

Medical Anthropology: A Review

Veena Bhasin and Vinay K. Srivastava

Department of Anthropology, University of Delhi, Delhi-110 007, India

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ABSTRACT Medical anthropology is one of the important applied areas in anthropology. It provides the base line data and strategies for successfully undertaking community health programmes. This article provides a broad overview of the discipline and surveys some of the important works that have been done at the international and national levels.

Basing on the distinction between 'science' and 'technology', anthropologists have also distinguished 'pure or theoretical anthropology' from 'applied and action anthropology'. Although no anthropologist would ever deny the existence of feedback relations between 'theory' and 'practice'—or, the unity of theory and praxis—there has been in vogue some kind of disarticulation between the two. The academic anthropologists (or the theory builders) have looked at the applied areas with skepticism, and the proper integration of these dimensions in the main body of anthropological theory and research has been unusually delayed.

The applied areas lie at the interface of anthropology and other cognate sciences. But their paradigmatic outlooks and modes of conceptualization, methodology of undertaking empirical studies, and operationalizing the research in a number of different contexts, are all rooted in anthropology. For example, industrial anthropologists are expected to know the scientific and technical aspects, the management theories, history of industrialization in the country of study, before laying down an anthropological research design. The inter-disciplinary interface research involves the core themes of many independent disciplines: a study in medical ecology would require concepts from medical science, ecology, and anthropology.

In the last thirty years or so, a number of sub-disciplines have emerged within the main discipline of anthropology, each endeavouring to lay

down a specific area of application of human relevance. Within these sub-disciplines have emerged various special anthropologies: for instance, ecological anthropology has specializations like irrigation anthropology, agricultural anthropology, farming systems research, anthropology of fishing, anthropology of ecological disasters. And they are all directed towards delineating strategies and programmes for human upliftment and betterment.

Of these application areas in anthropology, one of the important fields is medical anthropology, also referred to by expressions like anthropology of health-care systems, anthropology of medical systems, anthropology of health management, and anthropology of bio-medical and ethno-medical systems. Although anthropologists were always concerned with the native ways of handling the episodes of illness, and primitive medicine was often described as 'supernatural medicine', the field of medical anthropology started crystallizing in the sixties of this century. In 1963, the term 'medical anthropology' as a specialized study within the integrated field of anthropology came into existence. Distinction between anthropology of medicine and anthropology *in* medicine was also drawn.

In order to understand the scope of medical anthropology, it is important to draw a distinction between 'illness' and 'disease'. Following Fabrega Jr. (1972: 167), one discerns two foci in medical anthropology, the ethnomedical and

the Western bio-medical. In the first, one describes the ways in which a community or group handles the medical problems. Every culture provides cognitive categories that explicate the causes of an illness, the treatments that must be administered to revive the normalcy of health, the therapies that need to be advised to check the further recurrence of the ailments. Therefore, the term 'illness' must be understood from an 'emic standpoint', and what may be termed as 'illness' in one situation may not be so in others. For example, the Thonga believe that worms are essential for digestion, and thus they have no methods to eradicate them, but looking at it from the bio-medical perspective, one would find that the presence of worms is a disease, for which wormicidal dosages need to be taken.

Let us discuss another example from the Indian situation. In villages of Rajasthan, the eruption of warts is not considered an example of illness as they do not hamper any of the daily routines of the people. Yes, the warts do affect the cosmetic dimension, and the treatment—if at all it is to be sought—is advised in terms of ethno-medical practices. The person having warts is advised to circumambulate the platform (*than*) devoted to a local deity, Ramdeo Baba, regularly for a period of seven days. He is also supposed to leave a handful of millet (*bajra*) grains on the *than* for the birds. The people believe that as the sick starts circumambulating (*pheri lagana*), the warts begin drying up and disappear.

Whether it is the Thonga belief or a belief in Rajasthan, the commonality is that in both cases the categories of illness and their treatments are culturally constituted. Further, the characterization of behavioural and phenomenologic indicators into 'health', 'illness', or 'not-illness' is also culturally conditioned, and thus these characterizations may be diametrically opposed to what the Western bio medical science states. Leucoderma (vitiligo), for example, is not infectious; it does not disable a person; it has only cosmetic effects, but in a culturally-constituted situation, as is in rural India, it is confused with leprosy, thus a person afflicted with it is usually shunned.

Ethno-medical researches acquaint us with native theories of disease causation, the local specialists in health care system, the processes of health restoration, the pharmacopoeia that is usually resorted to.

When medical problems are dealt with the categories of Western scientific medicine, we enter the realm of bio-medicine. Here, the perspective is biologicistic (Fabrega Jr., 1972: 168)—in the sense that an ailment is explained in terms of germ theory, malfunctioning of body organs, problems in the physiological make up. Like science in general, the knowledge of biology is not culture bound: it has some kind of a universality. The ailment of a person is understood not in cultural categories but in universally held biological principles. Here, the term 'disease' is used and the standpoint of explanation is 'etic'.

In a community insulated from the impact of the wider world, there is every probability that it would have only its own ethno-medical system, which may be rooted in supernatural cure, herbal and humoral practices. But in the contemporary world, where even the erstwhile 'primitive' communities have come to be linked with the world system, it may not be possible to identify a society thriving only on its ethno-medical system with no impact of the Western bio-medicine. The Western medical system has been so powerful in its spread and acceptance that it has replaced—almost ousted—the traditional practices and cures. And if this has not happened in some situations, at least it has come to stay as a potent method of treatment, and along with it have survived traditional cures and practices. In some areas of India, the Western bio-medicine entered along with the Church. For example, in Nagaland, the Church—irrespective of its denomination—brought with it the Western medicine, but with it, it also encouraged the methods of healing on the lines of Christianity, thus gradually replacing the curative and diagnostic practices undertaken by the shaman. Today the traditional shamanistic cures are not only practised by the non-Christians, but they are also the 'public consumers' of these treatments. The

Christian Nagas approaching the shamans expose themselves to the likelihood of being fined by their respective Churches. In any case, the percentage of the non-Christians in a Naga village is almost negligible, and consists mostly of the old people.

The influence of the Western bio-medicine has been paramount. Stating that the Western medical system is founded on principles which are in sharp contrast to the native ethno-medicine, anthropologists have usually made an analytical distinction between the 'Western medical system' and the 'non-Western medical system'. Ideally, the latter is uninfluenced by the Western medicines; but is one justified in making this distinction. Worsley (1982: 315) finds the concept 'non-Western' dubious because, firstly, Western medicine has largely influenced regions outside the West, and its acceptance is exponentially increasing. In the Indian context, it has been seen that wherever the primary health care centres are being opened up, they are invariably specializing in Western medicine, or also called the allopathic system. The local people have not rejected it as may be presumed on the basis that its operational theory rebuts shamanism and spirit-intrusion beliefs. It has also been observed that the people link Western medicine with 'fast cure', and of all its practices, the intra-venous injecting of drugs is seen by them as the most efficacious. Often, the sick request the doctors to inject the drug in them for fast recovery. There are, of course, cases where the Western medicine, curative or therapeutic, has been outrightly rejected by the people: the pregnant women of the Baiga community in Mandala are often given iron capsules by *anganwadi* (the state sponsored institution set up in villages for the care of women and children), but they are rarely consumed by the women who think them to be redundant. Such rejections do not imply that the impact of Western medicine has been insignificant. Today, the parts of Asia, Africa and the Americas have all been influenced by the Western bio-medicine, and the countries constituting these continents are spending huge sums in having their own exper-

tise on Western medicines.

Besides the historical, there are other reasons of not fully accepting the term 'non-Western'. Worsley (1982: 315) says that the category 'non-Western' is an example of 'arrogant, residual ethnocentrism' which has no place in contemporary anthropology. And, further, it is difficult to consider all 'non-Western' medical systems as homogeneous and undifferentiated. The expression 'non-Western' includes not only the folk medicine, but also some well-established medical systems belonging to the Great Tradition, like Ayurveda and Unani system in India, acupuncture and osteopathy in China, homeopathy is another example of an 'alternate' medicine. Like differences in folk medicine, all these 'alternate' medicines—which now have started gaining respectability in Western societies also—were based on a body of well organized principles, often in sharp contrast to one another.

Further, Worsley (1982: 315) doubts the usage of the term 'medical' as a suffix to either 'non-Western' or Western system, because the treatment of 'body ills take place, in any culture, within a "metamedical" framework of thought'. Medicine is just one aspect of the entire healing process; the other aspects are, providing adequate psychic and social environment, regulation of the dietary and nutritional practices and intake, etc., the relation of the doctor and the patient is a very important factor; the ways in which the doctor explains the ailment to the patient, the psychological comfort he provides in the hospital setting, are important variables in treatment. It has been observed that the Indian doctors working abroad have been very successful because of the kind of relation they have been able to develop with their patients (Sachchidananda, 1988: 5). A typical formal atmosphere of diagnosing an ailment and extending its knowledge and treatment to the patient may not be conducive as the sick demands attention and his psychological dependence is considerably heightened. The psychosocial factors characterize every mode of treatment, whether based on ethno-medicine or bio-medicine.

Before we proceed further, let us offer a working definition of 'bio-medicine'. Hahn and Kleinman (1983: 305) write, 'The exploration of "Western" medicine—"Biomedicine"—extends a new frontier in medical anthropology'. For them, 'biomedicine' refers to 'the predominant medical theory and practice of Euro-American societies'. Referred to by various terms, 'Western', 'Cosmopolitan', 'Modern', 'Scientific', 'Allopathic', 'Bio-medicine', although having its origins in Western civilization, has incorporated many other traditions and fully interacts with them. According to Hahn and Kleinman (1983: 306) a working definition of bio-medicine could be: '...Biomedicine is the version of bio-medicine founded and dominant in Euro-American societies and spread widely elsewhere'.

We generally compare and contrast the ethno-medical system with the biomedicine and believe that ethno-medicine is a product of the people's culture while biomedicine is free of that. Thus the practitioners of biomedicine 'believe that their domain is distinct from morality and aesthetics, and from religion, politics and social organization, this form of medicine may be a more discrete system than others' (Hahn and Kleinman, 1983: 306). When a sick informs that he is visited by weird anthropomorphic powers, who incessantly torment him, and the local shaman divines that this is a case of spirit intrusion, or soul loss, the doctor trained in bio-medicine is less likely to be persuaded by these diagnostic aspects. The bio-medicine practitioner would diagnose the cause of sickness in some psychiatric phenomena, the treatments of which will be completely free from the native's culture and supernatural domain. The people may combine the medical treatment with spiritual methods, but such a decision is theirs and certainly not on the advice of the psychiatrist. Certain phenomena, for example, similar to the one reported in the movie *The Entity*, of 'supernatural visitations', as the people and also the sick describe them, may baffle the practitioners of bio-medicine, there is less likelihood that these specialists would succumb to finding an explanation

of psychic disorders in supernatural/superempirical agents.

As practiced, it seems that the realm of bio-medicine is simply natural; it is scientific; it cuts across cultural differences and native theories of nosology and aetiology. A relation may be drawn between ethno-medicine and bio-medicine on the basis of differences between nature and culture.

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But Hahn and Kleinman (1983: 306) are less persuaded by such logic. Bio-medicine is not 'simply a natural phenomenon', it is a creation of human society (Hahn and Kleinman, 1983: 306), founded in a cultural framework of values and premises. Rejecting the diametric opposition held between ethno-medicine and bio-medicine, they submit that bio-medicine is an 'ethnomedicine', although it is a unique one. To quote them (1983: 306):

In making this claim (bio-medicine is an ethno-medicine) we do not deny a natural connection. Biomedicine and other socio-cultural systems continually remake nature, including human nature; but nature reciprocally constrains what can be made of it. Biomedicine is thus the product of a dialectic between culture and nature. By making this dialectic a central focus, medical anthropology, we aver, will confront general anthropological theory with a vital problematic and offer a subject matter for its exploration.

A treatment of biomedicine as a sociocultural system has important implications for medical anthropology. In several learned circles it is believed that medical anthropology is chiefly concerned with describing the native/local procedures of handling a health disorder, which can be achieved using standard anthropological methods. But once biomedicine is also understandable in anthropological paradigms, the

domain of medical anthropology widens. Besides understanding the dynamics between biomedicine and the people, anthropologists provide biomedicine with 'social and cross-cultural settings in which to test its theories'. Hahn and Kleinman (1983: 327) further write:

Biomedical etiologies, etiologies, and therapies are most often examined in laboratory or clinical settings in which the utmost efforts are made to aseptically remove cultural and psychological influence. Anthropologists would insist first that this goal is impossible, then that cultural and psychological effects should themselves be taken account of, and finally that they should be encompassed within an anthropological medical theory and practice.

A consideration of bio-medicine as a socio-cultural system is part of the bigger effort that believes that science, in general, is not created in isolation—the sociocultural factors are entwined with it, and various decisions regarding scientific policies and research are taken in perspective of these factors.

Various medical systems are combined at the real setting. At the level of a community several ethnomedical practices are combined—shamanistic treatments, herbal methods, local procedures to handle cases of osteopathy, household therapies. In a society having non-Western treatments, but of great tradition, like Ayurveda and Unani, their combination exists with folk medicines. Impact of Western medicine does not mean, just because it is a 'leading edge of modernism' (Hahn and Kleinman, 1983: 305) having a wider spread and intensity, that all non-Western medicines are relegated to the back seat. What actually occurs is that different systems and ways of treatment are combined, and this is all done to achieve complete and effective treatment. The term 'medical pluralism' is often used to designate the state of co-existence and combination of various strategies, ways, methods and systems

of diagnosis and cure. Kakar (1983) in a monograph on distinct but co-existing medical practices in India, has analyzed the paradigmatic outlooks of each one of them.

Let us define medical pluralism. Medical pluralism is a concept, according to which different medical practices—of diagnosis, treatment, and therapy—not only exist in a society, but also come together, are richly combined, while handling a case of illness. From the perspective of these practitioners, their medical practices are rendered ineffective, or may even counteract, if combined with others not belonging to their system, but people—the consumers of different medical strategies and treatments—on their own take decisions to combine different medicines without necessarily seeing various systems of medicine as contradictory. In evolutionary sequence, as the new and more potent medical systems come to exist, the clientage of the old is gradually pruned, but it does not mean that they become completely fossilized. They exist in some corner of the society—in the household, with faith healers and traditional medicinemen—and may often be visited if the so-called 'scientific bio-medical system' is unable to provide adequate help.

Various medical practices in a society can be placed on a scale of differing clientage and importance. Lower the place of a curative practice in this scale, less adamant its practitioners are to a combination of different practices. Higher the scale of a curative practice, more adamant its practitioners are to a combination of different medical practices. The allopathic system, for example, will not in theory accept its combination with other systems, while shamanistic cure or household treatment strategies may be more in favour of administering different treatments.

One may here distinguish between how the person (the 'sick', the 'patient') is looked at by the medical system, and by the family (or any other primary group) of which he is a member. Howsoever well integrated the society is, the health practitioner will always treat his patient—when the 'sick' comes under medical

...to that of 'patient'—
...will be chiefly interested in
...and adequacy of his
...is to the knowledge
...and puts into practice, and his
...to be the subject on whom the
...of his knowledge are tested. If he is
...or when patients are largely cured, his
...in the knowledge he practices is streng-

But the group of which the sick is a member, primarily interested in getting his health restored, for which it will unhesitatingly combine different treatments irrespective of their respective ontological, epistemic, moral and aesthetic foundations. For the family (or any other primary group), the 'sick' is a 'total individual'—not the 'subject' on whom medical knowledge is to be tested—in whose welfare and well-being lies its chief good. Medical pluralism results out of this orientation where attainment of health is the primary objective and the individual is treated in its holistic self. When one subject of treatment fails to provide relief, the individual moves on to another, and this is individual's or his group's decision; the practitioner of a medical system will not advise his patients to shift to another, but within his own sphere of curative practices, he would struggle with his knowledge to devise an effective treatment for the patient. His overarching concern is to 'test his knowledge', the consequence of which hopefully is recovery of the patient.

Each medical system is not only a product of particular historical milieu and cultural apparatus, it also has its own cognitive categories. The combination of these categories produces dissimilarities between them. Human beings caught in illness episodes are less bothered about the issues of combination; they are singularly concerned with recovery and relief. For this, they usually abolish the distinction between 'rational' and 'non-rational' methods of diagnosis and treatment of illness. Here the distinction between 'science' and 'faith' categories collapses; and so is the distinction between 'magic' and 'religion'. Systems

of thought and explication, like astrology (see Pugh, 1984: 85-105) or Sufism (see Ewing, 1984: 106-114), which primarily are not medical, are approached for curative as well as therapeutic purposes, on the premise that religion is to be resorted to in cases of suffering, and illness is a kind of suffering, the alleviation of which can be sought through prayer, touch, invocation of spirits, sacrifice and libation, appeasing the unfavourable planetary configuration, or wearing talisman and charms on body. Intriguing cases of cure, mental and physical, from different contexts have been reported—there are incredible accounts of Philippine faith-healers (Chesi, 1981); through spells and charms, a case of cancer has been cured (see Themes and Issues, *Society for Indian Medical Anthropology—SIMA—Bulletin*, vol. 2, no. 1, 1989); there are accounts of healing in temples (Skultans, 1987: 661-679)—and they have been either analyzed in a psychological framework (see Harper, 1963: 165-197; Yoshida, 1967: 237-262; Kakar, 1982), or left simply recorded because the events leave the investigator more than baffled. In other words, the dependence of modern man on biomedicine does not exterminate his belief in either the existence of 'alternative' medicine systems, working on principles different from the Western medicine, or cosmic forces and powers which are inexplicable through methods and practices of modern science.

Medical pluralism entails from the general skepticism of the people about the singularity of a medical system. Promotion of non-Western codified systems, like Ayurveda and Unani (for a different viewpoint, see Morris, 1989a: 103-121), by the state of India is another step towards recognizing alternative medicines. Ethno-medical profiles of tribal and rural communities familiarize us with the medical practices the people have been following in the absence of Western bio-medicine. Medical biographies (see Srivastava, 1990) of the sick tell us how and what medical choices were made after the onset of the illness was announced.

This, however, does not imply that every

curative practices that people include in their medical choices is equally effective and needs promotion. Yes, the local knowledge must be respected, but since it is local knowledge, it need not be generalized and promoted. Let us present an incident to stress our point.

In a Rajasthan village, where Srivastava was doing his fieldwork in mid-1990, a boy, studying in tenth standard, was bitten by a poisonous snake when at night he went out to ease himself. Cases of snake-bite are always on rise during the *chaumasa* (agricultural period of four months, July to October). During the night the boy was provided with some first aid, and the next morning, instead of taking the victim to the hospital, the family members decided to take the services of a traditional healer who lived in the town. Enchanting the name of Goga Pir—the folk deity believed to be the guardian of all kinds of snakes, the healer tied a thread (*tanti*) around the affected area, and said that the boy should be protected from the touch or reflection of a lower caste person. Further, he almost guaranteed that the boy would be cured in a few hours. The patient was brought home, the family members maintained unexplained silence about the whole matter. The morning later, the boy succumbed to death.

The people believe in the existence of snake deity, and to safeguard them against any untoward happening, Goga is always worshipped. Before starting the agricultural work, the offerings are first of all made to this deity, along with some others of local variation—like of Hare Ram Baba in Bikaner and adjoining area. The faith in these deities provides the people with psychological protection, but when cases, human and animals, of snake bite come, should they be taken to the respective doctors or the Goga priests. At this juncture, the intervention of anthropologically oriented social work is urgently required. Respect to the local knowledge apart, the idea that the victims of snake bite should be immediately, without delay, taken to the hospital, needs to be fully instilled in the people.

Value-loaded questions emerge with respect to all the intriguing cases of cure. An astrologer

is able to cure a cancer patient through spells (*mantra*) and related instruments (*yantra*), but can this become a standard treatment for all the patients of cancer. Kakar's (1989) comment on the miraculous cure of a cancer patient, reported in the SIMA Bulletin, is worth quoting here:

The paper is interesting and is one more illustration of there being much in the world which our philosophies cannot even dream of. Yet, it raises questions but does not answer any in plausible fashion. We know of reports of cure of incurable cancer cases from all over the world with the most varied of remedies and even of spontaneous remission of cancer (Everson, "Spontaneous Regression of Cancer", *Connecticut Medical Journal*, 22, 1958) so that even to link any one practice with the cure becomes extremely difficult, except for the believer in that particular practice. Therefore, though I am quite in favour of suspending disbelief in cases such as to one you have described, I must also suspend belief as to the connections you draw, because of the so many other similar cases where very different connections were drawn.

Local herbs are used by people for various ailments—there are cases of restricting pregnancy through these herbs, or of facilitating abortion, but before they are incorporated in the general health care system, they need to be fully analyzed with their botanical properties sorted out.

In light of these theoretical and applied aspects of medical anthropology, let us formulate its definition and survey the salient aspects of the work done so far.

II

Medical anthropology may be defined as a branch of anthropology which studies the episodes of human confrontation with 'disease' (in biomedical framework) and 'illness' (in ethno-

medical), and the adaptive arrangements they make for dealing with the deviations from normal health standards. The ill health is not an individual problem; it is socio-cultural. It is around the sick that quasi-groups—P.C. Joshi (1965) called them 'therapy management groups'—are formed, which consist of kinsmen, neighbours, friends and colleagues. At the functional level, illness provides an occasion for reinforcing solidarity between relatives, friends, neighbours and all others concerned. Treatment is mediated through cultural mechanisms which interact with biological. Therefore, sickness is perceived in biological, social, cultural and psychological terms in a holistic framework. Functional analytical approach (in contrast to situational logic used by sociologists) may be useful in uncovering the links between various dimensions of health, and sickness may be taken as a symbolic perspective to comprehend their meaning.

For describing medical practices we generally use the term 'medical system'. A medical system can be conceptualized as a network, or a social system, or a cultural system. When we view a medical system as a network, it implies the search for relations or connection between parts—the parts may be individuals and persons, groups, institutions, roles, messages—and which of these has priority over others depends on the analytical perspective of the investigator.

Treating a medical system as a social system implies that we look for functionally related social relations which include rights and duties with attendant beliefs, values and attitudes. Following Parsons (1951), a medical system as a social system should have the four functional imperatives—adaptation, goal-orientation, integration and latency. As a cultural system, one has to analyze the beliefs, values and attitudes which are functionally related with sickness and death.

Medical anthropology, therefore, is a bio-cultural discipline concerned with both biological and socio-cultural aspects of human behaviour, particularly with the ways in which the two interact and have interacted throughout human history to influence the conceptions of health and

treatments and therapies of disease (Foster and Anderson, 1978: 2-3). The bio-cultural nature of medical anthropology is clear in a series of review articles (Candill, 1953; Polgar, 1962; Fabrega Jr., 1972; Lieben, 1973; Colson and Selby, 1974; Landy, Ed. 1980).

Earlier the data for medical anthropology were collected from three different sources by the specialists. Physical anthropologists collected data regarding evolution, adaptation, comparative anatomy, racial types, genetics and serology, genetics and environment and their relation with health and sickness. The culture and personality movement of the late thirties and forties was another source of data for medical anthropology. These data collected by psychiatrists and anthropologists (Hallowell, 1940, 1963; Henry and Henry, 1944; Paul, 1950) were primarily theoretical in nature having less applied value. The ethnographers collected details about primitive medicine, witchcraft, sorcery and magic. These beliefs and practices were dealt with with the conceptualization of disease as the product of indigenous cultural viewpoint and not in the conceptual framework of modern medicine.

Rivers (1924) classified some basic concepts, especially the idea that indigenous medical systems are social institutions and they should be studied in the same way/fashion as social institutions are studied in general. Further, the local medical practices are 'rational' and they should be understood in themselves. The theme that emerged from Rivers that religion, magic and medicine are interrelated, and should be studied in relation to one another, is still followed by many investigators working in relatively isolated communities.

Evans-Pritchard's (1937) work on witchcraft was a significant contribution to the native thinking on a phenomenon that was deemed to cause many unfortunate conditions, illness being one of them. The Azande, on whom Sir Evans Pritchard worked, believed that some people are born witches—they have a blackish hairy object locally called *mangu* under the sternum—and by virtue of this inherent quality, they can cause any

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misfortune. The affected persons fall sick; they may die also. Witchcraft provides a natural philosophy for explaining misfortunes. Evans-Pritchard described medical beliefs and practices using a conceptual framework which was intended for studying other aspects of social structure, such as the maintenance of ordered social relations.

There were other monographs that contained detailed descriptions of medical beliefs and practices, like of Turner (1967, 1968) or Spiro (1967). These and other monographs of the same type described the social and cultural responses to illness and death as afflictions or misfortunes from the emic standpoint. Here, the studies of health and illness were, to a large extent, reduced to those of witchcraft, sorcery, magic, or in general, curative or socially readjustive ritual practices, with herbalists and empirically rational diagnoses, treatment and prophylaxis as residual categories. It is because of this, they can be more properly considered anthropologies of religion, comparative mode of thinking, witchcraft, ritual and symbol culture and psychology, and so on. These were believed to originate in problematic and analytical frameworks where sickness events were vehicles to understand other constellation of facts.

Although abstraction of generalized principles is lacking in these studies, this does not reduce their importance as they provide rich accounts of health and sickness events in simple, kin-based societies. Truly, they are not proper medical anthropological works, but insights developed from them, particularly where sickness is so externalized that it becomes a social event (Lewis, 1979), have enriched the ethnomedical studies of medical anthropology, besides, of course, enriching symbolic anthropology.

The earlier anthropologists were pre-eminently involved in understanding societies, in evolutionary or functional terms, which were different from their own. Since the magico-religious system found one of its full expressions in events of sickness, these anthropologists studied sickness to understand native religion and magic.

Events of illness provided empirical material to reach the abstract propositions of magic and religion. Therefore, these anthropologists could not be called 'medical anthropologists'; they were not concerned with the possible significance of their findings to the health structure of the community they studied. Therefore to say that medical anthropology evolved from the earlier studies of illness in the context of religion and magic, may not be right. But once in the sixties, medical anthropology emerged as an independent but inter-disciplinary field of theoretical and applied value within anthropology, its disciplinarians started introspecting the earlier studies which collected empirical details on the treatment of sickness in simple societies. Medical anthropologists working in the field of public health have placed these studies under the title 'ethnomedicine'.

Some ethnomedical studies have focussed on the functional role of traditional medicines in particular cultures, others have emphasized the logic behind ethnomedicines; some others have offered the psychological and psycho-somatic implications of these medicines. Studies with the theme that sickness is a vehicle for pursuing other interests, have also been conducted (Frake, 1961) but they have been found to be of limited relevance (Good, 1977).

The studies by Evans-Pritchard (1937) and Gluckman (1972) gave primacy to social relations which produce the forms and distribution of sickness in society and social organization of ritual behaviour. Among the Azande, the diagnoses by the witch-doctor is held in public and heralded and accompanied by drums. These public performances are local events of a lot of importance (Evans-Pritchard, 1937: 154). Medical facts are not separated from values; physical manifestations are not torn from their social contexts, and it requires no great effort of mind to read social relations into material events.

Ackernecht (1942a, 1942b, 1943, 1945, 1947, 1971) may be considered one of the pioneers in the study of ethnomedicine. In 1942, he wrote, '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'. Further, 'what counts are not the forms but the place medicine occupies in the life of a tribe or people, the spirit which provides its practice the way it merges with other traits from different fields of experience'. Discussing the relationship of primitive medicine with culture pattern, he identified three aspects:

- i. there is not one but numerous different 'primitive medicines';
- ii. the differences between the primitive medicines are much less in elements than differences in the medical pattern which they build up and which is culturally contained; and
- iii. the degree of integration of different elements of medicine to the whole and of the whole medicine into a culture pattern, which varies considerably.

Ackernecht illustrated these points by comparing the systems of medicine in different cultures, attributing the success of primitive medicine to its psycho-therapeutic qualities.

Field (1961) studied the religion and medicine of Ga, a community of West Africa. Among them, the treatment of disease is done by medicinemen as it is believed that the cause of disease is an attack by evil spirits. There are broadly two types of medicinemen—good and bad. A good medicineman works with two sorts of materials—visible apparatus and herbs. Bad medicineman causes harm to the people with or without the help of familiars. Good and bad medicine men are mutually exclusive. Such dichotomies of 'good' and 'bad' are prevalent in other dimensions of human life—marriage is an example of 'good sacredness', while death of 'bad sacredness'; one who performs death rituals in the Hindu system is a 'bad Brahmin'. Similarly the local distinctions between 'good' and 'bad' medicinemen are based on distinctions between 'white' and 'black' magic, although it should not be forgotten that they are relative categories.

The dichotomy of 'tradition' and 'modern', or

'lay' and 'cosmopolitan' has affected the classification of medical systems. Polgar (1962) dichotomized health culture into 'professional' and 'popular'; Leslie (1960) discussed the 'cosmopolitan' system as opposed to 'indigenous' or 'popular' medical system. The idea of dual system, as forwarded by medical anthropologists for analytical reasons, does not imply rigidity of categories—the tradition is not impervious to modernity. This, as we saw, accounts for medical pluralism.

Dunn (1976) has classified medical systems with reference to their geographical and cultural settings. Thus, there are 'local medical systems', comprising 'primitive' or 'folk' medicine; 'regional medical systems', such as Ayurvedic, Unani, and Chinese medicine (for the latter, see Morris, 1989b: 1-33); and the 'cosmopolitan medical systems', often called 'modern', 'scientific', or 'Western'. A dictionary definition of 'cosmopolitan' conveys the worldwide character, rather than one which is limited or provincial in scope, involving persons in all or many parts of the world. Local and regional systems are invariably indigenous and traditional. They are normally intra-cultural, but not insulated from exchanges with other systems. The local systems tend to be popular and non-scholarly, while regional systems are scholarly (Dunn, 1976: 135-136). One may keep in mind the distinction between Little and Great Traditions for understanding the continuum of different types of medical systems. Each medical system evolves to meet a people's conception of their health needs. A long-standing indigenous, traditional system may be more effective in meeting with certain health needs than a recently transplanted system.

However, little attention has been paid to the specific character of interaction between 'primitive' and 'modern' medical practices. Few studies have been conducted among simple societies where these two seemingly divergent approaches to healing operate side by side and how the system operates. In urban societies, there is a persistence of folk medical practices, and they endure not as 'remembrances of nostalgic past'

but because of their survival strategies in critical situations. Social and economic functions of traditional medical systems are fairly well known. Press (1978) examines health practices in terms of their response to urban socio-economic characters. Such practices appear to serve functions of acculturation, ~~gulf~~ displacement resulting from failure to achieve, and sub-group identity maintenance among others. It is, however, not known as to what structural accommodations must be in the traditional environment with the advent of modern medical practices. Press, clarifying the concept of 'folk' medical system, said that it is at variance with Western, scientific medicine; with a codified, formal and literate medical traditions (Western, Ayurvedic, Unani, Chinese, etc.), with the official health practices of a community or nation. Folk medical systems are characterized by a high degree of shared knowledge between public and practitioners and this serves as an effective social control mechanism. Folk illness and medicines are aspects of the same cognitive system, but they are not identical.

Gould (1957, 1965) has discussed some of these problems in light of his study from a North Indian village. Although his data were meagre, as medical practices were not an original concern of the study. Yet they tend to fall into rather clear categories and are statistically reliable. Gould concluded that interaction occurs in the folk culture between systems of primitive and scientific medicine. This interaction tends to create division of functions between village and scientific modes of healing in which the former serves the chronic non-incapacitating dysfunctions while the latter serve the critical incapacitating dysfunctions. Folk pragmatism is a selective principle to determine which method of treatment should be called for. Further, socio-economic status is another factor in the interaction between folk and scientific medicine. Choice of scientific over folk therapy is increased by economic well-being, formal education, and occupational and spatial mobility. He observed that the limited utility of scientific medicine leaves open a relatively permanent area of

chronic non-incapacitating dysfunctions within which a primitive system of medical therapy may continue in a complementary structural position in folk setting. Depending upon the nature and character of illness, the medical systems are approached. Erasmus (1952) found that the folk people of Equador treat their illnesses with supernatural etiologies by folk specialists, while others such as infected wounds, measles, anger sickness and skin infections are treated at home.

Good (1977) used the 'semantic illness network model' for case studies of Turkic speaking region of Iran and an outpatient clinic in the United States. He used the network of words, situations, symptoms and feelings associated with illness and its meaning for the sufferers. He collected the information over a period of time regarding symptoms, choice of therapies, social situation and the etiological circumstances of the patient or informant. Good called his methodology a kind of 'social free association', by which he constructed his informants' semantic illness network, and organized these networks through 'core symbolic elements', which are parallel to Turner's 'dominant symbols' that organize the meaning of rituals in those societies.

Blumenhagen (1980, 1981) and Kleinman (1978a, b) also described semantic illness networks while explaining the nature of folk illness. Blumenhagen used semantic illness networks to explain how hypertension is perceived by a population of Americans who suffer from it. He organized his informants' responses into what he called 'nodes' and 'arrows'. Nodes consist of reports of symptoms (eg. dizzy spells), interaction (eg. family arguments), physiological functions (eg. ballooning veins), body states (eg. overweight), pathogenic agencies (eg. acute stress), and activities (eg. high pressure causes ballooning veins which cause rupturing in blood vessels). Reducing 1300 individual reports (nodes) to 59 categories, Blumenhagen redrew his arrows to indicate the relative frequency with which his informants reported causes and effects.

Like Good and Blumenhagen, there are others who reject the physicalistic reductionism of

o-medical model and emphasize that the main of medical anthropologists is sickness, though their special contribution may be towards understanding 'illness'. Similar views are held by Eisenberg (1977) and Fabrega, Jr. (1974, 1975). Anthropological studies of illness and disease were conducted by Alland (1966, 1970), Fabrega, Jr. (1974, 1975, 1979).

Kleinman studied the 'core clinical functions', that is how systems of medical knowledge and practice of clinical processes enable people to adapt to certain worrisome circumstances. However, he does not maintain that every medical practice is necessarily adaptive (1980: 130). The adaptation premises are reflected in Kleinman's choice of words: guiding, managing, coping, explaining, negotiating alliances.

Although Kleinman refers to semantic illness networks in his studies, his semantic networks are related to systems of medical knowledge through people's 'explanatory models of illness', abbreviated as EM by Kleinman. An EM is a set of beliefs which 'contain any or all of five issues: etiology, onset of symptoms; pathophysiology; course of sickness (severity and type of sick role); and treatment (1978a: 87-88). It may seem at first glance that EMs conceptualize that every culture has its own explanation for sickness, but in fact it resembles Clifford Geertz's (1973) idea that every culture provides the people with ways of thinking that are simultaneously *models of* and *models for* reality.

The explanatory models simultaneously create order and meaning, give plan for purposive action, and help to produce conditions required for their own perpetuation or revision. EMs are attributed to individuals and not to cultures; they may be heterogeneous within a community and may be seen in different dimensions at different locations by different or the same set of people. Kleinman includes semantic illness network and EMs within a single diagram.

Young (1982) summarized that semantic illness networks are the products of EMs. In other words, an informant's semantic illness networks are related to a set of statements he actually makes over

a given period of time, using EMs to respond to particular contingencies. The EM approach settles certain fundamental issues like distinction between diseases, illness and sickness; the connection between sickness and people's statements about it and the practical (or clinical) role of medical anthropology. Kleinman and Good focussed on clinical events and the healing (illness) process, clinical setting dyadically radiating social relations between patients and practitioners, parents and individual family members, and so on. Other social factors that fall outside this circle, were not touched. According to the critics, the explanatory models overlook the fact that power originates and resides in arrangements between social groups and between classes.

The practical interest of the authors propagating the explanatory models lies in the issue of medical efficacy. They intend to augment the effectiveness of clinical medicine in the context of healing process; for example, they want to enhance the patients' education, remedy problems of non-compliance, and challenge maladaptive courses of treatment.

In Western society, the commodity mode of production dominates the social order. It creates a situation in which human beings and their experiences are constructed as de-historicized objects in themselves. Western medicine, among other things, is a part of the ideological apparatus of the social order (see Illich, 1975; Tausig, 1978). All knowledge of society and sickness is socially determined. Medical facts are pre-determined by the processes through which they are conventionally produced in clinics, research settings, etc. The perspective of anthropology of sickness is oriented to a point beyond the healing process, the inner logic of illness and the consciousness of the individual. This practical interest is in what can be termed as *medical productivity*. Here, attempts are made to identify the direct and indirect impact of particular clinical practices and perspectives on the levels of morbidity and mortality of the population at large. Because a medical system's degree of productivity depends on its effectiveness, technical skill

and the knowledge of its practitioners, there is no question of productivity without efficacy, but the reverse is not true.

Young (1982) gives a schematized outline of medical anthropology and its fields.

1. Biological orientations
 - a. Bio-medicine
 - b. Anthropology of diseases (Biological Anthropology)
2. Socio-cultural orientations
 - a. Empiricist ethnologies
 - i. Medical anthropology
 - ii. Empiricist medical anthropology
 - b. Non-empiricist ethnologies
 - i. Traditional anthropological approaches
 - ii. Anthropology of illness
 - iii. Anthropology of sickness

According to Lieben (1973: 1034), 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. His schema of medical anthropology is a useful paradigm but collaborative researches, transcending any particular discipline, will prove to be of great utility than the atomistic ones. The medical system of the people should be grasped as a whole, rather than in a fragmentary way, dealing with medical choices or the innovation of new medicines to the present situation, or sundry others, which acquaint us with one part of reality.

Studies of medical beliefs and practices are valuable to anthropologists for theoretical and practical reasons. On a theoretical level, medical beliefs and practices constitute a major element in every culture. Consequently they are interesting in their own right and also for the insight they give into other aspects of culture of which they are a part. On a practical level, knowledge of folk or ethnomedicines is important in planning health programmes and devising health services for the people. Medicine and health thus

provide valuable grounds for collaboration between medical scientists, health professionals and anthropologists.

Despite the valuable nexus of 'pure' and 'applied' research, the latter have not achieved a laudable breakthrough. One of its reasons, we suggested at the outset, is the lower status assigned to application areas by most anthropologists committed to theoretical research. Medical anthropology can significantly contribute to applied aspects since it deals with the management of ill health. The role of medical anthropology is to be understood in proper context; surely it does not offer any 'medicine'. It tries to understand the dynamics of illness, sickness, disease and health in the context of social structure (see Joshi, V. 1986: 125-137). Notwithstanding the biological implications of medicine, the fact that medical systems interact with social forces should not be lost sight of (see Bhasin, 1990). To support the social relevance of medicine, we may quote Virchow's characterization of medicine as social science.

Intensive study of traditional system of medicine is extremely important. The traditional medicines are still surviving not as relics of nostalgic past but because of their survival strategies in critical situations. The ethno-medical studies reveal how people survive in the absence of the so-called 'cosmopolitan medicines'. How do they face perilous situations and what is the efficacy of ethnomedicines? Besides these, it has also been noted that the introduction of new highly effective medicines is thwarted by values which act as bulwarks of traditional medicines. For a smooth functioning of cosmopolitan medicines, a rich knowledge of folk medicines is urgently needed. It is in continuity with the premise that one should know the recipient culture before embarking on any programme of change.

III

Let us now briefly survey the medical anthropological studies in India. Elwin (1939) started a small medical centre in Patangarh among the

tribes of Mandala. He studied the tribal culture in totality and observed the relation of culture to health and medicine.

Khare (1963) described the general characteristics of folk medicine and the conceptualization of illness among the people of Gopalpur (Uttar Pradesh). The village had three hamlets, two multicaste (Gopalpur proper and Thakurpur) and one unicast (Ahipura or Rampur). He observed, 'A detailed account of the concept of *jamaga* (tetanus) clearly reveals gradual elaboration and sanskritization of ideals regarding diseases as we move from lower castes to higher castes. The higher castes think about a disease more with the help of the ideas embodied in the great tradition, while the lower castes largely seek explanation in spirits, impersonal forces and tribal gods. These latter beliefs are mostly local in content. There is also a difference in the elaboration of ideas as we move from lower to higher castes'.

Hasan (1967) noticed two types of social and cultural factors that affect the health of any community: (a) factors that directly affect the health of the community because certain customs, practices, beliefs, values and religious taboos, etc., create an environment that helps in the spread or control of certain diseases; (b) factors that indirectly affect the health of the community as they are related to the problem of medical care to the sick and invalid.

Carstairs's (1955) study in a village of Rajasthan depicted the case of a Western trained doctor whose efforts to treat villagers met with some obstacles due to traditional local beliefs. There were misunderstandings on both sides because of different theories of etiology, different techniques of cure, and different conceptions of the role of the physician. According to him, villagers were not likely to change their world view to conform with that of the Western trained doctor.

Introduction of Western techniques in public health and medicine is not sufficient, but adaptation of the role of doctors and other health personnel to fit the existing culture and expectation of the people is more important.

In contrast, Marriott (1955a) critically examined the social and cultural problems involved in introducing new techniques of medicine in Kishan Garhi, a village in Aligarh. It may be remembered that it was in the context of this village that the concepts of universalization and parochialization developed (Marriott, Ed. 1955 b). Marriott's description of the village social organization and analysis of the village medical institution and examination of the role of the Western doctor as it appeared to the villagers in the context of their society and medical institution, is of great significance. Using social structure as the primary framework, he described the village as comprising three concentric social realms—kinship and family; village and caste; and that of the outside world, government or market. The first two are based on demand, mutual trust, obligations and formal respect; the third one is controlled by money and power. Varying degrees of trust are common in all the realms. Thus, Marriott observed that despite good medicines and good intentions, the Western trained doctor must obtain a suitable position in between the realm of the outsider and the inner realm of kinship. His analysis described the constraints and conflicts that acted as obstacles to the spread of Western medicine in Indian villages.

These two cases show that while Carstairs's approach was psycho-cultural, Marriott was primarily concerned with the doctor-patient relationship, relating the patient's expectations to the general climate of Indian community.

In the Indian cultural setting, a number of studies have been carried out which point that rural people attribute diseases to certain external conditions which may involve not only natural but supernatural powers acting in conjunction with certain internal conditions of the body. The internal conditions may consist of physical or natural weakness, and the external conditions may be the action of certain goddesses that cause diseases and evil spirits.

Rizvi (1968) studied health practices of the Jaunsaris, a tribal population of Jaunsar-Bawar

in the hilly region of Dehradun (Uttar Pradesh). He found that the Jaunsaris use household remedies for a number of ailments; for certain specific diseases, the herbalist is consulted. The medical facilities in the area are insufficient, but whatever are available, the people are reluctant to use them. The concept of manifestation of illness is due to indirect factors—supernatural or magical causes cannot scientifically explain illness. In evaluating how for modern-scientific medicines have been accepted, Rizvi stated that the people spend very little money or sometimes nothing on the treatment of an illness either by priests or herbalists, because payment is in kind. Traditional medicines do not have to be purchased; they are prepared from common plants and animals found in the region.

To some extent, these traditional systems of medicine obstruct the path of cosmopolitan medicine. The question generally asked is: why we cannot absorb the indigenous knowledge to form a multi-tier system rather than imposing a single system from outside. Integration of indigenous systems of medicine in primary health care has become the contemporary need.

A number of studies done in India show the presence of multiple medical systems (see Bhat, 1985, 1986; Nichter, 1978, 1980). In a detailed study in Karnataka, Nichter found the local people practiced what he called *masala* medicine, a mixture of different practices. He observed that the rich would generally try a remedy for four days and see its effects before switching on to an alternative. Bhat (1986) has described the ethnomedical concepts, beliefs and practices in two villages of Jaintia Hills in Meghalaya. The ethnomedical system of the local people was an amalgamation of both tribal and non-tribal customs, beliefs and practices. The people have integrated elements from other cultures.

In India, both scholarly medical traditions—Ayurveda and Unani—continue to flourish. Although Ayurvedic care is available in rural and urban areas throughout India and it cuts across social and economic status of the people, the Ayurvedic physicians (or *vaid*) are usually male.

Female access to Ayurvedic cure, at least for certain disorders, is limited as long as the practitioners are males. Further, a strong governmental support to these systems is lacking, thus making it hard for the marginal socio-economic groups to seek the medicine. The indigenous systems remain enormously important as providers of health care to most villages, and the Ayurveda and Unani substantially contribute to the cumulative impact of these systems on Indian health and ill health. Cosmopolitan medicine is at home in urban India, but its adaptive influence remains to be seen in rural areas. The cultural gap between villagers and cosmopolitan health workers is one of the barriers that limits the adaptive strategy and efficacy of cosmopolitan medicine.

A policy decision has been taken by the Indian government to promote community based development and deliver health, nutrition and welfare services through primary health care approach. This approach and philosophy is for planning organization and delivery of health services. It is based on certain concepts and principles such as accessibility (geographic, economic and social) of services as close to the homes of people as possible, continued availability, provision of all components of basic health services, providing referred services at secondary and tertiary levels for those who require intensive care, reaching vulnerable groups (such as mothers, children, those socially and economically underprivileged), integrated development to ensure maximal impact of various development programme involvement of community in health care.

For sustained improvement in the quality of life of the people, community involvement (awareness and participation) plays a pivotal role. Programmes without adequate understanding and recognition of community process do not actually produce desired results. Here Khan's (1986) study of the Santals with special reference to the Santals of Bolpur (district Birbhum), may be referred. The state government has been undertaking a number of development programmes including health programmes in the rural areas of this region. Sri Niketan, being the pioneer in

the field of rural development, has been implementing several programmes (including health) in the nearby villages. It may be mentioned here that Sri Niketan had the tradition of organizing health services in the village through cooperative approach since 1930. Health cooperatives were organized in different clusters of village around Sri Niketan to fight malaria and other epidemic diseases.

By analyzing the data it was found that 36 of 50 families in the village away from Sri Niketan, still practiced folk medicine, it was only 29 per cent in case of villages under Sri Niketan. By analyzing various other parameters, it was shown that the state government's health programmes failed in motivating the Santals, whereas the health programmes initiated through Sri Niketan influenced the Santals in a positive way. To achieve desired results in terms of coverage, effectiveness and efficiency, health related activities *by the people and for the people* should be encouraged. Community participation for health care theoretically requires promotion and inculcation of a value system which is based on mutual concern for members in a community. Villages in India are not homogeneous; the society is stratified according to caste and kinship groups, and efforts must be made to organize people according to these features. Who is to organize, and for whom, should be the central points. Indian studies have heavily inclined towards 'hospital studies' (Madan, 1969, 1980; Minocha, 1980), ethnomedicine (Bodding, 1925; Bhowmick, 1955; Bhowmick and Chaudhuri, 1966; Kakar, D.N., 1972a, 1972 b, 1976, 1977, 1980; Joshi P.C., 1985; Freed and Freed, 1985; Chaudhuri, ed. 1986; Sahu, 1986), and drug abuse (Shukla, 1987). With these, studies having applied foci need to be given more attention.

IV

There are lacunae in our research methods and objectives. Our research is largely not problem oriented and overall regional comparisons of people living in different geocultural environ-

ments are lacking. In the absence of proper baseline research, we lack properly formulated hypotheses and original standpoints. Presently, we do not have much to contribute towards action-oriented research which will influence planning and change the administrative outlook on current problems. The identification of the problem has to be discovered from within rather than follow an outside lead. There are a number of problems in India with regard to medicine studies for which researchers and scholars can come together and form basic strategies towards the pressing national problems.

Since anthropology is a field science, we must use our expertise to prepare ethnomedical profiles of the country and their potentialities. Case studies of various types of healers and the process of healing will provide an insight into the cultural categories. Health needs of the people have given rise to medical pluralism, which need to be studied. Therapeutic interviews, observed in field and experimental situations, are to be collected for they reveal the dynamics of relations between patients and practitioners. Evaluation of health care programmes, herbal medicines, biocultural study of disease and culture bound reactive syndrome, are other important areas of study.

In the context of the tribals of India, the health problems need special attention. This is primarily for two reasons. Firstly, many of the tribal communities live in isolated and remote areas where modern health facilities are not available. Secondly, the growth rate among different tribes varies: it is alarmingly slow in some communities like the Great Andamanese. One of the problems of the Primitive Tribes in India is their near stagnant or constant population. Acculturation and contact situations have drastically reduced the population of some tribal groups. Commenting on the demographic decline of the Great Andamanese, Onges and Jarawas, the Gazetteer of Andaman and Nicobar of 1908 made the following observation:

The cause of diminution of the populations is infectious and contagious disease, the

result of contact with higher civilization. Epidemics, all imported, of pneumonia (1868), syphilis (1876), measles (1877) and influenza (1892) together with exposure to the sun and wind in cleared spaces, the excessive use of tobacco (but not of intoxicants) and overclothing, have been the means of destroying them.

This definite decline, threatening the survival of certain communities demands a careful attention and study of the socio-cultural habits and health practices. It has been observed by medical practitioners and public health workers that family planning services, medical and preventive practices available are not being utilized by the social group, so it is essential to study the constraints of acceptance of modern facilities along with the socio-cultural dimensions of health and family welfare.

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