Pill, Plant or Pray?

Siwan Berbers’ experiences of illness, relief and cure

Stephanie Eriksson
Maria Johansson
Abstract
This study is a part of the Minor Field Study Programme funded by the Swedish International Development Cooperation Agency (Sida). The study was carried out during the spring of 2008 in the oasis of Siwa. Siwa is situated in the western desert of Egypt. The authors had been informed about the health care resources available and that people only to some extent used those. The study has a qualitative approach and the essay is based on the experiences of seven respondents. The aim of the study is to describe Siwan Berbers’ experiences of illness, cure and relief.

Semi structural interviews were conducted and the data was analysed through a qualitative content analysis. The result was compiled into three themes which further were divided into sub themes. The themes were: “the idea of illness”, “explanation models to illness” and “relief and cure”. The result shows that the views on causes to illness affect the actual choice of cure and relief chosen. Furthermore, financial aspects are considered and it is also essential to feel confidence to the caregiver in order to achieve cure and relief.

The result is discussed in relation to the background and relevant literature concerning cultural and developing issues. This Minor Field Study is important since it enlightens some of the factors a person takes into consideration when he or she selects alternatives for cure and relief during the illness experience.

Keywords: illness, cure, relief, traditional medicine, western medicine, Siwa
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Introduction

Ill health is something everyone experiences independent of culture, belief or gender. As a professional nurse, one will meet people with different customs, religions and ideas. In order to obtain a caring relation, the nurse must respect the patient for who he or she is. It is essential for all persons, trained or not, to have knowledge about different cultures and how these influence people’s beliefs. This Minor Field Study enlightens the cultural aspects of illness and you as a reader will hopefully develop an interest for health care issues in developing countries.

We have had the opportunity to participate in the Minor Field Study Programme (MFS). The programme enables students to write their Bachelor thesis in a developing country. It is funded by the Swedish Agency for International Developing Cooperation (Sida). The aim of the programme is to give Swedish students an opportunity to learn more about developing countries and development issues. The Minor Field Study should be related to the international development process. It should also enlighten aspects which are of relevance to for instance the social, political or economical developments in the country where the study is carried out. Another criterion is that the essay should be interdisciplinary.

Christina Rinaldo, a lector at the Faculty of Textile at the University College of Borås had contacted the Faculty of Nursing Science were we study with the intention to establish a cooperation between the faculty and the Oasis of Siwa in Egypt. She described the health care situation in Siwa to be problematic. Even though there were health care facilities available, the Siwan people did not attend these for medical help or advice. With this information, we applied for a Minor Field Study scholarship. This essay is the result of the eight weeks long field work. We wish to enlighten some of the health care issues in a developing country with the focus on Siwan Berbers’ experiences of illness, relief and cure.

Background

Egypt

The Organisation for Economic Cooperation and Development (OECD) and the Development Assistance Committee (DAC) (2007) define Egypt as a lower middle income country and therefore a developing country. Egypt is situated in the north eastern part of Africa and the country is estimated to have the largest population in the Middle East. The Egyptian population consists of approximately 77 million people, and 99% of the population are Arabs, Berbers and Bedouins. Nearly 60% of the population lives in rural areas (WHO, 2006). The official language is Arabic, and 94% of the population are Muslims (Landguiden, 2008). Islam is the second largest religion in the world in numbers of believers. The Koran is the Holy Script and Mohammed is the most essential prophet. Islam is a religion based on monotheism where Allah is the sole creator, sustainer and restorer of the world (Encyclopedia Britannica, 2008).

The Egyptian population is young, nearly 40% percent is 15 years or younger, and only a few percent
people are over 65 years old (Landguiden, 2008). The escalating population increases the inability to create work for everyone and this is an extensive problem for the Egyptian government. (WHO, 2006). The governmental goal in order to settle the population growth is that in 2010, 70% of the Egyptian families should use contraceptives. In year 2000, 56% of the women in child bearing age used some kind of contraceptive. Every third Egyptian is estimated not being able to buy the most essential items, and the great urbanisation has also an influence upon the social conditions (Landguiden, 2008). The national currency is Egyptian Pound (£P) and in the time of writing, 1 £P equals 1,20 SEK. The economic growth in Egypt is poor and the economy relies mainly on tourism, revenues from the Suez Canal, trading with oil and incomes from Egyptians working abroad (WHO, 2006). One of the major socio-economical challenges facing Egypt is the educational aspect. 45% percent of the adult population are illiterate (WHO, 2006).

**Egyptian health and health care**

Egypt ratified the United Nation’s declaration of human rights in 1945 and it also means that article number 25 is ratified. It states that:

> “Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.”

The Egyptian constitution states that health care should be available for every individual but the health care conditions in Egypt are comparatively poor compared to other low-middle-income countries (Rannan-Eliya, Vidal-Blanco & Nandakumar, 2000). According to WHO (2006), the country is a low health care spender in comparison to other countries with similar conditions in the region. Nevertheless, Egypt has made essential progress in the establishment of an extensive network of health facilities and basic health services are provided for almost the entire population. Mortality rates and the population growth have during the last years been reduced. The major provider of health care is the Ministry of Health and Population (MOHP). MOHP has a nationwide system of health care services with outpatient clinics and large urban hospitals where both inpatient and outpatient care is available. These services are administered on a decentralised basis and most of these services are run by the 27 Egyptian governorates (Rannan-Eliya et al. 2000). The health care system is pluralistic and divided into several care providers and financing agents. It is financed through a general government budget, social insurance contributions and by the people themselves (WHO, 2006). According to Rannan-Eliya et al. (2000) the services provided by the MOHP are subsidized and they are said to provide the entire population with health services. The facilities at the governmental hospitals are though scarce and the available resources are described to be used in an inefficient way. Consequently, the public confidence is incomplete and more and more people turn to private care givers. The private sector is growing and it is poorly regulated. When a private alternative is chosen, the Egyptians need to pay for all treatments by themselves. This is not an option for the majority of the population since it is presumes an extensive amount of money (WHO, 2006).

Poor health is in developing countries often related to low incomes and poverty. These circumstances affect the quality of water, food, clothes, sanitation and medical care people are able to afford. The social inequalities and the economical factors are some of the most vital causes to ill health within a population. Poverty is a major contributing factor which results in
poor nutrition, low educational levels and overcrowded living conditions (Helman, 2007). WHO (2006) estimates that 100% of the urban population and 94% of the rural population in Egypt has access to improved and safe drinking water even though there are logistic problems.

Certain life style factors contribute to a significant proportion of the overall mortality and morbidity rates in Egypt. Smoking, substance abuse, non use of seat belts in cars and non observance of traffic rules are some examples of these life styles factors. The body disabilities and the shortened life time for people exposed to these factors have developed into health problem. Most common diseases are cardiovascular, digestive and chronic respiratory diseases. Mental ill health is also common even though it is not prioritised in the health facilities or in the financial budget. Most of the services for mental ill health are allocated to a few hospitals in larger cities (WHO, 2006).

The oasis of Siwa and its people

Siwa is an oasis located in the desert, 300 kilometres south of the Egyptian coastline. It has approximately 25 000 inhabitants and they provide their living mainly on agriculture. There are many gardens around Siwa where people cultivate plants such as olives, dates, fruits and vegetables. Tourism is another important source of income and it becomes more and more essential for the Siwan population (Aldumairy, 2005). However, some people are afraid the tourism will demolish the traditional ways of the Siwan living.

There are two ethnic groups living in Siwa, Berbers and Bedouins. The majority are Berbers. The Siwan population speaks a local language and it differs a lot from the Egyptian Arabic. The language is called Siwi and it is originally a Berber language. Most Siwans speak Arabic as a second language but Egyptians do not comprehend Siwi (Malim, 2001).

The Siwan woman spends most of her days at home, cleaning, cooking and caring for the children. When she leaves the home, it is custom for her to wear the traditional tarfott, an outfit that totally covers her so no one will recognise her in the streets. She is not allowed to show herself to men other than her husband and her closest relatives. Girls wear veils before the marriage and thereafter she needs to be completely covered. The marriages are arranged and Siwan girls usually get engaged at the age of seven or eight. The marriages commonly occur when the girl has finished high school at the age of 17. Men are normally a few years older. Potential spouses are decided by the parents however the youth are also involved in the process. The Siwan men work outside the home and they are financially responsible for the families. Siwan men usually base their income on the cultivation of plants in the gardens or the work with tourism (Malim, 2007).

The need for education has become more important the last decades. All children have the right to go to school; nevertheless, not everyone is able to. Some families can not afford the expenses the elementary school brings and others believe that girls do not need education. Nonetheless, the majority of the youth finish high school. Higher education is reserved for those with money and the education takes place in larger cities like Alexandria or Cairo. This is not an option for younger women since they are expected to marry, have children and take care of the family from early age. Therefore, education is not regarded as necessary for a woman since she will not be able to work outside the home anyway (Malim 2001).

Siwan folklore

Magic has still a notable impact on the beliefs and values of the Siwan people. According to Malim (2001) and personal contacts (2008), Siwans believe in black magic and the evil eye
and these phenomena are said to be connected to Satan. Black magic is in Siwa associated with an evil spell, cast on someone with the purpose to cause illness or divorce. A spirit known as jinn is also said to be prevalent in the society of Siwa and it is commonly known in the Islamic world. According to Helman (2007) this spirit possesses the body and it can cause several different symptoms for the victim. The jinn can only disappear if someone expels it from the body and only then one can regain health. The phenomenon evil eye is known in many communities where Islam, Judaism, and Christianity are practised and it is also known in the society of Siwa. It is believed that certain individuals are born with the ability to look into someone’s eyes with the outcome that the person gets bad luck or illness (Malim, 2001). The evil eye as a cause to illness has been reported throughout many parts of the world; Europe, the Middle East and North Africa. The belief in the evil eye has existed in most cultures all over the world and it still remains in certain parts of these areas (Helman, 2007).

Siwan health care
The Siwans have different alternatives of medical support to choose from. Established alternatives both in the western and the traditional medicine exist.

Western medicine
Western medicine is a wide term and it is not a single entity. It has been changed over time; however the term is generally accepted and used all around the world. Modern western medicine is the legally and culturally dominating form of medicine nowadays. The criticism the western medicine often receives is that it attempts to treat the symptoms of the disease rather than heal the whole person (Loudon, 1997).

There are some options available for the Siwans and the major health care unit is the general hospital which is accessible for the entire population. Women and children are considered to be its most frequent visitors. The most common reasons to why people visit the hospital are eye or kidney problems. Skin problems caused by the sun and gynaecological problems among women are also frequently occurring. The facilities available at the hospital are among others renal dialysis and radiological equipment. If someone arrives to the hospital in an acute state, only first aid can be provided. Thereafter the person will be transported with ambulance to the general hospital in Marsa Matruh, 300 kilometres away. There are eleven doctors working at the general hospital in Siwa, six with different special competence and five general doctors. The special competence of the doctors lies within the field of medicine, surgery and gynaecology. One dentist and 13 nurses also work at the hospital. Almost everyone comes from places outside of Siwa, for instance Marsa Matruh, Alexandria or the upper Delta. In order to improve the health care facilities in rural areas, the MOHP orders a delegation with doctors to visit Siwa once a month. The delegation consists of approximately 30 doctors with different specialities and they travel from larger cities in Egypt. The delegation provides examinations, advice, surgeries and medicine for the locals during their five days of work. The care is given at the hospital and at mobile clinics formed around the available ambulances. Approximately 3000 patients are estimated to arrive to the hospital during the time when the delegation is in Siwa and 50-60 operations are carried out every month. The MOHP also tries to improve the health care in rural areas by contracting doctors working for a year in these locations.

Another health care facility is a military run hospital for women and children. The army also offers an outpatient clinic which is said to offer care for all civilians. However, these facilities do not work properly and many Siwan people do not know of their existence. There are also few private clinics which are run by doctors who work at the hospital but these are only open in the evenings. (Personal contact, 2008)
Traditional medicine

Approximately 80% of the African population uses some form of traditional medicine for primary health care. According to WHO, “traditional medicine refers to health practices, approaches, knowledge and beliefs incorporating plant, animal and mineral based medicines, spiritual therapies, manual techniques and exercises, applied singularly or in combination to treat, diagnose and prevent illnesses or maintain well-being.” (WHO, 2003).

The Siwans have through generations been depending on traditional ways of healing. The knowledge has been passed on to following generations within the families who had the special skills. There are still traditional alternatives existing today. The use of different herbals and the knowledge of its benefits is basic knowledge. Some medical plants are used for the well being in general and some have specific purposes to cure. There are several different healers in Siwa who have certain skills that can give cure and relief to specific complaints. These medicine men and women are said to have the skill to cure broken bones, remove blood clots (adegy) and withdraw blood from the head to treat sleeping disorders or headaches (higama). There are also traditional midwives who can give assistance during deliveries. When someone is ill from black magic or the evil eye, there is a man in Siwa who has the skills to cure. He is called “El Sheik”. He cures people with his knowledge of the Koran, in the name of Allah and without charges. Different rituals are performed by the sheik and verses are read in order to give relief to suffering people (Malim, 2001).

Gender

Gender is a term used in the social sciences. It is used to distinguish and understand ideas and actions which form social gender roles among humans. The term is used to describe the social process which for instance gives collective skills to men and women (Nationalencyklopedin, 2008).

Central aspects of nursing science

Defining suffering

One of the most essential assignments a nurse in her profession has is to give relief to a patient who suffers. The term is therefore important in the nursing science. The suffering is not only about visible symptoms. It is also an inner process in the unique individual. Suffering can be described as a kind of threat, violation or loss of identity and loss of self control. This can lead to feelings of shame within the person and the suffering is often hard to express and share with others. Hence, the caregiver needs to help the patient to “deliver” the suffering (Eriksson 1994).

Eriksson (1993 pg.182) describes three different types of suffering; “suffering of illness”, “suffering of caring” and “suffering of life”.

Suffering of illness

The symptoms and complications which follow a disease or illness can cause a suffering of illness (Eriksson, 1994). Symptoms like pain in the chest and the experience of not being able to function as before after a heart attack could for instance cause a suffering of illness (Wiklund, 2001).

Suffering of caring

This type of suffering is due to the treatment or care the patient is subjected to, or the insufficiency in any of these. It can also be due to wrong treatment. One central aspect in the
suffering of caring is that the patient experiences violation of dignity and lack of control. Not being treated with respect, not being listened to or taken seriously when wishing to share the experiences of illness is a huge violation to the identity of a human. Another dimension in suffering of caring is when surgeries or treatments are cancelled or delayed. This can be experienced as if one is not valuable as a person (Eriksson, 1994).

Suffering of life
Eriksson (1994) means that a patient could experience suffering of life when he or she is ill and the illness devastates and takes away the daily life. The suffering of life is related to the existence of the human and can therefore be seen as a threat to one’s whole being.

Defining caring relation
The relation between the care giver and the patient is an essential part of the caring process. It is when this relationship has been established, the patient will feel confident enough to express his or her problems and thoughts. (Eriksson, 2004) The caring relation should protect the dignity of the patient. The caring relation is always asymmetric. The care giver has in his or her profession more knowledge and therefore more power. It is important for the caregiver to use this power to support the health resources of the patient (Wiklund, 2001).

Formulation of issue

“Everyone has the right to a standard of living adequate for the health and wellbeing of himself or his family including (…) medical care and necessary social services…”

Egypt has ratified the United Nation’s declaration of human rights and the Egyptian constitution states that public health care should be available for all individuals. Even though the health care facilities in Egypt have improved over the last years, a great lack of trust to the public caregivers has developed. It is described that the oasis of Siwa has similar problems. Health care facilities are available nevertheless many people do not attend these for medical advice or consultation. There is no research made about the circumstances in Siwa, however it is essential to enlighten these factors in order to understand what a person takes into consideration when he or she makes the choice whether to visit a health care facility or not. This study attempts to describe how the view on illness affects the type of care the individual would consider for relief and cure.

Aim

The aim of the study is to describe Siwan Berbers’ experiences of illness, relief and cure.

Method

The qualitative research approach enables the researcher to understand the world from the respondents’ point of view. This method further allows her to get a deeper understanding of people’s experiences (Kvale, 1997). The study is based on empiric data and the aim of the study makes therefore a qualitative approach suitable.

How to collect data

The conversation is a basic form for communication between humans. It enables people to express their life stories. The qualitative interview is a unique method to apprehend experiences and meanings in the respondents’ daily life. The respondents can through the interview convey their situations and their perspectives in own words (Kvale, 1997). There are different types of interview models and one is the semi structural. Bell (2000) is of the opinion that the benefit of using a semi structural model is that the respondents are given more freedom to speak about what they find important within the area enlightened. The technique to use the semi structural model gives the researcher the opportunity to have something in between focused and open ended questions. The questions are normally specified within a topic, however the interviewer is free to ask further questions (May, 1997). It is important to establish a confident relationship with the respondent when an interview is carried out so that he or she will feel safe enough to share opinions and thoughts. The interviewer should introduce herself properly; describe the aim of the study and the rights the participant has to be anonymous (Lantz, 2007). Using a tape recorder is the most common way to register the interview. It enables the interviewer to concentrate more on the dialogue and how the respondent describes something rather than on the precise words expressed (Kvale, 1997). However, it is important to remember that many people find it uncomfortable or at least a bit unpleasant to know that their voices are recorded. Some people feel a need to express their ideas wisely and this can restrain their expressions. The participants in a study are also aware of what they say will be used and analysed later on. This is important to remember in the analysis of the collected data. The respondent can choose to focus on some aspects whereas other aspects of the same topic are ignored (Kaijser & Öhlander, 1999). Another factor that could affect the result is where the interview is performed. It is vital to choose a place which is familiar for the respondent and where he or she feels safe (Thomsson, 2002).

This study is a Minor Field Study (MFS) and it is of empirical character. The result is based on material received from the interviews conducted; however scientific articles have been used for background information and result discussion. The articles are primarily of qualitative character in order to get a deeper understanding of the issue. The articles have been found in different data bases; SAMSÖK, Blackwell Synergy, Pub Med and Cinahl. The primary keywords used were: Egypt, developing countries, rural areas, traditional medicine and health. It was noticeable that articles based on nursing sciences were limited and it was in general hard to find research related to the aim of this study.

Selection of participants

Some inclusion criteria were defined to give the study some consistency. These were; the participants had to be over 18 years old, they should be Berbers, they should live in the town of Siwa and their families had to have lived in Siwa for at least four generations.

The participants in the study were selected in two ways. The supervisor in field helped to establish contacts with three of the seven respondents. Four of the interviews were conducted with persons the authors became acquaintance with during the stay in Siwa. Three women and four men were in total interviewed. The male respondents were chosen due to their different levels of education and income in order to seize the perspectives different social classes can give. The women in the study were all in some ways related to the men participating. The average age of the participants was 44 years, with a range of 19 to 80 years. All men except one worked with tourism and all spoke English. All the women were house wives and they did not speak English.
Collection of data

The interview questions were prepared in advance before the arrival to Siwa. However, to be sure about that the respondents would understand the questions and that they would not be offended by them, a pilot interview was performed. The pilot interview was conducted with the supervisor in field. His opinions and advice created changes of some questions so they would be better adjusted to the circumstances in Siwa. Both authors participated during all interviews. When one had the role as interviewer the other one took notes and observed the body language of the respondent. These roles would then be changed during the next interview. The interviews took place in the home or workplace of the participants. When the men were interviewed the language used was English and these interviews were tape recorded. A male relative acted as interpreter during the interviews with the women. He translated from English to Siwi and back. These interviews were not tape recorded; only notes were taken. All respondents were informed about the aim of the study, that nothing they would say would be detected to them and the material would be handled in a confidential way. They were also told that if they would find any question too personal or uncomfortable to answer they were not obliged to. When an interpreter was used, he was informed that his assignment was to translate the questions and the answers as precisely as possible, without the influence of his own thoughts and opinions. Each respondent was asked six questions concerning illness, relief and cure (appendix 1). Further questions were sometimes asked to clarify or expound the statement of the respondent. The duration of each interview was approximately 40 to 60 minutes. The respondent was always asked if he or she wanted to ask something or add anything to the material before the interview was concluded. They were also asked if it would be possible to contact them again if something from the interview would be unclear. The collection of empirical data was performed during three weeks and the material was transcribed directly after each interview.

The impact of a cultural setting

Several problems could occur when the researcher and the participants do not share the same culture, traditions or language. It is important for the researcher to be aware of that the pre-understandings one has may affect the result of the study. Everyone has unconscious pre-understandings and some of these are so “true” that they are not even reflected on. The researcher must be aware of that the own pre-understandings affect in order to make a study of satisfactory qualitative character. If awareness is not achieved, there is a risk that the researcher only sees aspects which one already knows or considers knowing. One way to prepare before a study is to read literature about the subject to get a better understanding of the actual conditions (Thomsson, 2002).

Interpreter

The use of an interpreter can be problematic and this is in particular a problem when no professional interpreter is available. Mikkelsen (1995) describes the importance of men and women being interviewed separately since the gender roles in the society also affect a small interview. Berterö and Kapborg (2002) mean that there always is a risk that information will get lost in the translation process. This risk increases when the interpreter is non professional. The interview is affected by cultural factors and the ultimate situation is when the researcher, the interpreter and the respondent share the same cultural settings. Twinn (1997) means, that when a second language is used, there are obvious challenges to both the reliability and the validity of the data. Berterö and Kapborg (2002) further explain that a word can have different meanings in different languages. There are also words which can not be translated into English since they either are bound to cultural settings or they do not exist in the other language.
It is according to Bonnard-Sjögren, Söderlind, Martalo and Almroth (2002) important for the interpreter to be impartial. The interpreter should never express his or her own thoughts and ideas when interpreting. He or she should restrain the body language so that the personal opinion in the matter is not revealed. The interviewer and respondent must feel confident with the interpreter throughout the whole interview in order to express their opinions fully. The authors further discuss the risk of translating for a close friend or relative and they mean that there is a risk that the interpreter does not stay impartial because of own interests. It is also essential that the interpreter concedes the confidentiality agreement which must be set between the three parts before an interview is conducted. This agreement is truly important for both the interviewer and respondent in order for them to feel that what is said during the interview will stay between the three parts. It is furthermore vital that the interpreter does not leave any information out when interpreting. Everything said should be translated.

**Data analysis**

Lundman and Hällgren Graneheim (2007) explain that a qualitative content analysis focuses on the interpretation of texts. It is mostly used within human sciences such as nursing science. When a text is interpreted, it is important that the researcher has knowledge about the conditions of living the respondents’ experience. The focus in the qualitative content analysis is to identify similarities and differences in the content of a text. The similarities and differences are then expressed in different categories. The context is essential when categories are created. The authors further emphasise that the data based on narratives requires understanding of the cultural settings and that the texts from the interviews are contextual and value bounded. Hence, a text will always contain multiple meanings and there are always some degrees of interpretation when it is approached. There are some terms used when the content analysis is carried out. These are analysis unit, content area, meaning unit, condensation, abstraction, codes, categories and themes. An analysis unit can be the written document based on the interview made. The content area is parts of the text which deal with a specific issue. The meaning unit is the part of the text which contains a meaning. It can be words, meanings or parts of the text. The meaning units are then put together due to their content and context. The meaning units are the basis of the analysis and they are condensed during the analysis. The condensation process results in a shortened text. It is thereafter more easy to handle. It is though important not to let the central aspects disappear. After this, abstraction of the text is made and this involves descriptions and interpretations on a higher level. The code is the label of the meaning unit which briefly describes its content. A category is a group of codes sharing some common features. The creation of categories features the qualitative content analysis. It is important to note that no data related to the aim of the study should be excluded due to lack of suitable categories. The theme answers the question “how” and constitutes a feature of meaning through categories on an interpreting level. A theme can be divided into sub-themes (Lundman & Hällgren Graneheim, 2004).

**Analysis of the collected data**

The material was analysed in accordance to the qualitative content analysis described above. The interviews were transcribed and reread several times. The material was divided into three different content areas appropriate for the aim of the study. Thereafter, meaning units were created out of different parts or sentences of each interview which corresponded to the content areas. These meaning units were then condensed and coded. Themes and sub-themes were created out of the codes and these are presented under the content area that corresponds to its content. The raw material was read several times to ensure that nothing had been left out or been misunderstood and all material suitable for the aim was put into a category. The quotations from the respondents used in the result were rewritten so that the English language would be understandable and correct, however the meaning of the sentence remains.
Result

The result is presented in the following pages and described in themes and sub-themes.

Table 1

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The idea of illness

The experience of being ill is complex, and how one perceived it is depending on the beliefs and values a person has. With the seven Siwan Berbers participating in the study as a frame of reference, it appeared as the respondents had different views and opinions about illness. However, some patterns could be seen. The views showed that the emphasis was put on the bodily focused pain which affected the daily life. None of the respondents mentioned psychological or psycho-somatic issues as something which was considered to as being ill.

Experiencing illness as an obstacle for daily activities

The respondents were asked what it meant for them to be ill and many mentioned pain in different parts of the body, with the focus on the organs. Stomach and kidney problems were in particular mentioned. Several respondents talked about rheumatism as a chronic disease. It was described as pain appearing in every part of the body, not only in the joints. Further questions had to be asked in order for them to discuss whether having a cold or other similar complaints could be regarded as illness.
“Ill is when you cannot think clear and you have some pain. And as for myself I sometimes feel big headache.” He also said: “You are ill when you have a cold, or you have big pain in your feet, or rheumatism or pain in the stomach.” (Interview no 1)

Experiencing strong pain was the main reason that would make the men in the study stay home from work and the women stop cooking and cleaning. When someone had a minor complaint like a cold, some male and female participants regarded this condition to be worsened by resting. They meant that it was better to be active and focus on the activities rather than the experience of illness.

“People say that when you have a cold, you do not have to stay at home. You have to work because then you do not feel that you are ill (...) but if you stay at home and sleep then the cold will stay longer, three days, one week.” (Interview no 4)

Some of the male respondents who had higher incomes meant on the other hand that it was important to stay home and rest when having a cold. The sensitivity to illness and the decision whether to stay home or not could be depending on what kind of job the person had, and if he would lose income by staying home. When someone did not have a constant salary and was depending on the items purchased, perhaps it was harder to stay at home and rest.

“Before I had my brother, but my brother is now working in another country. So now I have to close the shop if I do not feel good enough to go to work.” (Interview no 4)

Differences between genders in the expressions of illness

Some of the respondents meant that there were differences between men and women in how they expressed the experience of illness. Some of the male participants considered women to be more sensitive and easier suffering, and this should be due to the anatomy of women. Furthermore, they considered women and children to visit the hospital more often than men. Women were regarded to have a more urgent need to visit a health care unit when feeling ill.

“I think that when women fall ill, they want to go to the hospital immediately, but men do not care about going to the hospital. They can stay at home for one day or three days until everything is okay and then he can go back to work. That is the difference between men and women. We say that women have small hearts, and men have big hearts so for example, if the man has a problem with the stomach he can still go to work (...) but for women she will not be able to eat, she will cry and she wants to check with the doctor.” (Interview no 4)

An issue mentioned by one of the male respondents was that women who experienced illness sometimes had to wait several days before consulting a doctor. The reason was that women should not visit a health care unit without being accompanied by a male relative.

“(…) Women sometimes they do not go (to the hospital) because they are not able to go. This is because they have to wait for their husband or son or someone else to take them. Sometimes they (the women) get delayed one or two days until (they) get to the hospital to a doctor to see her.” (Interview no 2)
Nevertheless, none of the females mentioned this and it did not appear as if they regarded it as a problem. Some female respondents did however not agree with the male impression about that women in general should be more ill than men.

“I do not think there are any big differences between men and women when it comes to illness.” (Interview no 7)

Explanation models to illness

The result of this study shows that causes to illness were explained from the outlook on life one had. The belief in the explanation model affected the actual choice when the participants chose cure and relief. There were a few explanations to illness in Siwa, and all participants believed that a person could fall ill both from natural and supernatural causes.

Natural causes

All respondents had an idea about different natural causes that could generate complaints. They mentioned for instance poorly cooked food, unclean water and weather changes. In this issue, neither the educational level nor gender seemed to affect the knowledge about natural causes to illness. A majority of the respondents mentioned problems with the stomach as an extensive health issue in Siwa. This complaint was described to be caused by unclean water or food. Several respondents believed that stomach pains often were caused by the tap water the Siwans drank. They described that the water caused kidney problems, and they also explained that most people knew that the condition of the tap water was poor. One could see that it was cloudy. However, the bottled mineral water was too expensive for one to afford, and most people had no choice but drinking the unclean tap water. A few respondents meant that kidney and stomach problems were associated with similar complaints, and it could therefore be hard to know if the pain was related to the kidneys or the stomach.

“Stomach pain might be common in Siwa because of the water. Nowadays we drink water from the taps, see, (shows a glass of water) it is not filtered. You will have to leave the water for three days so that the dust will fall on to the bottom, then you can drink it. You will be able to see the dust at the bottom. This is dangerous for the kidneys and the stomach. But we have no choice. We are not able to drink bottled water. Too expensive...” (Interview no 1)

Stomach pains among children were described to be caused when they played outside. They would eat things which were not appropriate for them. This was also a considerable reason for many children to visit the hospital. Some respondents meant that this was a factor affecting the health of the children negatively.

“We leave our children playing in the sand and they eat the things they find. If you go to the hospital you will see ten or 15 children every day, because they have eaten something that they shouldn’t have done.” (Interview no 4)

The belief in the products produced in Siwa was extensive. Another reason to illness and stomach pains was described to be the “unnatural” food, brought from other places. Siwan food have been grown and produced in organic ways since ancient times, and some respondents believed that chemicals in the new products could cause complaints.
“Maybe some chemicals cause stomach pain. Food is now coming from outside, from Alexandria, from all over Egypt.” (Interview no 1)

Furthermore, unhealthy, sugar rich and fat food was described to be health issues, because some people the respondents knew about had got diseases such as diabetes and high blood pressure during the last years.

“Sugar and sweet things can cause diabetes and some food can make your blood pressure to go up, like fat.” (Interview no 7)

Some participants said during the interviews that they did not know what caused illness. Some also mentioned that one should not ask the doctor. The central aspect at a health care unit was not to get educated about prevention or what caused the illness, the central aspect was to get “fixed”.

“The doctor never says and you do not ask. Because you are ill and you leave your body to the doctor. He will check, you will see. And in the end he will write to you some medicine. You do not ask what medicine it is or about the problem you have. You are looking to be better (...) because you don’t know, if they explain scientifically people will never understand because farmers have no idea about anything.” (Interview no 1)

Religious and supernatural causes

Religion was a vital part of the Siwan society and the Islamic values affected what people believed in. The will of Allah was described as an obvious explanation to illness. The attitudes the respondents had towards life seemed to be that whatever happened was already predestined. One respondent expressed an idea about that diseases had their origin in the will of Allah.

“I think that sadness can cause cancer, like if you carry sadness for a very long time. But all comes from God.” (Interview no 7)

A few respondents mentioned verses in the Koran which described black magic and the evil eye. They further explained that many people in Siwa believed these phenomena to create complaints and cause illness. All respondents admitted that they to some extent believed in the evil eye and that it could cause illness. The participants with higher education had though some difficulties admitting it. They explained that the existence of the evil eye was more common before when people were more ignorant. They meant that if one did not believe in the evil eye and had knowledge about Islam; the evil eye would not harm.

“Myself, no I cannot fall ill from the evil eye. Sometimes people can fall ill of the evil eye (...) The evil eye, if you believe you will get it. If you do not believe it will not hurt you (...) I am aware enough and I have a strong personality. I know religion very well so this will not affect on me. The evil eye is mentioned in the Koran so I do not deny it totally but in Siwa they think more about it. (...) You can get any illness from the evil eye, general illness. I don’t believe very much in it, but later on I believe. Sometimes it happens.” (Interview no 2)
It was more evidently expressed among the men with lower education and the female participants that the evil eye existed and that it could cause illness.

“You can also fall ill from the evil eye (...) you can get whatever disease from the evil eye. For example, I have experienced that when someone with the evil eye looks at my basket, and if I do not read from the Koran afterwards, I will get a pain in my arm or lose sight for a while.” (Interview no 5)

Knowing the differences between when the illness was caused by natural reasons and when it came from the evil eye could be hard for an outsider to understand. The respondents meant that it was obvious and it was something one felt. There were a range of complaints which the evil eye was described to give. These could range from suddenly falling down and hurt oneself to exhaustion and fatigue. Symptoms described were feelings of being cold, loss of appetite, incapability to move, and visible body disorders such as the loss of hair. Furthermore, the person exposed to the evil eye felt sad, isolated himself and did not want to talk to others. Most of the respondents meant that these symptoms appeared slowly and this was an indicator for the illness to be caused by the evil eye.

“What will happen is that you feel cold or you feel that your body can not work and you have to relax. Your skin can change from white to yellow. If the person has beautiful long hair, the hair starts to fall down into pieces.” (Interview no 1)

Black magic was the other phenomenon the majority of the respondents believed in. It was also said to cause illness. Depending on the educational level among the respondents, there were though some contrasts in the belief in black magic. The persons with higher education believed less in it compared to the others. The respondents explained some of the symptoms to be incapability to move and work, a violent behaviour, infertility and pain that moved around. It was also described that more women than men in Siwa believed in magic forces.

“I know about some black magic. The wife of my cousin is always ill and if she is going to her husband’s house she is feeling very ill and she goes inside to the rooms, closes the door. She does not eat every day and she talks with a (possessed) voice. (...) She will have a hurting in her body and she will not know what has happened. She cannot walk, she cannot work, she cannot do many things.” (Interview no 4)

“Your arms stop to work, you hit your husband, a woman cannot get pregnant and she is angry all the time.” (Interview no 6)

**Relief and cure**

It was not always obvious to visit a health care unit when someone in Siwa is ill. The answers distinguished when the respondents were asked about what they did and where they went when they experienced illness. Various alternatives for cure and relief were mentioned, and depending on the cause to the illness, a range of methods were used. It appeared as if the respondents first tried to reveal the complaint by self medication or with advice from family or friends. If any of these did not help, methods believed to be appropriate for the certain complaint were used. Respondents who believed in western based treatments used these and traditional methods were used among those who put their trust to those elements.
Experiencing western medical relief and cure

The common apprehension among the respondents was that the Siwan health care was inadequate. It did not correspond to the needs of the population. The respondents mainly talked about the general hospital when they described the available health care. Several reasons for the consultation of a doctor appeared. It seemed as if a person mainly was brought to the hospital when something acute occurred. Problems with kidneys, teeth, eyes and big cuts were mentioned as other reasons. Differences could be seen between the respondents when it came to their opinion about drugs prescribed by doctors. The men with higher education described a pill to be preferable in need of relief or cure whereas the men with lower education and the women described it to be more desirable to use natural alternatives.

Experiencing lack of trust in the caregiver

One of the main reasons for people not visiting the hospital seemed to be the lack of confidence in the working doctors. The quality of the care given was according to some respondents to a large extent due to who was working that day. An issue described was that only a few doctors conveyed trust and were recognised to be skilled. The different doctors had various reputations and their achievements were described among people. Furthermore, several participants meant that the majority of the doctors arriving to Siwa had recently graduated from medical school. They were described to be on a “training level” and therefore failed to convey trust. A lack of confidence to the offered care was also described and several respondents felt that the doctors wrote prescriptions by guess.

“The doctors come and they are still at training. (...) They check your stomach and by imagination they choose medicine. He is not sure about exactly what it is.” (Interview no 3)

The respondents meant that people who were in need of hospital care often got transported to Marsa Matruh or Alexandria. They also meant that patients often needed to go to Marsa Matruh after a while even though they had been treated or had gotten a medical prescription. One of the respondents had a personal experience of this:

“Before I sometimes had these painful headaches (...) I wondered what it was so I went to the hospital. The doctor said that my blood pressure was very high. Then he gave me some medicine “-here”, he said, “try these tablets for three days”. They did not work so he changed them, gave me some different tablets for one week. Neither they did work and then another two. Finally I went to Alexandria. The doctor there gave me two tablets, one in the morning and one in the night. So, I spent three days there, and my blood pressure came no high with those tablets.” (Interview no 1)

Another reason for Siwans getting transported to Marsa Matruh was that the general hospital lacked doctors with specialties.

“The doctors at the hospital do not know what to do, like if you have bad ears or nose or if you break one of your fingers. For emergencies you cannot do anything here in Siwa. You have to go to Marsa Matruh. So this is our problem. We need some specialists to be at the hospital.” (Interview no 1)
An issue described by some participants was also related to the lack of trust in the caregiver. They meant that communication problems sometimes occurred when a doctor was consulted. Many Siwan women, especially the elder generation, were described not to speak or understand Arabic. They only spoke Siwi and doctors from cities outside Siwa did not comprehend this language. One of the male respondents described the problem; however none of the women mentioned it.

“My wife goes with me or my son, because most of the Siwan women can not understand Arabic very well. The doctor is talking and she can not understand, and women are very shy.” (Interview no 3)

Furthermore it also appeared as if a lack of confidence to the organisation of the hospital existed. Some respondents meant that the management of the hospital was inadequate. This created an insufficient hospital and it was said to affect patients in a negative way since the people did not get the care needed. Some respondents described that at intervals of one to three months, a delegation with medical staff came to Siwa. They were supposed to fulfil the demand of advanced hospital care. Their presence and achievements were parts of a project run by the MOHP in order to improve health care situations in rural areas such as Siwa. However, some respondents meant that these achievements were not fulfilled.

“As tomorrow or the day after tomorrow there will be five to 15 professors that will arrive to the hospital. They are specialists, but I will tell you what will happen. They will arrive here late, they need to sleep. Early in the morning they need breakfast and some tea. At this time people will already have come to the hospital, 200-300 persons will be waiting for doctors to come. They will start with two, three, four persons and then it is time to have some lunch. They go to lunch, and “-oh, it is hot, we need to have some rest”. Then there is a football game “-oh, we have to watch”. Then the day is finished. They stay one or two days possibly.” (Interview no 1)

Experiencing money to be necessary in order to obtain satisfactory health care
The quality of the care received was described to correlate to people’s level of income. Treatments and care in cities like Marsa Matruh and Alexandria were described to be expensive but they were also believed to be better than the options available in Siwa. In need of hospital care, all respondents said that most people first turned to the hospital in Siwa. If the care would not be satisfying and if the person had the financial opportunity, a visit to another health unit in Marsa Matruh or Alexandria would be considered for further medical consultation. Some people did not even consider going to the hospital in Siwa; they went directly to hospitals in larger cities. Nevertheless, many respondents found it hard to afford the treatments needed and a hospital in another city would only be considered when it was extremely necessary or acute. A man described how he went to Marsa Matruh with the purpose to save his children. Both of them died because the help came too late.

“I have been there (to Marsa Matruh) twice. One time at the hospital and one time at a private doctor for two little babies, but both of them died. Fatma and Mohammad died both of anaemia. (...) We went to the hospital in Siwa first but they couldn’t help us, so we went to Matruh. The last one, Fatma, this was about three years ago. The private doctor checked, and gave her some medicine but she died after a week anyway.” (Interview no 3)
Extensive amount of money was required when someone needed to consult a health care service which was not supplied in Siwa. When lacking financial means one option would be to borrow money from relatives and friends. One respondent estimated it to cost at least 1000 £P to get treatment at a private hospital with convenient facilities. This was a significant amount of money in relation to that a teacher in Siwa was described to earn approximately 400 £P per month.

The families played a central role in the Siwan society and it was essential for them to participate when a family member was ill. Accommodation for the family and the travels back and forth the hospital were also expenses to consider. Because of high expenses, many people did not regard a visit to a hospital with more advanced care as an option even though they were in great need of it. Nevertheless, there were examples of solidarity, characterising the people of Siwa. A man told about when he accidentally hurt his knee a few years ago. He went to one of the local healers, however this was not enough. He then had to go to Alexandria to have a knee surgery and including the rehabilitation, he spent two months at the hospital.

“It cost me like 12 000 £P in total and I had to pay for everything myself. Ten friends of mine helped me by putting money together. When you have something like this, we try to help each other.”
(Interview no 4)

Some of the respondents described a visit to the Siwan hospital to be expensive, in particular if there was a need for surgery. They believed that the more one was able to pay, the better care one would get.

“When my wife had her operation it cost me 1200 £P. 800 £P went to the surgeon; we made up the price in his office. Because I could pay, my wife got the best care at the hospital but still, my family and I had to bring food and medicine to her. The patients are supposed to get food when they stay at the hospital but the staffs take it home instead. If you cannot pay the surgeon enough he might still do the operation but they will not care about you afterwards.” (Interview no 3)

People who needed special surgeries but did not have the financial ability to go to Marsa Matruh had to wait for the delegation of specialists from Cairo to arrive. However, a few respondents meant that the requirements were larger than the supply and everyone did not get the aid needed. Consequently many patients did not get helped during the time the delegation stayed in Siwa. The untreated could do nothing but wait until the next time of the delegation’s arrival.

“There are lots of people that are ill and 90 % don’t have the money to go even to Marsa Matruh to get help. So when the specialists arrive they go to the hospital and wait and hope that they will get helped. But no, not this time because the doctors are too busy. So they have to wait for the next time or the next and this is the way it works.” (Interview no 1)
Experiencing traditional relief and cure
The Berbers participating in the study had different opinions about the use of traditional medicine in Siwa nowadays. The male respondents with higher education and salaries meant that traditional relief and cure were something of the past and people today preferred to consult a doctor when feeling ill.

“I know about the herbs, but we (the people) do not use it. We use something like mint. It is also medicine for the stomach but if you are ill or not you drink it anyway. It is good for the health. But the other herbs no, no, I do not use them. It is faster with medicine.” (Interview no 1)

The male respondents with lower education and incomes and the women participating in the study meant that alternative methods indeed were alive. They described self medication with different natural plants and herbs to be preferred compared to a visit to a doctor. Even though the hospital care would be better, the respondents meant that they still would try these methods first. If these would not help them, they would consider the public health care for treatments.

“When we get ill in my family we first try with herbs. If I try at home and it does not work, then I go to the hospital.” (Interview no 3)

Experiencing traditional relief and cure as inexpensive
Some respondents described the use of natural elements for cure and relief to have a financial aspect. Many people cultivated plants like mint, onions and olives in their gardens. These were believed to have positive effects and therefore used in different healing processes. The plants had been used for centuries as medicine, and it was much cheaper to use these rather than going to the doctor to get a prescription.

“(…) the doctor will check you and then give you a prescription, so you can buy medicine at the pharmacy. But many people cannot afford the medicine.” (Interview no 3)

Some respondents also meant that a visit to a local medicine man would be a cheaper alternative compared to if the person would attend the public care.

“If you break your leg there is someone here in Siwa who can fix it; we call him “Yabbar”. He helped my daughter when she had a crack in her arm. It does not cost anything to get his help, he will not take any money from someone he helps, when it is acute you know…” (Interview no 3)

Experiencing confidence in traditional relief and cure
Several respondents explained people to prefer traditional relief and cure since these were without artificial substances. They believed chemicals to have a negative effect on the body by bringing side effects. The origin of cultivated plants was on the other hand known, and so were also the effects on the body. This knowledge brought a sense of security.

“I like to use plants, organic things from Siwa. It is better than having medicine (...) I like to have everything from here in Siwa, from the
plants here because they are organic and there are no chemicals. I do not like to take medicine because when you drink medicine you feel okay for a while and then you have a new problem or illnesses then you try the medicine again and again and again. After a few years, I don’t think this is good for the body. It is better with organic things of course.” (Interview no 4)

Security and confidence were also the motives for visiting a medicine man instead of the hospital. The medicine men and women had always been parts of the Siwan society and they were familiar with local traditions. Therefore, the confidence and trust to these people were deeply rooted. These persons had trustworthy reputations and information about if a suffering person was helped or not spread rapidly in the small society of Siwa.

“Why...? Well it is about trust you know... We know what he can do and he has helped a lot of people.” (Interview no 3)

The respondents who expressed that they preferred to use traditional alternatives said that they would go to the hospital when nothing else seemed to work. They further explained that they would consider going to the hospital with issues such as eye or teeth problems or big cuts. The hospital facilities were also considered when surgery was needed or when a pregnant woman would deliver a child.

“People go to the hospital, especially when people have eye problems because it is hard to find natural medicine for that. Also when people need operation they go to the hospital. Today, most women go to the hospital to give birth especially young women. Earlier the women had another woman, a mid-wife, who came to the home to deliver babies, but nowadays most women give birth at the hospital.” (Interview no 4)

Experiencing confidence in religious relief and cure
If someone was exposed to black magic or the evil eye, the respondents meant that this person could not be cured at the hospital since the cause was out of natural reasons. The treatments would instead be based on the consultation of a sheik or someone else who could read the Koran and prepare different herbal medicines.

“You cannot get cured at the hospital. You have to read the Koran or you bring someone to read for you. This is how you stop it. There are some ways in the religion and there are special people who read the Koran and know what to do. There are special people in Siwa.” (Interview no 1)

There were also other methods practised. Some of the women mentioned incense which gave plenty of smoke. It could be used to get rid of the evil eye. Furthermore, if it was known who had given the evil eye, sand from this person’s foot prints could be collected and mixed with the incense. Thereafter, the symptoms of the evil eye would disappear.

“To get rid of the disease you burn incenses – fasokh, which gives a lot of smoke.” (Interview no 5)

The common opinion was that the religious procedures had curing effects on the body and soul. The respondents meant that most people felt better afterwards. However, it was also
described that if the suffering person would not feel better, he or she would be taken to the hospital for consultation. This could for example be when a woman was incapable to become pregnant, and the religious cures did not help.

“If the sheik cannot help you go to the doctor.” (Interview no 6)

Discussion

The study is limited to seven respondents and their experiences about illness, cure and relief. We do not claim that the study is transferable to the whole Siwan society or to other societies. However, anthropological research made in similar contexts is used to increase the validity of the study and it appears as if many aspects we have enlightened also are recognised in other societies.

Discussion of method

Only a few studies about the Siwans and their customs existed and the opportunity to prepare ourselves in advance was therefore limited. Previous authors to Minor Field Studies reports had described that they had had a too narrowed research question and this contributed to little material to analyse. We decided therefore to have a broad perspective in order to get a wider understanding of the experiences and perceptions.

Data collection

Participants

Three women and four men were in total interviewed. According to Thomsson (2002) an empirical bachelor essay should consist of between five and ten interviews. We decided to end after seven interviews because we considered the material being enough to handle and analyse. We met no obstacles finding male respondents, however we had some difficulties finding females. The women spent most of their time inside and since they did not speak English, it was hard to get in touch with them. The only way for us to involve women in the study was to ask the men we interviewed if they regarded it as possible for some of their female relatives to participate. We chose between the options to include or exclude the women, since the selection of female respondents were due to such premises. However; even though we were aware of the limitations we still regarded it as essential to make an attempt to enlighten the female perspective. The female respondents were in some ways related to the male respondents; they were mothers, daughters or cousins. None of them spoke English and it was the male relative who acted as interpreter. These aspects limited the trustworthiness of the study and we can not say that we have enlightened the female perspective enough. Furthermore, the selection of male respondents was also narrow. All men in the study except one worked with tourism; nevertheless they do represented different social classes. They were chosen because they comprehended and spoke English enough to use it. The fact that almost all respondents worked with tourism could affect the validity of the result because they might have a different view compared to Siwans with other profession. We had certain inclusion criteria and these were adequate to have since they gave some consistency to the study.

The interviews

All interviews were performed in the respondents’ familiar settings and this is something also Thomsson (2002) describes to be vital. All of the interviews with female participants were performed in their homes where we hoped they would feel secure and comfortable. Some of the smaller children were also present during a few interviews; however it did not seem to bother the women. The interviews with the men were carried out at their work. Some of the
interviews were disturbed by people coming and interrupting. This could have a negative impact on the study even though it did not seem to bother the respondents. The interviews lasted between 40 and 60 minutes, and we noted that it was hard both for us and the respondents to focus in the end. A tape recorder was used when the men were interviewed. The women did not want their voices to be recorded, therefore only notes with key words were taken. These aspects and the limitations we experienced related to the use of an interpreter decreased the amount of material and the quality of the data received.

The respondents were informed about the opportunity not answering a question if they felt that it was inappropriate. This did not occur, nevertheless, we did not know if they had answers in mind which they decided not to mention. Receiving plenty of material to analyse, this indicated that the questions used were easy for people to understand. Some questions were changed in order to adapt its content due to the gender of the respondent. All participants were asked six main questions and these were sometimes followed up with further questions of interest. We found the choice of interview method suitable for the study; however, we have now realised that we may asked too many questions. We had some problems handling all the material. Because of the language barriers, words in the questions were limited to expressions the respondents were familiar with. It was noted that all respondents did not understand the meaning of the word “ill health”, and we spoke in terms of ill, illness or sickness.

**Linguistic barriers**

It was sometimes problematic to make interviews because of the linguistic barriers. Neither the respondents nor we had English as a native language and this factor had indeed an impact upon the conversations. All male participants spoke English but many of them were only familiar with the daily language. When it came to more medical or focused terms, all respondents did not use them freely. Misunderstandings and feelings of frustration linked to the issue not being able to express the opinion occurred. It is likely that this has led to a misleading picture of their opinion of illness, relief and cure. Thomsson (2002) also describes this issue; there is a risk that essential details are excluded when someone fails to express the right words. Even though all men did not have the skills to express themselves fully, we still decided not to use an interpreter when the male interviews were performed. This gave us the opportunity to talk to people without “a third person” in the dialog, and we believe that the content became more coherent. There were no professional interpreters in Siwa. Even though the collection of data was limited because of the issues related to communication, we believe that even more information would have been lost in the translation process if we had used an interpreter who was not professional.

We did not meet any woman who spoke English enough to have a conversation and it was soon understood that interpreters were needed when the interviews with women were performed. We regarded it as essential to make an attempt rather than to neglect the original plan to interview men and women. Nonetheless, a considerable limitation to the study is that we have not been able to seize the perspective of women fully. Since the Siwan society has its gender structures, the only possible option in order for us to talk to women was to let the male respondents act as interpreters. This has indeed affected the result. There were no professional interpreters available and our interpreters were not aware of the complexity of translation. Furthermore, also our knowledge about the dilemmas with a third part in the interview was narrow. We tried to inform the interpreters about that we wanted them to repeat our questions and the answers of the respondents exactly without any inputs of own opinions and thoughts. This was easier said than done, and we noticed that some interpreters sometimes did not translate all of what the women were saying. We experienced the interpreters sometimes to
answer for the respondents, and also that the respondent explained something comprehensive which then only was translated into a few words. Furthermore, it was also likely that the women did not give us their true views and opinions since a man they knew was present. In one case, the father acted as an interpreter for his daughter and he also mentioned that he believed this to affect what she expressed. We also experienced situations the other way around. The son acted as an interpreter for his mother and elder people were much respected. It appeared as if it was hard for him to ask certain question or encourage her to explain further. We also experienced the men sometimes asking leading questions if the respondent did not understand what was asked. This was due to that the males had been interviewed before the women, and they probably considered themselves to know the “right” answer.

Another linguistic issue was that we did not know how the interpreter translated words, and if the meaning of the words was the same. Words are always charged and connected to some values and contexts. We are well aware of that this limits the study. Information got indeed lost in the translation process but the premises were as described above. We find that we have received plenty of important material even though the communication issues limited the validity of the study.

Establishing a confident relationship
We believe that we were able to establish a relationship based on confidence with the men in the study. We had the chance to meet and talk to them a couple of times before the interviews were performed. Unfortunately, we did not have the same opportunity with the women. Since they did not speak English and we did not speak their language, both parties had to rely on the men. Since we did not get the same chance to establish a confident relationship, lack of trust may also have had an impact upon what the women chose to tell us. Nonetheless, as mentioned before, the arrangements through the men were the only options to get in touch with the women. The men informed about who we were and what the aim of the interviews was. Unfortunately we did not know what kind of information the women received. This information to the respondents is something we would improve if we would repeat the study since it certainly affects how the participants expressed themselves. One idea could be to ask someone who both speaks English, Swedish and Arabic to write an introduction letter that could be given to the possible respondents.

Analysis of data
The recorded interviews were transcribed immediately. The transcription process was time consuming, nonetheless it was worth it since the material and details became more vivid. As mentioned before, the notes from the interviews with the women did not give the same depth and meaning as the recorded interviews. Some respondents were asked more questions after the interviews in those cases where we felt that there were uncertainties.

The quotations from the respondents used in the text were sometimes rewritten since many of the respondents did not use the English grammar properly. However, the content and meaning of the sentences remain and we do not believe that it has affected the interpretation process.

We decided to make a qualitative content analysis and it appeared to be the right method for the aim of this study. There is always a risk for the researcher to be bias when a text is analysed if the pre-understandings influence the process. It is necessary for the researcher to be aware of his or her prejudice and pre-understandings in order to achieve a study of satisfactory quality and validity. This is in particular important when the analysed text has a cultural setting (Thomsson, 2002). It is possible that our own pre-understandings and our
values have had an impact upon the analysis and the discussion in this study. Nevertheless, we have tried to put our pre-understandings aside, even though it sometimes has been hard.

**Discussion of result**

**The idea of illness**

Helman (2007) means that the experience of being ill can be based on people’s own perceptions of illness but it can also be based on the perspectives of others. The response from others and the way the patients present their ill health is to a large extent determined by socio-cultural factors. The respondents in this study seemed to be of the opinion that being ill was associated with having pain and pain seemed to be the main reason for visiting a healthcare facility. One reason to why many respondents mentioned pain correlated to illness could be because people in general could not afford to be ill. The survival of the family was to a large extent depending on the income the daily work brought. Having one “sick-day” off could mean that the man was unable to feed his family. Reasons for staying home from work were different between the respondents with higher and fixed salaries and those with lower and unfixed wages. The first category of men meant that they would consider staying home when having a cold while the second category of men would not consider that. These men had their own shops and they were depending on the everyday sale of products. Only severe complaints and unbearable pain would keep them home. These statements agree with the results of a report made by Rannan-Eliya et al. (2000, pg. 19). They argue that actual ill health is concentrated among the poorer groups of the society; however wealthier individuals often report higher levels of morbidity than poorer persons in the same population. In Egypt, “there is a clear gradient in sensitivity to illness, with poorer people being less likely to recognise illness or report being ill”.

The respondents of this study defined illness and how they experienced it in similar terms, regardless gender. It appeared as if the differences existed more in the way men and women expressed illness and suffering. The men argued that women, because of their gender, were weaker than men and therefore more sensitive to illness. The women on the other hand, did not regard themselves as more sensitive to illness. According to a personal contact at the hospital (2008) more women than men visited the clinic. Perhaps this had nothing to do with the prevalence of illness but with the way it was expressed. We argue that men and women in Siwa embodied their experiences of illness in different shapes. These expressions were in accordance to socially constructed roles which had been created out of Siwan traditions and values. Helman (2007) means that there are several aspects of the male gender culture that could contribute to the ill health of men or for such ill health to develop. Men are expected more than women to have an unemotional language when they experience pain and suffering. Independent of culture, they have a higher threshold before consulting a doctor. In many cases social behaviour may be a reason for developing ill health, since some men ignore early symptoms of serious disease. It is, on the other hand, more socially accepted for women to show feelings of poor health and ask for help.

According to several male participants, women should always be accompanied by a male relative when visiting a health care facility. None of the women interviewed mentioned this as a problem. A male respondent described many Siwan women as very shy and not speaking Arabic so well. From this point of view, it was possible that the women felt safe and secure when accompanied by their male relatives to the doctor. However, there was also a risk that the women could find it difficult to express feelings and thoughts related to for example gynaecological issues when a close male relative was present. Nowadays young girls learn Arabic in school; however there were still many women, especially of the elder generation,
who did not comprehend Arabic well enough to speak it. All doctors did not speak the local language Siwi and this created communication problems. In those cases, the man who accompanied the woman acted as an interpreter and it was likely that her ideas and thoughts not fully were expressed.

One male respondent meant that Siwan women sometimes had to wait for several days before attending the hospital, since they had to be accompanied by men. None of the women mentioned this problem either, and since our study is limited to seven respondents, it is hard to value how often this occurs. Nonetheless, if it is common, it will certainly bring more suffering to a woman who already suffers from her illness. Eriksson (1994) means that every person who experiences illness suffers and when he or she is not being seen or taken seriously in his or her illness, the suffering will be increased. This could cause feelings of being lonely and deserted.

None of the respondents mentioned psychological or psychosomatic problems as being ill and the explanation could be cultural. Research shows that in all societies there are some conventions and opinions about how people should behave and act when they experience illness. A society also provides its members with ways of becoming ill, ways to get cured and ways to shape the suffering into a recognisable illness (Helman, 2007). In many parts of the world, mental illness is taboo and it is something which is not spoken about or recognised. Mental illness is in Egypt associated with stigma and families with members who suffer from mental illness are often afraid of how social attitudes will affect their reputation. Furthermore, they often try to hide the fact that someone is ill because of the risk that the daughters will lose their chance to marry if the family is associated with mental illness (Endrawes, O’Brien & Wilkes, 2007). The stigmatisation of mental illness could be one reason to why none of the respondents mentioned or talked about psychological or psychosomatic problems as being ill.

Explanation models to illness
According to Helman (2007), there are different models used to explain illness. Some models are based on beliefs in the functional and structural aspects of the body. With the seven respondents as a frame of reference, the Siwan Berbers seemed to believe in several explanation models to illness. They expressed beliefs in both natural and supernatural explanations and the participants in this study seemed to be well aware of natural causes to illness; however they did not talk about it in terms of natural science. All participants seemed to have a good comprehension of the kidneys being negatively affected and that kidney stones could occur when drinking polluted water. Some of the respondents also described what could happen to the blood sugar when something sweet was eaten. It was interesting to note that none of them mentioned illness to be caused by virus or bacteria. Illness was, as described before, associated with pain in different parts of the body and the kidneys were especially mentioned. Kidney problems were common health issues in Siwa. When the respondents described the symptoms of kidney problems these were associated with pain in the stomach. A person educated in the medical discipline would probably not agree with that since pain in the kidneys more likely would cause pain in the side of the body and possibly in the scrotum, rather than in the stomach (Järhult & Offenbartl, 2006). Helman (2007) means that the inner structure of the body for many people is a matter of mystery and speculation, and without access to modern technology, people generally base their perceptions on apprehensions of inherited folklore, books and personal experiences. Research has shown that the knowledge doctors and patients have about anatomical properties in the abdominal cavity differs tremendously. Participants in a study were asked to point out where organs, for example the stomach was situated. The spectrum of answers was large and the researcher interpreted his result in terms of that a patient complaining about pain in the stomach might refer to virtually
any part of the abdominal cavity (Helman, 2007). Rheumatism was another term frequently used during the interviews and several respondents meant that it could occur in all parts of the body, not only the joints. There is a risk for misunderstandings when the patient and the care giver have different views on the anatomical properties and it is likely that these types of misunderstandings can hinder the doctor from making a correct judgement.

Several respondents experienced the drinking water as a major problem in Siwa and it was also described to be one of the main health issues. This was something we could not get confirmed; however the respondents were afraid of the effects the water could have on their health. Believing the water to be inappropriate for the health but not being able to buy the purified water must create feelings of frustration and uncertainty among people. Nevertheless, this is not a unique problem for Siwa; many developing countries have the same problem. According to the United Nation Development Programme, 1, 2 billion people around the world had in 2005 still not access to safe drinking water (Helman, 2007).

Religion was a vital part of the Siwan society and the Islamic values had a major impact on people’s beliefs. It appeared as if religion had an impact on coping strategies as well. A few respondents had suffered a lot through their lives; some had lost children or spouses. According to our participants and their beliefs, life on earth is temporary and Allah has set out a path for everyone. Life is already predestined and according to them it is the will of Allah if people fall ill and die. This outlook on life does not minimise the sorrow when someone dies, but it seemed as if people more easily could find ways to reach acceptance and reconciliation. Eriksson (2001) means that mankind, irrespectively of culture or age innermost is religious, bearing a longing after a God or after something “bigger”. Faced with illness, suffering or death, man will ask existential questions about the meaning of life. The belief in something greater can help and give comfort in the quest for these answers. Acceptance and reconciliation can in this way be achieved. From this point of view, the religious beliefs that the Siwans shared, could to a large extent be regarded as health resources.

However, the religious beliefs could also influence health in other ways. The majority of the respondents believed the evil eye and black magic to be religious phenomena causing illness. Since the cause was said to be out of natural reasons, it was believed that the hospital could not give treatment or relief; instead the help was achieved from a sheikh. When the participants during the interviews talked about the symptoms caused by these supernatural phenomena, we recognised many of them as symptoms of mental illness. None of the respondents mentioned psychologically related complaints as illnesses. Helman (2007) refers to a study made by Foster & Anderson and states that in the non-western world is common that mental illness often is explained by supernatural reasons. The study made by Endraws et. al. (2007) confirms that belief in magic and the evil eye exists in Egypt and that these phenomena can cause mental illness. We see a risk, when these supernatural forces are said to create conditions like mental illness, because it can prevent people from receiving the correct help or treatment needed. This could in the end not only increase the illness suffering; there is also a risk that the illness suffering could develop into a life suffering.

Several respondents described how people they knew, in particular women, were unhappy and it seemed as if these women did not find themselves comfortable in their life-world. It was said that these persons had been exposed to the evil eye or black magic and the symptoms described were often diffuse and not obviously bodily related. We could from our outlook on life see a connection between their ill health and a major life change, for example marriage. A female respondent described for example how one of her relatives always felt ill and changed personality when she came to the house of her husband. This could be an expression of the
frustration and hopelessness the woman felt. From this point of view, it was understandable if more women than men believed in supernatural phenomena. It is likely that the woman could feel that it was not her fault if she had been exposed to something supernatural and this could give a sense of relief. Helman (2007) means that even though the explanation models are based on scientifically incorrect assumptions, these models give consistency and coherency for the suffering patient and the relatives. The models can give explanations to why something has happened and they can also give relief to the soul since the illness can make a sense.

Relief and cure

People in all societies, who feel that they do not find relief or cure by self-treatment when experiencing ill health, will make choices of who to consult for further advice. Based on the beliefs and explanation models to the illness, various reliefs will be tried. There are many factors that affect the actual choice, for instance the contextual settings where the decisions are made, the actual help available, the payment needed for the services and whether the patient or his relatives indeed have the financial opportunities. Patients chose the advice they find appropriate for their condition (Helman, 2007).

When the participants described what alternatives for relief and cure they knew about, different options were mentioned. The male respondents who were well educated and had a better financial situation meant that traditional methods no longer existed and western medical treatments were the only options they regarded as possible. This stood in interesting contrast to the other point of view, which revealed that traditional alternatives indeed were practised. It is possible that different methods for relief and cure were associated with different ideas depending on who was asked. It could be that traditional alternatives were associated with poverty and lack of knowledge among the richer population, and then these types of methods were not considerable alternatives for them. There were respondents with deprived financial situations who did not even mentioned it as an option to go to larger cities like Alexandria to get care. This indicates that within the small society of Siwa, there were various experiences of relief and cure. As one can see, there were differences among the respondents’ views on western medicine and traditional relief and cure.

However, the respondents expressed similar views about relief and cure available for someone who suffered from illness caused by supernatural causes. When the cause was not of a natural character, the respondents did not first believe that relief and cure were available at the hospital. The sheikh was believed to be able to heal through the Koran and many respondents described how people they knew had experienced relief and cure by this arrangement. However, some respondents also described suffering people who did not experience a relief when consulting a sheik and these persons were then taken to the hospital.

There were different opinions about when to visit a health care facility and also respondents who expressed that they tried to avoid the hospital used its facilities when no other alternative could help them. It is, as Helman (2007 pg. 81) describes, “To the ill person, however, the origin of these treatments is less important than their efficacy in relieving the suffering.”

All respondents agreed upon that the facilities offered by the public hospital were inadequate and there were several reasons for this. The oasis is situated 300 kilometres into the desert from the coastline; therefore it was hard to recruit educated and skilled staff to the health facilities in Siwa. A personal contact at the hospital (2008) has described that no one who
worked clinically at the hospital originally came from the oasis. He did not confirm the apprehension several respondents had, about the lack of clinical experience the general doctors working at the hospital had, but he mentioned that they did not speak the same language as their patients. Many patients, in particular women, found it difficult to speak Arabic. The society of Siwa differed in many aspects tremendously from the rest of Egypt and many traditions were unique for Siwan culture. With these conditions in mind it is understandable, that cultural clashes could occur, and respondents in this study can experience lack of trust in the available public health care. Helman (2007) means that the cultural background influences the life of each individual in an essential way and it has an impact upon aspects such as beliefs, manners, emotions and religion but also how one perceives illness and pain. The respondents in our study mentioned this cultural conflict in terms of lack of trust in the caregiver. If the confidence in the doctor was inadequate, the caring situations would be doubtful. The issue several respondents described was that they did not experience all doctors as skilled enough to make correct judgements. Eriksson (2004) means that the relation between the caregiver and the patient is essential for the caring in order for the patient to feel confident enough to share his or hers problems and thoughts. It appeared as if it could be this caring relation the respondents sought and missed in the meeting with the professional. The lack of trust in the doctors could also lie in the origin of the expectations. It seemed as if some participants expected the treatments based on western medicine to cure directly and this was an unrealistic idea. It could be connected to the issue which earlier was described. The caregiver and the patient had different views on the anatomical properties and how something should be handled and this could lead to unsatisfied patients.

The respondents had different opinions about western medical drug therapy and these differences seemed to be due to the educational level or to the financial situation of the participants. Some meant that medicine was reliable because it worked fast and these respondents expected it to work immediately. Their expectations of western medicine were therefore high, and since many Siwans did not have knowledge of the body from a medical perspective, the distrust of the doctors could also be connected to the high expectations. Other respondents, who preferred not to use western medical medicine, meant instead that the medicine was collected inside the body and this could give damaging side effects. Both views could develop a suffering for the individual and there were probably patients in Siwa who would be helped by western medicine if they had knowledge enough to try. Patients who had a blind faith to medicine could suffer if their expectations did not correspond to the outcome. As described in the result, when people were at the doctor’s office, they did not ask about the cause to the complaint or how the medicine worked, and the doctor did not explain. Furthermore, respondents experienced that the doctors did not sufficiently instruct the patients about the treatment. Since there were some communication problems and many patients lacked basic knowledge of the body from a medical perspective, it is likely that a patient could be afraid to ask the questions he or she had in mind. As a caregiver, it is important to remember that the caring relation always is asymmetric. Since the caregiver in his or her profession has more knowledge, he or she has also more power (Wiklund, 2003). If the patient does not dare to ask what has caused the complaint or how to prevent it and the doctor does not inform, the illness suffering for the patient could develop into a life suffering. Hence, the patient information is a vital part of the caring.

The Egyptian constitution asserts that the state shall guarantee health services for all Egyptian citizens and there were indeed health facilities available in Siwa. Nevertheless, as the result described, several respondents experienced the help they received from the hospital to be due to how much they were able to pay. Possibly, this could generate feelings of frustration, anger and uncertainty. We argue that one of the reasons to why people chose alternative methods...
The majority of the respondents we have talked to considered western medical health care expensive and many of them found it difficult to pay for an operation even at the public hospital in Siwa. Therefore it was understandable that people hesitated before they went to the hospital. They found it difficult to trust the staff and their expectations of the care available were low. When they visited the health care unit, they expected the doctor to write a prescription for an expensive or not affordable medicine and some respondents did not believe that it would help anyway. With this in mind it was not hard to understand that many people would try traditional alternatives first. The Siwan population had developed coping strategies in order to settle the everyday life also when someone experienced illness. It appeared as if they found it essential to take care of each other. The collective feeling in Siwa was strong and this collective responsibility people felt for each other could be seen as a health resource. The families were in general large and the Siwans regarded both the closest members and more distant relatives as parts of the family. This social “institution” played a central role and it was obvious for them to participate when someone was ill.

Although people tried to help each other, everyone did not get the help he or she needed. Hovering between hope and despair must add another suffering to someone who was already experiencing illness suffering. This was likely to be the reality for those who could not afford to visit health facilities outside Siwa when the local hospital could not provide enough help. Consequently, people had to wait for the delegation of doctors from Cairo to come, but the arrival did not guarantee them getting the care needed. There was a risk that the delegation did not have enough time to help everybody, with the result that they would have to wait until the next time. This added another dimension of suffering to an already suffering person. Eriksson (1994) means that a suffering of caring occurs when care is not given or cancelled. She furthermore describes that when a person is not being seen or taken seriously in the illness or in the suffering, this can be regarded as a harassment of the person’s identity. Being forced to wait for care could also be regarded as not being confirmed as a human. This was the reality many patients in Siwa might experience when they needed to wait for care.

Even though the hospital facilities for the Siwan population were scarce, we argue that this was not the only reason why people chose traditional alternatives for cure and relief. It was indeed a contributing factor, and there were probably many people who would prefer to be helped at the hospital if they knew that it would be easily accessible and a possible option independent of income. However, we would argue that many Siwans believed in the healing factors of nature and this alternative for cure and relief was connected with safety and trust. It seemed to be a common belief that natural plants and herbs from Siwa had healing effects and a majority of the respondents were proud of their organic heritage. It is understandable that people had such beliefs, considering that Siwa is isolated in the middle of the desert. Until quite recently, the Siwans had been earning their own living and they had grown their own products for survival.

As the result showed, many Siwans turned to other options than the alternatives provided by the public facilities in need of relief and cure because they knew how these worked. These traditional methods were performed by local medicine men and women and they were well tried over time. The medicine men and women shared similar traditions, language and beliefs as the respondents. Possibly Siwans found the healers being more understanding of their different aspects of suffering. When the existing methods were used, it seemed as if the respondents who used one of them for relief and cure felt safe because they knew how it would affect their bodies. From this point of view, it was not strange that male respondents with lower education expressed a great disbelief of western medicine. If they did not
understand how the medicine affected the body, they would not regard it as safe even though it had been scientifically proven. It was interesting to note that these respondents described that even though the quality of the health care in Siwa would be better, they would still avoid the hospital. This could be due to the different paradigms the respondents and the doctors belonged to. The participants however; admitted that when traditional alternatives had been tried but not been effective, the hospital treatments would be attended.

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Electronic resources:


Personal Contacts

Dr. Mohammad, director of the women and children hospital, Siwa, Egypt
Mr. Mahdi Hweiti, director of tourism, Siwa, Egypt
Mr. Sayed Ali, handicraft dealer, Siwa, Egypt
Appendix 1

1. When people fall ill in Siwa, what do they do and where do they go to get help?

2. Which are the most common diseases/symptoms in Siwa?

3. When you fall ill, what do you do and where do you go?

4. What is illness for you?

5. What makes you ill?

6. Do you think that the health care in Siwa is satisfying?