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Medical Pluralism in Morocco: The Cultural, Religious, Historical and Political-Economic Determinants of Health and Choice.

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Medical Pluralism in Morocco

The cultural, religious, historical and political-economic determinants of health and choice

Tyler Martinson

SIT Morocco: Multiculturalism and Human Rights - May 2011

Dr. Abdelhai Diouri

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Abstract: Morocco is a culturally diverse intersection between the African continent, the Arab world and Europe. This multiplicity is mirrored in the country's pluralistic medical system and beliefs surrounding the concepts of illness and health. Explanations of health are endorsed by culturally specific knowledge and are then naturalized and taken as objective. A synthesis of theoretical descriptions and political-economic of medical pluralism, along with historical analysis, explains the presence of multiple health practices and how a person's choice of medical practice is heavily influenced by dynamic socio-cultural, religious, historical, political and economic factors. This study will help improve practitioner/client narratives of illness and foster a more holistic health sector in a medically pluralistic society.

Keywords: [Morocco, medical pluralism, complementary medicine, colonial medicine, political-economy theory]

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Preface

“And what makes people sick?” I realized the question was rather broad immediately after I posed it. I was not even sure how I would have answered the question.

The natural light coming in through the stained-glass window hit his face so that he could not look at me in the eyes but he took a deep breath and with a low voice began to tell a story.

“One afternoon on the fifth day of the week, a group of three men were in a car driving in the countryside somewhere. On the country road they stopped suddenly when they saw some sort of blockage, a round object in the middle of the road. When the driver stopped the car and got out to investigate what the curious object was he realized it was a turtle. Pleased with his find he picked up the quite large turtle, decided he would bring it home to put on his terrace, and placed it in the trunk of the car and continued on his journey.

“He drove a mere distance of four feet before his car jerked to a stop, the engine failed to continue to function and the back end of the car sank. The driver got out of his car and went to see what the problem was. He checked the tires for a blow-out and when he saw no evidence of a flat tire he kicked the wheel to check for air pressure. He had no idea what the problem could be but decided to open the trunk to check for various tools. When we opened the trunk he realized that the turtle had grown to an enormous size and began to speak to the man:

The turtle said, ‘You should take me back to the very place you found me.’”

And then he stopped talking. ‘That was his response?’ I thought worriedly. Perhaps he did not understand the question? Maybe my translator did not correctly transmit the message? It was a possibility that the man simply did not want to talk about my topic – I had been warned that people would not necessarily be interested in the proposed subject of study or understand what sort of information I was interested in. My question had been “How do people become sick?” and I had no idea how the question and his anecdotal story were connected. I asked a clarifying question about what became of the man and why he had told the story.

“Well, he fell very ill after that of course and came to see me to get well.” The man answered in an impatient voice.¹

¹ Dabir. Personal interview. 20 April 2011.

Introduction

Morocco exhibits a high level of cultural diversity as a result of its extensive ethno-history. The country's history extends from the indigenous Amazighi societies, to Arab influence under the Islamic expansion during the seventh century, onward and past the nation's experience as a protectorate of France. As a result of the country serving as an intersection of sub-Saharan African, Arab and European cultural groups – and being a product of a recurring influx of assorted ethnic bodies and colonial conquests – conceptions of health and illness are equally diverse. Some of the many categories of medicinal practices in Morocco are those of Amazighi herbalistic and animistic, Islamic-inspired biological, mental spiritualistic healing, and European biomedical persuasions – all of which are still prevalent in the ever-globalizing and diversifying country of Morocco. These are not rigid categories, neither ethnically nor medically, and their definitions are just as fluid as ethnic definitions in the country. Health should first, and foremost, be analyzed and researched as a social system. Health and illness are complex phenomena that humankind has been toiling with throughout, and preceding, recorded history. All medical practices and perspectives of health should be analyzed as cultural systems and products of social reality. Health cannot be described or understood from a single viewpoint and instead must be seen as a culturally-specific expression as opposed to an objective truth in and of itself. These explanations of disease etiology, display or interpretation of symptoms, and means of treatment and healing combine to form a description of illness that is individually cognitive, culturally relative, and structurally restricted in its expression.

The various medicinal practices in Morocco have distinct explanations of health and wellness. Amazighi herbalism and animism, being common in many sub-Saharan communities as well, attribute supernatural powers to natural surroundings. Islamic medical scholarship and

medicine of the Prophet alludes to a balance-based humoral medical system and advocates for equilibrium in all aspects of life – social, physical, and spiritual. Biomedicine, of European origin, is characterized by a mechanical explanation of the body describing any illness as a pathological infection and disruption to the biological balance of mechanistic physiology. With an analysis and rhetoric calling for cultural relativity and specificity these explanations of health and illness and the epistemologies behind particular healing practices within Morocco can be better discussed.

Most efforts to describe medical pluralism and how an individual navigates in such an environment have been limited in scope. A theoretical and disciplinary pluralism is necessary in describing the phenomenon of medical pluralism. Contemporary literature concerning medical pluralism and anthropological theory often presumes cultural subjectivity, historical analysis, as well as economic and political inequalities to not be organically intertwined and complementary as they are. The relationship between medicinal practices, and their underlying explanations, displays a restrictive dominance and objective legitimization of ‘Western’ and ‘objective’ ideologies. The ambiguous quagmire of social and cultural determinants of disease, as well as general illness and misfortune, is often overlooked or deemed unnecessarily complicated and senseless. Understanding of medical systems as cultural systems is crucial in explaining the prevalence of medical pluralism and “medical dialogue therefore can serve as a window through which one can view social processes”² which affect a person’s choice in which medical service and practice he or she seeks out. In environments that are ethnically and medically pluralistic,

² Crandon, Libbet. 1986. "Medical Dialogue and the Political Economy of Medical Pluralism: A Case from Rural Highland Bolivia". *American Ethnologist*. 13 (3): 463.

medical dialogue is an arena in which political and economic processes take place. Descriptions of well-being are born of social processes and the explanation of illness is driven by a necessary mélange and theoretical synthesis of historical, political-economic, cultural and religious attributes. An interpretive anthropological study supplemented by historical analysis, and political-economic theory explains the prevalence of medical pluralism in Morocco and the complex of underlying cultural, historical, economic and political influences in an individual's choice of health service. This study shows that, with the continuing presence of medical pluralism, although an individual's choice is greatly constrained by historical and political-economic factors, including proximity to particular health services, the choice lies in a person's cultural and individual epistemology of illness and well-being. With this understanding of health and medical pluralism more appropriate explanations and movements for cultural sensitivity, alongside integration of diverse medical practices, can more holistically define human experience with illness.

Methodology

This project is based on the information gathered from numerous interviews with six informants that were audio recorded and transcribed with their permission. All people who were interviewed and provided qualitative and ethnographic data, in order to respect anonymity, confidentiality, and privacy, are referred to by pseudonyms. In addition to these interviews document review of various texts, useful in describing various medical practices, and participant observation of interactions between practitioners and patients greatly supplemented and enriched the information gained through interviews.

Given Morocco's comprehensive background of multiple ethnic and medical customs being available to the general population, the project's basis lies in ethnographic research with

various medicinal practitioners in two urban centers in Morocco: Fez and Rabat. Field research about the different healing practices available in these areas ranged from interviews with medical practitioners at a pharmacy and clinic, professors of pharmacology and social medicine, a *fqih* (Moroccan Arabic: *هيقف*, an expert in Islamic law, science and arts), custodians of healing shrines where saints have been interred, and an *attar* (Moroccan Arabic: *عطار*, an herbalist, spice vendor, learned sellers and prescribers of herbal remedies with curative medicinal plants). Most of the ethnographic data presented in this study is drawn from conversations with the *fqih*, whom I have called Dabir – appropriately meaning ‘teacher’ in Arabic – although all information resulting from the ethnographic interviews has been put to use in understanding the concepts and organizing the paper.

Research is based predominantly upon participant observation supplemented by formal ethnographic interviews, meetings and consultations with public health workers and professionals, as well as informal conversations with individuals about health, illness and medicine. With ethnographic research come difficulties in interpretation and issues of representation. There are limitations concerning the collection and meaning of data resulting from these interviews and ethnographic experiences. This account is therefore not an attempt to create an all-encompassing and objective picture of all individuals’ experience in the Moroccan health sector. The basis of this study, the collection of data, and the subsequent analysis of ethnographic material is based solely upon the information provided by the informants who are only able to touch on their own personal experience and connection to the phenomena of health and illness. Furthermore this collection and analysis of data is based upon the interpretation of my informants’ collection of cultural knowledge they have chosen to share with me. As a result from this inadequate picture which materializes throughout the ethnographic process, an

anthropologist has a choice in how the cultural encounter will be represented to the desired academic or public audience. The options available to a researcher typically include either an objective interpretation of the data as scientifically observed reality, or the option to position oneself within the narrative in more of a fictional or novel account. Although an admirable goal, it is impossible to remain completely objective even in a situation in which a person is completely ignorant of the target culture and it is very difficult to incorporate oneself into the ethnographic experience without representing it with naiveté or without proper critique and analysis of one's own role in the interactions. While both options alone are wildly scarce in their scope, I have chosen to attempt a hybrid ethnographic account. The fusion of ethnographic interviewing (admitting the limitations exhibited in the research carried out, the information gathered, and my imminent subjectivities and cultural assumptions in the categorization and organization of the resulting ethnographic account) and critical analyses (historical, economic, and political analyses of the historical and current public health spheres in Morocco), provides a more appropriate and legitimate representation of individuals' experience with medical pluralism and the anthropologist's role in the ethnographic experience.

Additional difficulties encountered in this study involved problems of access, language, continuity and time. Unfortunately some places of healing, such as shrines, are restricted to faithful Muslims and although I was granted entry into one such shrines, I was obviously not allowed to enter the actual chamber and received limited information as a result of my not being religious myself. Language proved to be a substantial obstacle in the interviews with practitioners of herbalism and spiritual medicine although I was able to find phenomenal translators who helped me to set up interviews and foster communication and rapport with the informants throughout the process. Fluency in Arabic, more specifically the local dialect *Darija*,

would have been of substantial help relating to my proposed method of ethnographic interviewing – ethnosemantics. Although semantic analysis was therefore not an option, I was able to collect a fair amount of data from the interviews and translations provided for me. I was able to conduct many interviews in French on my own with practitioners and scholars in the fields relating to biomedical studies. The issues of time and continuity intersect and greatly influenced the resulting study. With the time restriction of three weeks, virtually only two weeks considering time allotted for the final write-up, rapport is difficult to develop with multiple informants and the option of multiple interviews and follow-up with a past informant is diminished.

A focus on historical narratives, the effect of the French protectorate and the introduction of European biomedicine on the health sector in Morocco, and a current analysis of the political and economic determinants of medical pluralism are appended in order to foster a more appropriately interdisciplinary nature to the study. The scope of the study is to explain underlying metaphors and explanations beneath medical practices and how they interconnect, deviate, and may still be compatible with one another. This study is an examination of how an individual can explain health, perceive and categorize other explanations, and navigate in a medically pluralistic society choosing between the multiple practices available. As the study of cultural anthropology has become a science of amplifying the marginalized voice, this account seeks to form social action from its ethnographic focus and an understanding for the integration of medical practices in ethnically diverse environments in order to encourage further medical discourse and self-reflexivity. This research will foster communication between practitioners of various medical practices in order to create a more culturally sensitive public health sector accommodating for all aspects of human health and epistemological categorizations of illness

and healing. In order to further discuss the particular societal factors at play in constraining an individual's navigation through a medically pluralistic society, varieties of medical practices must be emically described in their current expression in order to, in turn, discuss their origins, use, and interactions with other medical traditions to illumine the potential for complementarity.

Prophetic medical theory and its present practice

"I used to be the owner of a beautiful restaurant, it was a great job but I was filled with anger all the time and I could not explain why. I became sick and the doctors could not tell me what was wrong. I came to the shrine, took a shower in the water of the well. This was three years ago."

She paused and glanced over at the doorway of a small section of the shrine which led to the well. I could see the bucket with a rope tied around the handle lying at the threshold of the door.

"That was three years ago," she repeated.

"I bathed in the water and I received my old life back – even better – a new life!" It was apparent that her happiness was difficult to hide and she spoke with a solemn sense of thankfulness and piety, with pursed lips to refrain from bursting with joy or laughing it seemed.

"I have volunteered here ever since." She was the woman who collected water for visitors and clients and cared for the grounds surrounding the shrine.

As we left she filled my water bottle with water that was collected from the well from the shrine. I was told it contained baraka. I drank it and I felt the cool refreshing liquid quench my thirst that I did not even know I had. It was a warm day and I did not realize how thirsty I had been.

The custodian turned to me, shook my hand and said "Bon courage." ³

³ Amina. Personal interview. 16 April 2011.

History of Islamic medicine–

The basis of prophetic medicine lies in the guidance of spiritual, psychological, ethnical, behavioral, socio-cultural and economic role of health in the Muslim's life. The tradition of Islamic medicine is incredibly eclectic and draws from earlier medical knowledge spanning from Indian and Persian philosophies to Roman and Greek attitudes toward health and physiology. The practices and beliefs have been recorded and developed in the collections of Ibn Sīnā (more popularly known by his Latinized name Avicenna), Ibn Rushd (better known in European literature as Averroes) and Imam Ibn al-Qayyim al-Jawziyya (Ibn Qayyim). They have provided knowledge and commentary in a number of works on the natural sciences and medical practices of Islam such as Ibn Qayyim's *Medicine of the Prophet*, Avicenna's *The Canon of Medicine*, and Ibn Rushd's *Generalities in Medicine* which actually recognized the function of the retina and the tact of immunity in cases of smallpox.⁴ These works were utilized in medical schools worldwide, including Montpellier, until the mid-17th century. The fields of pharmacology and chemistry are most influenced by scholars of Islamic medicine. Scholars studying the sciences of Hadiths described many new drugs such as senna, camphor, nutmeg, and cloves as well as developing and using new diluters for drugs such as rose water, orange water and tragacanth. These innovations and developments in attempting to understand the human body and interpreting sickness further demonstrates the heterogeneous nature of prophetic medicine in history.

⁴ Ibn Qayyim al-Jawzīyah, Muḥammad ibn Abī Bakr, and Abdul Rahman Abdullah. 2003. *Healing with the medicine of the Prophet*. Riyadh, Saudi Arabia: Darussalam. p. xxii.

Galenic Humorial Medicine

The eclecticism exhibited by prophetic medicine was spear-headed by a Galenic description of human body composition. According to this explanatory model of health the body contains four natural properties; blood, phlegm, black bile and yellow bile. Each of these crucial elements is then comprised of temperaments (*amziga*) and humors (*axlat*). The four temperamental types are sanguinous, phlegmatic, bilious and melancholic and each is associated with a combination of hot, cold, dry, and moist qualities. It is the maintained balance of these four elements, and their respective temperaments and humors, which provides good health and favorable well-being (i.e. ailments that are deemed to be *dry* must be countered with an appropriately balancing *moist* remedy). That is to say that any imbalance in the humoral composition of the body is an interruption in equilibrium which is the source of all illness and requires a return to balanced existence. This paradigm of imbalance and disruption being the root of all illness is also apparent in the existence of *jinn* (Arabic: جن).

Jinn

One of my informants discussed the existence and manifestations of the *jinn*. *Jinn* are malevolent spirits which are specifically associated with causing illness and misfortune by entering into the body. There are about 70,000 types of *jinn* all categorized by tribe, kingdom, religion and language group. There are two tribes, sun(day) and moon (night) tribes each with numerous kings within which control the *jinn* at different times of the day – one king controls them from sunrise to noon until another replaces him after that time and so on as the day continues. There are various religious groups within these intersecting tribes and kingdoms, including Muslim, Jewish, Christian and even infidel *jinn*.

Jinn are mostly associated with locations which are secluded, unsanitary, and foul-smelling such as latrines, garbage dumps, caves, wells, as well as certain foods and stagnant or sources of water.⁵ Cemeteries are said to be haunted by *jinn* as well, as they usually crouch between graves. They are even known to inhabit date seeds and turtles – as introduced in the anecdotal interlude of this study shared by Dabir about one of his patients. In the case of a possession by *jinn*, resulting ailments range from joint pain in the knees, wrists and digits of the elderly, to a pain in the stomach after ingesting a substantial, and potentially gluttonous, amount of food. Most possessions by a *jinn* require the expert attention of a *faqih* or an *attar*; either would be capable of casting the harmful *jinn* out, although the deed is usually left for a *faqih* as indicated in interviews conducted.

While eclecticism is apparent in Islamic spiritual medicine, it is clear that the underlying and binding belief connecting all diverse medicinal beliefs into one prophetic philosophy of health is the understanding of all healing deriving from Allah. Treatment and healing is explained as being the will of Allah as “only God can cure an illness, and people’s knowledge is limited to what He makes available to their level of understanding.”⁶ The fact that distribution of such knowledge is limited by the will of Allah places the healer, or scholar of various medicinal methods and techniques, in a position of prestige – held by the *faqih*.

⁵ Sharaf, Sarah. Mental Health in Morocco and the Perception of the Professionals and General Public. SIT 2002.

⁶ Ibn Qayyim al-Jawzīyah, Muḥammad ibn Abī Bakr, and Abdul Rahman Abdullah. 2003. p. 11

The *fqih*

The *fqih* is a graduate of a Qur'anic school who has memorized the Qur'an, read many inherited texts explaining the historical development of the medical practices and respective theories, and continued on to become a sort of 'professor' of the Islamic sciences and medicine with his own methods and techniques of study and practice— as described by Dabir in translating the title of *fqih* as somewhere between saint and teacher. Historically a *fqih* was expected to travel extensively in order to witness variant healing practices of other cultures and territories in order to further his studies and improve the efficacy of his techniques, theories and explanations of health and illness to his clients – fostering a basis of medical practice on collaboration and pluralism. Part of the difficulties in contacting Dabir and meeting with him on a regular basis were a result of his travels. He shared some of his teachings with me and his materials he used in healing; mostly consisting of plant and herbal bases, animal parts, and minerals, as well as the Qur'an.

Typically he will write charms and verse from the Qur'an in order to protect a person from harm, a means of preventative medicine so to say, or to heal a current ailment through the recitation of the holy words. His specialties include both spiritual illnesses, such as possession by *jinn*, as well as physical ailments such as headaches, or joint pain – which can also result from *jinn* possession although not necessarily in every case. Headaches, according to his studies and teachings, can be cured by taking a black cloth rolled with a killed insect inside, and wrapping it tightly around the forehead. A *jinn* possession or a body inhabited by *jinn*, which is the healing required of the typical client visiting Dabir, is performed by ritual recitation of charms and the writing of Qur'anic verses into the palm of the afflicted client. The belief behind the use of the Qur'an in healing practices lies in the acceptance that the Qur'an is the untarnished word of God

and can transfer inherent *baraka* (بركة), or divine blessing, to an aggrieved individual. All compensation for such healings and treatments is reduced to a mere gift of food goods, usually either salt or sugar, given in exchange for medical advice or exorcisms. The prestigious position in the case of healing following the literary Qur'anic descriptions of health and their cultural expressions is held by the person who displays *baraka* – legitimation of earthly power through the process of healing. It is not merely the *faqih* who holds the ability to transmit *baraka* from Allah, or His holy words in the Qur'an, but the grace also lies in deceased saints and the shrines or tombs associated with their bodies and life works.

Healing shrines

Any visitor to Morocco will immediately notice the omnipresent white dome of the shrine throughout the Moroccan landscape – including urban centers. In the north of the country there is a tradition of health shrines associated with mineral springs and baths that extends even back to the period of Roman influence in Morocco according to Dabir. These shrines sanctify the personae of Moroccan Muslim saints who are, according to Dabir, “God’s representatives on earth.”⁷ The person buried in the shrine has usually “left books, he abided by the law on Earth and died as a very beloved person who lived in God’s image”⁸ as Dabir explained. Sick people visit the shrine to witness the teachings of the saint and to seek healing from their inexplicable ailments and health concerns.

Health shrines have been divided into two categories by past academics focusing on sainthood and healing shrines in Morocco. The first category is the shrine of a female saint,

⁷ Dabir. Personal interview. 20 April 2011.

⁸ Dabir. Personal interview. 20 April 2011.

which attracts especially women and deals mostly fertility and other gynecological concerns. Usually the visitors who visit these shrines return home with an assortment of herbal remedies, ointments or amulets that they can purchase at the shrine. A shrines of this type was not included The second category of shrines caters to men and women alike and is a place where people suffering from another ranging from physical to mental afflictions may come or be brought in search of a cure.⁹ This latter category of shrines, of which I was able to collect personal data, provides healing by prayer and Qur'anic recitation as well as providing water (for either consumption or bathing) drawn from a well within in the shrine itself containing the grace and divine blessing, *baraka*, of the interred saint.

The custodian at the shrine at which I was permitted admittance, apart from the actual enshrined room with the tomb due to my not being Muslim, shared many stories with me about the various patients and ailments that have been representative of the shrines visitors and clientele. The shrine, known colloquially as *Mon docteur*, is the tomb of the late Sidi Abouri who was a famous scientist – a “father of science”¹⁰ according to the custodian who spoke to me, Amina. Amina described the clientele, ranging from Moroccans, Algerians, Egyptians and even Europeans occasionally. She focused on a particular story about a young woman who came from Europe hoping to be cured.

⁹ Hatt, Doyle. 2009. "Moroccan saints: shrines as systems of distributed knowledge". *Shrines in Africa: History, Politics, and Society*. 153-203.

¹⁰ Amina. Personal interview. 16 April 2011.

“There was a young lady who came from Europe one time. I am not sure which country she came from but she was a very wealthy person. She had gone to all of the doctors in Europe in order to seek treatment for a terrible headache that she had. She was told that she had a tumor in her brain.”

She continued to cycle through various medical doctors and specialists of oncology but they were unsuccessful in providing her with treatment and she was told that she did not have much time left to live.

“She came [to the shrine] and swam in the well and afterwards she immediately started feeling better. And that led to call this man – this shrine – my doctor – in French Mon docteur.”

The woman was so pleased with the shrine and the healing and peace that she felt after bathing in the well and continues to give gifts and visit the shrine from time to time. She has not gone back to a medical doctor or oncologist concerning her tumor and she continues to live to this day.¹¹

This story is not described as a mere miracle but as a result of the *baraka* which once belonged on the hands of the saint, Sidi Abouri, and now inhabits the shrine and the well of curative springs and wells. “This is not a miracle, this is *baraka*. God’s *baraka* – God’s grace. The only thing that exists here is God’s grace”¹² and this is the method of healing that people seek when they come to a shrine. This was both an example of a functioning cure witnessed by the shrine, not a rarity according to the custodian, as well as the story behind the colloquial name of the shrine. Shrines exist as systems of distributed knowledge¹³ as well as providing a place for healing – which can only occur under the power and willingness of Allah through his *baraka*.

Healing and efficacy of baraka

In terms of efficacy in the practice of visiting a shrine, *baraka* must be described emically and analytically. In the context of the Islamic-based medicinal practice it is the practitioner who, endowed with *baraka*, serves as a vessel through which Allah’s healing flows. Within Islamic tradition and according to the hadith “there is no disease that Allah has created, except that He

¹¹ Amina. Personal interview. 16 April 2011.

¹² Amina. Personal interview. 16 April 2011.

¹³ Hatt, Doyle. 2009.

also has created its treatment."¹⁴ This healing is carried out through the grace of Allah through a blessed person – as well as a place or object associated with a particular person (as discussed above) – that is considered to possess a substantial amount of *baraka*. *Baraka* is a concept that can be defined as anything between a sort of blessed virtue, spiritual influence or power, and potentially even simply luck. Some academics have defined it as “a mysterious wonder-working force which is looked upon as a blessing from God.”¹⁵ Others claim on a more social-contextual reliance that it is “an explanation for uncanny events, extraordinary political sagacity, and range of mundane situations indicating well-being, abundance, or merely sufficiency of any quality or material.”¹⁶ The transmittance of *baraka* from Allah is explained as having the ability to heal and foster well-being in ill or emotionally troubled individuals. While many of the understandings of illness and healing are inspired by Islamic texts and tradition, the actual belief in healing power assumed by various practitioners or saints in Moroccan Islam, the transmittance of *baraka*, and the special relation and favored proximity to Allah, is not textually justified by the Qur’an. The practitioner, with his potential healing abilities, plays the role of translator between the natural world and the cultural symbolic in order to fulfill the needs following the religious and social needs of the client.

The efficacy of this medical tradition, and the concept of *baraka*, is predominantly based upon religious belief. The most important aspect in all of the various methods used by such practitioners – ranging from herbal remedies, to sorcery and charms, and even simply prayer and

¹⁴ Hadith: Volume 7, Book 71, Number 582: Narrated Abu Huraira.

¹⁵ Westermarck, Edward. 1926. *Ritual and belief in Morocco I*. London: Macmillan and Co. p, 35.

¹⁶ Eickelman, Dale F. 1976. *Moroccan Islam: tradition and society in a pilgrimage center*. Austin: University of Texas Press. p, 158.

Qur'anic recitation – is faith in Allah. Faith is the means by which one is cured of illness and the “patient should have faith at least in [the *fqih*], if not in Allah, and [the *fqih*] has to have full faith in Allah ... and be aware that the healer is Allah and only Allah.”¹⁷ In other words, the faith serves as both the means and the end when illness and healing are concerned. Faith is meant to be strengthened throughout the process prior to (as the healing will not work without a client’s faith in both the healer and Allah) and following the procedure or performance of healing (since the result, whether recovery from or exacerbation of the condition, is in accordance with the will of Allah). Religion and social cohesion play integral roles within the practice of medicine to the point where Islam, the submission to Allah, and social health and well-being are reinforced through medicinal practice and explanations of illness and understandings of healing.

The medicine of the Prophet, as practiced today on the part of Dabir, draws its medicinal focus from Islam’s holistic approach to health which covers all aspects of the mind, body and soul. A truly healthy and conscious person blends diet, nutrition and exercise with the remembrance of God and an intention to fulfill all their religious obligations. When one part of life (i.e. physical, mental, social, spiritual) is injured or unhealthy, the other parts suffer. Islamic-based spiritual medicine, with its basis on spirituality and *fqih* and saints serving as educators and healing vessels at shrines cared for by volunteer custodians, demonstrates the often ignored factors of faith and spirituality within understandings of health and illness. Only when all aspects of cultural specificity and intricacies are accounted for and appropriately described can medical systems be explained as a cultural expression of categorical knowledge and subsequent practices.

¹⁷ Kiyamaz, Sehnaz. 2002. "Sufi treatments: methods and philosophy behind it". *Journal of the International Society for the History of Islamic Medicine (ISHIM)*. 1 (2): p, 11.

Cultural Expression of Health -

Health should first, and foremost, be seen as a social system. Health and disease are complex phenomena that humankind has been toiling with throughout, and preceding, recorded history. All medical practices and perspectives of health should be analyzed as cultural systems and products of social reality.¹⁸ In order to fully understand varying interpretations of well-being and illness, it is necessary to complete a “thick description” in order to explain underlying symbolic relationships to make sense of any cultural act and founding psychological justification and symbolism.¹⁹ Health cannot be described or understood from a single viewpoint and instead must be seen as an explanatory model as opposed to an objective truth in and of itself. Explanatory models “contain explanations of any or all of five issues: etiology; onset of symptoms; pathophysiology; course of sickness (severity and type of sick role); and treatment.”²⁰ These explanations combine to form a narrative of illness which is individually cognitive and culturally and epistemologically relative.²¹ Each cultural entity has a distinct metaphorical categorization and explanation of health and what constitutes as, and in turn causes and treats, illness. Understanding illness narratives and the cultural expression of health facilitates communication between a practitioner and a patient and therefore is more easily and readily understood from an etic perspective – upon which most cultural analysis is based and by which most of ethnographic research gains its critics.

¹⁸ Kleinman, Arthur. 1978. Concepts and a model for the comparison of medical systems as cultural systems. *Social Science and Medicine*. Vol. 12. Pergamon Press Ltd. 85-93.

¹⁹ Geertz, Clifford. "Thick Description: Toward an Interpretive Theory of Culture". In *The Interpretation of Cultures: Selected Essays*. New York: Basic Books, 1973. 3-30.

²⁰ Kleinman. 1978. 87-88.

²¹ Kleinman, Arthur. 1988. *The illness narratives: suffering, healing, and the human condition*. New York: Basic Books.

The various practices in Morocco have distinct ontological bases on which social realities are organized. Amazighi animism has a basis in attributing supernatural powers to natural surroundings, animate and inanimate objects alike, and linking illness to sorcery or imbalance in social networks and kinship groups.²² Islamic-based medicinal practices emphasize a humoral medical system constituting health as a balance of the four humors; blood, mucus, yellow bile and black bile.²³ Biomedicine, expanding in familiarity and prevalence, is characterized by an understanding of the body as a complex biological machine and any illness as an intrusion and disruption of a mechanical physiology. Medicine is not a natural thing but is instead a product of culture – intrinsically “culturally shaped.”²⁴ Many traditional medical systems emphasize explanations of etiology that locate the origin of illness and sickness in the social sphere, in the relations among people, animals, animated objects, as well as the heavens. Illness is commonly dissected into two distinct treatable realms; that of the physiological symptomatology and the psycho-social treatment of fluid etiology which reaches beyond the concerned individual into his or her social environment and interpersonal relations.

A culturally focused explanatory model framework can be utilized in order to describe all medical traditions as innately similar in value but explains their origins and acceptance using significant culturally-relative symbols and vital cultural metaphors.²⁵ Some mentally ill in Morocco for example, as opposed to being viewed as victims of a neurological misconnection in

²² Stein D. 2000. "Views of mental illness in Morocco: Western medicine meets the traditional symbolic". *CMAJ : Canadian Medical Association Journal - Journal De L'Association Medicale Canadienne*. 163 (11): 1468.

²³ Sheehan, Helen E., and S. J. Hussain. 2002. "Unani Tibb: History, Theory, and Contemporary Practice in South Asia". *The Annals of the American Academy of Political and Social Science*. 583 (1): 123.

²⁴ Kleinman, 1988. p. 5.

²⁵ Lakoff, George, and Mark Johnson. 1980. *Metaphors we live by*. Chicago: University of Chicago Press.

the physical being, are understood as having ingested *jinn*— a religious concept of malevolent spirit, perhaps similar to a demon. In fact, the Arabic word used to describe insanity is *jinn*, and for the insane, or mentally-unstable person, is *majnun* (مجنون). Both words are derivatives of *jinn*, or malevolent spirits causing *majnun*, or mentally ill people, to (as aforementioned) be interpreted as a person who is possessed by evil spirits. *Jinn* can also be placed upon people in order to seek revenge and the visiting of a *faqih*, or appropriate religious medicinal practitioner, will restore spiritual and social balance. Particular cases of illnesses experienced by some Moroccans, who subscribe specifically to this model of disease, are explained as ‘magico-spiritual’ phenomena in response to, for example, a breakdown of social relations or acts deemed profane or irreverent. While person of European descent or cultural influence may describe an infection as a foreign pathogen infecting the body, potentially ‘caught’ from another person who had the same infection or from exposure to contaminated food or an unsanitary location, an illness interruption by a *jinn* is similarly described as being ‘sent’ from another person and becomes more likely when a person is in an unsanitary location such as latrines, water, and certain foods. These seemingly antithetical descriptions of health explain sickness in incredibly similar fashions with vastly different epistemological meanings and understandings of infection and understandings of efficacy of treatment. As humans, we are limited in our experience of nature by how we culturally construct it and instill or legitimize meaning in it.²⁶ Social construction of reality can also describe reified scientific notions of medicine as a product of culturally specific naturalized ideologies.²⁷

²⁶ Baer, Hans A., Merrill Singer, and Ida Susser. 1997. *Medical anthropology and the world system: a critical perspective*. Westport, Conn: Bergin & Garvey. p. 39.

²⁷ Berger, Peter L., and Thomas Luckmann. 1966. *The social construction of reality; a treatise in the sociology of knowledge*. Garden City, N.Y.: Doubleday.

The metaphor for external intrusion into the body of the ill, and the interruption of normalcy or desired experience on the part of the infected, is perhaps a universal metaphor for health and can be found in the majority of cultural explanations of health. In this case, the *jinn* are connoted with the pathogen or germ as well as with the inexplicable in illness. When a person is inhabited by *jinn* a *faqih* will generally advise against him or her going to the *hammam* (public baths) and not associate with many people until after the ailment has lessened in intensity, which provides a culturally relative description of a biomedical notion of infection and contagion.

God's Messenger said: "Evil spirits of jinns have no access to human beings expect through the evil spirits of other human beings." Hence, one must choose his environment, be selective about his companions, answer the call of God Almighty, and pray for protection and guidance.²⁸

These potential universal metaphors of interruption, intrusion and infection provide possibility to complementarity and integration of medical traditions and customs, as will be discussed in full in a succeeding section.

Regardless of its utility, a limited concentration on the cognitive production of conceptions of health and illness has led to much criticism. Cognitive and symbolic theoretical frameworks in medical anthropology are viewed by some as excessively abstract, rendering them inapplicable to study in the field. Biomedicine, in relation to other medical practices, has been described as a long-lasting global institution which has been indigenized, imposed upon

²⁸ Ibn Qayyim al-Jawzīyah, Muḥammad ibn Abī Bakr, and Abdul Rahman Abdullah. 2003. p. 93.

indigenous peoples, and a “powerful regimen of capitalism.”²⁹ The explanatory models framework and thick cultural descriptions of the relative psychological alone cannot describe the relations between the various medical practices in the case of Morocco because it fails to analyze the unbalanced power relations and social inequities remnant of the colonial era. Explanatory models emphasize the inherent cognitive differences between diverse medical practices but offer nothing regarding their relation to one another or the restriction of choice between health services. Moroccan medical pluralism perpetuates and aggravates discrepancies between the health conditions and availability of resources between preexisting historically constructed societal schisms; rich and poor, urban and rural, colonial and nationalist. The availability and prevalence of multiple medicinal remedies and practices do not alleviate these social disparities. Basically, a cultural explanatory model framework alone ultimately does not supply sufficient scrutiny toward a social and historical analysis of medical systems. However, this is something that is well accommodated for in historical analysis of colonial medicine and critical political-economic theory.

Historical influences on medical pluralism

Outside the shrine known as Mon docteur, there is a yard and garden that attracts many visitors. Amina, the custodian at the shrine, shared stories about the rituals practiced around it

²⁹ Kleinman, Arthur. 1995. *Writing at the margin: discourse between anthropology and medicine*. Berkeley: University of California Press. p. 37.

and the types of people that are attracted to it. Along the beach outside the shrine there was historically a line of French and Portuguese cannons presumably from the colonial and protectorate era. The regime of cannons used to be a formidable sight according to Amina and there used to be several however only one, the biggest one, still stands today after the French left the country.

“Recently the Moroccan government tried to take all the [cannons] to a museum and there was a big problem. They tried to lift the last one with a tractor, or a crane, but they couldn’t.” It was believed that the cannon was possessed by jinn so they tried everything they could to take it out but they could not move it at all.

“As a result it is left here and people come here once in a while – people who want to get married, want to have kids, get a great job, be healed, and get well. They come here and they turn their backs to the arsenal and they make a wish. And they throw henna and some limes or lemons. By doing this, through this process they leave all their jinxed life here to start a new life – as new healthy people.”

The area also attracts fortune tellers. They are not true healers and are merely in it for the money. Amina described their practice as staining the reputation of this existence of a shrine.

“Shrines exist to help people but fortune-tellers fraud people and guide them to the wrong direction because they realize that they can make money off of offering people healing and treatment.”³⁰

Psychological and symbolic understandings help to shed light on the underlying explanations and metaphorical categorizations behind various medicinal practices within a medically pluralistic society, but refuse to elucidate how the medical pluralism came about and how the diverse cultural groups with their respective explanations of health came together. Due to the shortcomings of the ability to provide an analysis of the relation between various medical practices solely based upon culturally relative explanations, historical analysis is necessary in its interdisciplinary focus to show how social systems influence one another. Historical accounts recording specific events as well the resulting retrospective descriptions of societal reactions are crucial in explaining the current existence of medical pluralism in Morocco. From a historical anthropological perspective it is evident that Morocco’s current prevalence of medical pluralism

³⁰ Amina. Personal interview. 16 April 2011.

results from the recurring colonization of the region, beginning with the initial Amazighi settlement of the region, the introduction of Islam and the expansion of the Islamic Empire in the seventh century and extending through and beyond the economic and political influence under the era of European colonization on the African continent and the country's time as a protectorate of both France and Spain.

Most historical accounts of European colonialism in Africa written from 'Western' perspectives define the colonization as a *mission civilisatrice* (civilizing mission). The European act of colonizing African is often described as a harvest of information, drawing maps, taking census data and cataloguing the regions' floral and faunal specimens and documenting the archaeological record, as well as introducing European concepts of empirical science, social hierarchy, ethnic tensions, economic distribution and political organization. In the case of Morocco, French colonization was influential in perpetrating an ideological expansion of economic biomedicine with a blatant disregard for cultural sensitivity in public health regimes of campaigns. It is apparent that:

Africa's exploitation by the European powers shattered earlier social patterns and governance institutions. Colonialism established new economic and political relations based on authoritarianism, brutality, racism, and ethnic and class stratification to ensure the profits of multinational firms and white settlers' ventures. Although Europeans claimed a "civilizing mission," Africans were forced to finance their own domination through taxes and forced labor.³¹

Social control, if any, was frequently an unexpected or regretted result, and perhaps not a stated goal in the minds of colonizers. The issue of humanitarianism does need to be brought up and,

³¹ Kim, Jim Yong. 2000. *Dying for growth: global inequality and the health of the poor*. Monroe, Me: Common Courage Press. p. 95.

although it was not necessarily within the scope of the research, it is important to distinguish between intent and result. It is crucial for historians to allot time to the analysis of baser motivations of humans in terms of cultural interaction and underlying justifications behind acts in order to distinguish between the humanitarian action and the political one. It is true throughout medical history that public health measures often mean an increase in state power or awarding of legitimacy of a particular regime or administration. In the case of colonial public health investigations and crusades, inspection and condemnation of buildings, quarantines, isolating the sick, and obligatory immunization all exemplified intrusion on the part of the government into private matters. Without proper explanation, and potential assumptions of shared explanations of ideologies beneath medical practices, campaigns for vaccination sparked political rumor and produced anxiety because of who was administering it and what they power meant. There were deep tensions between the meaning and use of French medicine in the protectorate.³² Public health campaigns were often misread, disliked, and opposed, sometimes brutally, which is explained by culturally relative explanatory models of illness and the need for culturally relevant means of treatment and healing.

Historically, medicine in Morocco was intertwined with imperialism and served as a means of social control. Doctors were used as diplomats and agents of espionage or pacification of the colonized Moroccans through socialization of capitalistic control, while medical systems provided societal control and created a labor force to accommodate for the needs of capitalism.³³ Expressed blatantly, medicine was organized around the accumulation of capital and medical

³² Amster, Ellen. 2004. "The many deaths of Dr. Emile Mauchamp: medicine, technology, and popular politics in pre-protectorate Morocco, 1877-1912". *International Journal of Middle East Studies*. 36 (3): p. 418 – 417.

³³ Paul, Jim. 1977. "Medicine and Imperialism in Morocco". *MERIP Reports*. p. 3.

patients as sources of revenue. The importance of economics in medicine was passed on in the changing of hands in the medical systems following the independence of Morocco from the French. Current Moroccan medical pluralism is partially a result of capitalist colonial expansion maintaining the presence of biomedicine. This theoretical framework examines how health disparities are regulated by social structures that create, enforce, and perpetuate control over which populations will experience disadvantage or privilege according to historical determinants as well as economic and political ones.

The colonial conquest of Africa took place during the peak of Western monopoly capitalism and the emerging dominance of the institutions of finance capital. This historic influence is still apparent to this day as the public health sector has drastically shifted its focus further toward a biomedical and capitalistic emphasis which even seeps into the public and state hospitals. According to Jim Paul, who has developed much material on the colonial and imperialistic nature of biomedicine in Morocco, the main concern of the health policies under the French and Spanish protectorate governments was to supply an exploitable labor force to colonial capital. He goes further to argue that the present post-colonial government reflects the same kind of concern. Anthropology has incorporated the history of medicine as a procedure and outline to further guide the argument and location of culture's role to medical epistemology and the role of the political-economy to the issue of cultural difference in medical practice and explanation. While historical investigation and scrutiny is necessary in further examining or describing any cultural phenomenon more entirely, is it also necessary to relate historical medical events and their respective developments in order to explain and analyze the current political and economic state and its influence on Moroccan public health and expression of medical pluralism.

Political-economic: the lack of resources and means to choose

The social determinants of health are the conditions in which an individual is born, grow, and live, including the health system they use and have access to. The culmination of, political and economic conquest under the protectorate government, and the introduction of European biomedicine created an enduring legal and structural imbalances as well as rooted asymmetries between Africa and the ‘West,’ – Morocco and France – and between rich and poor within Morocco.

According to many advocates of biomedicine I spoke with stated that the major crisis and concern of Moroccan public health is the lack of availability of state of the art private health care for the entire population. It is not available to everyone and there are very good medical doctors although they are few and far between and are not available to a large portion of the population. The population without access to biomedical health services is mostly people living in distant rural areas which create difficulties in distribution. There is clearly residual economic expression of the French protectorate and its health practices within the public health and medical sector in Morocco. Health systems depend upon the dominant mode of production and dialectically productive in and of themselves.³⁴ The medical services that are available to a population, Han argues, are restricted by the allocation of resources. As a result, decision-making and choice in which medicinal practices are chosen is restricted. The choices and accessibility to certain services have transformed throughout and following the protectorate era. For example, at the time of biomedicine’s introduction a resident of Rabat theoretically had more options readily available: (1) utilize local ethno-botanical knowledge and home herbal remedies

³⁴ Han, Gil-Soo. 2002. ‘The myth of medical pluralism: A critical realist perspective’. Sociological Research Online, vol. 6, no. 4 <<http://www.socresonline.org.uk/6/4/han.html>>. 4.10.

from an *attar* or *ashab*, (2) visit a local religious practitioner (*fqih*), or (3) seek the treatment of an accredited medical doctor. This continues to be the case in modern-day Morocco, although in terms of true accessibility the choices are structurally constrained.

A patient's choice between the pluralities of health services is limited to the point of being deemed as totally controlled as opposed to structurally restricted. Due to such drastic structural constraints, some scholars have argued medical pluralism to be an illusion in that all medicinal practices, in a modern capitalist society, are simply varying manifestations of the homogenous dominant capitalist medicine.³⁵ This is apparent in urban marketplaces where herbal remedies, medicinal spices and other medicinal services began to be sold as opposed to being traditionally exchanged for salt or sugar (as exemplified by my experiences with the *fqih*) or freely given in order to foster social cohesion and solidarity. While his opinion of medical pluralism being illusory is drastic, choice of medicinal services does exist although it is very much restricted across lines of ethnicity, economic and political enfranchisement as well as geographic locality. The economic disparities between various demographics is exacerbated in rural communities in peripheral areas around the core urban centers where biomedical clinics and large-scale medical sectors are based.³⁶ Monetary and geographic access to biomedical clinics leads to further economic enfranchisement and increased affiliation with the dominant capitalist mode of production – to which medicine is now knotted together within Morocco as well as in many countries in which biomedicine has become a common practice. With a political-

³⁵ Han, Gil-Soo. 2002. 6.11.

³⁶ Boutayeb A. 2006. "Social inequalities and health inequity in Morocco". *International Journal for Equity in Health*. 5. p. 4.

economic focus, regional disparities, social inequalities and economic inequities can be determined and ameliorated.

While this is a strong argument this political economic theory is limited in its scope of initially explaining the occurrence of medical pluralism and the continued existence of other medical practices alongside the reified European biomedicine. This theory states that the plurality of medical practices is merely of economic and political concern and that all health issues are subject to hegemonic control of professionalized health and medical sector in Morocco. Moroccan medical pluralism cannot be analyzed as an illusory plurality exhibiting overall economic dominance by biomedicine due to the fact that multiple practices coexist and can be used as mutual supplements by a great portion of the population. Critical theory's legitimacy is limited if the application ends at a social critique of inequities since it ignores the underlying cognitive explanatory models of health which is why various disciplines and foci were utilized in this study in order to more holistically describe medical pluralism as experience in Morocco today.

This oversimplification of the relationships between the seemingly antagonistic medicinal practices and ignores the emic definitions and ethnographic construction of health and illness which are so crucial to a sound anthropological methodology. The use of diverse medical practices does not strictly refer to a particular explanatory model. An ill Moroccan living in a rural village can seek out medical advice from either a practitioner trained in biomedicine, a religious scholar or *fqih*, an *attar* or *ashab*, or even simply resort to herbal home remedies depending upon geographical proximity to each option, economic means, religious background and cultural descriptions of health.

Although the latter is generally more geographically and financially accessible the use of various curative practices, which alleviate health afflictions differently, can still be used in response to the same underlying cultural explanation of why the individual originally fell ill. Both practices and treatment processes explain the question of how the person is ill symptomatically, although it is the patient's explanatory model that describes the reasoning of why the illness befell him or her specifically regardless of which practice is chosen. The analysis of medical pluralism must be founded in both anthropology to understand the particular health beliefs, in history to explain the prevalence of various medicinal practice, as well as critical political-economic theory in order to describe the interactions and relationships between the practices. The circumstances of a persons' access to particular medical services are shaped by allocation of resources, both money and power, at the global, national, and local levels, which are themselves influenced by popular policy choices but it is the argument of cultural ideologies and symbols of health which dictate the choice in the case of medical pluralism to the greatest extent. As mentioned earlier and intended throughout this project, in order to evaluate the policies of health of a population depends on the intersection of historical factors, economic and political policy, as well as culture which –above all else along with religion – dictates a person's choice and the individual through a medically pluralistic society. With this complicated analysis of choice and access in a society exhibiting medical pluralism, it is crucial to consider the possibility for exchange between philosophies and areas on which to promote integration and mutual respect between diverse practices. Before integration can be realized, however, it is necessary to analyze the existing distinctions and epistemological legitimacy of naturalized cultural perceptions and theories of health.

Ideological hegemony and naturalization of cultural specificities

The leading political and economic entity, dictating policy in production and distribution of material goods and services also deals with the production of ideology. This is apparent through the perpetuation of biomedicine being legitimized as a natural reality and other medicinal practices being deemed as mere barbarism, sorcery, or simply an ‘alternative.’ The current public health sector and the perceptions of the various medicinal practices available are a result of ideological hegemony in order to further the legitimacy of biomedicine and silence advocates of other practices. Humans have an affinity for categories. We categorize and attribute meaning and truth to everything including our perceptions of our world in the construction of social realities. Power comes in the right to define and once that power is achieved it is difficult to break away from the discourse – especially since the discourse is controlled by a particular naturalized and reified ideological entity.

Our world is constantly being split in two, resulting in several dichotomies along lines of development (“developed”/”developing”), modernity (“modern”/”traditional”), progress (“progressive”/”stagnant”) and geography (“Northern”/and “Southern”). All categories being arbitrary these dichotomous categories essentially distinguish between the countries that are mostly poor and those with a greater number of resources at the disposal of the majority of their populations. The reasoning behind the difference in economic affluence is usually not as neutral as the terminology may appear to be as it is usually the entities in part of the ‘First World’ that, through violent histories of colonialism and neocolonial exploitation, have played a phenomenally large role in the very creation of what may be deemed as the “Third World” ideologically as well as economically and politically. Such terms exemplify asymmetries of power that remain following colonialism and protectorate governments become naturalized and taken as reality as opposed to being views as the politically charged constructs they are. The

word “development” immediately brings to mind a metaphor for an idealized model for human society and a directional pull toward an ideal existence and organization of humankind. The distinction between “modern” biomedicine and “alternative” or “traditional” medical practices is no different. The question and definition of modernity, and the distinction between various medicinal practices must be examined in order to further describe the relationship between the several types of services that are at the disposal of the Moroccan public and the potential for integrative methods of practicing health and discussing illness across cultural lines.

Since medicine and health are best understood as naturalized cultural ideologies it is crucial to note how these constructed models become cultural systems that have political and economic power dictating their expression and relations to one another. The synthesis of these two main components of each theoretical background provides ample sustenance to facilitate analysis of medical pluralism in Morocco. The history of medicine is defined as being a “struggle for the supremacy of one type of knowledge and one model of diagnosis over a number of others.”³⁷ These ideologies, or explanatory models, revolving around biomedicine become naturalized, deemed as objective truth, and prescribed and indigenized in (for example) Morocco. The ideological basis behind European scientific medicine is justified and made objective through validation by minimizing the roles that social circumstances served in the production of disease.³⁸ This construction is crucial in evaluating the relationship between non-biomedical practices and biomedicine in Morocco and the ontological distinctions that are constructed between them. This fusion of cultural explanations of health with the hierarchical

³⁷ Jones, R. K. 2004. "Schism and heresy in the development of orthodox medicine: The threat to medical hegemony". *Social Science and Medicine*. 58 (4): Pergamon Press Ltd. p. 704.

³⁸ Baer 1997, p. 209.

categorization and legitimatization of various medicinal practices is crucial in explaining medical pluralism in a globalizing Moroccan society.

The main components used to award biomedicine its alleged superiority are its empirical objectivity and progressive nature. Biomedicine's historical development attributes most of its progress and epistemological basis upon the germ, or pathogenic, theory of disease – which is, of course as stated by its name, a theoretical explanation of the spread of illness which has been shown to produce some results. Scholars, including practitioners of biomedicine, have argued against the assumed paradigmatic sketches which separate 'modern' biomedicine and 'traditional' 'alternative' medicine. Some medical doctors have come to recognize the "remarkable domination of the germ theory as the chief model of a disease and its treatment; and the equally remarkable hegemony of scientific medicine, and corresponding lack of medical diversity" in many regions of the world.³⁹

The distinction between the dynamic and progressive 'modern' biomedicine and stagnant 'traditional' indigenous medicine is incredibly incorrect considering the overlooked aspects of efficacy and progressive natures exhibited in herbalistic and spiritual medicinal practices. Obviously clients are attracted to the treatments that are effective and trustworthy. There has unfortunately been no systematic ethnology or comparative history of public health and there has actually been widespread consensus that, before colonization swept across the African continent and missionaries and colonial health authorities arrived, there was no indigenous public health. There are a few studies which refute this argument and describe public health efforts including

³⁹ Bates, Don G. 2002. "Why Not Call Modern Medicine "Alternative"?" *The Annals of the American Academy of Political and Social Science*. 583: p. 14.

prevention and relief of mass starvation during the early modern Alawi rule ca. 1670 – 1790, as well as the common practice of inoculation, or more specifically variolation, exhibited by Amazighi communities living in the mountains. Public health campaigns such as efforts including nutritional programs, pollution control and food and water purity [which] required no special knowledge or technology” were widespread in areas deemed to have no pre-existing public health system prior to European contact, such as Morocco.⁴⁰ It has also been noted that historically among the mountain-dwelling Amazighi, after the introduction of smallpox to the African continent “whereas the Jennerian vaccine is a serum harvested from infected cattle, Moroccan variolators took pus directly from a person sick with smallpox and introduced it through an incision on the healthy body.”⁴¹ This provides evidence for the human, not merely European or biomedical, tendency to adapt and develop new healing techniques as the physical environment changes. Yet, still European biomedical traditions are described as distinct from, if not opposing, current Islamic or ‘traditional’ sciences. Professor Ellen Amster brings about phenomenal questions:

How can we speak of “Islamic” and “Western” medical techniques when “Islamic” variolation is similar to vaccination—indeed, is its historical forerunner? If Islamic and Western science are so different, why were Moroccan *at.abb`a* able to mix French medicine with their own techniques, and why does such heterogeneous medicine continue today?⁴²

⁴⁰ Meyers AR. 1981. "Famine relief and imperial policy in early modern Morocco: the political functions of public health". *American Journal of Public Health*. 71 (11): p.1267.

⁴¹ Amster, Ellen. 2004. p. 417.

⁴² Amster, Ellen. 2004. p. 423.

Indeed, the arbitrary dichotomy between the ‘traditional’ and the ‘modern’ medical systems is not only illegitimate in its simple semantic analysis (western biomedicine has a tradition; the prophetic medicinal teachings are practiced modernly) but is also misleading in that it ignores the dynamic and diverse representations of practices that are deemed ‘traditional’ and ‘alternative.’ All medical systems in Morocco which would be defined as ‘traditional’, referred to as the informal public health sector, vary greatly in practice and theoretical basis. The idea of modernity and tradition implies a progressive trend and that the former will eventually eradicate the latter given enough time. This concept is, as proven by this descriptive and analytical study, a false assumption. The concept of medical pluralism refers instead to an environment in which there is more than one medical tradition and since the presence of multiple medicinal practices in one setting remains, an integration of some kind if necessary and beneficial to the public health scene.

Ideological pluralism constituting medical pluralism

While biomedicine in Morocco is definitively viewed as the dominant medical practice, it has not reached a completely monopoloid status as expected with an expanding capitalist global economy and influence on healthcare from the Moroccan economic and political elite. Due to the prevalence of multiple narratives behind medical practices and services the existence for multiple understandings and treatment for the same affliction is justified. According to the biomedical tradition in which we are submerged a stomachache is easily explained as a result of ingesting too much food or perhaps being infected by a foreign biological agent, whereas the same affliction, were an individual familiar with medicine as practiced by a *fqih* to experience it, would be described as a humoral imbalance, or possession by a malevolent spirit, mirroring a social and spiritual unevenness. From the ethnographic data collected there are many Moroccans

of higher socio-economic standing who, at an increasingly accelerating rate, subscribe fully to the European biomedical model of health and deny the existence of any other tradition in Morocco. Some Moroccans maintain other ‘traditional’ cultural explanations of health and merely acknowledge the economic viability and benefits behind a subscription to European ‘objective’ biomedicine or the use of prescribing illnesses in a market as a capitalist endeavor. The Moroccan biomedical scene strives to banish several other explanations of health and some practitioners encountered in the period of fieldwork have claimed that there no longer exist any practitioners or users of ‘alternative’ practices in the country.

During the colonial period, the introduction of biomedicine became more than a mere interaction between cultural practices. The clinic became a site “marking the interaction of (mostly) European physicians with (mostly) indigenous patients in colonial settings, and injecting into that interaction a new vocabulary, a new set of meanings.”⁴³ The new set of meanings, categorizing health and treatment regimens for illness, is adopted and the directional understanding of development and the naturalized cultural description that is biomedicine becomes internalized and viewed as the norm and goal. “We are becoming just like France,”⁴⁴ a gynecologist stated in a conversation with me. Contrary to some informants’ obstinacy the commitment and availability of herbal and spiritual healing is still pervasive in the society and this becomes apparent in urban centers where their choice in medical service is neither dictated by economic enfranchisement nor geographic proximity to biomedical facilities.

⁴³ Keller, Richard C. (Richard Charles). 2007. "Clinician and Revolutionary: Frantz Fanon, Biography, and the History of Colonial Medicine". *Bulletin of the History of Medicine*. 81 (4): p. 826.

⁴⁴ Rashid. Personal interview. 23 April 2011.

Interpretive theory explains the plurality of medical practices by describing each tradition as a result of cultural norms and symbols put into practice and naturalized and this is where explanatory models can exert hegemony through political and economic expression. This explains the occurrence of medical pluralism since the practices are direct responses to an innate understanding of illness and health that is legitimized by its function, both as a method of healing and in its fostering of cultural cohesion and social integration. The multiple medical traditions, however, form a relational hierarchy. This hierarchy is a remnant of colonial emphasis on and control of biomedicine in the Moroccan colony. While the colonial powers left a dominantly biological understanding of illness and an economic emphasis on the practice of medicine, the plurality of explanations survives and continues to serve as the explanatory models underlying the use of varying medicinal remedies and practices.

Standing alone each of the aforementioned theoretical frameworks and contributing factors in the constraint of a person's choice has its limitations, which justifies the need for synthesis-driven and interdisciplinary analysis of interpretive and critical perspectives in describing an occurrence in ethnographic and emic explanatory terms. The fusion of explanatory models and critical theory the incomplete dominance of European biomedicine describes and the existence of medical pluralism in the case of Morocco is explained not only politically and economically, but also ethno-historically. This additional analysis of the ethno-historical is arguably of greatest weight with the question of applicability of and importance to anthropological inquiry. This combination of two seemingly conflicting theories notes the possible function of theory and illumines a more plausible application of anthropology in integrative social and medical development. As opposed to mere description of medical pluralism as a result of different cultures and economic variation, the argument of medical

pluralism's description requiring a pluralism of theory to match leads to a much more holistic and appropriately vibrant explanation of medical pluralism. With a more viable description of the medically pluralistic environment, more educated and culturally sensitive suggestions for integration can be proposed.

Integrative public health and medicinal practice

With a process of integration, providing a more all-encompassing health sector in Morocco, health services can more extensively cover the needs and desires of their clientele from various economic, political, cultural and religious backgrounds. The main critique that biomedicine receives is the dehumanization of its patients – a result of the mechanistic rhetoric used to describe the patient and ease impartial decision-making on the part of the practitioner in which treatment is necessary. Including, or at the very least being aware of the existing belief of, more holistic – social and spiritual – explanations of health would be very beneficial for all. Social determinants of health are not a completely new concept in biomedicine, although it could be further developed to include various arguments of culture and religious beliefs being acknowledged.

With this knowledge of the cultural relativity of illness and its representation, expression and treatment, medical pluralism can be embraced and improve overall efficacy of public health in Morocco. The understanding of multiple explanations of health will not only help to interpret a client's illness narrative regardless of location (conversation in the clinic, shrine, or souk) but will also, but will also give deeper understanding and critical eye on one's own cultural explanatory model of health with all off its historical, economic and political attributes. Social medicine, and illness being viewed as a social phenomenon, is not foreign to biomedicine. Inequalities and transnational forces are apparent in scholars of social medicine and the

determinants of illness. For example, within the scope of a social-medicinal analysis an individual's ailment can be described by proximate and ultimate or distal determinants. Social inequalities and transnational forces, historic and present, play vital roles in the empowerment of a person to have access to and choose a particular medical service.

There are proximate and ultimate (distal) determinants to health and the contraction of illness as expressed by social medicine. In the case of human immunodeficiency virus (HIV) the contraction of the virus can be explained in simple proximate terms, familiar to all practitioners and subscribers to a biomedical explanation of medicine; infection usually occurs by contact with infected blood, semen, vaginal fluid or breast milk. While the most widely used explanation of contraction is unprotected sex this is the proximate determinant. For example, if a woman contracts HIV and had unprotected sexual relations then the cause is explained. Ultimate, or distal, determinants include wider etiological descriptions including social, economic, and political determinants. Depending on a woman's social, economic, and cultural background a person may not be in a position to negotiate for strict monogamous or safe sexual practices depending on socio-economic status, rural/urban disparities, and the level of gender equality exhibited in the location. Religions may also be added to this is contraception is not permitted or utilized in accordance with a particular doctrine or belief system. It is explanations like this that give more of a legitimately holistic perspective to medicine but is not sufficient in and of itself. There is still a need more holistic and interpretive descriptions of health – not merely social medicine which includes society in describing why people get sick – but theory which explains various descriptions of what illness is, how to describe the etiology of an ailment, and how to best treat it.

The social aspects of health and illness, which are crucial in animism and spiritual medicine, are yet to be seriously researched or funded within biomedical clinics and health service institutions. This has obviously been an incredibly simplified description of the religious and spiritual medicinal tradition due to the lack of a substantial academic research surrounding spiritual explanatory models of health and understandings of efficacy of treatment. It is necessary to appreciate all aspects and cultural explanations of health, including faith and religion, in order to better supply any given multicultural population with medical services to foster biological, mental, social and spiritual health.

It is necessary to include cultural and religious beliefs and practices into the discourse of health, illness and disease. If a person comes to Dabir seeking a treatment for *jinn* possession and he finds nothing in the body of the patient he will send him away to seek help from a doctor. This displays not only the desire for medicinal collaboration, but a necessity of cooperation and mutual learning across various medicinal practices. This is not to say that this is a one-sided battle to merely award more legitimacy and voice to marginalized, deemed 'traditional,' medical practices. Health practitioners and policy-makers must formulate ways of improving marginalized and stigmatized medicinal practices in order to further advocate for liability of practitioners, efficiency of treatments, regulation of potentially harmful treatments and compensating for a lack of proper counseling with dosages and explanations of particular prescriptions. With deeper understanding of various perceptions and explanations of health and illness client narratives of illness can be better understood and the patient can be empowered in defining their ailment and discuss the most favorable options available for continued complementary and supplemental treatment regimens. This will improve conversation between client and practitioner in order to facilitate effective treatment with cultural sensitivity and

respect – leading potentially toward a further complementary sphere of public health and the practice of medicine.

As expressed by one of my informants, “health is the pillar of society.”⁴⁵ Without the study of health and the treatment of illness, society is nothing. With more holistic and fluid treatment techniques to match fluctuating and socially influenced theories and methodologies of medicine, the ageless struggle against illness and inexplicable manifestations of misfortune can be better undertaken. It is important to note that populations in locations which exhibit medical pluralism, often leads to serial and simultaneous use of seemingly antithetical medicines. This not only supports the notion of a fluid conception of efficacy, but also of the ability to sustain opposing ideologies at the same time as well according to interplaying political, economic, cultural and religious attributes.

Conclusion

Only with appropriate interdisciplinary inquiry and research can the phenomenon of medical pluralism and the factors influencing an ill person’s choice in medical practice and services be described. Explanatory models framework, while applicable to the description of medical pluralism’s prevalence, does not provide an appropriate analysis and explanation of the relationships between the medical practices exacerbating preexisting social health inequities. Medical pluralism is best described by a fusion of frameworks and this shows that collaboration between multiple viewpoints actually leads to an overall stronger argument based upon an overall mutual critique and improvement of argument through synthesis. This argument sheds light on the complexity of medical pluralism in the case of Morocco and explains it as much more than merely a few options regarding medicinal care and practice. With this holistic

⁴⁵ Tarek. Personal interview. 02 May 20011.

synthesis, an application is more readily available and realized in medical practice and international health and development organizations.

A successful fusion of anthropological, political-economic, as well as religious frameworks will result in a more culturally appropriate complementary health care system and a progression toward better alleviation of social inequities. Clinical practice in multicultural environments, as exhibited by Morocco, will be improved by adopting proper cultural perspectives and integrating cultural knowledge into the seemingly naturalized and solely scientific practice of medicine. Much more theoretical work is necessary in order to further facilitate a social and postcolonial interpretation of medical pluralism.

Illness has plagued humankind since time-immemorial. Differing explanations, while exhibiting very similar epistemological explanations of illness – using basic metaphors of disruption and intrusion as portrayed in the biomedical pathogen and the Islamic *jinn* – are dynamic responses to the fluid experience of health. Medical doctors are becoming more and more willing to refer patients to practitioners of a wide variety of medicinal practices for states of illness that they are unable to diagnose or provide effective treatment. Complementary medicine is beginning to flourish in many regions of the world as people become more willing to try these fashions of promoting health holistically, with social awareness and metaphysical understandings of intersecting factors at play when illness and well-being are concerned.

This is not to say that this research is complete. As with all descriptive and analytic studies the search for answers surfaces more innovative and profounder questions. While it is clear that the medical discourse in Morocco and the prevalence of medical pluralism reflects political, economic, social and ideological relations what will the future hold? As the medical

and health discourse in Morocco is focused on the distribution and legitimacy of biomedicine what other factors besides cultural and religious attributes are affecting people's choices in continuing to pursue other options such as *attar* and *fqih*? How are these practices sustained despite relentless campaigns to discredit and marginalize them? How will medicine as a metaphor change over time and how will it continue to reflect of social realities and political-economic disparities? Practices surrounding the *attar* at work in the spice markets, custodians relaying *baraka* from enshrined saints, and *fqih* performing physical and spiritual healings with the power of the Qur'an will always carry their relative cultural and spiritual meanings. The Moroccan public, regardless of region, is constantly developing more chances for cultural and informational exchange and gaining access to a greater amount of resources. Perhaps assuming certain infrastructural improvements concerning access to, and the ability to afford, all medicinal services in the country practitioners of various medical traditions will find themselves diminished simply because of the wide range of choices available. It is extremely interesting to postulate how medical pluralism, as exhibited in the country of Morocco, will manifest itself in the years to come after even more cultural pluralism and economic and political responses to globalization and further cultural pluralism and influx.

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