# SECTION ONE

# ETHNOPHYSIOLOGY

## INTRODUCTION

Highlighted in this section which is coauthored by Mimi Nichter, are lay perceptions of physiology. Documented are perceptions of bodily processes which influence women's health practices during pregnancy, fertility related behavior during the month, and the demand for fertility control methods. The importance of ethnophysiology is noted in several other essays in this volume where medicine taking behavior and folk dietetics are examined. Much popular knowledge of how the body functions is tacit. It is embodied, known through health practice and habit as distinct from being objectified and abstract. Notions of ethnophysiology and contingent health concerns index key cultural values as well as images inspired by analogical reasoning. We demonstrate that health practices associated with metaphorical models of ethnophysiology have profound public health ramifications.

# SECTION TWO

# ILLNESS ETHNOGRAPHIES

## INTRODUCTION

In this section I focus attention on illness classification, the manner in which different illnesses are and are not spoken about, perceptions of illness causality and patterns of health care seeking. Several features of illness related discourse are discussed in Chapter Four followed by an ethnographic investigation of states of malnutrition in South India and diarrheal illness in Sri Lanka. The latter two chapters include data on notions of etiology and patterns of curative resort. I may briefly note the importance and limitations of such data.

To understand how illness is perceived in South Asia it is necessary to appreciate the wide range of factors thought to predispose, cause, confound, and aggravate illness. This is a complex subject because one symptom (or a set of symptoms) may be caused by a number of different factors influencing the body alone or in conjunction with other factors. Very few types of illness or symptom states are thought to be caused by one and only one etiological factor. In most instances of ill health, several factors are implicated by the afflicted and/or significant others.

Often different members of a household or extended therapy managment group will have varying opinions about the cause or course of an illness. Their ideas are emergent with multiple forms of knowledge being produced in context. These forms of knowledge range from the knowledge of prototype illness experiences and illness narratives to knowledge negotiated between people. They include explanatory models constructed around popular metaphors as well as labels which imply sociomoral relations.

Knowing how actors describe illness, perceive etiology and evaluate courses of treatment is important to an understanding of popular health culture. It is not, however, sufficient to explain why households or individuals respond in particular ways to illness episodes. Health behavior is complex and based upon contingencies of social and economic as well as cultural significance. When studying health care decision making, predisposing, enabling and service related factors need to be considered in relation to household dynamics, time and resource demands, the impact of education etc. Just as important, it needs to be recognized that sickness is viewed as

more than a set of disvalued symptoms. Symptoms are often interpreted as signs of misfortune and vulnerability within the overlapping domains of one's lifeworld.

In South Asia, correspondences are drawn between poor health and events in other areas of life. For example, the infertility of a woman or the poor growth of a child may be linked to failed crops or poor yield and associated with stars, spirits, witchcraft or one's fate. In life, an opposition is broadly perceived between:

*labba* (profit): *dosha* (trouble)
health: illness

Recognizing that ascriptions of etiology are often emergent, negotiated and context specific, it is valuable to identify popular ideas about illness causality, characteristics and appropriate treatment. While of limited predictive value, this data provides descriptive generalizations against which actual behavior patterns may be studied. In chapters five and six, which examine states of malnutrition and diarrhea, I employ a mix of case study and survey data to provide a thick description of these health problems and a sense of cultural heterogeneity in the way they are interpreted. Health care practices are highlighted to emphasize the ramifications of interpreting illness in various ways.

# SECTION THREE

# MEDICATIONS, MEANING, AND PHARMACEUTICAL PRACTICE

## INTRODUCTION

Pharmaceutical related behavior is a subject of increasing international health interest. Anthropologists have conducted extensive research on medical systems. Much less is known cross culturally about medicine taking practice and the meanings accorded to medications. In this section, I examine the user's perspective of medicine; modes of paying for treatment and collecting a fee for curative services, and lay cost reckoning as it influences the practice of medicine. Medicines are assessed in a number of different ways. Highlighted are cultural interpretations of medicine related to their form and power, the processes of habituation and dependency, and the attributes of short term fixes as distinct from restorative medicines promoting health.

Social and economic factors contributing to the commodification of health are also considered. Increasing reliance on commercial medicine products for life's problems is viewed as both a feature of cosmopolitan life and and a practice through which capitalist ideology is subtly embodied. It is argued that models of primary health care need to extend beyond the public to the private sector and address health consumerism.

# SECTION FOUR

# HEALTH EDUCATION

## INTRODUCTION

Anthropology has an important role to play in contextualizing health education and transforming it from the passive handmaiden of a reductionistic biomedical tradition to a decentralized approach to community health problem solving. I have suggested in previous essays that an anthropologically informed health education will better be able to convey meaning and engender trust by: 1) addressing popular images of ethnophysiology; 2) acknowledging popular health concerns; 3) working within local illness classification systems and established patterns of folk dietetics; 4) maximizing cultural resources (both material and conceptual) and 5) identifying perceived and biomedically recognized risk factors for disease. I have also highlighted the role of the health educator in consumer education. Patterns of self treatment and over-the-counter drug use need to be identified and assessed culturally as well as biomedically.

In this section two additional contributions of anthropology to health education are noted. The first is the evaluation of existing health messages and how they are interpreted. The second contribution is helping health educators communicate health concepts more effectively. I suggest that health educators need to build upon the familiar to describe the new. As distinct from linear didactic teaching, an analogical method of health communication is proposed.