Anthropology and International Health

Asian Case Studies

Mark Nichter
and
Mimi Nichter

Theory and Practice
in Medical Anthropology
and International Health

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THEORY AND PRACTICE IN MEDICAL ANTHROPOLOGY AND INTERNATIONAL HEALTH

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INTRODUCTION TO THE SERIES

Theory and Practice in Medical Anthropology and International Health seeks to promote works of direct relevance to anthropologically informed international health issues, practice, and policy. It aims to bridge medical anthropology—both biological and cultural—with international public health, social medicine, and sociomedical sciences. The series' theoretical scope is intentionally flexible, incorporating the most current advances in social science theory, while its topical breadth ranges from specific issues to contemporary debates to practical applications informed by current anthropological theory. The distinguishing characteristic of this new series is its emphasis on cultural aspects of medicine and their links to larger social contexts and concrete applicability of the anthropological endeavor.

FOREWORD

Mark Nichter and Mimi Nichter bring many years of field experience to this book. Their observations and interpretations reflect the best that social science has to offer international health. Working with them in the field gave me an opportunity to observe firsthand the way in which they engage in problem solving and the respect and affection they hold for the people with whom they work. What is unique about their book is that the case studies are at once rich in anthropological detail and sophisticated in terms of an understanding of the public health issues they address—be this the prevention or timely treatment of illness. It is for this reason that it seems appropriate for me to write a foreword to their book as a public health clinician who has worked for decades in developing countries on the very issues presented.

There is much talk about cultural sensitivity in public health these days, and considerable confusion about intracultural variability and such taken-for-granted concepts as "community participation." Implicit in much of the discussion is a concern about cultural imperialism captured by the question: "What entitles *us* to think that *our* way of problem solving is any better than other ways?" In some cases, our own arrogance precludes us from learning from the empirical observations of others, observations inspired by different ways of looking at the world. In other cases, existing patterns of reasoning about health and illness place the lives of people at great risk.

Two of the public health problems the Nichters focus upon in this book are acute respiratory infection and diarrheal diseases—the chief causes of death in children. These two diseases are a source of great confusion, both to practitioners of all types of medicine and child caretakers. The case fatality rate (CFR) for diarrheal disease is especially low. According to the best estimates —and estimates are all we have to work with—the CFR for diarrheal disease is roughly 1:1000. What this means is that everyday around the world, thousands and thousands of children

survive their episode of diarrhea, regardless of how it is treated or who provides the treatment. The same is true of respiratory complaints, which seem to trouble young children six to eight times a year regardless of where they live. Mothers and practitioners, whether modern or traditional, assume on the basis of high rates of recovery to these diseases that whatever they offered as treatment was efficacious; it was the "right thing to do."

It is important to recognize when "treatment as usual" or the "best that traditional medicine has to offer" is not the right thing to do. Inexpensive, simple treatment measures exist that can prevent needless deaths in children from diarrhea and respiratory infection. Simple and effective as these measures may be, their effectiveness depends on timely recognition of illness severity, the need for treatment, and prompt and correct administration of appropriate treatment regimes.

In order to be successful in encouraging the proper use of effective treatments, the challenge is to understand why parents do what they do and the assumptions and beliefs upon which existing actions are based. It is necessary to make remedies and recommendations understandable and acceptable to local populations. Simple as this prescription may sound, anyone who has tried to administer it knows how complex and difficult the task at hand is to implement. The Nichters make the difficulties and complications abundantly clear. They do not, however, leave us with the impression that the practice of culturally sensitive population-based medicine is hopeless. Rather, they invite us to engage local health cultures (and problem solvers) instead of viewing them as intractable barriers to progress—an impression which leads many in public health to devalue, if not dismiss, "culture."

This book spells out in detail a range of issues which need to be considered when attempting to introduce or evaluate public health interventions. The Nichters provide many useful suggestions on how to collect appropriate baseline data before planning an intervention and how to communicate complex ideas to local populations using conceptual frameworks which are familiar. Illustrated are methodological approaches to working within local cultures which are described as dynamic, not "traditional" in the sense of being rigid or closed. The book makes a convincing case for putting in the time and effort to understand local problems and existing solutions before attempting to offer new answers, and for studying the way local populations have responded to "new solutions" and their reasons for doing so. Among other things,

they invite us to take a hard look at the way in which medicines are currently being used by lay people in developing countries and to critically examine "rational drug use" from the vantage point of the practitioner trying to survive in a competitive marketplace. Given alarming rises of drug resistance which threaten to undermine the success of public health programs, their investigations could not be more timely.

The type of medical anthropology which the Nichters practice seems to me to be essential for effective health education. Why *essential*? One salient reason is that improvement in family-level treatment requires real and sustained behavior change on the part of mothers or other caretakers. Immunizations, for example, seemingly demand minimal behavior change; the mother takes the child to receive an injection and that's it. But the perceived efficacy of these injections and how many of them a mother feels her children need depend upon what she thinks the injections are for in the first place. Improving the management of infants or children with diarrhea or pneumonia requires the mother to change her understanding of the disease and to learn new ways of evaluating her child's condition prior to as well as during treatments. Educational campaigns designed to elicit changes in thinking about illness as well as treatment must address local notions of causation as well as expectations from treatment. With respect to the evaluation of public health messages, the Nichters invite us to monitor the local understanding of interventions over time as opposed to being content with short-term measures of message familiarity or medicine use.

In their preface to this volume, the Nichters note the sensitivity that medical anthropologists feel when working with those in public health or medicine. After all, their role is to study all aspects of health culture: from the conditions which foster ill health and the treatment of illness by different types of practitioners, to health programs and the factors which influence how they are carried out and who gets the lion's share of the resources. When anthropologists do get involved in public health problem solving, it seems that they run the risk of being accused of complicity in propagating the influence of the biomedical system.

During my career, I have seen my fair share of social scientists "manipulated" by doctors. I can recall several occasions when clinicians called on anthropologists to "evaluate programs" when all they really wanted was someone to tell them how to get their target population to "comply" with their orders—in other words, to blindly do what they were told. Some anthropologists have been willing to do just that. The Nichters are examples of a very different

type of health social scientist-medical anthropologist who critically examines the appropriateness of solutions put forward by public health colleagues in particular contexts. To do so in a constructive manner requires a firm understanding of both the problem being addressed and the solutions being offered.

Other medical anthropologists I have had occasion to meet have been satisfied with describing health problems as interesting cultural artifacts. This has often resulted in the accumulation of information which is often not read by practitioners or health planners because they are not quite sure what relevance it has for them. What makes this book so valuable to public health practitioners is that it highlights why information on health culture, illness behavior, medicine-taking practice, and styles of cultural communication are relevant and indeed crucial to public health success. Practitioners are also asked to take a sobering look at relationships among staff at primary health centers who are affected by changes in health policy which threaten their professional identity. Readers are asked to examine not just the lay person, but the health care system and how it is managed.

This book is thought provoking. It will cause the most experienced practitioner to reflect and the practitioner preparing to enter the field of international health to pay heed to more than just what is found in their books on tropical medicine. Other medical anthropologists, I trust, will find the book inspiring.

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PREFACE

The second edition of this volume has been revised substantially yet its goal remains the same: to provide a series of case studies illustrating how medical anthropology has contributed to the study of international health problems and initiatives. The cases chosen for the volume have been drawn from two decades of field research conducted in South and Southeast Asia. They focus on issues related to women's reproductive health, child survival, infectious disease control, pharmaceutical use, health service research, and health education.

Eight of the original eleven chapters from the first edition have been retained and five new chapters have been added. Section One on women's reproductive health has been revised but its content is largely unaltered. Three chapters are presented which examine lay perceptions of fertility, popular interpretations of how modern family planning methods work, and folk dietetic practices during pregnancy which affect maternal nutrient stores and infant birth weight. Section Two is entirely new and focuses on two of the major threats to child survival in less developed countries: diarrheal disease and acute respiratory infection. A chapter on anthropological contributions to the epidemiological study of diarrhea and dysentery highlights and expands upon points raised in the three chapters originally included in this section.[1] This is followed by two chapters which focus on acute respiratory infection (ARI). The first provides an overview of lessons learned from research on diarrheal disease and their relevance for the study of ARI, while the second presents a detailed ethnographic study of ARI in the Philippines. The utility of employing a mix of research methods when conducting focused ethnographic studies of illness is emphasized.[2]

Section Three focuses on different aspects of pharmaceutical-related practice ranging from the lay perception of medicines to patterns of paying for practitioner consultations through medicine costs, and from prescription practice to medicine production and

the commodification of health. This section has been retained from the first edition, but has been revised significantly.[3] Emphasis is shifted from the theme of rational drug use prominent in international health discourse to rationales underscoring how and why medicines are used, prescribed, and combined in particular ways.

Section Four explores the role of anthropology in health service research and health education. Two of the four chapters in this section are new. The first examines consumer demand for preventive health services. Expanding upon an earlier article (Nichter 1990), lay notions about immunizations are considered in relation to perceptions of need and issues related to program sustainability as well as the politics of immunization. A second chapter considers teamwork among different cadres of primary health workers. It draws attention to the primary health care system as a social system requiring ethnographic research which attends to issues of social organization, power, and status. Factors which inhibit teamwork within primary health centers are identified.

The remaining two chapters in Section Four appeared in the first edition and focus on health education. The first chapter is concerned with the critical evaluation of a health education message concerning the boiling of drinking water. This case illustrates why even "simple" messages require formative research and cultural assessment. In a final chapter, an approach to health communication is explored. This approach to "teaching by analogy" is modeled after an indigenous process of knowledge transfer common in Asia. A procedure for framing teaching analogies is presented which advocates participatory research and a privileging of local funds of knowledge.

Several of the issues raised by new and expanded essays invite consideration of: a) how determinations are made about whether an illness is deemed serious enough to warrant health care activity which is out of the ordinary; and b) how health fixes (both curative and preventive) are assessed in terms of perceived vulnerability, need, and impact over time. A sampling of issues raised includes: Are temporary methods of family planning (such as pills) viewed as benign or thought to compromise one's long-term fertility? Do trends in self-medication mirror prescription practice in countries where medicines are readily available over-the-counter? Do changing patterns of self-medication affect prescription practice? How serious does a child's illness have to be before a drugstore attendant suggests that a caretaker consult a

doctor instead of engaging in self-medication? On what basis is such advice made and does it differ by age of the child?

Questions raised in relation to specific categories of illness include: Are cases of watery and bloody diarrhea responded to in the same way by populations exposed to health education messages recommending oral rehydration in cases of "diarrhea"? Are children promptly brought to a doctor by concerned parents when they develop bloody stools or noisy, labored breathing? Or is it deemed prudent to consult a traditional practitioner first to rule out the possibility of factors which might obstruct expensive treatment prescribed by doctors? Is educating parents about ARI enough or is setting up patterns of triage with traditional practitioners called for in such circumstances? Is health-care seeking substantially different for a child having labored breathing with/without manifest fever? How is fever perceived culturally; are different types of fever recognized? If "measles" (or an indigenous illness category encompassing measles) is rumored to be in the area, does this affect the health-care-seeking behavior of mothers? Are individual immunizations perceived to protect against different diseases or are all immunizations thought to protect against the same diseases? Are all children thought to require the same number of immunizations or does a child's health status and relative strength affect parental decisions? To what extent does a concern about decreasing parental trust lead primary health care workers to miss opportunities to immunize children who have mild illnesses?

Issues highlighted in this volume emerge from studies inspired by both ethnomedical agenda and applied medical anthropology directives attentive to international health priorities.[4] In our experience one type of study often leads into the other. Let us illustrate such cross-fertilization with the case presented in chapter 1.

The case study presented in the first chapter focuses on indigenous perceptions of fertility: when in the monthly cycle do South Asian women think they are most/least likely to become pregnant? The case study has clear applied relevance for family planning, but its genesis was ethnomedical. Our initial interest was gender ideology as it is articulated at the site of the body through ideas and practices related to reproduction.[5] In an area of South India populated by both matrilineal and patrilineal castes, we wondered whether marked differences in ideas about reproduction might coexist. We searched for distinct ideas favoring women's or men's roles in reproduction which might serve as a charter for ideologies of descent and inheritance.

We did not find such marked differences, but rather an eclectic and loosely formulated set of ideas about fertility. Many of the ideas informants expressed took the form of extended analogies which indexed common conceptual frameworks such as agriculture and the lunar cycle. Data from this ethnomedical study led us to consider popular perceptions of contraceptive need at various times during a woman's monthly cycle and following delivery. One might suspect that this would have been a well-researched topic, given the amount of funds invested in family planning in Asia in the 1970s. Surprisingly, we found little data on popular perceptions of fertility in the applied social science or family-planning literature.

Follow-up "applied" research on lay response to family planning and other biomedical technology in India (such as immunizations and medicines) led us to reconsider ethnomedical data we had previously collected on notions of ethnophysiology. We came to recognize that notions of ethnophysiology were not static, but are constantly being revised partly in re sponse to interpretations of how new technical fixes worked. Interpretations often indexed established conceptual frameworks (such as hot/cold), while extending analogies which drew upon new funds of knowledge, empirical observations, and imagery. An "applied study" of when and why family planning fixes (immunization, medicine fixes, and so on) were/were not used, deepened our understanding of South Indian perceptions of the physical body as well as the social body and body politic. We were led to revisit concepts such as "strength" which index issues ranging from social to physiological control, collective anxieties associated with purity, to sources of anxiety related to gender and generational identity. We offer this example to illustrate how applied medical anthropology and ethnomedicine can inspire one another and render important insights for international health.

In addition to ethnomedical studies and focused illness ethnographies responsive to international health program needs, issues highlighted in this volume emerge from research explicitly conducted to study life contingencies which affect health care decision making. Case studies draw upon investigations of the household production of health (Berman et al. 1994, Nichter and Kendall 1991) and the microeconomics and social relations of health care seeking, as well as the practice of medicine in a world marked by changing expectations and resource bases.

Who is the intended audience(s) for this volume? Our primary audience(s) are anthropologists and practitioners (broadly defined) working in the field of health and development who wish to

examine practical examples of how medical anthropology can contribute to international health.[6] This includes the critical examination of international health initiatives and medical practices to the extent that new lines of inquiry facilitate problem solving.[7] Does this endeavor have an inherent management bias? We feel that it places us in the type of creative double bind that Hazel Weidman described some years ago (Weidman 1976) when speaking of the necessity for anthropologists working in applied settings to maintain reflexivity. To keep from "going native" or being blindsided, Weidman noted how important it was for anthropologists to examine problems and "solutions" through the multiple lenses of social science theory(s) offering the researcher myriad perspectives from which to view the terrain.[8]

This brings us to the remarks of one reviewer of the first edition of this book (van der Geest 1993). In a largely positive review, he questioned whether we had privileged health education as a means of solving public health problems. He then proceeded to caution anthropologists about becoming "middlemen" brokering local funds of knowledge to the public health world. His caution is noteworthy.

We are acutely aware of the issues highlighted in Taussig's (1980) strawman critique of Kleinman's work on a negotiated approach to patient care in the United States.[9] Taussig speaks to anthropology's complicity in furthering the agenda of medicine, noting that increases in patient manipulation may result from providing practitioners with greater knowledge about patients and their culture. At the population level, the same critique may be extended to anthropologists who contribute to international health education efforts.

As argued in an article on anthropology and therapy facilitation (Nichter, Trockman, and Grippen 1985), we believe that it is important for anthropologists operating in applied contexts to engage in two-way brokering of information. Just as information about local worlds needs to be brought to the attention of health practitioners to facilitate culturally sensitive care management, so information about the agenda, resources, constraints, and procedures of practitioners (ministries of health, donor agencies, and so on) needs to be brought to the attention of the patient, "community," local action groups, and so on. Through such an endeavor, alternative approaches to the solving of problems may be explored in relation to contingencies influencing all stakeholders.

Is such an exchange possible given vast differences in knowledge and power? If being a middleman means looking for

middle ground in which rapport may be established and agency enhanced, we are so motivated. Only when such rapport is established will "participation" have meaning beyond compliance such that partnerships may be established. Will new knowledge translate into behavior change? Clearly, this is too simplistic. It is not just knowledge which needs to be assessed, but power relations and resource distribution, stakes in knowledge production/reproduction, perceptions of entitlement and responsibility, factors favoring alternative approaches to problem solving, and the socialization of practitioners as well as health care consumers. In need of consideration are reasons why particular health ideologies and practices are privileged, neglected, or resisted by different actors at different times in specific contexts. This requires the longitudinal monitoring of health perceptions and health care practices in environments sensitive to social, political-economic, and ecological transformation. It further requires the monitoring of national as well as international health policy and its implementation.[10]

Our aim in this volume is to broaden the scope of inquiry in international health by illustrating the contribution anthropology can make in grounding international health initiatives in the shifting realities of local worlds. In a field dominated by body counts and rational man calculation, there are important lessons to be learned from ethnographic investigation. If nothing else, such studies invite practitioners to pause and reflect on how health problems are conceived and "solutions" responded to by different segments of given populations.

Such reflection is surely needed at a time when funding crises and mounting debt threaten the implementation of international health initiatives and the long-term effects of development programs are being questioned (e.g., Sardar 1988). In such a climate, renewed emphasis is being placed on "community participation" as a means to achieving program sustainability through cost-sharing. Given such an emphasis and increased recognition of the private sector as a source of health care, there is mounting interest in popular perceptions of health need, demand for services, and health care provision. At a time of health transition marked not only by changes in demographic and epidemiological patterns but changes in lifestyle, health practice, and health care consumption, new challenges await medical anthropologists.