PGSO S4 05

Exam Code: E SOH

Sociology of Health and Illness (Elective)

SEMESTER IV

SOCIOLOGY

BLOCK- 1

KRISHNA KANTA HANDIQUI STATE OPEN UNIVERSITY

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ISBN : 978-93-89955-59-0

July, 2020

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Printed and published by Registrar on behalf of the Krishna Kanta Handiqui State Open University.

Head Office : Patgaon, Rani Gate, Guwahati-781017

City Office : Resham Nagar, Khanapara, Guwahati, 781022; Web: www.kkhsou.in

The University acknowledges with thanks the financial support provided by the **Distance Education Bureau**, **UGC** for the preparation of this study material.

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COURSE INTRODUCTION

The course 'Sociology of Health and Illness' attempts to introduce to the learners the ideas of health, illness, medicine, etc. from a sociological perspective.

This course comprises of 14 units. It has been classified into two blocks (Block 1 and Block 2). Each Block consists of 7 units. The course provides a holistic understanding of the social dimensions of health and illness. It begins with a discussion on the broad arena of sociology, medicine, health. It is followed by an understanding of the basic concepts, the different theoretical perspectives to understand health. Then, the course attempts to contextualise the ideas of health, disease in the colonial roots of India.

Further, the course progresses with special emphasis laid on the gender dimension of health, the cultural understanding of health, health care institutions, public health, etc. It also throws light on the aspects of social inequality in health, and the idea of social control over the body.

BLOCK INTRODUCTION

This is the first block of the paper 'Sociology of Health and Illness' offered in the 4th semester of M.A. Sociology programme of Krishna Kanta Handiqui State Open University.

Here, Unit 1, titled "Introduction" focuses on the meaning of health, and the meaning and developemnt of Sociology of medicine.

Unit 2, titled "Basic Concepts" highlights the concepts of medicalistion, demedicalisation, illness narrative and medical tourism.

Unit 3, titled "Theoretical perspectives to understand health" throws light on the functionalist, Marxist and Post-Modern theories.

Unit 4, titled "Disease, poverty and colonialism in India" provides the colonial roots to understanding the concept of disease, the colonial perception of medical measures to treat diseases, and also the nature of response that they received from the common people in general.

Unit 5, titled "Culture and disease" highights the role of culture in conceptualising the phenomenon of disease.

Unit 6, titled "Medical Pluralism" throws light on the issues, trends and practices in this arena.

Unit 7, titled "Gender and Health" focusses on the gendered aspects of health and nutrition.

In order to make the text more interesting and informative, a section called LET US KNOW has been provided in the units. This section tries to provide some additional information regarding the content of the unit. Further, in order to enable the learners to continuously check their progress regarding the content, some questions have been put at the end of various sections of a unit with the heading CHECK YOUR PROGRESS. The answers to the questions of CHECK YOUR PROGRESS section have been provided at the end of each unit. In the end of each unit, few MODEL QUESTIONS of long and short type are provided in order to provide an idea of the question pattern to be expected in the examinations by the learners.

UNIT 1: INTRODUCTION

UNIT STRUCTURE

1.1 Learning Objectives

1.2 Introduction

1.3 Meaning of health

1.4 Meaning of sociology of medicine

1.5 Origin and development of sociology of medicine

1.6 Difference between sociology of medicine and sociology in medicine

1.7 Let Us Sum up

1.8 Further Reading

1.9 Answers to Check your Progress

1.10 Model Questions

1.1 LEARNING OBJECTIVES

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

- understand the meaning of health
- know the meaning, origin and development of sociology of medicine
- know about the difference between sociology of medicine and medical sociology

1.2 INTRODUCTION

Over the years the promotion of heath care has became one of the supreme focus of the health care policies at local, national and international levels. The World Health Organisation has promoted for the global health care initiative. Most people are increasingly becoming concerned about healthy lifestyle. Sociology of health and medicine critically examines the health situation and its developments and tries to locate them within a set of wider socio-cultural changes. Sociology of health analyses the contemporary health policies, lifestyle, consumption,

risk and health. It tries to critically examine the implication of the health policies on the society, the way those policies are practiced, the impact of the various diseases on the social life and on other aspects. Earlier, diseases and conditions were attributed mainly to genetic predispositions. Now, health issues are looked at from a more global prospect keeping in mind the factors such as family, education, religion, economic conditions, etc. It is essential for us to know both the positive and negative aspects of the sociological factors on diseases, as it helps us to explore the core issues and obstacles to the progress of humanity. Adequate knowledge will help in better policy making. As we progress as a society, it is vital that we fully acknowledge potential healthrisks and make a joint effort to share and spread knowledge about preventability and curability of diseases.

The interaction between society and health is studied under sociology of health and illness. For example, sociologists will examine how social life impacts morbidity and mortality rates, and how morbidity and mortality rates in turn have an impact upon the society. The discipline of sociology looks at health and illness in relation to various social institutions such as the family, school, organisation, religion, work, etc. It also looks into the reasons for types of care for various diseases, the compliance and noncompliance of the patients towards the care and services of the health system. In the past, good health or lack of good health were thought to be related only to biological or the natural conditions. Sociologists broke that thought process and demonstrated that the spread of diseases is also influenced by socioeconomic status of individuals, ethnic traditions or beliefs, and other cultural factors. The sociology of health and illness has a global approach of analysis because the influence of societal factors varies from society to society in the world. Diseases are examined and compared based on the traditional medicine, economics, religion, and culture that are specific to each region. Regional disparity of practices is also taken into account while understanding health and illness holistically.While it is extremely problematic in certain areas, in others it has affected a relatively small

percentage of the population. Sociological analysis can help to explain why these discrepancies exist.

In this unit, we will know about the sociological approach to health and illness, in details.

1.3 MEANING OF HEALTH

Health is the one of the basic human rights. Overall activity of a person depends on his/her health system. The Universal Declaration of Human Rights stated in Article 25: 'Everyone has the right to a standard of living adequate for the health and wellbeing of himself and his family' (United Nations, 1948). The Preamble to the World Health Organization (WHO) Constitution affirms that it is one of the fundamental rights of every human being to enjoy the highest attainable standards of health. Article 21 of the Constitution of India also identifies health as an integral aspect of human life. Further, Article 47 (Part IV: Directive Principles of State Policy) states: "The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties and, in particular, the State shall endeavour to bring about prohibition of the consumption except for medicinal purposes of intoxicating drinks and of drugs which are injurious to health".

To understand the meaning of health, few points have to be kept in mind. Health is a metaphor for well-being of a person. To be healthy means to be in sound mind and body as an integrated whole. The concept and understanding of health may vary from society to society. Many societies believe that being balanced is a symptom of good health. According to Gilman, one of the perspectives on health is oriented by the cultural values. For example, contemporary Western medicine evaluates the health of a body organ or individual through a series of technological laboratory tests used to determine if indicators of structure, such as readings of radiographs, and function, such as kidney filtration rates, fall within a 'normal' range for this individual in these

circumstances.The World Health Organization (WHO) defines health as “a state of complete physical, mental and social well being, and does not consist only of the absence of disease or infirmity”. Health is not just a matter of personal choice, nor it is only a biological issue. Health is a pattern of well-being and illness in a body which is also rooted in the organization of a society. Health, by the definition given by WHO, is also regarded as a social issue and is borne out by evidence which demonstrates that standards of health varies over time and space. It not only differs from one society to another, but also from one culture of a country to another.

There are various approaches to understand health. Initially the concept of health was dominated by biomedical approach. Biomedical approach dominated the concept of health till the end of 19th century. This approach was based on the concept of ‘germ theory of disease’ which views health as an absence of diseases’.This approach to understand and define health almost ignores the role of environmental factors, psychological factors and other socio cultural factors in defining health.

Second approach to understand health is the ecological approach. This approach views health as a dynamic equilibrium between human beings and their environment. In ecological approach, disease is the maladjustment of the human being due to environment or change in the ecology.

Another approach to understand health is the psychological approach. According to the psychological approach, health is not only related to the body, but also to the mind and the attitude of the individual in certain situations.

The socio-cultural approach is yet another approach to understand health. According to this approach, health is considered as a product of social and cultural structure of a society.

According to the functional approach, health refers to the ability of a person to participate in normal social roles.

The sociological understanding of health considers structural and

social factors, rather than simply biological explanations of health and diseases. It describes the complex relationship between structural factors and personal choice in relation to health inequalities.

For the social welfare of common people at present times, it is necessary to facilitate, encourage, and secure individual autonomy and dignity. Defining health as an operational and working term is necessary for creating policies and programs that will help in maintaining and improving health. The Ottawa Charter from the 1st International Conference on Health Promotion, held in Ottawa, Canada, in 1986, asserts that health is created in the context of everyday life and environment, where people live, love, work, and play. Thus, active and interactive understanding of health was introduced. Health promotion has the goal to combine the approach for addressing the social determinants towards health with the resolution and commitment to motivate and encourage the individuals and the community for their active participation towards health and embracing healthy lifestyles. The definition given by WHO also underwent changes within last few decades. The definition of health has been amended and supplemented by the fourth dimension i.e. spiritual health. Spiritual health is a sense of fulfilment and satisfaction with our life, system of value, self-confidence and self-esteem, self-awareness and presence, peacefulness and tranquillity with proper emotional balance. Spiritual health is balance between internal as well as the external environment.

1.4 MEANING OF SOCIOLOGY OF MEDICINE

Medical sociology is a sub-discipline of sociology, which tries to understand the medical sector from sociological perspectives. It provides an analytical framework for understanding health, illness and health care in a social context. The subjective experiences of health and illness are included keeping in mind the political, economic and environmental circumstances that lead to ill health. The societal forces that may act as constraints to the medical care system, and individual response to illness comes under the study of sociology of medicine. The field of

medical sociology draws from the traditional sociological issues and contributes to the field through reformulations of basic concepts as social systems, institutions, social movements, social change, social interactions and negotiation. From a pluralistic perspective, the field of medical sociology is concerned with sociological research and its implication on the health policy.

Medical sociology is a sub-discipline of sociology that draws on the methodological substances and middle range theories of sociological perspectives to elaborately understand the importance of health, health services and health care issues. Medical sociology also analyses the medical organizations and institutions. It emphasises on the production of knowledge and selection of methods for health care. Medical sociology also attempts to understand the actions and interactions of healthcare professionals with the patients, and how the social or cultural factors affect medical practices. This field of study commonly interacts with the sociology of knowledge, science and technology studies, and social epistemology. Medical sociologists inquire on the qualitative experiences of patients, people who often work at the boundaries of public health, social workers, etc. They also try to understand the demography and gerontology to explore the phenomena at the intersection of the social and clinical sciences. Health disparities in our society are commonly related to different class, caste and race. Sociological research on medical sociology tries to understand such disparities and sometimes findings become a normative and political issue. Medical sociology is the study of the effects of social and cultural factors on health and medicine. Specializing as a medical sociologist helps individuals view the healthcare system as a function of the society and serve it by examining and improving all its facets.

1.5 ORIGIN AND DEVELOPMENT OF SOCIOLOGY OF MEDICINE

The intellectual lineage of medical sociology can be traced to the

late 1800s. In the 19th century disciplines of sociology and allopathic medicine started to cross paths in a significant way. Allopathic medicine witnessed the beginning of medicine's ongoing attempts to consolidate its professional powers and social legitimacy. Simultaneously, Sociology began to emerge as a distinct discipline to understand society and its interrelated elements. Herbert Spencer's book *The Principles of Sociology* (three volumes, 1876–1896) was a seminal publication, along with the establishment of the first American sociology course called "Elements of Sociology" at the University of Kansas, Lawrence, in 1890, and the founding of the first department of Sociology at the University of Chicago in 1892 by Albion Small. Albion Small also launched the first sociology journal called the *American Journal of Sociology*, in 1895. There are a number of works from those times which formally linked "medicine" and "sociology". For example, Charles McIntire's *The Importance of the Study of Medical Sociology*, Elizabeth Blackwell's *Essays in Medical Sociology (1902)*, James P. Warbasse's *Medical Sociology: A Series of Observations Touching Upon the Sociology of Health and the Relations of Medicine* (1909). The initial period of developing links between medicine and sociology reflected a much broader aspect of transformation that took place within allopathic medicine and between medicine and society.

There are many ways in which the development of medical sociology in the second half of the twentieth century can be traced. The development of medical sociology can be comprehended by understanding the fluctuating strengths of the various theoretical approaches to the subject during that period. The trace can be made by looking into the achievements and failures judged by different criteria. As the effectiveness of medicine grew in clinical spaces and organizational complexity of the health care grew, the social-psychological and the behavioural sides of medicine started occupying the field of medical sociology. While scattered "sociology of medicine" articles continued to appear in medical journals between 1920 and 1950, few of them had an impact on sociology than on medicine. In 1960, E. Gartly Jaco published a paper that became the first disciplinary journal in medical sociology. The development of medical

sociology as a sub discipline of sociology went through certain phases and processes. In 1967, the American Sociological Association (ASA) took the *Journal of Health and Human Behaviour* (JHHB) under its organizational wing where it was renamed as *Journal of Health and Social Behavior* (JHSB). Eliot Freidson was the first editor. The same year the first issue of Social Science & Medicine (SS&M) was published with its distinctively international and multidisciplinary social science focus. In 1970s, the field of medical sociology section of the British Sociological Association established its own organization and in 1979 published its own medical sociology journal called *Sociology of Health & Illness*.

Between 1950s and 1960s, the field of medical sociology underwent extensive growth before reaching the peak in early 1970s. During that period the field enjoyed considerable academic growth and success and also got support from both private foundations and the federal government. In early 1970s, the National Institute of Mental Health subcommittee for social science training awarded 1,500 graduate students 80 percent of stipends of the year to sociology departments. The amount was more than what was needed to support medical sociology graduate students, and the field was much benefitted from that act. Also, the foundation of medical sociology and adaptation of various journals related to medical sociology received funding from external sources. In less than a year, the medical sociology section grew to 561 members. By 1964, membership had risen to nearly 900. In less than a half dozen years, the field went from publishing introductions to the field, to summative reviews (one notable example is Eliot Freidson's *"The Sociology of Medicine: A Trend Report and Bibliography"* published as a special issue in *Current Sociology* (1961). By mid 1970s, the signs of trouble in the discipline started to show up. The established funding sources of the boom time of the field started to dry and the field had to look for other alternative sources of funding. The publication of articles related to medical sociology started becoming less frequent in sociology journals such as the American Journal of Sociology and the American Sociological Review. Meanwhile, colleges and universities, due to their

own upheavals and considerable financial pressures, began to drop programs, and sociology was high on a number of lists. Yale University's Department of Sociology, which housed the first medical sociology program in the United States, decided in the 1990s to eliminate that program. The 1980s and 1990s were also difficult times for allopathic medicine. The rise of managed care, the commodification of medical services, and the discovery of medicine by Wall Street and corporate America during the "go-go" years between 1985 and 1997 had earth-shattering implications for the future of medicine as an autonomous profession. The 1970s and early 1990s were also time of debates within academic sociology about the fate and future of allopathic medicine as a profession. Beginning with the work of Eliot Freidson's *Transformative Profession of Medicine and Professional Dominance,* a number of distinguished medical sociologists in the United States started to debate on the changing fortunes of organized medicine's status as a profession. Once again medicine and sociology crossed paths. The discipline of sociology again started looking into issues of health from a sociological perspective.

1.6 DIFFERENCE BETWEEN SOCIOLOGY OF MEDICINE AND SOCIOLOGY IN MEDICINE

In 1955, Robert Straus highlighted a division of medical sociology into two categories, the sociology of medicine and sociology in medicine. Sociology of medicine is concerned with studying the organizational structure, role relationships, rituals, and functions of medicine as a system of behavior. Sociology in medicine consists of research involving the integration of concepts, techniques, and personnel from many disciplines where the sociologist is collaborating with the physician in studying a disease process or factors influencing the patient's response to illness. For Straus, sociology in medicine had a strongly applied component, in that the social sciences could be employed to inform and instruct medical professionals in recognizing and responding to the social factors associated with health and disease.



CHECK YOUR PROGRESS

Q1. What is meant by health?

.....

.....

Q2. Define sociology of medicine.

.....

.....

Q3. State the definition of health given by WHO.

.....

.....



1.7 LET US SUM UP

- The promotion of heath care has become one of the supreme focus of the health care policies at local, national and international levels. The World Health Organisation has promoted for the global health care initiative.
- Sociology of health and medicine critically examines the health situation and its developments and tries to locate them within a set of wider socio-cultural changes.
- The interaction between society and health is studied under sociology of health and illness. For example, sociologist will examine how social life impacts morbidity and mortality rates and how morbidity and mortality rates in turn impact upon society. The discipline of sociology looks at health and illness in relation to various social institutions such as the family, school, organisation, religion, work, etc.
- The Universal Declaration of Human Rights stated in Article 25: 'Everyone has the right to a standard of living adequate for the health and well being of himself and his family' (United Nations, 1948). The Preamble to the World Health Organization (WHO)

constitution affirms that it is one of the fundamental rights of every human being to enjoy the highest attainable standards of health.

- Article 21 of the Constitution of India also identifies health as an integral aspect of human life. Further, Article 47 (Part IV: directive principles of state policy) says: The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties and, in particular, the State shall endeavour to bring about prohibition of the consumption except for medicinal purposes of intoxicating drinks and of drugs which are injuriousto health.
- The World Health Organization (WHO) defines health as “a state of complete physical,mental and social well being, and does not consist only of the absence of disease or infirmity”.
- Biomedical approach dominated the concept of health till the end of 19th century.This approach was based on the concept of ‘germ theory of disease’ which views health as an ‘absence of diseases’.
- The ecological approach views health as a dynamic equilibrium between man and his environment.
- According to psychological approach, health is not only related to the body but also to the mind and the attitude of the individual in certain situations.
- According to the functional approach, health implies the ability of a person to participate in normal social roles.
- The sociological understanding of health considers structural and social factors, rather than simply biological explanations of health and diseases. It describes the complex relationship between structural factors and personal choice in relation to health inequalities.
- Medical sociology is a sub-discipline of sociology, which tries to understand the medical sector from sociological perspectives. It provides an analytical framework for understanding the health, illness and health care in a social context. The subjective

experiences of health and illness are included keeping in mind the political, economic and environmental circumstances that lead to ill health.

- The intellectual lineage of medical sociology can be traced to the late 1800s. In the 19th century disciplines of sociology and allopathic medicine started to cross paths in a significant way. For allopathic medicine witnessed the beginning of medicine's ongoing attempts to consolidate its professional powers and social legitimacy.
- In 1955, Robert Straus first highlighted a division of medical sociology into two categories, the sociology of medicine and sociology in medicine. The first is concerned with studying the organizational structure, role relationships, rituals, and functions of medicine as a system of behaviour. The second consists of research involving the integration of concepts, techniques, and personnel from many disciplines where the sociologist is collaborating with the physician in studying a disease process or factors influencing the patient's response to illness.



1.8 FURTHER READING

1). Freidson, E. (1962). 'The Sociology of Medicine,'*International Sociological Association*, Sage Publication, 11:123-14



1.9 ANSWERS TO CHECK YOUR PROGRESS

Ans to Q No 1: Health is a metaphor for well-being of a person. To be healthy means to be in sound mind and body as an integrated whole. **Ans to Q No 2:** The sociology of health and medicine critically examines the health situation and its developments and tries to locate them within

a set of wider socio-cultural changes.

Ans to Q No 3: The World Health Organization (WHO) defines health as “a state of complete physical,mental and social well being, and does not consist only of the absence of disease orinfirmity”.



1.10 Model Questions

A) **Short Questions** (Answer each question within 150 words)

Q1. How does the notion of health vary from the perspective of a physician and that of a sociologist?

Q2. Differentiate between sociology of medicine and sociology in medicine.

B) **Long Questions** (Answer each question within 300-500 words)

Q1. Explore the development of medical sociology.

Q2. Discuss the approaches to understand health.

*** ***** ***

UNIT 2: BASIC CONCEPTS

UNIT STRUCTURE

2.1 Learning Objectives

2.2 Introduction

2.3 Medicalization

- 2.3.1 Genesis and the Rise of Medicalization
- 2.3.2 Medicalization- A Boon or A Bane

2.4 Demedicalization

2.5 Illness Narrative

- 2.5.1 Rise in Illness Narratives
- 2.5.2 Dynamics of Illness Narratives

2.6 Medical Tourism

- 2.6.1 Factors and Developments in the Field of Medical Tourism
- 2.6.2 Definitions of Medical Tourism

2.7 Let Us Sum Up

2.8 Further Reading

2.9 Answers to Check Your Progress

2.10 Model Questions

2.1 LEARNING OBJECTIVES

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

- Understand the basic concepts relating to Sociology of Health and Illness.
- Understand in detail the process of medicalization and demedicalization.
- Analyse the concept of illness narratives
- Explicate the concept of Medical Tourism and its position in the global market with emerging, developing and developed nations competing for health tourists

2.2 INTRODUCTION

In the previous unit, we have obtained a general overview of the area of sociology of medicine. This brief overview shall now enable us to understand some basic concepts of this area of study. In this unit, particular focus shall be laid on the ideas of medicalisation, demedicalisation and illness narratives.

2.3 MEDICALIZATION

Medicalization is a process by which non-medical problems become defined and treated as medical problems, usually in terms of illness or disorders. According to Conrad, medicalization is a term used to define the behaviours which were once taken as immoral, sinful or criminal, as something which has a medical meaning, thus moving them from badness to sickness. Examples of medicalization include conditions such as alcoholism, eating disorders, sexual dysfunction, learning disabilities and so on. Along with these it has also included categories such as Attention Deficit Hyperactive Disorder (ADHD), Premenstrual Syndromes (PMS) and so on. Certain common life processes like anxiety, birth control, menstruation, childbirth, death etc have been medicalized.

Medicalization need not be total; there are degrees of medicalization. Some conditions like death, childbirth and severe mental illnesses are fully medicalized. Others such as menopause and drug addiction are partly medicalized. Again, sexual addiction and spouse abuse come under conditions which are taken as minimally medicalized. Thus, this has become an important emerging issue in health care with the availability of medications to treat such conditions which have otherwise been regarded as normal range of human emotions and reactions. Over the past half- century, the social terrain of health and illness has been transformed. Some observers have suggested that the process of medicalization has moved more into the scientific realm with the demise of traditional values and change in social attitudes.

2.3.1 Genesis and the Rise of Medicalization

The ideas behind the concept of medicalization have their beginnings with Michael Foucault and Ivan Illich. The term entered academic and medical publications in the 1970s. Analysts have long pointed to social factors that have encouraged medicalization. Some of these include an abiding faith in science, rationality, the increased prestige and power of the medical profession and a general humanitarian trend in Western Societies.

The growth of medicalized categories suggests an increase in medicalization, but it is not simply a result of medical colonization. Barsky and Boros point out that the public's tolerance of mild symptoms has decreased, thus needing for these symptoms to be classified as diseases. Most early sociological studies took a social constructionist approach in investigating the rise of medicalization. The focus was mainly on the creation of new medical categories with the expansion of medical jurisdiction. Concepts like moral entrepreneurs, professional dominance etc were central to analytical discourse. According to Conrad, studies on the medicalization of child abuse, menopause, alcoholism among many others broadened the understanding of the range of medicalization and its attendant social processes. Michael Foucault tried to analyse the impact of medical discourses on people's lives. But most studies inclined towards social-constructionist approach rather than Foucauldian orientation

Conrad also argued that medicalization is a form of collective action. Along with doctors, patients and other lay people are also active collaborators in the medicalization of their problems or an eager need for medicalization.



LET US KNOW

Pharmeceuticalization- Process by which social, behavioural, or bodily conditions are treated, or deemed to be in need of treatment with pharmaceuticals by doctors, patients or both.

2.3.2 Medicalization- A Boon or A Bane

Many have argued that the process of medicalization does bring health benefits for millions of people around the world. One such benefit is that, in recognizing a condition as a disease, certain conditions can be treated that affect the quality of life. Also, it is taken as an easy way to learn about new drugs and it promotes morale for the clinic staff. However, the process of medicalization has also received criticism from those who are worried about the increasing jurisdiction of the biomedical profession.

Most analysts of medicalization have written in a critical mode, either emphasising the problems of over-medicalization or its consequences. Broom and Woodward (1996) maintained that medicalization can be both helpful and unhelpful to patients. They distinguish medicalization from medical dominance; which they see as problematic for patients. Talcott Parsons in his classic formulation of the sick role pointed out that medical diagnosis can legitimate a range of human troubles. Elsewhere, Illich argued that dependence of medicine would make people obsessed about health as a value and lead to gradual loss of the right of people to self determinism. Thus, most medicalization analysts contend that increasing parts of life have become medicalized and that medical remedies are sought for expanding range of human difficulties. Conrad in his studies has also talked about the shifts in medicalization to a new techno-scientific era of biomedicalization and pharmaceuticalization (cited in Arunima & Kohli, 2012: 256). To put it crudely, medicalization of all sorts of life problems is now a common part of our professional, consumer and market culture.

After going through the various intricacies, it can be said that medicalization is probably neither good nor bad. It is like a "two edged sword" as Conrad (2007) refers to in his study, since the very definition of quality of life has to be questioned.



LET US KNOW

Biomedicalization- It refers to the medical interventions designed not only to extend life and promote health but to enhance our biological selves (via cognitive enhancements or cosmetic surgeries). It places a significant emphasis on genes.

2.4 DEMEDICALIZATION

Medicalization is two directional, in the sense that there can be both medicalization and demedicalization. According to many scholars demedicalization is simply the obverse of medicalization. For demedicalization to occur, the problem must no longer be defined in medical terms, and medical treatments can no longer be deemed appropriate interventions. A classic example is masturbation, which in the 19th century was considered as a disease but by the mid twentieth century was no longer seen as requiring medical treatment. Another example is homosexuality which was officially demedicalized in the 1970s. Although the general trend over the past one hundred years has been towards the medicalization of human problems, there are a small number of cases of demedicalization. Homosexuality remains the exemplary case of nearly complete demedicalization.



CHECK YOUR PROGRESS- A

Q 1. Talcott Parsons formulated the concept of sick role.

True/False.

Q 2. Homosexuality is not an example of demedicalization

True/False.

2.5 ILLNESS NARRATIVE

There is considerable renewed interest in narrative analysis in humanities, social sciences and medicine. Illness narratives, particularly those of patients or lay people are a particular focus in health related settings. In medical anthropology, scholars often use illness narratives to explore how individuals embody the memory of an illness experience. This is in contrast to traditional medical case histories that present patients' illness as generalised diseases with a focus on the symptoms and pathological processes. Illness narratives differ from medical case histories because narratives focus on the patient's subjective experience and understanding of the illness, and they can highlight the social and cultural factors that may have influenced the symptoms.

2.5.1 Rise in Illness Narratives

Writings in the history of medicine make clear the importance of illness narratives particularly with the rise of doctor-patient relationship in early modern times. Before the advent of 'bio-medical model of illness' in understanding the disease during the mid and late 19th century, the doctor used to take the history from the patient which included his/her lifestyle, moral stance and the wider environment in which the patient lived. This was in the 17th and the 18th century when the doctor was expected to attend to patients' narratives and treat them accordingly.

However, with the rise of scientific bio-medicine, the importance of illness narratives diminished. As the study and treatment of disease became separated from the individual, and located within systems only understood by the experts, the need to attend to the patient was reduced to taking information about the signs and symptoms of the disease. The task of the doctor, in the 19th and 20th century was to translate these pieces of information into a definite diagnosis that linked to the biological causes and outcomes, rather than the patient's lifestyle. Thus

illness was separated from everyday life by professional medicine, and the patient's suffering was silenced.

But overtime, various factors have acted to bring lay narratives back to focus. With the growth in chronic illness, the heterogeneous character becomes the focus of both lay and professional concerns. Also, illness narratives and links with 'history taking' in medicine have been associated with moves to improve care that do not entirely depend on a narrow view of scientific medicine.



Sick role : It is a term used in medical sociology regarding sickness and the rights and obligations of the affected.

2.5.2 Dynamics of Illness Narratives

Illness narratives are 'performed' by patients who are characters in their ongoing stories, actors constantly influenced by their social environments. Thus, studying illness narratives and medical histories can provide insights into a patient's society, specifically about the following aspects.

1) How group experience moulds individual experiences: This can be explained through the ethnographic study done by Skultans (1997) concerning the health of Latvian people after the collapse of the Soviet Union. While studying a medical condition, 'Neurasthenia' which causes fatigue and emotional disturbance, Skultans observed that the narratives by those people brought together the past, present and future. The narratives encompassed terrible events that occurred half a century ago which the Latvians used as foundations to construct their life stories, functioning as a medium for their anxieties and hopes for the future. Narrators drew upon stories and fragments of stories to translate their brutal tales into a meaningful story, and Skultans could identify cultural values and knowledge of identity through individual accounts. Testimonies came from witnessing awful events, but in doing so, the informants speak from solitary experience and yet they also speak for others. Thus it can be said that societal trauma are commemorated in the lived experiences of individuals who are

suffering. It is through these common narrative forms that one can better understand the personal and social memory of a given people within a society, as well as their collective experience.

2) How cultural values and social relations shape the body's illness experience: This can be understood by taking into account the study done by Good (1994) on people suffering from seizure disorder in Turkey. The study was initially designed to look at the prevalence of epilepsy and the social disability associated with it, yet, through the stories he heard, Good learned much more about the sufferers. He explains one instance in which a lady described her experience of 'fainting'. She said when she was a young woman, she had resisted her father's wish for her to marry a particular man and instead chose another husband far away. When she saw her father with a knife in his hand, she received a "shock," she was frightened, and from that day until today, she has been fainting''. This story revealed more than a biomedical diagnosis. In her narrative she used the word 'fainting' instead of 'epilepsy' which reveals that in her society fainting is associated with acute distress or suffering. So in this case questions arose as to whether this condition of hers was caused by epilepsy or due to some psychological trauma.

3) How societal influences may trigger the body's memory of an illness: Illness narratives and case histories may reveal not only how suffering is situated in an individual's world, but also how it might be triggered by broader societal influences. This can be explained further with the ethnographic work done by Eli (2016) on Israeli women who had recovered themselves from eating disorders. After listening to their narratives she found out how the memories of their past illness are triggered by social pressures and affect their present day recovery. She explains this with one particular case of Tamar, a recovered anorexic, and how the social pressure to exercise caused her body to remember her troubled past. She and her partner started a new training

programme, years after she was classified as 'recovered,' until one day she realized what she was doing to her body after which she quit. What illness narratives thus reveal are not only how a disease manifests itself in one's own world, but the societal-cum sensory pressures that may activate it.

4) How the society helped create illness: This can be understood with the help of Steffen's (1997) study on members of a Danish organization of Alchoholics Anonymous (AA). Here one can see the purpose of illness narratives in merging individual and group experiences in a therapeutic process that gives meaning to the individual sufferers' lives. In this work, Steffen recounts short summaries of several individuals who lost part of their lives due to excessive drinking. After each narrative, together they would recite the prayer: 'God grant me serenity, to accept the things I cannot change, courage to change the things I can, and wisdom to know the difference'. Telling a story/personal narrative helps an individual process what happened, processing events being the first step towards recovery. Such openness is a therapeutic necessity as well as a moral duty for members, who find solace in knowing that their story is quite similar to the stories of those around them.



Chronic illness : A long lasting condition which can be controlled but not cured.

Together, these narratives offer a lens into a patient's sociality, as well as providing a more holistic understanding of a patient's condition, illustrating the ultimate causes of suffering and helping determine more productive ways to help the patient. By contextualizing meaningful events, illness narratives contribute to the understanding of individual experience by showcasing social relations and cultural values. In this regard, they offer much more than a brief medical history of a patient, they offer patient perspectives not only about the illness but about the patient's perceived role in society. They also allow for a better understanding of the ultimate causes of a disease that cannot be boiled down to mere pathological description. Finally, they demonstrate how

society becomes embodied in illness, and which societal values may outweigh others in the shaping of an illness experience. Narratives show how collective societal experiences mould individual experiences, how values may embed themselves in the body in periods of sickness, and how suffering is tied to larger societal triggers.



CHECK YOUR PROGRESS- B

Q 3. Illness narratives are ways to explore how individuals embody the memory of an illness experience.

True/False.

Q 4. The coming of biomedicine in 19th century diminished use of illness narratives.

True/False.

2.6 MEDICAL TOURISM

Sociological studies of tourism have largely categorized tourism as a leisure-related activity separated from the everyday, whereby the tourist gazes upon the 'other' in a foreign locale. Health and medical tourism, however, challenge such understandings. Firstly, medical tourism does not necessarily involve a retreat from everyday experiences. Secondly, this reveals tourism is not necessarily a passive activity, but an embodied experience. For the health and medical tourist, their 'tourist experience' is partially or solely motivated by their health or perception of their health.

In today's scenario, healthcare has become a global market, with emerging, developing and developed nations competing for health tourists. Consequently, the political interest in health and medical tourism is based on the financial benefits it can bring. Such economic incentives for the state has also led to increasing options for medical tourists, who have more disposable incomes and in some cases portable health insurance

policies. Therefore, while medical tourists still predominately flow from the developed world, medical tourist sites are found globally, with many medical tourists flowing to world-class facilities in the developing world.

2.6.1 Factors and Developments in the Field of Medical Tourism

Starting from the late 20th century, there have been various changes in the field of tourism for health purposes. There has been the emergence of a new term, 'medical tourism', which is sometimes differentiated from health tourism and sometimes not. Medical tourism is opted because of different reasons which include- Better quality care for medically necessary procedures, most advanced technology, lower cost care and quicker access for medically necessary procedures, trust in the healthcare system of the target country and so on. In addition, there are some other developments in the field of medical tourism, which are explained below.

i) Types of health and medical interventions have considerably diversified, ranging from superficial treatments (such as facials and massages) to highly invasive and risky surgical procedures (such as open heart surgery) and, in some cases, a combination of both (for example cosmetic tourism, which encompasses cosmetic and reconstructive surgery and some forms of dentistry).

ii) Another important development in health and medical tourism appears in the emphasis placed on marketing, and the varied priority placed on health. While health concerns may have been a primary motivator for health tourists prior to the 19th century and in particular the 20th century, today the 'tourist experience' appears to take precedence over health. Healthcare and beauty treatments may form part of a tourist package in international resorts or on cruises, which often include site-seeing to major destinations.

iii) Health may also remain the primary - or only - motivator for travel. This can be influenced by delays in or the unavailability of medical treatment/s at home. Transplant tourism, for example, occurs because of the long waiting lists for kidney transplants in the developed world that may lead to death before the individual can receive a transplant, an apparent willingness of people in the developing world to sell their kidneys and so on.

These considerations reveal that health and medical treatments can be considered an addition to the traditional tourist site-seeing experience as stated by Goodrich and Goodrich (1991), and a significant or sole motivator for travel.

2.6.2 Definitions of Medical Tourism

After going through a brief on medical tourism and the factors behind it let us delve into some of the definitions by scholars on health and medical tourism. Mc Kinsey (2008) defined it by stating- When a person, whose primary and explicit purpose in traveling is to obtain medical treatment in foreign country, it is called medical tourism.

Lubowiecki-Vikuk (2012) described it as a conscious activity, in which a traveler (a medical tourist) aims to receive healthcare services – in his or her own country or abroad to preserve (or acquire) a better health condition, and/or aesthetic appearance of his or her own body, sometimes combined with relaxation, regeneration of physical and mental strength, sightseeing and entertainment.

From the above definitions we can see that there are many differing definitions of health and medical tourism. Some of these appear to be influenced by the previously explored history of health tourism, which is largely based on resorts, spas and general wellness. These understandings largely replicate the traditional understandings of mass tourism in sociology, where tourism is understood as a binary structure that operates as

escapism from the everyday life. Whereas, there are other perceptions which acknowledge health tourism as a very broad category that encompasses a wide variety of treatments and services. In such understandings, medical tourism becomes a subset of health tourism. For example, some scholars view health tourism as 'travel where the primary purpose is treatment in pursuit of better health' that may involve 'hedonistic indulgences of spas and alternative therapies', while medical tourism 'incorporates health screening, hospitalization, and surgical operations'. Thus answers to the similarities and dissimilarities on health and medical tourism seem a little confusing. All in all, this is a relatively recently recognised, unregulated industry with speculation-based insight. However, this is not to subsume the importance of tourism and the growing political, economic and social interest in health and medical tourism. Rather, it appears more relevant and important to examine and understand these phenomena subjectively and socio-culturally, including the political tensions arising between competing interests.



CHECK YOUR PROGRESS–C

Q.5. Medical tourism is opted for better medical facilities.

True/False.

Q.6. Define medical tourism.

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2.7 LET US SUM UP

- Medicalization is a process by which non-medical problems become defined and treated as medical problems.
- The ideas behind the concept of medicalization have their beginnings with Michael Foucault and Ivan Illich. The term entered academic

and medical publications in the 1970s.

- Medicalization is two directional, in the sense that there can be both medicalization and demedicalization.
- For demedicalization to occur, the problem must be no longer be defined in medical terms, and medical treatments can no longer be deemed appropriate interventions.
- Illness narratives are 'performed' by patients who are characters in their ongoing stories, actors constantly influenced by their social environments. Thus, studying illness narratives and medical histories can provide insights into a patient's society.
- In medical tourism, the 'tourist experience' is partially or solely motivated by their health or perception of their health.



2.8 FURTHER READING

1. Bury, M. 2001. "Illness Narratives: fact or fiction?" in *Sociology of Health and Illness* 23.3.
2. Conrad, P. 2007. The Medicalization of Society. Baltimore. John Hopkins University Press.
3. Cook, Peta S. 2007. "What is health and Medical Tourism", in Humanities Research Program Queensland University of Technology.



2.9 ANSWERS TO CHECK YOUR PROGRESS

A. 1) True 2) False

B. 3) True 4) True

C. 5) True

7) Medical tourism involves people who travel to a different place to receive treatment for a disease, an ailment, or a condition, or to undergo

a cosmetic procedure, and who are seeking lower cost of care, higher quality of care, better access to care or different care than what they could receive at home.



2.10 MODEL QUESTIONS

Short Questions (Answer each question in about 150 words)

Q1. Define medicalization.

Q2. What is meant by illness narrative?

Long Questions (Answer each question within 300-500 words)

Q1. Write a short note on demedicalisation.

Q2. Discuss the idea of tourism for health purposes.

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UNIT 3: THEORETICAL PERSPECTIVES TO UNDERSTAND HEALTH

UNIT STRUCTURE

3.1 Learning Objectives

3.2 Introduction

3.3 Functionalist Theory

- 3.3.1 Parson's Sick Role
- 3.3.2 Durkheim's study on Suicide

3.4 Marxist Theory

3.5 Post-Modern Theory

- 3.5.1 Advent of Post modern theory
- 3.5.2 Foucault's theory in the context of post-modernism
- 3.5.3 Dynamics of knowledge and power
- 3.5.4 Health, Culture and Society
- 3.5.5 Limitations

3.6 Let us sum up

3.7 Further Reading

3.8 Answers to Check Your Progress

3.9 Model Questions

3.1 LEARNING OBJECTIVES

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

- Understand why sociologists study health and illness
- Discuss the study of health and illness from a functionalist perspective
- Understand health and illness through Marxist analysis
- Discuss and analyse health and illness through post modern theory.

3.2 INTRODUCTION

Sociological theories provide frameworks and insights that allow for the systemization of knowledge of the social world. This is why theory

is fundamental in empirical investigation and the scientific explanation of events. While medical sociology is moving closer to Sociology, it has removed itself from a subordinate position to medicine. There are four reasons for this development-

- Medical sociologists bring more expertise to the analysis of health related social conditions than physicians who typically receive little or no training in this area.
- Medical Sociology has a significant body of literature which is relevant to clinical medicine and health policy.
- Success in research has promoted the professional status of medical sociologists both in relation to medicine and Sociology.
- Medical Sociology has set its own research agenda which includes medical practice and policy as an object of study.

Changing social conditions associated with the transition of society from the post industrial to post modern period requires sociology to account for the various transitions taking place in the society, as well as the health sector and thus formulate new concepts. Under these conditions medical sociologists are making great use of Social theory because it promotes explanatory power to their empirical findings.

In this unit we will try to understand some of the major theoretical approaches to understand health and illness. Here, we shall know about the functionalist perspective to health and illness which is dated to the works of August Comte, Emile Durkheim, Herbert Spencer, and many other scholars. Then, we will move on to the Marxist Perspective followed by the Post modern approach to health and illness.



LET US KNOW

Sickness is culturally constructed and defined by the society. Five dominant perspectives to understand health and illness are: Functionalism, Symbolic Interactionism, Marxist, Feminist and Foucauldian perspective.

3.3 FUNCTIONALIST THEORY

The Functionalist approach considers the society as a whole comprised of its constituent elements; namely norms, customs, traditions, and institutions, etc. A common analogy, popularized by Herbert Spencer, presents these parts of society as “organs” that work towards the proper functioning of the “body” as a whole. This approach looks at society from a macro perspective, which is a broad focus on the social structures that shape society as a whole. This approach looks at both social structure and social functions. Auguste Comte, Herbert Spencer, Talcott Parsons, Emile Durkheim and Robert Merton amongst others, are some of the prominent functionalist theorists.

In the 1940s and the early 1950s, the field of Medical Sociology was almost completely an applied area of research. However, a notable change occurred in 1951 with the growing orientation of medical sociology toward theoretical concerns. In this context, Talcott Parson’s book, *The Social System*, based on a structural-functionalist model of society attracted great attention because it contained the concept of sick role. It was the first time when a major social scientist included an analysis of the function of medicine in his view of society.

3.3.1 Parsons’s Sick Role

The term ‘Sick role’ is used in medical sociology to refer to the idea of sickness and the rights and obligations of the affected people. Parsons argued that the state of being sick means that the sufferer performs “sanctioned deviance”. This is because, from a functionalist perspective, a sick individual is not a productive member of society. Therefore this deviance needs to be policed or treated, which is the role and responsibility of the medical profession.

In the functionalist model, Parsons thus argued that the best way to understand illness sociologically is to view it as a form of deviance that disturbs the social function of the society.

The general idea is that the individual who has fallen ill is not only physically sick, but adheres to the specifically patterned social role of being sick. In Parsons' definition, the sick person had two rights and two duties to fulfill. The first duty was to recognize that sickness creates dysfunction in the life of the affected. This lead to the second duty of seeking technically competent assistance to cope with their sickness, whereby it was assumed that advice would be followed. The fulfillment of these two obligations guaranteed the sick person the rights of being exempted from normal obligations and from usual blame.

This definition captured the culturally and socially accepted patient behavior during the 1950s. However, it had many limitations. One of the limitations is that the rights and obligations do not apply to patients with chronic illnesses, such as diabetes, heart disease, epilepsy and others. While patients with chronic illnesses are expected to seek medical help and to comply with recommendations, they are also encouraged to learn how to continue with their activities of daily life independently. Furthermore, if a patient with chronic illness exercises the rights prescribed to him/her under the Parsonian sick role for an extended period of time, then the individual contributes less to the functionality of both the personal life and society at large. Additionally, the Parsonian definition of the sick role assumes that people living with ailments accept their status as being sick or their willingness to act the prescribed role. However, that is not always the case. For example, deafness is considered by many to be a physical limitation. However, they do not consider themselves living with a dysfunctional attribute, and refuse to participate in the Parsonian sick role.

Therefore, the combination of these factors and the greater understanding of modern diseases led to a situation where his role was no longer valid and a new sick role was needed. However, the great contribution of Talcott Parsons could be his analysis of

sick role in the context of Sociology. He also tried to suggest how a sick person should behave in the society.

3.3.2 Durkheim's Study on Suicide

Another structural functionalist whose work can be cited in medical sociology is Emile Durkheim. He mainly emphasized on the importance of macro–level social processes, structures, norms and values which are external to the individuals that integrated them into the society and shaped their behavior. One of his works which had direct application to medical sociology was his theory of Suicide (1951). In this study he argued that the act of taking one's life was determined by the individual's ties to his her community or society.

This can be seen in his typology of three major types of Suicide :

- Egoistic- which arises from social detachment
- Anomic- which arises from the state of normlessness and
- Altruistic- A normative demand for suicide.



LET US KNOW

Mechanical solidarity- Mechanical solidarity is the social integration of members of a society based on common values and beliefs which constitute a collective conscience.

Organic Solidarity- Organic solidarity comes from the interdependence that arises from specialization. It is a social cohesion based upon the dependence of individuals on each other in advanced societies.

The merit of his concept is that it shows the capability of the larger society to create stressful situations where people are forced to respond to conditions not of their own choosing. Thus, Durkheim helps us to recognize that macro-level societal events (like economic recessions) can affect health in a variety of ways through stress and that the effect of stress can be mitigated through social support. Indirectly Durkheim also influenced the study of health professions

in noting the transition from mechanical to organic solidarity, with its emphasis upon specialization in the modern division of labour.



CHECK YOUR PROGRESS

Q 1. Who introduced the concept of sick role?

Q 2. Cite one work of Durkheim relating to the field of Health and illness.

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3.4 MARXIST THEORY

The Marxist perspective derives from the ideas of Karl Marx who believed that class conflict is the driving force which bridges changes in society. He believed that the main conflict in society was entirely economic. The Marxist tradition regarding health and health care completely rejects the views of the functionalists that society is tied together by values and norms. The conflict theorists believe that these values and norms benefit only the rich and the powerful. They feel that social and economic factors are the root cause of health and health care disparities in society. The rich and the affluent get access to health and health care facilities because of their financial status in society.

Marxists claim that capitalism moves healthcare professions to privatization of healthcare services and establishes the drive to increase profit and power for a certain social class. This economic tendency makes the medical field a profit oriented organization. Therefore, Marxism focuses on political and economic determinations of medical care in capitalist societies. Marxism has contributed to the healthcare field. Medicine is viewed as 'bourgeois' which aims to maintain dominance of certain groups in society. Marxists argue that health care systems are designed to satisfy the interests of the bourgeoisie rather than improve health conditions of the whole population. According to Marxism, inequality in distribution of healthcare services in capitalist society arises from the

marginalization of some categories of the population who do not contribute to economic system. This exclusion may include women, people with disability, elderly people and every person who doesn't contribute to the economy, regardless of the health status and needs of the person.

Along with class factors, Marxist theory pays attention to the role played by health care institutions and health care 'industry' in the economy; the impetus behind the ever expanding activities of large industrial and financial enterprises in the sphere of health and health care; its effects on shaping of health care services; role of a medical professional vis-a-vis the health 'industry' on the one hand and the patient- consumers on the other; the role played by these institutions in social control and perpetuation of values which are reinforcing the existing social order based on class, gender and racial domination.



LET US KNOW

According to Marxist perspective medical industry and state nexus can be deadly as the marginalized section of the society suffers the most.

Marxism also talks about monopoly capitalism which has entered the medical industrial complex. Increasing costs of medical care has led to the rise of medical insurance giants but per se medical care was still under the autonomous control of the medical profession. The same logic of capitalist accumulation that drives any other capitalist industry also drives these hospitals. All the management and financial techniques employed elsewhere are used here in order to derive maximum profits. Multi-hospital chains are being formed and mergers of small hospitals take place. Not only that, they are having collaborations with similar hospitals in many third world cities. With the rise of monopoly capitalism and given forthcoming industrialisation of health services, small- scale medical practice will become untenable and professional prerogative will erode slowly.

Thus, we can see that the theories based on conflict have the capacity to explain the politics associated with the health sector. It allows

us to chart the tactics of various entities, like medical profession, drug companies, insurance companies, business community etc as they struggle to acquire, protect or expand their interests. Other conflict approaches are connected more directly to classical Marxism by relying on class struggle to explain health policy outcomes and the disadvantages of the lower and working classes in capitalist medical systems where the emphasis is on profit.

However, there are also inherent limitations of the Marxist or the conflict perspective as a whole. While some health situations are affected by conflict related conditions, others are not. People may maintain their health or become sick and these outcomes can have little or nothing to do with conflict, politics, interest group competition, class struggles and so on. Moreover, Marxism began losing influence from the late 1970s onwards. By the beginning of the 1990s with the coming up of post modernism, and the collapse of the 'existing socialism' in Eastern Europe and the Soviet Union, the importance of Marxism declined.



CHECK YOUR PROGRESS

Q 3. Social and economic factors are the root cause of health and health care disparities in society.

True/False.

Q 4. Functionalism believes that society is tied together by values and norms.

True/False.

3.5 POSTMODERN THEORY

The theories of both Poststructuralism and Postmodernism are crucial to our understanding of the relationship between health, culture and the society. They offer a critique to modernism, and, in relation to health, show how the micro-politics of power relate to medical knowledge and medical power. These two approaches also help to explain the

resistance to techniques of power of a postmodern era.

Modernity is associated with the age of enlightenment in western societies which began around the 18th century. It involved social, economic and political upheaval with increasing secularization of societies and a growing dominance of philosophical and scientific rationalism. The basic assumptions of 'modernity' are that human order is essentially governed by general principles which can be elucidated by scientific analysis. Scientific knowledge was based on an empiricist epistemology and was believed to be the instrument by which true knowledge could be found. Modernism is associated with humanism which takes the human experience as the starting point for man's knowledge of himself. The aim of social sciences was thus to liberate humanity from prejudice and ignorance using scientific knowledge.

3.5.1 Advent of postmodern theory

Post Modern theory was seen to have born from within the democratic left of French politics in the 1960s. The postmodernists claim that the fundamental socio-historic changes cannot be adequately explained by the modern theories. Thus they call for new categories, modes of thought and politics to overcome the deficiencies of modern discourses and practices. Postmodernists favor social analysis which incorporates local, contextualized strategies that have a more practical or moral intent. Local narratives are preferred in place of grand narratives and theories.

3.5.2 Foucault's Theory in the context of post-modernism

Foucault's theory of Governmentality could be considered as an example of how poststructural and postmodernist ideas can help in understanding the relationship between health, culture and society. Governmentality describes the range of mechanisms that allow different groups and discourses to regulate, construct and constitute individuals, groups and society. It is drawn from discourse

theory which focuses on how meaning is socially constructed semiotically.

Governmentality highlights the centrality of 'the body' and how it is disciplined, inscribed and subjected within the realms of power and knowledge of experts within the realms of governance. This is a major contribution by Foucault to medical sociology where he showed the social functions of medical profession, including the use of medical knowledge as a means for social control and regulation, as he studied madness, clinics and sexuality. Foucault found two distinct trends emerging in the history of medical practice; "medicine of the species" (the classification, diagnosis and the treatment of the disease) and "medicine of social spaces" (the prevention of disease). The former defined the human body as an object of study subject to medical intervention and control, while the latter made the public's health subject to medical and civil regulation. The surveillance of human sexuality by the state, church and medicine subjected the most intimate bodily activities to institutional discourse and monitoring. Thus bodies themselves came under the jurisdiction of experts on behalf of the society.

There is therefore a clear distinction between modernist and post modernist conception of the body. Modernist thought views body as independent of the various discourses which represent it, whereas postmodernist thought views 'the body' as discursively produced. The objective of the postmodernist 'de-centering' of the self in medical sociology allows analysis of the effect of inscription of health and illness.

3.5.3 Dynamics of knowledge and Power

Foucault believed that modern societies regulate and discipline their members by their 'expert knowledge' such as medicine, education, law, social work etc. The power/knowledge of the new disciplines was mediated through disciplinary mechanism which

stipulated norms for human behavior. In terms of medical sphere, Foucault suggested that the basis for medical dominance lay in the knowledge claims of the medical profession about the 'body', 'health' and 'illness'. The new disciplines were seen as having insights into problems, knowledge and techniques and as a consequence were given license to diagnose, treat and thereby 'normalise' the population.

Medical discourses however have come under increasing criticism for being uncaring, stigmatized and disempowering. Despite the claims to objective scientific reasoning, these discourses have been shown not to be value-free but often prejudiced and socially-constructed. A postmodern perspective questions the knowledge claim of the new disciplines on how they claim authenticity, authority and how is it that people are willing to accept their knowledge of the character of health and illness. According to Foucault, sociological discourse is implicated in discipline and regulation, the discipline of the 'gaze' through examination, hierarchical observation and regulation.

Sociology itself therefore is implicated in the fabrication of discourses which make 'health', 'illness' and 'social problems' culturally defined phenomena despite the fact that it claims to be superior to biomedical discourse or lay prejudice. Ideas from postmodernism can help to analyze how sociology creates subjectivity through its discourse and supports the need for reflexivity in understanding the problems of representation in health illness and social problems which modernist sociology articulates.



LET US KNOW

Medical gaze- Informed way of looking at the human body. In other words, it refers to the scientific examination of the body.

3.5.4 Health, Culture and Society

Another idea drawn from Postmodernism which can help to understand the relationship between health, culture and society is that of the 'postmodern era' itself. There is considerable debate about whether or not we are entering a new 'postmodern era' one which is characterized by pluralism, variety, contingency and relativism where beliefs in rational science, knowledge, truth and the universal state are undermined.

The principles of free-market competition and deregulation contained in the neo-liberal critique of 'welfarism' can be seen in changes in consumption patterns. This together with the commercialization of intellectual life and medicine, challenges the power/knowledge of traditional institutions. Turner states, we may expect the hierarchical division between scientific medicines and alternative medicines to collapse, as the traditional autonomy of medical profession is eroded through the invasion of corporations into the health market.



CHECK YOUR PROGRESS

Q 5. Who introduced the theory of Governmentality?

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Q 6. ———————— offers a critic to modernist theory.

Q 7. Postmodernists favor social analysis which incorporates local, contextualized strategies that have a more practical or moral intent. True/False.

3.5.5 Limitations

Postmodern theory has been criticized for a number of reasons including its failure to explain social conditions after the rupture with modernity is complete, lacking an adequate theory of agency,

being too abstract, not providing clear conceptualizations, and not having empirical confirmation. While its demise has been announced in Britain, it is still popular in France and has gained adherents in the US. The advantage of postmodern theory is that modern society is indeed shifting into a new form with social conditions different from the recent past and the perspective provides a theoretical framework, despite its complex literature for explaining the social changes.



3.6 LET US SUM UP

- In the functionalist model, Parsons thus argued that the best way to understand illness sociologically is to view it as a form of deviance that disturbs the social function of the society.
- Durkheim helps us to recognize that macro-level societal events (like economic recessions) can affect health in a variety of ways through stress and that the effect of stress can be mitigated through social support.
- Marxists claim that capitalism moves healthcare professions to privatization of healthcare services and establishes the drive to increase profit and power for a certain social class. This economic tendency makes the medical field a profit oriented organization.
- The theories of both Poststructuralism and Postmodernism are crucial to our understanding of the relationship between health, culture and the society. They offer a critique to modernism, and, in relation to health, show how the micro-politics of power relate to medical knowledge and medical power.
- Foucault's theory of Governmentality could be considered as an example of how poststructural and postmodernist ideas can help in understanding the relationship between health, culture and society.
- Governmentality highlights the centrality of 'the body' and how it is disciplined, inscribed and subjected within the realms of power and

knowledge of experts within the realms of governance.

- Foucault found two distinct trends emerging in the history of medical practice; “medicine of the species” (the classification, diagnosis and the treatment of the disease) and “medicine of social spaces” (the prevention of disease). The former defined the human body as an object of study subject to medical intervention and control, while the latter made the public’s health subject to medical and civil regulation.
- Medical discourses however have come under increasing criticism for being uncaring, stigmatized and disempowering. Despite the claims to objective scientific reasoning, these discourses have been shown not to be value-free but often prejudiced and socially-constructed.



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3) Reynolds, N. 2014. “The Sick Role- Sociology of Illness and Disease.” http://clubrunner.blob.core.windows.net/00000050029/en-ca/files/sitepage/global-scholar-nathan-reynolds/final-sociology-paper/Final%20Sociology%20Paper_Nathan%20Reynolds.pdf.



3.8 ANSWERS TO CHECK YOUR PROGRESS

Ans to Q No 1): Talcott Parsons

Ans to Q No 2): Suicide

Ans to Q No 3): True

Ans to Q No 4): True

Ans to Q No 5): Michel Foucault

Ans to Q No 6): Postmodern theory

Ans to Q No 7): True



3.9 MODEL QUESTIONS

A) Short Questions (Answer each question in about 150 words)

Q 1: What is meant by 'organic solidarity'?

Q 2: Define 'sick role'.

B) Long Questions (Answer each question within 300-500 words)

Q 1: Write a brief note on Post Modern theory to understand health, with reference to Foucault.

Q 2: Explain the Functionalist perspective towards the understanding of health.

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UNIT 4 : DISEASE, POVERTY AND COLONIALISM IN INDIA

UNIT STRUCTURE

4.1 Learning Objectives

4.2 Introduction

4.3 Meaning of disease

4.3.1 Objectivist view

4.3.2 Social Science view

4.4 Understanding disease in colonial India: A perspective from Cholera epidemic and Smallpox

4.4.1 Colonial perception of disease and relation to poverty

4.4.2 Interpretation of disease by the natives

4.5 Colonial Measures for prevention of disease

4.5.1 Measures for smallpox

4.5.2 Measures for Cholera

4.6 Nature of resentments by natives

4.7 Let Us Sum Up

4.8 Further Reading

4.9 Answers to check your progress

4.10 Model Questions

4.1 LEARNING OBJECTIVES

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

- apprehend how disease is not just a medical issue, but also has social and cultural dimensions
- interpret the colonial as well as a native understanding of disease from examples of Cholera and Smallpox
- know about the different modes of techniques used by the natives to deal with the disease
- critically analyse colonial interpretation of disease and measures they provided

- popular resentments against British imposition of western medicine versus indigenous knowledge system of medicine

4.2 INTRODUCTION

This unit is going to introduce the concept of disease and the complex meaning associated with it in the context of colonial India. To do so, the unit will take examples of two cases- smallpox and cholera epidemic that broke out in nineteenth and twentieth century India. Both smallpox and cholera have thrown insights to comprehend modern medical measures versus indigenous forms of knowledge critically. The Western-centric view of colonialist, governed by rationalism and scientific outlook tended to undermine the knowledge systems of their subjects as inferior. They often considered the Indian ways of looking into a disease as out-dated and governed by superstition. Therefore this unit points that the term disease is not just a medical terminology but also derives its meaning from various cultural, historical and political contexts. The first section of the unit will look into different ways to understand disease and argues that it has much more than objective medical definitions. This will be followed by a general understanding on how the disease was perceived in colonial India both by the coloniser and the colonised. To examine this historical trajectory of disease, the unit, with examples, will see how there was a conflict between the European notion of scientific rationality versus indigenous forms of knowledge systems. The unit will then comprehend various measures taken by the British to control these diseases and popular resentments it received from the natives.



LET US KNOW

Implementation of vaccination was a difficult task for the British. It was in 1804 that Lord Wellesley formally banned variolation in Calcutta. But this law had little impact as natives were more comfortable with variolation than vaccination

LET US KNOW

Objectivists view disease as a fact. It should be clinically identifiable, objective and a thing in itself.

Disease is not just a medical terminology but derives its meaning from cultural, historical and political context.

4.3 MEANING OF DISEASE

4.3.1 Objectivist view

Objectivists conceptualised disease as a discrete entity. It is understood as clinically identifiable, objective and a thing in itself. Therefore L Rhodes (1996) calls disease in modern medicine to have an “aura of factuality”. According to objectivists, the human body is made of organ systems to function naturally. Sometimes these organs can depart from normal functioning in many ways. To have a disease, therefore, there should be a claim about the abnormal functioning of the bodily system. It should also have a judgement that abnormality associated with it has a negative impact. Similar views are also shared by a group of scholars who belong to the naturalist school of thought. They think that disease is a bodily malfunctioning that ultimately causes the body to deteriorate and if not treated, can eventually lead to death.



LET US KNOW

Michel Foucault in his book ‘Birth of a Clinic’ (1963) argues that there is not a particular way to define medical prescription. The disease has a context and time.

4.3.2 Social Science View

The medical sociologist and anthropologist have been long critiquing the idea of identifying disease as objective and detached

from other social variables. They contend that there is no objectively definable malfunction as disease. We judge certain bodily discomfort as abnormal because they do not adhere to our specific culture and share a similar conception of human nature. Michel Foucault (1963) writes that there is no fixed way to define medical perception. Hence the definition of disease also takes its shape according to context and time. The perception towards disease may change over time, related to wider socio-cultural transformation. Thus, many diseases of the past may not be a disease today. Or, many bodily disruptions may be a disease in one culture and may not be in another. Hence medical anthropologists argue that disease is not only biological but also socially constructed. Therefore numerous bodily disruptions which the British perceived to be disease were blatantly refused to be so by the Indians. Rather, they had other interpretations like the individual being possessed by a spirit or God's playfulness in the human body. Similar is the case of western medicine.



CHECK YOUR PROGRESS- (A)

Q 1 : L Rhodes comments that modern medicine has-----

a) Essence of rationality (b) aura of factuality

(c) tendency of superiority

Q 2 : What is social science view of disease

(a) Not any objectively definable malfunction

(b) It is objectively definable malfunction

(c) Disease has a universal character

4.4 UNDERSTANDING DISEASE IN COLONIAL INDIA : A PERSPECTIVE FROM CHOLERA AND SMALLPOX

The cholera epidemic and smallpox breakout were the deadliest diseases among few others like plague, malaria or leprosy in colonial India. These diseases were caused to have a notorious effect on both natives

and the British in the nineteenth and twentieth-century India. Cholera infected persons would have severe watery diarrhoea, loss of fluid, loss of appetite, fever and cramps. Whereas symptoms of smallpox were painful eruption of skin with pustules, sloughing and scars left permanently. It was so severe that persons affected with smallpox died within two weeks. And even if survived, it could leave a deformed body. Both of these conditions have taken millions of life until it was reduced or eradicated through national/ international programmes. The strong connection of spreading the disease cholera was traced from Hindu pilgrimages. In India, the disease got widely spread through tanks and watercourses used by the contaminated person, as immersion in a tank or a river for religious purification is a ritual among the Hindus. Kumbh Mela of Haridwar is one such instance when pilgrims immerse themselves into the water. The situation becomes worst when the pilgrims bring this 'holy water' of Ganges for family members to consume. In 1867 almost three million pilgrims came to attend the Kumbh Mela. Although only nineteen pilgrims were treated in Haridwar, most of them have carried it with them while travelling back home through different parts of the country. On the way, the pilgrims used the tanks and wells and left the fatal disease behind. Here the attack on cholera was therefore also an assault on Hinduism. It was also another reason for more reluctance and resistance to western medical sciences. The pilgrims were made a 'dangerous class' that required special surveillance and regulations.



LET US KNOW

The colonial government regarded Hindu pilgrimages attending Kumbh Mela or Jaggannath Rath Yaatra of Puri as primary carriers of Cholera

Accurate statistical data of the period of the 1860s is not available, and therefore no accuracy of death could be found before that era. From the available statistics, David Arnold (1986) a prominent historian traces that at least twenty-three million people died in colonial India from 1865 to 1947 due to the cholera epidemic. Therefore it was regarded as one

of the first deadly epidemics in the nineteenth century. Jameson's statistics of the 1820s suggested that mortality exceeded 10,000 in several districts. Likewise, for smallpox, Arnold estimates that in Calcutta mortality from smallpox was 11000 in between 1837 to 1851. The children were primary victims, and it was said not to count the children as a permanent members of a household unless and until they survive an attack of smallpox.

4.4.1 Colonial perception of disease and relation to poverty

Studies have reflected that the diseases were significantly more among the poorer sections in India. It does not mean that Europeans were unaffected, but they took precautions with healthier living style and a good diet. For example, Jameson in Calcutta in 1820 speculates that Cholera is more among the slum dwellers where sanitation hygiene is in worst condition. These places are crowded with water stagnation and polluted drinking water. Rural areas were doubly affected by the disease accompanied by famine. During the 'Guntur famine' in the Madras Presidency in 1833, cholera killed almost 2 million people. Therefore decline in famine after 1900 was a factor in the decline of cholera mortality in the 1920s and 1930s. Likewise, the breakdown of Bengal Famine in 1943-44 brought Cholera epidemic back, although it was temporary.



LET US KNOW

1) There was a relationship between poverty and disease in colonial India

2) Deadly diseases like smallpox and cholera were worsened by famines which hit the country

3) However, the colonial government was more interested in researching bacteriology or parasitology, paying no attention to the poverty factor.

A similar case was seen when the bubonic plague epidemic broke out in Bombay in 1896 and spread to larger western and Northern India. Poverty did have a direct impact on the major famines that shook the country. Poor housing, unclean neighbourhoods and insufficient diet were seen as major players in transmitting the disease. A popular English daily in Bombay said that plague mainly chooses to attack the poor. The wealthier also occasionally fall victim, but it is the poverty-stricken who usually suffer. Similar was the case of Malaria. Sir S.R. Christopher investigated into the 1908 Punjab malaria epidemic and argued that there was a direct relationship between malaria and high food-grain price that led to mortality among the poor people of the region. However later he changed his position about the relationship between malaria and disease. It was interesting to see how colonial government was least interested in relating the diseases that were prevalent in India with the factor of poverty. Rather, the common understanding seemed to be that the cause of poverty were the diseases, not the other way round. The colonial government attributed the primary cause of diseases mostly to the environmental and cultural factors.

Moreover, the rise in research interest in bacteriology or parasitology diverted the attention from poverty in the nineteenth and early twentieth century. It was only after the nineteen thirties when poverty gained worldwide discussion, the topics and interconnections of disease and poverty were brought to the table. Otherwise, the colonial government found no interest in studying poverty, ironically which was caused by their actions of exploitations.

4.4.2 Interpretation of disease by the natives

It is mentioned above that western outlook towards disease and medicine was in contrast to indigenous ideas of the knowledge

system — epidemics like Cholera and Smallpox which were seen to be diseases by the British, were comprehended by the natives as revenge by deities or playfulness of God. Though India is a diverse country regarding religion or culture, the native's views were not very different from each other. As a consequence, the colonialist regarded them to be superstitious and backward. Indians also had their interpretation. There was an episode where British administrator Warren Hastings's army was attacked by Cholera in Bundelkhand area of Northern India. The villagers believed that it is because they have offended a Hindu God. A cattle was slaughtered in a grove sacred to a prince called Hurdou Lal to feed the British army despite warnings from the local Brahmins. Therefore they believed that the epidemic outbroke as it offended the spirit HurdouLal and therefore they started worshipping him. Similar examples were seen from Southern and Eastern parts of India as well. Therefore in possible ways, the British were seen as responsible for spreading this disease, either through offending Indian Gods or by disrupting the Hindu cosmos by their military interventions.

Perhaps because there was no equivalent technique of inoculation for cholera (unlike smallpox) which would need Goddess' blessings, Cholera had no specific deity which was popular in the country. Only in Bengal, the place of Cholera origin, there was a Cholera deity called "Ola Bibi" by Muslims, and "Olai-Candi" by Hindus. Likewise, HurdouLal was pressed into service as a male cholera deity. Thus there was an effort either to manifest the deity as the power of existing deity like Maa Kali or as new deity known as 'jarimari' (sudden sickness) or "Kala mari" (black death). The Europeans took these as sickening examples of superstition and fatalism versus European rationality to treat disease. However, the colonial government was also worried that the association of deities with diseases might lead to panic among the people and can have political complexities. Hence apart from

medical treatment, the British also saw the need for a political response to the popular reactions that the epidemic cholera had aroused.



LET US KNOW

- Diseases like Cholera and smallpox were seen as being related to 'revenge of God' in human body by the natives
- Cholera had a deity only in some regions but 'sitala' is known as the deity of smallpox in most parts of India
- The deity associated with smallpox is- Sitala. She is an embodiment of 'shakti' and is known by names such as- 'mata', or 'Aai'.
- The circulation of chapattis from village to village to keep away cholera in North-India was a kind of solidarity among the natives. The British feared it may be some kind of mass mobilisation and hence kept close vigilante on the items circulated.

Ceremonies that were done to get rid of or keep away cholera were also seen as having political connotation by the British. For example, on the eve of Sepoy Mutiny in 1857 chapatis were circulated from village to village. The British were suspicious that this could have latent meanings of organising people against the British. However, it was virtually certain that Chappatis were passed on from one village to another in North-India for protection from Cholera deity. Guha argued that the chapattis might have served this purpose to avoid cholera. It was also an expression to show their solidarity of the collective anxiety they have against British rule. Likewise whenever there was cholera outbreak one could see new tokens were circulated as a symbol to keep away the cholera deity from the village. It was established that this transmission was merely for the purpose to avoid Cholera and had no political meaning attached. However, the administration

was asked to be vigilant over anything transmitted even though it seemed to be an innocent act devoid of political connotation.

Like Cholera, even smallpox was related to a deity called Sitala. Sitala is an embodiment of Shakti, female energy which has both productive as well as destructive powers. Therefore the destructive part was needed to be prevented so that it does not cause mortal harms. When the disease showed up, it is said that the Goddess has taken rest in a human body. Therefore even the smallpox inoculation practised in the nineteenth and twentieth century was performed within a context of religious rituals. Sitala is worshipped in almost all over India in different names. Particularly in Assam and Bengal, she is also known as Goddess of Basant which means Goddess of the Spring and the disease known as 'Basanta Rog' (disease of the spring). It is to be mentioned here that although Sitala is known to be the Goddess of smallpox, the natives believed that smallpox is more of a manifestation of her personality and presence rather than the essential character. Hence the disease is the 'sport'or 'play' which should be respected with rituals and offerings.

Therefore smallpox was not regarded as a disease by the Hindus, but as a divine form of the 'Mata' or 'Aai'. The burning fever and pustules marked in the body, therefore, demanded rituals more than therapy. Sitala, thus, means the 'cool one'. Therefore the common offerings made to the 'Aai' are the cooler substances like 'cold rice, curd, plantains and sweets'. It was advised to avoid hot cooked food; domestic fires were needed to be extinguished,and the affected one should debar from sex as it is considered to be a heating activity. The body is washed with cold water and soothed with wet neem leaves, the favourite tree of the Goddess. Therefore Sitala was both the source and also means to gain protection from it.

David Arnold argues that smallpox occupied a paradoxical place in the history of European medical ideas in India. It was

seen as a disease by the Europeans but not by the natives of India. Though the condition of smallpox was prevalent in both Europe and Asia, the cultural context associated with India made the case unique. The way Sitala was worshipped, despite being a threat to human lives, looked obscure and absurd to the western medical practitioners.



CHECK YOUR PROGRESS- (B)

Q 1 : What was the native's view of Cholera outbreak in Bundelkhand?

(a) Bathing in Kumbh- Mela

(b) Killing of cattle and offending Hurdolal

(c) Offending deity Sitala

Q 2 : What was the food item circulated to keep away Cholera in North-India?

(a) Chapati (b) Rice (c) Bajra

Q 3 : By what name Sitala is known in Assam?

(a) Mahamari (b) Basanta Rog (c) Kala- Ajar

Q 4 : Who investigated Punjab's Cholera epidemic in 1908?

(a) Sir Warren Hasting (b) Sir Dalhousie (c) Sir S.R Christopher

4.5 COLONIAL MEASURES FOR PREVENTION OF DISEASE

4.5.1 Measures for smallpox

The religious texts of Hinduism did not have a much-prescribed form to treat smallpox. One way to deal with protection from it was through the method of 'variolation' or 'inoculation'. This was the most common way to deal with Sitala before it was displaced by Jennerian vaccination in the second half of the 19th century. The accounts suggest that it was more of a religious

offering than a medical procedure. Variolation was widespread in Northern and Eastern India, but not very popular in Madras presidency. There is no one way to conduct variolation as it differed from region to region in India. The standard ways to do was by taking pustules from a patient or a recently variolated individual and then rub or inoculate the material made from smallpox pustules into artificially scratched skin of the infected body. The patient would then develop pustules from this artificial method which are less severe than the naturally occurred smallpox. In the latter part of the nineteenth century, the British tried to suppress this method.

Soon there was a substitute to variolation that was invented by Edward Jenner in 1790s. Jenner is now regarded as the father of immunology. He observed that it was possible to have immunity against smallpox if they were infected with cowpox. His experiment was successful, and vaccination grew in prominence in Europe as well as in India's British Empire. First vaccination was adopted in India in the city of Bombay in 1802. However until 1890, the use of vaccination failed largely. It was because the vaccinations were to be imported from Europe by ships. And till the time it reached the probable destinations its validity expired. Through the use of vaccination, the Europeans were getting less vulnerable to smallpox. However, it was very poorly performed in Bengal. Many people from the poorer class of British died who were mainly soldiers and sailors. The wealthier were well protected with vaccinations, diet, spacious houses and gardens and most importantly in having lesser contact with Indians.

But vaccination was never intended only for the Europeans although large sections covered by it were the Europeans. Vaccination was introduced at a critical history of colonialism in India. It showed that the regime although established by force of arms was benevolent to the subjects and vaccinations offered were a good opportunity to portray their 'good intentions' towards Indian people. The first law on vaccination for India came in 1804.

It was Lord Wellesley's government who formally banned variolation in Calcutta. But this law was not enforced with coercion, and hence fifty years later Lord Dalhousie declared that it was impossible to prohibit variolation in India given its wide practice. The latter officials were also reluctant to take any other coercive means fearing political tensions in the air. By an Act IV of 1865, the government of Bengal recommended to implement the Smallpox Commission of 1850 and practise of variolation in Calcutta would lead to imprisonment of three months or fine of Rs.200. This was followed by underground variolation. By the end of the 19th century, even western educated Indian scholars like Sir Sayid Ahmad Khan, a leading Muslim leader during the period, asked the government to implement laws for compulsory vaccination. He introduced a compulsory vaccination bill in the Viceroy's Council in September 1879. He spoke wisely about Western rationality and argued that natives of India might have had prejudices against vaccination. He said that vaccination is needed to protect the infants who are easy prey to smallpox.

4.5.2 Measures for Cholera

The long persistence of Cholera led the British government in 1864 to appoint 'provincial sanitary commissioners'. Even after 50 years of 1817 epidemic, the government was still in considerable ignorance about the scale of cholera mortality. There were reports on problematic sanitation and hygiene, but there were fewer solutions to the problem. It was only in the 1890s that the contamination of cholera was recognised, and the state began to take serious measures. In April 1892 the government of North-Eastern Provinces took a bold step to ban Haridwar Kumbh Mela when cholera broke out. Before the first world war, the patients were injected with saline to compensate for the water loss, the body undergoes during the disease. It helped in reducing the

mortality rate to some extent but at a mass scale, this measure was not possible in implication. In 1890s W.M Haffkine pioneered the anti-cholera vaccine. However, the British administration was reluctant to experiment it in India during 1894-95. They had reservations partly for its doubt in effectiveness and also feared the public reaction the inoculations might instigate. Even till the 1930s the government was not in favour of compulsory inoculation to be used on the pilgrims on Allahabad Kumbh Mela. The primary objection to it was political as they did not want to risk un-necessary public outrage against the colonial rule.

4.6 NATURE OF RESENTMENTS BY THE NATIVES

As mentioned at the beginning of the unit, western medical sciences did not find an easy penetration into the Indian society. The people were satisfied with the traditional healers like the Hakims, Vaidyas or Bej. Therefore they were not readily accepting British means of healing, like vaccination or hospitalisation for cholera patients.

British saw the primary reason in associating diseases with religion and variolation. The inoculators were also seen as the main obstacle to vaccination. Therefore in between the years of 1803 – 06, only 11,000 to 18,000 vaccines were used in the whole of Eastern and Northern India. In 1818-1829 in Bengal it was 30,000 a year and reached 62,000 in 1828-29 but reduced again to 15000 in 1832.

The British commissioners called for the prohibition of variolation as they must save the wilful destruction of the subjects above whom the Europeans have taken charge. There were other reasons for which the native population was reluctant to use vaccinations. Once the vaccines were established in India efforts were made to give arm to arm vaccinations. But vaccine was lost in human transition as parents were not allowing their children. Again when calf lymphs were introduced, it was very expensive to fund. And above all the Hindus rejected to it for their belief that it involves cruelty to animals. Animal vaccination was first

used in 1870 and 1880s, and the opposition was strong from Western India. However, in later years, the resistance softened because the people preferred calf vaccine instead of the painful arm to arm method. Greatest of all, the secular nature of vaccination was surpassing the caste taboos which were not acceptable to Hindu caste societies. Moreover, it needed no Pujas or ceremonies to offer to Sitala.

Likewise in case of Cholera the natives were not happy for blaming Hinduism as a reason for Cholera. When the British tried to clean the streams near river Godavari, the natives stood fiercely against it. Likewise, they were not willing to accept the government's action of banning Kumbmela during the epidemic season. The natives were also not comfortable in secular modes of hospitalisation and social isolation they received from hospitals. Rather, they wanted to be taken care of by their families. Moreover, hospitals were more exposed where caste taboos of purity and pollution were not followed. The British did not opt for compulsory measure for Cholera because they feared political outrage.



CHECK YOUR PROGRESS–C

Identify if the statement is true or false :

Q 1 : In between 1803 to 1806 only 11,000 to 18000 vaccinations were used against smallpox

(a) True (b) False

Q 2 : British regarded variolation as a better option than vaccination.

(a) True (b) False

Q 3 : Natives refused to calf lymph because it was made of human postules

(a) True (b) False

Q 4 : Animal vaccination was first used in 1870s and 1871

(a) True (b) False



4.7 LET US SUM UP

- Disease is not just a medical terminology, but is socially and culturally constructed.
- Both the British and the Indian natives had their ways of interpreting a disease. There was also sharp differentiation between the western medical system and indigenous knowledge system of medicine.
- The colonial government, although to a large extent was trying to bring reforms in modes of treatment, they were not merely interested in saving the natives from the disease.
- The way they wanted to enforce western medicine of allopath discarding indigenous forms of medicine was seen as a political game of imposing their superiority of knowledge.
- The reaction of Indians to Cholera and Smallpox can be comprehended as signifiers of the cultural divide between the colonisers and the colonised.
- British initially did not forcefully impose their methods such as vaccination on the Indians fearing political consequences. Even for Cholera no compulsory hospitalisation or banning of religious sites was encouraged although they always portrayed that their knowledge of medicine was superior.
- The Indians had their resentments towards the western imposition of medicine. It was not just resentment for medicine but a message that British ways should not be accepted. The aversion towards colonial medicine and their understanding of disease was therefore religious, cultural as well as political.
- However gradually the significance and need of some modern measures to treat diseases were accepted by the society at large.



4.8 FURTHER READING

Q 1: Arnold, D.; 1993; Colonizing body : State

medicine and epidemic diseases in Nineteenth century India; University of California Press.



4.9 ANSWERS TO CHECK YOUR PROGRESS

Ans to Q No A: 1) b
2) a

Ans to Q No B: 1) b 2) a
3) b 4) c

Ans to Q No C: 1) True 2) False
3) False 4) True



4.10 MODEL QUESTIONS

A) Short Questions (Answer each question in about 150 words)

Q 1: State the objectivist view towards diseases.

Q 2: State the significance of associating diseases with particular deities.

B) Long Questions (Answer each question within 300-500 words)

Q 1: Discuss the colonialist perception of diseases in India.

Q 2: Why did the natives of India resent the colonialist measures to treat or prevent diseases?

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UNIT 5 : CULTURE AND DISEASE

UNIT STRUCTURE

5.1 Learning Objectives

5.2 Introduction

5.3 Defining Culture

5.4 Understanding Disease: The Medical Perspective

5.5 Disease: A Cultural Understanding

5.6 Let Us Sum up

5.7 Further Reading

5.8 Answers to Check Your Progress

5.9 Model Questions

5.1 LEARNING OBJECTIVES

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

- Understand the meaning of the word 'culture'
- Understand 'disease' in medical and cultural terms
- Understand the relationship between culture and disease

5.2 INTRODUCTION

This unit introduces you to the concept of culture, the concept of disease and the relationship between the two. It will look into the scientific or medical understanding of the concept of disease as well as the cultural understanding of it. It will address the notion of disease as a cultural construct as much as it is a medical condition.

In the common-sense understanding, culture is referred to as 'a way of life'. The term culture encompasses a host of material as well as non-material things that human beings use in their everyday life. It is a broad and inclusive term that refers to anything that human beings do that does not have a biological basis and are not the products of biological inheritance. In this sense, culture can be understood as something human-made or learnt by human beings. Culture, therefore, includes any skill,

any particular piece or pattern of behaviour, belief or value or any attitude that a human being learns as a member of a human group. It also includes all and any tangible material objects that have been manufactured or are used by humans, that is a derivative of the said human abilities. Although in the common sense understanding of the term 'culture', it is often taken to refer to a particular level of refinement in behaviour, taste in food, music or art, etc. one needs to understand it in broader terms.

The word 'disease' is usually used to refer to any deviation from the normal state of health of any human, animal or plant. Any condition that makes an individual feel discomfort, owing to a disorder of structure or function, but is not merely a direct result of any kind of physical injury can be called a disease. A disease usually produces certain specific symptoms or affects a particular area of the body.

The concept of disease has got as deep roots in the cultural context of a community as it does in the medical or biological context. One needs to understand that the notion of a biological pathology as a disease is defined by cultural norms of health and wellness too. The standard of what is understood as normal or pathological in terms of health and illness depends on the values within a society and so, it is important to understand the relationship between culture and disease. In this unit we shall look into certain effects that culture might have on the understanding of and approach towards disease.



LET US KNOW

Culture :

That complex whole that includes knowledge, belief, art, moral, law, custom and any other capabilities and habits acquired by man as a member of society.

It also refers to all historically created designs for living, explicit and implicit, rational, irrational and non-rational, which may exist at any given time as potential guides for the behaviour of men.

5.3 DEFINING CULTURE

In common parlance usage, when one refers to a person as 'cultured', one means to point out their taste for refinement in aspects of everyday life such as food, clothing, music, art, etc. However, culture encompasses much more than that. In sociological terms, 'culture' refers to every aspect of human life that does not have a basis in biology, but is something that human beings learn as members of a human group. The culture of different human groups or communities differs from one another, but they may influence each other when they come into contact with one another. The term culture has been defined by Sir E.B. Tylor in his book "Primitive Culture" (1871) as 'that complex whole that includes knowledge, belief, art, moral, law, custom and any other capabilities and habits acquired by man as a member of society'. A.L. Kroeber and Clyde Kluckhohn in their book "Culture: A Critical Review of Concepts and Definitions" (1952) defined culture as 'all historically created designs for living, explicit and implicit, rational, irrational and non-rational, which may exist at any given time as potential guides for the behaviour of men'. The culture of a group is the cumulative deposit of different aspects of everyday life which are followed by the members of the group within a particular geographical area. Culture includes norms, values, mores, folkways, laws, cultural institutions, artifacts, food habits, attire, art, music and dance etc. of a community. The various aspects of culture are inherited by people from the preceding generations but culture is not a stagnant thing. It may change over time with the addition or omission of certain aspects that form this cumulative whole. Moreover, any change or alterations in one part or aspect of culture causes changes in other related parts or aspects and the reverberations thus created, can affect the system as a whole.

The study of different human cultures across the globe has been a part of the subject matter of the disciplines of Anthropology, Sociology and Psychology. The origin of the word 'culture' can be traced back to the Latin word cultura which means "cultivating or agriculture," and

figuratively “to care or to culture” from past participle stem of colere which means ”to tend or to guard; to till, cultivate”. The figurative sense of “cultivation through education, systematic improvement and refinement of the mind” came into use by c. 1500. The Century Dictionary writes that it was, “Not common before the nineteenth century, except with strong consciousness of the metaphor involved, though used in Latin by Cicero.” The use of the word to mean “learning and taste, the intellectual side of civilization” was by 1805; and the closely related sense of “collective customs and achievements of a people, a particular form of collective intellectual development” is by 1867. According to Kroeber and Kluckhohn, E.B. Tylor was the first scholar to have made the currently used meaning of the word ‘culture’ popular in academia through his definition of the word in his book “Primitive Culture” in 1871.

Different Aspects of Culture :

Any given culture has several important aspects. Some aspects of culture are highlighted below :

- Culture can be explicit or implicit. The explicit aspects of culture include those which the bearer of a culture is conscious about. The implicit aspects are those which the bearer knows on an unconscious level.
- The smallest meaningful unit of culture is called a trait. Ralph Linton stated that some traits are general to the entire population of the group (known as universal traits), while other traits are shared by only some members.
- The culture of a group may be learned directly by interacting with members of the group, or indirectly by reading about it or observing the group.
- Although culture is abstract and intangible, it has very deep influence on the people who follow it. They tend to internalize culture.

The process of cultural diffusion is an important aspect of culture. It refers to ‘the process through which the cultural traits invented or

discovered in one society are spread to another society over physical (geographical) space whether directly (through actual physical contact between people or groups) or indirectly (through other means of communication like television, radio, books and other printed materials, exchange of goods in commerce)'. The processes of adaptation and assimilation bring about cultural diffusion. However, in a rapidly transforming society there arises the issue of cultural lag. W.F. Ogburn stated that 'cultural lag exists when two or more variables which were once in some form of agreement become dissociated and maladjusted by their differential rate of change'. For instance, rapid advances in technology in contemporary societies across the world today may be far more fast paced than the changes in the customs, values and beliefs that exist in the society.

Another important term related to culture is ethnocentrism. It was coined by W.G. Sumner in 1906 and it refers to the prejudiced views and attitudes that one might carry about another culture or the members of a culture other than one's own. When one takes the values attached to a certain trait of one's own culture and uses it to judge that of another culture, one can be said to be indulging in ethnocentrism. 'Ethnocentrism judges the worth of other cultures in terms of the standards of one's own culture'. Ethnocentric attitudes create a divide between an ingroup and an outgroup and discourage change within the ingroup. However, within the ingroup it may also have a positive effect of promoting group solidarity and continuation of the status quo. Here, it is also necessary to understand the process of acculturation. It refers to the process 'when a whole way of life undergoes change under the influence of another culture'. This process is different from cultural diffusion in the sense that diffusion refers to the process of transformation of a few traits of a culture, but acculturation refers to a transformation of the entire culture under the influence of another, more dominant culture.



Activity 1

Think of some examples of ethnocentrism?

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5.4 UNDERSTANDING DISEASE : THE MEDICAL PERSPECTIVE

The Encyclopedia Britannica defines disease as 'any harmful deviation from the normal structural or functional state of an organism, generally associated with certain signs and symptoms and differing in nature from physical injury'. A human being/ animal or plant affected by a disease exhibits signs or symptoms indicative of its state. Thus, the normal condition of an organism must be understood in order to recognize the symptoms of disease. The study of diseases is called Pathology . It involves the determination of the cause of the disease, the understanding of the mechanisms of its development, the structural changes associated with the disease process (morphological changes), and the functional consequences of those changes. In order to identify the course of action or treatment for a disease, it is important to first identify the cause of the disease.

In medical terms, disease refers to a definite pathological process which has a characteristic set of symptoms and signs. A disease is caused due to extrinsic influences like pathogens such as virus, bacteria, etc.

The concept of disease or illness is commonly understood as the opposite of the concept of health. Diseases can be broadly classified into two categories: (a) noncommunicable diseases and (b) communicable diseases.

LET US KNOW



Disease : *It is an impairment of normal physiological function affecting all or part of an organism, especially a specific pathological change caused by infection, stress, etc. producing characteristic symptoms, illness or sickness in general.*

It may be any harmful deviation from the normal structural or functional state of an organism, generally associated with certain signs and symptoms and differing in nature from physical injury.

Noncommunicable diseases

A disease may originate within the individual or might be caused due to a reaction to some medication, or as a side effect of a course of medication. It may also be caused by some external agent, such as a chemical that is a toxic agent. In such a case the disease affects only the individual organism exposed to it. Noncommunicable diseases generally are long-lasting and they progress slowly, and thus they are sometimes also referred to as chronic diseases. They can arise from environmental exposures or from genetically determined abnormalities, which may be evident at birth or which may become apparent later in life. The World Health Organization (WHO) has identified four major types of noncommunicable disease. They are: cardiovascular diseases like heart attack, stroke, etc.; chronic respiratory diseases like asthma; diabetes mellitus; and cancer.

Certain noncommunicable diseases arise out of inherited genetic abnormalities which can leave the individual in need of some form of treatment in order to survive. Some diseases that can be hereditary include down syndrome, cystic fibrosis, Huntington disease, certain forms of cancer like breast cancer, etc. Other noncommunicable diseases may be a result of metabolic faults within the body, such as those associated with aging (e.g.: osteoporosis), or due to environmental hazards such as those that arise out of a deficiency or excess of a certain mineral (e.g.: goitre, mottled enamel of teeth in humans) in one's diet or one's immediate

surroundings due to environmental causes or geographical location. Some noncommunicable diseases can also be caused by toxins in one's living or work environment, such as respiratory diseases, toxic metal poisoning or radiation poisoning etc.

Communicable diseases

Communicable diseases are also often called contagious diseases. The external agent that causes such a disease may itself be a living organism which has the capability of multiplying within the host, thereby infecting other organisms. These diseases are carried from one organism to another and are also known as infectious diseases. These diseases can spread from one host to another through direct physical contact, clothing or items of daily use if they are used by the infected person and are not disinfected before another person uses it. They can also spread through air, or water from the infected people to others. Some of the most common and harmful types of infectious diseases are lower respiratory infections, diarrhoea etc. Since the latter part of the 20th century, however, death rates from infectious disease have declined to a large extent, because of increases in vaccination and other methods of disease prevention.

Prevention of diseases

The extent of the affect that a communicable disease may have on the affected person depends on a number of factors like, the relationship shared between the host and the parasite, the particular type of parasite, the resistance capacity or immunity of the host, amongst other factors. Infectious or communicable diseases may be prevented in one of two following ways:

- by preventing contact with the infected being
- by making the host unsusceptible, either by selective breeding or by providing an effective artificial immunity.

Most diseases except the idiopathic diseases (such as the ones which occur due to inherited metabolic defects) are preventable to a certain extent. Other noncommunicable diseases such as those resulting from factors related to environmental exposures, can be prevented by

reducing or diminishing the factors responsible in the environment.



CHECK YOUR PROGRESS-(A)

Q 1. Disease refers to a definite pathological process which has a characteristic set of symptoms and signs. True/ False

.....

Q 2. Except the idiopathic diseases, most other diseases are preventable. True/ False

.....

5.5 DISEASE: A CULTURAL UNDERSTANDING

Apart from the medical explanations, diseases can also be understood from a cultural perspective. Every society has its own understanding of disease and illness and have certain culturally approved methods of prevention or cure. Traditional healing practices or methods and alternative medicine, such as Ayurveda, acupuncture, aromatherapy, homeopathy, clinical hypnotherapy, massage, etc., are practiced in almost every society. These culturally accepted methods of disease control, prevention or cure may not always be scientifically or medically viable, but may act as psychological suppressors for certain ailments. In many cases, however, these traditional methods may lead to deterioration of health of the affected individual and sometimes death.

There exist a number of social and cultural constructs about disease and illness and these ideas about disease often affect our perception and our reaction to diseases. For example, in most parts of India, there used to be certain taboos associated with certain diseases, especially those that lead to physical impairment such as polio or leprosy. It was often believed that one suffers from a disease because of one's karma in the last birth, or because of some misdeeds by one's parents. There are also certain misconceptions related to some diseases which

place the onus of the disease on the person suffering from it, rather than looking at the medical or environmental factors that cause the illness. Some diseases (for instance, diarrhoea among infants) are labeled as 'the poor man's disease', and are believed to affect only those who are poor. Therefore, it gets attached to a particular cultural perception and carry a kind of stigma attached to it. But the fact which is overlooked in such a case is that the child suffering from such an illness does not have access to hygienic food, clean drinking water or proper sanitation, which are issues that need to be addressed. The poor economic and social conditions act as catalysts for the spread of the disease, but associating a certain disease with a particular community or group is a problem.

Social stigma is one of the cultural aspects of certain diseases. Stigma attached to a disease or disorder is most apparent in the case of sexually transmitted diseases (STDs), especially AIDS, all over the world. Talking about sex in public is a taboo in most cultures, and so diseases like AIDS are not talked about. People often do not understand the preventive measures because these measures are not discussed openly owing to the stigma attached to the topic of sex and sexual intercourse. Even in countries like the USA where talking about sex is not much of a taboo, there is a kind of stigma attached to AIDS because of the cultural belief in the association of the disease with homosexuality or having multiple sexual partners.

Social stigma is also one of the reasons that mental health disorders are not taken seriously or discussed openly in our society. In India, as Renu Addlakha has stated in her work, women, more often than men, fall prey to such an attitude towards mental health. There is a notion of shame and guilt attached to psychological disorders as the person suffering from it may not be able to hold a job, or participate in everyday activities the way a "normal" person would be able to. This labeling of a person as "abnormal" attaches a biased umbrella view about all kinds of mental health issues, and to stay away from such stigma, instead of seeking medical help people often overlook or try to hide any problems that they or their family members may be suffering

from. Stigma is also associated with the visible marks that might be left on a person's body after recovering from a disease, such as pock marks after recovering from chicken pox, especially for women who may not fit into the cultural notion of beauty any more if they have such marks on their body or face.

Another cultural approach towards disease which is often seen across cultures is the lack of empathy on the part of society towards the one who is suffering. This is not true for every member of the society, as there are a number of people who volunteer to help the sick and engage in charitable activities as well. Many cultures have a tradition of being empathic and helpful towards their fellow human beings. But we often come across individuals who express pity instead of empathy towards a disease or disorder. This might be a result of the lack of awareness about a certain medical condition, but it is more often a culturally formed attitude of apathy towards illness or the rehabilitation of survivors. For instance, in India many individuals who become physically impaired due to a bout of polio in their childhood or if they had suffered from Hansen's disease (leprosy) were seen begging on the streets and in other public places. The apathy of the society as a whole, as well as the government in rehabilitating those who have suffered such a condition is quite apparent. The lack of awareness about a certain disease combined with a lackadaisical attitude towards bio-medicine can also result in stopping medical care or intake of the prescribed medicines without completing the course, which doesn't cure the disease completely and run the risk of its recurrence.

Culture specific superstitions related to diseases also add to the problem of delaying diagnosis and cure of a disease. People often tend to prefer shamans, witch doctors, traditional or religious healers, or those who dabble in pseudoscience like quacks, over legitimate practitioners of bio-medicine. The lack of awareness about diseases, financial constraints, lack of proper medical care facilities, or the existing superstitions and beliefs about a certain kind of illness may contribute to such choices.

However, it is not always culture that affects our understanding of

and experience with diseases. Diseases can and often do, affect the existing cultural rules. For instance, the way one feels grief due to the suffering or death of a loved one owing to a disease may affect one's behaviour or actions and steer them away from the culturally acceptable behaviour. Moreover, caring for a loved one suffering from an ailment may result in the reversal of traditional roles within the family. Therefore, there is a nuanced relationship between culture and disease and it is important to understand the culture specific nature of diseases as well.



Activity 3

How does social stigma affect the understanding of diseases? Think.

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CHECK YOUR PROGRESS-(B)

Q 1. Name a few methods of traditional healing.

a) b)

c) d)

e) f)

Q 2. Some cultural understandings of diseases include

a). Disease as taboo b). Disease as stigma

c). Superstitions about the cause of disease

d). All of the above

Q 3. Caring for an ailing loved one can result in traditional role reversal. True/ False

.....



5.6 LET US SUM UP

- In the common-sense understanding, culture is referred to as 'a way of life'.
- In sociological terms, 'culture' refers to every aspect of human life that does not have a basis in biology, but is something that human beings learn as members of a human group.
- The process of cultural diffusion is an important aspect of culture. It refers to 'the process through which the cultural traits invented or discovered in one society are spread to another society over physical (geographical) space whether directly (through actual physical contact between people or groups) or indirectly (through other means of communication like television, radio, books and other printed materials, exchange of goods in commerce)'.
- Another important term related to culture is ethnocentrism. It was coined by W.G. Sumner in 1906 and it refers to the prejudiced views and attitudes that one might carry about another culture or the members of a culture other than one's own.
- Acculturation refers to the process 'when a whole way of life undergoes change under the influence of another culture'.
- The word 'disease' is usually used to refer to any deviation from the normal state of health of any human, animal or plant.
- Diseases can be broadly classified into two categories: (a) noncommunicable diseases and (b) communicable diseases.
- Apart from the medical explanations, diseases can also be understood from a cultural perspective. Every society has its own understanding of disease and illness and have certain culturally approved methods of prevention or cure.
- There exist a number of social and cultural constructs about disease and illness and these ideas about disease often affect our perception and our reaction to diseases.
- Social stigma is one of the cultural aspects of certain diseases.

Stigma attached to a disease or disorder is most apparent in the case of sexually transmitted diseases (STDs), especially AIDS, all over the world.

- Social stigma is also one of the reasons that mental health disorders are not taken seriously or discussed openly in our society.
- Another cultural approach towards disease which is often seen across cultures is the lack of empathy on the part of society towards the one who is suffering.
- Culture specific superstitions related to diseases also add to the problem of delaying diagnosis and cure of a disease.
- Diseases can and often do, affect the existing cultural rules. For instance, the way one feels grief due to the suffering or death of a loved one owing to a disease may affect one's behaviour or actions and steer them away from the culturally acceptable behaviour.



5.7 FURTHER READING

1) Affliction: Health, Disease, Poverty. Veena Das, New York: Fordham University Press, 2015, 255 pp.

2) Bisht, S. A Lester Coutinho, 2000; When Cure Is Better Than Prevention: Immunity and Preventive Care of Measles; *Economic and Political Weekly*, pp. 697-708

3) Sax, W.S. 2009; God of Justice : Ritual Healing and Social Justice in the Central Himalayas. New York: OUP



5.8 ANSWERS TO CHECK YOUR PROGRESS

Ans to Q No A :

1) True

2) True

Ans to Q No B :

1) a) Ayurveda (b) Acupuncture
   (c) Aromatherapy (d) Homeopathy
   (e) Clinical hypnotherapy (f) Massage
2) d) All of the above
3) c) True



5.9 MODEL QUESTIONS

A) Short Questions (Answer each question in about 150 words)

Q 1: Define culture.

Q 2: State the meaning of disease in medical or scientific terms.

B) Long Questions (Answer each question within 300-500 words)

Q 1: Explain the relationship between disease and culture with examples.

Q 2: Differentiate between communicable and non-communicable diseases.

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UNIT 6 : MEDICAL PLURALISM

UNIT STRUCTURE

6.1 Learning Objectives

6.2 Introduction

6.3 Meaning of medical pluralism

6.4 Issues of medical pluralism

6.5 Trends and Practices of medical pluralism

6.6 Let Us Sum up

6.7 Further Reading

6.8 Answers to Check your Progress

6.9 Model Questions

6.1 LEARNING OBJECTIVES

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

- understand the meaning of medical pluralism
- know the issues related to medical pluralism
- know about the trends and practices of medical pluralism.

6.2 INTRODUCTION

In this new century, the impacts of globalisation on health services and for formation of health policies brought the focus of researchers towards health sector. The new focus of the researcher is because of the growing globalisation and its exerting complex impact on public health, health related policy formulation and implementation. The question arose about the role of globalisation on health and it was thought that globalisation itself was a contributing factor for the worsening of global public health and the failure of global health initiatives. The impact of globalisation on health was extensive in the developing countries where there was slow, unstable and unequal pattern of growth, and stagnation in health indicators. The worsening condition of the global public health was a situation that led to the framing of global health agenda by World

Health Organisation to achieve health for all. The health for all was a landmark initiative that was taken in consideration with the inadequate biomedical heath care system and was influenced by the optimistic movement for a more holistic approach to development of that time. A new approach using local resources and knowledge was advocated. WHO endorsed the policies and integration (formalisation) of traditional medicine (TRM) into health care systems. They were required in order to achieve optimal health care coverage. However, implementation of this objective on national levels was hindered by a variety of factors, some of which were associated with globalisation. Despite consensus at the international level in the 1970s that such an approach was rational, practical, and offered social and economic benefits, it proved difficult to realise over the following decades. The policy of formalising traditional medicine in health care system was not taken seriously in the initial period but it became a trend in the developed countries in the later period. With time people started seeking alternative approaches to the biomedical system.

Biomedical system began to enter in a new era of development and progress. Traditional medicine became a subject of clinical and commercial interest. Although traditional medicine became intense but the lack of progress in policy formulation and implementation left it vulnerable to economic exploitation. In 2002, the WHO announced a global TRM Strategy. The TRM Strategy called for all member states to integrate and formalise the role of TRM/CAM in health care systems. Since the WHO originally promoted the role of TRM, only 25 out of the 191 member states had developed an associated policy. Over the period of time, it was seen that demographic changes, growing medical pluralism and changing economic and social trends lead to the creation of a policy convergence. The applicability of TRM/CAM in health care had broadened and forced a range of policy issues onto the global agenda. Traditional medicine strategy of WHO was seen as an example of one of the trends in a globalising world. There has been an increasing emphasis on global models, where policies from one part of the world are transplanted elsewhere. Therefore, the global-local interface in terms of policy transfer

was created and the role of international organisations in that process was worthy.

6.3 MEANING OF MEDICAL PLURALISM

Medical Pluralism can be defined as the employment of more than one medical system or the use of both conventional and complementary and alternative medicine (CAM) for health and illness. Since 1990 complementary and alternate medicine (CAM) was included within the state health administrations of the various countries and medical pluralism had become state sponsored. Medical Pluralism has become a modern phenomenon and is no longer confined to the deprived societies.Traditional medicine as defined by WHO as the “diverse health practices, approaches, knowledge and beliefs incorporating plant, animal and/or mineral based medicines, spiritual therapies, manual techniques and exercises, applied singly or in combination to maintain well-being, as well as to treat, diagnose or prevent illness”. Traditional medicine in India has codified systems (Ayurveda, Unani, Siddha, Sowa-Rigpa and Homeopathy) as well as non-codified systems (Folk Medicine). In codified system of traditional medicine, “knowledge has been codified, either in the form of pharmacopoeias or ancient scriptures”. In non-codified system of traditional medicine, “knowledge is transmitted by oral means and is mostly acquired through trial and error approaches”. Non-codified system of medicine was developed according to local needs and resources available to local people. Therefore, the system differs from region to region and is given different names like folklore medicine, little traditions, indigenous medicine, ethnomedicine, bush medicine etc. To preserve the non-codified ancient knowledge, there is a need for proper documentation. The term, indigenous systems of medicine, is used to emphasize the civilizational origin of a particular system of medicine. For example, biomedicine, homeopathy and naturopathy have their origins in Europe and so are indigenous systems of Europe. The Ayurveda, Siddha and Unani systems of medicine have their civilizational origins in India.

Historically the concept of medical pluralism is against the official definition of medical profession. Officially medical profession is defined as monopoly' with 'exclusive competence' over the exercise of its work, and its aim towards establishing itself as prime source for the criteria of medical qualification that should generate a 'general public belief in its competence' and expert authority. Medical professionals aimed at the monopoly but social scientists pointed towards the pluralism of the profession. Charles Leslie is said to have coined the term while talking about Indian medical system. Medical pluralism as a concept is regarded as cosmopolitan, western, modern, and scientific. Medical pluralism has emphasized on how social change had an effect on local medical care. They took into consideration the internal logic and coherence of other medical practice and also speak of 'medical theories', and highlight the related concepts of practitioner and patient and emphasized on their cultural embeddedness. Some also highlight, what they call syncretic ideas and practices, others call it fluidity between medical fields with overlapping jurisdiction. Some also highlighted similarities in treatment from different medicine-style professionals and it showed that practitioners advertising themselves as either 'Ayurvedic' or 'Western medical' prescribed much the same treatments. While studies on 'medical pluralism' had initially praised the systemic aspects of other medicines, with the post-modern turn authors working on the theme pointed out partial knowledges.

6.4 ISSUES OF MEDICAL PLURALISM

Medical pluralism is an advance perspective to deal with health care.The medical systems have a bird's eye view about the medical professionals and their medical learning. However, medical pluralism is all about understanding from the perspective of the health care consumer. In medical pluralism patients experience through the perceived choice of commodities on sale, such as drugs, and their colours, taste, and packaging, or stethoscopes or scissors, and choose from which are

considered relevant. Amidst of all the possibilities and relevance of medical pluralism, there are lots of issues related to medical pluralism that are being criticised. There are critique evident about the 'medical pluralism' from the perspective of a medical doctor working at a local hospital. There is criticism about the explanations about the medical pluralism in social sciences.From the patients' perspective, treatment choices were explained in terms of social pragmatism and social efficacy. Contrary to the cultural assumption intrinsic to some writing on medical pluralism, it became apparent that many healers and herbalists were marginal figures who often did not speak the language of their client, and derived their medical powers precisely from being associated with the other, the exotic or the wild. Healers thus emerged as brokers who straddle boundaries.

One of the core themes of medical pluralism is the 'health seeking behaviour' of the patient and his/her 'therapy managing group', which emphasises on the importance of the perceived severity of the condition, the way in which it was classified and the range of treatment choices on offer to the patients. Research into it often centred on the individual and often operationalised accounts of decision-making processes, frequently within cognitivist frameworks. Early studies had identified 'hierarchies of resort', which outlined the nowadays somewhat obsolete 'acculturative' (and 'counter-acculturative') sequences, from medical doctor to priest to local exorcist (and the not exactly 'symmetrically reverse') , but which remained important for pointing out that choices depended not merely on a treatment's perceived speed of recovery but also on its 'socio-moral functions'.

Another issue related to health pluralism is that most health care takes place within what is called the 'popular sector' through the application of home remedies. Health system can be differentiated between three sectors: the 'popular', 'folk medical' and 'professional medical sector'. There are explanatory models' which are used for explaining the choices of health care and it was initially developed in an attempt to assess and improve the doctor-patient relationship which became a well-known problem from medical sociology perspective. Research on 'health seeking

behavoiur' and 'explanatory models' focused too much on the individual and the micro-social and left aside the exploration of sociological issues, as, for instance, what Pierre Bourdieu in his book 'Distinction' called taste and habitus, which highlighted that patterns of consumption are guided by aesthetics particular to social groupings. The local healers have a relatively strong position in the local medical field due to their social and cultural capital, while the government health centre, which was by comparison higher in economic capital, and to a certain extent also symbolic capital, did not dominate the health field.Within the contexts of discussing health seeking behaviour, as well as in some contexts of applied medical anthropology, the notions of 'medical pluralism' and 'medical systems' tended to be used in historically, sociologically and politically less sensitive ways, and intrinsic differentials in power and authority within the medical field and society at large tended to be overlooked. Many studies also highlighted how medical pluralism is also related to race and ethnicity and the class structure and it also shows that 'medical pluralism' focused on health care without embedding it in problems concerning society at large. The concept of medical pluralism is also heavily criticised claiming that it had led medical anthropologists into a theoretical impasse. He framed his ethnography around the notion of 'healing powers', which embraced ideas about clinical effectiveness, moral authority, political coercion and collective identity.

Marxist scholars have their own way of looking into the issue of medical pluralism. The term pluralism as a concept or system which recognizes more than one ultimate principle' and gives as an opposite of 'monism', no doubt was appealing to anthropologists who in the 1970s and early 80s were caught up in debates of relativism and rationality. The first generation of medical anthropologists instantly embraced it, although Marxist authors had dismissed it, saying that it created a false consciousness within late capitalist society. Herbert Marcuse has stated that 'at the most advanced stage of capitalism, this society is a system of subdued pluralism, in which the competing institutions concur in solidifying the power of the whole over the individual' , and claimed that

'the contemporary form of pluralism would strengthen the potential for the containment of qualitative change'. The term 'medical pluralism' was a 're-emergence' of 'alternative', 'unconventional' or what others have called 'heterodox' medicines in Britain, and the 'West' at large. This movement of the late twentieth-century, as they stressed, was neither trivial nor marginal, nor one that was likely to be short-lived. Based on a study of the interplay of 'the state', 'the medical profession' and patients as 'consumers', they suggested the diversity the 'new medical pluralism' referred to was far more structured than that observed in the 'rest' of the world. They claimed an 'ideal type pluralism' involved players on a level playing field and promised 'equity' and 'choice', which, as is obvious from the above, never was an assumption among the anthropologists who first used the term.

6.5 TRENDS AND PRACTICES OF MEDICAL PLURALISM

Biomedicine got well accepted in Europe and America during 19th century. But in India, the cultural ideologies supported indigenous system of medicine and it was not possible to ban these systems of medicine or even regulate them. Some of the early experiments related to medical pluralism was done in India. There were attempts at National Medical Institution in Calcutta. Later on, the institution was replaced by a modern medical college. The Vaids and Hakims were given training during 1860-70s and traditional midwives (dais) were also trained in 1900s. After independence there was different perspective on indigenous medicine and many debates opened regarding this topic. Even though there were debates but there was a positive perception about the indigenous systems among policy makers.The various merits of indigenous system recognized by policy makers were; a) the people of country had faith and belief in these systems, b) the country had rich biodiversity to provide for traditional medicines, c) the emphasis of indigenous system of medicine was on ensuring prevention of diseases and adopting healthy lifestyles.

As a result of recommendations made by many committees, there

emerged a “compromise” between Allopathy and the indigenous system of medicine. The prime focus was given to modern medicine in a hierarchical order, at the same time making the pluralism “official”. The indigenous system was marginalised in terms of budget allocation also. In 1978 Primary Health Care approach was adopted with its principles being community participation, appropriate technology, comprehensive healthcare, and universal accessibility. It recognised traditional medical practitioners as important allies and recommended their training and engagement in primary health care. It was a paradigm shift in the Indian medical system. In National Health Policy of 1983 indigenous system was defined as, “our rich, centuries old heritage of medical and health sciences”.The policy recommended the integration of indigenous systems and their services to the overall healthcare delivery system at various levels.The department of ISM&H (Indian Systems of Medicine and Homeopathy) was created in March 1995. The department was renamed as AYUSH (Ayurveda, Yoga, Unani, Siddha and Homeopathy) in November 2003. The Central Council of Indian Medicine was set up under Indian Medicine Central Council Act 1970.In 2005, National Rural Health Mission (NRHM) was launched, “to provide accessible, affordable and quality healthcare to the rural population, especially to vulnerable groups”.The strategy of NRHM was to “mainstream” AYUSH in the health service system and to “revitalise” it. Under NRHM, one AYUSH doctor was to be posted at primary health centre (PHC) and two at community health centre (CHC). The separate department of AYUSH was created. At the level of CHC, separate room was allocated to AYUSH doctors with separate paramedical personal and AYUSH medicines. This is a new trend in Indian medical system, which is giving scope to the old age medical practices of our country a new hope and strategy.



CHECK YOUR PROGRESS

Q.1. What is meant by medical pluralism?

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Q.2. Explain about trends in medical pluralism.

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Q.3. What are issues related to medical pluralism?

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6.6 LET US SUM UP

- The impact of globalisation on health was extensive in the developing countries where there was slow, unstable and unequal pattern of growth, and stagnation in health indicators.
- The worsening condition of the global public health was a situation that led to the framing of global health agenda by World Health Organisation to achieve health for all. The health for all was a landmark initiative that was taken in consideration with the inadequate biomedical heath care system and was influenced by the optimistic movement for a more holistic approach to development of that time.
- Biomedical system began to enter in a new era of development and progress. Traditional medicine became a subject of clinical and commercial interest.
- Medical Pluralism can be defined as the employment of more than one medical system or the use of both conventional and

complementary and alternative medicine (CAM) for health and illness.

- Traditional medicine is defined by WHO as the "diverse health practices, approaches, knowledge and beliefs incorporating plant, animal and/or mineral based medicines, spiritual therapies, manual techniques and exercises, applied singly or in combination to maintain well-being, as well as to treat, diagnose or prevent illness".
- Traditional medicine in India has codified systems (Ayurveda, Unani, Siddha, Sowa-Rigpa and Homeopathy) as well as non-codified systems (Folk Medicine).
- Historically the concept of medical pluralism is against the official definition of medical profession. Officially medical profession is defined as monopoly' with 'exclusive competence' over the exercise of its work, and its aim towards establishing itself as prime source for the criteria of medical qualification that should generate a 'general public belief in its competence' and expert authority.
- While studies on 'medical pluralism' had initially praised the systemic aspects of other medicines, with the post-modern turn authors working on the theme pointed out partial knowledges
- One of the core themes of medical pluralism is the 'health seeking behaviour' of the patient and his/her 'therapy managing group', which emphasises on the importance of the perceived severity of the condition, the way in which it was classified and the range of treatment choices on offer to the patients.
- The concept of medical pluralism is also heavily criticised claiming that it had led medical anthropologists into a theoretical impasse.
- Marxist scholars have their own way of looking into the issue of medical pluralism. The term pluralism as a concept or system recognizes more than one ultimate principle' and gives as an opposite of 'monism'. No doubt was appealing to anthropologists who in the 1970s and early 80s were caught up in debates of relativism and rationality.
- Biomedicine got well accepted in Europe and America during 19th century. But in India, the cultural ideologies supported indigenous

system of medicine and it was not possible to ban these systems of medicine or even regulate them.

- In 1978 Primary Health Care approach was adopted with its principles being community participation, appropriate technology, comprehensive healthcare, and universal accessibility.
- In National Health Policy of 1983 indigenous system was defined as, “our rich, centuries old heritage of medical and health sciences”.
- The department of ISM&H (Indian Systems of Medicine and Homeopathy) was created in March 1995. The department was renamed as AYUSH (Ayurveda, Yoga, Unani, Siddha and Homeopathy) in November 2003.



6.7 FURTHER READING

1) Hörbst, Viola& Rene Gerrets, Pino Schirripa(2017). ‘Revisiting medical pluralism,’ L’Uomo: pp. 7-26.



6.8 ANSWERS TO CHECK YOUR PROGRESS

Ans to Q No 1 : Medical Pluralism can be defined as the employment of more than one medical system or the use of both conventional and complementary and alternative medicine (CAM) for health and illness.

Ans to Q No 2 : Biomedicine got well accepted in Europe and America during 19th century. But in India, the cultural ideologies supported indigenous system of medicine and it was not possible to ban these systems of medicine or even regulate them.In 1978 Primary Health Care approach was adopted with its principles being community participation, appropriate technology, comprehensive

healthcare, and universal accessibility.In National Health Policy of 1983 indigenous system was defined as, “our rich, centuries old heritage of medical and health sciences”.The department of ISM&H (Indian Systems of Medicine and Homeopathy) was created in March 1995. The :department was renamed as AYUSH (Ayurveda, Yoga, Unani, Siddha and Homeopathy) in November 2003.

Ans to Q No 3 : While studies on ‘medical pluralism’ had initially praised the systemic aspects of other medicines, with the post-modern turn authors working on the theme pointed out partial knowledges. Medical pluralism is an advance perspective to deal with the health care. The medical systems have a bird’s eye view about the medical professionals and their medical learning.Another issue related to health pluralism is that that most health care takes place within what he called the ‘popular sector’ through the application of home remedies. Health system can be differentiated among three sectors: the ‘popular’, ‘folk medical’ and ‘professional medical sector’.



6.9 MODEL QUESTIONS

A) Short Questions (Answer each question in about 150 words)

Q 1: When was AYUSH formed?

Q 2: Why was NRHM formed?

B) Long Questions (Answer each question within 300-500 words)

Q 1: Explain Marxist approach to medical pluralism.

Q 2: What is the trend in medical pluralism in India?

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UNIT 7 : GENDER AND HEALTH

UNIT STRUCTURE

7.1 Learning objectives

7.2 Introduction

7.3 Meaning of gender

7.4 Gender and health

7.5 Nutrition and gender

7.6 Differential health practices and gender

7.7 Let us sum up

7.8 Further Reading

7.9 Answers to check your progress

7.10 Model Questions

7.1 LEARNING OBJECTIVES

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

- Differentiate between sex and gender
- Understand the relationship between gender and nutrition
- Understand the differential practices of healthcare and its relation to gender
- Know the impact of gender on healthcare

7.2 INTRODUCTION

In the previous units, we have known about the significance of the socio-cultural dimension to understand health and disease. That health and disease are not merely biological phenomena has been established by the sociological approach to study health and medicine. In this unit, we shall know about the gender dimension to the ideas of health and nutrition. Here, you will be able to obtain a sociological understanding of the concepts of health, nutrition and gender, and the significance of the interrelationship among them.

7.3 MEANING OF GENDER

It is essential to distinguish between sex and gender when we are looking at the gendered idea of health. Sex and gender are different from each other. Sex is biological and physiological whereas gender is social and cultural. While male and female are sex categories, masculine and feminine are categories of gender. Health policy and health research should keep in mind the differences between sex and gender to properly develop ways to prevent and treat various kinds of diseases. Some might argue that health inequalities between men and women are natural because of the biological differences between the two.But this is a misunderstanding and needs to be corrected. Social and cultural factors influence biological aspects. For instance, globally, men are more prone to road accidents than women as more men drive and are more susceptible to driving while being drunk. Thus, death is linked to not just exposure to driving, but also riskier forms of doing it.



LET US KNOW

Gender and sex are different but related to each other.

The right to health is recognized by the Universal Declaration of Huamn Rights (United Nations, 1948).

Therefore, intersectoral action to address gender inequality is crucial to the recognition of the Millennium Development Goals (MDGs) of the United Nations.Promoting gender equity and empowerment of women is the third goal of the MDGs. The right to health is recognized by the Universal Declaration of Human Rights (United Nations, 1948) and is also a vital portion of the World Health Organizations' (WHO) main principles. The WHO created a women's health unit, which in 2000 evolved into the Department of Gender, Women and Health (GWH).

What is gender?

It is a common misconception that gender is equated to women and women's issues. But gender is much more than that – it is a socially

constructed term that refers to roles, behaviours, activities, and characteristics that are generally associated with men and women as considered appropriate by a particular society.

In the past, gender has been looked in two aspects – the masculine and the feminine. The masculine is generally associated with men while the feminine is associated with women. But in the present, the term gender is used more inclusively as it also includes the third gender, who are categorized as neither men nor women by society.They are more commonly known as the intersex people.

Gender may or may not be physiologically or biologically encompassing at all times, but generally, it is. It is also cultural and differs from society to society. For instance, healthier women in some parts of Africa are considered physically desirable, whereas, in most parts of the West, thinner women are considered physically attractive. Therefore, the notion of gender differs from society to society. Gender relations are the norms, values, attributes, attitudes, and expectations that guide how men and women should behave in any society.



LET US KNOW

Gender is the social role, norms, practices, behaviour,activities and expectations associated with one's sex category. It is culturally determined.

Historically speaking, men have been considered superior to women in almost all societies, and as such, the masculine has been seen as more powerful compared to the feminine. Men's work is considered more valuable than the work that women do. The third gender has been further marginalized.

Women have less land, wealth and property in almost all societies but more burden of work. Girls, in some contexts, are fed less, educated less, and more physically restricted. Women are mostly employed in lower paid jobs. Gender hierarchy governs how human behaviour operates. Even in places where extreme gender inequality does not exist, women

have less access to political power and participation, and economic and social opportunities.

Speaking about the relationship between gender and health, one's gender impacts their health conditions.One's health relations reflect the differences that exist between the genders. Having briefly outlined the meaning and kinds of gender, and the gender inequality that exists in society, we will now move on to describe how gender and health are connected.



CHECK YOUR PROGRESS – (A)

Q.1. What is the main difference between gender and sex?

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Q.2. Are gender categories rigid or fluid?

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The primary objective of this unit will be to show how the differential and unequal gender relations in society adversely impact women's and men's health. Gender plays a specific role in both the prevalence and treatment of diseases. This is because of interconnections that exist between biological and social factors. The gender perspective in health is a way of analysing and interpreting health situations from a perspective that takes into account gender constructs in society and searching for solutions to overcome gender-based inequities in health.

7.4 GENDER AND HEALTH

As already stated in the previous section, differences in the status of gender impact one's health. In societies in which higher gender inequality exists, there can be a disparity regarding access and

understanding of knowledge about disease management, prevention, and control for men and women. Men and women experience different kinds of illnesses subjectively,and attitudes towards treating diseases also differ for them.

Since men are seen as more important in most societies, their health is considered more important than women's. Therefore, within families in unequal societies, men seek more healthcare than women. Improvement in the status of women will enhance their healthcare facilities and reach. Many health conditions affect both men and women in varying degrees and ways.

Although women live longer compared to men in most countries, they have more age-related disabilities. With an aging population, the risk of chronic diseases such as diabetes and mental health problems - dementia, Alzheimer's disease, and depression - is amplified, among women.Moreover, some diseases such as breast cancer, osteoporosis,and eating disorders are more common in women, while others, such as endometriosis and cervical cancer, affect women exclusively. Men are more likely to die from lung and colorectal cancers, heart diseases and traffic accidents. Some diseases, such as prostate cancer, affect men solely (EIGE 2016: 3).

Mental health is also related to biology and gender. Women who have non-communicable diseases like diabetes and Polycystic Ovarian Syndrome (PCOS) are more likely to suffer from depression as these diseases are associated with gaining weight and suffering from fertility issues. This can lead to low self-esteem and feeling undesirable and as such depression.Women's depression is also related to pregnancy and menopause. Mental health problems linked to puberty, like identity crises, on the other hand, are common amongst boys. In many cases, sex and gender interact to contribute to create certain health risks. For instance, women's high risk of depression is influenced by genetics and hormones, but gender plays an instrumental role in magnifying the relative risk.

While biological differences between men and women impact their health differently, in this unit, we will be talking about health in social

terms; that is, looking at how social factors affect health. For instance, nutrition is one factor that is heavily impacted by the social status of gender. The next section discusses how one's gender affects one's diet.



LET US KNOW

Social and Biological ideas of health are inter-related. For example, in many societies women's lower position affects their health.

7.5 NUTRITION AND GENDER

The World Health Organization (WHO) defines nutrition as the intake of food in relation to the human body's dietary needs. Good nutrition – an adequate well-balanced diet – is fundamental for good health. Body shape and nutrition are also dependent on one's material and social conditions.

In this section, we will locate the factors that have an impact on the nutrition of men and women.

Many of the factors responsible for differences in the quantity and quality of food that a household gives to male and female children are interlinked and can be traced to the values and ideas generated in the kinship system, family structure, and ideology linked to them. The different rates of mortality and morbidity for girls and boys are explained in part by discrimination in nutrition and health care. While men are encouraged to eat appropriately to fill their stomachs, it is believed that women can starve if the need be. Women who might crave for food are laughed at by others and seen as greedy. Women and girls are not only the last to receive food, but they also get less of it and lower quality. Immunization rates are also very low for women. Many girls and women have high levels of anemia as a result of poor nutrition. Anemia affects pregnancy and increases the risk of maternal deaths.

For instance, meat is often made selectively available to males, and more specifically, preferred cuts of meat are reserved for men in

some cultures.Physical strength, an attribute more characteristic of males, requires optimal nutrition and meat is often seen as the most nutritious and strength-inducing of foods.

Another example that highlights the differential relationship that exists between health, nutrition,and gender is the consumption of milk. Customarily in many places,a girl is not given milk to drink. This is a typical pattern among Marathas and Brahmins in western Maharashtra and is, in fact, a general feature of Indian culture except among educated upper 'middle class' and well-to-do sections (Dube 1997: 137). Women are entitled to milk only in special circumstances such as lactation or illness, and sometimes pregnancy (ibid 138). There is differential access to food determined by one's gender which is altered during special times like illness and pregnancy.

Therefore, from the above argument, it is clear that one's gender has an impact on one's nutrition and health. However, it is not just nutrition, but gender also results in other kinds of differential health practices amongst men and women. In the next part, we will converse in detail some of the reasons why men and women have different access to healthcare services.

7.6 DIFFERENTIAL HEALTH PRACTICES AND GENDER

Let us now look at the various influences that lead to varying health practices amongst the two genders. First, we will discuss how specific gender barriers exist for women to access healthcare and then move on to those for men.

- **Gender barriers for women to access healthcare**
  - **Limited decision-making power** : Women generally and specifically in South Asian countries have very less or no decision making power within families, especially in rural areas. They are not able to decide who to marry, when to marry and when to give birth. Early marriage and childbearing pose health risks like complicated pregnancies, unsafe child deliveries,

and miscarriage.Many women also do not have access to abortion facilities.These are crucial decisions that can affect a woman's health and thus, create hindrances in women taking proper care of their bodies. There are also instances in which women cannot decide how many children they should have and this leaves a long-lasting adverse impact on their bodies. Control on women's movement, reproductive health, sexuality and decision making are seen as natural and in many cultures, rewarded. Women are taken as objects rather than subjects and as second class citizens.

- **Time Constraint** : Most women are busy with household chores throughout their day, and in urban areas, they do double duty in the sense that they have to work both outside and inside their homes. They hardly find time to take care of themselves and going for health check-ups is considered non-important. For many women, going out of their homes is also a concern, especially in rural areas. They are dependant on their husbands or other family members to take them to the hospital. For many married women, the health of their children and husbands become more important.
- **Economic reasons** : In many countries, although public healthcare facilities exist, they are overloaded, and people have to rely on private healthcare. However, it is expensive and not accessible to people from all classes and genders. Since women are not seen as equal members of society, their health needs are not considered as essential as men's and children's, and when there is money involved, their health issues are even more neglected. Economic barriers like user fees for maternal health services and a dearth of affordable primary healthcare means that women do not get adequate care. Increasing women's education can change this situation as it is directly linked to bettering women's economic opportunities. Education for women also influences the age of

marriage, fertility, number of children, nourishment, and health.

- **Intimate partner/domestic violence** : Violence against women is a result of macho male behaviour and unequal power relationships between men and women. It includes domestic violence, trafficking of women, rape, sexual harassment, female infanticide, female genital mutilation, dowry and honor killings. Domestic and intimate partner violence against women shows how men exercise dominance over women. Many women face intimate partner/domestic violence at the hands of their partners and husbands and families which impacts their physical and mental well-being. In a ten-country study on women's health and domestic violence which was conducted by WHO, between 15-71% of women reported sexual and physical abuse at the hands of a partner.

  Women tend to hide this fact, and as such both, their physical and mental scars go untreated. It takes a toll on their lives and their physical and emotional well-being as such women need legal protection from violence. Many governments have made policies to protect women from cases of domestic violence. For instance, India has a Protection of Women from Domestic Violence Act 2005 that gives women legal protection against domestic violence from their partners.

- **Health system barriers** : WHO defines health systems as all the activities whose basic function is to promote, restore or maintain health. Women in most places need more health services than men but do not have access to them. These barriers are a reflection of women's low position in society. Many women treat pain as a minor inconvenience and do not see it as a health issue that needs medical treatment. Many women do not talk about their health issues because it might mean lower chances of marriage.Women in some situations are reluctant to use existing health services because the overcrowded health systems do not ensure respect, privacy,

and confidentiality about treatment.

The WHO has embarked on a journey of changing health systems by focusing on building Primary Health Centres (PHCs) to make these systems more equal, fair and accessible.These PHCs are intended to pay special attention and care to women's health issues and needs. These PHCs are supposed to correct the gender imbalance in men and women accessing healthcare.

Let us now look at some of the factors that impact men's access to healthcare services. While we have seen that women neglect their health for social reasons like their inferior position in society and financial dependence, men face the risk of health hazards because of their superior status. Until recently, gender in relation to health meant women's health. But an inclusive approach also needs to take into account men's health. Therefore, a discussion on gender and health cannot be complete without paying attention to men's health.



ACTIVITY - I

Why do women have less decision making power compared to men in issues related to their bodies? Think.

ACTIVITY - II

What are the health system barriers that exist in women accessing healthcare? Find out.

- **Gender barriers for men to access healthcare**
  - **Notion of masculinity** : Rigid gender norms and the idea of masculinity that exists in every society act as a barrier in men accessing proper healthcare. Characteristics associated with masculinity like toughness, control, strength, etc. govern men's bodies and emotions. They are taught to see themselves as strong and hence a lot of times; they do not seek help from the doctor. In cases of issues related to mental health, men's suppression of their needs is even more as it involves emotions. They do not talk to even people close to them about their concerns, and that is why many men suffer from emotional crises. Men are expected to be aloof, unemotional and aggressive. Expectations of masculinity mean that men practice more risk-taking in accessing healthcare.
  - **Health system barriers** : The health system itself, particularly in India, acts as a barrier for men to access healthcare services. Shortage of human resources for health and lack of gender sensitization among health workers, especially about men's health means that men do not feel comfortable seeking medical help. This is all the more true when it involves mental and sexual health. The staff in most hospitals, public or private, are not sensitized to handle gender-based health issues. Reducing gender bias in health systems needs systematic approaches to generating awareness and changing values among service givers, processes to enhance health facilities and operative apparatuses for accountability. Advancing the local health centres, setting up systems for reliable emergency transport and making it possible for patients and their attendants / caretakers to stay near a health facility can yield positive results.
  - **Time constraint** : While many women work both inside and outside their homes, most men work outside in various kinds of jobs and have to put in long hours. They hardly get time for themselves and their families. As such, just like women, men

are hesitant to do routine health check-ups and take care of their health when they get some time off from their busy lives. For married men, their children's health becomes more important and as such their health becomes neglected. Another issue is the long waiting time in hospitals. When basic services are available at the primary care level, the over crowding in hospitals can be considerably reduced and this can save time and motivate people to come for regular check-ups.



CHECK YOUR PROGRESS–B

Q.1. Name two gender barriers that are common to both men and women in accessing healthcare facilities.

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7.7 LET US SUM UP

- Sex and gender are different from each other. Sex is biological and physiological whereas gender is social and cultural.
- In the past, gender has been looked at in two aspects – the masculine and the feminine. The masculine is generally associated with men while the feminine is associated with women. But in the present, the term gender is used more inclusively as it also includes the third gender, who are categorized as neither men nor women by society. They are more commonly known as the intersex people.
- Speaking about the relationship between gender and health, one's gender impacts their health conditions. One's health relations reflect the differences that exist between the genders.
- The World Health Organization (WHO) defines nutrition as the

intake of food in relation to the human body's dietary needs.

- Many of the factors responsible for differences in the quantity and quality of food that a household gives to male and female children are interlinked and can be traced to the values and ideas generated in the kinship system, family structure, and ideology linked to them.



7.8 FURTHER READING

1) 2010. *Gender, Women and Primary Healthcare Renewal: A Discussion Paper.* World Health Organization.

2) 2016. Report on *Gender in Health*. European Institute for Gender Equality. Luxembourg: Publications of the European Union.

3) Kawachi Ichiro, Bruce P Kennedy, Vanita Gupta, and Deborah Prothrow-Stith. 1999. Women's Status and the Health of Women And Men: A View from the States. *Social Science and Medicine.* 48(1): 21-32.

4) Sen, Gita and Piroska Ostlin. 2010. *Gender Equity in Health: The Shifting Frontiers of Evidence and Action.* New York: Routledge.



7.9 ANSWERS TO CHECK YOUR PROGRESS

Ans to Q No A :

1) Sex is biological whereas gender is social and cultural.
2) Gender is fluid.

Ans to Q No B (1) :

a) Health system barriers and time constraint.



7.10 MODEL QUESTIONS

A) Short Questions (Answer each question in about 150 words)

Q 1: How are nutrition and gender related?

Q 2: Highlight some gender barricrs which affect man's access to health care.

B) Long Questions (Answer each question within 300-500 words)

Q 1: Discuss the relationship between gender and health.

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