UNIT 2  THE PRAGMATICS AND POLITICS IN PRACTICING ANTHROPOLOGY OF HEALTH

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Learning Objectives

After going through this unit, you will be able to:

- understand the theoretical approaches to the study of practicing anthropology of health;
- understand the interplay between theories related to health and its practical applications;
- indicate the importance underlying the use of varied methods and techniques in health studies by enhancing community participation in disease prevention;
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- understand the social and cultural contexts of an illness; and health-related behaviour of people; and
- indicate how this knowledge of the theoretical perspectives of health can play a vital role in assisting practicing anthropologists to develop policies and programmes to create culturally responsive health programs.

2.1 INTRODUCTION

Medical anthropology is the fastest growing sub-field of anthropology today, with scholars engaged in research from different theoretical perspectives and methods and methodologies, and working across the world in an array of medical, health and healing settings. Medical anthropology studies various facets of how human health is affected by culture. More than a system of health care practices, medical anthropology works to identify customs and procedures that shape how people take care of themselves. A medical anthropological study encompasses diverse areas including primary health care, social medicine and mental health as well as research and strategy to formulate and change policies for the enhancement of human health. For achieving the common goal of good health and ensuring social change across different populations, the role and function of medical anthropology is imperative.

Medical anthropology as a very broad interdisciplinary sub-sector of anthropology concerns itself with the concept of holistic health and medicine in human culture and explores all the intricacies of man as a social animal. The multidimensional aspects of medical anthropology can be clearly understood from the fact that its study deals with evolution of the concept of medicine and health in diverse cultures, alternative forms of medicine, impact of culture and society on health. Furthermore the social peculiarities that affect health care systems and health awareness are also taken into consideration in such studies. In short, it’s a field that encompasses the social aspect of medicine and the complications it creates and it also studies the implications of this fact on the health of an individual and also the genesis of medicine or healing practices that emerged in different cultures over the centuries. Such studies are conducted with the motive of achieving the ultimate goal i.e., betterment of health of the society as a whole and the prevention of diseases in all its forms, through various remedial and preventive measures that address deep rooted causes.

We need to remember that pure medicine solves only the immediate causal problems of a pathological condition, considering only the biological evidence that can be gathered through tests, in situ. Whereas, medical anthropology studies and investigates the deeper social causes and combinations of social situations along with behavioural traits that direct to the cause and spread of the disease. It also concerns itself with the distribution of health care services and what influence the structure of a society has on them.

For centuries medical scholars have laid emphasis on the social dimensions of health and illness in their research. In recognition of the presence of certain social and cultural variables as etiological factors in disease, Rudolph Virchow (1848) of Germany declared medicine as a social science in his journal Applied Medical Anthropology. Applied medical anthropology is the practical application of the theoretical principles to actual and real data and putting the theories...
propounded by it to test in the field. Collection and interpretation of biometric, genetic, social, and medical data of diverse ethnic groups and communities is the main focus or predominant activity in the field of applied medical anthropology. This data enables a medical anthropologist to understand the various aspects of endemic diseases and other locally prevalent diseases and thereby facilitating the process to ascertain the causal connection between certain endemic diseases and other local problems.

Practicing anthropology of health refers to how applied medical anthropology deals with intervention, prevention, and policy issues and analyses the socio-economic forces and power differentials that influence access to care in varied health situations. Applied and practicing anthropologists confront special challenges. They are called on to offer the anthropological perspective – a view of humanity grounded in a tradition of cross-cultural scholarship and action. They may work in teams with other professionals; they must communicate across disciplines. An attempt has been made here to provide an understanding of the pragmatics and politics in practicing anthropology of health. We need to understand here that politics refers to theories related to health and by pragmatics we imply the practical applications in studies related to health. Henceforth we will refer to politics and pragmatics as theories related to health and its practical applications.

### 2.2 HISTORY OF MEDICAL ANTHROPOLOGY

Before we go into further details of the theories related to health and its practical applications we need to have an understanding of the history of medical anthropology. As described earlier, medical anthropology is a specialised branch of anthropology whose main concern is with the relationship between cultural factors, perceptions, and beliefs on the one hand and health and health disorders on the other. Medical anthropology is considered a branch of applied anthropology, which studies diseases, health care system and theories of disease and curing in pluralistic, socio-cultural perspectives (Scupin and De Corse, 1995). Medical anthropology, in general, grew very rapidly as a specialised field of study in anthropology, particularly since the 1950s and 1960s. The growth of this field is mainly due to the increasing interest of social scientists in general and anthropologists in particular in health and illness, and the increasing awareness of medical professionals and health policy makers about social sciences’ role in health issue (Foster and Anderson, 1978). It may be stated that when anthropology arose in 19th century, investigating health and disease issues seemed to be not from among the overriding concerns of cultural anthropologists. However, social scientists in general and anthropologists in particular, began to develop both academic and practical interests in studying health and diseases in socio-cultural contexts. At the root of the emergence and development of medical anthropology also lie the need for studying the world of health and disease from evolutionary and ecological perspectives (Scupin and DeCorse, 1995 Zerihun, 2001:167).

George M. Foster and Barbara Gallatin Anderson (1978) trace the development of medical anthropology to four distinct sources: the interest of early physical anthropologists in human evolution and adaptation, ethnographic interest in primitive medicine, studies of psychiatric phenomena in the culture and personality school, and anthropological work in international health. William H.
R. Rivers (1924), a physician, is considered the first ethnologist of non-western medical practices. Early theoretical work by Forrest E. Clements (1932) and Erwin H. Ackerknecht (1942, 1946) also attempted to systematize primitive medical beliefs and practices. Paralleling theory development were early applications of anthropological principles to health problems. Increasing number of medical anthropologists work in Australia, Latin America, the Philippines, and India (McElroy et. al., 2002: 2).

Medical anthropology is thus by no means limited to questions directly related to the ways in which people deal with disease. Instead, the subject matter includes the aetiology of disease and its treatment, preventative measures, medical pluralism, stress and social support, and eradication of diseases.

**Reflection**

Prior to the 1950s, the study of medicine by anthropologists was done within the larger context of cultural and social studies (Baer et. at., 1997). Early interest in ethno-medicine was restricted to questions regarding the ways other people dealt with sickness and, generally, enhanced personal health. Currently, medical anthropologists have expanded their interests from the way other people conceptualise health to include wider ranging issues. Stewart and Strathem (1999:3) observe that the field has undergone “... a circular migration: from the jungle to the city, and back again.” This circular migration is a result of researchers asking questions, not only of other cultures and healing practices, but also of their own. It is necessary to understand this circular movement in order to understand the current state of research in medical anthropology.

At this point, however, one must recognise that there exist a number of distinct cleavages in medical anthropological theory. It is possible to clearly identify three distinct theoretical positions. These positions are very different from each other as a result of their different epistemologies (Alexandrakis: 2001(9) 73-74).

### 2.3 THEORIES OF HEALTH AND ILLNESS

We need to understand here that theories about health and illness deal with the various perceptions and ideas of people regarding the various causative factors of diseases and also the explanation they provide towards health maintenance through health protective and preventive measures. Ideas about illness causation may include such ideas as breach of taboo, soul loss, germs, upset in the hot-cold balance of the body, or a weakening of the body’s immune system. It must be kept in mind that while working on data derived from the study of the underlying cognitive orientation of a cultural group the same cultural logic is followed to ascertain the theories of illness causation and therapeutic practice.

Before going into the details of the various theories it is necessary to understand the meaning of the terms disease, illness and sickness and their differentiation: Disease refers to pathological states of the organism, whether or not they are culturally or psychologically recognised, whereas illness refers to culturally or socially defined or conditioned perceptions and experiences of ill health, including some states which could be defined as diseases and others which are not classifiable in terms of medical definitions of pathological states. Accordingly,
disease is now universally referred to as a western bio-medical term while illness is culturally defined and identified with the local indigenous knowledge (Fabrega, Jr., 1972:167). Sickness is a general global term which refers to all events involving ill health.

We must understand that all theories of health and illness serve to create a context of meaning within which the patient can make sense of his or her bodily experience. A meaningful context or understanding for illness usually reflects core cultural values, and allows the patient to bring order to the chaotic world of serious illness and to regain some sense of control in a frightening situation. Medical anthropological theory may thus be understood in two ways: first as a set of anthropological concepts and second as the application of these concepts.

2.3.1 The Functionalist Perspective

This perspective views medicine and the systems of health care as important social institutions; and it focuses on the functions and roles played by the institution in maintaining order and stability in society. The medical institutions whether scientific or traditional and the various practitioners exist to meet the needs of individuals and society (Henslin and Nelson, 1995). The ethno-medical approach attributes the existence of this system to the cultural, or perhaps, ideological tradition of the peoples who use it. So when we come across societies or communities who are exposed to multiple treatment options i.e. a pluralistic system of medicine where people are able to choose between bio-medical treatment and traditional indigenous treatment, the advocates of ethno-medical approach would argue that the health seeking behaviour of the people are primarily influenced by the cultural values of that community or society.

2.3.2 The Ecological Perspective

An ecological approach was first proposed for medical anthropology in the area of biological and cultural evolution, as a unifying, central position between the biological and socio-cultural perspectives (Alland 1970; 1977). Based on evolutionary theory, it looked at health and disease in the context of human ecology. Specifically, this approach attempted to show the biological adaptability, or value, of various culture traits in a given environment which influence disease and resistance to disease organisms (Walker 1998, 13:75).

This perspective focuses on the human biological and behavioural adaptations to diseases in different ecological and environmental contexts. Hence, diseases evolve in line with specific ecological niches, and people’s responses to health problems have also evolved in the context of their specific local ecosystems (McElroy and Townsend, 1989). However, this theoretical model has been criticized as the theory’s limited focus does not allow for explanations of how or why certain political and economic factors influence the environment, and contribute to disease causation. Critics also consider the theory to be reductionist, focussing too narrowly on ecological variables instead of looking at the dynamic relationship between the environment, biology and culture (Singer 1992). Another controversial point which has been raised is whether culture functions as an adaptive mechanism, or is part of the environment to which people must adapt. Still other critics feel that the theory is unable to satisfactorily explain the problem that culture is not genetic, and hence is not subject to evolutionary laws. In an attempt to respond to these perceived deficiencies, a “bio-cultural” approach emerged, which elaborated the ecological perspective (Walker 1998, 13:76).
2.3.3 Bio-cultural Approach

The bio-cultural approach aims to measure, describe and interpret how constraining factors in the environment affect the body (Wiley 1992). It combines concepts from physical anthropology with those from cultural anthropology to explain “the ability of the individual to adapt to the environment by biological or behavioural means” (Wiley 1992: 222). This approach expands the concept of the environment to include social factors, and while political and economic influences are considered determinants of health, they are not explored as an explicit goal of the theory. Adaptation is considered to be an essential concept which reflects a dynamic relationship between individuals and their environment.

The model follows a Western scientific paradigm, using bio-medical categories and biological indicators (for example, anthropomorphic indices, blood pressure measurements) to assess constraining factors on health. Health is defined in biological terms as an individual's ability to adapt by biological or behavioural means. For example, people are infected by AIDS because their behaviours expose them to the causative virus. Interventions aimed at prevention would focus on education, using western ideas of causation and prevention aimed at changing behaviour (Walker 1998, 13:76).

Cultural anthropologists have criticised this approach because it relies on a western bio-medical model and is not applicable to the study of non-western situations (Armelagos et al. 1992). As with the ecological approach, critical medical anthropologists object to the fact that a bio-cultural perspective does not emphasise the social, political, and economic factors that underlie and influence health (Singer 1989). Since health is concerned with successful adaptation, disease, then, is a failure to adapt. Lynn Morgan (1993) also points out that Wiley, a researcher involved with genetics, does not discuss the political factors that affect how research is funded and executed, or how the knowledge that is produced might be interpreted by others.

2.3.4 The Critical Perspective

Critical medical anthropology (CMA) takes a very different approach to looking at questions regarding health. CMA believes that there exists a hegemonic relationship between the ideology of the health care system and that of the dominant ideological and social patterns. CMA views disease as a social as well as a biological construct. Critical medical anthropologists examine issues such as who have the power over certain social institutions, how and in what form is this power delegated, and how this power is expressed (Baer et. al. 1997:33-36).

This theory is also called the “radical political economy”. It is an approach which stresses on the socio-economic inequality in power and wealth which in turn significantly affects the health status and access to health care facilities. Individuals, groups, communities and even nations thus tend to have unbalanced share of health resources; and these often leads to the unequal distribution of morbidity and mortality patterns among a given society; those in power and dominance enjoy better health and the marginalised groups suffer from the burden of diseases (Turner, 1987).

The primary objective of CMA is the transformation of social relations. Critical medical anthropology “emphasizes the importance of political and economic forces, including the exercise of power, in shaping health, disease, illness
experience and health care” (Singer and Baer 1995:5). It looks “toward a more holistic understanding of the causes of sickness, the classist, racist and sexist characteristics of biomedicine as a hegemonic system, the interrelationship of medical systems with political structures, the contested character of provider-patient relations and the localisation of sufferer experience and action within their encompassing political-economic contexts” (Singer and Baer 1995:6). CMA is concerned with the phenomenology of illness and pain, and the social construction of the individual. The body is considered to be a passive, socially constructed organism, whose relationship with the environment is an aspect of social relations. The environment is a social, rather than physical one. Health is also considered to be socially constructed, rather than organic, and is defined as “access to and control over the basic material and non-material resources that sustain and promote life at a high level of satisfaction” (Baer et al. 1986:95). Critics of CMA, the most outspoken of which is Wiley (1992), say it is “unscientific”. It does not consider the biological aspects of disease, confuses genetic diversity with social inequality, is only concerned with the recent historic past, and is perhaps irrelevant in the field because of its focus on macro-level restructuring. Singer responds convincingly to each of these criticisms in his 1993 reply to Wiley. Regarding the criticism that CMA is not concerned with historical aspects, Singer indicates that CMA has concentrated its study on contemporary issues, but does not limit itself to this historical boundary and acknowledges the importance of human biological evolution for the current state of the species (Walker 1998, 13:78).

Therefore, if one wishes to study disease, it is necessary to start by identifying political, economic, social, and environmental conditions within a particular society or group. It is necessary for a researcher in the CMA tradition to understand these and subsequently, understand the local group’s etiology, before it is possible to attempt to understand the medical system.

Let us take into consideration the application of CMA theory described in Paul Farmer’s book *AIDS and Accusations: Haiti and the Geography of Blame* (1992). In this work, Farmer explores political and economic factors, a wide range of historical events, and epidemiology in his analysis of AIDS in Haiti. He looks at the increased susceptibility to AIDS among the poor and common social reactions to HIV/AIDS in Haiti. Farmer’s focus is clearly political-economic; he takes a very heavy neo-Marxist approach in his analysis. As we have seen the focus of this approach is on the healing process itself. Moreover, it studies sickness as a social practice. One of the most common areas of study when dealing with this kind of analysis is the exploration of different constructions of the concept of illness as a function of differing cultural ideologies. In their book *Pain as Human Experience*, Brodwin et. al. (1992) explores the concept of pain and how it differs from culture to culture. From describing pain as “sound” in Japan, to differentiating between headaches and brain aches among North American Latinos, these authors attempt to understand the experience of pain and its treatment in different cultures. Thus, they examine the experience of pain as “... an intimate feature of lived experience of individuals in the context of their local social world and historical epoch” (Brodwin et. at., 1992:2). Interestingly, with this perspective in mind, it is possible to detect differences between groups of people depending on the type of pain, or more generally, the suffering they experience and how they express it. Suffering, in this case, can be attributed to a number of acute social and economic factors.
In line with this thinking, the most promising directions for integrating political economic and adaptability perspectives seem to be the “political economy of health” and the “critical biological anthropology” paths. The former aligns itself with critical medical anthropology, establishing as a starting point for research the social, political, and economic forces affecting health and health systems, rather than the bio-physical environment. Critical biological anthropology is a reflexive and explicitly political-economic perspective, which aims to “expose and analyse the underlying assumptions and ideological dimensions of their work and the socio-political and economic use of ideology in biological anthropology” (Blakey, 1992 in Leatherman et al. 1993:205).

Today, bio-cultural anthropologists are being challenged to abandon the adaptationist perspectives and develop an approach which sees nature and political economy as indivisible (Singer 1996). It remains to be seen whether critical medical anthropologists can gain insight from the bio-cultural approaches, but Singer (1993) sees a nexus between critical biology and critical medical anthropology. Baer (1996) feels that both groups will benefit from the work of political ecologists, as more environmentally induced diseases emerge due to the world’s capitalist, productivist ethic. He sees that both critical medical anthropologists and political ecologists share a “commitment to merge theory and social action” (Baer 1996:453).

2.3.5 The Cultural Interpretationist Perspective
This is also called “the symbolic interactionist” approach. This approach focuses on the social and cultural constructions of health, illness and disease. According to this theory, illnesses and health are not just things that exist “out there”; they are productions of the complex social interactions; and health and illness are highly shaped by the manner in which people as actors give meanings to them and how the actors respond to them in socio-culturally sanctioned ways (Zerihun, 2001:169-170).

2.3.6 The Biomedical Perspective
The bio-medical perspective incorporates the bio-medical theory in which patients are assumed to be passive recipients of doctors’ instructions. Treatment is focussed on the patient’s body as health or disease is traced back to bio-medical causes such as bacteria or viruses. This bio-medical theory has recently been integrated into a larger “bio-psycho-socio-environmental” theory, which incorporates the wider socio-environmental context. However, this theory is not located strictly within the bio-medical approach. But it is pertinent to note here that assuming patients as passive recipients while focussing on bio-medical factors may create certain limitations in the study of medication. This is due to the fact that patients are generally active decision makers and we cannot expect them to merely receive and follow instructions passively or without any qualms.

From whatever has been discussed above it is quite obvious that ignoring factors like patients’ perspective of their own illness, the psycho-social influences, the beliefs regarding acceptance or rejection of curative measures coupled with the impacts of the socio-economic environment on health behaviour has been a fundamental limitation of this theory.
2.3.7 Behavioural Perspective

This perspective incorporates behavioural learning theory (BLT) which is focused on the environment and the teaching of skills to manage adherence. The main focus is to understand how behaviour is influenced by the use of the principles of antecedents and consequences. In simple terms it implies that antecedents which are either internal (thoughts) or external (environmental cues) and consequences which may be punishments or rewards for behaviour are the variables which will affect or influence the probability of a patient following a specific behaviour. BLT has been critiqued for lacking an individualised approach and for not considering less conscious influences on behaviour which are not linked to immediate rewards. These influences include, for example, past behaviour, habits, or lack of acceptance of a diagnosis. The theory also is limited as it focuses on external influences on behaviour. It is therefore necessary for programme planners to consider carefully individuals’ perceptions of appropriate rewards before using such theory for implementation.

2.3.8 Communication Perspective

We are all aware that in any kind of patient – practitioner relationship and communication plays a vital role. It is often referred as the cornerstone in such a relationship. The communication perspective is an approach based on the notion that communication needs to be clear and comprehensible to be effective. It implies that patient education and good health care worker communication skills ensures an improved provider – client communication which will further enhance medical adherence. Communication interventions are also typically restricted to provider-client interactions and additional social or financial support may thus be required.

2.3.9 Cognitive Perspective

The cognitive perspective includes theories such as the health belief model (HBM), social-cognitive theory (SCT), the theories of reasoned action (TRA) and planned behaviour (TPB) and the protection motivation theory (PMT). These theories are based on the assumption that attitudes and beliefs as well as expectations of future events and outcomes are major determinants of health related behaviour and therefore they focus on cognitive variables as part of behaviour change. These theories propose that in view of the presence of various alternatives, individuals have a tendency to choose or select the action that will ensure in all probability a positive outcome.

a) Health Belief Model

The HBM views health behaviour change as based on a rational appraisal of the balance between the barriers to and benefits of actions. According to this model, the perceived seriousness of, and susceptibility to a disease, influence individual’s perceived threat of disease. Similarly perceived benefits and perceived barriers influence perceptions of the effectiveness of health behaviour (Munro et.al. 2007).

b) The Protection-Motivation Theory

According to this theory, behaviour change may be achieved by appealing to an individual’s fears. Three components of fear arousal are postulated: the magnitude of harm of a depicted event; the probability of that event’s
occurrence; and the efficacy of the protective response. These components tend to affect the health behaviour of the individual (Munro et.al. 2007).

c) **Social-cognitive Theory**

This theory evolved from social learning theory and may be the most comprehensive theory of behaviour change developed thus far. It posits a multifaceted causal structure in the regulation of human motivation, action and well-being and offers both predictors of adherence and guidelines for its promotion (Munro et.al. 2007).

d) **Theory of Planned Behaviour and the Theory of Reasoned Action**

The theory of reasoned action assumes that most socially relevant behaviours are under volitional control, and that a person’s intention to perform a particular behaviour is both the immediate determinant and the single best predictor of that behaviour (Munro et.al. 2007).

e) **Information-Motivation-Behavioural Skills (IMB) Theory**

This theory was developed to promote contraceptive use and prevent HIV transmission. IMB was constructed to be conceptually based. It has since been tailored specifically to designing interventions to promote adherence to. This theory focuses on three components that result in behaviour change: information, motivation and behaviour skills. This theory is said to be moderately effective in promoting behaviour change (Munro et.al. 2007).

**Reflection**

Cultural understandings of the human body:

It can be difficult to understand the function of a healing practice without also being aware of the rationale upon which the practice rests. Different understandings of how the human body works should, and do, lead logically to different ways of ‘fixing it’. It is therefore useful briefly to consider some of the different cultural metaphors for understanding the workings of the human body. Perhaps the most widely held view is that which refers to the notion of balance and imbalance in the body. According to this concept the various systems within a healthy body are seen as being in harmony. Imbalance, causing illness, can result from physical, psychological, nutritional, environmental or spiritual influences that trip this balance.

The humoral theory is an example of a balance metaphor. This theory was developed into a systematic account of disease by Hippocrates and subsequently elaborated upon by Galen in the second century BC, spreading throughout the Roman and Arab world.

**2.3.10 Self-regulation Perspectives**

Self-regulatory theory is the main theory in this domain. Developed to conceptualise the adherence process in a way that re-focuses on the patient, the theory proposes that it is necessary to examine individuals’ subjective experience of health threats to understand the way in which they adapt to these threats. According to this theory, individuals form cognitive representations of health threats (and related emotional responses) that combine new information with past experiences. These representations ‘guide’ their selection of particular
strategies for coping with health threats, and consequently influence associated outcomes. The theory is based on the assumption that people are motivated to avoid and treat illness threats and that people are active, self-regulating problem solvers (Munro et al. 2007).

2.4 Theories of Illness

Let us now take into consideration some theories of illness.

2.4.1 Theories of Naturalistic Causation

Theories of naturalistic causation will imply “any theory, scientific or popular which accounts for the impairment of health as a physiological consequence of some experience of the victim in a manner that would not seem unreasonable to modern medical science” Five distinct types of theories which fall into this category are mentioned in the following pages.

Type 1- Infection: defined as invasion of the victim’s body by noxious microorganisms with particular but not exclusive reference to the germ theory of disease deriving from the discoveries of Pasteur and Koch (Murdock et al., 1998 : 248).

Type 2- Stress: defined as exposure of the victim to either physical or non physical strain such as over exertion, prolonged hunger or thirst, debilitating extremes of heat or cold , worry, fear, or the emotional disturbances which constitute the province of modern psychiatry (Murdock et al., 1998 : 249).

Type 3- Organic Deterioration: defined as decline in physical capacities attending the onset of old age, or the earlier failure of particular organs such as the heart or kidneys, or the appearance of serious hereditary defects, often manifest at birth or in childhood (Murdock et al., 1998 : 249).

Type 4- Accident: defined as the suffering of some physical injury under circumstances which appear to exclude both intention on the part of the victim and suspicion of supernatural intervention (Murdock et al., 1998 : 249).

Type 5- Overt Human Aggression: defined as willful infliction of bodily injuries on another human being , as in violent quarrels assault or mayhem, brawls, crimes of violence, warfare, and even attempted suicide (so called ‘aggression turned inward’).

So now we can say that in naturalistic causation, illness is explained in impersonal terms. When the body is in balance with the natural environment, a state of health prevails. However, when that balance is disturbed, illness results. Often, people invoke both types of causation in explaining an episode of illness, and treatment may entail two corresponding types of therapy.

In India, the ancient system of ayurveda is based on naturalistic ideas of illness causation. Therapy in ayurveda includes a vast pharmacopeia of preparations made from herbs and minerals, and dietary advice also forms part of every prescription. Ayurveda is actively practiced in India today and has shaped the way Indians think about their bodies in health and in illness.
2.4.2 Theories of Supernatural Causation

Theories of mystical causation may be defined as any theory which accounts for the impairment of health as the automatic consequence of some act or experience of the victim mediated by some putative impersonal causal relationship rather than by intervention of a human or supernatural being. Four specific types of causation fall into this category. (Murdock et al. 1998:251). They are: Fate or Personified Ill Luck; Ominous Sensations; Contagion; Mystical Retribution; Spirit Aggression; Sorcery and Witchcraft.

Fate is reported as one of the major detriment of illness. Ill luck brings untold miseries, which makes the person to believe that some unseen power or spirits have been controlling his life and bringing ill luck. Ominous sensations refer to experiencing of particularly potent kinds of dreams, sights, sounds or other sensations believed to cause illness. Disease may also be caused if one comes in contact with a polluting object, substance or person – (contagion). A disease caused by mystical retribution implies breaches of appropriate behaviour towards kinsmen, strangers or superiors or towards the supernatural or violation of some taboo. Diseases are often believed to be caused by the malevolent actions of some hostile and aggressive spirits or supernatural beings. Spirit aggression is often reported as the predominant cause of illness in many societies. Besides the above mentioned disease causing factors it is pertinent to note that disease may also be caused due to the covert action of an envious affronted or malicious human being who employs magical means to injure his victims. Such actions to inflict diseases may be performed either through sorcery or witchcraft (Murdock et al., 1998: 251-255).

Supernatural or Personalistic disease causation theory thus attributes illness to causative agents which are considered to be intelligent beings. This theory is particularly common among most non-western societies. Even if a person may know that mosquito bite causes malaria, he or she often thinks and believes the cause of the illness is due to the power and evil work of such agents as evil spirits, sorcerers, witches, ancestor ghosts, curses made by elders, wrath of supernatural beings, etc.

2.4.3 Emotionalistic Causation Theory

Emotionalistic causation theory states that illnesses occur due to some intense negative emotional experiences. A number of ethnographic studies have found out that there are for example mental illnesses that are unique to certain cultural settings (Pilgrims, 2000; Scupin and DeCorse, 1995). Such emotionalistic diseases that result from particular environments and cultural traditions may be termed as culture-bound syndromes (Howard and Dunai-Hattis, 1992). In some cultures, emotional experiences such as anxiety and fright may cause an illness called susto, or what is also called ‘soul loss’ in anthropological literature. A person who is believed to be caught with this psychological illness may develop symptoms such as lethargy (tiredness or weariness), inactivity, vagueness, distraction (or thought disturbance), etc. In Ethiopia, which is predominantly a traditional society, traditional, non-scientific explanations of diseases are very important in diagnosis, treatment and management of diseases. Belief in the power of various intelligent agents such as ginnies, mitch, seitan, ganel, budda, etc to cause different psychological and physical ailments is very common in most cultures in the country (Zerihun, 2001). People in some cultures do not go
The views of disease causation people hold thus are very important in determining the people’s health care seeking behaviour and type of diagnosis and treatment; that is why it is crucial for health care professionals to be culturally sensitive and to have some basic understanding of socio-cultural anthropological knowledge when dealing with the care of patients from different cultural and religious backgrounds (Hellmann, 1984; Galanti, 1997).

2.5 METHODS AND TECHNIQUES IN HEALTH STUDIES

“Methods” are ways of studying people from an anthropological perspective. They are the various approaches anthropologists take to learn about a given people or culture. They include such general things as “participant observation” (a key method of study in socio-cultural anthropology), as well as including more specific things such as survey research, archival research, and more. Here we need to remember that whatever the area of focus, anthropologists generally use the same research techniques (Lambert et.al.2002).

Medical anthropology utilises all methods that are also used in other areas of socio-cultural anthropology, for example, participant observation or different forms of interviews. However, these methods have to be adapted carefully to the specific research topics of medical anthropology. For example there may be general guidelines for the execution of an “expert interview”, but in application there is a big difference whether the expert is a physician, an ayurveda doctor or a self-trained homeopath. Other unique and at times unusually complex problems in medical anthropology research can be the access to healers and patients and the ethical dimensions of research about life and suffering.

Applied anthropology methods are eclectic, ranging from qualitative to highly quantitative. Ethnographers have developed rapid assessment techniques to document community health needs during brief field trips. Others trained in public health, epidemiology, nursing, or medicine may do clinical or laboratory procedures or work with vital statistics. In quantitative approaches, rigorous attention is paid to sampling issues and sophisticated statistical analysis, and informed consent procedures are followed. As Carole E. Hill (1991) points out, many medical anthropologists are now working outside academia and combining standard anthropological skills with technical planning and evaluation skills.

2.5.1 Participant Observation

The classical research method in anthropology is participant observation. As defined by Malinowski, the investigator in the field has to integrate him- or herself into an unknown cultural context. Participating in everyday life of other human beings only becomes possible by learning the foreign language. Participant observation thus involves a researcher, or researchers, living within a given culture for an extended period of time, to take part in its daily life in all its richness and diversity. The anthropologist in such an approach tries to experience a culture “from within,” as a person native to that culture might do. Researchers doing participant observation often take part in the daily life of the culture, trying to
exist in the culture as if they were born into it. This is probably the most frequently included, if not necessarily the most heavily utilised, technique. Much depends on the interpretation of the researcher concerned and so emphasis has been laid on the proper orientation of the researchers (Lambert et.al. 2002).

The ideal of anthropological field research is participant observation, where a “disturbance” of the observation situation should be avoided by the researcher. This is particularly valid for research about “medical pluralism”, indigenous perception of and behaviour towards illness and people’s attitudes towards the different therapeutic options.

**Reflection**

The methodological implications of doing research on a ‘stigmatised’ topic (which may be AIDS as well as any other stigmatised topic), illustrates the risks and benefits of qualitative research. The exploration of stigmatised and tabooed topics has direct implications for the actions and the position of the field researcher himself: the anthropologist becomes the bearer of secrets who is not only restricted by his role as a ‘participant observer’ but who for ethical reasons, cannot make his knowledge public even if the decision to stay silent may lead to new infections and, therefore, to increased suffering. Even before beginning fieldwork it is for these various reasons essential to reflect on the potential ethical dilemmas which may result from doing research on a stigmatised topic.

2.5.2 Case Study Method

Nichter and Nichter (1996) who takes an ethno-medical approach when investigating international health proposes that the best way to approach the subject is to examine a number of individual case studies. They argue that each case study can shed light on specific issues including reproductive health, disease control, health education, and pharmaceutical use, etc. To illustrate their point, they studied women’s reproductive health by examining women’s health practices during pregnancy, fertility related practices, and interpretations of and demand for fertility control (1996: 1). By researching individual cases Nichter and Nichter were able to investigate many diverse factors, both social and biological, that contribute to each of these issues.

By studying about one illness or problem in many different cultures we are able to understand about it from varied perspectives. It is sometimes thought that by taking away the cultural ‘noise’ we can reveal the true nature of the illness or problem outside its cultural context. An alternative view developed here is that the causative factors, experiences, expressions and consequences of physical or mental suffering may vary in different cultures. A complaint makes no sense in a cultural vacuum, because its meaning cannot be accurately communicated. A society’s culture can be likened to an individual’s memory. Health practitioners while acknowledging the presence of certain outstanding personality dimensions across cultures must therefore realise the need for understanding the interaction of collective and individual identity.

2.5.3 Survey Research

Survey research is a method in anthropological research that describes any technique that involves asking respondents questions. The survey in the title can
be an in-depth one-on-one interview or a short questionnaire. Anthropologists who use surveys frequently do so in combination with another method, and much has been written about respondents falsifying answers to questions. Nevertheless the importance of this method in understanding the health situations of various communities cannot be denied (Lambert et al. 2002).

2.5.4 Cross-cultural Comparisons

Cross-cultural comparisons are just what they sound like, a research technique that compares one culture with another or several others. These comparisons can be comprehensive or focus on a specific element of a culture’s practices. These comparisons grew out of an attempt to document the similarities, rather than differences, among cultures and to hypothesize probable causes of human behaviour beyond explanations deemed cultural, ethnic or environmental. Practicing anthropologists can use cross-cultural comparison methodologies to compare field data or case studies from a wide variety of cultural groups in attempts to gain a greater understanding of the health status of humanity as a whole. This method is sometimes called worldwide cross-cultural analysis. Researchers conducting health studies can also instigate a controlled comparison among a set number of cultural groups that have some element in common to try and gain a deeper understanding of that element and the people it impacts (Lambert et al. 2002).

2.5.5 Documentation

Practicing anthropologists can use this cross-cultural approach in the related techniques of media analysis, archival research and historical analysis. These are all terms that describe applying cross-cultural inquiries to written documents. The documents could be directly from the culture being studied, from documents studying particular cultures or documents created in response to second hand studies of a culture. Presently, these terms go beyond written documents to include digital representations. We can well understand the importance of this method in health studies (Lambert et al. 2002).

2.6 ROLES OF PRACTICING ANTHROPOLOGISTS AND CONTRIBUTIONS OF ANTHROPOLOGY TO HEALTH

Applied medical anthropology is strongly interdisciplinary in its nature and approach. Medical anthropologists often work with academics in the field of sociology, medicine, psychology, and demography. Applied medical anthropology brings with it anthropology’s comparative framework which helps medically trained people avoid a limited one culture perspective, to see how social and environmental factors affect health, and to be aware of alternative ways of understanding and treating disease (Kottak, 2002; Scupin and DeCorse, 1995; Howard and Dunai-Hattis, 1992; and Brown, 1993).

In general, medical anthropologists play two important roles i.e. they work in collaboration with health and other professionals and researchers, as consultants, advisers and researchers and they are involved in independent research for the advancement of anthropological knowledge (Kottak, 1994; Scupin and DeCorse 1995; Hahn 1999).
Some of the specific applications or contributions of practicing anthropology in the field of health and illness include helping hospitals and health agencies to deliver health care more effectively to the people, helping the national and international health organisations by providing anthropological data on the cultures of peoples of the world and working with epidemiologists in identifying the effects of cultural practices and beliefs on the transmission of disease and assisting health professionals in the area of disease prevention and control. Their contribution in the fields of general health education efforts relating to family planning maternal and child health, improving community sanitation and nutritional counselling has helped immensely in enhancing community participation in disease prevention.

The publication of Philippe Bourgois and Jeff Schonberg’s book, *Photo Ethnography, Righteous Dope Fiend*, part of the University of California’s Series in Public Anthropology, makes a case for “critically applied public anthropology” through its focus on the unintended consequences of public policies that inadvertently exacerbate the suffering of street-based drug users in the United States (Brondo, 2010: 112(2):212). The work was on exhibit at the Slought Foundation of Philadelphia from December 3 to 31, 2009, and at the University of Pennsylvania Archaeology and Anthropology Museum from December 5 through May of 2010. The exhibition was designed as a public conversation in conjunction with the Penn Center for Public Health Initiatives’ 2009–10 series, *Creative Action: The Arts in Public Health*. Policy recommendations that emerged from their research include the expansion of single-room occupancy hotels with in-house Medical staffs, mobile health clinics, and methadone clinics and better case management for emergency room “frequent flyers (Brondo, 2010).

### 2.7 SUMMARY

As we have noted, health is a multidimensional state. It can be broken down not just into physical, mental and social domains, but also into further subdivisions within each of these. We can at once be relatively healthy in some aspects of life and relatively unhealthy in other aspects of it. There is no clear line that we cross to move from an unhealthy category into a healthy category. People, and their health, are more complicated than that. In the Alma Ata declaration of 1978, the WHO put greater emphasis on the social dimensions of health by focusing on primary healthcare. This declaration stated that resources were too concentrated in centralised, professionally dominated, high-tech institutions – especially hospitals. Instead it emphasised the importance of community participation in healthcare and the importance of communities having some ownership over their health services. In focusing on the primacy of the community, this declaration allowed for the incorporation of community values. Different communities have different values. These differences often reflect different cultures or subcultures. Thus the movement towards community health also offered a mechanism for integrating cultural values into healthcare. Perhaps the clearest integration of culture into a community-focused definition of health is the following, adopted by Health and Welfare Canada (cited in Kazarian & Evans, 2001:7) “…a resource which gives people the opportunity to manage and even change their surroundings . . . a basic and dynamic force in our lives, influenced by our circumstances, our beliefs, our culture and our social, economic and physical environment”.

Qualitative methods are now common in research into the social and cultural
dimensions of ill health and health care. Anthropology as an applied science when utilised in health issues is related most commonly to the biological, social and cultural dimensions of health, ill-health and medicine.

In short, applied medical anthropology or practicing anthropology of health requires the combined expertise of a medical professional, a social worker and an anthropologist. Satisfaction in work is immense for practicing anthropologists working in areas related to health as it can contribute to understand and solve health problems and their origins in their totality. Practicing anthropologists are in great demand in the developing countries of Africa and Asia, who can guide their governments in creating a sustainable, holistic and effective health care program.

The breadth and reach of practicing anthropologists in 2009 suggests that anthropology has entered a new phase of advanced engagement at local, national, and international levels. Anthropologists here were active in bringing to light long-standing issues of health disparities and global health–related human rights violations, as well as in providing recommendations for national and community-level policy initiatives in the wake of this renewed public interest (Brondo 2010:208).

References


**Suggested Reading**


**Sample Questions**

1) Discuss the importance of an understanding of the theoretical aspects of health in the study of practicing anthropology?

2) Discuss the different methods and techniques used by practicing anthropologists in health studies?

3) What do you understand by critical medical anthropology. Discuss?