

MODERN AND TRADITIONAL
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Convenience, Cost and Courtesy: Factors Influencing Health Care Choices in Rural Morocco

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CHAPTER 5

Data is presented on health care options for people in a town of about twelve thousand in north central Morocco. Several cases of how traditional or modern options were chosen are described, and the reasons for these choices are compared to those for American populations. It is suggested that, in spite of the diverse cultural settings, similar factors are involved.

Factors Influencing Choice: The U.S.

IN MOST PARTS OF THE DEVELOPING WORLD, BOTH TRADITIONAL and modern types of health care are available. An understanding of what each of these options involves and what leads to the choice of one over the other is essential for those concerned with health care delivery. Much of the research on factors influencing health care delivery however has been done in the United States and other western countries. That research suggests that specific factors, such as convenience,

cost and courtesy influence the choice between modern and traditional health care, or lead to the underutilization of modern health facilities.

In the United States, Hines (1972) found that some American blacks will first consult local healers and paraprofessionals, and only approach the official health care system when these fail. In a study of black folk healers in Chicago, Snow (1978) points out that these healers have many positive characteristics: they treat the patient as a whole instead of focusing on isolated symptoms, charge less than M.D.s, and are more locally available to the poor. These traditional healers, like the Mexican-American *curanderos* studied by Monstafa and Weiss (1968), combine the natural and the supernatural in their diagnoses and treatments.

Like in third world countries, there is also underutilization of modern medical care facilities by the poor in the U.S.A. Dutton (1978, 1979) found three reasons for low use of such modern health facilities. In her study of poor families in Washington D.C., she hypothesized that these families used less medical care than they actually needed because of (1) cultural values, in which they less readily defined themselves as ill or had less faith in medical treatment, (2) insufficient financial coverage, and/or (3) a systems barrier. The latter means it is difficult for poor patients to locate and travel to the service they need, and that on arrival they may find it impersonal and feel uncomfortable. She concluded that this last factor is the most important. The first factor has some weight, but Medicaid has made the financial aspect relatively unimportant. Struss echoes her feelings: "The poor, with their meager experience in organizational life, their insecurity in the middle class world, and their dependence on personal contacts, are especially vulnerable to [this] impersonalization" (1970:14). Dutton's findings, based mainly on blacks, were duplicated in a study of whites in Michigan (Rundall and Wheeler, 1979), in which they found the same three factors having the same orders of importance. These explanations will be evaluated in the Moroccan context.

Factors Influencing Choice: The Moroccan Case

Background

Described are health care choices made by people in a town of about twelve thousand in north central Morocco. Morocco shows the influence of African, European and Arab culture, with the latter dominant. The town of Zawiya (a pseudonym) is situated on a rich agricultural plain and enjoys a California climate, with hot dry summers and cool winters. The people are Muslims, and nearly all have Arabic as their native tongue. Zawiya is an excellent site to examine health care practices because of its intermediate position: it is neither an isolated rural community, nor is it fully urban. Many third world people live in such settings; they have access to modern medical care, but are still close to their own traditions. This is certainly true for Zawiya, where people's choices include a dispensary in town, a hospital in Kabur (the nearby market town of about forty-five thousand), or various traditional healers who live nearby.

The data was collected by the participant observation method. Although local doctors, nurses and midwives were interviewed, the information presented here comes primarily from contact with the townspeople during the authors five year stay in that area, observing their experiences with both modern and traditional medicine. It became apparent that both economic and sociological factors made access to modern medicine difficult for the people, so that they usually tried the traditional cures, ("Muslim medicine") first.

Local Health Care Facilities: Modern

Morocco built a modern health system during the period of French colonization (1912-1956), and has maintained it as the official system after Independence (Paul, 1975). There are two small medical dispensaries located right in Zawiya. One is government-operated and staffed by two male nurses, who provide limited care for minor injuries like cuts and adminis-

ister injections prescribed and purchased in the larger town. They also serve as a referral agency, sending people with more serious problems to the hospital or a dispensary in town. The other local dispensary is operated by the Red Crescent (the Muslim Red Cross). It is staffed by one male nurse who gives injections purchased elsewhere; he may also provide advice on health questions. Thus in an emergency, local people can easily walk to a dispensary (the town is quite compact) and get the advice of trained nurses. In addition, a program begun locally in 1985 sends three paramedics door-to-door to give advice on child health and birth control; they give the pill to those who desire it and have been screened.

The larger town of Kabur, only two kilometers away, provides a much wider range of medical services. The main facility used by local people is the government hospital, offering both inpatient and outpatient care. There are a head doctor and two or three interns, several nurses, and three midwives. The town also has two large government-run dispensaries, operated by nurses, which treat less serious cases than the hospital. They dispense a variety of medications on doctor's orders, including birth control pills, and hold mother-infant nutrition classes. All these services are provided by the government at a minimal charge, or free if one has a certification of poverty from a local official.

For those able and willing to pay more, the larger town also has several private sources of health care. There are about four private doctors, mainly in general practice, but one is a cardiologist and another a gynecologist. There are several dentists who mostly do extractions and make false teeth, but some also fill cavities. Finally, there are several pharmacies selling a wide variety of drugs, many without prescription. This sometimes leads people to avoid the expense of a visit to a private doctor or the wait at the government hospital, and go directly to the pharmacist for treatment. For example, the pharmacist may give a man with an infected cut a penicillin shot and tell him to return in two days if it is not better.

Finally, for serious illness, cases needing surgery, or acci-

dents, people may be sent to the provincial hospital about sixty miles away, or may seek private care in the capital. Some towns even had acupuncture available from visiting Chinese practitioners.

Local Health Care Facilities: Traditional

In contrast to the modern facilities, almost all the varieties of traditional care are available in Zawiyā. If someone is not cured by the local person they consult, they may go to someone in another town who they have heard is especially effective, but s/he will be the same type of practitioner. There are many midwives in Zawiyā, who assist at routine deliveries and sometimes know cures for sick babies and children. Most women practice folk medicine, in which they know herbal treatments for minor family illnesses. Other practitioners go beyond physical treatment and add a supernatural aspect. Sorcerers and sorceresses may treat infertility with herbal or chemical means, or may use written or spoken spells or prescribed actions to cure the condition. The *fqi* or religious teacher is often consulted to cure sick children with an amulet. A *fqi* may also treat an adult with a regimen of special diet, prayer, and isolation from others.

Moroccan Islam varies in many areas, in that local saints are considered to have healing powers. Sidi (Saint) Qasim founded Zawiyā over 300 years ago. His descendants are known for their ability to treat specific maladies. For example, their saliva is thought to be good to cure sores. They also set broken bones, make small cuts to bleed people, or use a hot iron for cautery. In addition to consulting descendants of saints as curers, traditional medical help may be sought by visiting the tomb of a deceased saint or a shrine where a holy person once sat.

With this range of choices, several reasons lead people to start with traditional care. First, it is available right in town, even though the larger town is close because convenience is important. Second, it is usually less expensive. For example, childbirth in the hospital cost about \$25 in 1982, while one

could give a town midwife a 'gift' of about \$5. A visit to the *fgi* with a sick child may cost \$0.30, while it costs \$0.20 to ride to the town pharmacy, and \$1-\$6 for a prescription. A final reason that people use traditional care first is that the practitioners are their neighbors and they know they will be received graciously; this is less clear when dealing with strangers in town. However, people may use both traditional and modern treatment, often simultaneously, if they feel it will benefit them. The following cases provide examples of the factors involved in health care choices.

Health Care Choices: Childbirth

Traditional childbirth always involves one of the several local midwives. A woman usually uses the same one for all her children, who later treat the midwife almost as a relative in terms of affection, and also may send her small remembrances on holidays. Here we will describe Dunya (only pseudonyms will be used) to show the training and duties of a midwife.

While some midwives learn this skill from their mothers, others do not, and Dunya is one of the latter. Once as a young woman she was returning from the outdoor market and heard a moan from the brush. She found a woman giving birth and helped her, cutting the cord with a piece of stone or wood; she had no other tool with her. After that, she began to help other village women with births, and recently the portly grandmother delivered her hundredth baby.

When Dunya delivers a baby, she is usually assisted by the mother or sister of the pregnant woman. The helper supports the woman, who is seated on a low stool or cushion, from behind, and Dunya sits in front to receive the baby. After the baby is born, she cleans it, cuts the cord with a razor, and ties it with a thread. Some midwives feel that the bones are "loosened" by childbirth, and have the new mother lie on her side while they sit on her, working from feet to head, pushing the bones "back together".

The traditional midwife is highly valued in Moroccan society; her skills are essential and frequently used. We see the

respect accorded her in the fact that when Dunya delivered her one hundredth baby she was said to have "made the *Hajj*". This refers to the pilgrimage to Mecca in Saudi Arabia and is something that all Muslims should do once in their lifetime if possible. Few local people can afford such a trip, and those that do, are highly honored. While Dunya is very poor and could never afford to go, it is felt that she has gained the same amount of respect in God's eyes by her one hundred deliveries.

Traditional midwives have other skills as well. Dunya diagnoses pregnancy, and also treats infertile women by "cupping" (*lanbyal*): she places a lit candle under a clay cup on various parts of the abdomen. As the candle is extinguished, it creates a vacuum and thus suction on the skin. This is felt to open certain internal passages to allow conception to occur. Another midwife supplements insufficient breast milk with mint and sugar "tea" for the newborn; she may use peppermint or thyme. She further noted that peppermint is good for a baby with stomach pain.

We also see in Dunya an example of how the traditional health care provider often goes beyond dealing with physical or medical problems. In this instance, a local man was to appear in court to have his case decided. His family asked Dunya to borrow a client's baby's first shift for them; she could do so because people trust her not to misuse the special power associated with such a garment. She obtained the shift and the man carried it in court, because it is felt that God favors people who have such a garment.

Modern childbirth in the hospital in Kabur is also usually assisted by a midwife rather than a doctor. In this case the midwife, Chazela, has had formal training in Casablanca. This is valuable because she often has to deal with more complicated deliveries, since most traditional women come to the hospital only for prolonged or especially difficult labors. Delivery in the hospital is done prone, which most women dislike but will accept. The midwife tells women to push when she sees they are ready, and she may also break the

water or use chemicals to speed up labor; traditional midwives do not usually intervene so directly. After the delivery, women do not stay long in the hospital; they prefer to be home among their families.

Health Care Choices: Childhood

Children in Morocco are highly valued, and both traditional and modern methods are used to prevent and cure their illness.

Much traditional protection of the child focuses on preventing illness caused by the evil eye. As in many Mediterranean lands, Moroccans believe people who envy a person can inadvertently harm them with a look. They also worry that compliments attract evil spirits. One can compliment a baby or child, but only after saying "Tharek Allah" (the same as the "God bless" of many Italian-Americans), which serves to protect the baby. People may further protect a child by having it wear amulets, which often contain verses of the Koran written by the local religious teacher.

There are various traditional treatments for a sick child. *Sif* may be taken to the religious teacher to get an amulet. Mothers also know herbal remedies for various illnesses, like a tea of *zatar*, a thyme-like plant, to relieve stomach cramps. Many of the traditional cures involve the supernatural, calling for a visit to a saint's tomb, or physical contact with esteemed objects.

Modern means of protection are also available through the government's free childhood immunizations. Infants born in a hospital are vaccinated against tuberculosis, and mothers are told to return soon for oral polio vaccine. However, since the majority of births are at home few children are reached in this way. Even mothers who were told to return never followed through on the polio series; perhaps the importance was not clearly explained, or it was too much of an effort to get into town at the right times. These problems were dramatically illustrated in the experience of a young woman who took her preschool niece and nephew to get their childhood immunizations.

The first step was to find out whether the injections were available free and where to get them. Amina went to one of the hospital doctors in Kabar, who told her the children needed a written slip from her. Amina requested the slip, but was told to return with the children to get it. Four days later, Amina brought the children. She got the slip and was directed to the larger town dispensary where the shots are given. En route, she met the male nurse she was to see, and he said the shots were only given on Monday and Tuesday; since it was a Friday, she had to return the next week.

Amina's third trip was about three weeks later; she had been delayed because her nephew had been ill. She went on a Tuesday, but was told to return the following Monday. On Monday morning Amina took the children to town and was told they only did shots in the afternoon. When she said she was just told "Monday" last time, the male nurse curtly remarked she must have had far in her ears; she felt angry to be embarrassed in front of the other patients.

That Monday afternoon, on their fifth trip, the children finally got their TB tests. Amina had to take them back on Wednesday to get them read, and find out whether they could receive the other four DPT shots. Her experience discouraged Amina from pursuing immunizations.

Thus although the government provides free immunizations, many obstacles stand in the way of their use. These include the cost and logistics of transportation, the need for several visits for even one injection, and the fear of how one will be dealt with in a culture that stresses dignity. Moroccan sociologist Fatima Mernissi (1978) also found the latter problem, noting Moroccan paramedics often spoke French or literary Arabic to their uneducated female clients to stress the difference in their social classes.

Sick children seldom receive modern medical care from a doctor unless they are seriously ill or injured. Since no doctors have offices in the smaller town, a visit is inconvenient, but the main factor is the cost. Even with the free medical advice available at the hospital, a child ill enough to be taken will nearly always require medication, some of which may

have to be bought. With a private doctor, there is in addition the fee of at least \$5. It is common for a doctor to prescribe \$15 to \$40 of medication for a patient (child or adult); many people know they cannot afford this so do not go at all. Others too shy to tell the doctor they cannot afford it all, randomly buy two of five medications and see if they work.

An example of both types of medical care for children is provided by the family in which the youngest daughter, Saida, had been plagued by itching skin for weeks; several attempts at herbal cures did not work. She was finally taken to the doctor, who diagnosed her condition as scabies and prescribed three medications. In addition, her mother was told to wash all the clothes and bedding—no mean task in a household of eight children, no washing machine, and no running water. The treatments were followed and the girl recovered fully. However, soon her brothers of 10 and 12 were complaining of itching and sores. One would assume that since the daughter had recovered so well, the family would return to the doctor. Instead, the boys were taken to a nearby saint's tomb beside a sulphurous spring, said to be good for skin problems. Although they bathed in this, the itching persisted. Both the expense of the visit and medication and the inconvenience of washing all the linens led the family to choose the traditional course.

The circumcision of all male children, usually between the ages of three and seven, provides a recurring need for health care. Townspeople can have the operation done in the traditional way by a barber-surgeon in their homes, or take the child to the Kabar dispensary for a nurse to cut the foreskin under sterile conditions. Although the modern method is available nearby, few take advantage of this—why? Again, both price and convenience are involved, especially the latter. The traditional operation is done near or in the boy's home, after which he lies down immediately. Since almost none of the local households own cars, the boy would have to walk or be carried the 2-4 kilometers home from the hospital, or his family would have to rent a taxi. Further, a hospital circumcision may cost approximately \$15-\$20, while at home it would

be about \$5. For both these reasons, local circumcisions are usually of the traditional kind.

Health Care Choices: Adult Women

We will use birth control as the one example space permits of adult health care because it is useful in demonstrating problems found in other cases. Further, birth control involves the largest number of people with modern health care. Although few rural women attempt to limit births before having three or four children, then nearly all try either traditional or modern birth control.

There are many traditional ways of preventing unwanted births, suggesting this as a longstanding area of concern. One method is used at a wedding, and involves inverting and hiding the bowl in which the cosmetic *henna* was mixed. People believe that the bride will not conceive for as many years as the number of days during which she does not see the bowl. Another traditional method involves a woman's friend getting bread from the home of a third woman, who lives in a different area and is unknown to the first woman. The latter takes a few bites of the bread, then puts it where she won't see it until she wants to become pregnant; then she takes it out and eats a bit more.

It is interesting that these, and several other traditional methods, involve the woman not seeing the materials involved. This may suggest an ambivalence on women's part about limiting births in a culture where children are much wanted, and in which their labor is a great help to the family and traditionally cost little. If there is this ambivalence about birth control in the traditional realm, it may also help us understand some of the problems we find in acceptance and usage of modern methods.

Traditional forms of abortion also exist. One involves the plentiful and poisonous oleander plant, and another requires the pregnant woman to ingest a mixture containing sulfur. In contrast to traditional birth control, many abortions use herbal or chemical agents and may be quite dangerous.

Modern forms of birth control have been available in small-

town Morocco only since the late 1960s. The author saw a dramatic increase in women's knowledge of them in only three years. In 1967, women wondered if birth control pills really existed. By 1970, with no public information campaigns, women knew of both pills and IUDs (intrauterine devices) as ways to prevent pregnancy, that they preferred the pills, and that if they missed days on the pill, they were likely to become pregnant. This demonstrated women's ability to pursue and absorb knowledge that mattered to them personally.

There are several modern options available to the local woman who wants to limit births. She can go to the hospital to be examined, and they may have an IUD inserted, or be given a slip for free birth control pills at the larger dispensary; she must pick them up every month during her period. Few women want the IUD, whether well-founded or not, they have heard too many stories of problems with them. Another source of pills for wealthier women is the pharmacy, where they can be purchased without a prescription for about \$1.20 per cycle. A third source of pills is the Moroccan Organization for Family Planning, a private group which sends a van to Zawiya every three months. Until March 1982 they distributed pills free of charge, reaching many women who could not afford pills or get into town. However, needing funds for operating expenses, they now sell pills at the low cost of about \$0.35 per cycle. Unfortunately, a woman must purchase three cycles at once, and for many \$1.05 is too much. Many women expressed interest in another method they had heard about: an injection which lasts one or six months. These are sometimes imported from Spain, but the Moroccan government has not yet approved their safety. The fact they do not need to be taken daily nor purchased often is probably the basis of their appeal. Finally, although technically illegal, abortions by doctors are available and used by women who can afford the price of \$100-\$200.

Two examples of users of modern birth control will help the reader to understand the attitudes and the problems involved. The first was a woman in her thirties, married to a widower

and raising his three children as well as the three she bore him in five years; at this point she decided to use modern birth control. She bought one brand of pills at the pharmacy (several are available), but found they made her dizzy and also "weakened" her heart. She then requested free pills at the dispensary, switching brands, a reasonable move because pills vary widely in the amount of hormone contained. Unfortunately, she had the same problems and thus went to a heart specialist, who advised her to stop the pills or endanger her health. She now has another child.

Another case was that of Mina, who had used the pill successfully for five years, ever since her fifth child's birth. She had no side effects to motivate her to stop. Yet when a neighbor said she need not take pills daily, but only after she had slept with her husband, she did so . . . and soon became pregnant (as did the neighbor). Mina wanted an abortion, her husband was older with little income and she also dreaded the extra work. However, her mother was opposed to an abortion. She felt it was killing a soul (although that is not a universally-held tenant in Islam), and stated the common belief that "each child that's born will be provided for." While Mina grumbled, in the end she had the child.

Implications for Health Care Planners

The above examples concerning birth control illustrate many general aspects of the uses of and problems with traditional and modern health care in Morocco. As with much of modern medicine, people eagerly try modern methods, but their full scale adoption is inhibited by various problems. A major barrier is whether people have easy access to the new methods. Access may be limited by even a minimal cost if the people are poor. Another limitation is the need to travel even a short distance for treatment; many women found monthly visits to get free pills hard to arrange. Others reported difficulty getting the pills once at the dispensary because of supply or staff problems. (It is hoped the VIDNIS program described

in note I will overcome these cost and access problems.) With such difficulties, people often turn to traditional methods. Further, the patient's own state may limit her use of modern birth control. The first woman felt her health was impaired and stopped the pills. The second woman's problem was atitudinal; while she was ambivalent about having another child, she could not overcome a family member's objections to an abortion.

The local use of birth control also allows us to perceive interactions between traditional and modern methods of treatment. Traditional birth control often forbids women seeing the "active ingredient", perhaps indicating ambivalence about the matter. This helps practitioners understand why local women say they would prefer long-term injections to daily pills.

In spite of wide cultural differences, we find several of the factors which determine how some Americans seek medical care are also relevant for many traditional Moroccans. The Moroccan data support Cockerham's statements that "The effects of time, energy, effort and distance have . . . been found as significant barriers to physician utilization . . ." (1982:90), and that ". . . the social organization of services is another factor highly related to help-seeking behavior" (1982:100). These refer to what Dutton (1978, 1979) called the systems barrier, which she and others have found inhibit the use of medical services by some Americans. Dutton's other two explanations for low usage are also relevant in this Moroccan setting; cultural views of illness may lead people to a traditional healer first, and the higher cost of modern treatment excludes many potential users. The financial aspect is more important in Zawiyā than in America; in both cases there is governmental aid, but the systems barrier makes it more difficult to obtain for most Moroccans. These conclusions underline the importance of both an awareness of traditional health care practices and a user's view of how modern health facilities operate in understanding why people seek or do not seek a certain type of help.

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