TRENDS IN MEDICAL ANTHROPOLOGY : ITS RELEVANCE TO PUBLIC HEALTH

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CERTIFICATE

This is to certify that the dissertation entitled "TRENDS IN MEDICAL ANTHROPOLOGY: ITS RELEVANCE TO PUBLIC HEALTH", submitted by MISS SANJUKTA MISHRA, is in partial fulfilment of the requirements for the award of the degree of Master of Philosophy of this University. The dissertation has not yet been submitted for any other degree of this University or any other University, and this is her own work.

We recommend that this dissertation be placed before the examiners for evaluation.

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CHAPTER - 1

EMERGENCE OF MEDICAL ANTHROPOLOGY-GLOBALLY

Introduction

Humans everywhere, at all times and places and under all forms of social organisation and culture design, have had to deal with the threat of disease and illness. Injuries to human organism have always challenged the ingenuity of human individuals and groups to devise means and forms towards their prevention, control and treatment. Disease did not begin with man, but in a sense, as Sigerist has noted, disease is a part of life itself; that is a manifestation of life under altered conditions.

There is an intimate and inexorable linkage between disease, medicine and human culture. In part , cultures are responses made by human groups to obstacles placed by sickness and trauma in the path of successful adaptions. Theories of disease, including etiology, diagnosis, prognosis, treatment and amelioration or cure are all part of cultural repertory and equipment of human groups. These differ as cultures differ; they are similar as human cultures resemble each other as universal problem solving adaptive organisations and technologies.

The various theories of disease can not be studied and understood apart from an understanding of the culture and social structure of the groups holding there.

The study of human confrontations with disease and illness, and of adaptive arrangements that is medicine and medical systems made by human groups for dealing with these ever-present and pan-human dangers, which has come to be known as medical anthropology[1].

Medical anthropology is a newer subdiscipline of anthropology with a formal history of thirty years and an informal history as old as its parent discipline. Medical anthropology, as a sub-field of inquiry deals with the study of peoples point of view in medicine. In its goals, it is not merely limited to the extent of assisting medical sciences in health care delivery, but it also covers a much broader spectra of inquiries. Its multifaceted objectives include the study of culture - specific trends in the domain of illness, inter-relationship between medical arena with other sphere of the society and finally identification, evaluation and utilisation of resource potential in a particular culture in terms of therapeutic cures, health care and adherence[2].

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1. David Landy, "Introduction : Learning And Teaching Medical Anthropology" in David Landy, ed., Culture, Disease and Healing: Studies in Medical Anthropology (New York, 1977), p1.

2. P. C. Joshi, "Medical Anthropology: An Overview", in P. C. Joshi and Anil Mahajan, eds., Studies in Medical Anthropology (New York, 1990), P.5

Since the end of world war II anthropologists both socio-cultural and biological have turned in increasing numbers to the cross cultural study of medical system and to the bioecological and socio-cultural factors that influence the incidence of health and disease now and through out the human history. In part their interests have been theoretical, sparked by the desire to understand man's health behaviour in its widest manifestations and part their interests have been applied motivated by the belief that anthropological research technique theories and data should be used in programmes designed to improve health care in both developed and developing nations.

Today anthropologists with these interests work in schools of medicine, nursing and public health; in hospitals and health departments; and in traditional University of Anthropology departments. They are doing research on topics like human evolution, anatomy, pediatrics epidemiology, mental health, drug abuse, definitions of health and disease, the training of medical personnel, medical bureaucracies, hospital organisations and operations, the doctor-patient relationship, and the processes of bringing scientific medicine to communities that previously have known only traditional medicine. These anthropologists are called "medical anthropologists" and the field they represent is the new anthropological sub-discipline "Medical Anthropology".

Conceptually medical anthropology may be placed along a continuum, one end of which is marked by a biological pole and the other by a sociocultural pole. Towards the biological pole the interests of the anthropologists include human growth and development , the role of disease in human evolution, and paleopathology....Towards the sociocultural pole anthropologists dominant interests include the traditional medical systems, (ethno-medicine) medical personnel and their professional preparations,

illness behaviour, the doctor-patient relationship and the dynamics of introduction of western medical services into traditional societies[3].

In short, medical anthropology is viewed by its practitioners as a biocultural discipline concerned with both biological and socio-cultural aspects of human behaviour, and particularly with the ways in which the two interact and have interacted throughout human history to influence health and disease. The biocultural nature of medical anthropology is made clear in a series of review articles that have appeared in the last 25 years such as by Caudill 1953; Polgar 1962; Scotch 1963; Fabrega 1972; Lieban 1973; Colson and Selby 1974.

The origin of medical anthropology can be traced by knowing the roots to medical anthropology. Mainly medical anthropologists interested in medicine and medical problems, or the contributions of physicians to physical anthropology. Hasan argued that "the roots of contemporary medical anthropology are traceable to the development of anthropology itself[4]."

In the history of medical anthropology, Rivers was the first to conceptualise the medical beliefs of primitive peoples as theories of disease and theories of disease causation, with an internal logic of their own, and not to be dismissed lightly as bizarre, esoteric, illogical and irrational bits and pieces of belief and behaviour in exotic cultures. Rivers interpreted theories of disease causation as consisting mainly of three classes of agents: human, spiritual or super-natural and natural, and he showed how similar categories exist in the medical beliefs of contemporary western culture. He dealt in detail with much more in medical anthropology. His contributions were extremely significant[5].

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3. Foster and Anderson, "Medical Anthropology", (Canada, 1978),pp1-2

4. Ibid., p.3

5. Landy, n.1, p.4

The survey of emerging anthropological and other bahavioural science interests in the health field, published in 1953, was titled "Applied Anthropology in Medicine " by Caudill. Then Scotch entitled a major survey article "Medical Anthropology". Then Paul spoke of "Medical Anthropologists" in an article on medicine and public health (Scotch 1963, Paul 1963). American anthropologists fully appreciated the implications of health and illness research for Anthropology. Further legitimizing the new subdiscipline was the appearance in the smae year of the anthropology oriented Medical Behaviour Science (Pearsall 1963)[6].

Definitions of Medical Anthropology

Hasan and Prasad (1959) defined Medical Anthropology as that branch of science of man which studies biological and cultural (including historical) aspects of man from the point of view of understanding the medical, medico-historical, medico-legal, medico-social and public health programmes by human beings. Weaver (1968) defined it as that branch of applied anthropology which deals with various aspects of health and disease[7]. Hochstrasser and Tapp (1970) defined medical anthropology is concerned with the biocultural understanding of man and his works in relation to health and medicine[8]. Fabrega (1972) defined a

6. Foser and Anderson, n.3, p.3

7. Joshi,n.2, p.7

8. Foster and Anderson, n.3, p.9

medical anthropology inquiry as one that a) elucidates the factors, mechanisms and processes that play a role in or influence the way in which individuals and groups are affected by and respond to illness and disease, and b) examines these problems with patterns of behaviour[9]. Lieban(1974) defined medical anthropology as one which encompasses the study of medical phenomena as they are influenced by social and cultural features and social and cultural phenomena as they are illuminated by their medical aspects. He again said (1974) that medical anthropology not only a way of viewing the state of health and disease in society but a way of viewing the society itself[10].

Fosters two fold definition highlights the biocultural inter-relationship of "human behaviour" and "health and disease" as a theoretical exercise and the utility of this knowledge in health related planning through changing of health behaviour in direction believed to promote health.

Mc Elory and Townsend described Medical Anthropology as the study of human health in cultural and environmental context. stressing the inter-disciplinary comparisons of disease pattern[11]. Joshi attempts at a fresh definition of Medical Anthropology as follows - Medical Anthropology is the holistic study of health, illness and related misfortunes, as there are culturally perceived, classified, experienced and communicated on one hand,

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9. Joshi, n.2, p.8

10. Ibid, p.7

11. Susan S. Hunter, "Historical Perspective on The Development of Health Systems in Medical Anthropology", Social Science and Medicine,vol. no.21, Issue No.12,1985, pp1297-1307, p1299

and socially constructed roles, stresses and institutional networks which are believed to help in the health enhancing process, on the other, with a view to identify cross-cultural similarities and variations in the patterning of such behaviour[12].

Medical anthropology mainly relies on the following central attributes of anthropology:

a) the themes of culture and evolution
b) the dimension of time and space
c) concern with human cultural and biological variability
d) the methods of comparative and holistic analysis[13]

Medical Anthropology: Its Various Dimension

Medical anthropology is one of the subdivisions of anthropology bridging the discipline's two major fields of physical anthropology and cultural anthropology. In addition, it meshes the established disciplines of anthropology, medicine, epidemiology and ecology.

The sources or roots of medical anthropology are probably as deep as anthropology itself. Ethnographic accounts of medical cultural data are found in the writing of Frazer and Taylor. Early in the 16th century,

12. Joshi, n.2, p.8
13.Hunter, n.11, p.1299

anthropologists made some contributions on the social cultural aspects of illness and curing. From holistic point of view, anthropology seems to have combined in one discipline, the approaches of several sciences, including the biological sciences, the social sciences and the humanities[14].

Lieban discussed somewhat selectively four major areas of medical anthropology:

a) Ecology and Epidemiology

b) Ethnomedicine

c) Medical aspects of social system and

d) Medicine and cultural change.

The problems encountered in these areas, approaches to these problems and relevant research findings[15].

Foster and Anderson trace contemporary medical anthropology to four rather different sources, each of which developed in relative (but not absolute) isolation from others:

a) Physical Anthropology

b) Ethnomedicine

c) Culture and personality studies and

d) International public health[16].

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14. D.N. Kakar,"Anthropology in Medicine: A Review" in P.C. Joshi & Anil Mahajan, eds. Studies in Medical Anthropology, (New Delhi,1990), p.17

15. Ricard W. Leiban, "The field of Medical Anthropology", in D. Landy,ed., Culture, Disease and Healing: Studies in Medical Anthropology, (New York, 1977), p.16

16. Foster and Anderson, n.3, p.4

The intellectual roots of contemporary Medical Anthropology as a social science sub-discipline can be legitimately linked to post-renaissance development of human knowledge, characterized by analytical separation of mind from matter. The ensuing coercive reific separation of anthropological phenomena into biology, psychology and culture for the convenience of institutionalized academic specialization have tended to produce fragmentary and distorted academic images of human realm[17].

Gurumurthy says that Anthropology as a science of man can help in the management of health and hygiene mainly in four areas by way of

a) providing information on the concept of health, hygiene, medicine cure and so on to the health managers and planners.

b) Policy formulation with regard to health and hygiene.

c) Action modalities and

d) Monitoring and evaluation of specific programmes from a holistic cultural ecological perspective in terms of short term and long term impact assessment[18].

According to Gurumurthy there are mainly three subfields of Anthropology which related to the relevance of health management programmes. They are,

a) Ethnomedicine

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17. Anil Mahajan, "Medical Anthropology and Third World Development Needs: Symbiosis or Disarticulated Concern ? "in P.C. Joshi & Anil Mahajan, eds., Studies in Medical Anthropology, (New Delhi, 1990), p.44

18. K. G. Gurumurthy, "Anthropology and Management of Health and Hygiene, An Indian Case Study", in P. C. Joshi & Anil Mahajan,eds. Studies in Medical Anthropology, (New Delhi, 1990), p.24

b) Medical anthropology and

c) Cultural ecology or Ecological anthropology[19].

So, from the above, it can be traced that there are five major sources of medical anthropology. Those are,

(1) Ecology and Epidemiology:

It is one of the important sources of Medical Anthropology according to Lieban. In the study of medical aspects of the adaption and maladaption of human groups to their environments, cultural factors are of major importance. Consider May's (1960) experience, he was an epidemeologist in a village in China before World War II, May observed that some of the villagers were seriously affected by a heavy infestation of hook worm, while others were not. An investigation showed that almost all the hook worm patients were rice growers; there were no rice cultivators among those not ill with the malady. The rice cultivators worked in mud mixed with night soil, which helped explain the infestation of hook worm larvae. The other villagers were engaged in silk work farming, and spent most of their working days on ladders tending mulberry leaves. Here disease boundaries and cultural distinctions virtually coincided. In a case such as this, the effects of culture on the prevalence of disease is striking, but it is also apparent that the hook worm infestation was part of a complex ecosystem involving relationships between human and non-human organisms and their environments[20].

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19. Ibid., p.28

20. Lieban, n.15, p.16

In the source of ecology and epidemiology the social and cultural aspect of epidemiology is most important. Francis (1959) says that epidemiology is essentially devoted to selective distributions of disease and their meanings. Scotch (1963) says that epidemiology is both descriptive and analytic. Suchman (1968) says that the filed has become increasingly concerned with the origin and cause of diseases rather than with its distribution alone.

Epidemiology has a close relationship of ecology.. sociocultural factors than may help determine disease etiology and distribution through their influence on the relationship between a human population and its natural environment; or through their direct influence on the health of the population.

Social and cultural distinctions associated with differences in age, sex, occupation,class,ethinicity and community, can have significant effects on epidemiological phenomena[21].

(2) Physical Anthropology or Human Biology

Almost by definition, physical anthropologists are medical anthropologists, since their concern with human biology parallels and overlaps many of the interests of medical doctors. Mainly physical anthropologists taught and did research in schools of medicine, usually in departments of anatomy. Hasan and Prasad (1959) list a number of areas, including nutrition and growth and the correlation of body build and a wide variety of diseases such as arthritis, ulcers, anemia and diabetes. Anthropological studies of human growth and development are as much as anthropological as is the study of serology[22].

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21. Ibid., p.18

22. Foster & Anderson, n.3, p.4

Alland says about the pivotal role which medical anthropology should play in unifying biology and cultural anthropology through ecological studies of small population adaptation. This research strategy has been pursued recently and prior to Alland encountered for an early and exemplary study in medical anthropology and genetics.

Exposure to and protection of population from disease risks by cultural and social factors such as migration, colonization and urbanization are often included in research on modernization. Labelled diseases development well known examples include trypanosomiasis (sleeping sickness), bilharziasis (schistosomiasis), onchocerciasis (river blindness), filariasis and malaria resulting from such conditions as river basin development, land reclaimation and road construction. Anthropology is also seeing a resurgence of interest in the study of other infectious diseases[23].

Underworld (1975:58) and others have sought a broader understanding of disease processes by looking at the influences of human evolution and the differential exposure of populations affected by cultural factors such as migration, colonization and the spread of urbanization. Fiennes (1964:23-26) argued that disease, as encountered in human populations is a specific consequence of a civiized way of life, dating from the time when agriculture began to provide the basis for the rise and growth of expanded, heavily settled communities.

For many decades, physical anthropologists have engaged in Forensic Medicine, an area of medico-legal problems involving identification as to age, sex and race of human remains where foul play is suspected and

23. Hunter, n.11, p.1301

through blood types the determination of possible paternity when there is disagreement as to who the father of child may be.

In the development of preventive medicine, physical anthropologists have contributed to research on the recognition of high risk groups such as persons with sickle cell anaemia and carriers of hepatitis. They have also utilized their knowledge of human variation to aid in the field of "Biomedical Engineering", contributing to the development of appropriate arctic and tropical clothing and gear for American serviceman and for U.S. field stations. The astronauts clothing as well as work spaces were built to anthropometrical specifications. Damon (1975:366) says that "Measurement norms and standards derived from a host of anthropological studies are used in such areas as general and pediatric medicine and dentistry and in surveys of nutritional levels and etiology of disease in diverse populations as well as with a population. This list for applied biological Anthropology is almost endless[24].

(3) Ethnomedicine

Hughes (1968) says that the domain of ethnomedicine is indigenous medical features those to which "not explicitly derived from the conceptual framework of modern medicine"[25].

According to Foster and Anderson the subdivision of medical anthropology today is called ethonomedicine.

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24. Foster & Anderson, n.3, pp4-5

25. Leiban, n.15, p.20

As our primate ancestors evolved into human form, the diseases they brought with them and those they acquired along the evolutionary way, became social and cultural facts as well as pathological states. For human beings disease threatens not only the well being of sufferers of their fellows, but also the integrity of the community. Illness and death are disruptive events that impose high economic, social and psychological costs wherever they occur. Quite apart from humanitarian reasons, therefore, it is of primary importance to the members of every group to try to maintain their health and to restore to health those who fall ill[26].

(a) Health Practices

In addition to ethnomedicine, various other terms have been used to refer to the domain under discussion or parts of it. Folk medicine, popular medicine, popular health culture, ethnoiatry (Scarpa 1967), ethnoiatrics (Huard 1969).

Polgar (1962)has distinguished the professional health culture of medical practitioners from the popular health culture of unspecialized lay practitioners. He would include folk healers among health professionals so long as they are recognized as specialists by others in their society.

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26. G. M. Foster, An introduction to Ethno-Medicine in R. H. Bannerman, J. Burton and Chen Wen-Chieh,eds. Traditional Medicine and Health Care Coverage, W.H.O, 1983, p.17

A distinction should be made at the outset between professional health cultures and popular health cultures. The first term reflects to the institution, roles, values and knowledge of highly trained practitioners of the indigenous medical system of South Asia as well as practitioners of cosmopolitan scientific medicine. Popular health cultures include the health values and knowledge, roles and practices of layman of specialists in folk medicine and of layman specialists such as the avocational practitioners of homeopathic medicine[27].

(b) Medical Systems

The published accounts of the worlds medical systems have made possible the new discipline of "ethnomedicine", i.e., "those beliefs and practices relating to disease which are the products of indigenous cultural development and are not explicitly derived from the conceptual framework of modern medicine[28].

Medical systems are made up of a more or less uniform set of schools, hospitals, clinics, professional associations and agencies who train personnel, maintain an infrastructure for biomedical research and deploy a network of services of varying degrees of complexity for the prevention, caring, care and rehabilitation of the sick[29].

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27. Leiban, n.15, p.20

28. Foster, n.26, p.17

29. D. Pedersen & V. Barruffati, "Healers, Deities, Saints and Doctors: Elements for the Analysis of Medical Systems", Social Science And Medicine, Vol.29, No.4, pp.487-496, 1989, p.487

Anthropologists who today work in the health fields have "recaptured" and given a formal name "ethonomedicine" to the traditional study of non-western medicine and made it a part of their speciality. As medical anthropology has developed especially in the broad areas of international public health and transcultural psychiatry, the practical as well as theoretical importance of knowledge about non-western medical systems has become apparent. This recognition has sparked renewed interest in ethnomedical research, elevating it to major importance in Medical anthropology.

(4) Psycho-anthropological Health Studies

Beginning in the mid 1930s anthropologists, psychiatrists and other behavioural scientists began to ask questions about adult personality or character and the socio- cultural environment in which this character was displayed. Behaviour scientists also were interested in the possibilities of new "projective" tests, such as the "Rorschach inkblood cards" and the Thematic Apperception Test, shedding light on the functioning of the human mind and thus affording clues to the answers of the questions being raised[30].

Although the culture and personality research was theoretical in nature, the anthropologists were concerned with the ways in which anthropological knowledge could be used to raise the levels of health care. Devereux (1944) studied the social structure of a schizophrenic ward with an eye to determining its therapeutic fitness, and the Leightons wrote a marvelous book showing the conflict between Navaho culture and society and the problems of introducing modern medical services to the Navahos (1944).

30. Foster & Anderson, n.3, p.6

At the same time, Alice Joseph, a physician and anthropologist, described the problem of interpersonal relations between white physicians and Indian patients in the American south west, showing how role perception and cultural differences prevented the most effective therapeutic interaction (Joseph 1942) [31].

(5) International Public Health

Health workers in cross-cultural settings come to see far sooner than those working within their own culture and particularly those involved in clinical medicine, that health and disease are as much social and cultural phenomena as they are biological. They quickly realized that the health needs of developing countries could not be met simply by transplanting the health services of industrialized countries[32].

Beginning in the early 1950s, anthropologists were able to demonstrate in practical utility of their knowledge (and of their research methods) to international public health personnel, many of whom welcomed anthropologists with open arms. Anthropology provided insight into why many programmes were less successful than had been hoped and in some instances, anthropologists were able to suggest ways to improve programmes. The anthropological approach was acceptable and public health personnel, too, because, it did not threaten them as professionals. They saw it

31. Ibid., p.7

32. Foster & Anderson, n.3, p.7

as a safe approach, in that it defined the problems of resistance of change as lying largely with the recipient people. Representative studies dealing with the early participation of anthropologists in cross-cultural and international health programmes include Adams (1953), Paul (1955) and Saunders (1954) [33].

So these are the major dimensions or sources medical anthropology, that more than any other precipitated the realization that here was a new and major subfield within Anthropology, one whose potential at the time was only beginning to be sensed.

Basic Premises of Medical Anthropology

Anthropologists wanted not only to observe and describe the behaviour of members of a group but also to explain why people behave in the ways they do. We have found that one very important way to understand better the why of human behaviour is to search for the deep seated premises or assumption or postulate that underlie and we believe determine behaviour. The premises or assumptions of which we speak characterize individuals. As diagnostic tools, they are more profitably thought of as applying to anthropology groups such as tribes, peasant villages, entire nations and state minority ethnic groups, bureaucracies and professionals.

All the members of the group share a series of common cognitive orientations, comprehensions, interpretations and ordering of the phenomena of the world about that set the conditions under which they feel life is lived. Some of these premises lie at the conscious levels, while others are deeply subconscious.

33. Ibid., p.8

Speaking specifically of health, the wide spread African belief that death and illness are always caused by sorcery is a premise that explains to non-Africans much African health and interpersonal behaviour, it stands in contrast to the premise of scientific medicine that whatever the specific cause, it can be understood in naturalistic terms.

Premises or assumptions or postulates must be thought of as lying on a continuum from overt and conscious to covert and subconscious. Whether the former or the latter, they play enormously important roles in determining individual and group behaviour since all behaviour seem to be a response to or a function of the premises that, whatever their degree of consciousness, characterize an individual[34].

Joshi says about the basic premises in Medical anthropology that there are mainly three basic empirical generalizations, which guide the research work. These are a) illness is an obiquitous entity which is not necessarily a biomedical deviance (disease) but in reality a socio-psycho-bio-cultural entity (illness) and is present if and only if the affected person and the surrounding social group recognizes it so.

b) Every society is capable of constructing cultural framework set of ideas, beliefs and norms and values in their past and persisting encounters with illness episodes. Thus, illness has a cultural domain which means that illness experiences are not individual, impersonal and objective encounters, but are subjective, shared and social experiences and therefore are understood, labelled, communicated and expressed in cultural specific (realistic) manner.

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34. Foster & Anderson, n.3, pp. 218-219

is the social domain of illness. In this, the pivotal attention is the affected person, surrounded by his family and significant others (Therapy Management Group) at one end and the socially recognized health actors (popular or professional or lay healers) on the other. These culture specific sets of roles and statuses are placed in a particular institutional setting.

Holism dominates the theoretical perspective in Medical anthropology. Medical systems have been quite distinctly perceived as social systems (Paul, 1955), as cultural systems (Kleinman, 1979) as adoptive systems (Alland, 1970) but always within the perview of holism. Finally another apparent objective of medical anthropology is in the direction of cross cultural generalizations which have a direct bearing on the international health care planning[35].

Studies in Medical Anthropology

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Four decades ago, ackerknecht (1942) a medical historian contributed a series of scientific papers on primitive medicine. These papers provided useful guidelines to anthropologists for conducting research on primitive folks and indigenous systems of medicine.

Henry (1947) and Mead (1947) wrote a series of research papers emphasizing the importance of the relationship of anthropology to psychosomatic medicine. Clarsen (1950) reviewed the contributions of social science research in the field of mental health. Hall (1951) attempted to highlight the progress of sociological research in the field of medicine. There were also earlier classical works of Riverse (1924) and Clements (1932)

35. Joshi, n.2, pp.6-7

traced the world wide distribution of five basic concept of disease namely sorcery, breach of taboo, object intrusion, spirit intrusion, and soul lose. Other studies are Field's study on the "Religion and Magic of the "Ga" people" 1937, Spencer's study of Disease, Religion and society of "Fizi" Island 1941 and Horley's study of "Mono" of Liberia 1941.

The history of primitive and archaic medicine has been reviewed by Sigerist (1951). However, it was Ackerknecht (1942) who brought out for the first time that "primitive medicine is not a queer collection of errors and superstitions, nor is to be explained by simply stating that in the medical field, primitives used spells, prayers, blood-letting, human fat and spittle.

According to him what counts are not the forms but the place medicine occupies in the life of a tribe or people, the spirit which pervades its practice, the way it merges with other traits from different fields of experience" while discussing the relationship of primitive medicine with culture pattern he preferred three important points.

a) There is not one primitive medicine but numerous different primitive medicines.

b) The differences between the primitive medicine are much less differences in the medical pattern which they build up and which is conditioned fundamentally by their cultural pattern.

c) The degree of integration of different elements of medicine into a whole and of whole medicine into a culture pattern varies considerably. He was able to illustrate these points by comparing the systems of medicine in different cultures. And also, his cross-cultural analysis of the practice of medicine in different cultures is of considerable value to the anthropologists working on the field of medicine. Ackerknecht also described how and why medicine of

the preliterate people was often successful. He collected useful information on their varied practices, including baths, cauterization, surgery, inoculation and also on their pharmacopoeia. According to him, primitive medicine succeeded because of its psychotherapeutic qualities.

In 1952, Whiting and Child used cross-cultural material from 75 societies to test the hypothesis that child socialization practices are related to adult conceptions of the cause of the disease. They based on the analysis of explanation of illness on five factors:

a) The agency causing the illness
b) The degree of patients responsibility of the illness.
c) The act or failure to act of the patient
d) The material which have to do with production of illness
e) The means by which such material have an effect - whether they are ingested: brought into an external contacts with the body or used in rituals etc.[36].

Logan (1973) reported that peasants of Guatemala classified foods, medicinal plants in humoral scheme of medicine which influences individual's selection and assessment of medical treatments. Another important generalization about folk medicine is that the local people tend to divide illness into two identifiable classes: (i) Those that respond to treatment by folk practitioners or indigenous medical practitioners; and (ii) those that are amenable to scientific medicine. Paul (1955) had compiled a series of cross-cultural case studies related to people's reaction to health programmes,

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36. Kakar, n.14, pp.14-15

Carstrairs (1955) had brought out how attempts by a western trained doctor to treat villagers in rural Rajasthan in northern India met with some obstacles due to traditional local beliefs, Marriot (1955) had critically examined the social and cultural problems involved in introducing more effective medical techniques to the conservative Indian village of KishanGiri[37].

The studies reviewed here provides a vivid description of how the holistic perspective of health and disease have been ignored by the scholars who have been guided mostly by the western theories and methodologies. Because of this the contribution of medical anthropologists were loosing their wider acceptability and appreciation from the community health specialists. This demanded a critical rethinking in the field of medical medical anthropology.

A recent growth of critical medical anthropology has given quite a bit of solace. This venture has made an attempt to reinvent the holistic perspective and have placed the field of health within the context of the class and capitalist expansions. Critical medical anthropologists ultimately aspire to merge theory and practice in their desire to promote experiential health as opposed to the functional health associated with contemporary political economics around the world. As part of this endeavour, Wright and Johnson expressed toward a critical clinically applied Anthropology, the hope of synthesizing critical medical Anthropology and clinically applied work[38].

Critical medical Anthropology itself has been concerned most commonly with (a) the effect of capitalism, imperialism and western

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37. Ibid., p.16

38. Hans. A. Baer, "The Possibilities and Dilmmas of Building Bridges Between Medical Anthropology And Clinical Anthropology: A Discussion, Social Science & Medicine, Vol.30, No.9, pp.1011-1013,1990, p.1011

technology upon health status, typically in the third world nations; (b) the logistics, availability, distribution of and access to biomedical resources, both in the third world, and in the lower income regions or urban neighbourhoods of industrialized nations, such as U.S. and (c) the role of biomedicine as an agent of world capitalism.

Clinical anthropological studies most commonly involve the nature of interactions between patients and care givers within the biomedical, clinical setting. This setting is generally in the U.S. or other industrialized, capitalist nation.

Critical approaches often begin with the assumption that health and nutritional deficits, asymmetry in the availability of health resources, medical management strategies, interactional asymmetry, medicalization, sexism, racism, classism, social control all are a function of capitalism. Although Singer suggests the need for uniting macro and traditional micro approaches, he defines the foci of a critical medical anthropology as largely macro level global social relationships, their dependency upon capitalism, and the net effect on health and health care. Referring to biomedicine as "bourgeois medicine" he suggests that a critical approach must recognize biomedicine's key role in the promotion of the hegemony of capitalist society generally and the capitalist class specifically[39].

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39. Irwin Press, Levels of Explanation And Cautions For a Critical Clinical Anthropology, Social science & Medicine, Vol.30, No.9, pp.1001-1009, 1990,1001

So, medical anthropology as a new scientific discipline emerges as a subdiscipline of anthropology. While the scholars wanted to delve into the complex health and the related practices among the different human groupings. As a result of this, a wide canvass of approaches for medical anthropology has been traced globally to put the threads of insights in a scientific exercise.

In the next chapter, an attempt has been made to trace the trends of medical anthropology as practices in different parts of the globe in order to develop a proper perspective keeping in view the complex interdisciplinary nature of the community health problems among the developed and the underdeveloped human groups.

CHAPTER - II
TRENDS IN MEDICAL ANTHROPOLOGY

Medical Anthropology being a branch of Anthropology grew up as a subdiscipline at the global level. The scholars of Anthropology while understanding the total life process of the various human groupings, came across the various diseases causing ill health at this cultural and sub cultural level. In order to study the dynamics of illness and suffering of the people the anthropologists used the classical theories and methodologies, instead of raising the relevant questions of holistic understanding of health, disease and man, which touches the core issues of epidemiology. In this chapter an attempt has been made to show how the medical anthropologists handled these complex multifaceted issues theoretically as well as methodologically.

In the third world, health policies neglect a few fundamental facts: they tend to perceive and treat the health situation as an ahistorical and natural product rather than a historical and social one.

Health problems were defined as technical problems, rather than political and economic policies. This emphasis was nurtured by the progress of medical sciences in the west, because of the understanding of the germ theory of disease, and the resulting discovery of the wonder drugs. As a result, concurrent improvement in public health in the west gave an apparently much importance in the medical technology rather than understanding of social and economic dynamics of health[1].

1. G. Djurfeldt & S. Lindberg, "Pills against Poverty: A Study of the Introduction of Western Medicine in a Tamil Village", (London, 1975), p.15

According to recent review of medical anthropology, two distinct emphasis can be discerned within the field. They work with two different concepts of disease: In the first type, medical problems are approached from the view point of the groups, and individuals studied. The illness, tends to be viewed as a cultural category and as a set of culturally related events. It will be observed that in ethono-medical studies, behavioural and phenomenological indicators are usually employed to define a state of illness. At the other extreme are studies that view medical problems using the categories of western scientific medicine. The organizing perspective toward disease in these studies is a biological one. That is, emphasis is given to disease as an abnormality in the structure and / or function of any system of the body, and evidences of biological system malfunction serve as indicators of disease. In many studies that use western medical disease categories, the beliefs, perceptions or practices of the groups regarding the disease are not emphasized.

Fabrega calls these two emphases the "ethnomedical" and the "western biomedical", respectively. Now our problem is: shall we select "illness" or "disease" as our analytical category ? To be able to make a choice, we have to make a critical evaluation of the two research traditions. what can ethnomedicine offer us ? Studies in that tradition typically deal with topics such as sorcery, witchcraft, shamanism, folk psychiatry and culture specific syndromes[2].

2. Ibid. p.20

Medicine and disease have had an undeniable effect on the history and culture of mankind. Disease has been co-eval with existence of animal life. Since man is peculiar in having cultural environment apart from biological and physical environments, every known human society has developed a pharmacopeia and a therapy - be it magico-religious, secular or empirical or scientific. In order to understand the total culture of particular period it is necessary to pay attention to assessing the health status of the human group involved[3].

Health and disease are measures of the effectiveness with which human groups, combining biological and cultural resources, adapt to their environments. The fact that health and disease are related to cultural as well as biological factors underlies the convergence of medical and cultural anthropological interests[4].

Mainly medical anthropology is a biocultural discipline. It studies both the biological and sociocultural aspects of human behaviour. And how these two aspects interact and interacted throughout human history to influence health and diseases.

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3. Khwaja A. Hasan, "Anthropology and Medical History" in L.P. Vidyarthi, ed., Applied Anthropology in India, (Allahabad, 1968), p.495

3. R. W. Leiban, "The Field of Medical Anthropology" in D. Landy, eds. Culture, Disease and Healing: Studies in Medical Anthropology, (New York, 1977), pp13-14

Bio-Sociocultural Trend In Medical Anthropology

Conceptually medical anthropology may be ranged along a continuum, one end of which is marked by a biological pole, and the other by a sociocultural pole. Towards the biological pole anthropologists interest include human growth and development, the role of disease in human evolution and pleopathology. Towards the sociocultural pole anthropologists dominant interests include traditional medical systems, medical personnel and their professional preparation, illness behaviour, the doctor-patient relationship, and the dynamics of the introduction of western medical services into traditional societies[5].

Alland says medical anthropology has served primarily as an adjunct to applied anthropology and public health. The evolution of man's sapient form has been an interactive process between cultural and physical development (Spuhler 1959, Washburn 1959, Dobzhansky 1962). Simpson (1962) has suggested that culture itself is an adaptive process of biological evolution. While most physical anthropologists accept the role of culture in physical development , many of those interested in cultural evolution have tended to bypass the biological aspect of cultural development. They have concentrated instead on the cumulative aspect of the evolutionary process. No one can deny that biological evolution is cumulative in the two senses that there has been a proliferation of species through the time and that greater complexity of the nervous system has been a constant of phylogenetic development. Nor can one deny that functional interrelationship exists between specific ecological niches and different levels of cultural complexity[6].

5. Foster and Anderson, Medical Anthropology, (New York, 1978), pp 1-2
6. Alexander Allard, "Medical Anthropology & The Study of Biological and Cultural Adaption", in D. Landy, ed., Culture, Disease & Healing: Studies in Medical Anthropology, (New York, 1977), p.41

Medical anthropology encompasses the study of medical phenomena as they are influenced by social and cultural features, and social and cultural phenomena as they are illuminated by their medical aspects. These distinctions may be seen as two facets of a set of interrelated phenomena. But depending on the nature of the study and the interests of the investigatior, one or the other at times may receive greater emphasis or be the focus of attention[7].

Disease in some form is one of the fundamental vital problems facing every society, and every known society has developed methods for coping with disease and thus created a medicine.

In the modern anthropological and medical viewpoint on primitive medicine, Ackerknecht (1942-47) emphasizes that primitive medicine is not a queer collection of errors and superstitions nor is it to be explained by simply stating that, in the medical field, primitives use spells and spittle.

Ackerknecht (1942): " what counts are not the forms but the place medicine occupies in the life of a tribe or people, the spirit which it merges with other traits from different fields of experience".

In discussing primitive medicine and culture pattern, he stresses three points:

(a) There is not one primitive medicine, but numerous primitive medicines.
(b) The differences between primitive medicines are much less differences on

7. Leiban, n.2, pp. 15-16

elements, than differences in the medical pattern which they build up and which is conditioned fundamentally by their cultural pattern ;

(c) The degree of integration of the different elements of medicine into a whole, and of the whole medicine into a culture pattern, varies considerably[8].

Ackerknecht illustrates these points by comparison of the systems of medicine in Cheyenne, Dobu and Thonga cultures. This is a cross cultural analysis of primitive medicine in terms of culture patterns.

Some authors refer to the structural and organizational aspects of medicine and health, using the term medical systems and health systems. Health systems comprise the whole array of elements or components of the broader social system which are related to the health and physical, mental and social well-being of the population. The term medical systems for the organized array of human resources, technologies and services specifically designed for the development and practice of a medicine for individual or collective health care.

Medical systems are made up of a more or less uniform set of schools, hospitals, clinics, professional associations and agencies who train personnel, maintain an infrastructure for biomedical research and deploy a network of services of varying degrees of complexity for the prevention, curing, care and rehabilitation of the sick.

8. W. Coudill, "Applied Anthropology in Medicine" in A. L. Kroeber, ed., Anthropology Today, (Chicago Universtity Press), p.772-3

Every medical system has its own distinct and more or less organized set of techniques, (materiamedica, drugs, herbs or procedures such as adinnation, surgery or acupuncture) and practitioners (doctors, nurses, dentists, pharmacists, therapists, shamans, healers, bone setters, herbalists, midwives etc.), with their own ideological sub-stratum (concepts, notions and ideas) which form an indissoluble part of the cultural repertoire of society[9].

Health is a part of overall development. Its analysis will acquire a meaning and significance by the medical anthropologists only when they are relevant in the present social, cultural, economic, political, ecological and biological milieu and are carried out with broader imagination and holistic framework in the developing world[10].

Alland explained biological and cultural anthropology through the junction of medical anthropology. His approaches to this study is mainly evolutionary. But he suggested that studies of health and disease in human societies should be examined as investigations in human ecology.

Sahlins and Service (1960) have applied an analogue model of the Darwinian theory to the problems of culture, but in their system there are no measurable biological variables and no generalizations may be made from established biological laws.

The question that must be raised is: can the Darwinian model of evolution be applied to cultural evolution and if so, to what extent and how ? Before an attempt can be made to answer these questions certain theoretical points associated with the organization and the analysis of data must be classified.

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9. D. Pedersen & V. Baruffati, "Healers, Deities, Saints & Doctors: Elements for the Analysis of Medical Systems", Social Science & Medicine, V.29,N.9,pp487-496,1989,p487
10. S. K. Sahu, "Research in Medical Anthropology: Issues and Alternatives",Man & Life, Vol.30, pp. 1-13

First of all it must be emphasized that the unit of such studies is a human population characterized by a configuration of biological and cultural traits and occupying a specific ecological space.

The term culture shall be reserved to denote traits which are shared by a significant numbers of individuals and which are transmitted through the learning process. This should help us to avoid the tendency towards typological thinking which too often accompanies the use of the term culture to describe human societies and faciliate the study of cultural and biological variables as interacting factors in the adaptive process.

Secondly, it must be understood that what is to be studied is neither a teleological nor a unidirectional process. Traits which have adaptive value do not necessarily arise as a response to need. Thus there is no question of causality in the analysis. This is in keeping with the theory of evolution which provides functional explanations for the fixation or loss of random events (mutation) within a defined system (a population). Factors responsible for mutation may be investigated independently, just as factors responsible for the origin of particular cultural traits may be investigated independently...

Traits which have survival value may be sorted out in a process which may well be, though it need not be, independent of the individuals involved. This is not to say that all cultural traits are adaptive; but the proposition that many of them are is not a new one. What is new is the proposed investigation of the biological adaptability of such traits within a given environment.

Lastly medically oriented studies are only one means of pursuing research in the field of human evolution. Adaptive environmental exploitation

importance, but medical studies will provide units of analysis which are more directly measurable and which may reveal more readily the relationship between biological and cultural variables.

It is often pointed out that the major difficulty in applying Darwinian evolution to so called cultural adaption is the fact that culture traits are extrasomatic and therefore not bound to genetic mechanisms. Hence it is said quite correctly, that different rules govern their transmission. They are not only passed from generation to generation through a learning process, but may easily transgress societal boundaries without concomitant interbreeding. But it should be known that how important is this difference. The adaptation is the major concern here, not the origin of traits nor the mechanism of their transmission. The relationships between traits and environments have the same effect on adaptation whether the traits are biological or cultural and adaptive in human groups is bound to be the result of combined biological and cultural forces[11].

Anthropologists believe the utility of Anthropology to the health sciences lies within three major categories. Firstly, Anthropology offers a distinctive way of looking at both - whole societies and their individual memebers, it uses a holistic or systemslike approach in which the researcher constantly asks how all of the parts of the system fit together and how the system itself works. Anthropology's distinctive way also stresses the importance of cultural relativism in evolutionary ways other than our own, the need to interpret indigenous forms within context of the culture in which they are found instead of judging them against western or supposedly universal standards.

11. Alland, n.4, pp. 41-42

Secondly, Anthroplogy offers an operationally useful model to explain the process of social and cultural change and to aid, in understanding the conditions under which members of "target groups" respond to changed conditions and new opportunities. Anthropologists have no formulated laws that predict accurately all individual and group behaviour under specified conditions, but they are able to foretell quite accurately the probable range of choices that will be exercised when people find themselves in new situations that permit or force on them new behaviour forms.

Thirdly, Anthropology offers the health sciences a flexible and effective research methodology for exploring a wide range of theoretical and practical problems that are encountered in medical programmes. As one element in this methodology anthropology offers the concept of "premises" or "assumptions" that underline behaviour, these premises afforded an important key to understanding the rationale of acts that, when viewed from vastly different cultural assumptions, often seem irrational[12].

As far as the methodological orientation is concerned most of the biologists accept the fact that careful studies on the microevolutionary level are essential than understanding of the mechanisms of evolution. If we accept the principle that microevolutionary studies are a necessary prerequisite for this type of research, then it becomes possible to discuss specific lines of attack on those areas which are subject to biological measurements. Generally speaking the measurements are fertility and fecundity, morbility and mortality. The material to be examined falls into two groups. First, those relationship between culture and biological variables which affect the distribution and frequency of genes, and second, those relationships between culture and

12. Foster and Anderson, n.3, pp. 208-9

biological variables which directly affect disease frequency, disease outcome and fertility. The first group reflects primarily the effects of culture on physical developments, but changes in genes may well feed back to culture. The second group is concerned specifically with cultural development as it is affected by biological variables. Where genes are concerned we have the added measure of gene frequency.

There are a number of studies of biological and cultural adaptations to the field of medical anthroplogy. One of the most important studies is Livingstone's brilliant paper on sickle cell aneamia (Livingstone, 1958). He opened a vast field of research into the relationships among genes, diseases and cultural practices. Here Livingstone has correlated the distribution of the vector in the west Africa for Falciparum malaria with the introduction of agriculture to this area. The increase in the vector population is related to the increase in disease incidence and the increase of disease incidence to the development of an adaptive polymorphism based on the resistance of heterozygotes for the sickle cell trait to a highly fatal form of malaria[13].

There is a data in the literature on the genetics of disease resistance and susceptibility (Schull-1963, Blumberg-1962, Butter Janusch-1959). Cultural factors which act to increase the frequency of disease organisms in particular ecological areas on which act to reduce or increase resistance will have an effect on the genetic constitution of populations.

A recent paper by Lambrecht (1964) on the evolution and ecology of the tsetse fly and trypanosomiasis provides much material of anthropological interest which Lambrecht does not investigate the genetics of disease

13. Alland, n.4, pp. 42-43

resistance to trypanosomiasis in present human populations, he does relate the distribution of various species of carrier and disease organism to both environmental and cultural factors. The author raises the question of relationship between primate and hominid evolution and the incidence of disease. To quote his summary paragraph: "Exposure to and invasion by parasitic organisms may play an important part among many other intrinsic factors that guide the evolution of animal forms. Trypanosomes, two species of which cause African sleeping sickness today, are blood parasites of great antiquity. Their presence in Africa at the time of the first stages of human evolutions may have been of great consequence, at first acting as a discriminating agent between resistant and nonresistant types of hominids and later also in shaping migration routes and settlement patterns. As a possible clue as to why man arose in Africa, the author postulates that trypanosomes may have precluded the development of certain ground dwelling faunas, allowing certain more resistant primating to fill the empty ecological "niches".

The suggestion that disease has been a factor in primate evolution (Schultz-1950-53). It is interesting to note in this respect that macques will drive sick animals away from their territory and thus protect the group from an increased frequency of disease organisms. Thus disease may well have played a selective role in the evolution of certain primate behaviour traits as well[14].

14. Ibid., p.43

Medical anthropology is the term used by anthropologists to describe,
(i) their research whose goal is the comprehensive description ar
interpretation of the biocultural interrelationships between human behaviou
past and present, and health and disease levels, without primary regards
practical utilization of this knowledge; and
(ii) their professional participation in programs whose goal is the improvemei
of health levels through greater understanding of the relationships betwee
bio-sociocultural phenomena and health, and through the changing of healt
behaviour in directions believed to promote better health[15].

It is clear; if we choose "illness" as our unit, we end up with a cripple
medical anthropology, unable to deal with the most important health problem
in the world today. If we want this science to serve the people of the thir
world, then malaria, cholera, small pox, tuberculosis and other mass killer
and cripplers should be given priority[16].

The ethonomedicine and biomedicine show that both approache:
suffer from serious weaknesses. On the theoretical level, the ground for thei
weakness can be found in the conceptions of illness and disease. Wher
ethonomedicine defines, illness as an entirely cultural or subjective and idea
category, it ends up studying peripheral and picturesque problems, while the
serious health problems affecting the peoples of the third world fall outside its
scope of interest. If we want to evolve a sound conception of disease, and i
we want to avoid falling into the ethonomedical trap, we have to take intc
account that disease is not only a subjective or cultural category, but also an

15. Foster and Anderson, n.3 , p.10
16. Djurfeldt & Lindberg, n.1, p.21

objective physiological reality. On the other hand, in defining disease as an entirely objective or physiological category, biomedicine denies the fact that which form the rationale for the ethnomedical tradition, namely that disease is also a subject or cultural category, and that diseases are influenced by life situations that transcend the direct impact pf physiochemical forces. A sound definition of disease must recognize the dual character of health as a natural reality that is socially defined[17].

The practice and the trends found in the medical anthropology in the third world countries in general and in India in particular has been influenced greatly by the western theories and ideas. Because of this Fabrega defined that medical anthropology is a discipline, which is meant solely for understanding the health problems in the developing countries. Because of this the dominant trend found in India among the medical anthropologists either in the category of ethnomedical studies or biomedical studies. There is a serious lacking for combining this two dimensions for a holistic understanding of health problems found among the deprived sections in the society. If medical anthropology being a branch of science, how can it be only practice without addressing the health problems which is a part of overall problems of humanity of this group.

This trend has been examined in the next chapter and in subsequent chapters by examining the place and relevance of medical anthropology in public health and growth of medical anthropology in India.

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17. Djurfeldt & Lindberg, n.1, pp. 25-26

CHAPTER - III

RELEVANCE OF MEDICAL ANTHROPOLOGY TO PUBLIC HEALTH

The prevention of illness and the containment of disease are part of every medical system. But much more is involved than questions of sanitation and private and public cleanliness and robustness. For notions of contagion are bound up with religion and world view and with perceptions of the powers and intentions of one's neighbours and friends, not to mention the strangers. Though intent may not be subject to control or change, behaviour to some extent is, and therefore, the medical system, especially with regard to contagion and sanitation, is directly hooked into local systems of social organization and social control. In the ultimate sense, public health as a separate field of study and practice is in fact the attempt by a society to control the behaviour of its members for what the reigning groups and belief systems define as the welfare of the community as a whole. In pre-industrial societies this usually includes also the control , or at least the effort to influence, the spiritual and cosmic forces that may attack the health and well being of any mortal.

In some instances these societies evolve pragmatic means of sanitation that, whatever the intended religious or magical purpose, may in fact function to protect health and ward off disease. That is, through a long process of trial and error a society learns to invent at least some measures that will aid its quest for health and freedom from sickness. But, empirical devices are not to be fully depended upon and appeal to spiritual beings must also be effected through ritual, prescribed ways of behaving and not behaving, and the uses of fetishes, amulets and talismans to ward off all forms of evil that may bring disease or other misfortune (Sigerist, 1951) [1].

1. David Landy, "Public Health & Preventive Medicine in D. Landy ed., Culture, Health And Disease: Studies in Medical Anthropology, (New York,1977), p.231.

In large part, the practice of public health was always governed by legislation, first by the public health acts, and after 1946 by the NHS act. In fact, public health as a form of state regulation has a remarkably long history. Cipolla has described the efforts of the seventeenth century Italian city states to control the spread of plague, and Rosen, the operations of the medical police in United Kingdom during the eighteenth century. During the nineteenth century, industrialization and rapid urbanization made more extensive and more formal protection of the community necessary. State intervention went farthest in matters of health policy, largely because of the threat of diseases, such as cholera and small-pox posed to the whole community. Indeed vaccination against small-pox was the only measure that the central government made the obligatory responsibility of the local authorities. The central board of health , set up in 1848, was abandoned in 1854 and its responsibilities transferred to the privy council and later again to the local government board. Despite the recommendation of the sanitary commission of 1869 in favour of a ministry of health, none was set up until 1919. Primary responsibility for health initiatives rested at the local level, where the public health act 1872 made the appointment of an MOH obligatory for local sanitary authorities in England and Wales, and the local government Act 1888 permitted the new country councils to do likewise (they were not compelled to do so until 1909). MOHs were charged with enforcing the public health acts in their communities, for inspecting food, sanitation, housing and for publishing an annual report on their activities and the state of the public health in their communities. Winslow, the early twentieth century American authority on public health, identified three phases in the development of public health: the first from 1840 to 1890, was characterized by environmental sanitation; the second, from 1890 to 1910, by development in bacteriology, resulting in an emphasis on isolation and disinfection, and the third, beginning around 1910, by an emphasis on education and personal hygiene, often referred to as

personal prevention. This chronology is broadly congruent with developments in Britain[2].

For nearly fifty years international public health programmes and their medical specialists operated largely on the assumption that better health depended on the design and execution of scientifically sound programmes, in which the people to be benefited would be enthusiastic participants. In 1916, after having demonstrated in the southern United Sates how hookworm could be controlled and ultimately eliminated, the Rockfeller Foundation turned to Ceylone for a massive demonstration of how disease control methods could

2. J. Lewis, "What Price Community Medicine ? The Philosophy, Practice and Polcies of Public Health Since 1919", (Sussex, 1986), pp4-5

be applied in other parts of the world. The technical part of the programmes appears to have been sound: a census, sanitary surveys to locate sources of infection, microscopic examination of feces and blood samples of everyone in the trial area, treatment of the infected persons, and latrine installation campaigns. But six years later, when the programme was brought to an end, hookworm was still widespread; and even today it is endemic. In 1942, when the institute of inter-American affairs (a forerunner of the agency of international development) began public health programmes in cooperation with Latin American governments; the same ethnocentrism prevailed. Better health for Latin Americans, it was assumed, would result from the adoption of U.S. practices, especially the dichtomy between clinical, curative, private sector medicine, and preventive, public health and public sector medicine.

With the post World War II establishment of the World Health Organization and the development of a vast international health bureaucracy designed to bring modern medicine to all of the world's countries[3].

The corpus of data on primitive and peasant medical beliefs and practices that had been gathered by cultural anthropologists in earlier years, their information on cultural values and social forms, and their knowledge about the dynamics of social stability and change provided the needed key to many of the problems encountered in those early public health programmes. Anthropologists were in a position to explain to health personnel how traditional beliefs and practices conflicted with western medical assumptions, how social factors influenced health care decisions, and how health and

3. Foster and Anderson, "Medical Anthropology", (New York, 1978), pp. 224-225

disease are simply aspects of total culture patterns, which change only in the company of broader and more comprehensive socio-cultural changes.

Beginning in the early 1950s, anthropologists were able to demonstrate the practical utility of their knowledge (and of their research methods) to international public health personnel, many of whom welcomed anthropologists with open arms. Anthropology provided insight into why many programmes were less successful than had been hoped, and in some instances, anthropologists were able to suggest ways to improve programmes[4].

Hughes, in his essay (1963) "Public health in non-literate societies", makes a signal contribution to this area of study by drawing the topics of public health and preventive medicine into the purview of anthropology. Hughes finds that in a basic sense all health is public, that is, that no person is ever isolated completely from society so that his health necessarily is a cause of concern to others, and each ailing person, no matter how rare his disease, is a member of a class of persons suffering from the same disability. His review of cross-cultural data impels (Hughes, 1963:166-174) to make four generalizations.

1. In any society , practices relevant to public health are generally neither wholly "magical" nor wholly "empirical" or "scientific", they are a mixture of both orientations, and often may simply be habitual...

4. Ibid., pp.7-8

2. The relations between the state of public health of any group and its way of life are reciprocal...

3. In primitive societies the health is a continual and encompassing concern of the entire group, which recognizes few bounds in protecting itself from disease or the threat of disease...

4. People's health is a function of total life situation.

Hughes believes that the behaviours of pre-industrial societies that have a direct bearing on the health of the community may be subsumed under the following categories: magico-religious prevention, empirical prevention, personal hygiene, clothing and adornment, physical culture, cosmetic and nutritional practices, occupational health, housing and settlement patterns, handling of contagion and other health relevant practices. These propositions are profusely illustrated with ethnographic data[5].

In the paper of "The role of Beliefs and Customs in Sanitation Programme", Paul indicates that public health workers in this case sanitation engineers, must "case" the culture of the community with which they intend to deal. As in the assessment of Paul's theoretical contributions of medical anthropology, he treats culture as a system of interlinked beliefs and customs. Introducing sanitation programmes is an exercise in culture change, and Paul shows why the health worker must identify and understand the linkages of that sector of a culture he or she wishes to change instead of

5. Landy, n.1, pp. 231-232

simply presuming that the people should be able to grasp the rationality of the beliefs and practices being introduced. As Paul says in his case book of public reaction to health programs (1975):

"If you wish to help a community improve its health, you must learn to think like the people of that community. Before asking a group of people to assume new health habits, it is wise to ascertain the existing habits, how these habits are linked to one another, what functions they perform and what they mean to those who practice them."

Polgar (1963) describes four fallacies that community afflict public health programs:

(1) The fallacy of the empty vessels (the subject populations do not have established health customs and are empty vessels waiting to be filled with whatever health programme is being advocated.
(2) The fallacy of the separate capsule (health beliefs and practices comprise a bounded, separate capsule of behaviour and cognition apart from the remainder of culture).
(3) The fallacy of the single pyramid (the communication structure of a society is organized with the social units as a single pyramid so that information and bahaviours poured in at the top will trickle down to all levels).
(4) The fallacy of the interchangeable faces (all clients are alike).
All of these errors derive from a lack of understanding of the nature of culture and social organization and their involvement in public health practices. Incidentally, the high valuation placed on health not only shared by the members of another society but may not be shared by members of the health worker's of own society, either. Here Polgar differs a bit from Paul's statement in this study:

"An engineer can construct health facilities in his home area withou worrying too much about the cultural characteristics of the people who wil use the facilities". Members of our own society still place the pleasures o smoking, eating, easy living and many other practices far above thei valuation of health. The billions of dollars spent on advertising demonstrate that most Americans have to be persuaded to be concerned about thei health (or have their anxiety level needlessly raised over what may not really be a critical health problem at all)[6].

Heyneman (1971) explained that in northern Malaya house spraying largely eliminated the indigenous vector mosquito that lived in houses, on walls and in thatched roofs. This opened the way for forest dwelling species of Anopheles to move in on a new human source of blood, feeding on people without alighting on walls, and then returning to the jungle, where no spray could reach them. New out-breaks of malaria from an uncontrollable haven of infection was the result. Attempts to persuade desert dwelling villagers to construct sanitary latrines have been known to backfire.

Foster (1962) explained that in Iran, in the early 1950s, American public health consultants insisted, in the face of visible evidence to the contrary, that defecation in the open air would produce flies. In fact, the dry atmosphere quickly dries the fecal matter and flies do not breed. The advisers, however insisted that latrines must be built which, when installed in numbers and properly maintained become only breeders.

Kelly (1959) explained that in 1959 a yellow Cuban maize was intoduced into the eastern low lands of Bolivia. This maize, nutritionally sperior

6. Benjamin D. Paul, "The Role of Beliefs and Customs in Sanitation Programmes", D. Landy, eds. Culture, Disease and Healing: Studies in Medical Anthropology, (New York, 1977), pp233-234

to the indigenous variety, seemed to be an excellent device to improve the diet of both humans and animals. Unfortunately, its hardness, desirable from the stand point of storage, made it difficult to grind, and the people were unwilling to take the time to haul it to commercial mills in towns. The maize, however, makes excellent alcohol in home stills. so that a seemingly desirable innovation promoted alcoholism instead of better nutrition.

In Ryukyu islands, Trachoma, an infectious disease that leads to blindness, is caused by a virus thought to spread from person to person by direct contact or indirectly by water, towels or clothing. With good environmental sanitation and pure water, trachoma prevalence is low or absent. This is true in the Ryukyus in areas with pure water and good environmental sanitation. But incidences run as high as 40 percent where these conditions do not prevail. Scarcity of water, particularly, and the subsequent use of a single bowl for washing by a number of people is an easy way in which the virus is passed on. In an effort to control trachoma, school children in water abundant areas are required to wash their hands and faces before being allowed to eat. But, since the schools lack funds for individual paper towels, hand kerchiefs are pressed into service, a single one is used by as many as ten children to dry their hands and faces. Thus it is almost certain that trachoma is transmitted from child to child in this manner (Marshall 1972).

Another ecological topic and health problem is that the implication of increased stress that often characterizes people who are also undergoing rapid urbanization, in cultures as different as the Zulu Scotch(1963) and western north carolina (Tryoler and Cassel 1964), it has been found to be associated with increased hypertension and/or coronary disease. The epidemiology of psychological disorders in situations of rapid change also

merits discussion, a good deal of evidence indicates that an increase in such disorders is the consequence of stressful living conditions (e.g. Hughes and Hunter 1970)[7].

Cassel, a public health physician and epidemiologist exhibits a fine appreciation for the contributions to be made by social science knowledge to public health problems and by the use of social scientists on teams dealing with the problems and attempting to introduce cultural changes. This study illustrates, through a descriptive analysis of a programme for changing health practices among Zulu peoples in south Africa. This study is concerned only with food but similar experiences have been found in attempting to change other categories of cultural practices and values without in any way underestimating the factor of poverty in the malnutrition and undernutrition of the Bantu people, it is nevertheless clear that ingrained food customs as well as many other attitudes tightly wrapped in deeply held beliefs, some ancient and some only thought by the people to be of long tradition, obtruded in the path of healthful nutrition. The success of the programme ultimately is reflected in the changes that took place after a dozen of years in infant mortality and the near disappearance of pellagra and kwashiorkor[8].

In Khare's study "The Ritual purity and Pollution in Relation to Domestic Sanitation", he explained about an anthropological inquiry on domestic sanitation. The relation between the concepts and practices of ritual purity and those of a pragmatically hygienic nature are not always clearly

7. Foster & Anderson, n.3, pp. 30-31
8. John Cassel, "Social & Cultural Implication of Food & Food Habits", D. Landy, Ed. Culture, Disease & Healing: Studies in Medical Anthropology, (New York, 1977), pp. 236-237

spelled out in ethnographies or in studies of religions. Theologicians not only infrequently attempt to prove that the original purpose of many ritual practices and taboos was actually health directed, often thousands of years after such concepts first appeared. In many anthropological accounts, moreover, little effort may be made to link the two, in either an emic or etic sense. This study strives to do just that, drawing upon the data of the complex religious system of Hinduism in a northern Indian village.

Khare explained an anthropological inquiry on domestic sanitation. He says that whereas the extermination of the sources of disease - germs and insect pests - may be uppermost on the agenda of public health experts, they are not part of the villager's notion of cleanliness. Nevertheless, although in some instances practices of ritual purification are irrelevant to health, and some practices of cleanliness are, in some instances, irrelevant to ritual purification, there are many instances and areas where they overlap, and as Khare shows, promote and reinforce each other. Even practices that are presumably secular and with a specifically hygienic intent may in time become ritualized. Khare shows that pollution varies by gradation in different sectors of life and of the domestic household, and that the same act or object may be variously polluting depending upon circumstances, actors and so on. Thus, the system differently affects members of the several castes, with a claim of greater purity as one ascends the caste ladder though not in a single fashion. Finally Khare discusses some of the changes taking place under "modernization" and presents a three stage model of modifications occurring in practices and ideas relating to ritual purity and pollution, both in terms of modernization and sanskritization. Khare urges public health workers to attempt to keep this process in mind when institutionally changes in health and sanitation policies and behaviours. As he points out in a concluding passage, not included in this abridgment, both the public health system and

the traditional one of ritual purity promote health and have several points of overlap and potential linkage or transference, and the public health worker can utilize this knowledge to increase communication, efficiency and understanding between himself and the villager[9].

In 1956, when the government of India wanted to introduce sanitary latrines as a part of the community development programme in the villages for improvement of the environmental conditions through the Research Cum Action (RCA) approach, the anthropologists were invited along with other social scientists to suggest ways and means for implementing the programmes. In fact, Foster suggests that instead of imparting health education to educate the villagers for adopting sanitary latrines in their houses, it is desirable to understand total life process of the villagers at their customs and practices regarding their behaviour in the open air deficacy.

In another instance, when WHO was involved for eradication of smallpox from India in the early seventies, it was realized by the programme executives that non-acceptance of the smallpox vaccination by the villagers, when the small pox was there in the village, because as per the cultural and customary practices the villagers do not want to annoy "SitalaMata". However, it has been scientifically proved that the vaccine is effective during the time of epidemic. This was brought to the understanding when the anthropologists were involved in the small pox programme to understand the "SitalaMata" issue[10].

9. R. S. Khare, "Ritual Purity & Pollution To Domestic Sanitation", ed., D. Landy, Culture, Disease & Healing: Studies in Medical Anthropology, (New York, 1977), pp. 242-243
10. R. N. Basu, "Smallpox in India", Government of India, 1975

So, above studies have done by the medical anthropologists and they showed that how these studies are relevant to public health programmes. Landy said that in whatever segment of culture certain measures may result in the improvement of health and avoidance or control of disease. These should be included as parts of the system of public health and preventive medicine, and therefore, a part of the medical system[11].

Sigerist the medical historian stated that every culture of human being has developed a system of medicine and medical history is, but one aspect of the history of culture. The scope of medicine is broaden considerably during the recent years. The realization has dawned that illness is to a large extent due to the interaction of men with physical, biological and social environment. The community health seeks to bring together all the available health services within the reach of the people, and also prepare the people who need this services, receptive to these services: this is known as "social engineering", which has been generated from anthropology. So, medical anthropology is nothing but the core science of modern community health or "NEW PUBLIC HEALTH"[12].

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11. Landy, n.1, p.232
12. J. E. Park, "Social & Preventive Medicine", (Jabalpur, 1974), p. 6 & 13

CHAPTER - IV

GROWTH OF MEDICAL ANTHROPOLOGY IN INDIA

Unlike pre-eminent concerns of colonial anthropology to provide a data base for perpetuating colonial subjugation as also to provide an ideological rationale for a sinister dehumanizing colonial system under a humanitarian garb, post-colonial anthropologists at least in the third world, can no longer afford to ignore the vital issues of perpetual poverty, accentuation of inequalities, denial of individual and socio-political freedom, systematic degradation of world's natural ecosystem, and deteriorating levels of quality of life and ensuing poor state of psychological and biological health for the bulk of humanity inhabiting the country. Continued failure to do so will only add to the exploitation dynamics in an unjust social order[1].

A continuous debate is developing over the nature and function of "Anthropological" research in the former colonial societies and the extent of collaboration between anthropologists and colonial administrators. On the one hand, anthropology has been levelled as a child of imperialism, while on the other it has been stated that anthropology is not "a bastard of imperialism but the legitimate child of enlightenment", a full-fledged discipline which has developed its own autonomy and is now an art and a science[2].

The collection of data at grass root level resulted in a radical orientation of politics. Certain ideological trends in anthropology supported anti-colonial movements. Anthropology also stresses the role and function of

1 K. S. Singh, & Kalia, eds., Anthropology in Nation-Building, (New Delhi, 1982), p. 2 .
2. S. K. Sahu, "research In Medical Anthropology : Issues & Alternatives", Man and Life, Vol.13,1989, p.1

ethnicity and diversity in the formation of a nation state. In India, most of those trends could be witnessed. It was not the anthropologists but the colonial activist, who played the key role in making use of the anthropology in various fields of social developments, in which health is one of them[3].

A great deal that is happening in world anthropology today is intellectually exciting, but this excitement does not extend beyond a select band of the practitioners of the discipline. it leaves the socially concerned intellectual cold and makes little sense to the common people at large. By tradition, anthropology has been more at home in the study of equilibrium systems and stability models. This tradition has been turned to medical anthropology, which is a sub-discipline.

Anthropology confines its concerns to small scale societies and deals with them as if they are autonomous systems. As yet it cannot relate these societies to global forces and to the dialectic of power operating in the contemporary world. Despite debate and dissent, the discipline continues to maintain, by and large, a value free posture, is uncertain about the role of anthropologists in society, and is shaky in determining the criteria of the relevance of research. In consequence, its analytical handling of gut issues such as poverty, exploitation, population growth and health is feeble[4].

3. Ibid., p.2
4. S.C. Dube, "Role of Anthropology In Development", Presidential Address to 10th International Congress, 1978, p.4

Anthropologists lopsided values of research result in cultivation of conceptual trivia to a neglect of purposive research on the vital and live issues of today. Until recently most of them had a lopsided idea for applied anthropology (Medical Anthropology), their principal concern was a theory. In a genuinely holistic human study such as anthropology, insights and perspectives from the third world could have considerably enriched our understanding and assessment of the human condition. But the reality is that, anthropologists of the third world do not address themselves to the problem of people they study in a holistic way[5].

With this above background, it is necessary to see the expansion and growth of medical anthropology as an academic discipline in different universities and research institutions since independence. This will provide us an opportunity to assess the growth and importance of medical anthropology in India, as well as how the contribution of this discipline has been utilized in various programmes and policies in community health in India.

Growth of Medical Anthropology In Academic and Research Institutions:

Although medical anthropology as a special discipline , emerged in 1960s, and studies which could be called medically oriented date back to the first half of this century, in India it picked up momentum in early 1980s. Ten years have elapsed, but medical anthropology has yet to achieve a respectable place in the group of special anthropologists[6].

5. Dipankar Gupta, "Anthropological Dimension of Health & Health Practices", CSM & CH, SSS, 1981, p.6
6. P. C. Joshi, "teaching of Medical Anthropology in Indian Universities", (new Delhi, 1990), p.2

There are seventeen universities in India where medical anthropology is taught. Those are[7]:

1. Bilaspur University, Bilaspur
2. Calcutta University, Calcutta
3. Dibrugarh University, Dibrugarh
4. Delhi University, Delhi
5. H. N. B. University, Srinagar (Garhwal)
6. North Bengal University, Darjeeling
7. Poona University, Pune
8. Vidyasagar University, Medinapur
9. Calicut University, Calicut
10. Utkal University, Bhubaneswar
11. Punjab University, Chandigarh
12. I.S.I Calcutta, Calcutta
13. Jawaharlal Nehru University, New Delhi
14. Mysore University, Mysore
15. N.E.H.U, Shillong
16. Ranchi University, Ranchi
17. Central University, Hyderabad

Teaching of medical anthropology first began in Delhi University in 1982. But it was an optional subject. Punjab university has a specialization in medical anthropology for social anthropology special course. In Delhi and Punjab the course is titled "Medical Anthropology", In NEHU, it is called "Culture, Health and Disease" and "Medical Anthropology" in parentheses. In JNU centre for Social Medicine and Community health has a course in M.Phli. It bears the title of "Application of Anthropology in Health"[8].

7. Moni Nag, "Institutional Context of Social Science Research on Health In India", (New York, 1991), Population Council, p.1
8. Joshi, n.6, p.3

Institutes of Health Research And Training

There is also medical anthropology course in the institutions of health research and training. These institutes are:

1. All India Institute of Hygiene and Public Health (AIIHPH)
2. Central Health education Bureau (CHEB)
3. Gandhigram Institute of Rural Health and Family Welfare (GIRHFW)
4. International Institute of Population sciences (IIPS)
5. National Institute of Health & Family welfare (NIHFW)
6. Centre For Development Studies, Trivandrum

Institutes of Economics, Social and Management Studies:

1. Centre For Development Studies (Trivandrum)
2. Council For Social Development (Delhi)
3. Gujurat Institute of Area Planning (Ahemedabad)
4. Institute of Economic Growth (Delhi)
5. National Council of Applied Economics (Delhi)
6. Institute of Management (Ahemedabad and Bangalore)
7. Administrative Staff College (Hyderabad)
8. Centre for Rural Industrial Research (Chandigarh)
9. Tata Institute of Social sciences (Bombay)

Voluntary Organizations

1. Family Planning Association of India (Bombay)
2. Foundation For Research In Community Health (Bombay)
3. Child In Need Institution (Calcutta)
4. Voluntary Health Association of India (VHAI)
5. National Tuberculosis Institute (Bangalore)
6. Voluntary Health Service (Adyar, Madras)
7. Gandhi Leprosy Foundation of India (GLF) (Wardha)

Social Marketing Agencies

1. Operations Research Group (ORG)
2. Indian Marketing Research Bureau (IMRB)
3. Management And Research Group (MARG)
4. Management of Development and Education (MODE)[9]

This above growth and expansion of medical anthropology as an academic discipline has suffered from various limitations, because of its narrow conceptualization and practice. The main text books available to the Indian students are mostly western oriented, which has not addressed holistic issues of man and its environment and his various problems. Many scholars have raised various limitations from time to time in the following studies.

9. Nag, n.7, pp.2-3

Anthropology as a science of man can help in the management of health and hygiene mainly in four areas by way of :

(a) providing information on the concept of health, hygiene, medicine, cure and so on to the health managers and planners;

(b) Policy formulation with regard to health and hygiene;

(c) Action modalities; and finally,

(d) Monitoring and evaluation of specific programmes from holistic cutural-ecological perspective in terms of short term and long term impact assessment[10].

As a sub-discipline of anthropology, medical anthropology has grown in India very recently. Though the term medical anthropology was first used in India itself, it could not be pursued systematically in this country. At present, we appear to have a modest data base in the form of ethnographic notes with medical anthropological contents but a systematic appraisal of what should be done and how it should be done has yet to be established. Indian work further suggests that our studies are heavily influenced by the ideas and approaches developed in the western world. As a result, the contribution of Indian medical anthropology is being increasingly getting limited and suffers from wider application in Indian situations[11].

10. K. G. Gurumurthy, "Anthropology And Management of Health And hygiene: An indian case Study", P.C. Joshi & Anil Mahajan, eds. Studies In Medical Anthropology, (New Delhi, 1990), p.23

11. P.C. Joshi, "Medical Anthropology: An Overview", P.C. Joshi & Anil Mahajan, eds. Studies In Medical Anthropology, (New Delhi, 1990), p.8

The intellectual roots of contemporary medical anthropology as a social science sub-discipline can be legitimately linked to post-renaissance development of human knowledge characterized by analytical separation of mind from the matter. The ensuing coercive reific separation of anthropological phenomena into biology, psychology and culture for the convenience of institutionalized academic specializations and ideological correlates of such separation have tended to produce fragmentary and distorted academic images of the human realm.

Purporting to deal with socio-cultural aspects of health, illness and curative systems in human societies cross-culturally in general, and cognitive-cultural, structural-institutional and behavioural correlates of medical systems in particular, the theoretico-methodological orientation of medical anthropology seem to have been uncritically borrowed from dominant trends in mainstream academic anthropology. As a consequence, we witness (i) culture-trait, (ii) functional, (iii) symbolic, (iv) semantic and (v) processual approaches in medical anthropological researches in various phases of its development.

True to the mainstream trends in academic anthropology, medical anthropology has never tried to measure the relevance, validity and adequacy of its perspectives and analytical modes in relation to the needs of underprivileged people who provide the data base for its hedonistic academic pursuits. At applied level, macro-institutional and bureaucratic needs appear to have dominated anthropological concerns, viz- application of anthropological information and knowledge for effective management and dispensing of medical care by a predominantly western institutional curative

system. Even these, in its studies of social system of curative institutional domains and the ethonomedical pluralism, it has never felt the urge to explore the interest norm configuration, ecological nexus and the issues of temporal sustainability / relevance of these systems as part of overall development processes. Of late, at an academic level, the researches seem to be aimed at attaining analytical sophistication in the ethno-semantic and micro-processual descriptions of health, illness, disease and cure, which seems to be emerging as an end in itself[12].

Medical anthropology as a specialized domain of anthropological research enjoys the distinction of being a post-colonial development. The crystallization of this subfield of anthropology is a consequence of practice of social anthropology in medical systems. In contrast to our health related sciences obsessed with their ethnocentric scientisms, medical anthropology specifically focuses upon peoples point of view in medicine, ie. socio-cultural contexts of medical systems.

In view of such structural advantages, medical anthropologists are not only emerging to be quite successful in promoting their professional interests but also to uphold their claims as radical champions of people's perspectives by way of identifying and focussing upon their felt needs. As a consequence, services of trained medical anthropologists are increasingly being considered essential to an effective management of health care delivery systems in developed as well as developing countries.

12. Anil Mahajan, "Medical Anthropology & The Third World Development Needs: Symbiosis or Disarticulated ? " in P.C.Joshi & A. Mahajan,eds., Studies in Medical Anthropology, (new Delhi, 1990), pp44-45

As a consequence, in spite of general abandonment of modernization theories in other social sciences, by virtue of successful institutional integration of professional anthropological interests with those of imported western institutions of health care systems, social anthropology of medicine, ie. medical anthropology, appears to have found it convenient to perpetuate neo-modernization axioms in its theories as well as practice[13].

It is necessary for anthropological studies on health field in India to take a holistic view of all the cultural dimensions that are related to the health and health services of a community and to relate such a holistic perspective to the overall culture of the community. For developing such a holistic view it is necessary to consider simultaneously the various cultural factors which generate certain health problems in a community, the cultural perception and cultural meaning of various health problems encountered by the community and the various institutions that the community has either as a diffusion of an innovation from outside or as an intrinsic innovation by the community.

It may be observed that all these aspects related to health problems and health practices can be studied only in the context of the overall culture of the community. This composite of (a) cultural perception and cultural meaning of health problems, (b) the various cultural devices that are available and accessible to members of a community for dealing with health problems, and (c) the consequent behaviour of the community in response to these health problems which is generated as a result of interaction of cultural perceptions and cultural meanings of health problems. The cultural devices for dealing with them has been defined by Debabar Banerji as health culture[14].

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13. Ibid., p.46
14. S. K. Sahu, "Health Culture In transition: A case Study of Oraon tribe In Rural and Industrial Nexus", (New Delhi, 1991), p.10

The holistic concept of health culture provides a valuable framework for analysing the work of anthropologists in health fields. There are many anthropological studies which have taken a comprehensive, holistic approach which is embodied in the concept of health culture. In analysing the anthropological studies in the field of health in India, it is possible to divide them into various categories.

Some anthropologists have coined the term ethnomedicine to describe the concept of disease and health in ethnic groups. Studies of anthropologists like S.C. Roy, D.N. Majumdar, N.K. Bose, P.O. Bodding, L.P. Vidyarthi, B.K. Roy-Burman, Verrier Elwin, P. Chandra, M.G. Dannely, C. Gopalan, M.N. Das, S.C. Sinha and P. K. Bhowmik are examples of observations in the field of ethnomedicine, covering tribal communities, like santahl, soara, Juang, Naga, Oraon, Ho, Dubla and Toda. A positive feature of ethnomedicine is in the context of ethnography.

Anthropologists also studied certain specific health issues, such as family planning, diet and nutrition, communicable disease like yaws, cholera and smallpox. Studies of Verrier Elwin, B.K. Roy-Burman, U.B. Saxena and B.G. Prasad are relevant in this context. Some others have studied various health programmes in the tribal areas. H.S. Dhillon and S.B. Kar have reported on the response of Santal tribe to DDT spraying during the malaria control / eradication programme. B.N. Sahay has reported on the working of a primary health centre among the Khadias and the Birhors in Bihar[15].

15. Ibid., pp. 11-12

Basu studied traditional medicine and health care among the tribal groups of Bastar district of Madhya Pradesh and Phulbani district of Orissa. He says traditional medicine centres on two traditional systems of medicine, (a) Little traditional medicine, that is folk systems of medicine and (b) Great traditional medicine - Ayurveda, Unani, Sidha, Homeopathy, Nature Cure and Yoga. The practice field of this medicine is midwifery, bonesetting, supernatural cures of various types with main emphasis on utilizing natural herbs, roots, plants and other natural things in a given ecosystem[16].

Chaudhuri (1967) studied the Munda tribe, and noted that there is a great importance to understand and identify the cause of illness as the nature of treatment is intimately connected with the cause identified[17].

Carstairs, pointed out that the differences between the points of view of the physician and the village folk with regard to theories of etiology, techniques of curing and conceptions of the roles of physicians resulted in misunderstandings between himself, a physician and his clients (1955). Marriot has shown how contrast and conflicts between the roles assumed by the indigenous and the western medical practitioners resulted in obstacles to the acceptability of western medicine (1955). He came to the conclusion that modern medicine will have to "divest" itself of certain western cultural accretions and clothe itself in the social homespun of the Indian village[18].

16. Salil Basu, " Traditional Medicine And Health care Among The Tribal Groups of Bastar District (MP) & Phulbani District (Orissa)", NIHFW, (New Delhi, 1987), p.78
17. B. Choudhuri, "Medical Anthropology In India With Special reference To tribal Population", B. Chaudhuri, eds. "Tribal Health: Socio-Cultural dimensions", (New Delhi, 1985), p.6
18. Ibid., p.8

The area covered by medical anthropology goes much beyond ethnomedicine to cover also various health issues that are related to peasant societies. Leslie's studies on the practice of Ayurveda in India form a part of medical anthropology. Background documents on medical anthropology for the tenth international conference on Anthropology and Ethnological Sciences held in New Delhi in December 1978, provide a vivid picture of the state of knowledge in the field of medical anthropology today[19].

Sahu, studied the health culture of the oraon tribe in rural and industrial nexus of Sundergarh district of Orissa. A significant feature of the alternative approach presented by him is the conceptualization of health problem as a part of social problem around an appropriate methodological approach. He emphasised on understanding the people concerned, the patients, that family and the tribal community at large. These factors are central to formulation of any programme for any community's health problems. How do the members of the community percieve their health problems ? Problems mean what to them, socially and culturally (particularly in case of major diseases) ? How do they react to the suffering caused by them ? To what extent do they cause economic suffering ? What types of institutions have been evolved within a culture to alleviate the problems percieved by the victims, their families and the community? What is their response to the problems ?

What should be the approach for formulating programmes of intervention in the problem to deliver a package of technology which could blend with the pre-existing health culture to alleviate the suffering caused to tribal people by health problems.

19. Sahu, n.14, pp.12-13

He says as the health culture of a community and its related ecological, biological and overall cultural conditions are dynamic in character and any purposive interaction in the health culture through a health programme should take into account the changes that are likely to occur over a time dimension[20].

Banerji's (1972-88) nineteen villages study emphasised the study of behaviour in relation to much wider spectrum of health problems, in their curative, preventive and promotive dimensions. Community response to the family planning programme was also included in his study. The most significant feature of this study was that the entire methodological edifice was built around such an integrated concept. Depending on the linguistic competence of the investigator, ninteen villages, covering the states of Gujurat, Haryana, Karnataka, Kerala, Rajasthan, Tamilnadu, Uttar Pradesh and West Bengal were selected for a field work type of investigation of health behaviour in the context of the social and cultural setting. To study the influence of access, eleven of the villages chosen also had a fully staffed primary health centre (PHC) and two had a sub-centre of PHC[21].

Anthropologists have taken a lot of interest in recent days, studied the genetic factors with references to sickle cell anaemia, blood group and other chronic diseases in various populations. The genetic epidemiology has provided the tools for the study of disease risk factors, familial occurrence, segregation of genetic and environmental influences and their magnitude, proportional susceptibility to disease for an individual or a population.

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20. Ibid. 14.

21. Debabar Banerji, "A Socio-Cultural, Political And Administrative Analysis of Health Policies And Programmes In India in the Eighties: A Critical Appriasal", (New Delhi, 1990), p.49

Basu, Malhotra & Basu have done extensive field surveys of tribal as well as hill populations to generate wide range of data regarding the genetic marker for the different health disorders. But, McMohan (1970) pointed out that no disease is determined solely by either gene or environment[22].

A national workshop on Teaching and Research in Medical Anthropology in India" organized at the Centre of Social Medicine And Community Health by the Society for Indian Medical Anthropology (SIMA) which recommends that:

1. There is an urgent need to promote medical anthropology, which is basically of applied nature in Indian Universities, by people trained specifically in this sub-discipline who have put in considerable amount of research in medical anthropology.
2. There is a need to identify relevant areas of research most conducive to the needs of our country. As most of Indian research material is scattered primarily in the form of research papers and reports, it is urgently needed that this material be compiled and distributed to the departments which are teaching medical anthropology and to such departments which are identified as prospective centres of teaching medical anthropology. The panel further feels that there is a need to prepare extensive teaching modules and various topics generally taught in medical anthropology. Such modules should identify definitions and concepts; highlight theoretical framework; identify methodology and briefly discuss important research studies along with future directions.

22. S.K. Basu, "ICMR report: Genetic Epidemiology of Congenital Malformations - Final report", National Institute of Health & Family Welfare, (New Delhi, 1992), p.2

3. It is of atmost importance that the teaching courses in medical anthropology should as a rule be accompanied by anthropological field work.

4. It was felt that medical anthropology with an interdisciplinary perspective and the broad frame which is needed will not be suitable as a core course. Further, it was unanimously felt to keep medical anthropology as an optional course in view to develop the needed skill among the anthropologists to handle the multi-dimensional problems in the health sector.

The second session which is devoted to Research In Medical Anthropology In India recommended the following points for the future guidelines and the perspectives.

1. It was felt that under the fabric of ethnomedicine, medical anthropology has suffered for the same colonial hegemony and served the dominant values by blaming the people for their ills and sufferings. The medical anthropologists remain unscientific and supported the dominant class whenever they have studied the community health problems in biomedical perspective. The aim of medical anthropology researches therefore, is also to act as spring board for raising the issues in the right perspectives, keeping in view the health in broader multifaceted dimensions.

2. Health culture concept may be considered as a starting point to generate a broad based, pan-Indian knowledge with reference to people's health problems vis-a-vis health practices in Indian context.

3. the anthropologists who are interested to develop the skills and insights in the field of medical anthropology must be well conversant with the basic concepts of their subdisciplines ie. physical anthropology, social anthropology and other sister social science disciplines such as Sociology, Psychology, Political Science, Economics, History etc. and they must be well aware of the fundamentals of medical science ie. epidemiology of different health problems.

4. The research areas in the medical anthropology may be prioritized keeping in view the burning community health problems of the deprived and marginalized communities. A constant interaction is needed from other disciplines such as medical sociology, health Psychology, Health economics and Community health. As a result of this the medical anthropologists may not be spokesmen of the dominant class and technocrats.

5. The so called health programmes, policies and top down "package" approaches have to be demystified raising the issues in a scientific and peoples perspective. This endeavour will reiterate the research in medical anthropology in India from western technocratic and anti-people model.

6. Medical anthropologists may give emphasis in rethinking the concepts required in various community health problems and identify to appropriate interdisciplinary tools and techniques in bridging the gap between biomedical model and ethnomedical approach[23].

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23. CSM & CH, "The national workshop on Teaching & Research In Medical Anthropology In India", Society for Indian Medical Anthropology, (New Delhi, 1991), pp.1-4

CHAPTER - V

ISSUES AND PERSPECTIVE OF MEDICAL ANTHROPOLOGY

The gains of applied anthropology, action anthropology and anthropologically stimulated human engineering are of little permanent value. The strength of anthropology / medical anthropology lies in its analytical potential. So long as inequlaity of power prevails, access to social resources is also bound to remain unequal. so long as extremes in the ownership of wealth reflected in excessive affluence and low subsisteence, poverty and exploitation prevails, societies will also continue to experience bipolar sense of anomie, alineation, rootlessness and loss of human worth. The magnitude of dimensions to the tasks that lie ahead call for more and better anthropology, not for its rejection. To be able to articulate the consiousness of the deprived and regarded the anthropologists will have to relate themselves organically to these groups, identifying themselves with their cause and pursue their role with commitment and dedication[1].

Medical anthropology having its major links with public health, has developed in various ways. This narrow expansion of medical anthropology and western theoretical and methodological bias has missed the holistic perspective to contribute meaningfully in the policies and programme of public health in the third world in general and in India in particular.

The concept of public health is different today, what it was fifty years ago. In public health, the centre of interest is the whole community, of which the individual is a member, and the emphasis is on the organised community

1. P. J. Pelto, "Anthropology And Its New Perspective", 1982, p.6

effort. From the control of physical environment and communicable diseases, public health as moved to preventive, therapeutic and rehabilitative aspects of chronic diseases and behavioural disorders which are currently major public health problems.

The broad approach of public health is very close to the community health, which postulates a unified and balanced integration of curative, preventive and promotionbal health services. Its primary commitment is more to promotion of well being (physical, mental and social), than to relief of suffering to a reduction in the incidence of load of disease and disability in the community through preventive and promotional activity. This broad approach of community health activities fall into the discipline of medical anthropology, which deals with the cultural component in the ecology of health and disease[2].

Health And Medical Anthropology: Some Key Issues

Health is a part of overall development. Its analysis will require a meaning and significance by the medical anthropologists only when they are relevant in the present social, cultural, economic, poilitical. ecological and biological milieu and are carried out with broader imagination and hoilistic framework in the developing world[3].

Many of the prctical issues and concerns faced by medical anthropologists today are problems common to developed and developing nations alike, the problems inherent in designing and administering

2. J.E. Park, p.73 Text Book of Preventive and Social Medicine, 1976.
3. D. Banergi, "Social Sciences In Health Services Development".

economical, effective and equitable health care delivery systems, and attempting to redistribute scarce medical resources dedicated to appropriate technology and their intensive applications. Technological and economic imperatives have driven decision making in most health care systems, steadily increasing the cost of the provision of medical care and inhibiting the development of adequate rural primary care distribution networks at reasonable cost using trained and supervisory personnel. While some of the problems might better be approached by developing and communicating to policy makers macro level conceptualizations of health systems, goals and appropriate resource allocation strategies, the majority of health services and medical anthropological researchers alike concentrate instead on generating operational level solutions to discrete problems[4].

New questions arise how the medical anthropology in India meet the challenges to make the contributions a meaningful one in achieving "Health For All - 2000AD". For India, those general areas where anthropological research on health problems in developing countries may be useful suggest themselves: (a) specific disease, (b) specific problems and (c) health care delivery system and policy planning.

As a result of the work of the past three decades, a stage is now reached when one can conceive of an alternative endogenous paradigm for

4. S.K. Sahu, "Research In Medical Anthropology: Issues And Alternatives", Man & Life, Vol.13, 1989, pp.7-8

medical anthropology in health fields for a country like India. The following guidelines and the perspectives are to be followed by social scientists vis-a-vis medical anthropologists to contribute significantly.

That a health problem has to be seen in terms of the dynamics of the biological interactions between the causative agent and a human group against a background of human ecology, which includes cultural, social, economic and political conditions which influence the natural history of the health problems in that group or community.

Understanding of the people concerned - the patients, the families, the community at large is central to formulation of any programme for intervention in the epidemiological dynamics of any community health problem. How do people perceive their health problems ? What do these problems mean to them socially and culturally ? What do these problems mean in terms of suffering caused by them ? To what extent do they cause economic suffering ? What types of institutions have been evolved within a culture to alleviate the problems percieved by the victims, their families and the community ? What is their response to the problems ? What should be the approach for formulating programmes of intervention in the dynamics of epidemiology of the problem through an agency to deliver a package of technology, which would blend with the pre-existing health culture to alleiviate the suffering caused to people by the health problems, both at a point of time and in a time dimension ? The programmes so formulated will be expected, first to meet the unmet felt need of the people, and if necessary, keeping in view the epidemiological situation, active steps can be taken to generate addition felt needs to have greater epidemiological impact on the problems. In this approach, social and epidemiological aspects are considered together[5].

5. Mani Nag, "Anthropology In The Nationa Building", pp. 1 – 2.

Some scholars recently supported critical medical anthropology. The critical medical anthropologists ultimately aspire to merge theory and pracxis in their desire to promote experiential health as opposed to the functional health associated with contemporary political economics around the world. Question arises what should be the approach to build a bridge between critical medical anthropology and clinical anthropology and further what strategy do they persue for a creation of a truly human holistic health care system and society.

While viewed a perspective on capitalism as an important starting for a critical medical anthropology, it also maintained that critical medical anthropology would eventually have to address the nature of health concepts and practices in precapitalist and socialist oriented society[6].

Singer and Johnson hope to synthesize the macro level concerns of political economy of health and the middle level and micro level concerns of conventional medical anthropology. Baer and others argued that an analysis of power relations in the delivery of health services needs to distinguish four major levels of analysis: (a) macro-social, (b) intermediate social, (c) The micro social and (d) the individual[7].

6. H.A. Baer, "The Possibilities And Dilemmas of Building Bridges Between Critical Medical Anthropology And Clinical Anthropology: A Discussion, Social Science Medicine, V.30, n.9, pp. 1011-1013, 1990, p.1011
7. Ibid., p.1012

Critical medical anthropology maintains that discussion of specific health problems apart from macrolevel political and economic issues only serves to mystify social relationships that underlie environmental, occupational, nutritional, residential and experimental conditions. Importantly, the ultimate origin of these problems is not environmental or biological, but social, namely the existence of inherently oppresive social relationships of production and expropriation.

Marxist view of critical anthropology emphasize the relationship between sociopolitical formation, economic strategies and disease profiles. Following in the foot steps of political economists from other disciplines, not all critical anthropologists adhere to orthodox Marxism. Some prefer a phenomenological and humanistic, yet politically informed approach to sickness and healing[8].

The real question before us is whether it is critical medical anthropology or conventional medical anthropology addresses the multifacted problems in relation to the health and the people at different level of life patterns. It is important and mostly realized by the recent scholars of new public health that the intensive qualitative research with adequate inter-disciplinary conceptualization is required to generate insights to understand the health problems encountered by the people of third world countries.

8. L.M Morgan, "The Medicalization of Anthropology: A Critical Perspective On The Critical - Clinical Debate", Social Science & Medicine, v.30, n.9, pp.945-950, 1990, p.945

With this a new public health will be generated giving primacy to the people. With their roots in the dynamics of human ecology and history, health and health services department in a community is regarded as a socio-cultural process, a political process and a managerial and a technological process with an epidemiological and sociological perspectives. Elements such as modes of production and production relations, social and economic structure and epidemiological situation go into the formation of the foundation, which determines the architecture of the edifice of health service system. Medical anthropologists will not be effectively contributing without the above perspectives[9].

9. Banerji, n.3, p. 12.

BIBLIOGRAPHY

Alland, Alexander "Medical Anthropology And the Study of Biological and Cultural Adaptation", in David Landy ed., Culture, Disease And Healing: Studies in Medical Anthropology Macmillan Publishing Co., New York, 1977

Ahuluwalia, Anita "Sociology of Medicine", A Trend Report Indian Council of Social ScienceResearch Survey of Research in Sociology & Social Anthropology, Vol.2, 1974.

Banerjee, D. "Social Sciences In the Health Services Development In India" Lok Prakash, New Delhi, 1986

Banerjee, D. "A Socio-Cultural Political And Administrative Analysis of Health Policies And Programmes In India in Eighties: A Critical Apprisal" Century Points, New Delhi, 1990.

Banerjee, D. "Health And Family Planning Services In India": An Epidemiological, Socio-Cultural And Political Analysis And A Perspective" Lok Prakash, New Delhi 1985

Banerjee, D. "New Public Health", Unpublished, CSM&CH, SSS, JNU

Baer, H. A. "The Possibilities And Dilemmas of Building Bridges Between Critical Medical Anthropology And Clinical Anthropology: A Discussion", Social Science & Medicine, Vol.30,No.9 pp. 1011-1013, 1990

Basu, S. & Kshatriya, G. "Growth Trends And Adoloscent Spurts Among Kutia Khonds - A Primitive tribal Group of Phulbani District, Orissa, Original Paper", NIHFW, New Delhi.

Basu, S. K. "ICMR Project, Genetic Epidemiology of Congenial Malfunctions", Final Report NIHFW, New Delhi, 1992.

Basu, Salil "Traditional Medicine & Health Care Among The Tribal Groups of Bastar District (MP)&Phulbani District(Orissa)" NIHFW, New Delhi

Basu, Salil, "Health Scenario & Health problems of The Tribal PopulationIn India" NIHFW, New Delhi

CSM & CH "The National workshop On Teaching And Research In Medical Anthropology In India", Society For Indian Medical Anthropology New Delhi, 1991.

Chatterjee, Meera. "Implementing Health Policy" Under the Auspices Of The Centre For Policy Research, New Delhi, 1988.

Chaudhuri, B. "Medical Anthropology In India With Special Reference To Tribal Population" in B. Chaudhuri, ed., Tribal Health: Socio Cultural Dimensions, Inter-India Publications, New Delhi, 1985

Coe, R. M. "Sociology Of Medicine",MC Graw Hill, New York, 1970

Chaudhuri, B. & Chaudhuri, S. "Tribal Health, Disease & Treatment", A review Study, in B. Chaudhuri, ed. Tribal Health: Socio-Cultural Dimension Inter-India Publication, New Delhi, 1985

Caudill, W. "Applied Anthropology In Medicine", in A.L. Kroeber, ed., Anthropology Today, Chicago University Press.

Djurfeldt, G. & Lindberg, S. Co., New Delhi. "Pills Against Poverty: A Study of the Introduction of Western Medicine in a Tamil Village", Oxford & IBH Publishing

Dube, S.C. "Roll of Anthropology In Development", Presidential Address to 10th International Congress, 1978.

Dubos, R. "Man, Medicine & Environment", Harmondworth, Penguine Books, 1969

Dubos, Rene — Determinants of Health & Disease in D. Landy, ed. Culture, Disease & Healing: Studies in Medical Anthropology, Mc Millan Publis, 1977

Desai, P.B. — "Family Planning In India's Social & Economic Development", Institute of Economic Growth, Delhi.

Donald, Joralemon. "The Performing Patient in Rural Healing", Social Science & Medicine, V.23, No.9, pp.841-845 Great Britain 1986.

Foster, G.M. & Anderson, B.G. — "Medical Anthropology", John Wiley & Sons, 1978

Foster, G. M. — "Anthropological Research Perspectives on Health Problems in Developing Countries", Social Science & Medicine Vol. 18, pp.847-854, 1984

Gupta, Dpankar — "Anthropological Dimension of Health & Health Practices", CSM & CH, SSS JNU, 1981

Gupta, S.P. — "Tribal Concept of Health, Disease & Remedy" in B. Chaudhuri, ed., Tribal Health: Socio-Cultural Dimensions, Inter-India Publications New Delhi, 1985

Gurumurthy, K.G. — "Anthropology And management of Health & Hygiene", An Indian Case Study, in P.C. Joshi & Anil Mahajan,ed., Studies in Medical Anthropology, Reliance Publishing House, New Delhi 1990

Hasan, K.A. — "Anthropology & Medical History" in L.P. Vidyarthi, ed., Applied Anthropology In India, Kitab Mahal Allahabad, 1968

Hiramani, A.B. & Sharma, N. "Research In Health Practices" Central Health education Bueraeu New Delhi

Hultkrantz, Ake. "The Shama And the Medicine Man" Social Science & Medicine, Vol.20, No.5, pp.511-515 Great Britain, 1985.

Hunter, S.S. "Historical Perspective on the Development of Health Systems Modeling in Medical Anthropology", Social Science & Medicine, Vol.21, No.12, pp 1297-1307 Great Britain, 1985

Jena, Basantibala & Pati, RN. "Health & Family welfare services in India", Ashis Publishing House, New Delhi

Joshi, PC. "Teaching of Medical Anthropology In Indian Universities", HNB Garwal University, Srinagar

Joshi, PC. "Medical Anthropology: An Overview" in PC Joshi & A. Mahajan ed., Studies in Medical ANthropology, reliance Pub. House, New Delhi

Kakar, DN "Anthropology in Medicine: A Review", in Joshi & Mahajan ed., Std. in Med. Anthro., Rel. Publish, N. Delhi, 1990

Kaur, MS & Kaur, S "Utilization of Health & Family Planning Services Among Rural Women", in TM Dak, ed. Sociology of Health In India, Rawat Publication, 1991

Kaur, Malkit "Maternity & Child Health: A Socio-Cultural Analysis" in T.M. Dak, Sociology of Health in India Rawat Publication, Jaipur, New Delhi, 1991

Kalia, AK & Singh, K.S. "Genetic, Socio-Cultural & Health care Among tribal Groups of Jagdalpur & konta Tehsils of Bastar Dist. in MP" Reprinted from Anthropology Developemnt & nation Building, Concept Pub. Comp.

Lewis, Jane — "What Price Community Medicine ? The Philosophy, Practice and Policies of Public health Since 1919", Wheatsheap Book, 1986

Lieban, RW — "The Field of Med. Anthropology" in Landy ed. Culture, & Dis. & Healing, MacMillan Pub. Co. New York, 1977

Mehta, S& Lamba, R — "The Realm of Cure: A compariosn of tribal & Moden Systems of Med." in Joshi & Mahajan ed., Studies in Medical Anthropology, Reliance publish. House, New Delhi, 1990

Morgan, L. M. — "The medicalization of Anthropology: A Critical Perspective on The Critical Clinical Debate", Social Science & Medicine, Vol.30, No.9, pp.945-950, 1990

Mukherjee, D.P. & Nandy, S.K. — "Anthropology of Tribal Health - The Case of The Asurs In Netarhat Plateau", in B. Chaudhuri, ed., Tribal Health, Inter-Media Publications, New Delhi, 1985

Mahajan, Anil — "Medical Anthropology & Third World Needs : Symbiosis or Disarticulated Concerns", in Joshi & Mahajan,Studies In Medical Anthropology, Reliance Publishing House, New Delhi, 1990

Marriot, M. — "Western Medicine In a Village of Northern India", in B.D. Paul, ed., Health, Culture & Community, New York, Russel Sage Foundation, 1955.

Mangus, A.R. — "Medical Sociology: Study of The Social Components of Illness or of Health", Sociology & Social Research, Vol.39, pp.159-164, 1955

Leiban, R.W, — "The Field of medical Anthropology" in D. Landy, ed., Culture,Disease& Healing: Studies in Medical Anthropology, MacMillan Publishing Co., New York, 1977

Nag, Moni "Institutional Context of Social Science Research on Health In India", Population Council, New York, 1991

Navarro, V.(ed.,) "Imperialism, Health & Medicine", Baywood, New York, 1979.

Opler, ME, "The Cultural Definition of Illness In Village India",Human Organization,V.22, No.4, 1963

Onoge, OF. "Capitalism & Public Health: A Neglected Theme In The Medical Anthropology of Africa", Topics & Utopias In Health, Moulton Pubishers, The Hague, Paris.

Polgar, S. "Medical Problems from An Evolutionary View" in L.P. Vidyarthi,ed. Applied Anthropology In India (Principles, Problems & Case Studies) Kitab Mahal, Allahabad, 1968

Polgar, S. "Health And Human Behaviour: Areas of Interest Common To Social And Medical Sciences, Current Sociology, Vol.41, No.3, pp. 441-462

Paul, BD. "Health Culture And Community", Russel Sage Foundation, New York, 1955

Pokarna, K.L. "Health And Disease: Socio-Cultural Dimensions", T.M. Dak (ed.), Sociology of Health In India, Rawat Publications Jaipur, New Delhi, 1991

Peddersen, D & Barffati, V. "Healers, Dieties, Saints & Doctors: Elements for The Analysis of Medical Systems", Social Science & Medicine, Vol.29, No.4, pp.487-496, 1989

Park, J.E "Text Book of Preventive And Social Medicine", Banarasidas Bhanot, Jabalpur, 1974.

Pelto, P.J. "Anthropology And Its New Perspectives", John Hopkins University, 1982

Press, Irwin "Levels of Explanation And cautions For A Critical Clinical ANthropology, Social Science & Medicine, Vol.30, No.9, pp.1001-1009, 1990

Qadeer, Imrana "Health Services System In India: An Expression of Socio Economic Inequalities", Social Action, Vol.41, pp.31-48.

Raman, M.V. "Some random Reflections on Family Planning", Demographic Unit, Reprinted from 'Samvadadhran', House Journal of Indian Statistical Institute, Vol.6, No. 2&3

Reddy, B.S. "An Approach To The Integration of Traditional Medicine And Modern Medicine", B. Chaudhuri, ed., Tribal Health In Socio-Cultural Dimensions, Inter-India Publication, New Delhi 1985.

Sahu, S.K. "Socio-Cultural Dimension of Health, Disease And Family Welfare In India", Bharatiya Samajika Chintan, Vol.VIII, No.3-4, Sep-Dec, 1985.

Sahu, S.K. "Health Culture In Transition" (A Case Study of Oraon Tribe In Rural& Industrial Nexus), Khama Publishers,New Delhi, 1991

Sahu, S.K. "Social Dimensions of Health of Tribals In India", B. Chaudhuri, ed. Tribal Health: Socio-Cultural Dimensions, Inter-India Publications, New Delhi 1988.

Singh, Musafir "Sociology of Foods And Nutrition", T.M. Dak, ed., Sociology of Health In India, Rawat Publications, Jaipur New Delhi, 1991

Singer, M. "The coming of Age of Critical Medical Anthropology",Social Science & Medicine, Vol.28, No.11, pp.1193-1203, 1989

Somawat, G.S. "Population And Health In India: Policy Perspectives", T.M. dak,ed.,Sociology of Health In India, Rawat Publications, Jaipur, New Delhi, 1991

Wellin, Edward "Theoretical Orientations In Medical Anthropology: Continuity & Change", D. Landy, ed. Culture, Disease And Healing:Studies In Medical Anthropology, MacMillan Publishing Co., New York, 1977