.)

The Jawharat al-Kamal is considered to be the most sacred litany in the Tijaniyya order. So sacred is the prayer that a Tijani can say it only after he has performed his ablutions with water, not dust. It is believed that by the seventh time the Jawharat al-Kamal is recited the Prophet and the first four Caliphs are present in the room. They remain there until after the 12th prayer is said. Because of this belief the Tijaniyya always hold the wazifa in a large room. Five people are required to be in the room who are not participating. Abun-Nasr does not explain this point further. However, perhaps the five persons act as medians for the spirits.

In the zawiat, during a wazifa, a clean white cloth called izar (called sifsari in Tunisia) is placed for the unseen guests. This custom is an outgrowth from the days when al-Tijani used to hold wasifat in the streets of Fez before his zawiya was built. All participants stood on the white cloth, for the street was thought unclean. Once zawiat were built the cloth remained, but only for the Prophet and four Caliphs.

The third rite is the performance of the hadra. This is performed every week, if possible after the communal Friday

prayer, with a subsequent wazifa. The Tijani hadra is much the same as other Sufi orders' hadrat. In unison adherents usually form a circle and are seated. They begin swaying left and right while reciting the La ilalia illa Allah. They then join hands. All together they say La Ilaha illa Allah, or just "Allah, Allah" over and over again. Toward the end of the hadra the recitation becomes more intensive and those participating stand up together and start swaying more vigorously until someone falls unconscious. In some areas dancing is also part of the hadra. Abun-Nasr states that "The majority of the Tijanis have come to recite the hailalah 1,000 or 1,600 times in their hadra." (Ibid., p. 53) Most often the hadra lasts the entire Friday afternoon, from the noon prayer until the evening prayer.

The founder did not leave specific instructions on how these hadrat were to be conducted and thus variations did occur. Most of the variations did not cause conflict among the Tijanis. However one issue did, and that was over the use of breathing techniques while reciting the name of Allah. This induces hyperventilation and altered states of consciousness. It is believed that the founder did not mean for the hailalah to be reiterated while rapidly inhaling, but rather preferred to have it plainly read. However, even during the lifetime of the founder this type of chanting became established. The supporters of the breathing exercises say that if al-Tijani opposed the act he would have said so while he was still alive. In the formal hierarchy of the order there continued

to be criticism of the way in which the word "Allah" was used in the hadrat. Even so, the inhalation of "Allah" has continued in local zawiat. (Ibid.,p.50-57)

Prior to his death in 1815, al--Tijani appointed Sidi 'Ali al-Tammasini from the town of Tammasin as his successor. Abun-Nasr explains, "On appointing Sidi 'Ali as his successor, Ahmad al-Tijani stipulated that the leadership of the order after him should be held by the eldest male member of his own family and that of Sidi 'Ali alternately." (Ibid.,p.23) Such an arrangement could not help but instigate a dispute over rights of inheritance in regards to the leadership of the order.

The succession of Tijani leaders in early years went as al-Tijani had prescribed. However through quarrels over rightful successions a split occurred in the 1870's between the Tijani in Tamalhat and those in 'Ain Madi. After this they had little to do with one another. (Ibid.,pp.81-82)

The Tijaniyya order still exists today in Morocco, Algeria and Tunisia. However Tijaniyya zawiat and adherents are few. Orders such as the Tijanni have clearly influenced popular zawiya participation in Tunisia. Patterns of belief about divine revelations and communication with spirits can be discerned in the interviews collected in Mahdia. Furthermore the terminology, litanies and practice of the Sufi orders have penetrated the Tunisian folk medical domain. This will be illustrated in the following chapters.

Sufism and the Jnun-Oulaya System

Sufism with its various orders, such as the Tijaniyya Order, provide the institutional framework within which North Africans erect zawiat and interact with the saints. The zawiya, as I have mentioned earlier, was conceived by early Sufis as a place to seek union with God - a place of prayer other than the mosque. However, today in Tunisia zawiat represent places where one seeks communion with God's intermediaries - the saints.

Hadrat are held in the zawiya. They are not unlike the ones held among the earlier Tijaniyya order. However unlike the original hadrat, which were ceremonies designed to seek a union with God, the hadrat held in zawiat today are designed to contact a saint who in turn can tell the future or exorcise a possessing jnun. Thus, in popular terms the hadra has taken on a different meaning. (In the last 10 years the term hadra has evolved into a more general term that refers to any social gathering where musicians are hired. The same term can also refer to a gathering for purposes of exorcising jnun, such as those held at Sidi 'Akmer where both men and women attend.)

oulaya ("friends of God") have come to be known as those who can rid one of the troubling or possessing jnun. Thus through their baraka which they have come to possess through a union with God, saints can cure illnesses or rid one of plaguing jnun.

SUMMARY

Folk medicine, as it is practiced today in Tunisia, is rooted in the ideologies existing prior to and since the introduction of Islam. It has been influenced by the circum-Mediterranean belief in the evil eye, by the ancient belief in the _jnun_, by the religious institution of Islamic Sufism and the scientific endeavors of Arab medical philosophers and practitioners of the 9th through 15th centuries. The analysis of the Tunisian folk medicine to be presented in the following chapters must be analyzed within this historical context.

Given this context we can now proceed to analyze Tunisian folk medicine. In Chapter Six the focus is on illnesses particular to the natural sphere. Chapter Seven is devoted to an analysis of the diagnosis and treatment of illnesses classified within the supernatural sphere. In Chapter Eight, the ways in which these spheres articulate with one another will be discussed.

FOOTNOTES

1) Tibb is the Arabic word for medicine. Arab medicine, derived from Greek, Indian and Persian medical traditions, is called Tibb al-'Arbi. Arab medicine, according to Ahmed Milad (1980), would be any medicine conducted and recorded in Arabic. Medicine as taught by the Prophet Mohammed is called tibb annabi. According to Said (1976), the two together can be called Al-Tibb al-Islami.

2) Burgel (1976) and Ullman (1978), two German scholars, attest that the the downfall of Islamic (Arab) medicine was due to the rise of religious fanaticism and to magical practices. They claim that the desire for scientific (rational) inquiry was replaced with an attitude of inward self-reflection, manifested in occult studies and Sufi orders. Their position, however, ignores the social, economic and political events of the times.

3) E.E. Evans-Pritchard (1950) was the first to make a distinction between sorcerers and witches. His distinction between the two, according to A.D.J. MacFarlane (1970) and Lucy Mair (1969), has been overdefined. In fact there are regional definitions for categories of persons who use supernatural means to achieve an evil end. Mair suggests that one criteria, however, can be used to dichotomize witches from sorcerers and that is whether or not they obtain their power through possessing magical objects or words, or if the power is internalized. Using this criteria I have concluded that those magicians who cast spells in Tunisia can be categorized as sorcerers. Their power is achieved by memorizing a number of incantations and performing rituals which include the use of fetishes. Those who have the evil eye (and the dwarish described in Chapter Eight), on the other hand, require no such paraphernalia. The evil eye belief system, however, cannot be considered witchcraft because the person with the evile eye does not consciously will his/her curse, wheras the witch does.

CHAPTER SIX

DWA 'ARBI: ETHNOMEDICINE AIMED AT RESTORING OR MAINTAINING BALANCE IN THE NATURAL SHPERE

In the preceding chapter ideologies and institutions which serve as the foundation of contemporary Tunisian folk medicine were described. As stated in the previous chapter, it is believed that illnesses are caused by either natural or supernatural forces. In this chapter and the one that follows, an analysis will be made of ethnomedicine pertaining to "natural" illnesses and to "supernatural" illnesses. At this point they will be treated separately. However, in Chapter Eight the common cognitive threads that provide the underlying assumptions of the two ethnomedical traditions will be discussed.

Dwa 'arbi (Arab remedies) is primarily used to treat illnesses derived from "natural" causes, while spirit mediumship is used to treat illnesses thought to be caused by supernatural agents. In some illness-episodes, however, dwa 'arbi is used in conjunction with spiritual mediumship. Such therapy is designed to treat both the symptoms and the causes of an illness. Illnesses in both spheres are seen as states of imbalance. Preventative measures (in the form of diet, protective charms, and adherence to behavioral norms) are taken to maintain a somatic balance. Therapy is aimed at restoring that balance.

COLLECTING DATA ON DWA 'ARBI

Tunisians, regardless of their educational background, use dwa 'arbi in treating common illnesses. This is true even though the government has actively campaigned for the modernization of health care. In some homes dwa 'arbi is the only medicine used. In others, dwa 'arbi is used first. If there is no evidence of a cure, the sick person is taken to a local clinic or hospital. In Chapter Nine statistical data collected on health seeking behavior is analyzed.

Dwa 'arbi is administered by adults within the household. Usually, but not always, women are the care-givers, and thus are the ones who administer dwa 'arbi treatments. In most zneg, one or two women are thought to have the most thorough knowledge of dwa 'arbi. It is to them that families turn in cases of crises. Furthermore, some individuals become renown for their expertise and successful use of dwa 'arbi. These specialists receive patients from outside of their own zanga. In some cases they are paid a fee.

In the summer of 1983 arrangements were made to interview 19 informants - 18 women and one man. Family and friends in Zanqa Sfar and Zanqa Turki directed me to those whom they believed to be the most knowledgeable in dwa 'arbi. The interviews were structured in such a way as to encourage the informants to offer information about dwa 'arbi that they thought important. Nevertheless, I came prepared with a list of illnesses previously compiled during a pretest. Only after the informants had exhausted their recollections were they

asked about illnesses they had not already mentioned. Thus interviews began with the question, "What illnesses have you treated with dwa 'arbi?" Then, after a list of illnesses was elicited, the informant was asked, "Tell me about those cases. Whom did you treat? What was the treatment? Was it successful? What caused the illness? Was the patient taken for therapy elsewhere?"

The data collected in interviews included the names of 67 illnesses. Forty-six of the illnesses were spontaneously offered by the informants. This is significant in that the informants had the opportunity to talk about illnesses they felt were important as opposed to being directed by any biases that might have been held by the author.

Each informant described between 20 to 30 treatments resulting in a total of 475 treatment descriptions for 67 illnesses. Using an English-Arabic dictionary, it was possible to translate the meaning of many of the illness-names into English and to identify the medical substances used to treat them. In some cases the terms could be translated into French and then into English. However, English and French equivalents could not always be found. In Appendix I the transliterated Tunisian Arabic terms used to label each of the illnesses are listed. In those instances where the illness could not be translated, the literal meanings of the illness is given. Examples of standard treatments are presented. English terms for substances used in dwa 'arbi are given when possible.

Many of the illnesses can be treated by various means.

Someone administering dwa 'arbi may try two or three remedies while treating a patient. On the other hand there are some illnesses for which the same treatment is consistently used. Appendix II includes a list of illnesses for which there is a high degree of unanimity in the treatment descriptions. For example, measles, chicken pox, fever, and others each has a standard treatment elicited in the interviews.

Informants readily described treatment practices. However many of them had greater difficulty in explaining the cause of illnesses. Some informants would state simply that they did not know the cause of an illness. Some found the query irrelevant. However, three informants, in particular, possessed a theoretical as well as practical knowledge of dwa 'arbi. Their discourses on causality were particularly helpful. In total, causal explanations for 59 of the 67 illnesses were elicited.

Informants were asked to describe particular sickness episodes in which they were involved, either as a parent, administrator of dwa 'arbi, or patient. Symptoms, treatments, decision about health-care alternatives, causal explanations (if known) and outcome were described for each case. The time that these illness-episodes took place varies from 30 years ago, in some instances, to cases that were being treated at the time of the interview. In total, 151 case studes involving illnesses "naturally" caused were described. An additional 97 case studies involving illnesses caused by supernatural agents were elicited the following summer. These

248 case studies were the basis of the analysis made of the health seeking behavior in Mahdia. (See Chapter Nine)

BASIC TENETS OF CAUSALITY

Although the focus of this chapter is the ethnomedicine of dwa 'arbi, a brief summary of the etiology involved in dwa 'arbi may be useful to the reader at this point. Illnesses in the natural sphere are the result of either a physical disorder or an imbalance of bodily elements (humours). A physical disorder can be caused by a physiological malfunction or be the result of an accidental injury. Bodily elements are substances within the body that can be affected by the physical or social environment. This basic tenet is derived from the etiology of Arab medicine. However it has not been passed down intact. In Arab medicine four humours were identified - blood, phlegm, yellow bile and black bile. Each of these was derived from fire, air, earth and water, respectively. In dwa 'arbi natural illnesses that are not physical disorders are thought to be caused by an imbalance of blood, air and food intake. Thus some illnesses like diabetes, erysipelas, irregular heart beats, headaches, etc. are caused by bad blood. Coughs, asthma, kidney problems, sterility and others are illnesses caused by cold air. While constipation, diarrhea and stomach aches are due to a bad diet. Dirty surroundings, a concern for medieval Arab doctors, is also a concern of Tunisians. Scabies and eye infections, for example, are attributed to surface dirt. Finally, supernatural agents such as jnun, saints and the evil

eye are believed responsible for some illnesses. Physical disorders are frequently caused by the evil eye and can be treated with dwa 'arbi successfully. However illnesses caused by jnun and saints usually require a medium. (Appendix III illustrates the causal factors associated with each illness.)

In order to establish the cause of an illness, the patient and family must examine the symptoms and more importantly, reflect upon events leading up to the illness. Illnesses can usually be traced back to inappropriate behavior of some kind prior to the illness. Such deviant behavior, it is believed, results in an unbalanced state - physically, socially or spiritually - which in turn manifests itself into an illness. Theories of causation will be discussed more fully in Chapter Eight.

ETHNOMEDICAL PRACTICES

Treatment begins with an analysis of the symptoms exhibited in the sick person. Change in body temperature, presence of hab ("buttons") on the skin, change in skin color, irregular breathing, localized or general pain, dizziness, an irregular heart beat, nervous tremors, or abnormal behavior are some of the symptoms reported as indicative of illness. They may appear as a single symptom or as a syndrome. Initial diagnoses are made in the home and usually involve discussion with family or zanga members. Identifying the illness and its possible causes facilitates the decision making process in regard to further action. For example, one set of symptoms may indicate that a particular dwa 'arbi treatment is

required - a treatment that can readily be applied by the family. Another set of symptoms might suggest that further consultation is necessary, perhaps with a specialist in dwa 'arbi, an evil eye exorcist, a saint's medium or a doctor trained in European medicine. In cases where the individual or the family suspect the illness is caused by supernatural forces, a diviner is sought. The diviner will then recommend the appropriate practitioner based on the symptoms of the illness.

Most illnesses are treated in a number of ways. Often people know of two or three treatments for one particular illness. The decision to use one over another is based on personal preference from past experience, availability of an ingredient, the failure of the treatment first tried, the age of the patient, and the sex of the patient. After comparing the treatment descriptions elicited for each illness, standard treatments could be discerned. (See Appendix II)

I attempted to deduce either a typology or an organizational theme inherent in the variety of treatment descriptions. One pattern did emerge. Treatments tend to vary according to how much they involve symbolic behavior. Some treatments simply treat the patient's symptoms These types of treatments I am calling "symptom-specific" interventions. Whereas other healing procedures involve the use of symbolic materials or actions. Because many of the therapies involve a combination of both types of interventions, a simple dichotomy between symbolic and symptom-specific treatments can not be made. Hence I have

concluded that dwa 'arbi ethnomedical practices fall upon a continuum - a continuum whose two extremities range from symptom-specific to symbolic intervention and upon which treatments involving both types can be placed.

Symptom-specific and symbolic interventions differ in terms of their means (procedures) and goals. First, symptom-specific interventions use certain material objects ("tools") to alleviate discomfort. Materials used may include herbs, silex stones, leather straps or tisanes. The meaning of these instruments are singular. For example, earaches are treated with a specific herb, fajil. Fajil is collected, dried and stored for this singular use. Symbolic interventions utilize symbolic objects, substances, words and behavior to alleviate suffering (as is true of symptom-specific treatments) and to eradicate or neutralize the illness-producing agent. Such objects, words and behavior are symbolic in that they have a multiplicity of meanings. In a non-medical situation such an object, for example, would not be valued for its healing properties. However in a medical situation the objects take on a well defined meaning. For example, mogara is a red clay used in making a particular kind of pottery. In this context the meaning of mogara is profane. However when mogara is used in treating houmra (redness), the patient and practitioner are concerned with the red clay's ability to attract the bad blood. Fundamentally, symbolic ethnomedical practices possess an intrinsic, abstract notion of cause and effect. Causality is not really an important consideration in the performance of

instrumental therapy.

Second, for the most part, symptom-specific interventions are applied externally - to set bones, treat wounds or burns, alleviate skin irritations, etc. (Anal suppositories and herbal earplugs are an exception to this rule.) Ingredients used in symptom-specific treatments include oils, rosewater, salts, tar, (food, herbal and clay) plasters, food sources, leather and cloth bindings, massages and Vicks mentolatum. Reducing pain and discomfort is the goal of each of these treatments. Symbolic treatments consist of extraction-transference rituals. Substances and gestures are used with the intent of extracting the causal agent, and in some cases transferring it on to something else.

Often therapy includes treatments that incorporate both symptom-specific and symbolic interventions - with the alleviation of discomfort being the goal of symptom-specific therapy and the eradication or neutralizing of the causal agent being the goal of symbolic treatments. Thus treatment includes a combination of external applications, internal medicine, or extraction-transference rituals.

Below excerpts of treatments elicited in interviews will be presented. The reader will note that symbolic behavior is more prominent with each successive example. The examples have been taken from interviews with six women. Two of the women, Saida (age 54) and Chedlia (age 42), have charismatic personalities which has contributed to the fact that each are highly respected in their zneg. Both proved to be very articulate informants. Saida and Chedlia are reknown in each

of their zneg for their ability to treat illnesses with dwa 'arbi. Their expertise is sought by their neighbors. Saida's interviews were rich in detail, and she was particularly helpful in providing information about causality. The other four women included Khadeja (age 66), Jarmilla (age 47), Zoad (age 73) and Menoubia (age 38). As indicated earlier, the first few examples are of illnesses treated only with symptom-specific interventions. However, as one continues to read one finds that examples given begin to incorporate symbolic intervention as well.

In the first example Zoad, who had been explaining how she treats ringworm (sibina) went on to describe an illness experienced by her son when he was about 10 years of age. (He is now 30 years old.)

Example #1

Zoad: We also have another type of disease called nadra. Nadra is like sibina, but it oozes liquid.

Interviewer: How do you cure nadra?

Zoad: We start with m'a.

Interviewer: What is m'a?

Zoad: M'a is a product sold in the stores. Mix beeswax with this product called m'a. Boil them for a long time and then apply it to the affected area. (She explains that her son, Mohammed, frequently had ringworm, but one time he had nadra. Both conditions were caused by the evil eye.)

Interviewer: Did you use dwa 'arbi only?

Zoad: Well listen to me. I went back and forth to the hospital for six months. They could not cure his nadra. The only thing that cured him was dwa 'arbi.

Interviewer: Did you administer the treatment or

did someone else?

Zoad: No, he was treated by Mgarbi. I went to Mgarbi. He was our neighbor. I complained to him that I had been going back and forth to the hospital for six months with my son, and that the doctors couldn't cure him. After two treatments (of m'a) the oozing stopped and Mohammed was cured.

The excerpt below describes a treatment for a physical injury. Physical injuries are usually considered accidents, and thus "god-given".

Example #2

Interviewer: Do you know of any treatment for head injuries (damga)?

Saida: What do you mean, head injuries?

Interviewer: Well, for example, when somebody has a head injury caused by a stone or something like that.

Saida: In the old days we treated damga without ever going to a doctor. The basic treatment consists of filling the affected area with cobwebs. If no cobwebs are found, we can also use very fine powdered coffee to fill the injured area of the head.

Interviewer: Does this type of treatment leave any scar? (Note: other informants had commented that dwa 'arbi treatments are superior to biomedical treatments for cuts and burns in that they do not leave scars.)

Saida: Not that I know. Especially if it was done with cobwebs - no scar will stay. In the old days the only type of treatment for head injuries was cobwebs. You can ask your grandmother, Fatma, and she will let you know that she also used cobwebs to treat head injuries.

Interviewer: You have mentioned the use of coffee.

Saida: Yes, very fine powdered coffee can be used instead of cobwebs. I remember a case of a child who had a head injury. His mother was more or less in shock and she wanted to take him to the doctor and everything. I just told her to forget it. I took the child and just packed the injury with

cobwebs. In about five days it was cured. And that was that!

Comment: In each of the cases above, the patient was treated successfully with substances applied externally. In one case the substance had to be especially purchased. In the other case the substance could be found in the home. Interestingly, treatments were administered by someone outside of the family at a point where the mother felt unable to cope with the situation. In each case a neighbor was able to treat the patient and alleviate the anxiety of the mother. These two examples illustrate the extent to which illness-episodes bring zanga members together in search of a cure for one of its members. This proved to be a common phenomena when analyzing the case studies.

The following is a description of how one is to treat fadda, "shortness of breath", or asthma:

Example #3

Interviewer: What is the treatment for fadda?

Menobia: It is usually grown by some people. It resembles spinach leaves and has small purple flowers. It is called the "herb of fadda". For the treatment of women the leaves are boiled in water and the brew drunk by the woman who is suffering from the fadda. In the case of men, the herb is smoked like tobacco. The cure is usually quick. However, if you seek a doctor's advice, he usually says fadda is caused by the atmosphere in the house, like the presence of some trees.

Interviewer: Do patients treated with this herb have reoccurences of the illness?

Menobia: I do not know of any reoccurences. I had an uncle who was suffering from fadda. He had seen several doctors, spent time in the hospital, but was not cured. So he then took the fadda herb and he was cured. He did not have a reoccurrence, even after 15 years, when

he died.

Interviewer: Do you know the causes of fadda?

Menobia: I do not know.

Interviewer: Are you saying that your uncle was cured by the herb of fadda and not by the treatment prescribed by doctors?

Menobia: Yes, only the fadda herb cured him.

Comment: Out of the eleven cases of asthma reported, seven treatments included the use of "the herb of fadda" (euphorbia). Those who were able to comment on the causality of this illness attribute fadda to "cold air" - the cause of all respiratory problems. Even so, the "herb of fadda" was never recommended for the treatment of coughs or whooping cough. It was used specifically for asthma attacks. One can note, in this interview, that Menobia comments that the doctor said that the condition was caused by "the atmosphere in the house, like the presence of some trees". This, of course, suggests that the doctor diagnosed the condition as a type of allergy. But it would appear, as is often the case, that the doctor did not offer an alternative treatment.

Some treatments are strictly symptom-specific, as the two examples above demonstrate. Many treatments, however, combine symptom-specific with symbolic interventions. The following case is similar to the cases described above in that the treatments involve external application and manipulation. However reference is also made to a symbolic intervention. Below Chedlia describes how fatla (twisted muscles) can be treated. (Fatla means "twisted").

Example #4

Interviewer: Do you know of any cure for fatla?

Chedlia: We usually cure it by simply massaging the area with vinegar. "Stamping" methods are also used to cure fatla. Provided the person is healthy, one pulls on the leg or the arm of the person with fatla. You want to try and place the muscles back into their (proper) place. If the fatla is in the back the patient is told to lie on his stomach and then a person will stamp on his back and try to put the bones and muscles back into place.

Interviewer: What do you think are the main causes of fatla?

Informant: Well, in general, fatla occurs when someone turns around quickly. Then they twist the muscles. It is mainly caused by unconscious movements like jumping, bending down or twisting around too fast.

Interviewer: How do you cure fatla, of let's say,the foot?

Chedlia: We usually massage it with oil and vinegar. Also, if a woman who has twins comes and stamps on the part of the foot that has a pulled muscle, then they say that the pulled muscle will cure itself. The pain can also be eased by placing the foot that has fatla into hot water with salt.

Interviewer: Have you tried this kind of treatment, using hot water and salt to ease the pain?

Chedlia: Yes, I have used it and it was successful. I have treated my son's friend, my own friend, Zoubaida, and three days ago I treated a child here in the zanga. The cure is usually rapid and they have no problem after the treatment. Well, I can tell you that my husband always has problems with fatla, and I always come and stamp on his back or wherever he has a twisted muscle and the muscle gets replaced.

Comment: In this treatment a mother of twins is used, if

possible, to "stamp" on the patient. Other informants reported the same treatment for fatla. Being "stamped" by a mother of twins is an imitation ritual - the implication being that if a woman was successful in giving birth to twins (entangled within the womb), she would be able to effect a cure for fatla. Alone this would be a symbolic intervention. Furthermore this treatment is done in conjunction with an application of vinegar and oil or a water bath.)

The use of ingested food in treating a patient is probably the most frequent type of therapy. Again this type of treatment can be considered as both symptom-specific (in that the aim of the therapy is to treat the symptom and bring about immediate relief) and symbolic (in that specific foods are believed to have an inherent ability to eradicate or neutralize the causative agent). Prescriptive foods and herbs are used in the former case. For example, constipation is treated by ingesting large dosages of oil; diarrhea is treated with rice water; urinary problems are treated with various tisanes, in particular those made from parsley, anise or leeks. In each case the symptom is the primary focus of interest. Below are some examples to further illustrate this point. In the following excerpt Saida explains the treatment she has administered to her sons when they suffered with kidney stones.

Example #5

> Informant: One treatment for kidney stones consists of feeding a broth made out of leeks. The leeks, with their roots and leaves, are first washed in water. Then they are boiled in water. The water is fed to the person who is suffering from kidney

stones.

Anise seed tisane is also used for minor kidney stones. I have seen it with my own eyes. My son Hedi had some kidney stones (small stones), and we had him drink large amounts of anise tisane. Then he dropped three stones about the size of a pea. No doctor was needed for him; only the anise tisane caused the stones to drop.

One time my son Mustafa had difficulties with the urinal tract. (He seems to have kidney problems every winter.) This time there was blood in his urine. He did not want to go to a doctor. I gave him a tisane made out of anise seed and coriander, and he dropped a stone about the size of a chick pea. He seems to be cured, but we don't know what might happen in the future.

Later in the interview Saida described ways in which diarrhea could be treated. She explains:

Example #6

For adults we serve cold cereal made out of grilled fenugreek. The fenugreek is first grilled, then ground, then diluted in water. This water is then drunk in order to cure diarrhea in adults. The grilled fenugreek is very efficient. Fenugreek, as you know, is suggested for several types of preventative medicine. For example, it will protect people from getting excessive colds or from having diarrhea.

Interviewer: Can you tell me the causes of diarrhea?

Saida: Diarrhea can be caused by large intakes of cold water during very hot weather. Let's say on a very hot afternoon you drink a lot of cold water, you will get diarrhea. Other types of treatment consist of drinking the water from boiling rice. (This treatment is administered to children.)

In both instances described above the emphasis is on treating the symptoms and thus alleviating the discomfort. The causes of the illness (cold air in the case of kidney stones and "cold water" in the case of diarrhea) is known. In the case of kidney stones hot tisanes are administered in the

belief that they can counteract the cold air that caused the formation of kidney stones. Fenugreek is an all-purpose herb that is used to cleanse those areas of the body that are perceived as weakened or unclean due to an imbalance.

Headaches (of various severity) and nervousness are believed to be caused by bad blood, which in turn is the result of some kind of emotional upset. In the following two cases the women found relief from these symptoms by taking nefta (snuff) among other things.

Example #7

Interviewer: Do you know a treatment for headaches?

Saida: The treatment for headaches consist of grinding rand (bay leaf) and clove and mixing it with egg whites. The paste is then applied to the head. Normally the headache will ease up. My daughter has tried it and it does work. She says it is very common in Tunis. Rand is a wild herb that is kind of like henna.

Interviewer: What do you think causes migraine headaches?

Saida: When somebody gets mad or anxious they might get an attack of a headache.

Interviewer: Can you tell me the symptoms of a headache?

Saida: Well it is characterized by every sharp pain in the head.

Interviewer: Does this treatment result in the headache going away forever?

Saida: I don't know. I cannot tell, but I don't think so. I myself have some headaches and I am waiting for my daughter to bring some bay leaf from Tunis. In the meantime I am using nefta.

Interviewer: What is nefta? Why are you using it?

Saida: It is ground white tobacco which you sniff. I have a plugged nose most of the time and I have a

slight headache, and when I take the nefta the pain and blockage of the nose eases.

Interviewer: How did you start using nefta?

Saida: Well, I started using nefta when I had some problems with the nose. I started borrowing just a little nefta from the neighbors. It seemed to ease up the pain in the head, and now it is a habit. I am a habitual user of nefta. And when I use nefta the pain eases up and I can sleep all night without experiencing a headache.

Interviewer: If you are putting ground tobacco in your nose, perhaps it is better to smoke a cigarette, at least it is a show.

Saida: Are you kidding? In Mahdia when a woman smokes, she is considered a prostitute. When I told the doctor that I take nefta and I use it and that I feel better when I do, he told me to keep on using it. Then he just smiled.

Interviewer: Does that mean that when you told the doctor that you were using nefta (and feeling better) that he told you to keep on using it?

Saida: Yes. He said to keep on using it. There was no need to stop.

Interviewer: Aren't you afraid you will become addicted to nefta?

Saida: Of course. I already am addicted to nefta. When I don't have nefta I get so upset I might even tear your clothes, break your tape recorcder and chase you out of my house. I want you to understand that before, when I was married, I didn't have to use nefta. Now I don't have a husband and nefta keeps me doing all right.

Example #8

Interviewer: Do you know of a treatment for nervousness or irritability?

Jarmilla: I think drinking a lot of black coffee is a cause of the illness. Constantly angry people get the illness because their blood becomes bad. One can take fenugreek. It cleanses the blood. Or one can go to the doctor. He can give pills to cool down nervousness. In my case I sniff nefta to calm down my nerves.

Interviewer: Would you say that you are addicted to nefta?

Jarmilla: Well, when I take nefta I feel more relaxed.

Interviewer: Why and when did you start sniffing nefta?

Jarmilla: At a time in my life I became easily irritable and angered. That is when I started to take it to cool me down. Afterwards it became a habit and now I take nefta all the time.

Comment: From a Tunisian perspective Said and Jarmilla suffer from the same illness - bad blood. This condition has manifested itself in headaches, in the case of Saida, and nervousness, in the case of Jarmilla. Despite the fact that Jarmilla suggested that coffee might be a contributing factor to feelings of nervousness and that Saida acknowledged a sinus problem, both women were explicit in their statements that their conditions were due to states of anxiety or anger.

A closer look at the personal lives of these informants would lead one to conclude that they might qualify as likely candidates for a "bad blood"- related illness: 1) They both married men several years their senior and were widowed at an early age. 2) They both have nurtured large families - Saida had nine children and Jarmilla had six. 3) They had the responsibility of raising their youngest children alone. Having this responsibility thrust upon them undoubtedly proved difficult. They coped remarkably well. Saida was left in better financial circumstances than Jarmilla, who was obliged to do domestic work to support the family. Both women have sought financial and emotional support from their adult children. It is also interesting to note that only these two

women admitted to using nefta. Saida justified her actions by declaring that she did not use nefta while she was married. This would not have been acceptable. Taking nefta could be seen as a rebellious action - one taken because it relieves the symptoms of their illness, but also as a symbol of independence.

Some treatments involve changing the diet. This might include dietary restrictions or prescriptive foods. Dietary changes are designed to restore the body's equilibrium by "cleansing" and "strengthening" the blood. Such changes are meant to have a long term effect. For example fenugreek, believed to "cleanse" the blood, is consumed regularly by those who have illnesses caused by bad blood. Houmra, a condition arising from bad blood, is treated variously. But treatment always includes a change to a meatless diet. (The etiology and therapy particular to houmra are discussed in Chapter Eight.) Sesame seeds, honey and almonds are believed to "strengthen" the blood, and thus are prescribed for heart palpitation and impotency.

Below are examples of cases wherein a specific food or diet is required:

Example #9

> Interview: Do you know of any treatment for diabetes (soukar)?
>
> Saida: There are several types of treatments for diabetes. The first treatment is a diet with fenugreek without sugar. Another type of treatment consists of eating a plant called ommroubia. However you have to be careful. Ommroubia has a very active, nervous agent and the person may die if they take too much of it.

Interviewer: What is ommroubia?

Saida: Ommroubia is a plant. I don't really know where it comes from. You can ask some people and they can bring it to you.

Interviewer: Is this a seaweed or an earth weed?

Saida: No, it grows on earth. They also say that you can take bitter almonds, juices of bitter almonds. They are effective in controlling diabetes.

Interviewer: Do you eat the bitter almonds with or without sugar?

Saida: Without sugar. Diabetes does not like sugar. People who have diabetes should not eat sugar everyday. However, once every two weeks they are allowed to take a little sugar.

Interviewer: Do you know of people who are diabetic who are using dwa 'arbi on a regular basis?

Saida: Yes. They usually have a diet consisting of barley products. They also eat bitter almonds.

Interviewer: Do you know of people with diabetes who prefer seeing a doctor rather than using dwa 'arbi?

Saida: No. But I know the opposite. I have a cousin who has diabetes who has decided not to take pills anymore and she is reverting to dwa 'arbi. So she started eating bitter almonds. She is doing all right now.

Example #10

Interviewer: Do you know of any treatment for an irregular beat of the heart (daqa)?

Chedlia: Yes, I do. What you do is you take luban (a type of aromatic resin). You take the luban and place it in a clay pot and then add water to it.

Interviewer: How much luban do you use?

Chedlia: You usually start with about 100 grams and then you add more, little by little. I repeat again, this luban is soaked in water in a clay pot, at night. The water has to be well water. It

cannot be rain water. And then every morning the patient drinks from the water in which the luban has been soaked. When the taste becomes very weak additional luban is added to put in more taste and aroma. It is also possible to chew this luban instead of drinking the water in which it is soaked.

I usually use this type of medicine for daqa or for anxiety - when I don't feel at ease and when I have mild stomach pains.

Interviewer: Do you know of anyone that has had problems with daqa?

Chedlia: Yes, I did. I went to see Dr. Benawsar and he didn't seem to find a cure for me. But by using the luban myself I seem to be doing alright. By the way, the recipe for treating daqa was given to me by an Algerian woman. She had advised me of the treatment. I have given the recipe to several other people and it seems to work. Those who did not use it kept on having the irregular heart beat.

Interviewer: What do you think causes daqa?

Chedlia: Well, I think it is working conditions, anxiety and in some cases pregnant women get daqa. Nervous reactions can also create an irregular heart beat.

Comment: Like headaches and nervousness (examples #7 and #8), diabetes and irregular heartbeats are perceived as being symptoms of bad blood. In the last two cases, specific medicines (luban for daqa and the herb ommroubia and bitter almonds for diabetes) are prescribed for these conditions. Patients are advised to take these substances regularly and, in the case of diabetes, to eat barley and avoid sugar.

Undoubtedly there was cognitive dissonance between the patients mentioned in Examples #9 and #10 and their doctors. Saida's cousin was believed to be suffering from diabetes and was given "pills" which apparently did not relieve the symptoms. (Diabetes that occurs in adulthood can sometimes be

controlled by antidiabetic drugs such as sulphonyluereas, tolbutamide, chlorproamide or biguanides. (Hodgkin, et. al., 1984). One can assume that either the illness was diagnosed differently by doctor and patient, or that the prescribed drug was ineffective. In the case of Chedlia, we can assume that Dr. Benawsar, trained in France, did not consider an irregular heartbeat an illness. Thus he was unable (or didn't feel it necessary) to recommend any treatment for her condition. In both instances the women found that dwa 'arbi helped them feel better.

Illnesses that are believed to be caused by "cold" air (which is synonomous to "bad" air) are sometimes treated by inhaling "warm" or "clean" air. It is believed that the warm air entering the body offsets the effects of the cold air lodged somewhere in the body. Thus shahega (whooping cough) is always treated by taking the patient to the sea or to the country - "to change the air"; fadda (asthma) is treated, as described earlier, by inhaling the smoke of an herb called "herb of fadda"; and 'agira (female sterility) is treated by sitting over a steaming hot pot of an herbal tisane. Inherent in the vapour treatments is the notion of restoring the balance of air within the body. Examples of how shahega is treated follow. They illustrate the idea of cold air being subdued by warm air. In addition they present us with specific examples of symbolic intervention.

Example #11

Interviewer: How do you treat shahega (whooping cough)?

Saida: The treatment for shahega consists in the use of an owl or exposing the child to fresh sea air. Let me tell you the shahega is best cured by simply changing the air. So if the person has been living in the country, the best thing to do is to go and stay near the sea for a few days, and if the person has been living near the sea, it is better for him to go and stay in the country for a few days. That is the best treatment for shahega. Also, the child should be fed the meat of the owl. The owl is killed and then cooked. The meat is then given to the child. In most cases it is the fried meat of the owl that is being fed to the child. The oil in which the owl was fried should be saved and given to the child every morning - about one teaspoon every morning. Believe me, I have tried this type of treatment with my children and it did work.

Interviewer: Where did you get the owl?

Saida: What do you mean, "Where did I get the owl?" I bought it from the hunters!

Interviewer: Can you tell me who told you about the treatment of using the owl?

Saida: Just from neighbors and people I come in contact with. In the past, when somebody had a sick child they would tell the others about it and everybody would tell them about a type of a cure they have known or heard about.

Interviewer: Can you tell me what are the causes of shahega?

Saida: Well, it is caused by (cold) air. It starts off as a small cough and then it becomes shahega.

Taking the patient to the sea air is a common treatment described for whooping cough. However, three informants discussed an additional treatment that could be used. Menobia explains:

Example #12

It is very hard for people with shahega to get rid of the problem totally, especially if they are young. My young brother had shahega at the age of about nine months. They don't seem to have a specific cure. However, there is a ritual that is used - it is conducted supposedly for the child to

get rid of the shahega. They will take the bones of the kadmar (a type of fish). This fish has a flat white bone. The bone is decorated in such a way as to make it look like a doll. Then they throw the doll inside a stranger's house, saying "We threw away the shahega we did not throw away the doll." And then the shahega will leave the child and go into the stranger's home. Well, we tried it. It did not work. My brother died of shahega.

At that time people did not take their children to the doctor. My mother tried her best to treat him with rubbing alcohol and rosewater. The baby died in my lap. I was holding him, and he just passed away. When he had shahega he kind of acted violently. He seemed to be out of breath. He turned blue in his face and then he died.

Interviewer: What do you think are the principal causes of shahega?

Menobia: It is said that it is caused by a problem in the lungs. The person will have a pocket of cold air that gets into the lungs.

Below Chedlia recommends changing the air, but reports that she has used a "throat cutting" ritual as well. She explains,

Example #13

The patient with shahega is placed on a boat and taken for a ride in the open air. Also, one can apply a treatment called "throat cutting". It is a pictorial throat cutting. You lay the child down and then move a knife back and forth on the throat seven times. The edge of the knife (the sharp edge) is away from the throat. ..... I used this "throat cutting" treatment on two of my children and they were cured. I took my daughter to the doctor. She was very sick with this disease. The doctor said that she lacked calcium. We used both the doctor's and the Arab medicine and the doctor didn't seem to be able to cure the disease. We had more success with dwa 'arbi. In addition to the throat cutting treatment, I massaged them with a paste made from a mixture of chicken fat and chocolate powder. Once they were covered with this paste they were wrapped up in a wool blanket and slept.

Comment: Shahega is obviously an illness that has proven

difficult to cure with dwa 'arbi, hence the proliferation of treatments. Amongst these treatments we find extraction rituals - imitative and transferal. The "throat cutting" and kadmar doll rituals are examples of imitative magic. When the throat is "cut" the air, it is believed, is more accessible and thus the child is better able to breath. When the doll (which is a replica of the sick child) is thrown into someone else's house an attempt is being made to not only extract the symptom/illness but to transfer it to someone else. Finally, prescribing fried owl as a treatment for shahega was frequently mentioned in the interviews. However no one could tell me why it was efficacious. They simply said it worked. The owl is referred to as "the bird of doom". Its presence on one's rooftop is an omen of death. It is believed that should this happen, someone within the house will soon die. Thus, why is the "bird of doom" consumed? Could it be an act of defiance? Or is it based on the principle of extraction via repulsion, as in other cases to be described below? I do not know.

Some treatments are based on the assumption that the patient will be healed if the illness can be extracted and/or transferred to another object. (We have already seen this in the examples of shahega above.) Extractions are done through repulsion, attraction or imitation. For example in healing the two types of jaundice reported (safra and bousafer), bousba (measles), caba (coughing), fatla (twisted muscles) boumra (erysipelas) and minun (possession), there is an attempt to extract the illness through repulsion or imitation.

There is no reference to transferral. In treating spleen disorders, scorpion stings and ringworm, it is quite clear that the illness is extracted by attraction to an object, which then absorbs the illness. Finally, in the case of shahega (whooping cough) and rasmi yikbki ("continuous crying") of a baby, the treatments are clearly an example of imitative magic with the emphasis being on the transferal of the illness (the extraction is implied). Examples that illustrate the processes involved in extraction rituals follow.

Repulsion

Treatment descriptions for housba (measles) are almost unanimous. The standard treatment includes dressing and covering the patient with red cloth, rubbing the patient with goat milk, feeding the patient goat meat, goat milk and fish, and burning goat hairs. As one informant explained, "Measles do not like red things". Furthermore, everyone agrees that goat products smell bad. (Goats are not normally eaten in this region of the country.) Thus housba is encouraged to leave in order to escape the "red" and the smell of goat. The ritualized treatment attempts to extract the illness through repulsion - red (cloth) repelling red (measles). This principle is also found in the treatment of jaundice. This is illustrated in the case below:

Example #14

Interviewer: How do you treat housafare (a type of jaundice)?

Chedlia: You can feed the patient grilled fish or a piece of liver spiced with turmeric or saffron. The patient eats this every day for seven days. Or you can mix turmeric with raisins, and for seven days the patient is to eat seven raisins each day.

Another type of treatment is the burning with fire. Take a piece of blue cloth that is burning, and come to the back of the person without him knowing it and then stick them with it. You burn them with it. The fear that is caused by the burning will usually clear this type of jaundice.

Interviewer: What causes this type of jaundice?

Chedlia: Fear. If a person is scared then they will get it. Sometimes it is caused by anxiety too.

Comment: As in the case of housba (measles), "like repels like". Fear (the cause of safra) and yellow substances (yellow being a symptom of safra) can be used to repulse the illness from the body. (The numbers of three, seven, and forty are often used in treatment descriptions. This is a reflection of the Judeo-Christain-Islmaic tradition of the Mediterranean cultures.)

Attraction

Sibina (ringworm) is believed to be caused by the evil eye. Further it is said to "look like an eye". It is treated in the same fashion by all informants. The standard treatment for this problem is as follows: One is to find an egg that was laid by a black hen on a Thursday. The egg should be cooked until hard-boiled. The yolk is then wrappped in a cloth (often blue cloth is specified). The wrapped egg yolk is then heated over a charcoal fire. When heated thoroughly it is placed on the sore. As was explained by one informant: "The worm is attracted to the egg". The egg yolk and cloth

are then discarded.

Marɑ bit tihan ("sickness of the spleen") and varicose veins (ark el-isse) are also treated on the basis of "like attracts like". This is indicated in the excerpts below:

Example #15

Interviewer: How do you treat marɑ bit tihan ("sickness of the spleen")?

Chedlia: Spleen problems are cured with a spleen. Go to the butcher and obtain a beef spleen. Salt it and dry it. Place the spleen on the patient's spleen. Place a blue cloth on top of it. Take a piece of metal, usually a sickle, and put it into the fire. Then place the hot metal on the cloth that is over the beef spleen. Press on the piece of hot metal and then there will be smoke coming out. The beef spleen will most likely sizzle. Continue the treatment for about three days. Usually after three days the patient is cured.

Interviewer: What do you think causes "sickness of the spleen"?

Chedlia: Anxiety and sadness.

Example #16

Khadeja: The treatment for varicose veins consists of obtaining the root from a fig tree and a piece of thread. Both must be the same length. The root of the fig tree is first covered with incense and then placed alongside the affected vein with the thread. A white cloth is then applied to the leg as a bandage. The person then must leave the house quietly, not uttering a word until she comes to a desolate place in the cemetary. There she digs a hole, pulls the string and buries it into the hole. This is supposed to make the illness disappear.

Interviewer: Do you know if this is a successful treatment?

Khadeja: Yes. Si Hedi used this treatment himself to treat his own varicose vein. It was several years ago when he last treated his varicose vein. The varicose vein dried up completely.

Comment: The causal factors that result in ringworm, "sickness of the spleen", and varicose veins differ from one another. Nevertheless the principle upon which treatment is administered is the same. It is believed that the illness-producing agent can be drawn into an object or organ similar to the affected part of the body. Thus, in the case of varicose veins and "sickness of the sleen", the string and beef spleen become the receptacle of the illness-producing agent. In these cases bad blood and bad bile were thought to be the cause of the illness.

Summary

Whether or not dwa 'arbi ethnomedicine includes medical substances and techniques that are efficacious from a biomedical point of view is beyond the scope of this research effort. However it should be noted that many drugs used in biomedicine today are derived from plants that have been used by indigenous healers in various parts of the world. (Aikman, 1977, Torrey, 1972) Furthermore, the effectiveness of fats and oils, minerals and various herbs and animal products used by non-western healers has been documented. (Alland, 1970) Given that, I suggest that the tenacity of dwa 'arbi must be due, at least in part, to the fact that the herbal and dietary remedies have proven effective (through a trial and error process) in controlling or treating the symptoms of some illnesses. Further research, however, is necessary to validate this assumption.

Comparing the basic principles of tibb al-'arbi (described in the preceding chapter) and dwa 'arbi, it is

evident that the etiology, and probably the pharmacopoeia, of tibb al-'arbi has been handed down orally in the informal institution of dwa 'arbi. Furthermore, an analysis of the examples illustrates that the cognitive bases of dwa 'arbi have remained viable as a means of understanding health and illness in the Tunisian context.

Therapy in the natural sphere (as well as the supernatural sphere) is aimed at restoring a balanced condition within the patient. This is achieved by various modes of intervention, ranging from symptom-specific to symbolic treatments. Examples cited in this chapter can be placed on a continuum, beginning with the symptom-specific treatments for skin irritations and head injuries ending with symbolic treatments for "sickness of the spleen" and varicose veins. Illnesses treated by symptom-specific intervention tend to be those which are "god-given" and thus "natural", ie. burns, cuts, broken limbs, etc. Alleviation of discomfort is the primary concern. The cause may or may not be known. Whereas illnesses treated symbolically are generally those whose causality is understood and addressed. In the following chapter we will see that extraction rituals are particularly evident in the treatment of illness caused by supernatural agents. They thus supply a basic theme, or cognitive structure underlying the two spheres, natural and supernatural.

CHAPTER SEVEN

APPEASEMENT OR EXORCISM: ETHNOMEDICINE AIMED AT RESTORING BALANCE IN THE SUPERNATURAL SPHERE

The aims of the treatment in both the natural and supernatural spheres are very similar. In the natural sphere the illness-causing agents are neutralized or eradicated by dwa 'arbi treatments. In the supernatural sphere the illness-causing agents are perceived of as forces or spirits which can either be appeased (in the case of saints) or exorcised (in the case of evil eye or possession). Achieving a psycho-physiological balance is the ultimate goal of the ethnomedicine used in both spheres.

In this chapter the ways in which individuals attempt to mediate with the supernatural is described. Many individuals communicate with saints directly. They visit their shrines frequently and in times of need ask them for favors. These favors sometimes include healing a family member. However some illness-episodes require the services of a human intermediary - one who has been selected by a saint through a dream experience. It is the latter who administers treatment for illnesses caused by the supernatural.

THE SAINTS AND THEIR SHRINES

Throughout Tunisia, as in other parts of the Maghreb, shrines are found everywhere. They dot the countryside, they are focal points in small villages, and they are found in countless enclaves in towns and cities. (A list of shrines mentioned by the informants can be found in Appendix IV.)

Worshipping and communing with saints is a phenomenon that can be traced back to the introduction of Sufism in North Africa. Sufism (as explained in Chapter Five) is the experiential, the mystical expression of Islam. It is not respected by the more conservative Sunni muslims. Nevertheless, a large proportion of Tunisians who consider themselves Sunni muslims do venerate the saints, erecting tombs and shrines in their honor and visiting them frequently. They believe that saints can act on their behalf - telling them the future, granting them their wishes and healing their sick. This has been well documented by anthropologists such as Gellner (Saints of the Atlas), Eickelman (Moroccan Islam), Rabinow (Symbolic Domination), and Crapanzano (The Hamadasha) in particular.

Men and women do not become saints until after their death. At that time a tomb is constructed at the burial site. When funds are available, people in the community erect a shrine in their memory. The saints are remembered for their good works and generosity while alive. Legends of how they became saints and their miraculous deeds are told and retold. I was told the legend of Lella Oum Ezzine on several occasions. (See Appendix V)

Every shrine has a caretaker (hafid (male) or hafida (female)). (Plural forms are: hafideen (masculine) and hafidet (feminine).) Caretakers are responsible for the maintenance of the building, and in some cases are intermediaries for the saints themselves. The majority of the shrines are served by hafidet. This is so because women visit the shrines much more

frequently than men. Consequently it is viewed more appropiate that the caretaker be female. One woman explained that if the caretakers were male, husbands would not permit their wives and daughters to visit these shrines alone. In fact, if there is an instance where a woman must go to a shrine tended by an _hafid_, she will be accompanied by her husband, brother or father.

Caretakers or mediums may be the descendents of saints, but this is not always the case. More often than not the family ties connecting individuals to a saint are lost in antiquity. Being a caretaker is not dependent upon being related to a saint, as is the case in Morocco or Algeria (as described by Eickleman and Gellner, respectively). What I found instead was that in those cases where a person had been chosen by the saint to act on his/her behalf, the saint materialized in a dream and passed the healing power (_baraka_) to the invidividual by spitting into the medium's hand. In some cases the person chosen was believed to be the saint's descendant, but this was the exception, not the rule.

Shrines serve a variety of functions in Mahdia and elsewhere in Tunisia. Young people sometimes are given permission to hold club meetings there; migrants can find shelter there when the weather is inclement; and I was even told that clandestine meetings of young men and women took place in the surrounding fields of the shrines on the outskirts of town. However shrines are primarily places of worship and a gathering place for visiting friends and family.

I will return to this shortly.

Shrines and their devotees have not been immune to political activities. During the French rule they were often closed and thus public ceremonies became illegal. The French suspected (correctly so) that shrines were being used by political revolutionaries for organizational meetings.

After Independence the shrines were reopened. However the government did not at first encourage their use. President Bourguiba believed that they fostered a "backwards" mentality and were incompatible with his goal of modernization. Nevertheless he found it prudent to let people worship at the shrines as they wished. Approximately five years ago, according to rumour, the government was beginning to harbour fears that the shrines were once again becoming havens for the restless youth who want dramatic changes in national politics. Rather than squelching the use of the shrines and thus engendering the wrath of the population, Bourguiba has granted money to many shrines in order that they be used by a wide range of clientele -- not just the youth.

As a result of the infusion of government funding plus the overall increase in the standard of living, visiting shrines is on the increase. (People can better affrd the funds necessary to make a ilgrimage r hoold a feast at a shrine.) Primarily shrines are visited on the following occasions: a) for a casual visit as part of an outing; b) to celebrate an Islamic holiday; c) for a w'ada; d) to seek a cure for a specific illness; and e) to participate in a badra. Each of these occasions will be described below.

VISITING SHRINES

Casual Visits

Women will sometimes schedule a visit to a shrine during "visiting hours" (mentioned in an earlier chapter). These visits are usually included in the weekly pilgrimage to gravesites in the cemetery. Thus every Friday one can see groups of women and children strolling to and from the cemetery. If they have time they will stop at a favorite shrine. They will take candles and incense with them as offerings to the saint, as well as light snacks (cookies, sunflower seeds, soft drinks) to eat while there.

Upon arrival certain rituals of etiquette are observed. One enters into the courtyard and walks directly to the "room of the tomb", addressing the hafida if she is present. Upon entering the elaborately decorated "room of the tomb" shoes are removed. One then walks across the fiberous mats to the tomb of the saint. The tomb is usually to the side of the room behind a four foot high partition. It is covered with numerous banners that often come from Mecca. Here one says a prayer, or at least stands quietly for a few moments paying homage to the saint and Allah. Afterwards the candles and incense are either lit or, if some are already burning, they are given to the hafida for later use. Once etiquette has been observed the women find a spot to sit down either within the "room of the tomb" or on mats outside in the courtyard. After an hour or two has passed the women will leave for home, giving the hafida a few millimes. (If the shrine is crowded

with other visitors they will not stay to visit among themselves as planned, but will return home.)

Occasionally visits to shrines outside of town are made. These visits involve the whole family. In this case a picnic meal is prepared.

Calendrical Rites

Some of the larger shrines can accomodate large numbers of people, either because of the size of the shrine itself or because it is located in an open area. It is these shrines that receive visitors during Ramadan, the 'id al-Kabir and on Mohammed's birthday. Families come to visit the shrine and to be part of a larger celebration. Music is played by hired muscicians, hadrat are held and healers perform miracles. Depending on how far the family must travel, some will bring food and bedding for an overnight stay.

W'ADAT:NEGOTIATIONS WITH THE SAINTS

A w'ada is a promise given to a saint, whether publicly or privately. An individual asks a particular saint to grant them a wish, promising to perform a specific deed or give a gift in honor of that particular saint should the wish be granted. For example, a woman may promise to give a dinner at the shrine of Sidi Jebar if her wish is fulfilled. This she does in honor of Sidi Jebar. W'adat, then, are social gatherings that take place at a shrine, hosted by the person whose wish was granted. Promises are always performed publicly, acknowledging the power of the saint.

Every shrine is littered with hundreds of gifts, including fans, chandeliers, rugs, baskets, scarves, pictures, etc. Gifts promised vary depending on the affluence of the family and the importance of the wish. Thus promises range from the donation of a banner to promises of slaughtering and cooking a cow on the premises, and then distributing meat to guests and residents living close to the shrine. In some cases larger donations are promised, such as additional rooms, kitchen appliances, doors, partitions, etc.

Wishes made to the saint vary according to the situation of the person making the wish. In some cases the wish is for the safe delivery of a baby or for a baby of a particular gender. In other cases the wish may be for the health of a baby through its first year, for the safe return of a traveling son or for the speedy recovery from an illness.

Once the wish is granted the person making the wish makes preparation for the w'ada - the fulfillment of her promise. The consequences for not fulfilling the promise are discussed later.

The number of people attending a w'ada depends on what was promised. Most w'adat include the distribution of food, and thus the number in attendance will be determined by the amount promised. W'adat may include a small party of ten for just the immediate family, or may exceed 100 persons.

The hafida's role during the w'ada is to oversee the activities guaranteeing the safe-keeping of the shrine. She will visit with the guests, direct them to existing facilities, etc. At the end of the day she is given money for

her services. The amount of money is left up to the family holding the w'ada. According to one informant, if a sheep was slaughtered and distributed on that day as part of the w'ada, the hafida should be paid one fourth the price of the sheep. The hafida uses this money for her personal needs and for the upkeep of the shrine.

Two W'adat at the Shrine of Sidi Masoud

The shrine of Sidi Mas'oud is located at a highway junction just outside of Mahdia. It is believed that Sidi Masoud was a man who lived during the Turkish era. (Although some contend that he dates back to the Beni Hilalah invasion during the 11th century.) Most everyone agrees that he was a military man who traversed the Sahel (coastal region), making this area his permanent base. He was a man of great wealth and prestige. But he was particularly known for his kindness and generosity for those living in the area. When he died he was buried at the present site, which at that time served as the burial grounds for people living in the area. Thus many of his comrades and descendants are buried there as well. Today Sidi Mas'oud's tomb is all that remains of the ancient cemetery.

Throughout the years people have paid homage to Sidi Mas'oud. Long ago the community erected a shrine in his name which has been maintained intermittently through the years. Located on the main thoroughfare between two major towns (Sousse and Sfax) many people visit the shrine, contributing to its maintenance with their donations. Depending on the

affluence of the economy and the political situation, additions and renovations have been made. Recently the shrine has received a number of donations from patrons as well as funds from the government. The government has seen the value of utilizing these shrines as community centers. Thus the influx of funds has made it possible to expand the facilities at Sidi Mas'oud, increasing its capacity to hold large crowds of people.

A description of two w'adat follow. The first one, a hair-cutting ceremony, was called by the woman herself a "little w'ada". The second w'ada was much more elaborate, involving a hadra.

Hair-cutting Ceremony

Quite often w'adat coincide with childhood rites of passage such as a first haircut, male circumcision, a celebration announcing the graduation from primary school, or the passing of an entrance exam into secondary school. For example, a woman might promise that if her wish is granted she will hold a w'ada when her son is circumcised.

When Fatma discovered she was pregnant she was not very happy about it. Her four children were now all in school, leaving her more time to pursue her craft - knitting. For several years she had been selling sweaters, coats and dresses made on her knitting machine. Now that she had more time to spend at the machine her small business was beginning to show a profit. She was a devoted wife and was very fond of her children -- three girls and one boy. This pregnancy was not a

planned one. She debated what she must do. The next child could be a boy, which would be nice, but it also could be another girl. She considered aborting the pregnancy and discussed the matter with her mother, sisters and the rest of the family. It was in this context that I learned about her dilemma. Many in the family felt that having an abortion would be _haram_ (a sin). Whether or not this was indicated in the Koran was argued at length - both in her presence and in her absence. Eventually she decided to continue the pregnancy.

While pregnant Fatma made a promise to Sidi Mas'oud that, if this baby was a boy, she would have his first hair-cutting ceremony at the shrine of Sidi Mas'oud thus attesting to the saint's greatness.

During the winter months she had a healthy baby boy to the delight of the entire family. He quickly became the interest point of his older siblings who doted on him continuously. As promised the hair-cutting ceremony was arranged for a Thursday afternoon in July at Sidi Mas'oud. This was to be a small _w'ada_, for hair-cutting ceremonies are minor affairs.

Members of the extended family on both sides of the family were invited. The women came first, driven by the men who would return later. Thus Fatma's mother, sisters, mother-in-law, sisters-in-law and a few cousins came, bringing with them their daughters and sons under the age of eight years. The women brought their own _drebik_ (clay drums made locally)

and tishtri (tambourines). After praying in the "room of the tomb" near the saint's tomb, which they did individually, they assembled in the shaded area of the courtyard. Here they talked, laughed, played the instruments and sang songs. Several rounds of soft drinks and cookies, tea and baklawa were served during the two hours of visiting.

Then the men returned - the father of the child, Fatma's brother-in-law, her brother and her eldest son. The hafida led the family into the "room of the tomb" and brought them up to the tomb itself. The mother held the five month old baby in her arms. Her husband and other children were nearby. The hafida said a short prayer. Then, using a razor, she quickly cut a one inch patch of hair off the back of the child's head. (This was indeed a ritual haircut, for that was all the hair that was removed.) Unfortunately the hafida inadvertently cut into the baby's head drawing blood in the process. He wailed! The women gave their traditional high pitched trill as a show of happiness. But then the older women broke out into a feverish rage - hurling verbal assaults against the hafida. They were angry! How could she be so incompetent? Why wasn't she more careful? Why didn't she take her time and do it correctly? The incompetency of the hafida was a topic of conversation for days after. (Note: The younger women, including the mother of the child, quietly complained about the baby being cut but did not attack the hafida directly. A younger person always shows respect to their seniors.)

The w'ada was over. Despite the displeasure of the

participants, each woman, in turn, gave the hafida about 500 millimes. People began to leave, with the men driving the women home.

Hadra

Frequently women's gatherings such as a w'ada are punctuated with a hadra. Occasionally hadrat are held at home for no particular reason. Hadrat are defined by the presence of hired musicians who play hadra music. This music is very characteristic in having a rather hypnotic drum beat that continues endlessly. The musicians are led by a mashta who is the lead singer and determines what songs will be played. The songs are about saints - their powers, their good works, etc. Women get up one by one, and dance to the monotonous beat. They dance a noba, which is a song that lasts approximately five to ten minutes. Sometimes a woman will dance several nobat in a row and fall into a trance, communicating, it is believed, with a saint.

Men have similar gatherings, but they are called hazb. Women are not permitted to attend hazbs. With the exception of the hadrat that are held at Sidi 'Akmer, which are similar to those held by the Hamadasha in Morocco (Crapanzano, 1973), hadrat are strictly female gatherings.

Rachida, while pregnant with Ali, made a promise to Sidi Mas'oud. (I am not sure the reason for doing so, but presumably it was to insure a safe delivery or a male child.) However after the child was born she forgot about the promise and never held the w'ada. Time went by and Ali was now 10

years of age. The family began to experience "difficulties". At one point Rachida dreamt of Sidi Mas'oud who reminded her of her promise. She awoke and remembered making the promise - but then did nothing about it. Soon the family began to have trouble with their car. Everytime they took the car out of town the car had some type of mechanical breakdown. Over the last year the car was in the garage four months in total. One night when they were returning from Tunis the family had an accident. No one was badly hurt but they were badly shaken. Rachida, her mother-in-law and two children remained in the car while Rachida's husband went for help. While stranded the two women reflected on their run of bad luck and Rachida traced the cause of their problems to an unfulfilled promise to Sidi Mas'oud while pregnant with Ali. They made a promise then to Sidi Mas'oud: If they were rescued safe and sound they would hold a hadra at Sidi Mas'oud, slaughtering a sheep and preparing a meal for their invited guests to enjoy in the name of Sidi Mas'oud and Allah.

Thus it was that the w'ada was held at Sidi Mas'oud. This w'ada was considerably larger than the hair-cutting w'ada held by Fatma. Approximately 50 people attended, two thirds of whom were women.

Rachida, her husband and mother-in-law went to the shrine early in the morning. This was necessary in order to slaughter and butcher the sheep for the couscous meal to be served at midday. (Couscous is a dish made of steamed semolina and is served with meat, chicken or fish, plus an

assortment of vegetables.) All of the preparations were made in the kitchen of the shrine. Rachida and her husband were assisted by Rachida's mother and sisters.

At about 11:00 a.m., people began to arrive. (Some people who had come a great distance went around to the side of the shrine where there was a tree. Here they tied pieces of cloth to the tree which was already filled with similar bits of cloth. Then they asked the saint to grant them a safe return.) The women and their children went into the "room of the tomb" while the men mulled around outside in front of the entrance. Then the women and children were ushered into the entrance hall where several low tables were set with plates of couscous (one plate for two to three people), pitchers of water and two loaves of bread per table. The women and children sat on the floor around the table and began to eat. The atmosphere was generally quiet throughout the meal.

In the meantime the men were being served in the open courtyard. After they had eaten they left, leaving their mothers, wives, sisters, daughters, and small sons to enjoy the hadra. The women and children were then free to return to the courtyard and the "room of the tomb".

By 2:30 p.m. the mashta and her muscians arrived for the hadra. They brought with them two or three drebik and the same number of tambourines. Rachida and her mother-in-law had made previous arrangments with the mashta as to their renumeration.(1)

As the musicians settled in one corner of the courtyard the women assembled themselves around them. The instruments

were heated over the kwanin in which incense was already burning. (Kwanin are small clay pots where a fire is kept burning for tea and incense. They are found in every household.) The hadra had begun. Women took turns dancing their nobat. The movement of their dance was very soft and feminine. Small steps were taken while the body swayed back and forth. The movement was enhanced by the twitches of the scarves held by the dancer. Most women danced only one noba, but some danced longer. When the dancer was tired she sat down and another dancer took her place. At this hadra, as at most women's gatherings, little girls on the sidelines were imitating their mothers and older sisters, dancing on their own. The girls did not go unnoticed, but rather were encouraged to continue and perfect their dance.

The music and dancing continued for about 45 minutes and then one woman in her late 30's got up and began dancing. She began as the others had, but her movements became more abrasive - lunging backwards and forwards. The mood changed. The steady drum beat got louder, as did the singing and everyone focused their attention on the dancer. She danced four consecutive nobat before she became obviously out of control. She lifted her head back, her eyes rolled upwards, and she began to stagger around. Children were moved out of her way and she was led into the inner room of the "room of the tomb" where she was left alone. The music and dancing continued and eventually the woman came out from the "room of the tomb". She gave a short speech wherein she presumably

talked about her experience while in the trance. Neither of the women sitting next to me could understand her utterances. Clearly she had "experienced" the presence of a saint -- not necessarily that of Sidi Mas'oud. She sat down with the rest of the women but remained quiet and sedate for the rest of the afternoon.

(On the following day we tried to set up an interview with this woman but she had left early that morning for Tunis. She had been holidaying in Mahdia with her family.)

About 5:00 p.m. more platters of couscous and stuffed tripe were served, but this time we remained in the courtyard for the men were still absent. Afterwards the hadra resumed. At 6:00 p.m. our ride came for us and it was time to go home. The hadra continued, however, for a few more hours.

W'adat Held as a Result of a Healing - Two Cases

Approximately one half of the w'adat described in the interviews are related to maintaining or regaining health. In almost all cases women are the ones who make the promise. Usually the promises are made on behalf of their children. Below are excerpts from two interviews. They exemplify the majority of the cases that involve spiritual healings stemming from a promise given to a saint. The first case is a first hand account of a miraculous healing. The second case is told second-hand and illustrates the dire consequences of not fulfilling a promise.

Case No. 1

One time I promised Lella Ezzine a hadra if my

daughter (two years old), who had been ill for a long time, was cured. I had already spent more than 2000 dinars in medical care with no success. She had polio. It was shortly after my pledge to Lella Ezzine that Saida started sitting down and feeling better. When she started being cured (moving her fingers and being able to sit), I fulfilled my promise to Lella Ezzine, including holding a hada, spending a night with the family at the shrine and giving Lella Ezzine a banner.

At the shrine I applied henna to my daughter and to myself - on the feet and on the hands. Then we had a hadra. Early in the morning of the next day (about 4:00 a.m.) I heard a noise coming from near the well which sounded like somebody was playing with the pail. I went to check and I found my daughter playing with the water with her shoes and socks on. She had never been able to put her shoes and socks on by herself before. She was taking water out of the pail with her hands and placing it into a dish that was left there the night before.

Later in the interview this woman told me that her husband had originally scoffed at the promise made to the saint and was not interested in fulfilling the promise. The following day he "had problems with one eye". He sought medical help but to no avail. He then agreed to go with his wife and family and spend the night at Lella Ezzine. He was "miraculously" cured the following day.

Case No. 2

A friend told me about an incident involving her mother-in-law. The woman went one day to harvest wheat in a field near Sidi Bou Hassine. The woman spent the nights with her young daughter in the shrine of Sidi Bou Hassine. A rat was living in the shrine and was getting into her food. So one night she took some flour and made some flour dough adding poison. She made balls and placed them near the tomb. The young girl woke up, found the balls and ate them. The mother came back to find the child very sick after eating the balls. The woman started praying and calling on Sidi Bou Hassine to cure her daughter. With God's help the girl vomited and was cured.

During the episode the woman promised Sidi Bou Hassine that she would give half of the harvest in

his name. Unfortunately for the girl the promise was never fulfilled. Many years later the young girl fell sick and they tried several treatments, but they didn't work. The girl (a young woman now) saw in her dreams visions of Sidi Bou Ḥassine telling her that she was possessed and that the promise had to be fulfilled on her behalf. The young woman refused to accept the vision claiming she had not made any promises. In her dreams of Sidi Bou Ḥassine he told her she would have to become "part of his shrine". (This meant that she was expected to marry the saint, holding the ceremony at the shrine.) She remained ill for a long time. She continued to refuse compliance with the wish until she died.

The Consequences of Unfulfilled Promises

As is evident in the cases described above, most w'adas follow a similar pattern. First, a promise is made by an individual, usually a mother on behalf of her child. Second, the wish is granted by the saint. Third, a w'ada is performed by the family. However there can be deviations from this pattern. For example, sometimes the saint does not grant the wish made by the "promiser". This is readily accepted as "God's will". More likely, however, it is the "promiser" who defaults on the promise. Sometimes promises made are simply forgotten. They may have been made under duress during a crisis and then once the crisis passed the promise was put out of mind.(2) In other cases the promise represents an economic sacrifice the family, especially the husband, is either unable or unwilling to make. Only after the saint sends reminders in the form of accidents, minor illnesses, bad luck or the materialization of himself/herself in a dream, will the family go on with the w'ada.

Every informant stressed the importance of fulfilling a

promise made to a saint. Regardless of how trivial or expansive the promise, if a promise is made it must be fulfilled to the letter. Every minute detail must be enacted if so stated in the promise. If the promise includes the slaughtering and distribution of a sheep to guests and people living in the zanga of the shrine, then this must be done. If any leftovers are brought home instead, then the person has reneged on the promise. It remains unfulfilled. If a promise has been made to hold a circumcision and hadra at a shrine there can be no deviation from this original plan, i.e. holding the hadra at home. The promise must be fulfilled exactly as stated.

Saints will take retribution if a promise is either unfulfilled or partially filled. One informant explained that saints are fairly lenient in the time they allow a person to fulfill their promises. That time period is roughly three to four years. But if a w'ada is not held within that time period the saint will begin to give the promiser trouble, in the form of illness or other misfortunes. Sometimes the saint may appear in a dream - either in a dream of the promiser or interestingly in the dream of a relative.

An Analysis

W'adat are held to give public recognition to the saint's power and benevolence. Latently, w'adat are a demonstation of the promiser's integrity. Thus w'adat are the manifestation of a successful transaction that has taken place between a saint and a human. The status of both the promiser

and the saint are enhanced by this public display. Belief in the saint's power is strengthened in the community and the prestige of the promiser rises in the eyes of her friends and family.

In addition to the benefits experienced by the people involved in the transaction, w'adat also act to reinforce societal norms and values. Values such as those related to generosity, gift-giving and being dutiful are expressed. Kinship roles, in particular that of the mother, are underscored.

Generosity is an extremely important value in Tunisian culture, as is true in other Arab cultures. The giving of food and presents is perceived as acts of generosity. One's status can rise or plummet on the basis of how generous one is with family, neighbors, friends or employees. Giving food is probably the most prevalent demonstation of one's generosity. When visiting a neighbor or relative the vistor brings with her a food gift to present to the hostess. (Traditionally that gift consisted of a box of sugar cubes, but more recently women bring pastries purchased in one of the local bakeries. Unless the vistors are particularly good friends, the pastries are eaten later after the guests have left. To serve the visitor with their own gift would be inappropriate.) The guest, on the other hand, is presented with several rounds of pastries and drinks.

If invited to a meal one is presented with a banquet, complete with a variety of dishes, heaped in large bowls. The amount of food prepared is always far greater than what can

possibly be consumed in one sitting. The goal is not simply to provide guests with a hearty meal, but to show one's generosity and to a certain extent one's affluence. (In this regard there are some similarities with the Pacific Coast Indian potlacth.) This spread is offered to the guest, often at considerable financial sacrifice.

Gift-giving occurs on a number of occasions in Tunisia. Sometimes presents are more appropriate than, or given in addition to, food gifts. For example, gifts of money, cloth and jewelry are given at weddings and circumcisions. Gifts are also given during the 'Id al-Kabir and other Islamic holidays. These gifts are given to the poor as a form of tithing and to children. Persons travelling abroad are given gifts on their departure and upon their return they are expected to bring gifts for each family member. Finally, children's birthdays have become an occasion on which to give gifts. This is a recent innovation which started in Tunis and is now spreading to Mahdia and elsewhere in the country.

Gift-giving serves at least two important functions in any community. First of all, an exchange of gifts acts as a means of distributing goods. Secondly, gift-giving establishes and perpetuates a norm of reciprocity. This norm often reinforces solidarity, particularly in egalitarian, kin-based communities. (Lee, 1969, Harris, 1971)

Reciprocal acts involving gift-giving or extending services (favors) create obligatory ties between giver and receiver. Both participants anticipate a reversal in roles,

generally within a specified time period. This sense of anticipation and feeling of indebtedness provides the cohesiveness of a community - one in which individuals are linked with various other individuals in the community. To a certain extent behavior is regulated in situations wherein the individuals are bonded by gift-giving. The norm of reciprocity requires that the debtor does not break off relations with the creditor. It is to the advantage of the creditor to also maintain good relations with the debtor. Thus social relationships are reinforced by this bond. (Gouldner, 1960)

In Tunisia gifts are exchanged in the context of both generalized and balanced reciprocity. Generalized reciprocity (wherein the amount to be repaid is indeterminate and the time period not specified) is exemplified by giving presents or money to children or servants and in tithing during the 'id al-Kabir. Balanced reciprocity occurs during certain occasions, such as afternoon visits from family or friends (boxes of sugar are brought by the visitor), at weddings (money gifts are given by guests attending the Henna, sheep may be given by a neighbor or relative, and food is exchanged between the family of the bride and groom), at circumcisions (gifts are given to the parents of the child), when travellers return from abroad (the travelers give gifts upon their arrival and receive gifts on their departure), children's birthdays, and dinner invitations between friends.

W'adat can be understood in this context. W'adat are a time for gift-giving. Not only are friends and family given

food at the shrine but more importantly, the saint is given a gift (one promised) and is honored publicly. This exchange (a wish fulfilled and a promise delivered) is one of balanced reciprocity. If the saint does not fulfill the promise a w'ada (gift) is not given. On the other hand if the wish is fulfilled and the promiser does not hold the w'ada, the saint will punish the promiser by causing an illness or some other kind of misfortune. The norm of reciprocity, then, serves to integrate the living and the saints just as it does among humans.

Gifts are not to be confused with bakshish. Bakshish is a bribe that is paid before the fact. Gifts that are given during w'adat, whether in the form of distributed food or a banner for the "room of the tomb", are given after the promise has been fulfilled. Thus the person does not bribe the saint with offerings but rather gives gifts as a matter of duty.

And this brings us to another important Tunisian value - the importance of being a dutiful human being. One is expected to be dutiful to one's family and neighbors. Children learn to respect their elders and to do their bidding without question. Often one hears a parent admonishing an adolescent who asks, "Why do I have to do this?" The parent replies, "Because it is your duty to do so." Parents likewise have a duty to provide shelter, clothing, food and a nurturing environment for their children. As adults both men and women show continued respect for their parents and will, as much as possible, obey the commands of their aging parents.

This attitude stems from the Islamic religion itself which is based on the notion of "surrendering" of oneself to the one and only god, Allah. ("Muslim" means "one who surrenders".) The Koran is a guide in "right behavior", explaining the duty of every member of society. For example, Suras 4, 6, 17, 29, 31, and 46 outline the behavior and duties expected of children toward their parents. Sura 17 also discusses the responsiblities parents have towards not only their own children but to orphaned children as well. The following quotes from the Koran best express the values learned by every Muslim in regard to duty and generosity. From Sura 4:40 -

> Be kind to parents, and the near kinsman,
> and to orphans, an to the needy,
> and to the neighbour who is of kin,
> and to the neighbour who is a stranger,
> and to the companion at your side,
> and to the traveller, and to that your
> right hands own. Surely Gold loves not
> the proud and boastful
> such as are niggardly, and bid other men to be
> niggardly, and themselves conceal
> the bounty that God has given them.
> (Arberry, Vol. 1, 1955, p.106)

From Sura 17:20-25 -

> Set not up with God
> another god, or thou
> wilt sit condemned
> and forsaken.
> The Lord has decreed
> you shall not serve
> any but Him,
> and to be good to parents,
> whether one or both of them
> attains old age with thee;
> say not to them 'Fie'
> neither chide them, but
> speak unto them words
> respectful,
> and lower to them the
> wing of humbleness

out of mercy and say,
'My Lord,
have mercy uppon them,
as they raise me up
when I was little.'
(Ibid., pp.304-305)

From Sura 46:10-15

We have charged man, that he be kind to his parents; his mother bore him painfully, and painfully she gave birth to him; his bearing and his weaning are thirty months. Until, when he is fully grown, and reaches forty years, he says, 'O my Lord, dispose me that I may be thankful for Thy blessing wherewith Thou hast blessed me and my father and mother, and that I may do righteousness well-pleasing to Thee; and make me righteous also in my seed, Behold, I repent to Thee, and am among those that surrender.'
(Ibid. Vol. 2, pp.216-217)

An honorable person, then, is one who is respectful to one's elders, parents in particular, and one who keeps his word and acts generously. In performing a w'ada the individual demonstrates their desire and ability to do their duty - in this case, to fulfill a promise made to a saint.

W'adat are opportunities in which women can perform their role as generous hostesses, and by doing so mobilize resources and family members. (They also does this during the women's part of the wedding and circumcision festivities, but not as exclusively as in a w'ada.) In the majority of cases women initiate w'adat. They usually make promises to the saints privately but will often tell a close relative (female usually) about the promise. When the promise has been fulfilled, provided she doesn't forget or is unable to finance it, a w'ada is scheduled. The woman makes the invitation going from house to house personally to invite the guests. She

arranges for the use of the shrine, hires the musicians and prepares the food, getting help from neighbors and women in the extended family.

Sometimes the women finance the w'ada alone. But more often, especially if it is a "big w'ada", the husband must provide the funds. His participation does not end there. He must purchase the food at the marketplace, provide transporation for those attending (which usually means finding other male relatives with cars), supply the money to be paid to the hafida, the mashta, and to purchase any gifts to be donated to the shrine. On the day of the w'ada the husband must slaughter and butcher the sheep and then, when the guests arrive, to play host to the men who attend.

To what extent men participate willingly varies from one household to another. Some ultra-conservative men do not allow their womenfolk to participate in any festivity at a shrine. These are probably few though. Some men are as staunch believers in the saints as their wives. Others are dubious of such affairs but participate anyway in fear of possible retributions made by either the saint or their wives!

If there is any contention between the husband and wife it is not over the efficacy of the saint's power but rather as to the wisdom of asking the saint's help in the first place. Such requests can lead to excessive demands. Nevertheless once a promise has been given it must be fulfilled. Most men agree with this point, knowing that promises that remain unfulfilled result in negative consequences. If the man

should refuse he would be accused of not caring about his children for whom the promises were made, or of being stingy, or of not believing in the power of God and his saints. In this way women who initiate a w'ada can be seen to gain invisible power.

The effect that w'adat have on children must not go unmentioned. Daughters and young sons are a woman's most intimate associates. They are with her continually. They are often privy to their mother's promise to a saint. They "see" whether or not the saint has granted her her wish. And if so, they are in on their mother's plans for the w'ada - plans that involve the participation and and in some cases the manipulation of the rest of the family, males included. This is indeed a learning experience. They see their mother as a "prime mover", a role she doesn't often play.

In addition to the new insight regarding the female role, the values and norms associated with gift-giving, generosity and the performance of one's duty is reinforced. Furthermore, this experience reveals to children the power and workings of the saints. They learn that misfortunes and illnesses can be caused by saints to whom promises were fulfilled. And they also learn that saints, if asked, can act as God's intermediary to enact a cure.

DIVINERS AND HEALERS AS INTERMEDIARIES

Illnesses strike without warning. That in itself is a mysterious phenomenon to most people. "Why me? Why now?" and "What will become of me(or whoever the patient may be)?" are some of the questions asked. In Tunisia a diviner is an acknowledged authority who can provide the answer to the last question. Not only can a diviner tell someone whether or not they will get better, but he/she can also advise them as to the steps necessary to achieve that end. Those steps usually include seeking the counsel of a healer.

There are a variety of healers available in Tunisia: biomedical practitioners, pharmacists providing western durgs, dwa 'arbi specialists, and spiritual mediums. The biomedical facilities available in Mahdia and dwa 'arbi ethnomedical practices were discussed in earlier chapters. In this chapter so far we have seen the way in which an ordinary person relates to the saints. I now want to focus on the spiritual mediums - those individuals that are believed to have a special relationship to the spiritual world. Spiritual mediums are not a corporate group. In fact, they vary in their abilities, their specialities, and their healing techniques. However they all share one common denominator. Their healing and divining power is derived from their association with a saint. Each medium has a familial saint for whom he/she is an intermediary. Their first contact with their familial saint is through a dream. In their dream the saint materializes and passes the power (baraka) to the

medium. From that time on the medium is able to act as the saint's intermediary, giving people advice or curing their illnesses.

Humans chosen by the saints include the following types of individuals: 1) lay persons who are neither affiliated with a shrine nor a descendant of a saint, 2) caretakers of a shrine, or 3) descendants of a saint. People who become diviners (dwarish, plural; derwish, masculine; or derwisha, feminine) and those who are given the "gift" to cast out the evil eye usually come from the ranks of the general population. That is, they have no prior association with a saint nor do they work for a particular shrine. Caretakers (hafidet) and exorcists ('azameen), however, live on or near the premises of a shrine and thus their affiliation to a particular saint is obvious. Some of the hafidet and 'azameen are believed to be descendants of the saint, but this certainly is not the case for all of them.

Below a description of each type of spiritual medium will be presented. Included in the descriptions will be excerpts from the mediums themselves or from people who have received their services.

Divination by Dwarish

Divination is a technique whereby signs believed to be sent by the supernatural are manifested in material objects or transmitted through human mediums. In either case the meanings of the signs must be interpreted. The diviner plays the role of the interpreter. There are a number of diviners

in Mahdia. Eight were mentioned by my informants alone. Undoubtedly there are more. Two of these diviners were interviewed.

Diviners can be placed on a continuum from those called qareen ("readers" of the Koran), rohanni ("seer of the soul"), dwarish to the degaza (migrant bedouin women who go door to door telling fortunes.) (3) With the exception of the degaza, diviners receive their power to foretell the future and to give advice from saints or God himself.

Qareen and rohanneen are the most highly respected diviners because of their knowledge of the Koran and because of their oratory skills. They rely on the Koran to tell the future. Qareen's will "open the book" for a client. Based on his interpretation of the text (signs) he then will advise them or predict their future. Rohanni, a "seer of the souls", may or may not be literate. If illiterate he will have memorized many verses from the Koran and will recite them at length. But most importantly he is able to "see into the heart of a person and reveal his most inner secrets".(PC) The presumption is that the message is being transmitted to him from a supernatural source, usually God.

Dwarish (the term most often used by informants) are next on the continuum after rohanneen. But even within this category there appears to be considerable overlapping. This was evident when the informants were asked about diviners in the community. The same diviners (later interviewed) would be classified differently by different informants. For example, one man was called a rohanni by one informant and a derwish by

another. Thus some diviners are perceived as having greater power than others. Some simply tell fortunes through messages from a saint while others have the ability to "know" an individual's past and desires. The difference seems to depend upon the depth of the prediction, the degree to which the diviner can state past events, and on the soundness of the advice given.

Diviners predict the future but their primary role is advisory. It is in this capacity that they must be included in any discussion of healing. Rather than attempting to heal clients, they diagnose the patient identifying the illness believed to be the cause of the person's suffering. He/she will then advise that person accordingly. If the person has not fulfilled a w'ada, the derwish will tell him to do so. If the illness is the result of possession, the client will be advised to go to an exorcist. If the illness is diagnosed as a biomedical illness the patient is advised to go to a doctor at the clinic or hospital. And if the illness is the result of an evil eye curse, the derwish will refer him to a "gifted one".

Dwarish have a familial saint who bestow upon them the power to foresee future events. They are illiterate and thus do not use the Koran to predict. At times they are incoherent or speak in rhymes, but this in itself is evidence that they are in contact with the spiritual world. (A person who is totally "out of this world" and into the spiritual world is a bohelli. A bohelli cannot act as a diviner because he is

unable to communicate to others.) Dwarish command respect from their clients. This is due to the fact that they have been touched by God (via the saint) and also because of their reputation for accurately predicting the future.

The way in which two dwarish came to be diviners is described below. In the case of Laila Ben Ahmed her story was repeated to me in three interviews. In the case of Aiesha Zyed, she related her story personally during an interview.

Derwisha Laila Ben Ahmed

Laila Ben Ahmed is quite elderly today and is no longer able to act as a derwisha. However she has given her services to many people throughout the years in Mahdia and is thus very well known. Sometime in the early 1940's Laila's husband, a candy vendor, died leaving her with a small daughter. After her husband's death she lived with her parents and later with her brothers, raising her daughter by herself.

One night she had a vision of Sidi Youssef in her dream. He asked her to marry him in a spiritual ceremony. She refused to do so. The dreams continued. In her dreams Sidi Youssef told Laila that she should not be dependent on others (her parents and brothers), that she should join his shrine and make a living there as a hafida. She continued to refuse his proposal even though he threatened her with death.

She was very troubled during this time because there was already a woman by the name of 'Agrabe who was believed to be Sidi Youssef's medium. 'Agrabe was becoming very greedy asking people to bring her sheep, oil, money, etc. - all in

the name of Sidi Youssef. Sidi Youssef told Laila that he was displeased with this woman and wanted Laila to be his new medium.(One informant recalled a time when Laila visited her mother in tears explaining her predicament.)

Finally Sidi Youssef appeared in another woman's dreams. This woman had a young son who was very sick. He had a fever and diarrhea. In her dream, Sidi Youssef instructed her to find a woman by the name of Laila Ben Ahmed. The woman was told to enter the house, burn some incense and fan the smoke in Laila's direction. Laila would then be able to cure her son.

The woman awoke and with her son in her arms began searching for Laila Ben Ahmed, asking people for directions (This indicates that Laila was out of this woman's social network.) When she reached Laila's home Laila was out of the house, attending a Henna but her sister-in-law let her in to wait. The sister-in-law said she knew nothing of Laila's powers, but allowed the woman to burn incense as directed by her vision. When Laila arrived she found this woman and her sick child waiting for her. As she entered the room the woman fanned the smoke in Laila's direction. Laila was surprised and asked her the purpose of the incense and her visit. The woman explained her dream to Laila. Laila told her to speak softly and to keep this a secret. Laila then took the child in her arms and began to say a prayer. She then handed the child back to its mother and told them to go home. The boy was cured shortly after.

That event was seen by her and others as a calling. She

then became Sidi Youssef's medium and spiritual wife. She participated in hadrat dancing as many as 50 dances in a row. She would go into a trance, vomit into a drum, pick out the stones from the vomit, place them in water and drink the liquid. She explained that this was the power of Sidi Youssef. As word spread of her powers, she was visited in her home by people seeking supernatural advice. This established her as a derwisha - a role she played for forty years.

Sidi Youssef does not have a shrine and therefore Laila always acted as his medium at her home. Here she was found in her room behind a curtain. Interviews could be conducted with the client(s) on one side of the curtain and herself on the other. She could be seen faintly, even though her long hair hid her face. Incense was kept burning. Often a sizeable crowd would wait for their turn. Loud bangs could be heard occasionally. Laila would tell the audience not to be afraid because this sound was made by Sidi Youssef. If people in the audience spoke to the spirit he would answer back through Laila, who spoke in a man's voice. Sometimes the words of Sidi Youssef were incomprehensible. In those instances Laila interpreted them for the audience.

People would come to her with their personal problems or the problems of a loved one. In the latter case, Laila would need a piece of clothing with which to divine.

Despite the fact that her initiation as a medium involved a healing episode, Laila is known more for her ability to predict the future and to give advice, including

where to seek help for one's sick relative.

Informants described a number of situations in which they were given sound advice or accurate predictions by Laila Ben Ahmed. They regret that now she is too old to act as a medium for Sidi Youssef and no longer holds divining sessions.

Derwisha 'Aiesha Zyed

'Aiesha Zyed is an elderly woman who is obviously in poor health. When we arrived at her home she was in her bedroom, which she shared with her great-nephews and nieces. She was lying down and at first did not sit up to greet us. Her sister, a woman probably 15 years her junior, was visiting with her. We introduced ourselves. 'Aiesha knew my husband's aunt (our introduction to her) but not well. She appeared very frail and her voice was almost a whisper.At first she said she was feeling too weak to talk with us, but then she must have changed her mind. During the course of the three hour interview her strength waxed and waned. Her voice at times was very strong and then it would fade. She remained seated throughout the interview, stopping to take a glass of water. (Refreshments were not served to us. I note this because this symbolized our visit as a professional-client relationship. She is one of the few informants to whom cash payment was given.)

She explained that her weakened condition, her swollen legs and her bent arthritic fingers were the result of the jnun who continuously take possession of her body. (The jnun, when exorcised, depart via the fingers, leaving them bent.)

'Aiesha is a medium for Sidi Turki. This fact, however, does not seem to be widely known. For example, informants would talk about going to see Sidi Youssef, when actually they would see Laila Ben Ahmed. At the same time they would tell of visits they had had with 'Aiesha Zyed, never mentioning Sidi Turki. (This coincides with the impression I got that they felt Laila Ben Ahmed was a superior derwisha.)

'Aiesha was twelve when she was first "stepped on" by the jnun. It was this experience that eventually led to the association with Sidi Turki. She describes the event below:

> One day my father bought some yogurt and all the family ate it for breakfast. After a few hours I felt very ill and had to vomit. The rest of the family was okay. My mother explained then that it was just because it was a little sour and that after I vomited I would feel fine. During that same day I was scared when someone knocked at our door and said he wanted to visit the house. (The stranger was a bailiff who came to evaluate the house which my father placed as a deposit to buy a business.) I was at the time scaling fish and I was so scared that I kept shaking for awhile.
>
> That night we were gathered in the hall and my mother asked me to fetch some water from the cistern. As I pulled the pail of water I saw a white dog in the pail which scared me. I was so scared that I dropped a pitcher which broke. The next day I was feeling alright. My mother left me in the kitchen to look over the dinner which was cooking over the clay oven. I placed the (couscous) collander on the pot and I felt something hit me on top of the head. I turned around and found nothing. I shouted for my mother. She came and took me to the hall. For seven days I was sick and dizzy and one day I passed out. I was feeling weak and sick for another six months. My mother then took me to the hospital and my disease was diagnosed as "weakness".
>
> It was then that my neighbor brought home a person by the name of Ahmed, so he would open the book for me. My aunt saw Ahmed coming into the neighbor's house and she took a piece of my clothing to him. (My aunt believed that Ahmed had

superantural powers.) Ahmed told my aunt that I was possessed and that I was the victim of bad writing (curse). After that my parents brought him so that he could heal me. He performed a ritual of turning the hand over my head (tadwir) and uttering verses from the Koran and/or Hadith (t'azime). During the ritual the spirits (who claimed that they came from the mosque of Lazahr) came through the wall and started talking. Ahmed said that my possession was due to writing and feeding (a curse through food). He then placed a paper with some writing on it on my chest and he showed me a worm that he said he pulled from my body. At that time my mother wasn't at home and my aunt explained to me what Ahmed said. He explained that the writing was done by another aunt on a palm tree leaf. (This explains why every time it felt windy I had the shakes.) Ahmed told them about the location of the tree and the "papers" (palm leaves) with the writings were brought home and shown to my father. The writing about the curse was easily cured. While the writing involving food ingestion cannot be cured.

For two years after this incident 'Aiesha continued to feel ill off and on. When she was about 14 years of age, however, she was contacted by Sidi Turki. She dreamed that a woman asked her for a match so she could light a candle at Sidi Turki (a little place in the rocky shore where contact with the jnun take place). In her dream it was too windy to light the candle. When she woke up, however, there was a candle in her room which had been lit, burned and then put out. This she said was a sign from Sidi Turki. She has dreamt of him ever since. When she goes into a trance he possesses her. When she gives clients advice or predicts their future, she is only able to do this through Sidi Turki.

Sidi Turki gave her a new name, Quirihia bint Sidi Turki (bint means daughter), and explained to her that she would have the power to divine through him.

When she began to tell fortunes she started with just

her relatives and friends. But then other people began to come and see her. For awhile she told futures at a shrine near Sidi Turki, but then she told futures in her own home.

Her parents brought a number of healers to their home and one time held a hadra for her benefit. At this hadra she danced "50 dances" without feeling tired or ill. She was possessed by Sidi Turki. He explained that "others" (who they were was not specified) had told him of her predicament ("poor situation"), that is being possessed by jnun regularly. After that she was freed from the grips of the jnun - at least temporarily. From then on she "had to participate in three hadrat every month to feel better".

After her parents died she continued to live with her brother and his family. She never married. (Her sister who was present at the interview explained that 'Aiesha never married any saints or jnun either.) At first her brother did not want 'Aiesha to tell futures and to participate in hadrat. Once he went to see a specialist (perhaps a qariah) in Monastir and inquired about his sister. He was told that she did indeed have the gift from God - the power to tell the future. He then let her continue.

She has been ill most of her life because of the jnun. (Her sister confirmed this.) She has gone to Sidi 'Akmer and elsewhere to be exorcised. (Once she went to see Laila Ben Ahmed, the medium of Sidi Youssef, but was told that she, 'Aiesha was involved in spiritual powers greater than hers.)

Hadrat do seem to help 'Aiesha at least temporarily.

She explained that while in a trance Sidi Turki speaks through her. He predicts the future for individuals surrounding "him". Usually people can understand "him", but if not an 'azam present will interpret the messages. While interviewing 'Aiesha she indicated that she was not feeling well and that it was time to participate in another hadra. This, she explained, would make her feel better because during the trance state Sidi Turki possesses her body and drives out the jnun, the cause of her illness.

When 'Aiesha becomes possessed her condition is manifested in various symptoms. For example, one time she had skin lesions which disappeared after the possessing jinn was exorcised at Sidi 'Akmer. Another time she went to see Sidi El-Ghariana for a burn. A description of this visit is presented below:

> One time I had a burn on my arm and it lasted four months. I saw two doctors who gave me ten shots but the burn lingered on. So I went to Sidi El-Ghariana in Kairouan where I participated in a hadra. My arm healed after the hadra. (I slaughtered three roosters and used the blood in a sacrificial manner, rubbing it over my hands and legs.)
>
> Question: When you saw the doctors for the burns, what did they say?
>
> Answer: They said it was a blood boil. Again, I can tell you that the medicines given to me by the doctors didn't help. It cost ten dinars. I went to a dwa 'arbi healer who gave me some medicines for five dinars, and still it didn't work. It is then that I went to Sidi 'Akmer. I went there on a Friday night and there was a lot of people. I was told by a man in Sidi 'Akmer that "they" (the jnun) don't like me. They are the ones who made me sick. They are the ones who burned my hand.
>
> Question: Do you usually feel better after a hadra?

Answer: Yes, I do.

Although 'Aiesha is plagued with illnesses all the time she nevertheless helps people seeking a cure for their illnesses. She described a case that she had just divined within the last month:

> Mohamed was sick for a long time. He went to Tunis to see a doctor who advised him that he had an ulcer in his stomach. After that he came to see me and wanted me to tell him how to heal it. I made contact with the spirit (Sidi Turki) who told me that this man does not have an ulcer. He is poisoned by his wife to whom he hasn't spoken for a year.
>
> Question: What did you tell him to do?
>
> Answer: When I told him that his problem was brought on by his wife, he asked me "What should I do?" I advised him to take a piece of lamb meat from the shoulder, grill it on a charcoal fire, sprinkle it with saffron and eat it. I also told him to drink rosewater and eat <u>luban</u>. After he did as I told him his stomach pain disappeared. This is how one cures ills brought on by "writings" (or curses).
>
> Once he was cured, he went to see Hajj Neddar and asked him for some protection against this curse. Hajj Neddar gave him an amulet and soon after his wife came back to him and spoke to him. For two weeks after Hajj Neddar performed anti-curses (writings) and he has been fine since. He returned and gave me a scarf and material for a dress. (4)

<u>Dwarish</u> are paid after a divinatory session. They are paid one to five dinars. If their predictions come true or their advice proves to be wise people return to them with gifts to show their appreciation. Sometimes a person will make a promise (<u>w'ada</u>) saying that if the outcome is good they will give the <u>derwisha</u> a scarf, a rooster, etc.

Divinatory practices can be found in all societies.

They are used in situations where the individuals involved feel they must make a decision but, for whatever reason, feel immobilized to do so. (Vogt, 1965) The use of divination is an attempt to appeal the case to a higher level of authority - one in which a decision can be made. Going to a diviner does three things for the patient and his family. First, it facilitates the decision-making process in that one of the various alternatives (most of which were already known to the individual) will be revealed by the signs. On that basis further action can be taken. (Evans-Pritchard, 1950, Moore, 1957, and Vogt, 1952). Second, it legitimizes whatever act the individual performs after obtaining the advice from the diviner (Park,1963). Third, it relieves anxiety brought on by the frustration of indecision and the feeling of uncertainty. (Malinowsky,1954)

Each of these three factors are operable in the Mahdian context. Dwarish are consulted for a variety of reasons, but when they are sought in regards to an illness it is because the family is uncertain as to why the person is ill. They are unable to decide upon a medical alternative from those available to them. However, given the fact that they have chosen the aid of a supernatural medium, they have in fact narrowed the possible choices open to them. If the derwisha says that the illness is caused by a possessing jinn, it legitimizes a trip to Sidi 'Akmer near Sousse. Furthermore, since divinatory rituals are performed in response to "emotional anxiety and cognitive frustration" (Vogt, 1965),

going to a diviner is in itself anxiety-reducing. One is seeking the advice of an outsider - someone who because of their supernatural connection can act (decide) on the patient's (or family's) behalf.

The "Gifted Ones"

The power to exorcise the evil eye is given to a selected few. These individuals, like the hafideen/hafidet, 'azameen/'azamet, and dwarish, are given this power by a saint in a dream. Unlike the other healers (some of whom also have the ability to exorcise the evil eye), the "gifted ones" do not make a living with their "gift". They live relatively normal lives as laborers or housewives in zneq throughout Mahdia. But when someone is struck with what is suspected to be an evil eye curse, it is to the "gifted ones" that they turn. (The family will usually give the man or woman a small payment for their services.)

Informants explained to me that there are two types of evil eye. The first type is caused by admiration. This may be manifested in the "pot and collander" evil eye resulting usually in accidents in the kitchen, or in the "evil eye of love" cast by someone close to the victim, perhaps even a mother. The second type of evil eye is called "harsh eye" ('ain harsha) and is caused by envy and hate. It is the most dangerous.

The first type of evil eye is the most common. Friends may extend compliments to a neighbor or simply look at an individual with silent feelings of admiration or jealousy. The

result is an accident or an illness. The second type of evil eye, however, can be lethal and therefore is greatly feared. Casters of *'ain barsha* possess a dreadful power.

The most telling symptom of evil eye is the suddeness with which the illness or mishap befalls the victim. Thus accidents, quarrels, sudden illnesses such as fainting, dizziness, vomiting, skin reactions, etc. can be seen as evidence of the evil eye, especially if these incidents coincide with meeting or hosting a person outside of the family. (As one informant said, "Death by evil eye and high blood pressure always comes suddenly.")

The pattern of an evil eye casting is standard for both types of evil eye. It begins with the exposition of the victim. Victims seem to fall into two categories of people -- good looking individuals (generally children) and hard working individuals. These individuals appear to be superhuman - for example a seamstress who sews quickly and beautifully and very quickly, a woman who starts back to work on the same day she gives birth, or a man who does a large job in a short period of time. After observing the victim the evil eye caster makes a complimentary comment (either to or about that person) omitting the invocation of the name of God. Shortly after the victim has an accident or falls ill. In some cases the victim dies.

It is at this time that the victim, often with the aid of the family, begins to reconstruct his/her activity prior to the sudden "attack". They try to remember what the victim was doing that might have exhibited her/his attributes. They

recollect who was present at the time and finally deduce who must have been the evil eye caster.

The family then searches for a "gifted one" that has the power to perform a tadwir. The tadwir is a ritual gesture designed to exorcise the evil eye. The healer puts salt in her hand, places it about six inches above the head and revolves it clockwise around the victim's head, neck and parts of the body that are aching. She does this seven times. While doing this she repeats the following incantation:

> Oh you sharp evil eye, leave this holy person.
> If you have to do with girls, leave the same night.
> If you have to do with young, unmarried women, leave from behind me.
> If you have to do with workers, then leave in front of me.
> Oh you evil eye, spread out and reach the clouds.
> All this in the name of Mohammed.

When she finishes the last revolution she repeats the last sentence of the incantation once again. The salt in the hand melts in the palm of the hand. It is believed that the sweat is produced by the evil eye itself. The hand with the salt is put into water which is then thrown out into a street intersection.

One informant explained that during the ritual the healer seems in pain and is "unable to yawn". But at the same time the onlookers get yawning urges and tears come to their eyes. If this does not happen the group will conclude that the illness was not the result of an evil eye.

Fatuma Debebe - A "Gifted One"

Fatuma Debebe is the hafida at Sidi Jebar in Mahdia. She is known for her ability to perform tadwir. She was given the "gift" long before she became an hafida of Sidi Jebar. In fact, her familiar saint is not Sidi Jebar but Sidi Abdellah. Below is an excerpt from an interview with her.

> Question: Who gave you this power of evil eye healing?
>
> Answer: Sidi Abdellah gave me this power.
>
> Question: How did Sidi Abdellah give you this power?
>
> Answer: It was transferred from my mother-in-law, who had it before me, and who spit into my hand as an act of transfer.
>
> Question: How did your mother-in-law get this power?
>
> Answer: One day when she was visiting Sidi Abdellah there was a little girl who was crying all the time and couldn't get to sleep. My mother-in-law went to sleep and saw in her dream Sidi Abdellah who asked her to twist the neck of the girl so she could be healed. My mother-in-law was surprised as she didn't know anything about healing. When she awoke she administered the treatment as told by Sidi Abdellah and the little girl stopped crying and went to sleep. Since then my mother-in-law practiced this type of healing in the name of Sidi Abdellah.
>
> When I treat a person with the evil eye I spit into my hand and revolve my hand around the head and the neck of the person, invoking the name of Sidi Abdellah and asking God to help heal the person.

Just as the dwarish receive their powers to divine from an association with a saint, "gifted ones" such as Fatuma also are bestowed with healing powers from a patron saint. Even so, neither of these healers are believed to be descendants of a saint nor are they associated with a particular shrine. (Fatuma is the caretaker of Sidi Jebar but is a medium for

Sidi Abdellah.) Hafideen/hafidet and 'azameen/'azamet, on the other hand, act as saints' mediums for whom shrines were built.

Healing Mediums: Hafideen/Hafidet and 'Azameen/'Azamet

Hafideen/hafidet are caretakers of shrines. They assume this position by various means. First, an elderly hafida may pass the position on to another woman - usually her daughter. Second, the community of devotees to the shrine will choose a widow to serve as the hafida. This provides the woman with a place to live and a small income. Third, a saint may appear in a dream and will tell that person that he/she has been chosen to act as the saint's intermediary. When this is done the saint passes on the divining or healing powers to his medium.

Thus, in the first two cases, the caretakers simply have a maintenance job. They have no supernatural abilities whatsoever. However, in the latter case the hafid/hafida must not only care for the building but do the saint's work as well.

Hafideen/hafidet who act as a saint's medium receive people on a daily basis who come with a variety of complaints. Healing hafideen/hafidet treat their patients by different means. Most hafideen/hafidet are well versed in dwa 'arbi and administer dwa 'arbi treatments under the auspices of the saint. They use both symptom-specific and symbolic interventions. Some mediums perform tadwirs, an exorcising ritual for the evil eye, described earlier. Others use dwa

'arbi treatments plus the recitiation of Koranic verse. Those *hafideen* who are literate and use the Koran for inspiration are considered as scribes. Some will also prepare "writings" which are put into an amulet. These amulets are to be worn home and then applied in either of two ways. The first technique includes placing the paper in water. When the ink is dissolved the liquid is drunk. The second method involves dousing the paper in rosewater and then rubbing it on the patients body. Whatever the ritual, it is believed that the patient is healed by the power of God through the power of His word, His saint, and the saint's intermediary (the *hafid/hafida*). (5)

The Hafida at Sidi Benour

There are some saints (via their *hafideen/hafidet*) who become famous for healing particular illnesses. People come from all over the country to seek their help. Sidi Benour is one such saint. Sidi Benour is known for his ability to successfully heal *houmra*. Practically every woman interviewed mentioned *houmra* healings they or their acquaintances have had at Sidi Benour.

Houmra is an illness that usually affects the lower leg but sometimes can be seen on the arms or face. The symptoms include a red swelling that is hot to the touch. This swelling can spread to cover the entire calf of the leg if it is very serious. It is very painful and in some cases the person is unable to walk. The patient usually feels feverish and sometimes vomiting occurs. *Houmra* has been diagnosed by a

local biomedical doctor as erysipelas, a skin infection caused by bacteria. It can be treated with antibiotics.

Houmra is universally known in Tunisia. People are adamant that it is an illness that biomedical doctors are unable to cure. It is treated by dwa 'arbi instead. The treatment includes the application of mogara - a red paste made out of red clay which is heated, pulverized into powder, then mixed with either vinegar, water or honey. The mogara is applied for three consecutive days. In between each application the leg is rubbed with vinegar or alcohol. The skin has a "tendency to peel off". After three days the swelling usually goes away and the fever abates. The person is instructed to follow a strict diet for 40 days, eating cereals, fruit and sugar, and avoiding meat, fish, eggs, milk, fat and salt.

If the treatment is administered at Sidi Benour, however, the saliva of the hafida is added to the mogara mixture. The saliva is not the hafida's, I was told, but rather that of Sidi Benour's. And it is that ingredient than insures the mogara treatment will work. Furthermore, during the treatment the hafida performs a tadwir. Houmra, although usually caused by anxiety or anger, can sometimes be induced by the evil eye or jnun. (Tadwir are effective in exorcising the evil eye particularly, but can also be used for "minor" jnun.)

Sidi Benour is located in a hamlet about 30 kilometers inland from Mahdia. On the two times I visited Sidi Benour

the shrine was a hub of activity. Families came to perform circumcisions, others for a w'ada, while some individuals came for advice on how to treat a sick relative.

Despite the fact that the hafida was extremely busy each time I went to Sidi Benour, I was able to talk with her for a short while. From information she provided plus data collected from others who knew her I learned something about the woman herself and her treatment practices.

Saida, Sidi Benour's hafida and intermediary, is a woman in her mid-40's. She lives at the shrine with her elderly mother, her husband and her younger children. Her husband is a landless farm laborer who gets work in and around Sidi Benour.

Saida did not offer the history of Sidi Benour, nor were my informants able to tell me anything about the man himself. Nevertheless his power of healing is known throughout Tunisia, according to Saida. She states:

> Many people come here from all over - Sousse, Tunis, Bizerte, Djerba, Ksar Hellah, Moknine, Mahdia and Teboulba. They stay here three days. We apply mogara the first day and by the third day they are usually cured. (If not, another treatment is applied.) We advise them not to eat eggs, milk, fish and meat. Believe me, people went even to France to find a cure, but could not find one. When they came to see me here, they were cured, thanks to the spirit of Sidi Benour.

Guardianship of Sidi Benour has been in Saida's family since the death of Sidi Benour. Saida inherited her power from her mother. At an earlier time both her grandfather and her mother-in-law had the power to heal. (This would suggest that the saint's power was held within an endogamous group.)

Today Saida's mother has retired, leaving Saida to heal the sick and to give advice in the name of Sidi Benour. (Saida's elderly mother was there when we visited Sidi Benour. In her daughter's absence she was counselling a family who came for advice on how to cure their child. She suggested various dwa 'arbi treatments. She did not like our presence there and expressed this opinion openly to Samia. She indicated that I was clearly not Tunisian and not welcome. She lectured Samia for bringing a suri (European) to this holy place.)

The saint's power is only given to a worthy person. Although the saint's descendants qualify as candidates, their relationship to the saint does not guarantee that they will be chosen to represent him/her. Thus the power is not automatically inherited. Often the power is, in fact, passed on to a non-family member.

In the case of Saida, she had a dream of Sidi Benour, her ancestor. In this dream Sidi Benour told her that she would have the power to heal through him. She became his medium after that dream, replacing her mother. Sidi Benour stands by her side and communicates his healing power (manifested in her saliva) and offers his advice on other matters.

Informants debated among themselves whether or not a person could obtain this power through an intermediary such as an hafida herself or whether the power could only be given by the saint directly. Some argued that they knew of people who were given the power to cure from an hafida who spat into the hand of the person saying, "Now you too have the healing

power." The following discourse illustrates the importance of Sidi Benour's saliva and the way in which it is believed his power can permeate the neighboring communities.

> Question: Since you all know what the treatment (for _houmra_) consists of, why don't you just treat it yourself?
>
> Answer: It wouldn't work. It has been tried and it doesn't work. It is essential to have the saliva of Sidi Benour. The _hafida_ and a member of her family are gifted with this power. However, only one at a time can treat the _houmra_ patients.
>
> Question: Does the person giving the saliva have to be a family member?
>
> Answer (a secondary informant at the same interview): No, the gift can be transmitted to a non-family member by the practicing _hafida_ after she spits in the hand of the new _hafida_ and asks Sidi Benour to transfer the power. As you know Salema (a neighbor) was given the power of Sidi Benour to treat _houmra_ in her own home in Mahdia. One time she was feeling ill and she transferred the power to me and told me to transfer it to el-Gizane (a man). El-Gizane has practiced that until recently when he died. El-Gizane used to say he was treating in the name of Sidi Benour.

Not everyone agreed with this woman's faith in passing Sidi Benour's power. They contended that only people who had received the power from Sidi Benour through a dream, had the ability to heal. This point was raised in other interviews and the general consensus was that a healer must have direct contact with the saint himself - through a dream.

'Azameen/'azamet, through the power bestowed on them by their saint, have the ability to heal illnesses and more importantly to exorcize possessing spirits. (Such mediums are almost always men and thus the male terms will be used, with

'azameen being the plural form, and _'azam_ being the singular form.) Unlike _hafideen/hafidet_, _dwarish_, and "gifted ones", _'azameen_ are comparatively rare. They cannot be found in every city. For example, there are no _'azameen_ in Mahdia. Thus people generally have to travel some distance to find a shrine that has an _'azam_. Sidi 'Akmer is one such shrine. It is found near Sousse, approximatley 60 kilometers from Mahdia.

At Sidi 'Akmer there are a group of men called "the sons of Sidi 'Akmer". They are believed to be his descendants. They live in the area and maintain the shrine. They have been given the power to perform the _tazime_ ritual - a treatment necessary to exorcize possessing spirits.

According to my informants mental imbalances cannot be healed by either _dwa 'arbi_ or biomedicine. Such imbalances, although often giving similar symptoms, can in fact be attributed to various factors: 1) the possession of "those who live under" (_jnun_), 2) possession of a ghost (relatively rare), 3) a revengeful saint, and 4) a mental illness, such as _'aṣab_ (fits of abnormal behavior, translated as "nervous breakdown"). (The different types of mental illnesses will be discussed in the next chapter.)

It is believed that possessing _jnun_ and ghosts create a disturbance of the mind not unlike a person suffering from _'aṣab_. Thus it is sometimes difficult to determine whether abnormal behavior is caused by a mental "breakdown" or spiritual possession.

The person is deemed mentally disturbed if he exhibits extreme behavior - either passive or active. In either case

the individual is perceived as behaving abnormally because of the imbalance of his comportment. The passive person will feel extremely weak, unable to work or even walk, and in some cases their limbs become paralyzed. Along with this they may experience dizziness and make nonsensical mutterings. The active patient will be hyperactive, argumentative and difficult to cope with. These symptoms (passive and active) are exhibited by those patients possessed, or considered mentally ill.

In time the family will usually be able to determine whether or not the patient is possessed or mentally disturbed. (For example, a mahboul (one type of mental patient) is not able to make rational arguments and certainly is not able to predict the future or talk in "foreign tongues". These are the feats of one touched by the supernatural.) However if the family is unable to tell for sure whether or not the person is possessed, they may choose to take the patient to Sidi 'Akmer for a badra. Here the patient is encouraged to go into a trance. While in a trance, the patient will be diagnosed by an 'azam. The 'azam will determine whether or not the person is possessed and if so by whom. If possession is determined as the cause then an exorcism will be performed. If the 'azam decides that the patient is not a victim of possession, he/she will be told so.

Usually patients are taken to biomedical practitioners or to the two existing mental hospitals (one in Tunis and one in Sfax) as a last resort. Basically the feeling is that such

illnesses are caused by supernatural forces and can only be healed by the saints and God.

Unless the illness is acute, the family will delay taking the disturbed person to Sidi 'Akmer until the 'Id al-Kabir. It is at this time that thousands make a pilgrimage to Sidi 'Akmer to participate in the hadra of the 'Id. Many go to the 'Id al-Kabir at Sidi 'Akmer for sheer entertainment. (There is a festive air on this occasion. The old year is coming to an end and a new one is about to begin.) However for some this is an opportunity to bring their sick son, father, or sister in order to be healed. It is during this ceremony that people with possession-like symptoms are diagnosed and treated.

Hadrat at Sidi 'Akmer

Several of my informants have visited Sidi 'Akmer as an observer. One woman was taken there to participate in a hadra. Through these informants I have been able to make a composite of the activities that take place at Sidi 'Akmer on the 'Id al-Kabir.

During the day of 'Id al-Kabir people begin to congregate around the shrine in Sidi 'Akmer. Facilities have been built to accomodate visitors who come on this occasion as well as on other Islamic holidays. When these accomodations are filled tents are set up in the fields adjacent to the shrine. Many will stay up to three days.

Sheep are bought on the premises and slaughtered. Meat is cooked on outside fires. It is distributed with a fraction

of the meat being given to the caretakers of the shrine.

As is customarily done when visiting any shrine, the tomb of Sidi 'Akmer is visited first, verses from the Koran are recited, and gifts of candles and incense are given. Everyone then awaits for the hadra, which is held in the evening.

The hadra is led by the "sons of Sidi 'Akmer" - the 'azameen. It is through them that Sidi 'Akmer is able to work his miracles, exorcising possessing spirits as well as healing other illnesses.

Before the hadra begins liver is broiled in each of the corners of the shrine. It is believed that the jnun and ghosts are attracted by the smoke of grilled meat, and particularly to that of lamb's liver. Thus in this way the spirits are invited to the ceremony.

Once people have gathered in the courtyard of the shrine the people are asked to sit along the edge of the courtyard. (Those who didn't come early enough to get into the courtyard are found standing on the rooftops or in the doorways, straining to see the proceedings.) At one end of the courtyard, near the "room of the tomb", the senior 'azam (Sheikh el-Hadra) stands surrounded by a band. Once everything is quiet, the Sheikh el-Hadra begins to recite prayers. (6) After the prayers are said the drummers begin their steady beating - the hadra beat. Candles and incense are burning. The 'azam asks male participants to come forward and to form a circle in the middle of the courtyard. The participants are only a small minority of those in the audience.

The 'azam walks into the circle of hadra participants. He has them link their arms together. The music starts and they begin moving in a clockwise direction. While doing this they bend at the waist jumping backwards and forwards, saying "Allah, Allah". The word "Allah" is said repeatedly, inhaling at every utterance. The result is either exhaustion or hyperventilation. (Although I have not been able to attend a hadra at Sidi 'Akmer I have surreptitiously caught glimpses of this "dance" performed at hzab in Zanqa Sfar.)

Throughout the night men come forward, led by a family member, to participate in the hadra dance. In the meantime others dance on the sidelines - men in groups and women individually. Some people fall into trances without dancing. These are people who have already experienced their first trance on another occasion. For them the sound of the hadra beat is all that they need to fall into a trance. (7)

Once in a trance-state the expertise of the 'azameen is required. They disperse themselves within the crowd, talking to each of the individuals in trance. They determine whether or not the person is possessed and if so whether they are possessed by a jinn or jinniya, a ghost, or a saint. Once identified the 'azam will act accordingly. If the possessing spirit is a saint, often Sidi 'Akmer himself, this will be announced and onlookers will approach the possessed person asking "Sidi 'Akmer" to tell them about future events. However if the person is diagnosed as being possessed by an angry saint, the 'azam will find out why the saint is angry with the

person. (Usually saints are only angry if a promise has not been fulfilled.) The most common problem, however, is not with a saint but rather with possessing spirits - usually jnun. (8). When the 'azam discovers that a person is possessed by a jinn he will begin the t'azime - the exorcising ritual.

A t'azime includes burning various kinds of incense, saying an incantation from the Koran, and inflicting pain on the jinn/person. The possessed person might be struck, burned or pierced with a needle. (The individual in trance does not feel this, but the possessing spirit does.) While questioning the possessing jnun or ghost, they are asked, "From what part of the body will you be leaving?" And generally the reply is "the thumb". It seems that the thumb when bent backwards indicates the presence and departure of the jinn. (As described earlier, derwisha 'Aiesha Zyed's fingers were all bent at an angle of approximatley 120 degrees.)

After the spirit exits the body the 'azam prepares an amulet consisting of a piece of paper on which verses from the Koran have been written. The piece of paper is folded up and placed into a packet which is then worn on a chain or strap around the neck. The t'azime ritual exorcises the jinn and the amulet ensures against the jinn's return. (Jnun are fearful of God's word as written in the Koran.)

After being healed by Sidi 'Akmer the individual's mind is now free from the influence of the possessing jinn and he/she can be expected to behave normally. According to my informants, the symptoms of mental derangement are abated

after a hadra at Sidi 'Akmer. The sick person's behavior returns to normal, if not permanently, at least for awhile. In some cases the individual's condition remains stable until the end of the year. It then worsens just prior to the 'Id. Arrangements are then made to take the person back to Sidi 'Akmer or to another shrine that has practicing 'azameen.

Analysis

When someone in a family becomes ill the family members, especially the women, will attempt their own diagnosis. If the illness can be treated with dwa 'arbi they will administer the necessary treatment. If they think it can be better treated by a biomedical practitioner, then the patient will be taken to the clinic or hospital. However, if these avenues fail or if they are unable to make the intitial diagnosis they will then seek a supernatural intermediary. Thus diviners are sought for their diagnostic skills. Healers are sought for their curative powers.

As was stated earlier, there is a tremendous variety amongst the saint's intermediaries. They range from neighborhood men and women who tell futures and cast out evil eye spells to groups like the "sons of Sidi 'Akmer" who are considered holy men. Despite this disparity there is one factor that they all have in common, and that is their association with a particular familial saint.

The first calling, as well as subsequent communication with the saint, takes place in dreams. The saints materialize

in the medium's dreams and are told that they have been chosen to use the saint's power (baraka) to do certain (good) deeds. Those deeds include giving advice, telling the future and healing the sick.

The medium's relationship to the saint varies according to whether or not the medium is a diviner or a healer. Thus diviners are adopted, as it were, by the saint. In the case of Laila Ben Ahmed, she became Sidi Youssef's spiritual wife. In the case of 'Aiesha Zyed, she became the saint's daughter. (I.M. Lewis (1971) and Erika Bourguignon (1976) have indicated that marriage or parent-child relationships between human and spirit are relatively common in cases of voluntary spirit possession.) Mediums who become the saint's healers, however, receive their healing power only after the saint has spat into their hand (within a dream).

If mediums wish to make contact with their familiar saint or with other spirits, such as ghosts or jnun, they do so by two means - by burning incense and cooking pieces of meat (in particular liver) or by going into a trance. All mediums burn incense when attempting to contact the supernatural. Some go into trance states themselves, in the case of hadras, or attempt to get the patient to go into a trance in order to communicate with the possessing spirit.

Mediums and their onlookers can point to evidence that they have been in contact with the supernatural world. Evidence offered as proof of their mediumship includes sweat in the palm of the "gifted one", pellets in the vomit of the derwisha Laila Ben Ahmed, thumbs and fingers of the

possessed, and, most importantly, the healed patient who has been cured with the saint's saliva. Each of these elements are seen as materializations of the saint's power. One can't help but notice that they emanate from two sources -- bodily secretions (saliva, vomit and perspiration) and the hand. The healing power (baraka) appears to be transmitted through the mouth and administered by the hand. For example, the healing bafida spits into her hand and mixes that saliva with the mogara mixture used to treat boumra. The "gifted one" spits into her hand before administering tadwir. Both healers utilize saliva and their hand. (The "readers" (healing bafideen) and the 'azameen recite passages from the Koran. Might these be oral secretions?)

The symbol of the hand is evident in preventative measures. Various configurations of Fatma's hand (the Prophet Mohammed's daughter) are frequently found on pieces of jewelry and on decorative items in the home. It is used to ward off the evil eye and the jnun. Children in particular are adorned with these items. The sign of a successful exorcism is also to be found in the hand. Jnun and ghosts depart via the thumbs in particular but also other fingers as well. This leaves them bent. And finally, the evil eye is drawn out of the body in the form of moisture found in the "gifted one's" hand.

SUMMARY

In this chapter an attempt has been made to demonstrate the way in which Mahdians (and Tunisians in general) treat

illnesses assumed to be caused by supernatural forces. Shrines and saints provide a framework of interpreting illness- (or misfortunate-) episodes. Some families may choose to interact with a saint directly. This is particularly true when attempting to prevent an illness or misfortune or when suffering from a minor illness. In such cases the saints are promised a gift if they fulfill the wish desired by the patient/promiser. However some illness-episodes require an intermediary. Illnesses that are not easily diagnosed by the family require the attention of a diviner. People suffering from illnesses caused by the evil eye or jnun require a medium who, through their association with a saint, can exorcise the illness-producing agent. By doing so the patient's somatic balance is restored and a healthful state is achieved.

In the following chapter the underlying assumptions common to ethnomedicine used in both the natural and supernatural spheres will be analyzed. In the process the etiologies involved in Tunisian folk medicine as a whole will be discussed.

FOOTNOTES

1) Clay drums and tambourines can be found in almost every household. Most children learn to play them moderately well. However some people excel in this skill. If they also have a good voice they can become mashtat playing for hire. Women play at hadrat, hennani, and circumcisions parties hosted by the boy's mother. Men form groups, each of which assumes a name for itself. They play at hzab, msawids, weddings and circumcisions.

2) One woman explained that her grandmother had made a promise. But before she could hold the w'ada she died. Since her daughter (the woman being interviewed) knew about the promise, she was obliged to carry it out even after her mother's death. The promise had been made on behalf of the informant's son. It was only after he fell ill that she remembered, with the aid of her sister, the promise that her mother had made. The w'ada was held and the boy was healed.

3) Degazat travel from town to town going door to door offering to tell the future to the ladies of the house. They are sometimes invited into the house to tell futures. The predictions are vague and nonsensical and usually provoke laughter. Degazat are never taken seriously but rather are seen as a form of entertainment. Thus to classify a derwish or a rohanni as a degaza would be a insult and would only be done by a non-believer.

4) At the close of the interview 'Aiesha offered to tell my future. I consented. She took my hands and held them and looked them over carefully. Then she concentrated her attention on the right hand and began to speak. She said that I would be returning to live in Mahdia. She said that my mother was very rich and that she would soon be giving me money. This money would be used to build a house on land owned by my husband. We would be very happy in our new home. Then she asked me to concentrate on a wish. I did. We remained silent for a few moments. Then she said, "Yes, the wish will come true."

Based on her cultural perception, I suspect she used the following deductions to make her predictions: 1) Most males inherit land on which to build a house. This would especially be true of family whose sons travel abroad. 2) Why else would a Tunisian marry a foreigner than if not to obtain some of her family's wealth? The advantages of marrying a "suree" are obvious. 3) Every Mahdian returns home after they have amassed their fortune.

5) Dwa 'arbi and tadwir are administered by laymen, but when performed in a shrine greater credence to the treatment is given.

6) Some of these prayers interestingly enough are those of the Sufi Tijaniyya Order described in The Tijaniyya: a sufi order in the modern world, by Jamil M. Abun-Nasr. This order dates back to the late 1700's. This is indicative of the prevalence of the Sufi legacy within Tunisia today.

7) Once I was at a circumcision ceremony (the ceremony held by the boy's mother the evening before the thour) in which a musical group had been hired. At one point a hadra beat was played and one of the older women, while sitting, began to sway and roll her eyes back into her head. The mother of the boys being circumcised stopped the music and shook the woman out of her trance. She made it clear that that evening we were here to celebrate the boys' passing into manhood and not to commune with the supernatural. The hadra music was stopped and more appropriate music was played.

8) Possession by ghosts are mentioned only occasionally in the interviews. It appears to be rare, but when it does occur it is caused by a ghost who was resentful of his death and wanted to return. The following excerpt from one of the interviews illustrates:

> There was once a young woman, a rather beautiful young woman, who was known to the family of Kersaoui. She was possessed with a spirit of a strong black man. She used to go into fits, speak in the voice of the black person and beat on her husband. (During the beating she talked just like the man.) Once she was over the fit she claimed she knew nothing. She was taken to a shrine (name unknown) where she was exorcised. The man at the shrine killed a black rooster to get in contact with the spirit. He asked the same type of questions "From what part of the body will you leave", etc. After many questions, the spirit answered, "I will leave from the thumb", which he did. After the spirit left through the thumb, it became paralyzed. The thumb later was severed and she is okay now.

CHAPTER EIGHT
THE COGNITIVE STRUCTURE OF TUNISIAN MEDICINE: A SYNCRETIC MODEL

In Chapters Six and Seven the focus was on the analysis of ethnomedical practices performed once an illness had been diagnosed. In analyzing the practices themselves, it was possible to discern patterns of activity that ranged from symptom-specific intervention provided by family members or dwa 'arbi specialists to highly ritualized healing ceremonies that involved family pilgrimages and spiritual intervention. In this chapter the cognitive framework upon which these activities are based will be analyzed. In this way the meanings of pathology and causality in Tunisian medicine will be revealed.

For heuristic purposes it has been convenient to divide the Tunisian medical domain into two spheres - natural and supernatural. Since Tunisians do distinguish between illnesses that are caused by "natural" means and those that are caused by the evil eye or jnun, this division has been appropriate. This dualistic model will be sustained in this discourse a little bit longer. However later in this chapter I will argue three points: 1) that, in fact, the Tunisian medical domain can best be understood as a syncretic explanatory model -- one in which historically disparate ideological frameworks have been fused and in which biomedical practices and institutions (devoid of Western theories of causality or pathology) have been incorporated; 2) previous researchers have failed to appreciate the degree to which

various health care traditions articulate behaviorally and cognitively with one another; and 3) the medical domain as a whole is couched in a "metamedical context" (Worsley, 1982) and includes various "models of medical knowledge". (Young, 1981)

THE NATURAL SPHERE

Illnesses that are perceived as "natural" (mard rabeni) include specifically God-given illnesses or afflictions which create a disordered physiology or an elemental imbalance. In any case these illnesses are seen as naturally occurring events which can often be traced back to "God's will" or to the patient's (or parent of the patient) inappropriate behavior. Such illnesses can be treated by either dwa 'arbi or biomedicine.

Specific God-given Illnesses

Although all natural illnesses are "permitted" by God, some illnesses come directly from Him. In particular childhood illnesses such as chicken pox or measles fall into this category. Symptoms can be treated to ease the patient's suffering but there is no attempt to address the cause. It is believed that the illness must simply run its course.

Physical Category

Physical injuries may occur as a result of accidents, as in the case of broken limbs, cuts, burns, scorpion stings, snake bites, or as a result of "false movements" as in the case of pulled muscles, neck aches and twisted joints. Such

injuries interrupt the normal physiology of an individual. Biomedical or dwa 'arbi treatments, including external applications and some extraction/transferal rituals, are necessary for the restoration of the injured patient.

Elemental Category

Some natural illnesses are perceived as manifestations of an imbalance in the constitutional elements of the body. The imbalance is believed to be caused by an excess, decrease, or pollution of a particular element. The elements include: blood, air, dirt (earth) and food. If any of these elements appear in excess or are polluted in some way, they are considered "bad", "dirty", or "weak". Symptom-specific treatments are administered to relieve any discomfort by either biomedical or dwa 'arbi practitioners. However it is believed that only dwa 'arbi treatments are able to relieve discomfort and at the same time bring the elements back to a state of equilibrium which insures a healthy body.

Most elemental imbalances are precipitated by improper behavior either at the personal level or in a wider social context. For example, on the personal level it is understood that illness can be avoided by correct, "sensible" behavior. Thus one "should not" walk into the night air after a hot bath; one "should not" over-indulge; one "should not" over work; one "should" keep clean, etc. A concrete example might better illustrate the point.

Household water taps in both Zanqa Sfar and Zanqa Turki are cold water taps. Cold water is used for household chores

and drinking, but bathing and shampooing involves warming up the water, either by setting a metal tub of water in the sun for a few hours or boiling water on the stove. One day, when the temperature was in the 30's celsius, I decided to wash my hair at the cold water tap. I dispensed with heating the water, for I was in a hurry. While washing my hair a couple of the women noted this "silly" behavior and went off clucking to themselves. On the following day, I had a sore throat and mentioned it while cooking with the women. My sister-in-law's reaction was quick. She said, "Well, that is because you washed your hair in cold water - your head got cold." I, in my defense, suggested that perhaps I had gotten the cold from Samia or Jarmilla, two others in the household with visible signs of a cold. (Jarmilla wore a towel around her neck to warm her throat which, she explained was sore due to cold air.) My sister-in-law asked, "Then why hasn't everybody gotten sick? Why did <u>you</u> get sick and not everyone else?" For her the reason was obvious. (This explanation poignantly illustrates the notion that everyone is responsible for one's own health. This was an attitude expressed consistently. I shall return to this point later in the chapter.)

In this case cold air was perceived as being the cause of my sore throat. Cold air had entered my head and lodged in my throat causing an imbalance of the warm air circulating in the body. The sore throat was the symptom of this imbalance. In the interviews I found many references to illnesses caused by cold air. The illnesses included earaches, whooping cough, asthma coughs, kidney stones, stomach aches, fever, cold

sores, frigidity and female sterility. It is believed that the patient becomes ill either because they were exposed to the cold air, and presumably the body reacts (i.e. cold sores and fever), or that the cold air enters the body and settles into a particular area, for example in the lungs, ears, throat, stomach, kidney, muscles, uterus or clitoris).

The etiology of female sterility illustrates the principle well. A woman who cannot become pregnant is a concern for both her family and her husband's family. Women discuss this at great length. The affliction is believed to be caused by "cold" air ("cold" also implies "bad" or "dirty") that has entered the body and settled, either in the genital area or in the woman's waist. The treatment is designed to warm the affected area. Tizanes made with oregano, mint, cloves and other herbs are prepared. The woman is also directed to sit on a steaming hot pot, allowing the warm air to enter into the body and "clean" the area. Other treatments involve taking hot baths, applying warm compresses to the waist, and inserting warm ointments or suppositories into the vagina. All are intended to warm up the air in the body, counterbalancing the excess of "cold" air.

It is felt that illnesses caused by bad diet or dirt are illnesses that could have been avoided if the person had behaved responsibly. Illnesses involving the digestive system are attributed to a "bad diet". They include stomach aches, diarrhea, hemmorhoids, constipation and bowel impaction. A bad diet can include an excess or a deficiency of certain

foods such as fats, meat, cereal and milk, or can be the result of the wrong mixture of foods, such as milk and fish. Thus avoiding such illnesses is contingent on eating properly. Treatments usually include the ingestion of foods that counterbalance the effects of the "bad" diet.

Diarrhea is the symptom of a variety of illnesses and is of particular concern to parents. Until approximately ten years ago the high infant mortality rate was primarily due to gastrointestinal disorders.) It is believed that diarrhea is caused by the ingestion of a number of food items: cow's milk (lactase deficiency is common in this area), an excess of watermelon or cantelope, spoiled food, or "large intakes of cold water on a hot day". And, as one woman explained, diarrhea can be caused by a bacteria creating a "fever in the intestines". (This last explanation represents a good example of how the two explanatory models of dwa 'arbi and biomedicine have been fused.) Treatment for diarrhea is usually rice water for infants and cereals for adults. If the condition persists the patient is usually taken to the hospital or clinic.

Communicability of illnesses via "dirt" has long been part of the Arab's explanatory model of illness causation. According to Amin Khairallah (1946, pp.97-98), the Arabs were the first to state that "epidemics were kind of putrefaction that was carried in the air and resembled stagnant putrefactive water." And as early as 900 A.D. doctors in Cairo hospitals were quarantining patients whose illness they suspected contagious.

The importance of cleanliness is reflected in daily behavior. Women work very hard to keep their homes clean. Floors are swept and mopped daily. Laundry is washed, if not every day, every other day. Kitchens and bathrooms are kept immaculate. But this cleanliness is not extended into the streets and thus it is there that children come into contact with dirt from animals, insects and other children. Children are admonished regularly for getting dirty. They grow up knowing that keeping clean is valued in this society.

Scabies is a common problem among children. Everyone explained that it is caused by dirt obtained from animals, flies or from "working in the fields". Treatment begins with cleaning the area. Then various materials are used to treat the sores. They include herbs such as sebadera, m'a, sanmahdia, as well as sulphur powder, calcium carbide, gun powder, dynamite and mineral salt. The goal of such treatments is simple enough: to get rid of the surface "dirt" that is causing the illness.

Thus it is believed that many illnesses can be prevented if an individual behaves responsibly - eats properly, avoids cold air and stays clean. Children are basically irresponsible and thus subject to more illnesses.

Not only is an individual's physical well-being affected by inappropriate behavior, it can also be affected by situations that affect his/her emotional stability. Strong emotional feelings of anger, anxiety, fear and sadness that arise out of interpersonal relationships can increase,

decrease or pollute the elements and thus can create an imbalance in the system. (Informants were rather vague in their explanations as to how this occurred.)

Illnesses caused by "bad blood" are usually linked to previous emotional upsets. Houmra (erysipelas), diabetes, jaundice, hepatitis, skin cancer, nervousness, muscle aches, spleen disorders, high blood pressure, pimples, stroke and memory loss are the result of an imbalance in the blood humour. People are said to have "bad", or "dirty" or "thick" blood. Bad blood is caused by an intense emotional state of anxiety, anger, fear or sadness. Family quarrels, economic uncertainity, a death in the family and surprises usually precede the emotional states. Bad blood is "cleansed" or "strengthened" by prescriptive foods (for example, fenugreek is used to "cleanse" the blood and almonds, honey and sesame seeds, are used to "strengthen" the blood). Extraction rituals (for example, blood letting and external applications designed to attract the illness-producing substance as well as others described in Chapter Six) may be used in conjunction with dietary treatment. The etiology and treatment of jaundice will illustrate this point. Later houmra will be described in greater detail.

Two types of jaundice were described in the interviews - bousafer and safra. It is believed that both types are caused by fright which in turn creates "bad blood in the intestines" resulting in the yellowing of the skin. Safra is considered extremely serious, usually resulting in death. Bousafer, on the other hand is considered less serious and can be treated

with dwa 'arbi successfully.

Treatment for both types of jaundice is the same. The patient is given a diet of yellow edibles - for example, fish or eggs spiced with tumeric, saffron or kercamen. This treatment is supplemented by an extraction ritual - a "surprise burning". Someone sneaks up on the patient and burns him with a charcoaled stick. His "fright" will cure the "fright" that caused his illness. In either treatment the pollutant is exculpated on the basis of "like attracts like."

Biomedicine as An Alternative to Dwa 'Arbi

While living in Zanqa Sfar and Zanqa Turki I found that there was indeed an intellectual understanding of the "germ" theory among people under the age of 30 and yet this theory was not put into practice. As explained above, visible surface dirt is known to be communicable and thus skin and eye infections are attributed to contact with "dirt". But the notion of infectious microbial diseases being spread by personal contact, although learned in school, is not incorporated into daily behavior. For example, food and water are taken from communal utensils regularly. Three or four people eat from the same plate at meal times. While relaxing in the courtyard after dinner one glass and a pitcher of water will be provided for as many as 15 people. Likewise, when visiting a shrine the communal dipper at the well will be used by all visitors, numbering up to 100 at times. There is absolutely no concern with potential infection.

Despite the fact that the biomedical etiology has not

been incorporated into the explanatory model of Tunisian folk medicine, biomedical ethnomedicine has been integrated into the domain. Biomedicine is perceived as an alternative instrumental mode of therapy. It is used to heal "natural" illnesses under the following circumstances: 1) if the patient has an illness for which biomedicine is known to be more effective than dwa 'arbi (for example, diabetes, trachoma, hepatitis, high blood pressure, rheumatism and surgery), 2) if dwa 'arbi treatments have failed after two or three days of administration, and 3) if the family is residing in a nuclear household removed from the collective knowledge and expertise of the senior women of an extended household.

Older informants explained to me that at one time biomedical facilities did not exist in Mahdia, and those available in Tunis were primarily for the French colonists. During that time everyone relied on dwa 'arbi. But since Independence biomedical health care has become accessible to everyone. Thus in recent years many have discovered that biomedicine is better able to treat certain "natural" illnesses. One woman, for example, said that when she began to have rheumatism she used dwa 'arbi and Vicks mentholatum. However, as her condition worsened she went to the hopital. She explained,

> In the hospital they don't call it "barred" (cold), they call it "rhumatism" and they give me some pills and they are very good at easing the pain. Last time I went to the doctor, he also found out I have diabetes. He gave me some pills I have to take every day and every month. I have to go take some tests. I usually follow the diet the doctor prescribed, but when I feel that I'm in good shape I

take other things that I am not supposed to eat.

(The last statement illustrates a common idea of self-diagnosis and regulatory behavior.)

In most cases people feel confident using dwa 'arbi. They have past experiences upon which to base their confidence. They remember seeing others being healed by dwa 'arbi or remember being healed themselves. One woman summed up what many others expressed. She said, "My philosophy is simple. If it (dwa 'arbi) doesn't work in two or three days, you should take them to a doctor."

But because these are natural illnesses and basically monitored by God, there is an underlying conviction that people are healed through the will of God, despite the type of treatment administered. Statements made by informants revealed their fatalistic outlook. In discussing the death of her child, one woman explained, "Don't kid yourself, when God wants someone to die, he will die, regardless of what kind of treatment is given -- be it dwa 'arbi or that of a doctor." In talking about her son she said, "We took him to the doctor but he didn't do much. He gave him a shot and he died anyway." Another woman explains,

> If dwa 'arbi is not successful, it is because the person has just come to an end, and it is their time to die.

In answer to the question as to whether or not she sought biomedical care for her ailing children, she said,

> Well, don't tell me about that. Many people took their children to the doctor in my time and they weren't cured. They died too. When life is over, it is over, period. Don't tell me anymore about this.

There is often a great deal of resistance in going to biomedical clinics, despite the fact that they are free and nearby. This is especially true for chronic illnesses. Persons with acute pain or discomfort are more likely to be taken to a clinic in search of immediate relief. Adults, however, will endure physical discomfort for months before going to see a doctor, and then they usually go at the insistence of the family. This resistance is not due to a fear of biomedical practices but rather it is based more on the conviction that the body will heal itself if given time.

There is one family I know whose infant daughter had an obvious respiratory problem. She often suffered from coughing and her breathing was continually raspy. Dwa 'arbi was used on the little girl but her condition continued to persist. Despite urgings from family members her father refused to take his daughter to see a biomedical practitioner. His position was that her body must resist on its own and heal itself. By the age of four the little girl's condition had cleared and she appeared to be quite healthy. (Subsequently his response to his son's illnesses have been the same.)

Finally, within those families who have recently migrated to Tunis, natural illnesses are frequently treated in biomedical clinics rather than by dwa 'arbi. The reason for this is that the young couple, without the tutelage of an older woman (a mother-in-law, aunt, etc.), lacks the confidence to administer the few dwa 'arbi treatments they may know. They may try a few remedies at the onset of an illness,

but if there is no visible, immediate sign of recovery, they take the patient to a clinic. This situation is exacerbated by the fact that in Tunis there is a self-induced social (not necessarily physical) segregation based on one's town of origin. Immigrants living in Tunis zneg do not associate with one another freely. Thus, unlike zneg in Mahdia immigrants cannot draw from neighborhood resources to find a treatment for an illness.

AN ANALYSIS

In analyzing the etiology and treatment of natural illnesses, there are three points upon which to concentrate: 1) the derivation of the elemental category from tibb al-'arbi'; 2) the emphasis on who, not what, is ultimately responsible for the cause of an illness; and 3) the notion of specificity in etiology versus a holistic explanation.

Derivation from Tibb al-'Arbi

It is apparent that the principles governing the elemental category of illnesses are derived from tibb al-'arbi. Over time the basic tenets of Arab medicine have not stayed intact. What we find today is a diluted version of the former medical system. In tibb al-'arbi it was assumed that a healthy body was dependent on the maintenance of a balance of yellow bile, black bile, phlegm and blood all of which corresponded to the primary elements of earth, water, air and fire. If any of the humours (secondary elements) became polluted or occurred in excess, an imbalance would occur making the individual ill.

Looking at the causal explanations elicited for 52 illnesses, one finds "natural" illnesses are attributed to "cold" air, "bad" and "weak" blood, "bad" diet, dirty surroundings, physical injuries and an assortment of illnesses attributed to God's will (in particular childhood illnesses). Not all informants were able to give causal explanations for every illness. Furthermore, there wasn't always unanimity in their responses. However, an analysis of etiological descriptions most commonly offered revealed how significant the concept of bodily elements is in determining illness or health. I found that 61.6% of the causal explanations expressed the belief that an elemental imbalance was the cause of illness.

In comparing the basic tenets of tibb al-'arbi and those related to dwa 'arbi, we find both differences and similarities. Let us concentrate on the differences first. Dwa 'arbi therapy is based on the assumption that illnesses are caused by bad/dirty blood, cold air, bad diet and dirt, one of which is a humour - blood. This represents a variation from tibb al-'arbi where an imbalance of humours such as blood, yellow bile, black bile and phlegm were the causal agents. In dwa 'arbi there is reference to the primary elements instead. For example, reference is made to "cold air" not phlegm. Finally, bad diet is neither a primary element nor a humour. A well-balanced healthful diet was stressed in Arab medicine as a preventative measure against illness. Thus dwa 'arbi is not truly a humoural system. At

best we can call it an elemental system.

Secondly, informants gave no indication that they believed that personality types were derived from a dominant humour as was held in tibb al-'arbi. The notion of dominating humours is not part of their explanatory model.

Despite these differences, however, there are many more similarities. For example, both systems maintain the notion that emotional disquiet can affect the bodily constitution creating an imbalance which can ultimately result in an illness. They both include treatments that are based on bringing the body into a state of equilibrium. And they both describe the bodily constitution in terms of two of the primary/secondary elements (secondary elements being humours) - air/phlegm and fire/blood and perceive dirt and bad diet as being the cause of certain types of illnesses.

Ultimate Responsibility

Natural illnesses including physical disorders and elemental imbalances are ultimately caused by God, who either "gives" them or "permits" them to happen, or they are caused by the individual himself who did not take preventative measures. God's will is not questioned, but an individual's behavior is. All adults are cognizant of certain behavioral modes regarding food intake, cleanliness and the maintenance of a constant body temperature. The Koran and the Ḥadith provide a set of laws which, if observed, will maintain an individual's health. Thus behaving appropriately is not only a practical, wise sort of thing to do -- it is morally correct

as well. Thus, when one is ill, the family or patient will analyze recent behavior, and try to deduce their deviant behavior, thus discovering who is ultimately responsible. As stated earlier, a fatalistic attitude is ever present. One is not condemned or shunned because of their illness.

Specificity vs. Holism

Bacteriology, which has been developed in the Western medical tradition, is based on the concept of disease specificity. That is, the goal of the diagnostic procedure is to ascertain the specific pathogen responsible for causing a particular illness. Once the pathogen has been identified, an antidote (i.e. an antibiotic) is administered to cure the disease. In many cases dwa 'arbi works on the same principle. For example, if the illness is perceived as being caused by one element (cold air), the antidote is simply the ingestion or application of hot air. However the goal of these treatments is different. The biomedical practitioner will prescribe an antibiotic to "combat and eradicate" the pathogen. Whereas the dwa 'arbi practitioner will prescribe hot tisanes and vapors to achieve a somatic balance.

The patient and his family is interested in the pathology of an illness but their concern does not stop there. In determining the cause of a particular sickness the circumstances that led up to the illness are evaluated. These circumstances may range from improper behavior at the personal level to poor relationships with family members, neighbors or spirits.

Biomedical therapy has been incorporated in the Tunisian medical domain because it is perceived as symptom-specific mode of therapy. It is known to be successful in eradicating pain and discomfort thereby treating the symptoms of some specific illnesses. However Tunisians feel that treatments administered in the clinics or hospitals tend to disregard the socio-psycho-spiritual factors that contribute to some illnesses. Such treatments do not shed light on the circumstances that led up to the illness and thus lack the holistic view held by Tunisians.

Illnesses that are caused by non-natural causes include yakhuda bin nufs (illnesses caused by the evil eye) and marḍ min tebt idihum (illnesses caused by jnun). Because these illnesses are not "natural" they are not sanctioned by God. In seeking a cure a person can in fact enlist the aid of God through His intermediaries - the saints and human mediums.

THE EVIL EYE

The antiquity of belief in the evil eye was discussed in Chapter Five. Here we will focus on the ways in which people in Mahdia incorporate those beliefs in their daily explanations of illness and misfortune.

Belief in the evil eye is very strong in Mahdia. Younger informants may have shown some hesitancy about the omnipresence of jnun, but they had absolutely no doubt about the existence and power of the evil eye. Several repeated the following verse, supposedly uttered by Mohammed: "The evil eye is real, but the bird of doom is not." (The bird of doom is the owl. It is a symbol of death. If one should perch on a rooftop, it is believed (by some) that someone in the house will die soon.) (1)

I was told that there are two types of evil eye curses. One is caused by admiration or mild feelings of jealousy (i.e. the evil eye of "love", from a doting mother, or the "pot and collander" evil eye); the other is caused by feelings of envy and hate ('ain ḥarsha or hard eye). The two types vary in their degree of intensity and correspondingly the severity of

illness that is manifested. Thus minor accidents or illnesses are attributed to the former type, while serious illnesses and death are attributed to the latter.

Below five cases of evil eye are presented. These were taken from data collected in 1984. The cases range from trivial accidents to accidents resulting in death, but all demonstrate the conceptual framework of belief in the evil eye. Treatment for illnesses caused by the evil eye include instrumental treatments and a ritual extraction called tadwir. These treatments were described in Chapters Six and Seven.

Case No. 1 - Example of "Pot and Collander" Evil Eye

> One day we were making couscous and a neighbor by the name of Fatuma came to visit. The neighbor said, "Why are you making all this couscous? Are you having a wedding or what?" All of a sudden the hot water pot and collander spilled all over. The lady shouted, "Oh my God, it's an evil eye and it's because of me."

Comment: This type of evil eye case was described many times by informants. This example illustrates that neighbors and friends possessing the evil eye can cast an evil eye if they are envious of even the smallest achievements. If this happens frequently, the woman, like Fatuma, might come to beleive that indeed she does have the power of the evil eye. This does not stop one from interacting with such a neighbor. One simply takes precautions when she is around.

Case No. 2 - Example of Evil Eye Caused by the Envy of a Neighbor ('Ain Harsha)

> I personally was the victim of the evil eye. One day I was knitting a sweater and a neighbor came to visit. She was very surprised to see that I could weave such a nice thing and said "How can you

weave such a (beautiful) sweater?" That same night I became very ill. I was taken over by dizziness and was vomiting all over. My neighbor helped me get through a ritual of tadwir . . . .

Question: What made you think she had the evil eye?

Answer: Because she looked at me with envy and jealousy.

Comment: Women who do handicrafts in their home are particularly susceptible to the evil eye. They are envied not only for their skill but probably because of the extra money they are able to acquire with their skill. Again, in this case, the caster of the evil eye was a neighbor. Perhaps her repuation preceded her, although the informant did not mention that. The woman recovered quickly after the tadwir was performed.

Case No. 3 - Example of Evil Eye Caused by the Envy of an Anonymous Person in a Crowd ('Ain Harsha)

I remember when I was about 12 years old and it was during the wedding of my sister. I used to kid a lot and I enjoyed playing the drums and laughing and joking. I even played better drums than some of the mashtas. That night after I played the drums I went in my room and dressed as a clown. At first I walked in the hallway, dressed in my scary clown costume and I scared everybody. Then I took off my masquerade and watched a woman dance according to the style of the Bekalta (little town nearby). The woman was dressed funny, with a man's hat on her head. Then I tried to dress like her and sing and dance like her. Everybody was surprised that I was such a good imitator. They were amazed. Suddenly, I fell to the floor with pains and fever all over. I wasn't able to even lift my head off the pillow. Three of the women surrounded me and started a spiritual treatment (tadwir) and uttering prayers. Next day my eyes were in very poor condition and my mother was scared that I would go blind because of the evil eye. My mother treated me with rubbing oil and lemon and I was sick for a few days. My father then took me to the doctor who

prescribed an ointment which I used for three days. That is what I believe is the effect of the evil eye.

Question: How long were you sick?

Answer: For three days. As you know, the evil eye normally lasts for three days. The spiritual treatment continued for three days.

Comment: Repeatedly I was told that the evil eye is most often cast at social gatherings such as weddings. People are especially vulnerable at such gatherings for the following reason. Women bring their most prized possessions to a wedding - their children and their gold jewelry and fine clothing. Here they can flaunt their wealth and social standing among their peers. It is also in these situations that women can display their daughters as potential marriage partners. However because such social gatherings may include strangers invited from other zneg or towns one runs the risk of exposing one's self or children to an envious look.

As explained in Chapter Three, young women are supposed to behave in a modest way, attesting to their purity, innocence and good upbringing. In the above case the girl was not behaving modestly but rather showing off. Such behavior would have been acceptable had she been younger, but at 12 years of age a girl should be making the transition from a rambunctious child into a passive, quiet young woman. Thus in exposing her youth, beauty and talent for mimicry she invited the envy of others.

This informant was the only person who stated that the evil eye lasts for three days. Other cases involve sickness

episodes lasting up to six months.

Case No. 4 - Example of Evil Eye Caused by Envy of a Stranger (*'Ain Harsha*)

> One day a poor woman came to our house and so my husband asked me to give her some food. That day we were having hot cereal, so I gave her a dish with some cereal in it and some butter and honey. While eating she saw one of the young daughters and so she started saying to my husband "Oh, how cute she is. She is lovely all over, be it her legs or her face." Then she left. Then my husband went to get the groceries for the day. I cooked the dinner and we gathered around the table to eat. After dinner I started to breastfeed my daughter while looking over a *kanun* with a teapot. My husband was playing with one of the boys. I felt a fly sting on my leg, so I covered it with a piece of cloth. By next morning it was all swollen and red. I suffered with it for a month. My husband was about to take me to see a healer in Sfax when a bedouin lady came to see us and advised me to rub the wound with oil and naphtalene. The treatment was successful, but I still have the scar on my leg. I believe this is the case of the evil eye.

Comment: Hospitality and generosity are considered virtues in Tunisia, as elsewhere in the Arab world. But obviously being kind to strangers and inviting them into your home for a meal is not without risk. Strangers are generally looked upon with a great deal of suspicion for that reason. In this case the guest foolishly made complimentary remarks about the child. Most people would know better and would refrain from saying anything complimentary to a stranger.

Case No. 5 - Example of Evil Eye Case By A Relative (*'Ain Harsha*)

> Some people are known to have hard eyes (*'ain harsha*). Take the case of my brother-in-law who is known to have a hard eye. When I gave birth to one of my children I got up the next day and went in front of the mirror to get dressed. My brother-in-law came to the door and said: "Should I congratulate you or should I say you are safe?" A

few hours later when I went to the bathroom I passed out. They called on my other brother-in-law, who cast an anti-spell (by reading verses of the Koran) and I felt fine after that.

When my little boy was about one and a half years, as you know, he was a rather cute little boy with red cheeks and bluish eyes. One day I dyed his hair with henna and so he looked like a red-headed European. My brother-in-law saw him and said: "Oh, how cute you are. If you were a little girl, someone would ask to marry you." He didn't finish the day when he started having an eye infection, from which he died.

Comment: In this case the possessor of the evil eye adopted this identity, and used it to intimidate others. It is rather unusual for 'ain barsha to attack a family member. Apparently this family found a solution by having another person able to counteract evil eye curses.

An Analysis

As the reader can see the cases described above range from a simple type of "pot and collander" accident caused by a neighbor in the kitchen, to a more serious 'ain barsha cast by an uncle, resulting in the death of his nephew. Thus not only does the type of evil eye vary but so also does the relationship between the victim and the evil eye caster.

Based on 18 cases reported in interviews a general pattern can be discerned: 1) casters are always adults, 2) nearly one half of the victims are children (8 of the reported cases were adult females and 2 were adult males); 3) adult females tend to play a prominent role in evil eye cases (13 out of 18 were casters and 8 out of 18 were victims); 4) the caster is either a stranger (8/18) or a neighbor/friend (8/18); 5) the most common result of the evil eye curse is

illness; and 6) techniques of curing illnesses caused by the evil eye include symptom-specific intervention, the ritual of tadwir and anti-curses.

The fact that the participants involved in the cases collected are primarily female is not surprising. For the most part women associate mainly with other women on a regular basis. Only another woman would be privy to, and possibly envious of, one's possessions and skills. Significantly, 13 out of the 18 casters were known by the victims (or mothers of the victims). One was an uncle (Case 5 above), 8 were neighbors or friends, and 4 of the strangers were women who directed comments to the victim as she walked down the street. The other 4 casters were strangers at a wedding. This is interesting because the victim is able to analyze the motivation of a known caster.

Anyone might possess this innate power of the evil eye - someone living in your zanqa, your town, or an outside visitor. When asked how one might recognize a person with the evil eye, most people explained that there was no way of knowing. Two informants did say, however, that blue eyes and crossed eyebrows were often characteristics of people having the hard eye ('ain barsha). Children were never identified as having the evil eye. Apparently the potency of this innate power is not realized until adulthood.

People with the evil eye cannot harm members of their nuclear families of orientation or procreation. They can, however, harm members of the extended family and in-laws.

Neighbors are likely to respresent a threat. Even so, they are not shunned but are rather treated with caution. Valuable objects are put out of sight when they visit and one is careful not to expose oneself in such a way as to invoke envy.

Persons possessing the evil eye establish a reputation for their malevolence. Thus measures are taken to either avoid them or to protect oneself with an amulet. Several of the women interviewed wear amulets for protection. The contents always consist of the herb nigella, bits of metal (broken nails or needles), and salt. Some women add a chameleon head or the roots of a raspberry bush to the standard packet. These are folded up in a piece of cloth and placed beneath undergarments next to the skin.

Another protective device is avoidance. The woman whose husband allowed a bedouin woman in for a meal explained that: "One way (to protect oneself) is to avoid bringing people into your home when you are doing things around the house. Another way is to stop what you are doing (such as sewing) when somebody comes in, especially if it is a stranger. Another way is to burn incense." Here she is referring to evil eye caused by admiration. She goes on to explain how to protect oneself against <u>'ain harsha</u>. She says, "First stay away from that person. As you know you cannot tell a person that they are responsible for an evil eye spell. This might hurt their feelings. If you ever do that you will lose a friend."

This last statement is particularly revealing in that it illustrates the fact that the person with the evil eye is perceived as blameless, for he/she has this power by the will

of God. Comments made by others confirmed the idea that one must not openly accuse someone of casting an evil eye spell for fear of hurting their feelings or showing disrespect. Someone with the evil eye is treated much like someone with a physical disability. His/her "handicap" is not discussed openly and is accepted as God's will.

It is believed that occasionally there are those who intentionally use their power for malevolent purposes, such as the man described in Case No. 5 above. These people are thought to be particularly dangerous. It is believed that it is difficult to find an anti-curse (verses from the Koran) strong enough to counteract the evil eye spell from such persons.

Although one can never predict when an evil eye will be cast, conditions that can initiate feelings of envy are known. Thus to a large extent the victim of evil eye is to blame for the curse he or she receives. (In the case of a child, the parents are to blame.) The victim is responsible because she/he has exposed something of value, something worthy of envy. The thing of value might be one's beauty, handicraft, or arduous labor. By exposing oneself or one's possessions, they make themselves vulnerable to an evil eye casting.

Evil eye curses are the result of feelings of jealousy and envy, whereas revenge is the emotion that leads to illnesses caused by spirits. Despite the differences in emotional determinants, often victims are victims because of their own behavior. Either they failed to behave modestly or

they did not take proper measures to protect themselves. Again we see the notion of personal responsibility in maintaining one's health. We will return to this later.

JNUN-OULAYA TRADITION

Man's Relationship with the Oulaya

Oulaya are "friends of God" in Sufism. In Tunisia, as well as elsewhere in the Mahgreb, the oulaya are also the friends and mediators of man. Oulaya are people who have lived a human life and can thus understand the problems that humans must endure. Oulaya are treated like friends. They are visited. They are given gifts. Favors are asked of them which, if fulfilled, are repaid.

Saints, however, because of their closeness to God, wield considerable power and so, just with any powerful friend, it is better to stay on their good side. Saints, through a human medium, can intercede on one's behalf. They can tell the future and, with their power of baraka, can cure illnesses and exorcise possessing jnun. But they can also cause misfortune if one forgets or omits to fulfill an obligation to them. (In Chapter Seven this was described fully.)

Man's Relationship with the Jnun

In comparing the beliefs held by Moroccans and Egyptians (reported by Westermarck and Lane) during the first part of this century to those held by Tunisians today, one finds some differences. However there are many more similarities.

First of all, Mahdians described the origin myth and characterized the behavior of jnun in much the same way as was related to Westermarck in the 1920's. Various explanations were elicited during the interviews that illustrated this point. For example, comments by derwisha 'Aiesha Zyed and others reflect the belief that jnun enter this earthly plane via water sources, just as Moroccans had described to Westermarck. 'Aiesha explained that some of the jnun with whom she has contact live just beneath a certain rocky enclave on the northern coast of Mahdia. It is a place that is known locally. Likewise, one of the cases she divined involved a young man living in Tunis. She claimed that he had been kidnapped by jnun who lived on a beach outside of Tunis.

The following case elicited from another informant illustrates the same point and also depicts the vengeful nature of the jnun.

> In Mahdia a man purchased a house from another man. When they began moving into it, the whole family found that upon entering they felt cold and had shivers. They felt that perhaps it was due to "electricity", so they called in electricians who after checking everything, said that the wiring of the house was all in order. The family then began calling in various sorcerers, one of which was from Morocco. All of the sorcerers agreed that the house was haunted by a family of jnun. However only the Moroccan sorcerer was able to find out the exact cause of the problem.
>
> Apparently the people who had lived there previously closed up the well. This prevented the free passage of the jnun, who came up from there in order to enter the earthly plane. This made the jnun angry, and they swore they would punish any humans living there. Under the suggestion of the Moroccan they opened up the well and freed the jnun. But the family was warned that they could live there only if they were careful not to insult the jnun. They never had fevers or chills again.

Some individuals are known to have familial jnun who can be summoned at will. For example, sorcerers make contact with the jnun in order to utilize their supernatural powers to cause illness or misfortune. "Writings" are performed by sorcerers who write down a curse on an egg or a piece of paper or leaf. Exactly what is written or what is done with the egg, paper or leaf, is not clear. But it is believed that through the power of words given to them by the jnun a sorcerer can cause an illness. The treatment for a "writing" is to obtain an "anti-curse writing" - which includes verses from the Koran.

Some sorcerers make sacrifices to jnun as payment for their services. I was told of the following case:

> In 1960 there were five Moroccans who came to Mahdia after being informed by a jinn that there was buried treasure in the town. One of the men, upon his arrival contacted a sorcerer and told him of his previous contact with a jinn who sent him to Mahdia. The sorcerer, after consulting the jinn himself, told him that before the jinn would tell him precisely where the treasure was buried he must make a human sacrifice. The man could not bring himself to do this. He remained in Mahdia after getting a job and taking up residence. Everyone was on guard around him thereafter, however.

Finally, informants explained that there were cases where people had long associations with one particular jinn or jinniyya. Here is a case that involved a man from Zanqa Sfar. He is deceased now, but his story is still told:

> Si Bendaly was known to be married, not only to an earthly woman who bore him two children, but also to a jinniya. They had been married for several years. He used to invite friends over and ask his jinniya wife to entertain their guests by performing tricks. One night in particular he asked her to put on her ankle bracelets (part of the

wedding outfit) and walk across the ceiling. When she did so his guests were able to hear the bracelets as she moved across the ceiling.

In general people are cognizant of the fact that the invisible jnun are around them at all times. Most people do not wish to form close relationships with them because of their vengeful nature. They therefore take measures to ward them off. Only the very brave or foolish attempt to develop a close relationship with one of them.

Possession and Exorcism

Jnun cause illness out of revenge. They are easily angered by inadvertent actions of humans. Once angered they will seek revenge by either striking one with an illness or by entering the body and taking possession of it. The result of the latter is a personality change due to the mental disturbance caused by the intruding spirit.

One informant described four situations where a jinn may take possession of an individual:

1) If a person steps on fresh blood during the slaughtering of an animal.

Comment: Blood is drunk by jnun. If a mortal steps on blood it contaminates the drink and angers the jinn.

2) If a person hits a young child when an animal is being slaughtered.

Comment: By hitting a young child the person has inadvertently fingered a victim. This act demonstrates that the child is held in low esteem and thus is vulnerable to the jinn's attack.

3) If a person throws hot water without invoking

the name of God.

Comment: One runs the risk, when throwing water into the street (or lowering a bucket into a well), of hitting a jinn. Thus to protect oneself one must say "in the name of God, the merciful and compassionate" when throwing anything in order to protect oneself.

4) If a person steps on dirty things without knowing it.

Comment: Again jnun are attracted to filth. Homes are kept immaculately clean. In the street one tries to avoid filthy things, but it is possible to step on something in the street which has attracted the jnun. By doing so you may bump into a jinn, making him angry.

Protective jewelry and amulets worn today are similar to those described by Westermarck. Likewise, treatment of illnesses caused by the jnun is much the same as it was in the 1920's. Instrumental modes of treatment are used for illnesses inflicted by jnun. If the patient has been possessed, however, one seeks the help of a spirit medium. Treatment for possession includes using an ingredient hated by the jnun to treat the patient, for example burning corriander seeds near the patient or "drinking" verses from the Koran (described in an earlier chapter) or exorcising the possessing jinn.

Possession - A Type of Mental Disorder

I discovered that in Arabic there are a variety of terms used to classify people who, because of their abnormal behavior, are considered mentally disturbed. Thus people who

are mahboul, btita magarg'a and bohelli are basically simple-minded individuals who have little reasoning ability. They live with their families and are able to function in society. Mtehteh and mlawths are mentally disturbed individuals as well, but they do not lack intelligence. Rather they are confused. Their thinking is deranged. Finally individuals referred to as 'asab, majnun and mackloub are those who have bouts of abnormal behavior (fits) interspersed with periods where they behave normally. These individuals are unpredictable and can become physically aggressive and dangerous at times. Thus their presence creates stress within the household.

Whereas those individuals who are considered mahboul, btita, magarg'a, bohelli, mtehteh and malwath can be incorporated into daily life, those categorized as 'asab, mjneens and mackloubeen require treatment. Treatment can be obtained at either one of the two mental hospitals in Tunisia (one in Tunis and one in Sfax) or at various university-run clinics located in Tunis. In addition, of course, family members can take their disturbed relative to see the 'azameen located at various shrines in Tunisia. He will diagnose the patient and perform a t'azime if necessary.

People who are possessed by jnun are called majnun. It is believed that the jinn has taken over the body. This has a physiological and behavioral effect on the individual. The person feels out of sorts, not fully in control of his body. He has an abnormal feeling. As one woman explained,

"Possessed people are usually unable to work or even walk. They feel weak most of the time and some of them have to stay in bed all the time. It is these symptoms that disappear after a ḥadra. Some are taken to see doctors a number of times, but are cured only after participating in a ḥadra."

As mentioned in Chapter Seven, those who become possessed by jnun fall into two categories - those exhibiting passive behavior (as described above) which is probably the most common, and those who become hyperactive (which is illustrated in the case below). Whether or not the possessed person is active or passive depends upon the personality of the possessing jnun. In either case there is an imbalance in comportment.

Usually the family can determine whether or not an individual is majnun or 'aṣab, and thus seek appropriate treatment. This was the case in the following episode as explained by one informant:

> They said that she (the sister) was possessed by the "ones who live under" (jnun). She used to go into fits, fall on the ground, and shake around. She would utter things in the voice of a spirit. The people at Sidi 'Akmer healed her by saying verses of the Koran and uttering words in the name of Sidi 'Akmer.
>
> They contacted the spirit possessing her and asked him to leave. The spirit spoke through her while in a trance and said that he wouldn't leave. So the people at Sidi Ahmer started burning oil lamps and started asking questions of the spirit. They would ask, "Do you live in her thumb? Will you leave from her thumb?" The spirit answered "no", so they burned the thumb. Then they asked the spirit the same question about the nose. They kept on burning (mildly) as long as the answer was "no". She was finally exorcised and she was healed. It left by the thumb.

Often this type of illness reoccurs cyclicly. For example, in the case of derwisha 'Aiesha Zyed, she used to feel the need of a hadra once a month. Another woman felt the need to have a hadra every spring, after which she felt normal again. And some informants explained that often people who have been "stepped on" by jnun once begin to feel ill again just prior to the 'Id al-Kabir - a time when pilgrimages are made to Sidi 'Akmer.

The diagnosis as to whether or not the individual is 'asab or majnun is not always clear cut. One may suspect that the individual is 'asab, but when the biomedical treatment fails that diagnosis must be reconsidered. An alternative type of treatment is then sought. That was the case for one of my informants. Over the years she has had bouts of hyperactivity at which time she becomes impossible to live with. She is quarrelsome and verbally, if not physically, aggressive. On two or three occasions her family has taken her to the mental hospital in Tunis. (She is a widow with one adult son. Her brothers and son took the responsibility of taking her to the hospital, not believing she was possessed.) After each confinement she was released with prescriptions for sedatives and sent home. She would remain normal for long periods of time and then would have a reoccurence of abnormal behavior.

Finally three years ago her sister convinced her to go to Sidi 'Akmer, thinking she was possessed by jnun. The informant herself explains:

> I was taken to Sidi 'Akmer by my sister when I became sick. At that time she believed that I was possessed either by jnun or ghosts. She held a

hadra at Sidi 'Akmer for me. Many people danced and went into trances. I just looked at them. I did not participate in the dances. Then they performed rituals of t'azime and "writing" on my behalf, but nothing worked. I became even more ill. And that is when I went to the doctor. The doctor told me I had a nervous breakdown ('asab).

The symptoms of my sickness consisted of fighting with anybody who talked with me and blurred vision at times. I thought bad of everybody I saw and I lost control of what I said. The doctor requested that I stay in the hospital and prescribed pills and shots. Whenever I took the pills I fell asleep. I was released from the hospital and soon after I stopped taking the pills. I was behaving normally. However I kept on drinking some type of medicine he gave me - three spoons and three viales per day. Sometimes I lose control of myself once in awhile if I am angered. But otherwise I feel fine.

Recently I have heard that she is no longer taking any medication and appears to be in excellent health, both mentally and physically. She made a pilgrimage to Mecca this fall (her second) and visited Sidi 'Akmer as an observer on the 'Id al-Kabir.

An Analysis

In one's daily activities an individual is neither concerned with the jnun nor the oulaya. However perhaps because of inattentiveness to these matters one may unknowingly anger a jinn. When this occurs an illness, either physical or mental, is the result. If the illness is a physical disorder then any instrumental mode of treatment (dwa 'arbi or biomedical) can be administered to alleviate the discomfort of the illness. However if the illness is diagnosed as possession, instrumental treatments are insufficient. The family must seek a healer who has

supernatural powers powerful enough to deal with the jnun. The oulaya, acting through a human medium, is just such a healer.

The individual who through no fault of her own is "stepped on" by a jinn experiences what Erika Bourguignon calls a nontrance possession. (Bourguignon, 1976). These individuals are considered blameless victims. There is no stigma attached to their affliction. However those who attend hadrat with the expressed purpose of voluntarily becoming possessed for the thrill of the transcendent experience are held in low esteem, especially by the more conservative Mahdians. They, as well as sorcerers who conjure up jnun and pay them to do evil deeds, are practicing ishterakeeya. That is, they are dabbling in something that God does not permit. It is felt that Man has no business trying to transcend this plane and enter into another realm of existence. To do so is haram (sinful). Thus when such a person becomes mentally deranged because of the possessed state, it is believed that he/she brought on his/her own condition and receives little sympathy. Once again we see the importance of personal responsiblity in staying healthy. To a large extent health is equated with morality.

Although it was convenient to dissect the Tunisian medical domain into its two primary components - the natural and supernatural spheres - it would be misleading to stop there. Rather I intend to demonstrate that these two are integrated, if not fused, into one medical system based on a set of common principles.

A SYNCRETIC MODEL

Reviewing the literature written on medical beliefs and therapeutic practices within the Middle East and North Africa, one is led to the conclusion that the medical domain is a pluralistic one. Anthropologists, sociologists and historians have quite understandably delineated one area of interest and presented material on that particular topic. As discussed in Chapters One and Five, research has been conducted separately on "magical" practices (Blackman, 1926, Lane, 1908, Westermarck, 1926), maraboutism (Eickleman, 1976, Gellner, 1969, Rabinow, 1975), herbalism (Hilton-Simpson, 1922), health seeking behavior (Auerbach, 1982, Benyousseff and Wessen, 1974, Hermanson-Klein, 1976, Gallagher, 1974), Islamic medicine, (Browne, 1921, Burgel, 1976, Dohls, 184, Khariallah, 1946, Milad, 1980, Plessner, 1974, Ullman, 1978), spirit possession (Crapanzano 1973, El-Shamy, 1972, Ferchiou, 1972), social and psychological factors involved in illness episodes (Morsy, 1978, Teitlebaum, 1975, 1976a, 1976b) , and more recently the semiotics of beliefs about health care (Creyghton, 1977, Good, 1977, Morsy, 1980).

After surveying this literature one could easily conclude that healings that take place in shrines are part of a different system than the healings that take place in the homes of the herbalists or bone-setter, or in the hospital or clinic. What I am suggesting is that the Tunisian medical domain is a syncretic paradigm that incorporates all of these medical situations.(2)

When I began my fieldwork I started by collecting data on dwa 'arbi. I began here because although some authors (Good, Teitlebaum and Morsy) had acknowledged the fact that today's folk medicine in the Middle East is derived from Arab medicine, none had explored the notion further. I wondered about this. I began with the assumption that dwa 'arbi was probably a subsystem within a larger pluralistic medical system and that as such it was competing with other subsystems. However when I started to analyze the data I began to suspect that my original assumption was incorrect. Interviews on dwa 'arbi elicited information on herbal remedies, massages, etc. but they also included ethnomedical practices aimed at treating illnesses caused by evil eye and jnun. Furthermore, references were made to biomedical treatment as well. Clearly these subsystems, which may have been separate at one point in time, have fused into one system.

As more data was collected and analyzed I became more sure that I was dealing with a syncretic medical system into which biomedicine was being incorporated. Some underlying themes cutting across the natural and supernatural spheres began to surface. These themes appear to integrate the two spheres cognitively. The themes are concerned with concepts of balance, correct behavior and responsiblity in health matters. These notions can be found in causal explantions, in questions asked during the diagnostic process, and in the ethnomedical practices themselves.

ETIOLOGY

In analyzing the etiology of the Tunisian medical domain two meanings prominently thread through all explanations. First is the notion of balance and second is the idea of personal responsibility for one's own health and welfare. Folk ethnomedical practices reflect concern with these notions and, in as much as biomedical treatment incorporates these meanings, such treatments are considered efficacious.

Illnesses are the result of a host of factors. These include physical excesses, emotional instability, nonobservance of behavioral rituals and taboos, evil (envious) eye, reprimanding saints, vengeful jnun, and God. In all cases except for involuntary possession and God-given illnesses, one's personal behavior, emotional state, or emotions of those afflicting an illness (evil eye casters, jnun or saints) precipitates or activates the causal agent, resulting in an imbalanced state - an illness. (See following chart.)

Health is maintained if one has a somatic, emotional and social balance. Illness is tangible proof - the evidence - the manifestation of an imbalanced state. Symptoms of an illness will indicate the type and severity of the imbalance. For example, coughing indicates an excess of cold air, heart palpitations indicate weak blood, and so forth. Having established the cause of the imbalance one then begins to analyze his/her behavior prior to the illness. Has the patient eaten properly? Rested properly? Behaved in a modest way? Repaid debts to either friends or saints? Invoked the name of

PRECIPITANTS TO ILLNESS

Preceding Events	Illness Caused By	Some Examples
(Individual is Responsible)		
quarrels bad news worry anger anxiety	bad/weak blood	boumra diabetes heart palpitations
lack of observance of health rituals • taboos	physical excesses cold air bad diet dirt	hernia constipation muscle aches asthma whooping cough scabies
immodest behavior/ jeolousy and envy	evil eye	any sudden illness or accident
unfulfilled promise	reprimanding saint	any illness or accident
contact with jnun	jnun	any illness or voluntary possession
Individual is Not Responsible		
Angered jnun	jnun	illness/ involuntary possession
God's will	God	accidents (involving physical injury) measles chicken pox

God at appropriate times? Argued with family members? Taken necessary precautions against natural and supernatural elements (cold air, dirt, the evil eye or jnun)? If all of these things have been done properly then one can only assume that this illness is a God-given illness and an instrumental mode of treatment including dwa 'arbi or biomedicine will be sought. Thus illnesses, if they are not God-given, are usually the responsibility of the patient, or in case of a child, the child's parents.

Physical or Emotional Excesses

In some cases one's illness is brought on by indulgences, for example over-eating or over- drinking. Thus stomach aches, constipation, diarrhea, bowel impaction and hemmorhoids are the result of over-indulgence. In other instances lack of exercise or the reverse, over-exertion, can result in twisted joints, pulled muscles, neck aches, hernia, etc. Thus these types of illnesses are caused ultimately by the foolishness of the individual who lacked the self-control necessary to eat, drink or work in moderation.

Illnesses caused by "bad" or "weak" blood can be traced back to emotional outbursts of anger or strong feelings of anxiety, worry, fear or sadness. These strong emotions represent in themselves a break from the steady emotional level one is supposed to maintain. The emotional instability caused by worrying about a child or spouse or quarreling with a family member results in polluting or weakening the blood. (No one could explain to me exactly how this happens.) It is

incumbent on the individual afflicted by these illnesses to reflect upon his relationships with others. In doing so he will discover that he allowed himself to feel too strongly about something rather than staying aloof and rational as is the supposed norm. This lack of self discipline has resulted in an illness. (People who have a "nervous" temperment are cautioned by their friends and family to "calm down" and to "take things easy".

Evil Eye/Saints/Jnun

Supernatural forces, whether they emanate from an evil eye, a saint or jinn, create an imbalance in an individual which in turn creates an illness. As discussed earlier, with forethought one can guard against being the victim of an evil eye curse. Amulets offer protection against the evil eye as does avoidance and seclusion. But for those who do interact with neighbors and friends known to possess the evil eye, they can also safeguard themselves and their children by behaving modestly and avoiding the exposition of valued items. Likewise if one lives up to his commitments one must never fear a sorcerer or a reprimanding saint to whom one has made a w'ada.

Jnun may inflict an illness on their own volition because they are angry with the individual or they can be persuaded through gifts or sacrifices by sorcerers to cause an illness. However some measures can be used to prevent against the jnun, such as avoiding dirty things including blood (note dirty things and blood can result in an elemental imbalance

creating an illness); sprinkling salt on the floor and food, burning certain substances repulsive to jnun, and most potent of all using the words of God to repulse the jnun.

Health Rituals and Taboos

When interacting with non-family members a couple of well-wishing phrases can be heard. Uttering these phrases is part of the ritual behavior expected in interpersonal relations. For example, upon greeting a friend one will inquire about their health and that of other family members. One will be asked "shnou-halic?" (How are you?). And the standard response is "la-bess" (in good health). Another term used with non-family members is "bishfey". After a guest has finished their drink, the hostess will say "bishfey", expressing her wish for her guest's good health. However there is one utterance that is used most commonly within the home and that is "sa-ha". I think it has a more particular meaning than the others which are said out of habituation. "Sa-ha" is a term that connotes good health also, but it is used in two specific instances: 1) when one has just completed taking a bath (and thus are in danger of moving from a warm to a cold environment), and 2) when one receives something new - either a recent purchase or a gift (and thus are in danger of creating envy in others). Uttering "sa-ha" then is a preventative ritual which family members make on behalf of their relatives. (Note: This utterance protects one from illnesses that may occur naturally or supernaturally.)

Protective (preventative) rituals and objects including

the invocation of God's name, wearing amulets and jewelry (i.e. replicas of fish and Fatima's hand) which deflect the power of evil eye or repulse the jnun have already been mentioned. Rituals where a saint is promised a gift (w'ada) in return for a safe delivery or journey, for example, are another means of prevention.

In addition to these rituals there are a number of taboos which, if observed, can insure health. One's respiratory, digestive and reproductive systems can be negatively affected, it is believed, if one does not observe certain cultural rules. Thus there are certain food taboos which when not observed lead to an illness. Cold air, the cause of much illness, can be avoided if certain preventative measures are taken. One should not suddenly go from a hot steamy bath into a cold area, or consume cold water on a hot day, or stand or sit on a cold floor without warm clothing.

Finally, one can avoid illness by maintaining cleanliness of one's body and surroundings. Scabies, eye infections, skin irritations and warts are attributed to dirt, usually picked up in the fields or streets via animals. (Thus, upon entering a house shoes are removed and hands and feet washed.)

Summary

Illnesses caused by God and the jnun are unpredictable and, in the case of specifically God-given illnesses, unpreventable. However the individual is responsible for taking preventative measures to insure that illness (or

accidents) do not occur. Improper behavior which leads to an imbalance in the bodily elements or in poor relationships between family members, neighbors or saints, is to be avoided to remain healthy.

If there is an imbalance in one's life -- at the individual level (physical excesses, improprieties), at the family level (emotional instability), with outsiders or with spirits (saints and sometimes _jnun_) then illnesses will result.

Many of the illnesses that occur within the natural and supernatural sphere involve excessive emotions - anger, anxiety, sadness (elemental imbalances), jealousy and envy (evil eye) and revenge (_jnun_ and saint-related illnesses). In any of these cases an imbalance of emotional feelings creates a physical imbalance resulting in an illness. A realignment or balance is needed for the restoration of health.

DIAGNOSIS

Diagnosis begins with consideration of the symptoms. Some symptoms are signs of a particular illness. Their presence singularly indicates a given ailment. Most, however, are analyzed in relation to other symptoms or in the context of the psycho-social situation of the patient. Thus the events surrounding the patient and their behavior prior to the illness is pondered. Usually through a process of elimination an illness (natural or supernatural) will be identified and the cause will be deciphered. An analysis of the diagnostic process reveals on the one hand the syncretic nature of the

medical domain and on the other hand the themes of balance, adherence to behavioral norms and responsibility. The following questions that are pondered by the patient (or family member) illustrate this point well:

1) Are the symptoms associated with elemental imbalances? (Here one reflects on food consumed, physical activity, observance of taboos, emotional upsets due to quarrels or sadness.)

2) Did the illness occur suddenly? (If yes, then the cause of the illness could be due to the evil eye. Then one must reflect on recent contacts made with non-family members - noting specifically the actions and words spoken by all parties.)

3) Does the individual have any outstanding debts made to saints (w'adat)? (If so, the saint is sending the person a warning and the person will be healed if the promise is fulfilled.)

4) Is there a personality change in the individual? (If so the patient may be possessed or maybe suffering from a "nervous breakdown" ('asab).)

5) Is the illness known to be a God-given illness such as broken limbs, measles, chicken pox, etc.? (If yes, then the symptoms will be treated.)

If all of these questions are answered in the negative then the individual is in a quandry as to why he is ill. In these situations he may seek a professional diagnostician such as a derwish or a biomedical practitioner. Symptom-specific

modes of treatment including dwa 'arbi and/or biomedicine will be used in the meantime to treat the symptoms.

ETHNOMEDICAL PRACTICES

Some basic principles are used in ethnomedical practices, both in the natural and supernatural spheres. These principles are complementary to the themes of balance, correct behavior and responsibility and serve to integrate the cognitive structure of Tunisian folk medicine. To illustrate this point let us look at the goals of various ethnomedical practices and the means employed to reach those goals:

1) Relieve Discomfort -- The goal of both biomedicine and dwa 'arbi is to relieve discomfort. This sort of treatment is sought regardless of the cause of illness. Such treatments include a variety of external applications (i.e. rosewater for fever, henna for jnun caused illnesses), ingested substances (i.e. drugs, herbs, "drinking" God's words), anal and vaginal suppositories, injections, bone setting and chiropractic practices.

2) Counterbalance Excessive, Deficient or Polluting Element -- If an illness is derived from an imbalanced state treatments will be administered with the intent of counterbalancing the negative illness producing agent within the body. For example a diet may be prescribed that "strengthens" or "cleanses" the blood. Or "hot vapours" will be prescribed to subdue the "cold air". Or in the supernatural sphere a hadra will be held in which the patient possessed by a jinn will become possessed by a spirit, thus

forcing out the jinn and bringing back a state of equilibrium in the individual.

3) Behavior Modification -- In some cases treatment requires that the individual change his behavior. If his illness is caused by an elemental imbalance then he must cease doing whatever caused the imbalance and try to behave in ways that will maintain a healthy balance - i.e. avoid certain types of foods (fats, or sugar or meat) or avoid certain situations that might provoke anxiety. (People are quite receptive to biomedical practitioners' request to follow a diet, for this fits into the explanatory model of folk medicine.)

A change in behavior is also expected from the patient who has not fulfilled his/her promise to a saint. Only after doing so will the patient get well. Finally, if a person is falling victim to the evil eye repeatedly, perhaps they should reexamine their own behavior. Perhaps they are not behaving modestly and should try to do so.

4) Extraction of Causal Agent through Repulsion or Attraction-Transference -- Various treatments are used not with the aim of counterbalancing negative agents but rather to exculpate the illness-causing agent. The means to do this varies. In some cases the agent is repulsed or driven out of the body. For example, during a t'azime pain is inflicted to drive out the possessing jnun. In evil eye cases salt is used in the tadwir to drive out the evilness. And in the treatment for houmra the saint's saliva (the manifestation of the

saint's baraka) is used to repulse the jnun. Some treatments include extraction through attraction-transference. For example, measles are treated with red substances as described in Chapter Six, while spleen ailments are treated by placing the spleen of an animal on the patient's stomach. The illness in the spleen will be attracted to the animal's spleen. Thus in both cases the principle is "like attracts like".

THE ETIOLOGY AND THERAPY OF HOUMRA: AN EXAMPLE

The etiology of houmra and the ethnomedical practices used to treat this ailment best illustrate the syncretic nature of Tunisian folk medicine. Houmra (diagnosed as erysipelas by a biomedical practitioner in Mahdia) is a skin infection that results in a reddening of the skin ("houmra" means reddish) and swelling. The affected area is warm to the touch and the patient often has a fever. The patient suffers discomfort and, in severe cases, pain and immobility.

In looking at the data collected on houmra one finds that it is an illness mentioned in almost every interview.(3) All informants, whether they were describing particular cases or just talking about houmra in general, were unanimous in their feelings that biomedicine, although capable of treating the symptoms of houmra, does not offer a permanent cure.

Self- or family diagnosis is made immediately upon observing the symptoms of houmra. At this point the patient will decide among various treatment alternatives: 1) to administer a dwa 'arbi treatment at home; 2) to make a trip to Sidi Benour; or 3) to go to a clinic. In some cases they

will do all three. If one chooses biomedical treatment then, according to my informants, only the symptoms will be healed and because of that the condition will return. If, however, one is treated by dwa 'arbi, especially under the auspices of a saint, the cause of the illness will be dealt with and thus there is less chance of it reoccuring.

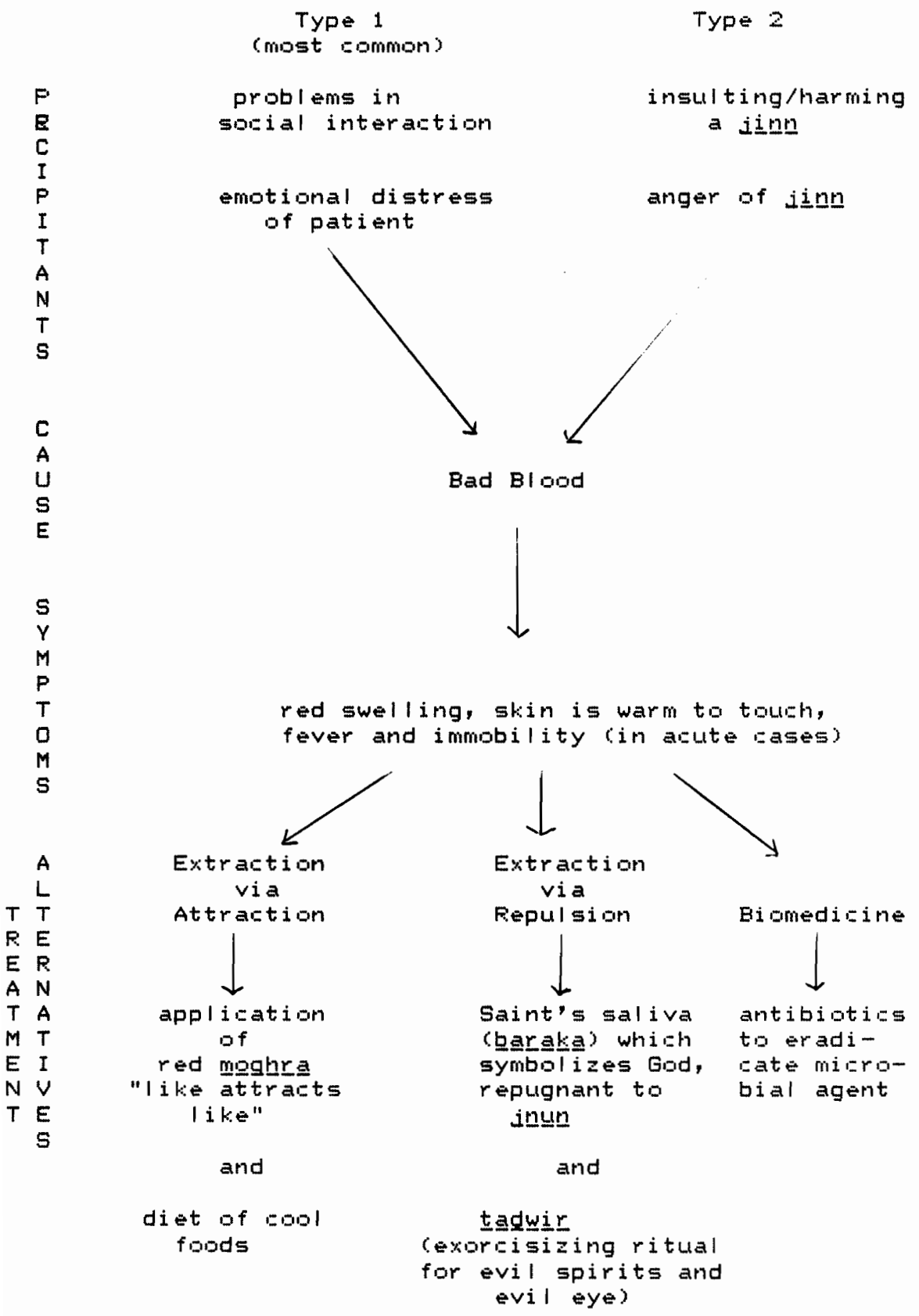
Houmra represents an imbalance in the body. Tunisian folk medicine attempts to cure the imbalance by establishing a balance within the body. This is achieved by four types of treatments used simultaneously if applied at Sidi Benour: 1) mogara, 2) a prescriptive diet, 3) the saint's baraka; and 4) a tadwir ritual that exorcises evil spirits and evil eye. The etiology and the treatments reflect the cognitive constructs of the natural and supernatural spheres that constitute the explanatory model of the medical system. (See chart on the following page.)

The mogara treatment acts on the principle of extraction through attraction ("like attracts like"). The red clay used in the mogara treatment attracts the red blood which is causing the illness. A diet of cereals, sugar and abstention from meat is prescribed which is intended to counterbalance the "hot" blood.

The saint's saliva is the materialization of the saint's baraka, which because of its holy power is capable of curing illnesses in general as well as repulsing the effects of jnun-related illnesses. Houmra is sometimes considered the result of a jinn who has struck (not possessed) the individual with

HOUMRA

ETIOLOGY AND TREATMENT ALTERNATIVES



the illness. So measures are taken to ward off the jnun. This is best achieved by symbols of God which are capable of repelling the jnun. (Perhaps the jnun are attracted to the excess bad ("dirty") blood associated with this illness. This was never stated overtly by the informants. However, when describing jnun in general informants did say that they are attracted to blood.)

Finally, a tadwir is performed to draw out an evil spirit that might be causing the bad blood. Tadwirs are not as powerful as t'azimat but can be used for "minor" jnun.

Thus extraction through attraction or repulsion and counterbalancing are the goals of the treatment administered to heal houmra. They cut across both the natural and supernatural cognitive structures.

SUMMARY

Studies of illness and healing in Tunisia have been fragmented. As indicated above separate investigations have been centered on ancient Arab medicine, the jnun-oulaya tradition, health care delivery systems and "magical" practices. As a result the holism of the medical domain has not been appreciated. I am arguing that health care, although varied, rests on some underlying principles that cut across the various medical alternatives and that these basic principles provide an ordered way of thinking about and dealing with illness episodes.

It is also important to acknowledge that sickness takes place in a social and intellectual context - a context that

includes metaphysial notions. Thus participants of an illness-episode draw upon their general knowledge of the workings of their world and upon their expectations of family, neighbors, supernatural beings and human specialists. In Peter Worsley's words, illness--episodes take place within a "metamedical framework". He explains in his article "Non-western Medical Systems" (Worsley, 1982) that although it is a fallacy to categorize medical systems into "western" and "nonwestern" medicines (4), some ethnomedicines (particularly those found in "sub-Saharan African cultures, indigenous cultures in Pre-Columbian America, contemporary jungle tribes in the Amazon (and) Australian aborigine societies (Ibid., p. 317) and fringe therapies in the western world) are similar in that they postulate an interdependence of "nature, supernature, society and person" (Ibid.) as opposed to the separation of nature and supernature inherent in Western medical thought. Thus he states, "Physical illness is . . . always approached within a framework that is not naturalistic, but cosmic." (Ibid.)

Tunisian medicine can be considered, then, to be a "metamedicine". As illustrated within this chapter the etiologies stemming from the natural and supernatural spheres often become meshed. Furthermore, the role of the individual and his social and spiritual relations is very much taken into consideration when evaluating the symptoms of an illness and considering the possible modes of therapy available. This is well illustrated in diagnostic procedures and some treatment

modalities.

Concentrating on diagnostic behavior one sees, for example, that the patient and family are called upon to analyze the symptoms. They must consider the types of symptoms expressed and evaluate their severity. They then must choose an appropriate health-care alternative. In doing so it is evident that the participants rely on a variety of explanatory models. Likewise, treatment can involve therapy which is derived from a variety of medical traditions. For example, therapy for _houmra_ is usually administered by a saint's medium (supernatural) and is concerned with counterbalancing the effects of "bad blood" (natural) which may have been caused by a _jinn_ (supernatural) or alternatively by bad relationships in the family.

The explantory models that compose the metamedical framework can be better understood by refering to Allan Young's model of medical knowledge (Young, 1981). Young suggests that there are five kinds of medical knowledge: theoretical, empirical, rationalized, intersubjective and negotiated. The cognitive structure(s) of a medical system, Young explains, is the theoretical knowledge. (Usually it is the goal of the medical anthropologist to identify this type of medical knowledge.) Thus one uses their theoretical knowledge to, for example, distinguish between bacterial and viral infections. However, Young argues, not everyone uses their theoretical knowledge in actual illness-episodes. Instead, people may draw from one of the other types of knowledge. For example empirical knowledge may be used where

facts are derived from concrete, observable experiences. These experiences may or may not substantiate one's theoretical knowledge. Nevertheless one's "common sense" based on personal observation often outweighs one's theoretical explanation. Sometimes illnesses are interpreted on the basis of one's rationalized or intersubjective knowledge. In the former case the individual conceptualizes his experience to minimize cognitive dissonance making the explanations "ontologically consistent with his beliefs about the nature of the material and existentially coherent with his beliefs and feelings about his and other people's essential nature, previous life experiences, fate, etc." (Ibid, p. 326) Illustrative of this process is an explanation given by one informant who stated that the bacteria in the intestines had caused bad blood. In the latter type of knowledge (intersubjective) the person perceives the experience (of his or someone else's illness) in ways that he believes will be "intelligible to the people with whom he wants to communicate". (Ibid.) (This would play an important role in the enculturation process, where the child is rewarded for correctly learning the illness-categories and preventative and curative therapy.) Finally, Young suggests that "negotiated" medical knowledge occurs as a result of an exchange of information most often between a patient (who describes symptoms) and a practitioner (who makes a diagnosis and prescribes treatment).

In the following chapter, the ways in which medical

knowledge are used to effect decisions will be analyzed. Other factors that enter into the decision-making process will also be considered. In short, the question being asked is, within the metamedical context, how does someone in Mahdia determine which health care alternative (or alternatives) is most suitable in a given situation?

FOOTNOTES

1) One evening we heard our neighbors/relatives making peculiar sounds up on their roof. We went out to look and found the entire family on the roof scaring away an owl that they had heard hooting over their house. It was then that I got an explanation as to the significance of the "bird of doom".

It is believed by some (but obviously not all as the saying indicates) that when an owl perches on a person's roof, the owl wants "a head from that house." Thus the appearance of an owl on the rooftop is a prophecy of death.

2) Hermanson-Klein (1976) concluded that Tunisians made "syncretristic responses" in health care choices in as much as the women in El-Ḥalfawin were apt to seek both traditional and biomedical therapy - either serially or simultaneously. However, I am suggesting that syncretism occurs at a more fundamental level as part of the cognitive process.

3) An analysis of the 17 cases (12 females and 5 males) of ḥoumra reveals the following points: 1) Sixteen of the patients explained that ḥoumra was caused by bad blood. Of those 16, four were explicit in describing the events that they believed contributed to the creation of bad blood. These included events in which the patient was physically exhausted, anxious or sad. (Significantly only one case of ḥoumra was not linked to bad blood and that was also the only case where the patient was a child. The informant explained that the child had been playing on the beach on the day prior to the onset of the illness. She voluntarily remarked that it wasn't caused by bad blood, like most ḥoumra cases. The implication here is that adults are affected by emotional excesses but not children.) 2) Thirteen (or 76%) were "successfully" treated for the illness - 10 by a saint's medium at Sidi Benour and 3 by dwa 'arbi administered at home. In all of these cases the illness did not return and thus the treatment was deemed successful. In four of the cases informants reported that treatments were partially successful in that the symptoms of ḥoumra disappeared temporarily but reoccurred subsequently. Although biomedical treatment was sought in 7 cases (6 as first alternatives and 1 as a third alternative), none of these patients believed that biomedicine was effective in treating their ḥoumra.

4) In his article "Non-western Medical Systems" he takes issue with the usage of the category of "non-western" medicine. As he points out this gross classification insinuates two things: 1) that there are only two types of medical systems - "western" and "non-western" (which is "not like ours") and 2) that there must be something in common between all "non-western" systems, which of course is false.

CHAPTER NINE

"ASK THE PERSON WITH EXPERIENCE, BUT DON'T ASK THE DOCTOR": CHOOSING MEDICAL ALTERNATIVES

In Chapters Six and Seven various examples were given to illustrate how individuals act upon their medical knowledge. From their explanations and the historical perspective gleaned from various scholars (discussed in Chapter Five) it was possible to outline the cognitive bases upon which today's medical beliefs and practices are founded. Through an analysis of etiological and therapeutic explanations taken from individual cases, it was concluded in Chapter Eight that the Tunisian medical domain is syncretic cognitively and behaviorally. In this chapter the focus will be on collective behavior. That is, I want to examine how Mahdians choose a health care alternative from amongst those that are available, and if the patterns of selection found in Mahdia confirm or differ from those found elsewhere in Tunisia (Auerbach, 1982, Benyoussef and Wessen, 1974, Creyghton, 1977, and Hermanson-Klein, 1976). Furthermore, I hope to ascertain whether or not factors I have found operable in individual cases are reflected in decision making patterns. To this end quantitative data regarding health care choices will be examined.

Fifty years ago the majority of Tunisians had no real access to Western medical facilities. The French established hospitals in the major cities - Sousse, Sfax and Tunis - and

some smaller clinics in the coastal region (called the Sahel). However health care in these facilities was not provided free of charge. The average Tunisian continued to rely almost exclusively on indigenous medical care. Today the medical alternatives available to Mahdians include: 1) the use of dwa 'arbi administered by a family member or a reknowned specialist in the zanga or elsewhere in town, 2) a visit to a saint's medium who will administer the saint's baraka, 3) an exorcism performed by a "gifted one", or 4) biomedical therapy administered by pharmacists or doctors in clinics (private and public) and hospitals. Folk medicine encorporates the first three therapies whereas the fourth alternative is considered professional medicine as defined in Chapter One. Corporately they make up the Tunisian medical domain.

During the interviews informants were asked if they had a preference for either folk medicine or dwa suri (European medicine) or whether they used both. Most replied that they used both but not at the same time. (This is verified by the fact that in 189 cases only nine reported being treated simultaneously by folk medicine and biomedical practitioners.) Then they were asked which one they usually used first. The answers that I received were often ambiguous and in some cases contradictory. A few informants were able to clearly articulate the circumstances within which they would go to the hospital, shrine or a dwa 'arbi specialist, but most found it difficult to make a summary statement on the matter. Some stated that they used dwa 'arbi or biomedical therapy first, despite the fact that they had just described cases during the

course of the interview where they had done just the opposite! Obviously my questions were ill-defined and much too general. In order to reach a conclusion regarding the health-care seeking patterns of the Mahdian community I found it useful to concentrate on the actual choices made in the 189 cases that involved treatments. Out of the 189 cases, 133 (70%)) of the cases involved only one treatment alternative. Whereas 56 (30%) of the cases involved treatment by two or more medical alternatives.

Factors Affecting the Health Seeking Process

Contrary to the results found by other researchers studying decision-making in health care (Kroeger, 1983), accessiblity to health services is not a determining factor in Mahdia. Private and public clinics are within walking distance. The hospital is located at the edge of town - easily reached by a taxi ride for a relatively low price. Likewise, dwarish, "gifted ones", saints' mediums and people knowledgable in dwa 'arbi are numerous.

As mentioned in Chapter Two, the cost of clinical or hospital care is minimal. However the cost of prescribed medicine can be relatively expensive depending upon the drug needed. Doctors dispense chemically-based drugs (i.e. aspirin, antidiarrhoeals, antihypertensives, tranquillisers, etc.) free of charge. However prescriptions for antibacterial drugs such as penicillin must be purchased at pharmacies and the price for such drugs is comparable to European and North American prices. Given the fact that the average annual

income in Tunisia is much less than that of the European or North American, buying prescribed drugs represents a large expenditure for a family. Even so, when informants were asked whether or not money was a factor in their choice of medical care they unanimously replied that their decision to use folk medicine instead of going to a clinic or hospital was never based on money. As one woman said, "If need be financial resources will always be found. But the last resort will be to use state programs. There is no question that a child would be left to die because of financial resources . . . ." Another woman explained, "In some cases dwa 'arbi costs more than dwa suri." This would be true in cases where the family would be required to travel to another town in search of a reknowned dwa 'arbi specialist or, as in many cases, the treatment is required for 40 days.

The influential role played by people surrounding the patient in choosing a health care alternative has been discussed in a number of studies. (Abasiekoong, 1981, Chrisman, 1977, Heller, et. al., 1981 Igun, 1979, and Low, 1982) I have found that in Mahdia this factor has proven to be far more important than accessibility to health care facilites or economic considerations. What Stoner(1984) calls the "microenvironment" of an illness episode provides the context within which symptoms are analyzed, an illness identified and a health care alternative chosen. The verifiable experience of those in the "therapy managing group" (Janzen, 1978) weighs strongly in the decision-making process.

(In Tunisia the therapy managing group would be the adult family members living in the patient's household and, in chronic cases, neighbors in the zanqa). There is a proverb frequently used in Tunisian parlance, both within and outside of the medical domain, which succinctly illustrates this point. It is: "ask the person with experience, but don't ask the doctor". Its meaning is clear. The opinions of one's support group - family and zanqa members - are the most influential factor in any decision-making situation. Their opinions are more important than the opinion of the expert. Thus, when choosing a health care alternative, the experiences of people close to the individual are given more credence than advice given by government health agencies.

If the patient's illness has been previously diagnosed and treated successfully within the family or zanqa, the same treatment will be recommended and most likely administered to the patient. If this ailment has been treated successfully many times, proof of the treatment's efficacy is even stronger. Thus the experiences of family and friends have a strong influence on the decision as to whether or not to use folk medicine or go to the clinic, hospital or pharmacist.

Charts A and B (at the end of the chapter) illustrate the health seeking patterns as gleaned from data on 189 cases. In Chart A the number of cases administered by various health care givers is indicated. In Chart B the correlation between illness-types based on causality and health care choices is presented. Based on the statistics shown on both charts it is evident that folk healers are the practitioners chosen most

frequently as the first alternative. We assume then that people have faith in the efficacy of folk medicine based on the positive experience of others. As Chrisman(1977) states,

> In a complex and compact network with many multiplex social bonds and restricted access outside the network . . . . there is the strong likelihood that existing health beliefs will be maintained. . . . Within such a network, positive health outcomes deriving from the health beliefs and practices of the group can be consistently communicated, increasing people's confidence in the beliefs. Further, and perhaps more significantly, the connection between successful health practices and the closely related people among whom they are transmitted endows the beliefs with a positive effect similar to that experienced in the social relationships themselves (cf. Turner, 1969) Chrisman, 1977,p.367.

On the other hand, people tend to avoid going to clinics with illnesses that have not been successfully cured by biomedical treatments. This negative experience becomes a lesson as well. The _boumra_ cases discussed in the previous chapter illustrate this point exceedingly well. Other cases were elicited where biomedical treatment failed and _dwa 'arbi_ succeeded. The following is a description of one such case. In response to the question "Do people first seek medical help and then _dwa 'arbi_, or vice versa?" Mohammed replied:

> Take my case for instance. I have been treating a blocked vein using medicine for five years with no success. I met one Moroccan who gave me some powder which looked like ash which I applied for four days. When I took it off, the skin around the vein peeled off and the vein started working. I applied some ointment (which he also gave me) for a few days after. As you see my vein has healed.

In addition to the confirmation of other people's experience, another factor that helps in making a decision as

to whether or not to seek folk medical or biomedical treatment is the extent to which the patient (or family) is able to fit their illness into a comprehensible cognitive model. Obviously, the etiology of the folk medical domain is consistent with the Tunisian world view. When a neighbor discusses the cause of an illness the explanation is intelligible to the listener. For example, when someone explains to the patient that his symptoms are the result of cold air which has settled in the kidneys, he can understand the logic of this. He will think back to the days prior to his illness, and indeed remember an afternoon when he sat on a cold floor in a draft for several hours. He now knows the source of his problem. (According to Young's model this would be an example of rationalized medical knowledge. (Young, 1981)) The treatment is then evident -- the patient must drink hot drinks that will flush out the cold/dirt from the kidneys. The kidney stones that are passed are tangible proof that the treatment worked!

Three cases involving kidney stones were described to me. In one of the cases the patient went to the doctor because the pain was so intense. The doctor wanted to operate on the man. An explanation as to the cause or derivation of the kidney stones was not offered. The man refused to be operated on and sought the aid of his niece who had treated similar cases before. She prepared a strong tea of mallow (<u>kha-beda</u>), which he drank every other morning. After the third day of administering the tea he passed two kidney

stones. He took them to the doctor and showed them to him. The informant explained that the doctor was surprised that he was able to pass the stones. This occurred seven years ago and he has had no further problems of this nature. This case illustrates the typical scenario of cases that involve a trip to the clinic or hospital. Medicine is prescribed or therapy given but without context and therefore without meaning.

The problems associated with little or no communication between biomedical practitioners and patients possessing an alternative explanatory model with regard to illness causation and treatment have been discussed in various accounts. (Lasker, 1981, Lewis, ,1955, Woods, 1977, Kroeger, 1983, and Steffensen and Colker, 1982). Invariably the patient leaves feeling dissatisfied or confused. Drawing from Anderson's et al (1977) article "Frameworks for comprehending discourse", Steffensen and Colker explain,

> Briefly, schema theory proposes that abstract knowledge structures -- schemata -- provide the framework for comprehension. What one understands from a discourse, either oral or written, is a function of how well the information fits one's existing schemata. If the underlying structure includes 'slots' for holding the details presented, the discourse will be understood and recalled. If the schema is absent, or only poorly articulated, the information either will not be recalled or will be distorted. Since experience and knowledge are embedded in culture, schemata are culture-bound. (Steffensen and Colker, 1982, p. 1949)

The premise upon which biomedical treatment is based is not understood by the average Mahdian. This is evident in some of the interpretations given to illnesses identified (and named) by doctors. For example, it is believed that strokes are caused by "thick/dirty blood" and pain associated with

ulcers is perceived to be the result of a "weakened lining of the stomach". One woman, in describing the diagnosis made for her asthmatic uncle, said that the doctor told her uncle that the asthma was caused by "the atmosphere in the house".

Marielouise Creyghton (1977) in her article "Communication between Peasant and Doctor in Tunisia" also noted the incongruence between the cognitive understanding of an illness episode held by the doctor and the Tunisian patient. She described a specific case involving a newly widowed woman who was taken to the doctor by her son. She had been refusing to eat and drink and was suffering from nausea and a swollen stomach. The doctor examined her and told her that there was nothing wrong and gave her a prescription without explaining its purpose. (The contradition between his words and his action was undoubtedly just as evident to the patient as it is to the reader.) Very few words were exchanged. In subsequent conversations with the woman Creyghton discovered that the patient had tried to interpret the doctor's behavior in terms of the expected behavior of the meddeb (scribe who reads "the book") or the shauwesh (dancer). (The shauwesh found in the north is somewhat like an 'azam in the coastal region where Mahdia is located. However, 'azameen do not dance.) She was finally cured by a meddeb. Creyghton concluded that "the lack of communication between doctor and peasant is due to ignorance of the healing (or medical) paradigm which the other party more or less takes for granted." (p.323)

Clearly patients and their family assess an illness on the basis of their own explanatory models of health and illness. Doctors working in facilities that are understaffed and lacking in resources do not always present their own explantory model. Thus the patient is given neither a causal explanation nor a reason as to why or how the treatment prescribed will work.

In reviewing cases elicited in Mahdia I found that sometimes the doctor did try to explain why the patient was ill, but when the patient attempted to repeat the diagnosis it got translated into the informant's explanatory model. (Thus it became, in Young's terms, negotiated knowledge (Young, 1981).) For example, in one case a woman said that the doctor at the hospital said she had a "weakness". Within the folk medical tradition this is usually a symptom of either "bad blood" or possession. Having received what she considered unsatisfactory care in the hospital, she went to see a derwish/sorcerer. He exorcised a possessing jinn which materialized into a worm on her chest. She was then cured. The same woman on another occasion went to a doctor with what the doctor called a "blood boil". He gave her "10 shots". The boil did not go away. She finally was exorcised by an 'azam at Sidi El-Ghariana who explained that a jinn had burned her. She was healed after the t'azime ritual.

Reference to bacteria by the informants was rarely made. However, when the term was used it was incorporated into the etiology of folk medicine. For example, one woman explained that jaundice was caused by "some type of bacteria that made

the blood go bad" and that "fever in the intestines" which results in diarrhea is caused by ingesting "bad foods (hot, greasy, spoiled or soured food) which brings bacteria into the intestines."

Some advice given by doctors is readily understood and valued for its sensibility. For example, when a doctor explains that the patient should modify his diet or get more rest this advice is well taken. This is true because such advice is common to dwa 'arbi where, like many other holistic ethnomedicnes, there is a concern with overall health. (Mechanic, 1982) It also allows the patient to take an active part in their therapy which fits into the expected role behavior of the patient in folk medicine. Likewise, preventative medicine as dispensed by biomedical practitioners has been well-received in Mahdia. Prevention is not a new concept. Preventative techniques to ward off the evil eye, to protect against angry jnun and to insure a balanced physiological state have long been part of the North African medical tradition.

The Utilization of Biomedical Alternatives

Because biomedical explanations (if they are given at all) are not fully understood by the average Mahdian, there is a reluctance on the part of most people to go to the doctor, as is illustrated in Charts A and B. However this reluctance is overcome if the illness is seriously actute (i.e. stroke symptoms, eye injury, severe abdominal pain, abnormal delivery), if dwa 'arbi and visits to the shrine have

failed to heal the patient, if a dwarish recommends taking the patient to the hospital, and if the illness is perceived as an end product rather than as part of an on-going episode. (Such illnesses I will refer to as "final illnesses".) Each of these situations will be discussed below.

Biomedical treatment for seriously acute illnesses has proven to be very effective. Thus families do not hesitate to rush an injured or seriously ill person to the hospital. Immediate relief from pain can best be administered there. One doesn't need to know the pathology of appendicitis to appreciate the life-saving treatment of appendectomy. (A bedouin woman whom I had interviewed in the summer of 1983 had an emergency appendectomy during the winter of 1984. When I returned in the summer of 1984 she invited me to her home and sang me a song she had composed which depicted her hospital experience and the praise she had for modern medicine.)

My observation regarding the readiness Mahdians have in choosing biomedical treatment of seriously acute illnesses is corroborated with the findings of Auerbach (1982), Benyousseff and Wessen (1974) and Hermanson-Klein (1976), each of whom conducted research in different parts of Tunisia. Benyousseff and Wessen did a comparative study of seven health dispensaries in urban and rural regions of Tunisia. They state,

> One is struck with the fact that most of the conditions diagnosed are acute conditions. Among the chronic conditions the only diagnoses which account for more than 1 per cent of all of the visits made are tuberculosis, rheumatism and syphilis .... The overall impression, therefore, is

> that the population uses the health service primarily for symptomatic relief connected with the ordinary illnesses which beset them, and that they use the dispensary most often only once for each episode of these conditions. (Benyousseff and Wessen, 1974, p.296)

These findings in Tunisia reflect a common pattern found elsewhere in societies having pluralistic medical systems. (Gould, H.A. 1957, Uyanga, 1979, Frankenberg and Leeson, 1976)

As illustrated in Chart A, dwa 'arbi is chosen as the first mode of health care in 80% of the medical cases, whereas biomedicine is chosen first in only 20% of the cases. However, when looking at second alternatives one finds a large increase of cases where biomedical practitioners are sought - an increase from 20% to 34%. This percentage again increases when one looks at the number of third alternatives - an increase to 62.5%. So although biomedicine is clearly not a majority first choice, it is a strong second and third choice.

Occasionally a derwish will recommend that a patient seek biomedical treatment for an illness. One informant described a case of a young man who, after his dismissal from the army, was subject to periodic seizures. During these seizures he would tremble and become incoherent. The parents took their son to a derwish for a diagnosis. He told them to do two things. First, fulfill an unfulfilled promise made to a saint by the mother, and then take the patient to a doctor.

Finally, illnesses treated most frequently at the hospital or clinic are those for which the prognosis is negative. These illnesses tend to fall into two categories --

both of which include acute illnesses: 1) final illnesses, that is those that are perceived as an end result of certain events rather than as a component of an on-going episode, and 2) high risk illnesses, that is those that have a (subjectively) low success rate of cure and frequently result in death. (Determinants of success and failure will be discussed below.) However, basically success means the alleviation of pain or discomfort and the restoration of patients in such a fashion that they may return to their daily functioning, as defined by the patient or family.)

Let us look at the first category - final illnesses. Illnesses that are caused by God and most cases of the evil eye are usually considered fait accompli. Treatment of such afflictions are aimed at relieving pain and if possible, aiding the natural restoration of the patient. In these cases treatments aimed at treating the symptoms are sought - either from folk medicine or from biomedicine. The episode is irreversible. It is believed that behavioral modifications by the patient or family at this point would not alter the outcome of the illness episode. This is unlike illness episodes involving elemental imbalances, angry saints or jnun, where behavioral modification can be effective in the eventual outcome. If the illness is the result of an elemental imbalance, for example, the healer takes the necessary steps to bring about an equilibrium. This may involve warming the patient (with tisanes, warm compresses, or hot vapors) or cleansing the blood (with certain herbs like fenugreek) or introducing certain food items into the diet. If the illness

is the result of a falling out with a saint or a jinn, then again the course of action is clear -- either the saint is appeased or the jinn is exorcised. Thus in the cases of elemental imbalances or quarrels with supernaturals the patient and his family have some recourse. There is some action that can be taken on behalf of the patient. Whereas in cases where God or the evil eye has caused the illness people, feeling that they have no other options, go to the hospital knowing that doing so does not circumvent any other plan of action.

Referring to Chart B one sees that cases most frequently taken to biomedical facilities are those that involve illnesses caused by the evil eye, are specifically God-given, or those that fall into the second category - high risk illnesses. In particular illnesses caused by bad blood can become serious. On the other hand, therapy involving illnesses that have a higher success rate include illnesses caused by angry saints, dirt, diet, cold air and physical injuries. (See Chart D) With the exception of physical injuries, these are illnesses which, it is believed, can be rectified with behavior modification on the part of the patient or family.

Final illnesses and/or acutely serious illnesses require immediate attention to first relieve the suffering of the patient and then , if possible, to restore health. In these cases the patient is passive. Things are done to him. He is a recepient of treatment - not a participant in his own

recovery. Since in these situations it is felt that there is no recourse for the family or patient, biomedical treatment is not in cognitive discord with the patient's explanatory model of health and illness.

Although pregnancy and childbirth are not considered an illness by Tunisians, and were never mentioned by any of my informants, the findings of Liesa Auerbach, who studied childbirth practices in Ksar-Hellal, Tunisia, have some relevance to this research endeavor. She found that women preferred to give birth at home and would only go to the hospital if there were complications. She concluded that the efficacy of modern medicine was not a priority used by women in determining where to deliver their children. Instead, she found that "The presence of emotionally supportive factors and absence of humiliation-anxiety producing factors represent a major condition of Ksar-Hellal women's childbirth decision-making." (Auerbach, 1982, p. 1503) Staying within the familiar environment of the home and drawing from the support of female relatives and friends during the delivery were considered very important to the women interviewd by Auerbach. Whereas being removed from a private/female domain in order to give birth in a public/male domain was considered an anxiety-producing prospect. These factors contributed to the decision of most women (90.6%) to deliver their children at home, usually with the assistance of a government-trained sage femme or a traditional midwife (qabla). Most of those who chose to go to the hospital did so after experiencing difficulties during home delivery. Thus Auerbach found, as I have, that

the more serious cases are taken to the hospital.

Health Seeking Patterns

Health care decisions in Mahdia, as elsewhere, are preceded by an analysis of the symptoms exhibited by the patient. Factors such as personal behavior (in terms of interpersonal relations and observance of health rituals), previous events or contacts (including the possibility of attracting the evil eye, jnun or angering a saint) and emotional stress (caused by anxiety, worry, anger, sadness or fear) are all taken into consideration when interpreting the meaning of symptoms. Despite the amount of ambiguity found in the way in which some symptoms were perceived (also found by Hermanson-Klein, 1976), there is a tendency to first assume that the symptoms are the manifestation of a "natural" illness. Consequently therapy aimed at treating symptoms is usually sought as a first alternative - either a dwa 'arbi or biomedical remedy. (My data indicates that dwa 'arbi is administered as the first mode of therapy, either by the family members or by a specialist. However Hermanson-Klein found that people living in El-Halfawin (in Tunis) go to a doctor before seeking a dwa 'arbi specialist. This undoubtedly represents a regional difference.)

In 64 (34%) of the 189 cases recorded in the interviews I found that family-care was used as a first step in the health seeking process. (Although women are usually the primary care-givers, I think the term family-care best describes the kind of care administered. Care is often a group

effort in an extended family. Furthermore, cases described in interviews often involved the intervention of a father or an uncle.) Of those 64, 51 did not seek further medical care. Folk healers (in total) were sought in 67 (35%) of the 189 cases as a first alternative. And finally, only 38 cases (20%) involved a biomedical practitioner as a first resort. (See Chart A)

In analyzing the folk medical alternatives, dwa 'arbi specialists were used in 21% of the cases, spirit mediumship in 19% of the cases and minor mediums (dwarish and "gifted ones") in 6% of the cases. The choice of a particular type of folk healer was dependent on the type of illness diagnosed by the therapy managing group and on the family's past experiences and orientation. Unfortunately I do not have statistical data to support the latter statement. However, when examining the statistics presented in Chart B one finds that illnesses thought to be caused by an angry saint or jnun were most often treated by saints' mediums; elemental imbalances, physical disorders and specific god-given illnesses (particularly childhood diseases) were treated primarily by dwa 'arbi and secondarily by biomedicical therapy; and finally, illnesses caused by the evil eye were treated almost equally by dwa 'arbi, "gifted ones" and biomedicine.

The statistics presented in Charts A and B do not in any way provide us with a universal "pattern of resort" (Schwartz, 1969) or "alternative curing strategy" (Woods, 1977). Rather,

like others (Finkler, 1982,1985, Igun, 1979, Janzen, 1978, Kleinman, 1980, and Kroeger, 1983), I found diversity in "healer shopping" (Kroeger, 1983). Choices were determined by factors such as a the composition of the therapy managing group, the age of the patient, the religious orthodoxy of the participants of the illness-episode, and the perceived cause and prognosis of the illness. Thus it would be more appropriate to conceptualize the patterns that emerge from the data as "pathways" of health seeking (Kroeger, 1983). Looking at the pathways collectively, a general hierarchical resort pattern (Kleinman, 1980) can be deduced where the majority of illnesses (but certainly not all) are first treated by the family, then by folk medical healers and finally by biomedical practitioners. Just which folk medical healer will be sought or whether or not the patient will choose to go to a public or private clinic or the hospital are subject to idiosyncratic factors.

Interpreting Outcomes: The Issue of Efficacy

Do dwa 'arbi treatments and spirit mediumship work? Do people actually experience a state of well-being after folk therapies are administered? The efficacy of ethnomedicine is often questioned - by its users (particularly if they have access to alternative forms of health care), by researchers and their audience. But what constitutes an efficacious medical practice? Allan Young (1983) defines efficacy in the following way:

> Efficacy is the perceived capacity of a given practice to affect sickness in some desirable way. It is an abstract notion in the sense that it ignores the social distriubtion of this practice: practice X is efficacious because it is thought to affect sickness Y in a desired way. Whether a particular person will actually have access to X when he contracts Y is another matter. (p. 1208)

He continues by clearly articulating the relationship between disease and curing and between illness and healing - a distinction that is widely accepted in medical anthropology today. He states,

> Disease refers to dysfunctions and abnormalities in organs and organ systems, i.e. pathological states as defined by biomedical science. Curing refers to practices which are efficacious, from the point of view of biomedical science, in either reversing, limiting, or preventing disease.
>
> Illness refers to people's perceptions and experiences of disease and other socially disvalued states which they lump together with disease. These 'people' can be sick people, their relatives, practitioners or other people immediately affected by the course of the sickness. Healing refers to practices which are efficacious, from the point of view of these people, in affecting illness or illness behavior in a desirable way. . . .
>
> . . . . Curing and healing efficacy contrast in two important ways. First, the biomedical science of curing is predicated on universalistic claims and applications, e.g. the curing of infections is specific to the nature of the pathogen not the culture of the patient. The process of healing, on the other hand, is predicated on the particularistic perceptions and expectations of sick people and the realities constructed by their medical cultures. Second, the forte of curing efficacy is treating acute ailments and preventive medicine. The scope of healing practices is less circumscribed, and includes chronic and psychiatric ailments. (Ibid.)

As Kaja Finkler (1985, p.118) points out, it is

difficult to "establish the efficacy of any type of therapy" - whether it is biomedical or nonbiomedical. This is true for a variety of reasons. First, often illnesses are self limiting and thus whether or not a particular therapy was effective cannot be easily proven. Second, only diseases caused by microbial agents can be cured, whereas, "there remains a large array of impairments that lack a cure comparable to that for microbial disease, such as cardiovascular, kidney, and liver diseases, cancer, arthritis, chronic pain, and acute resiratory infections such as grippe (Thomas, 1977). These ailments, however, are treated by both biomedical and nonbiomedical practitioners with differential results. Third, at this point it is almost impossible to measure the extent to which variables, such as psychosocial factors, alter the outcome of an illness. It should be noted, however, that studies of the placebo effect (Frank, 1974), psychosomatic illnesses (Cannon, 1958), and host-pathogen interaction (Solomon, 1970) have illustrated that the patient's state of mind has a great deal to do with the onset and duration of an illness and whether or not treatment is successful, and thus efficacious.

Reports of successful treatment by indigenous healers have up until recently been explained either in terms of the effectiveness of the medicinal properties of the plants used or with reference to psychological determinants of the therapy session. (Kleinman, 1980) In both instances the researchers have utilized the body-mind dualistic model as the basis of analysis.

In his article "Anthropology of Symbolic Healing", Moreman points out the fallacy of the body-mind dualism upon which biomedical therapy is based. (This fallacy has been discussed by a number of researchers, e.g. Capra, 1983) He suggests that we cannot begin to explain healing until we can shake loose this metaphor which guides our thinking. He uses recent research in neuroendrocrinology to illustrate the ways in which symbolic situations can trigger physiological symptoms. He states,

> The central nervous system is traditionally divided into two parts, the brain and spinal cord. The brain is in turn roughly divided into the forebrain, including the cerebral hemispheres, the middle brain, including the thalamus and hypothalamus, and the hindbrain, including the pons, medulla oblongata, and cerebellum. Symbolic activity, among other things, appears to be a unique function of the human forebrain; . . . The middle brain and hindbrain serve the vegetative and reflex ("unconscious, involuntary") functions of the organism. The hypothalamus is the key to a neurophysiological model for a nonsegmented conceptualization of the human organism, since it operates as both a neural and an endocrine organ, thereby urging us to drop the separation of "mental" and "bodily" processes.
>
> As a <u>neural</u> center, the hypothalamus regulates body temperature, water content, and food intake and digestion and controls several parameters of the cardiovascular system (influencing heart rate and blood pressure). Like all neurological centers, the hypothalamus controls these processes electro-chemically as adjacent neurons "trigger" electrical activity by producing various chemical neurotransmitters.
>
> As an <u>endocrine</u> center, the hypothalamus monitors hormone levels in the blood and manufactures hormones as well. This is in contrast to the classifical view which saw the endocrine system (pineal, thyroid, gonads, adrenal, pancreas, etc.) as under the control of the pituitary, the "master gland". In fact, the pituitary is under direct control of the hypothalmus. . . . (Moerman,

1979, p. 65)

Thus he concludes that there is no evidence to indicate that there is a separation of body and mind. Consequently, attempts to explain illnesses using this circumscribed model are counterproductive. The reliance on this paradigm has resulted in a situation wherein popular and folk medicines have been evaluated for their ability to cure, not heal. (Kleinman, 1980, Moreman, 1979) Evidence to the contrary has been accumulating in medical anthropology in recent years (Lock, 1980, Finkler, 1985, Kleinman, 1980, and others). Research indicates that patients following nonbiomedical therapy regularly report that they have been successfully healed and are able to return to their premorbid daily routines. Thus the healing efficacy of such medical practices has been demonstrated.

Adherence to a medical tradition (folk, popular or professional) is only maintained if its treatments are perceived as having "worked" in given medical situations. (Of course, every tradition has acceptable reasons as to why treatments might fail. But in the final analysis if the therapy is to remain credible there should be more successes reported than failures.) Demonstrable results become, in Young's terms, empirical medical knowledge. This knowledge is further reinforced if one's peers concur with the diagnosis of the illness and approve of the treatment process, and if that knowledge and behavior is couched in a cultural context articulated with symbols.

Mischel and Mischel (1958), Kleinman (1980) and Young (1976) have stressed the importance of reinforcement in the healing process. In their analysis of spirit possession Mischel and Mischel propose a theory which I think can be extended to discussions of other medical situations. They state that "other people's reactions of praise or reproof are the reinforcements and the determinants of whether or not the behavior will be repeated." (Mischel and Mischel, 1958, p. 254) Although they were discussing trance behavior, I would like to suggest that when treatment involves behavioral modification, such as a change in diet, an alteration in the work routine, etc., the support or nonsupport of the family is crucial to the healing process.

Kleinman (1980) advocates a holistic approach to the understanding of the healing process. He explains that therapy is effective if it is meaninful to the patient. He states

> . . . . healing on the cultural level is not so much a result of the healer's efforts as a condition of experiencing a fit between socially legitimated forms of illness and care within the cultural context of the health care system. Cultural healing is a necessary activity that occurs to the patient, and his family and social nexus, regardless of whether the patient's disorder is affected or not, as long as the sanctioned cultural fit is established. The health care system provides psychosocial and cultural treatment (and efficacy) for the illness by naming and ordering the experience of illness, providing meaning for that experience, and treating the personal, family, and social problems that constitute the illness. Thus, it "heals" the illness, even if it is unable to effectively "cure" the disease. . . . (p. 360)

Therefore the healing process incorporates not only

physiological change (which may or may not occur) but, more importantly, addresses the social, psychological and cultural changes that have precipitated an illness and within which the illness-episode is embedded.

Symbols, of course, permeate the cultural context of individuals and societies. Some of these symbols are used in healing sessions. Claude Levi-Strauss was probably the first to cogently illustrate the way in which symbols can be manipulated to effect the course of a medical situation. (Levi-Strauss, 1967) James Dow (1986) develops this notion further in his article "Universal Aspects of Symbolic Healing:: A Theoretical Synthesis" (1986). He explains that every society has a "mythic world" which he says is "a model of experiential reality". This mythic world is augmented from time to time with new myths extrapolated from recent events or known personalities. He suggests that symbolic healing is based on this "mythic world". He states,

> The first requirement for symbolic healing is that the culture establish a general model of the mythic world believed in by healers and potential patients. In the curing process the healer particularizes part of the general cultural mythic world for the patient and interprets the patient's problem in terms of disorders in this particularized segment. In particularizing the cultural mythic world, the healer forms transactional symbols to which the patient attaches emotions. (pp.60)
>
> . . . .I call the symbols particularized from generalized symbolic media for use in symbolic healing <u>transactional symbols</u>. (Ibid.,p.63)
>
> Once particularized by the healer, the manipulation of a transactional symbol in a particularized mythic world can suggest a change in the way that the patient evaluates personal experiences. To a culturally uninitiated observer or even to one outside the complementary

> relationship, the manipulation of transactional symbols may seem ridiculous. Nails may be pulled out of the body; "demons" may be cast into the darkness, "souls" may be found; sorcerers may be identified; and so on. However, if the healer has done the job well, the symbolic healing will be a significant experience for the patient.
>
> The effective transactional symbol is one that can help the patient transact emotions. (Ibid.,p.65)

Through these transactional symbols the illness, as I understand it, can be shifted away from self and possibly projected onto someone (i.e. the healer) or something else. In these instances the illness is perceived to be external to the patient.

Finkler (1981) describes the use of symbols in healing the "regulars" of spiritual temples. (The regulars are those who are involved in spiritualism both as patients and sometimes healers. They differ from the "first-comers" and "habitual temple users".) Finkler concludes that the regulars are subjectively healed of their (usually chronic) illnesses despite the fact that they still complain of their symptoms. In the healing process the regular patients are provided with a new explanatory model, complete with symbols. The repetitive use of these symbols reinforces their newly acquired explanatory model and this process yields positive results. She states,

> Participation in communitas generates cognitive and affective reorganization by subjecting the person to new sets of symbols and new ideologies (Wallace 1966). It also forces them to redirect their attentions from idiosyncratic emotioal preoccupations to a higher supernatural symbolic order. By so doing, the individual's focus is turned away from preoccupation with him or herself and turned to external concerns. Together with incessant reinforcement of Spiritualist symbols

> these modalities furnish a cultural and sociopsychological substratum conduced to the attenuation of dysphoric affect, perceived pain and the "feeling of being sick." (pp. 93-4)

To summarize, it is inappropriate to determine the efficacy of medical practices only on their ability to cure diseases. But rather it is more important to ascertain whether or not therapy has enabled the patient to return to a normal life. Whether or not the patient has been healed can only be evaluated, in my opinion, by the patient and their family.

An Analysis of Reported Outcomes in Mahdia

In Chart D the outcomes of illness-episodes elicited from 189 cases are presented. The various outcomes are correlated with illness-types based on causality. Illnesses that are specifically God-given, caused by bad blood or the result of an evil eye curse are illnesses that are the least successfully treated by either biomedicine or folk medicine. Whereas successful treatments are reported for illnesses caused by an angry saint, dirt or physical injuries.

Looking at Chart C we find that folk medicine is perceived as being very successful in treating illnesses - much more successful than biomedical alternatives. Folk medicine is found to be successful in 88% of the cases when it was chosen as a first alternative and as a second alternative, whereas biomedicine was found be be successful in only 60% of the cases when used as a single alternative, and in 34% of the cases when used as a second or third alternative.

The success rate of folkmedicine is striking. I suggest that it is high for a number of reasons: 1) The case material may be somewhat biased. First of all, the cases represent retrospective data. There may have been a tendency to recall the treatments that worked well and to forget those that did not. Secondly, informants being aware of my interest in folk medicine, may have been tempted to tell me about cases where dwa 'arbi or spiritual healing succeeded; 2) A number of the illnesses treated by dwa 'arbi are self-limiting and will heal on their own over a period of time. When dwa 'arbi is administered, and recovery is experienced, it is assumed that dwa 'arbi is the effective agent of cure; 3) Some of the herbs used in dwa 'arbi probably do possess medicinal properties as defined by biomedical pharmaceudics. To discover whether or not this is so, however, is beyond the scope of this project; 4) Pursuit and administration of a folk therapy is supported by community members (family and zanga) thus reinforcing this behavior and also the belief in the efficacy of treatment; and 5) Family and folk healers approach the patient with similar sets of explanatory models. The explanations that are given regarding the cause, pathology and prognosis of the illness concurs with the patients's own understanding of what is happening. In the therapy session the healer uses symbols (such as the tadwir, t'azime, fried owl, mogara, salt, etc) that import meaning to the patient (and onlookers/supporters). These symbols are important in fostering hope and faith in the patient. As research on the placebo effect has illustrated, such faith has a positive

effect on the healing process.

Despite the fact that there is statistical evidence that indicates folk medicne is the favored first medical option, biomedical treatment is certainly not considered unimportant. In fact, it is preceived as very effective in treating symptoms -- a point I have made earlier. I suggest, then, that the relatively low success rate for biomedicine is attributable to the following factors: 1) There is a tendency for only serious cases to be taken to the doctor. In some cases the patient is brought too late. When the patient dies, it is felt that biomedical treatment failed; 2) Medication is not always taken as prescribed. This may be due to the cost of drugs or it may be the result of an individual consciously deciding they no longer need medication. If the patient suffers a relapse they attribute their renewed illness to the failure of biomedicine and seek another medical alternative; 3) Biomedical practitioners are very successful at diagnosing and treating diseases defined by a specific etiology. (Dubos, 1965, Capra, 1983) However some of the illnesses brought to the hospital are chronic illnesses whose cause cannot be reduced to a single factor. The causes of these illnesses are multifactorial. Although biomedicine can treat the symptoms it cannot treat the causes and therefore the symptoms reoccur. When this happens the efficacy of biomedicine is called into question. And finally, 4) Treatment in clinics and hospitals lacks the "placebo effect" that exists when illnesses are treated in the company of relatives. Nor is this setting

supportive of the patient's explanatory model. The patient is instead confronted with physicians and staff who either present explanations that are relatively unintelligible, or is given no explanation at all. If they are being treated for a chronic illness they may experience some degree of anxiety which is counterproductive to recovery.

Summary

From the statistics presented in this chapter one can conclude that the folk medical alternatives are chosen most often as a first alternative. Generally family-care is administered at the beginning of an illness followed by folk medical treatment by practitioners and then biomedical personnel. Thus a general hierarchical resort pattern can be discerned. Factors affecting the decisions made in choosing a health care alternative are determined primarily by the opinions and experiences of the patient's family and neighbors, and by the cause of the diagnosed illness. People suffering with acute, serious illnesses and those illnesses for which the prognosis is negative are generally taken to the hospital or clinic immediately. However when it is believed than an illness can be healed by redressing an imbalanced state (physiological, psychosocial, or spiritual) folk medicine is used. These types of illness tend to be minor or chronic.

In the following chapter a more holistic approach will be taken in the examination of Tunisian medicine. An attempt will be made to demonstrate the ways in which the themes

identified in the medical domain articulate and overlap with wider cultural themes.

CHART A

ADMINISTRATORS OF HEALTH CARE

	Alternatives Chosen 1st (N 189)		2nd (N 53)		3rd (N 8)	
	#	%	#	%	#	%
FOLK MEDICINE						
Dwa 'arbi						
family-care	64	33.9%	13	24.5%	0	-
zanga specialist	31	16.4%	1	1.9%	0	-
town specialist	10	5.3%	4	7.5%	1	12.5%
Subtotal	105	55.6%	18	34.0%	1	12.5%
Spirit Mediumship						
saints (directly)	21	11.1%	4	7.5%	1	12.5%
via hafidet	8	4.2%	9	17.0%	0	-
via 'azameen	6	3.2%	0	-	0	-
Subtotal	35	18.5%	13	24.5%	1	12.5%
Minor Mediums						
dwarish only	3	1.6%	0	-	1	12.5%
derwish/reader	1	.5%	2	3.7%	0	-
dwarish/ gifted one	2	1.1%	1	1.9%	0	-
gifted one	3	1.6%	0	-	0	-
hafidet/ gifted one	2	1.1%	1	1.9%	0	-
Subtotals	11	5.8%	4	7.5%	1	12.5%
TOTAL	151	80%	35	66%	3	37.5%
BIOMEDICAL THERAPY						
doctors in clinics	25	13.2%	12	22.7%	0	-
hospitals	12	6.3%	5	9.4%	4	50.0%
pharmacists	1	.5%	1	1.9%	1	12.5%
TOTAL	38	20%	18	34%	5	62.5%

CHART B

HEALTH SEEKING PATTERNS:
FIRST ALTERNATIVE CORRELATED WITH CAUSALITY OF ILLNESS

ILLNESS TYPE	DWA 'ARBI MEDICINE	MEDIUMSHIP	BIOMEDICAL THERAPY
Bad Blood (N = 46)	61%	9%	30%
Cold Air (N = 39)	90%	2%	8%
Evil Eye (N = 20)	35%	40%	25%
Angry Saint (N = 16)	0	81%	19%
Physical Injuries (N = 20)	74%	16%	10%
Specifically God-Given (N = 17)	59%	2%	29%
Jnun/Spirit (N = 17)	5%	77%	18%
Diet (N = 7)	86%	0	14%
Dirt (N = 7)	57%	14%	29%

CHART C

REPORTED OUTCOMES

Cases where only folk medicine was used.

Outcome	#	%
Successful	109	88
Partially Successful	7	7
Unsuccessful	3	2
Unclear	4	3

Total = 123

Cases where only biomedicine was used.

Outcome	#	%
Successful	6	60
Partially Successful	0	0
Unsuccessful	4	40
Unclear	0	0

Total = 10

Cases where biomedical treatment failed, after which folk medicine was used.

Outcome	#	%
Successful	23	88
Partially Successful	2	8
Unsuccessful	0	0
Unclear	1	4

Total = 26

Cases where folk medicine failed, after which biomedical treatment was used.

Outcome	#	%
Successful	7	34
Partially Successful	3	14
Unsuccessful	11	52
Unclear	0	0

Total = 21

CHART D

STATISTICAL PRESENTATION OF PERCEIVED OUTCOMES

Cause of Illness	Successfully Treated	Somewhat Successfully Treated	No Change	Death	?
Angry Saint	100%	-	-	-	-
Physical Injury	100%	-	-	-	-
Dirt	100%	-	-	-	-
Diet	89%	-	-	11%	-
Cold Air	73%	2%	7%	9%	9%
Jnun/ Spirit	71%	18%	6%	-	5%
Evil Eye	66%	-	3%	14%	17%*
Bad Blood	60%	14%	14%	12%	-
Specifically God-given	58%	11%	-	26%	5%

*not applicable

CHAPTER TEN

THE TUNISIAN MEDICAL DOMAIN IN CONTEXT

In Chapters Six through Nine the ethnomedical practices, medical etiologies and health seeking processes have been analyzed. Behavioral patterns and cognitive structures particular to Tunisian medicine have been discussed. In this chapter the analysis moves to a more abstract level in that an attempt will be made to examine Tunisian medicine as part of a wider cultural system. Already the social and historical context of the medical domain has been described (Chapters Three and Five). Now I will attempt a cultural analysis in order to illustrate the holistic framework within which Tunisian medicine is embedded.

The Tunisian medical domain does not exist in isolation but rather is interlinked with other domains (economic, political, religious, kinship, etc.), all of which are permeated with basic themes (symbols). Patients and practitioners of health care participate in these domains, often simultaneously. Their regular participation in the domains is facilitated by an underlying set of assumptions that are known and used by members of the culture. The intent of this chapter is to elucidate the cultural themes which appear to exist both within and outside of the medical domain. Briefly these themes are: God's will, mediation, balance as maintained by reason, mutual obligations and proper conduct, and the use of specificity, fluidity and paired opposites in

verbal and behavioral discourse.

GOD'S WILL

In sha Allah (if God wills) is an expression that is heard repeatedly in Tunisia and elsewhere in the Muslim world. It reflects the monotheistic tenet of Islam in which the Creator is preceived as the supreme being - the decision maker, the absolute authority in all matters. Ultimately God's will is the determining factor in all events. This does not mean, however, that Tunisians passively await for God's will to unfold. On the contrary, Tunisians search out ways to manipulate situations to their own advantage. This is done in the political arena, in the process of arranging marriages, in contracting labor, in making purchases, seeking medical care and so forth.

Intermediaries are frequently used in negotiations. It is argued that a better deal can be struck with the use of an intermediary, for an intermediary can speak the brutal truth regarding the assets and deficits of a potential marriage partner, a piece of land, etc. In this way one avoids the risk of insulting someone whose services might be required at a later date. Thus mediation is a tool which can be employed to effect a desired outcome. But ultimately God has the last word.

In analyzing the medical domain we see that natural illnesses are "god-given". Attempts can be made to heal such illnesses through practitioners/ intermediaries (dwa 'arbi specialists, dwarish/readers, "gifted ones" and saints'

mediums). But the outcome, be it a cure, a chronic illness, or death, is understood as "God's will".

MEDIUMSHIP THROUGH DIVINE INSPIRATION

In Chapter Five a description of the founding of the Tijanniya Order was presented. It was founded by a man who received the power to act as a medium for God. This case exemplifies the belief that saints are chosen to be intermediaries for God. This is a cultural pattern not sanctioned by Islamic purists.

In comparing the characteristics of the Prophet Mohammed and spiritual mediums, such as al-Tijani and the diviners and healers described in Chapter Seven, two prominent themes arise. One is concerned with the way in which spiritual power is acquired and the other is concerned with the status these individuals held in society prior to becoming a medium.

Having supernatural power gives credibility to a spiritual leader or medium. Their actions are believed to be sanctioned, if not directed, by God himself. They obtain their power through a vision/dream, or through having the power "passed" to them from another medium. Mohammed had a vision in which God called upon him to be his Prophet. Al-Tijani's future was prophesized by a Sufi. He finally received his power from an Indian Shaikh in Mecca. Diviners and healers in Mahdia had dreams of saints who "called" them to begin their mediumship. And some of the Mahdian mediums claim that they were given their healing power from bafidet who spat into their hand, thus transmitting the saint's baraka.

Mediums, be they historical figures such as the Prophet Mohammed, al-Tijani, Mahdian saints or human intermediaries, were (or are) people who at sometime in their lives were without family. Mohammed was orphaned as a child and raised by an uncle. He later married and had children. Al-Tijani lost both his parents when he was 16 years old. He did marry but divorced soon after. Later in life he married two slaves that he had purchased. Lella Ezzine (a local saint outside of Mahdia), Laila Ben Ahmed and 'Aiesha Zyed (dwarish in Mahdia) were (or are) single unmarried women.

Middle Eastern cultures place a high value on the family. Orphans are pitied and taken care of by others. Both men and women are expected to marry. Not to do so is considered wrong. Thus each of the individuals mentioned above had an unusual, if not unacceptable status in society prior to their "call". Adopting the status of a leader/medium made them more acceptable to society.

A SENSE OF BALANCE THROUGH REASON, PROPER CONDUCT, AND OBLIGATION

Dale Eickelman (1976, 1981) concluded that there were five key concepts to understanding the Moroccans' view of their social world: 1) God's will (qudrat Allah), 2) reason ('qal), 3) propriety (hshumiya), 4) obligation (hagg), and 5) compulsion ('ar). (Eickleman, 1981, pp. 178-183) As explained above, belief in God's will is a very pervasive concept in the Tunisian culture. I also found that the notions of reason, obligation and proper conduct (hshumiya being only one modality) are prominent in Tunisian attitudes. I suggest, in

fact, that these three ideas are woven together to support yet another cognitive tenet - a sense of balance. If reason is used, appropriate behavior exercised, and obligations fulfilled, a balanced social and spiritual order can be maintained. The emphasis placed on a balanced state is a common denominator to the social, spiritual and medical domains.

Reason

All humans possess reason to a greater or lesser extent. A person with reason is someone who is in control of himself in terms of his emotions and behavior. One who allows emotions to influence his behavior is deemed a person with little reason - a person who is out of control. Women are thought to have less reason than men, their emotional displays being proof of that fact. And children and the mentally disturbed are perceived as having meager amounts of reason.

Possessing reason is important in social interaction because with reason one is able to understand the motivations and behavior of others. This, along with personal composure, allows for more positive and productive interaction. In some ways, then, reason is a matter of social astuteness.

Etiologies of illness in the Tunisian medical domain incorporate the notion of improper behavior prior to illness. Thus we see that lack of reason is often a factor which contributes to an illness-episode. This is particularly true of illnesses caused by bad blood. Bad blood is the result of emotional instability. For example, a person grieviously

effected by anxiety, anger, fear or sorrow will experience illnesses derived from bad blood. He was not able to control his emotions - to hold them at bay - and this then either weakened or polluted the blood, causing an illness.

Proper Conduct

Proper conduct includes various activities and is classified by different lexicons. The most serious acts of impropriety are called haram. These are acts that are clearly forbidden by God, such as eating pork, drinking blood, etc. Other improprieties include macrou (acts hated by God but somewhat accepted, i.e. divorce) and mubah (acts that God prefers not to be committed but for which no punishment will be given, i.e. smoking hashish). Behavior that is deemed virtuous and proper is variously labeled hallel (the religious way), shari'a (God's laws) hshumiya (propriety) and tagalid (tradition). Clearly much of the prohibitive and prescriptive behavior is derived from Islamic teachings. Whether or not acts of hshumiya and tagalid are sanctioned by God is subject to debate. One might argue, for example, that a tagalid that dates back to Mohammed's time, and therefore practiced by Mohammed, must be approved by God.

Ethical teachings are inscribed in the Koran and preserved in oral traditions. The Koran is believed to be God's word. The Prophet Mohammed through whom God transmitted His message became the interpreter of the Koran. Gibb explains,

The Koran is comparatively short, and even in this

> small book the greater part has no direct bearing on domatic ritual, legal, political, and social questions. In theory, the general principles by which all these matters should be regulated are to be found in the Koran, but not all of them are set out with equal clearness and detail. It is therefore essential to interpret and elaborate the relevant texts. The natural, and indeed the only possible interpreter whose judgement can be trusted is the Prophet through whom they were revealed. According to the Koran itself this Prophet was possessed not only of the kitab, the written 'book', but also of the hikma, the 'wisdom' whereby ultimate principles can be applied to the details and episodes of ordinary life. Consequently, his actions and sayings, transmitted by chains of reliable narrators, form a kind of commentary and supplement to the Koran. From this it was only a step to the further position that this commentary was itself inspired, in that in all his sayings and doings the Prophet was acting under 'tacit inspiration' and thus supplied solutions to the problems of good and evil as final as those of the Koran. (Gibb, 1962, p. 92)

In the first few centuries after Mohammed's death, the meanings of the Koran and Hadith (oral records of Mohammed's deeds and statements) were discussed by Islamic scholars. Through consensus the meanings became institutionalized into what is called shari'a, God's laws. Derived from the two holiest sources, shari'a is considered divine inspiration. Gibb suggests that all human actions fall into five classes: "1) actions obligatory on believers; 2) desirable or recommended (but not obligatory) actions; 3) indifferent actions; 4) objectionable, but not forbidden actions; and 5) prohibited actions." (Ibid., p. 101)

In Mahdia there is obvious concern with proper conduct. The morality of actions taken by family and nonfamily members is a frequent topic of conversation (as described in various incidents in Chapter Three). One of the discussants might

proclaim that a particular breach of norm goes against the shari'a. Another one will disagree saying that such action is really an example of mubah and a debate ensues. But, of course, not all codes of conduct have been defined by theologians. Norms also include behavior considered acceptable to the community simply through tradition (taqalid). As in most societies, Mahdians use inappropriate behavior on the part of a neighbor, for example, as a negative model. Such behavior becomes the subject of gossip - a powerful mechanism of social control in the zneg. Children learn that misbehavior not only reflects badly on the individual, it also tarnishes the family honor. Thus proper behavior in all situations is expected.

In addition to behaving correctly one should also display proper comportment. For example, the young are expected to show deference to their elders; public passivity is expected of women; generous hospitality is expected of hosts, and so forth. To act with propriety brings merit to the individual and the family, for such behavior displays self-control (reason) along with a knowledge of the social order.

In general, Mahdians believe that adherence to the laws that were inspired by the Koran and the Hadith plus the norms of propriety and tradition will insure a harmonious balanced social order. The processes of enculturation and social control are enlisted to perpetuate this ideal.

The concern with proper behavior spills over into the medical domain as well. As described in previous chapters, it

is believed that modes of behavior can influence a person's health. The tenets of folk medicine incorporate the idea that inappropriate behavior can lead to an imbalance - either in the body or in poor relations with members of the family, community or spiritual world. This imbalanced state can result in an illness. Many of the ethnomedical practices are designed to bring the body back into a state of equilibrium - either by exculpating the pathogenic element (i.e. bad blood, cold air, evil eye, or jinn), by neutralizing the elements, or by strengthening the curative agent (i.e. strengthening the blood or using baraka).

The historical tenacity of preventative health measures, according to some, is due to the fact that they stem from the Koran and the Ḥadith. Research conducted by Hakim Mohammed Said (1976) reflects this idea. He explains that in Islam the body and soul are thought to be intertwined with one another and that they exist in harmony with nature. This harmony, he explains, is maintained through proper conduct. He states,

> Islam has as its objective the maintenacy of balance. . . . (p. 10)
> (It) places greater emphasis upon preventive medicine than on remedy. Islam stresses the permissible; but even more so it emphasizes abstinence from the prohibited. The permissible element has a deep relationship with preventive medicine; but the prohibited element exercises even a greater effect. Harmony between the soul and the body is necessary for following the edicts regarding the permissible and the unpermitted. The basic diseases of man are due to vainglory, deceit, oppression, love of the body, ignorance, instability, avarice, excessive desire, etc. They are all against the unity of thought and only the idea of the cosmic unity can save us from these ills. (p. 32)

Said describes a number of prohibitions and prescriptions related to food, drink and personal hygiene. Some of these laws are stated clearly in the Koran, such as food taboos and ablutions. Others have been handed down from the Ḥadith. Mohammed (in the Ḥadith) cautioned man to "eat, drink and be not lavish" and to abstain from "the anger that results in the reddness of the eyes, swelling of the neck veins, and foaming of the mouth." And finally, it is claimed that the Prophet "asked God's protection on occasions of sorrow." Thus Said states, "happiness, anxiety, fear and gloom, etc. exercise considerable effect upon health". (Ibid, pp. 38-39)

Cleanliness is stressed in both the Koran and the Ḥadith. Said states,

> Bathing after coitus is compulsory. Prayers cannot be performed without purification or in a state of intoxication. No other religion has enjoined directions about keeping the body free from excrement and urine as Islam. It is not proper to blow one's breath on the food in order to make it less hot, and hands should be washed before eating, even though ablution might have been performed earlier. It is permitted to dry oneself after wudu (ablution) with a towel but the hands washed before eating are not dried with a piece of cloth. The drop of water that springs from the gound when water falls is, in all cases, impure, even though the ground on which the water has been spilled might be pure. If a mad dog has put its mouth into a vessel having water, it should be rubbed with sand and washed seven times. If several people are eating from the same dish, each one of them should eat with the dish facing him. An earthen vessel rendered impure cannot be purified by rinsing with water, unless heated on fire well.
>
> Dental rinsing has been stressed in Islam. The use of miswak, a dentifrice made of a special kind of wood, has been particularly exalted. Picking the teeth is also sunnah. (Ibid., pp. 36-

37)

Finally, in the Ḥadith there is reference to a number of substances which were used by the Prophet or whose virtues were exhorted by him. Garlic, black cumin, pomegranates, grapes, ginger, camphor, olives, barley, fenugreek, henna, honey and others were said to be important, particularly in warding off illnesses. (All of these items are found in the pharmacopoeia of dwa 'arbi.)

Mahdians believe that many illnesses can be prevented if proper modes of conduct are observed. Certain foods are to be avoided; certain foods are to be taken to enhance strength, fertility, etc.; cold drinks should not follow hot foods; milk and fish are not to be consumed together; cold air should be avoided; one should not fight with family members; children should be submissive to their elders; people should be kind and generous with their neighbors, etc. Proper behavior is traced back (in fact or fictitiously) to the Ḥadith and God's word. Thus, to a certain extent, to take preventative health measures is not only sensible but morally correct as well.

Obligation

Obligatory bonds are created and sustained primarily within the extended family. However, at times these bonds can be extended beyond familial ties. For example, a close relationship might be fostered with a neighbor or a former classmate. As discussed in Chapter Three, almost all Mahdians are involved in social networks in which participants are linked by mutual obligations. Such bonds are functional not

only for the individuals who participate but for the maintenance of a social structure in which goods, services and information are exchanged.

Through debts and credits networks are built whereby people rely on one another in difficult circumstances or in different parts of the life cycle. As Eickleman (1981) explains,

> In general, the reasonable individual strives for flexibility in relations in which he is under obligation to others, while at the same time fixing as firmly as possible relations in which he holds obligations "over" other individuals. Since by God's will the social world is viewed as in constant flux, an individual strives to be as free as possible to change the weight of obligations within his personal network, yet to remain within the bounds of propriety (<u>hshumiya</u>) or acceptable social conduct. (p. 182)

The role of obligatory ties can be seen in a number of contexts in Mahdia. Obligations begin within the family. It is the duty of all parents to provide nurturance, food, shelter and as much education and/or occupational training as possible. Children in turn have certain obligations towards their parents. All children are expected to be respectful to their parents as well as to other seniors. More specifically, however, the eldest son has a particular obligation to the family. Upon reaching adulthood it is incumbent on him to help his father rear his younger siblings. This may be done by contributing his labor in agricultural or business ventures. Or, as happens more frequently today, he may contribute money earned from a salaried job. Because of this supportive role, younger siblings feel indebted to the elder

brother. This relationship is reflected in the deferential behavior that younger siblings exhibit while in the presence of their elder brother. When the father dies, he quite naturally assumes the patriarchal role. He looks after his mother's well being. He is the main participant in marriage arrangements that involve his siblings. And he is responsible for decisions regarding their education and careers.

In time younger sisters marry and leave the household. Most, if not all, of the younger brothers establish separate households at the time of (or soon after) their own marriages. Despite this dispersal the senior brother is still sought for loans and advice. Thus the credit-debt system perpetuates the bond between members of the family.

Relationships within the family are supposed to strike a balance through generalized reciprocity. That is, ideally an equilibrium occurs. Money is given to one person who then repays the loan to someone else in need. For example, the patriarch may provide money for the educational training of his first son. The son, rather than repaying his father will instead contribute to the education of his siblings. Balanced reciprocity (as described in Chapter Three), however, can be seen in credit extended and debts accrued during rites of passage, particularly marriage and circumcision rites. Balanced reciprocity can also be observed in gift-giving customs.

The ideal of equality in gift-giving (thus maintaining a balance) is exhibited in gifts exchanged within the nuclear

family. It is customary to give gifts to children during the 'Id al-Kabir. At that time parents are careful to give the same gift to all the children. Older children might receive the equivalent in money. Also it is customary for travelers to bring gifts with them on their return. Thus a relative returning from Europe or North America is expected to bring gifts to members of his/her nuclear and perhaps extended family. These gifts are of equal value. When relatives depart, they in turn are given gifts. In both instances gifts are selected not on the basis of personal needs or tastes, but with a conscious effort to maintain equality - a balance. Everyone of the same sex and age category receives the same gift. (Thus women married into the family, like myself and my sister-in-law, have received as gifts: identical dresses, jewelry boxes, necklaces, wall plaques, figurines, etc.)

As in other societies, obligations are contracted through gift-giving. These social contracts bind the members of the community by maintaining bonds that have already been made and extending networks to encorporate people with whom one may receive or extend goods and services at a later date.

To uphold one's obligations is a matter of morality. This is verified in the Koran in Sura V:91. It says,

> God will not take you to task for a slip
> in your oaths; but He will take you to task
> for such bonds as you have made by oaths,
> whereof the expiation is to feed ten
> poor persons with the average of the food
> you serve to your families, or to clothe them,
> or to set free a slave; or if any finds not
> the means, let him fast for three days.
> That is the expiation of your oaths
> when you have sworn; but keep your oaths.

So God makes clear to you His signs; haply
you will be thankful.
(translated by A.J. Arberry, 1955, Vol.I:12)

Thus an assumed obligation is not to be taken lightly. One is obligated to fulfill any contracts made with family, friends or business associates.

The semitic concept of "an eye for an eye" held in Mahdia is an extension of the concept of obligation. If an outsider (non-family member) harms someone in the family, it is felt that the family has the right to avenge themselves. Not to seek vengance would result in lost personal or family honor. If, for example, one's daughter was violated, a man would be obligated to avenge the deed. Such an extreme case, in fact, rarely occurs but such hypothetical cases are discussed. In reality, disputes regarding brideprices, property lines, inheritance, theft, and others are more common occurrences. If the matter cannot be settled through family vengance or zanga pressure then it will be taken to court. Cases that are taken to court usually involve plaintiffs who feel socially or economically inferior to the protagonist. They believe they have no other recourse. Again, the goal of such actions is to even the score - to reach a new balanced state.

Turning to the medical domain, the concept of obligation and balance is most evident in the supernatural sphere. Relationships with jnun and saints are very delicate. Generally speaking, neither of the spirits initiate contact with humans. More often humans seek their services. This is

done, despite the fact that to do so is considered a sin by the most conservative Sunni Muslims. It is very clear, for example, that man is not supposed to seek an association with the jnun. That point is made in Sura LXXII:5. It says,

> The fool amoung us spoke against God
> outrage,
> and we had thought that men and jinn
> would never speak against God
> a lie.
> But there were certain men of mankind
> who would take refuge with certain men
> of the jinn, and they increased them in
> vileness,
> and they thought, even as you also
> thought, that God would never raise up
> anyone.
> (translated by A.J. Arberry, 1955, Vol.2:305)

If a contract is made with a jinn (through a sorcerer) to execute a spell, the requestor is then obliged to do the jinn's bidding. He has become indebted to the jinn, whose price is often unknown and never paid up. Thus striking a deal with a jinn is believed to be very foolish. Such an arrangement might satisfy a short-term goal, but in the long run the man becomes the victim of the jinn, who can at will make the person ill or take possession of their body.

Whether or not one is allowed to communicate with saints is a theological debate. But in practice, as has been described in Chapter Seven, contractual arrangements are made between humans and saints quite regularly. These contracts are symbolized by w'adat. In such cases the saint is asked to render a service which if performed, makes the "promisor" indebted to the saint. For example a mother of a sick child may ask the saint to heal her child with his baraka. A

healing is perceived as a manifestation of the saint's power and the performance of one half of the bargain. Now she must fulfill her promise. Only after she fulfills her promise does she clear the ledger and become free of obligations. As we saw in Chapter Seven, if the debt remains unpaid for too long the saint becomes vengeful. The imbalanced relationship will not be tolerated. The saint will send reminders (dreams, accidents, illnesses) to the debtor, who will then remember her oath. It should be noted that she often fulfills the promise by serving dinner to family, friends and strangers who live around the saint's shrine. This reflects the instructions given in the Koran, presented above.

Reason, proper conduct and obligation are interrelated. One is unable to exhibit self-control, behave correctly, or establish and maintain obligatory bonds if one does not possess reason. Furthermore, these concepts are based on another cultural priority - a sense of balance. A concern with balance can be found in the social and spiritual domains, as explained above. And the same concern with balance can be found in the medical domain. Admonitions regarding avoidance of cold air, dirt, particular foodstuffs, over-indulgences, and conjuring the jnun are reminders of the necessity to behave correctly and prevent illness. Health is maintained if one exercises self-control. This requires reason and the observance of proper conduct.

SPECIFICITY, FLUIDITY AND PAIRED OPPOSITES

Specificity is a particular characteristic of the Arabic language. Various scholars (Browne, 1921 and others) have noted that Arabic is a highly descriptive language. Thus there are numerous examples of the expansive lexicons found in the Arabic language. This specificity has been noted in various anthropological works as well. Anthropologists studying social organization in the Middle East (Gellner, 1969, Duvignaud, 1969, Eickleman, 1976, and others) have all come to appreciate the importance placed on memorized genealogies tracing descent back to Mohammed. Below I intend to show how specificity is a common denominator to various cultural contexts, including the medical domain.

Kinship

Specificity is illustrated in the kinship terminology used by most Arab speakers, Tunisians included. The cousin terminology employed is Sudanese. The Sudanese kinship system is the most descriptive of all cousin terminologies as outlined by George Murdock (1949). A kinship diagram presenting the kin terms used by ego is on the following page. Ego's patrilineage and ego's mother's patrilineage are noted in the kinterms. Thus the morpheme "am" and "khal" indicates the lineage of the uncle or cousin addressed. Cousin terms describe the exact relationship between ego and his cousin. Thus, one's FaBrDa is called "bint ami" (daughter of my father's brother). Grandchildren of ego's uncles and aunts

TUNISIAN KINSHIP SYSTEM
Azzizi
Omema
Khali
Mart Khali
Khalti
Rajel Khalti
Baba
Omma
Ami
Mart Ami
Amti
Rajel Amti
ego
Rajel Bint Khali
Bint Khali
Mart Wild Khali
Wild Khali
Rajel Bint Khalti
Bint Khalti
Mart Wild Khalti
Wild Khalti
Silfi
Okhti
Silfti
Khouya
Marti
Rajel Bint Ami
Bint Ami
Mart Wild Ami
Wild Ami
Rajel Bint Amti
Bint Amti
Mart Wild Amti
Wild Amti
Bint Bint Khali
Wild Bint Khali
Bint Wild Khali
Wild Wild Khali
Bint Bint Khalti
Wild Bint Khalti
Bint Wild Khalti
Wild Wild Khalti
Bint Okhti
Wild Okhti
Bint Khouya
Wild Khouya
Binti
Wildi
Bint Bint Ami
Wild Bint Ami
Wild Bint Ami
Wild Wild Ami
Bint Bint Amti
Wild Bint Amti
Bint Wild Amti
Wild Wild Amti

are referred to as "bint bint ami" (my father's brother's daughter's daughter), etc. Personal names are added for clarification if necessary.

Social Identities

The tendency towards specificity in social identities was also noted by L. Rosen in Meaning and Order in Moroccan Society. (Geertz, Geertz, and Rosen, 1980) Rosen elegantly demonstrated that individuals in Sefrou operate within a social matrix that is not as much governed by a hierarchy as it is by a multiplicity of identities. Thus terms of reference include personal names, patronyms, family ties (asl), relatedness (root w-l-d), ethnicity (nisba), three forms of locality (bled, derb, huma), spiritual brotherhoods (zawiya), religion, language and rural-urban distinctions. One's identity fluctuates from one situation to the next. In one context an individual's bled is X, in another it is Y. One's nisba may take priority in identifying a person's social status in one situation, but his zawiya may take priority in another, and so on. Thus to a great extent the individual may "slide" from one identity to another depending on the social, temporal and geographic situation. Rosen summarizes that social networks based on family, tribe and quarter do not determine behavior, obligations, or exchange but provide possibilities for interaction. It is up to the individual to choose from those possibilities. Rosen has depicted this social interaction in terms of a "sliding continuum". Both specificity, in the multiplicity of identities, and fluidity

(a term introduced in Meaning and Order in Moroccan Society) in the ease with which people choose their identities are thus demonstrated in the social structure.

In an earlier chapter the identities of Mahdian diviners are discussed. The credibility of these fortune tellers are subject not so much to debate but to definition. Basically four types can be delineated. If placed on a continuum they range from those who can "open and read the book" (gariah) to those who go door to door (degaza) giving vague predictions about the future. Most diviners are called dwarish (plural form). Fortune tellers who are particularly perceptive may be identified as robanni ("seer into the soul") - a position intermediary between dwarish and gariah. People refer to these diviners with marked fluidity. That is, a derwish to one informant would be a robanni to another. Furthermore, a person wanting to convince their listener of the authenticity of the fourtune teller may refer to the diviner as a robanni, rather than a derwish. On the other hand, one who seeks to ridicule the diviner calls the person either a degaza, or, worse, a bohelli (type of simple-minded person described below). Thus the attitude of the speaker is reflected in the terms used to describe the diviner in question.

The paradigm of a sliding continuum made up of specific types can also be used in the classification of the mentally ill. In an attempt to learn the distinguishing characteristics of people possessed from those who are mentally disturbed, I quickly found myself immersed in a

quaqmire of terms. I was finally able to differentiate between nine terms. Below various terms used to refer to those who are mentally disturbed are presented. I have placed them into groups as my informant did. However a label for each of these groups does not exist.

Individuals Who Are Simpleminded

mahboul

A mahboul is lacks the power of continuous reasoning. This term is used to identify certain types of individuals. But it is also used to denigrate a normal person for his actions.

ḥtiṭa

An Ḥtiṭa is simpleminded and very introverted.

maqarq'a

A maqarqas is feebleminded. He has less reasoning ability than a mahboul, but is not as introverted as ḥtiṭa.

bohelli

A bohelli is completely innocent in his actions. Sometimes a bohelli is perceived as saintly.

Individuals Who Appear Deranged or Confused

mtehteh

A mtehteh speak nonsensically drawing from a larg

source of knowledge, but twist the facts and principles of known data. For example, a mathematics professor exhorting various theories in the coffee shop but having all of the basic principles confused would be a mtehteh.

malwath

A malwath is confused about recent events and is easily led to believe anything. They tend to be quite paranoid.

Individuals Who Experience Bouts of Abnormal Behavior

'aṣab

Those who have 'aṣab experience fits that include explosive behavior and tremors. Fits are believed to be effected by a tightening of the muscles and hence constriction of the nerves in the back of the

neck. 'Aṣab is sometimes translated as a "nervous breakdown". The mental hospitals are called "Mustechfa El-'Aṣab".

majnun
A majnun experience fits similar to 'asab, o withdrawal behavior. The condition is believed to be caused by the body being possessed by jnun, leaving the mind disturbed and not in control.

mackloub
A mackloub becomes rabid. They exhibit bizarre unhumanly acts. These cases are rare.

Individuals that fall into the first two groups (simplemindedness and derangement) are incorporated into the family and community's daily life. However those who fall into the latter category are more disruptive. Families require help to deal with these individuals, and therefore treatment is sought. Despite the fact that each type is specifically defined, labeling a mentally ill person (just like diviners) is slippery. An individual may be referred to as a mahboul by one person and a bohelli by another. In the case of persons suffering explosive fits, they are taken to either a shrine or mental hospital. If the treatment is unsuccessful at the first institution then the patient will be taken to the second institution. His type of mental disorder is defined by where he can best be treated.

Thus in social identities not based on kinship there is a considerable amount of fluidity allowing people to place themselves, or others, on various points on the continuum. Furthermore, there are provisions that allow for one to slide from one identity to another, depending on the social context.

Color

In 1968 I conducted a linguistic study in Mahdia aimed at examining the relationship between culture and color perception. I was informed at the beginning of my investigation that only women knew the correct terms for colors. This point of view was confirmed by both men and women. Men were able to identify classes of colors, i.e. red, blue, etc., but they were unable to give the terms for specific colors within a color class. Eleven women and two men were individually presented 62 packets of differently colored embroidery threads. They were asked to group them into similar categories, naming each of the categories as they went. Then the informants were asked to name the color of each packet of thread. After an analysis of the data I concluded the following:

1) Color categories included: yellow, green, blue, oregano (violet), rose, coffee, red, black/navy and white/pastels. Six of the color category names were generic; three (oregano, coffee and rose) referred to edible foodstuffs.

2) Individual colors were highly differentiated from one another and were identified through the use of color-referents. The name of a color, in most cases, was derived from a foodstuff in its natural state, for example, egg yolk, unrefined olive oil, flower of oregano, etc. Food terms were made into color-referents by placing a suffix i, on the end of the term. For example, the color "kleeli" is derived from the term for oregano "kleel".
Significantly, there were no color-referents associated with domesticated animals or with fish. The terms clearly reflected the environmental stimulus of the woman's world. (Women are responsible for processing (and in some cases producing) agricultural foods.

Women do not participate in herding or fishing.)

3) For further definition of colors, informants used four adjectives (light-dark, hot-cold) when necessary to identify a color. The light-dark dichotomy was indicated by shades and the hot-cold dichotomy indicated the intensity (shininess or dullness) of the color.

Clearly the Tunisian color terminology is very specific. There is little room for error because most of the colors are linked by concrete reference to food items used regularly.

Dwa 'Arbi

Informants were very resourceful in explaining the various ethnomedical practices used in dwa 'arbi. Extensive descriptions were elicited for a variety of treatments. Specific instruction included the precise way in which the foodstuffs were to be prepared and administered. (I was impressed by the amount of information that some of these women had committed to memory, especially because this knowledge is not called upon daily but only when the need arises.) Often the women knew of three or four remedies that could be tried. And so, even though each treatment was specifically defined, there was no hesitation to move on to another treatment if it appeared that the first treatment was not working.

As explained in earlier chapters remnants of the ancient humoral medical system tibb al-'arbi can be seen in the etiology and ethnomedical practices of dwa 'arbi. Blood, cold air, diet and dirt refer to the elements/humours. In

inquiring about the cause of illness most people simply state that "bad blood" is the cause of their illness. But some are more specific. In studying their responses it became evident that "bad blood" can mean various things: the blood was "hot", "weak", or "dirty/thick/cold". Also, illnesses caused by cold air are sometimes described as being caused by dirty air. It became obvious, then, that cold (berd) and dirty (musach) are used synonomously when referring to the elements of blood and air.

Prescriptive foods are never explicitly defined as "hot" foods or "cold" foods as they are in humoral medical systems in Latin America and elsewhere. (Logan, 1977, Cosminsky, 1977, and others). However such a distinction is sometimes inferred. For example, red meat is not given to people who have "bad blood". Rather fish or sometimes poultry is given to the patient. We might infer, then, that red meat is covertly thought of as "hot". Warm thermal drinks are always given to people whose illnesses are caused by cold air.

To some extent dwa 'arbi employs a "selective use of paired opposites", a fundamental principle of humoral medical systems. (Logan, 1977) This principle is also operable, in a limited sense, in Tunisian color terminology. Here again there is a distinction between "hot" and "cold". Furthermore, like in dwa 'arbi, "dirty" is used in place of "cold". An embroidery thread labeled "dark sky blue" (in English) was called "cold blue" by some of the informants and "dirty blue" by others. The same tendency was found for particular shades of yellow, red and off-white.

The Decision-Making Process

In his analysis of the Moroccan bazaar economy, Clifford Geertz found that the search for information is the driving force behind market activity. Individuals, both buyers and sellers, spend a tremendous amount of time and effort in collecting information on quality, source and amount of goods in order to make wise decisions in the marketplace. Geertz explains that "The search for information one lacks and the protection of the information one has is the name of the game." (Geertz, Geertz, Rosen, 1980, p. 125) The bazaar economy is different from other market economies in that interest is not in balancing the options (supply, demand, quality) but rather to know what they are! He makes an analogy with horseracing. There is generally a great deal of ignorance and confusion among bettors at the track. However if a person has some knowledge about the horses and the others do not, that individual can capitalize on the situation, for the odds will be in his favor. It works the same way for the participants of the sug.

In the bazaar specificity can be demonstrated by the value placed on specific information sought (where did the goods come from? what is it being sold for in the city? how old is it?, etc.) Fluidity can be observed in the behavior of the buyer and seller who unlike many participants in market economies, do not fall into habitual relationships (i.e. patron-client). Both buyers and sellers keep their options open allowing them to select the best partner.

In many ways the health care seeking behavior, discussed in Chapter Nine, is similar to bazaar activity. It is similar in that information is sought from a number of sources and the variables of a sickness-episode are considered in every case, making each case more or less unique. Variables considered are age, symptoms (type, severity, duration), events that precipitated the illness and the practitioners available.

Another similarity to the bazaar system is the lack of faith in the "expert". Instead first hand experience is valued. In the bazaar no credence is given to the seller who claims his product is the best. He has an obvious bias. Instead more weight is given to the information collected in the marketplace. The same holds true in the medical domain. As the proverb "don't ask the doctor, ask the one with experience" suggests, the experiences of others which requires gathering information from various sources, affects the decision-making process more than the proclamation of the expert.

Geertz states that the search for information is usually a matter of "exploring matters in depth with particular partners more than surveying widely through the market". (Ibid., p. 244) In medical situations one finds that folk practitioners spend long periods of time with their patients. I suspect that this is one of the reasons Tunisian folk medicine continues to be so widely practiced. The causes and treatment of illness-episodes are the subject of in-depth discussion with family members and practitioners. In

biomedical situations such in-depth discourses do not take place.

To conclude, when analyzing the semantics used in various contexts one finds the principles of specificity, fluidity, and use of paired opposites in operation. These principles not only reflect attitudes, they also influence behavior. Specificity is exhibited in the high degree of refinement and definition at the lowest levels of a particular category (i.e. kinship, social identities, color, dwa 'arbi). Fluidity is most obvious in the category of social identity and is found again in the decision-making process. Finally, the use of paired opposites appear in two categories - color terminology and dwa 'arbi.

SUMMARY

There are a number of cognitive themes and behavioral patterns that criss-cross various domains in the Tunisian culture. Concepts such as God's will, reason and humoral opposition; belief in divine inspiration; values placed on obligation, proper behavior and choices based on in-depth analyses of information; and the semantic pattern of specificity play a role in the medical domain. In addition, they also provide the cognitive fibers for attitudes and behavior within a wider cultural context.

CONCLUSION

Initial observations of Tunisian medical practices indicated that medical pluralism existed there. Through documented sources and personal inquiry I researched the historical, social and cultural framework within which the medical domain could be understood. The results of my investigation have been presented above. In Part One a foundation was provided for the discussion of Tunisian medicine presented in Part Two. Firstly, a theoretical grounding was outlined in an attempt to orient the reader as to the methods used and the objectives sought in this research effort. The objectives of the project were stated as follows: 1) to collect data on the etiology and ethnomedicine of the medical alternatives available in Mahdia, Tunisia; 2) to ascertain the meanings of each of the medical traditions; 3) to analyze the way in which the medical traditions articulate with one another behaviorally and cognitively; and, 4) to determine the extent to which the semiotic components found in the medical domain are reflected in the cultural system as a whole. To this end data was collected by participant observation and interviews during the summers of 1978, 1983 and 1984. Secondly, the founding, development, demography and social organization of two Mahdian zneg were compared. A discussion of zanga social and cultural life, including factors that provide catalysts for conflict and bonds that foster cohesion, were described. This presentation was intended to facilitate the conceptualization of the fieldwork setting - one in which illnesses are diagnosed, health care

decisions made and treatement administered.

Part Two began with a discussion of the history of what I suggest are the antecedents of today's Tunisian folk medicine along with a history of the development and decline of this medical system as experienced in Tunisia. Parallel to the development of Arab medicine was the expansion of Sufism, which in Tunisia and elsewhere in the Mahgreb became entangled with an older tradition - belief in jnun. Finally, the pervasive belief in the evil eye was discussed in terms of its relevance to theories of illness causation. Thus I proposed that Arab medicine, Sufism and the jnun-oulaya tradition and the antiquated belief in the evil eye provide the historical context from which Tunisian folk medicine has evolved.

Chapters Six and Seven were devoted to the analysis of two spheres - the natural and supernatural - within which all illnesses are categorized. Dwa 'arbi, dwa suri or spiritual mediation may be used to treat all illnesses regardless of the sphere in which they are classed. It was concluded that symptom-specific interventions (including some dwa 'arbi treatments and biomedical therapy) are used primarily to relieve symptoms of natural God-given illnesses, whereas symbolic treatments are used (simultaneously or alone) for illnesses believed to be caused by a natural elemental imbalance (of blood, cold air or diet), the evil eye or the jnun. Symbolic therapy in Tunisian folk medicine is aimed at the restoration of balance. This may be achieved by the ingestion or expulsion of specific substances, the extraction

of an illness-producing agent, or a change in consumption, work or social patterns of activity. Saints may be enlisted in preventing states of imbalance or restoring balance through appeasement or mediation. In the latter case the human mediums are sought for their ability to use the saint's baraka to divine or heal.

Through a cognitive analysis made in Chapter Eight it was concluded that the Tunisian medical system is a syncretic one - one in which the folk medical traditions have been fused together at the cognitive level and to which biomedical therapy is being incorporated. In examining the ways in which diagnoses are made, causality and pathology are interpreted and therapy administered, themes which unite the medical tradition into a whole can be ascertained. The binding postulates include the following points: 1) Most illnesses are usually precipitated by events which are under the control of the individual or his/her family. These include the nonobservance of preventative health rituals, physical or emotional excesses, unfulfilled promises to saints, or cultivated relationships with the jnun; 2) Some illnesses are specifically God-given or are the result of a vengeful jnun whom the individual inadvertently harmed. These illnesses generally cannot be foreseen or avoided; 3) Illness is a state of imbalance. Its presence represents a manifestation of precipitant behavior leading up to the illness-episode; and 4) The goals of ethnomedical practices include the relief of discomfort, the counterbalancing of excessive, deficient or polluting elements, behavior modification and the extraction

of causal agents.

Factors affecting the health seeking process and the utilization of available medical alternatives in Mahdia were discussed in Chapter Nine. It was concluded that the experience and opinions of people living in the patient's household and zanga exert the greatest amount of influence on the decision-making process in any given illness-episode. These experiences and opinions are embedded in explanatory models which provide theories of causality, pathology and prognoses readily understood by the patient who then willingly conforms to the wishes of the therapy managing group or practitioner. Outcomes of illness-episodes are most successful, it was argued, if patients are treated by persons with whom they share a common explanatory model. In these cases treatment is believed to be more efficacious from the point of view of informants. Generally acute serious illnesses are treated at hospitals and clinics. Thus, in as much as biomedicine is effective in relieving discomfort and extracting causal agents, biomedical therapy (only) is being incorporated into Tunisian medicine. Dwa 'arbi, evil eye exorcism and saint mediumship are alternatives sought for minor or chronic illnesses. The latter are treated with therapy designed to restore a balanced psychophysical state. It is felt that biomedical practitioners are unable to administer this type of therapy.

Based on the assumption that cultural systems are composed of domains which possess symbols particular to that

domain as well as symbols that are shared with the wider cultural system, an attempt was made in Chapter Ten to elucidate the themes (symbols) which thread through the culture providing cognitive accord. These themes include God's will, the role of human and supernatural mediation, balance in personal comportment and social relations, semantic patterns of specificity and paired opposites and fluidity in discourse. These symbols give meaning to the everyday life of individuals participating in the culture.

I have attempted to approach the analysis of Tunisian medicine from a holistic perspective. To that end I have examined the way in which Tunisian medicine is affected by the interplay between historical, religious and cultural facets of Tunisian society. In doing so I believe a contribution has been made to the ethnography of the Maghreb as well as to the area of medical pluralism.

APPENDIX I

DWA 'ARBI MEDICINE

Below is a list of illnesses elicited from interviews on dwa 'arbi. When possible English equivalents are given for the named illness. Otherwise the illness is translated as closely as possible to its literal meaning.

Causal explanations vary in their depth and inclusiveness. For simplification, I have cited only the basic causal factor given most often for each illness. Furthermore it must be remembered that although most of these symptoms/illnesses are first assumed to be "natural illnesses", they can also be caused by the evil eye, jnun or an angry saint.

Examples of treatments given below reflect those most commonly elicited for each particular illness. Substances for which English equivalents are not available are given in transliterated Tunisian Arabic.

'ama
- Description: blindness
- Cause Elicited: God-given
- Example of Treatment: none

'amash
- Description: inability to open eyes in daylight
- Cause Elicited: God-given
- Example of Treatment: none

'aqira
- Description: sterility in women
- Cause Elicited: cold air
- Example of Treatment: hot vapors from boiling mint and cloves and//or a vaginal insertion of warm suppository made of wool treated with mint and caraway

'aqir
- Description: sterlity in men
- Cause Elicited: weakness
- Example of Treatment: none

ark el-isse
- Description: varicose veins
- Cause Elicited: not stated
- Example of Treatment: root of a fig (covered with incense) is tied to the leg with a white string, then the leg is bandaged in white cloth; root and string are then quietly buried in cemetary

'aṣma
Description: bowel impaction
Cause Elicited: diet of dry food or over indulgence of prickly pears
Example of Treatment: enema of oil and warm water

bandada
Description: pneumonia
Cause Elicited: cold air
Example of Treatment: tisanes of melilot or anise seeds

baraṣ
Description: discoloration of the skin (in patches)
Cause Elicited: bad diet (i.e. eating milk and fish together)
Example of Treatment: drink the blood of a turtle

bard
Description: (bard means cold) general term that includes arthritis, rheumatism, aching joints
Cause Elicted: cold air
Example of Treatment: apply ointment made of clay and onions, harmaline, tanning, or Vicks mentholatum

bouṣafer
Description: jaundice
Cause Elicited: fright
Example of Treatment: surprise burning of the patient and ingestion of yellow foods

bouzagar
Description: chicken pox
Cause Elicited: god-given
Example of Treatment: diet of sweet foods and drinks; application of rosewater, milk thistle or leaves from the maryam tree ("tree of Mary")

damɑa
Description: head injury that results in profuse bleeding
Cause Elicited: accident
Example of Treatment: injury packed with paste made from cobwebs and powdered coffee

dam ɑalid
Description: "thick blood" (characterized by dizziness in persons over the age of 40)
Cause Elicited: anger and anxiety
Example of Treatment: blood letting, henna tea and behavior modification if possible

daga

Description: heart palpitation
Cause Elicited: bad blood and weak heart, fright or anxiety
Example of Treatment: ingestion of honey, sesame seeds and nigella; behavior modification if possible

dekarsit el-akrab

Descrition: scorpion sting
Cause Elicited: accident
Example of Treatment: place halved scorpion (or small animal) on the area stung

douds

Description: worms
Cause Elicited: God-given
Example of Treatment: drink the broth of boiled seaweed ("weed of the snakes")

fadda

Description: asthma (fadda means "out of breath")
Cause Elicited: cold air
Example of Treatment: smoke euphorbia ("herb of fadda"

fas'a

Description: disjointed ankle (sometimes another joint is inolved)
Cause Elicited: accident
Example of Treatment: someone (preferably a mother of twins) will stamp on the joint, and ankle will be soaked in hot water

fatag

Description: protruding navel in infant
Cause Elicited: bad blood
Example of Treatment: talcum powder and a belt worn for seven years

fatla

Description: twisted muscles (in the waist, sides and back) -- (fatla means "twist")
Cause Elicited: irregular movement
Example of Treatment: massage

guedmet el-hanash

Description: snake bite
Cause Elicited: accident
Example of Treatment: place halved snake on the area bitten

ḥab shabab
Description: pimples (ḥab) during adolescence
Cause Elicited: bad blood
Example of Treatment: application of honey and egg whites

ḥajar fil klawi
Description: stones (ḥajar) in the kidney
Cause Elicited: cold air
Example of Treatment: tisanes of parsley, anise seed, leeks or mallow

ḥararat el-bard
Description: cold sore
Cause Elicited: cold air
Example of Treatment: place cold metal on the cold sore

ḥarq
Description: burning sensation of any kind
Cause Elicited: sun burn, burn from fire
Example of Treatment: rub burn with potato

ḥawi
Description: impotence (ḥawi means "like a woman")
Cause Elicited: weakness
Example of Treatment: mixture of sesame seeds, almonds, nigella and honey taken every morning

ḥoumra
Description: erysipelas (red inflamation of skin)
Cause Elicited: bad blood as a result of anxiety, anger, fear or sadness
Example of Treatment: application of a red clay mixed together with vinegar or water; a diet of grain, sugar and raisins, no meat; behavioral modification if possible

ḥousba
Description: measles
Cause Elicited: god-given
Example of Treatment: patient is dressed in red cloth and fed goat milk, goat meat, and fish

jadri
Description: small pox
Cause Elicited: god-given
Example of Treatment: apply poultice of sulphur, sebadera, sanmahdia, or the leaves of the maryam tree

jarab
Description: scabies
Cause Elicited: dirt
Example of Treatment: cleaning the area repeatedly; application of salts, sanmahdia, and m'a

jarab
Description: minor cuts
Cause Elicited: accidents
Example of Treatment: application of fish oil or chicken fat

jarian il-kirsh
Description: diarrhea (jarian means "running"/ kirsh means "digestive track"
Cause Elicited: bad diet
Example of Treatment: rice and/or rice water, fenugreek

ksar
Description: broken limbs
Cause Elicited: accident
Example of Treatment: bind limb in leather strap

majnun
Description: possessed by jnun
Cause Elicited: jnun
Example of Treatment: exorcism by a saint's medium

marid fil'ain
Description: (minor) sickness of the eye
Cause Elicited: dirt
Example of Treatment: application of rosewater and/or olive oil

marid klawi
Description: sickness of the kidney
Cause Elicited: cold air
Example of Treatment: tizanes of juniper, fenugreek, shih, or zegre

marid bit tihan
Description: sickness of the spleen
Cause Elicited: anxiety or sadness
Example of Treatment: Dried lamb or beef spleen is placed on the stomach of the patient. This is then covered with a wool cloth upon which is placed a hot iron.

mr'a berda
Description: frigidity
Cause Elicited: cold air
Example of Treatment: carob syrup applied to the vagina and cliterous

nadra
Description: oozing eczema
Cause Elicited: dirt
Example of Treatment: application of salt or m'a

nasla
Description: "pulling apart" of the neck
Cause Elicited: irregular movement
Example of Treatment: massage neck (internally and externally) with olive oil, vinegar, cardamon and crushed carnations

nougth.a
Description: stroke
Cause Elicited: bad blood
Example of Treatment: none

qabad
Description: constipation
Cause Elicited: bad diet
Example of Treatment: ingestion of honeysuckle oil and sea cucumbers

qaba
Description: cough
Cause Elicited: cold air
Example of Treatment: a leaf of palma christi (castor oil plant) or heavy paper pierced with holes and placed on the chest and back; tisanes of melilot, honeysuckle, or anise seeds

qourab
Description: stomach ulcer
Cause Elicited: unstated
Example of Treatment: drink of soda ash or soda bicarbonate

xaja fil mada
Description: object in stomach
Cause Elicited: sorcery
Example of Treatment: vomiting induced by magical healer

ramad
Description: trachoma
Cause Elicited: dirt
Example of Treatment: scrape the inside of the eyelid with a sugar cube, wash eyes with saline water and administer rosewater drops

rasmi yibki
Description: crying continuously
Cause Elicited: weaning
Example of Treatment: a loaf of bread is left in the street to be picked up by a stranger

riḥa
Description: fever "caused by the wind"
Cause Elicited: the air
Example of Treatment: poultice of egg, soap and rosewater applied to the head

risha
Description: hemmorhoids
Cause Elicited: diet
Example of Treatment: apply ointment made from boiling three dozen egg yolks, garlic and honey for three days; eat one spoon of the fat from the hump of a camel

sha'aira
Description: sty
Cause Elicited: dirt
Example of Treatment: application of olive oil and rosewater

ṣafra
Description: serious case of jaundice, perhaps hepatitis
Cause Elicited: fright
Example of Treatment: surprise burning of patient; diet of yellow foods

ṣahana
Description: fever
Cause Elicited: extremes in temperature (exposure to sun or cold air)
Example of Treatment: poultices of lavendar, juniper, or shiḥ mixed with olive oil and eggs; diet of fish (no meat)

shaqiqa
Description: headaches (of various severity)
Cause Elicited: anger and anxiety resulting in bad blood
Example of Treatment: herbal plasters made from a variety of sources: lavendar, bat leaf, maḥlib, shiḥ, and walnut tree bark; inhaling

smoke from burning kashfur; behavior modification of possible

shahega
Description: whooping cough
Cause Elicited: cold air
Example of Treatment: Patient is exposed to the sea air, then fed fried owl

sibana
Description: ringworm
Cause Elicited: evil eye
Example of Treatment: egg yolk is put into a blue cloth and heated over a charcoal fire, then this bundle is placed on the sore

soukar
Description: diabetes (soukar means "sugar")
Cause Elicited: anxiety and anger resulting in bad blood
Example of Treatment: modification of diet (i.e. no sugar) and ingestion of fenugreek, wild spinach, and ommrooubia

soukoum
Description: deafness
Cause Elicited: cold air
Example of Treatment: usually none, but rue and oil might be applied in the ear

soultan
Description: an incurable growth anywhere on the body (cancer)
Cause Elicited: anxiety and anger resulting in bad blood
Example of Treatment: eat fried snake; behavioral modification if possible

tadia el-akl
Description: memory loss
Cause Elicited: anger and anxiety
Example of Treatment: none

tahloula
Description: warts
Cause Elicited: donkey saliva
Example of Treatment: horse hair is tied around wart and pulled off

tatli'a essennine
Description: teething
Cause Elicited: not stated
Example of Treatment: rub olive oil on gums and face (near the ears); let the baby chew on sugar cubes

tawattir el-'asab
Description: nervous condition that yields tremors
Cause Elicited: intake of coffee resulting in bad blood
Example of Treatment: eat fenugreek, reduce coffee consumption

tousfia
Description: gonorrhea
Cause Elicited: not stated
Example of Treatment: tisane made from a mixture of melilot, oregano, juniper, ommroubia and zwega

trash
Description: loss of hearing
Cause Elicited: cold air
Example of Treatment: insertion of olive oil and rue into the ear

waj'a al-mada
Description: pain of the stomach
Cause Elicited: bad diet
Example of Treatment: tisane of tranjia or anise seeds, and ingestion of fenugreek

waj'a fil badan
Description: general body aches (not bard)
Cause Elicited: anger resulting in bad blood
Example of Treatment: hot water bath with an infusion of bay leaf; drink water and "black iron from blacksmith", behavioral modification

waj'a fil garouma
Description: pain in the throat
Cause Elicited: cold air
Example of Treatment: wrap neck in red cloth soaked in alcohol; burn insense to inhale smoke

waj'a fil oudin
Description: pain in the ear
Cause Elicited: cold air
Example of Treatment: insertion of olive oil and rue

APPENDIX II

DEGREE OF UNANIMITY FOR STANDARD TREATMENTS

	Illness	Percent
	fever	100%
	measles	100%
	chicken pox	100%
	eczema	100%
	sore throat	100%
	cancer	100%
*	seborrhea	100%
*	teething	100%
*	spleen disorder	100%
*	nervousness	100%
	eye infection	91%
	earaches	91%
	ringworms	90%
	jaundice	90%
	migraine	88%
	erysipelas	80%
	diarrhea	75%
	whooping cough	75%
	constipation	75%
	pulled muscles	75%
	hepatitis	75%
*	neck aches	75%
	stomach aches	73%
	scabies	72%
	smallpox	71%
	broken limbs	70%
	twisted joints	67%
	pimples	67%
*	burns	67%
	asthma	64%
	female sterility	63%
	diabetes	60%
	head injuries	56%
	heart palpitations	50%

* less than five treatments considered

APPENDIX III

CAUSAL FACTORS OF SPECIFIC ILLNESSES

Causation		Illness
		erysipelas
		jaundice
		diabetes
		nervousness
		muscle aches
anger anxiety fear sadness fatigue weakness	BAD/WEAK BLOOD	stroke migrain skin cancer spleen disorder pimples memory loss
		high blood pressure
		heart palpitations
		male sterility
		impotence
		whooping cough
		asthma
COLD		coughs
AIR		earaches
		deafness
		rheumatism
		sore throat

	kidney problems
	kidney stones
	cold sores
	frigidity
	female sterility
	ree-hea (fever)
IMBALANCED DIET	hemmorhoids
	bowel impaction
	constipation
	diarrhea
DIRTY SURROUNDINGS	scabies
	eye infections
	seborrhea
	warts
	discoloration of skin
PHYSICAL INJURIES	broken limbs
	head injuries
	cuts
	burns
	scorpion sting
	snake bite
	neck ache
	pulled muscles
	twisted joints

	smallpox
	chicken pox
SPECIFICALLY GOD-GIVEN	measles
	worms

Illnesses listed above may be ultimatley caused by supernatural causal agents such as saints, jnun, or the evil eye. However, ringworm is always attributed to the evil eye, and majnun is inevitably caused by jnun.

SUPERNATURAL AGENTS	mental disorder
	ringworm

APPENDIX IV

LIST OF SHRINES VISITED BY INFORMANTS
(in order of frequency mentioned)

*Sidi Benour
Sidi 'Akmer
*Lella Oum Ezzine
**Sidi Jebar
*Sidi Mas'oud
**Sidi Bohillel
Sidi Salem
**Sidi Snoubri
Sidi Ḥassen
Sidi Abdelqader
Lella Shelbia
Sidi Maḥjoub
Lella Oum Khmar
Sidi Bousaid el-Beji
Lella Ṣalḥa
Sidi Aḥmed el-Tijanni
Lella Ḥalima bent Abied
Sidi Ben Ghiaḍa
Sidi Faḍlan
Sidi Bourida
Sidi Bou Ḥassine
Sidi Jebar (near Beni Hassine)
Sidi Mahres
Sidi Maḥjoub (near Faḥs)
Sidi Qassim
Sidi Jbir
Sidi Saḥbid
Sidi Bou Said
Sidi Bouzid
Sidi Ali Belloun
Sidi Ali Salaḥ
Sidi Sayeh
Sidi Jlell
Sidi Al-Bissari
Sidi Shaieb

* Shrines located within a 20 kilometer radius of Mahdia.
** One of the approximately 15 shrines in Mahida. They are indicated on the map in Chapter Two.

APPENDIX V

THE LEGEND OF LELLA OUM EZZINE

The legend of Lella Oum Ezzine was told to me on numerous occasions. The women seemed to be particularly fond of Lella Oum Ezzine and enjoyed telling the legend. With some variations, the legend goes something like this:

As a young woman Lella Ezzine was a drummer and predicted future events. She was known as "a very good person". However she was rather badly treated by her family, more specifically by her brothers. They claimed she had no spiritual powers but rather was mad or sick. One woman explained,

> She was considered to be a very hard child who suffered many beatings from her brothers. They used to tie her up and leave her alone at home while they went harvesting the wheat.
>
> It was said that once when her brothers were returning from a trip from far away,one of the camels broke a leg. She materialized herself among the caravan and by rubbing saliva on the camel's leg cured it instantly. The brothers then came home and were amazed to see their sister at home.

After this event her brothers acknowledged that their sister had special powers, and permitted her to tell futures. Word spread of her good works and special powers. Eventually Bey Hazzine, who was governing Tunisia during the Ottoman Empire, heard about Lella Ezzine. He invited her to his palace as a guest for one evening. She told him that she was a saint. He gave her a dress (presumably payment for her divination).

Bey Hammouda also invited her to his home. He doubted her powers and decided to test her. She was put into a cage with seven lions. After some time she was let out and she was unharmed. Her power was verified. The Bey released her, promising not to interfere with her "work".

Upon her death the people in the community built a shrine at the site of her tomb. After this she became known as Lella Oum Ezzine (Lady Mother Ezzine). One woman concludes:

> This (the legend) is what the elders tell us and it is our duty to believe in it and to believe in God Almighty. That is why you hear people pray in the name of God through Lella Ezzine. Saints are people who believed in God and did good most of their life.

More recently proof of Lella Ezzine's powers have been demonstrated to public officials. This has occurred on two occasions. Once when the land around her tomb was being cleared in order to erect a school the tractor continually broke down as it neared the shrine. Another time it is said that President Bourguiba drove past the shrine and asked that the delapitated shrine be torn down. Lella Oum Ezzine "came to him at night and warned him not to do so." After that he retracted his order to remove the building and instead had the shrine renovated.

ANALYSIS

Lella Oum Ezzine possessed the qualities of most saints. For example, she was able to materialize "out of nowhere" and she used her saliva (<u>baraka</u>) to heal illnesses. Furthermore she became a parent figure to her devotees, who call her

"Oum", meaning "mother".

This legend presents the extreme possibilities for a Tunisian woman living in a society dominated by males. Brothers and sisters are very close - closer in many instances than siblings of the same sex. Normally a woman's brother is a valuable male ally. However, in this legend the heroine is subjected to beatings inflicted by her brothters - an act considered abhorent by most Tunisians. At the other extreme, the legend tells of how Lella Ezzine goes from a situation of total subjugation to the exalted position where she is able to influence heads of state - the Turkish Beys when she was alive and President Bourguiba after her death. (Thus a variation of the Cinderella saga is portrayed.)

GLOSSARY

'ain ḥarsha - evil eye caused by envy and hate

amin al-attiba - chief doctors during the Ottoman Rule in Tunisia

'ar - compulsion

'aṣab - fits of abnormal behavior

'azameen (masculine, plural) - ḥadra leaders at some shrines
'azamet (feminine, plural)
'azam (masculine singular)
'azama (feminine singular)

baraka - blessing

bakshish - bribe

bisissa - cereal made from barley

bohelli - type of simplemindedness

couscous - processed semolina

degazat (feminine, plural) - migrant fortune-tellers
degaza (feminine, singular)

dhikr - spiritual litanies

dinar - Tunisian currency equal to approximately $1.50 U.S., $2.00 Canadian.

drebik (plural) / derbouka (singular)- clay drums

dwa 'arbi - Arab remedies

dwa suri - European remedies

dwarish (plural) - diviners
derwish (masculine singular)
derwisha (feminine singular)

fetḥa - two meanings: 1) a prayer used at the beginning and/or ending of a ceremony. In standard Arabic the term means "the opening". However, in Tunisia the prayer is said more often at the end of ceremonies and has come to be known as "the ending". 2) a prayer held by male members and friends of the groom's and bride's families to acknowledge the acceptance of a marriage request.

ftour - dinner held for groom and his friends prior to the jilwa

ḥab - raised pink spots or blisters, "buttons"

ḥadith - traditions and sayings of the Prophet Mohammed

ḥadrat (plural) / ḥadra (singular) - general meaning is a gathering of people where musicians are hired. In some cases the express purpose of a ḥadra is to go into trance.

hailalah - the act of saying "There is no God but Allah"

ḥafideen (masculine plural) - caretaker of a shrine
ḥafidet (feminine plural)
ḥafid (masculine singular)
ḥafida (feminine singular)

ḥallel - the religious way

ḥaqq - obligation

ḥaram - sin

ḥarqous - black dye

hennani (plural) / henna (singular) - two meanings: 1) a plant, 2)the women's ceremony held during the wedding festivities

ḥshumiya - propriety, shame

ḥtiṭa - type of simplemindedness

ḥzab (plural) /ḥizb (singular) - men's party in which trances may be induced

iblis - satan

'id al-kabir - Islamic holy day celebrating Abraham's sacrifice made to God

ijazet (plural) / ajaza (singular) - certificates of (medical) competence issued during the Ottoman rule in Tunisia

jebaib (plural) / jeba (singular) - traditional garment worn by men

jilwa - procession where the bride is taken to the house of the groom

jnun (plural) - spirits that live underground
jinn (masculine singular)
jinnya (feminine singular)

kẖarja - wedding procession of groom and his male friends and relatives culminating at the groom's house where the bride awaits

ḵhautba - the first stage of an arranged marriage where the parents of a suitor approaches the parents of a girl and requests her hand in marriage

kwanin (plural) / kanun (singular) - clay burner used to prepare tea or broil meat

mackloubeen (masculine, plural) - abnormal rabid behavior
mackloub (masculine, singular)
mackloubat (feminine, plural)
mackloubа (feminine, singular)

macrou - acts hated by God

mahboul - type of simplemindedness

maqarq'a - feeblemindedness

marḍ min teḥt idihum - illnesses caused by "them who live under" (jnun)

marḍ rabeni - illnesses God permits

mashṭat (plural)/ mashṭa (singular) - woman who organizes and directs an ensemble of women musicians and singers

meddeb - scribe who reads "the book"(Koran)

millime - Tunisian currency equivalent to 1/1000 of a dinar

mjaneen (plural) / majnun (singular) - possessed by jnun

mlawth (plural) / malwath (singular) - type of mental derangement

msawid (plural) / mizwid (singular) - social gathering where folk songs are sung

mtehteh - type of mental derangement

mubaḥ - acts God prefers not to be committed

murabitun (marabouts) - two meanings: 1) living holy men who possess baraka, 2) shrines dedicated to saints

musach - dirty

nobat (plural) / noba (singular) - dance performed individually at social gatherings

oulaya (masculine plural) - saints (in Tunisian Arabic)
oulayet (feminine plural)
ouli (masculine singular)
oulia (feminine singular)

qabla - midwife

'qal - reason

qareen (masculine, plural) - diviner who "reads" from the Koran
qari (masculine, singular)
qariat (feminine, plural)
qariah (feminine, singular)

qouffa - gifts sent by a suitor

qudrat Allah - God's will

rashq - monetary donation given at rites of passage

robanneen (masculine, plural) - diviner that can "see into the soul"
robanni (masculine, singular)
robanniat (feminine, plural)
robannia (feminine, singular)

sbah - two meanings: 1) morning, 2) gathering of immediate relatives of bride and groom in the bride's home during the wedding festivities

shaikh (sheikh in Tunisian Arabic) - religious or political leader

shari'a - God's laws

shauwesh - dancer in a Sufi order

sheyateen (plural) / sheytan (singular) - devil, demon

soulayimiat (plural) / soulaymia (singular) - socio-religious gathering in which religious songs are sung

tadwire - ritual hand gesture designed to exorcise the evil eye and minor jnun

taqalid - tradition

t'am - donation of food or money made by the groom to the parents of the bride at the beginning of the wedding festivities

t'azimat (plural) / t'azime (singular) - ritual performed by 'azameen to exorcize jnun

thourat (plural) / thour (singular) - ceremony during male circumcision festivities

tibb al-'arbi - Arab medicine

tibb annabi - the Prophet's medicine

tibb arrani - folk medicine practiced during the time when the Kairouan School of Medicine was established (900 A.D.)

tishtri - tambourines

w'adat (plural) / w'ada (singular) - promise

wali - saint (in standard Arabic)

waqf - religious endowment

wird - a form of prayer

yakhuda bin nufs - curse of the evil eye (illnesses caused by the evil eye)

zawiat (plural) / zawiya (singular) - shrine

zdaq - signing of the marriage contract in the presence of civil (and/or religious) authorities

zneq (plural) / zanqa (singular) - neighborhood

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