COURSE CODE: MASOD 404

COURSE NAME: SOCIOLOGY OF HEALTH AND ILLNESS

CENTRE FOR DISTANCE AND ONLINE EDUCATION
TEZPUR UNIVERSITY

MASTER OF ARTS

SOCIOLOGY

BLOCK I

Tezpur University
Centre for Distance and Online Education
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Vision

To grow to be a leading centre for human resource development through distance, open and universal learning system.

Mission

To provide quality higher education at door step through barrierless, flexible and open learning mode in conformity with national priority and societal need.

Objective

- **To offer degree, diploma, certificate level programme of study through distance learning in various emerging subjects across the disciplines.**

- **To offer job oriented and vocational programmes in flexible terms in the line of the national and regional level demand of manpower.**

- **To offer various programmes under lifelong learning contributing to the local and regional level requirements and as per the need of the society at large.**

- **To undertake various research and academic activities for furtherance of distance education in the region.**

- **To contribute to conserve and promote cultural heritage, literature, traditional knowledge and environment conducting short programmes, workshops, seminars and research in interdisciplinary field.**

MSO-404: SOCIOLOGY OF HEALTH AND ILLNESS

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BLOCK I

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COURSE INTRODUCTION

This course introduces the learners to the conceptual and theoretical perspectives to understand how the medical practice, the medical profession, and medical technology are rooted in society and culture. The learners will get an insight into the ideas of health and illness of individuals as well as communities regarding different cultural contexts. This course also discusses the processes of professionalization of medicine, medicalization and de-medicalization.

The course is divided into four modules, each consisting of multiple units. This has been done to discuss the major concepts more elaborately and in a learner-friendly way.

Module I gives an introduction to the sociology of health and illness. It consists of four units. **Unit 1** deals with the theoretical foundations. The unit will help the learners to have a sociological analysis of health and illness. The unit explores the major theoretical debates and areas within sociology of health and illness, focusing on the social determinants of health and illness. **Unit 2** is about defining health and illness. The unit will further help the learners in understanding the meaning, aim, objectives and scope of sociology of health and illness. **Unit 3** deals with culture and disease. The learners will be able to understand the relationship between culture and health through this. The unit explores some theoretical frameworks on culture and health. **Unit 4**, on the other hand, explores illness narratives. The unit explains the significance of illness narratives in sociology of health and illness.

Module II is about medical pluralism and alternative medicine. While **Unit 5** deals with alternative medicine, **Unit 6** covers medical pluralism. **Unit 7** explores gender and health which will help the learners to have a clear grasp of the health inequalities between male, female and the third gender. **Unit 8**, on the other hand, deals with gender and sociology of

body. The concepts of medicalisation and de-medicalisation are covered in **Unit 9**.

Module III focuses on social health. **Unit 10** explores public health and community health while **Unit 11** deals with social epidemiology. **Unit 12** introduces the learners to the health policies of the government of India.

Module IV is dedicated to the politics of health and medicine. **Unit 13** deals with the politics of health insurance. On the other hand, **Unit 14** deals with pharmaceutical industries and medicines.

The complete course is divided into two Blocks. **Block I** contains Module I and II. **Block II** will have Module III and IV.

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MODULE I: INTRODUCTION TO SOCIOLOGY OF HEALTH AND ILLNESS

UNIT 1: INTRODUCING THE THEORETICAL FOUNDATIONS

UNIT STRUCTURE

1.1 INTRODUCTION

Health and illness are not merely biological and medical phenomena, but also important sociological phenomena that are caused and controlled by society. Sociology of health and illness provides an analytical framework for understanding the social contexts of health, illness, and health care systems. It includes the subjective experience of health and illness,

political, economic and environmental circumstances fostering ill health, and societal forces constraining the medical care system and individuals' responses to illness. It also includes ethical and social problems in advanced medical technology. In this course, we will discuss a broad view of sociology of health and illness that encompasses health, illness, healing, healthcare, and medicine. Sociology of health and illness studies the interaction between society and health. In particular, sociologists examine how social life impacts morbidity and mortality rates and how these rates in turn impact society. This discipline also looks at health and illness in relation to social institutions such as the family, work, school, and religion as well as the causes of disease and illness, reasons for seeking particular types of care, and patient compliance and noncompliance. Health, or lack of health, was once merely attributed to biological or natural conditions. Sociologists have demonstrated that the spread of diseases is heavily influenced by the socioeconomic status of individuals, ethnic traditions or beliefs, and other cultural factors. Where medical research might gather statistics on a disease, a sociological perspective of illness would provide an insight into what external factors led to it.

Sociology is a discipline that makes it possible to see how individual experiences—how we act, think, feel, and remember—are connected to the wider society. To understand the human experience better, we must understand all that we can about groups and social relationships. Sociologists examine the shared meanings that humans attach to their interactions with one another, and they study human experience as it unfolds within societies over time. It studies social patterns that are stable and also those that are changing. This course will introduce to some key sociological theories on health and illness. The sociology of health and illness is a large and historically important subfield within the discipline of sociology, but with important links to public health, social epidemiology, and health psychology.

1.2 OBJECTIVES

By the end of this unit, you will be able to:

- Discuss the sociological analysis of health and illness;
- Explain the major theoretical debates and areas within the sociology of health and illness;
- Analyse the social determinants of health and illness;
- Critically assess how health is produced through social, political, economic and cultural forces on a macro, meso and micro level.

1.3 THEORETICAL APPROACHES TO HEALTH AND ILLNESS

1.3.1 Functionalist Theory

Functionalism is based on the analogy between society and biological organism and it provides a 'consensual' representation of society based on an agreement to sustain society as it is. It offers an explanation of human society as a collection of inter-related substructures, the purpose of which is to sustain the overarching structure of society. From 1946 to 1951, the new field of medical sociology was almost completely an applied area of research. According to the functionalist perspective, health is vital to the stability of the society, and therefore sickness is a sanctioned form of deviance.

1.3.2 Talcott Parsons and Emile Durkheim

Talcott Parsons (1951) was the first to discuss the function of medicine in society. In the model, structural-functionalist includes the concept of the sick role: patterns of expectations that define appropriate behaviour for the sick and for those who take care of them. This was for the first time sociological theory began to include an analysis of the function of medicine in society. Sigmund Freud's concept of transference and countertransference has influenced Parsons in drawing analogies between

the roles of parent-child and physician-patient which was important in his notion of the sick role. (Cockerham, 2001)

According to Parsons, the sick person has a specific role with both rights and responsibilities. To start with, in the context of modern norms of individualism and individual responsibility, a person has not chosen to be sick and should not be treated as responsible for his or her condition. The sick person also has the right of being exempt from normal social roles; the person is not required to fulfil the obligation of a healthy person and can avoid normal responsibilities without censure. However, this exemption is temporary and relative to the severity of the illness. The exemption also requires validation by a physician, i.e. a physician must certify that the illness is genuine. The responsibility of the sick person is two-fold: to try to get well and to seek technically competent help from a physician. If the sick person stays ill longer than is appropriate (malingers), he or she may be stigmatized.

Parsons argues that since the sick are unable to fulfil their normal societal roles, their sickness weakens the society. Therefore, it is sometimes necessary for various forms of social control to bring the behaviour of a sick person back in line with normal expectations. In this model of health, doctors serve as gatekeepers, deciding who is healthy and who is sick—a relationship in which the doctor has all the power.

Durkheim's theory is concerned with macro-level social processes, structures, norms and values external to individuals that integrated them into the larger society and shaped their behaviour. From Durkheim, Parsons incorporates the ideas on moral authority to explain the doctor-patient role relationship i.e. how the doctor or the physician plays a dominant position when visited by a sick person.

Durkheim's work on suicide, in which the act of taking one's life is determined by social factors or society, explains different types of suicides

in society namely egoistic, anomic and altruistic. His theory on suicide can be used to understand how macro-level social events can affect health in a variety of ways through stress and that the effects of stress can be lessened through social support.

Stop and Read

Robert K. Merton's book *The STUDent Physician* published in the year 1957, discusses the structural-functionalist analysis of the socialisation of medical students.

1.3.3 Conflict Theory

Conflict theory has its roots in the work of Karl Marx and Max Weber. It provides a powerful insight into the structure of society which is based on the economic aspect that determines the social relations contained within that structure. It is the distribution of the ownership of the means of production that gives rise to specific patterns of class relations, which crucially in all societies are characterised by inequalities of power as society is divided between those who privately own the means of production and those are dependent on selling their labour-power to make a living. The relation between these two classes, bourgeoisie and proletariat, is unequal based on exploitation and oppression.

1.3.4 Karl Marx and Max Weber

Marxist theory is concerned with how the dominant economic structure of society determines inequality and power as well as shaping the relations upon which the major social institutions are built. Marxist explanation relating to the cause of ill health and the relationship between the state and the medical profession is based on the insight of the relationship between health and illness and capitalist social organization. The main focus is on

how the definition and treatment of health and illness are influenced by the nature of economic activity in a capitalist society. Medicine is a major social institution, and in capitalist societies, it is shaped by capitalist interests. Medicine has changed from an individual craft or skill to 'corporate medicine'. Medicine has become increasingly specialized and hierarchical. Medicine now has an extensive wage-labour force (including employees in the pharmaceutical industry and related industrial sectors). Medical practitioners have become proletarianized, that is, their professional status has gradually been undermined as a result of administrative and managerial staff taking over responsibility for health care provision. These four processes mean that medicine has become a market commodity, to be bought and sold like any other product. Furthermore, it has become increasingly profitable for two dominant capitalist interests: the finance sector through private insurance provision, and the corporate sector through the sale of drugs, medical instruments and so on. The power to direct and exploit the medical system has been seized by large corporations that enjoy monopolistic control over related market sectors. This process is characteristic of (late) capitalism as a whole.

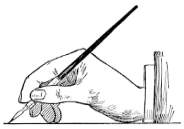
Marxists also claim that health problems are closely tied to unhealthy and stressful work environments. Rather than seeing health problems as the result of individual frailty or weakness, they should be seen in terms of the unequal social structure each, for different reasons, derives power from the continuation of these conditions of inequality. For the ruling classes, health inequalities are an indication of the difference in life chances that exist between themselves and working classes in particular. The Marxist approach states that the definition of health and illness and health and social care services serves the interest of the higher social class. Healthcare professionals are seen as agents who make sure that individuals go back to work as quickly as possible.

Whereas Functionalists see ill-health as something which happens randomly, the Marxists define it depending on an individual's social class.

For example, it is more likely for those in a low social class to have increased rates of illness and lower life expectancy due to lack of good housing, poor nutrition, etc.

Weber's contribution to sociology of health and illness is related to the study of healthy lifestyles. He identified life conduct and life chances as the two central components of lifestyles and healthy lifestyles. Healthy lifestyles are collective patterns of health-related behaviour based on choices from options which are available to people according to their life chances. (Cockerham, 2001). However, Weber's idea of health is not directly associated with the discipline of sociology of health and illness.

CHECK YOUR PROGRESS



1. What does sociology of health and illness emphasise on?

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2. What is 'Sick Role'?

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3. Fill up the blank:

Weber's study of Health Sociology is related with the study of _____.

1.3.5. Symbolic Interactionist Theory

While the functionalist approach deals with physical, inanimate objects, the subject matter of symbolic interactionist theory consists of people whose actions are motivated by human consciousness. This approach focuses on

micro-level individual interactions based on shared symbolic meanings. The theory of symbolic interaction is mainly based on the work of George Herbert Mead and Herbert Blumer. According to symbolic interaction, social reality is constructed in the process of individual interaction.

Erving Goffman is another notable symbolic interactionist who has initiated a study of the life of mental hospital patients in his work *Asylum: Essays on the Social Situation of Mental Patients and other Inmates* (1961) and has incorporated the concept of 'Total Institution'. This concept has gain sociological importance pertaining to health institutions. Goffman's work, in particular, promoted interplay between sociology and sociology of health and illness, with his analysis of total institutions, developing theoretical insights for those interested in institutions in general and hospitals in particular.

Symbolic interactionist approach explains a social phenomenon from the perspective of its participants. It advocates that meaning of human action must be interpreted by studying the meanings that people attach to their behaviour. It is concerned with how people see and understand the social world. This approach is concerned less with the larger social system or structure than with interpreting human behaviour. The significance of this approach in relation to understanding health behaviour is that it is concerned with examining the interaction between the different role players in the context health and illness. The focus is on how illness and the subjective experience of being sick are constructed through the doctor-patient interaction. The argument here is that illness is a social accomplishment among actors rather than just a matter of physiological malfunction. Interactionists focus on individual's choice and take into account that social roles exist, even though it is not visible, the only issue is that they do not research where the social roles came from. Another thing is that they pay little attention to issues of social class and power in society. Also, it does not explain why individuals act familiarly. The approach is often defined as

describing social behaviour 'in a vacuum' and through gangs and relationships with health and social care professionals and service users. It is, however, unable to explain the bigger social factors that affect this. When looking at sociology, interactionists do not focus on structures and institutions but on complicated relationships with other individuals e.g. their family, friends and their connections with professional services. Interactionists think that these social relationships have as much influence as a medical diagnosis to decide whether an individual considers herself/himself ill.

Stop and Read

Total Institution: Erving Goffman defines this as a place of residence and work, where a large number of like-situated individuals cut off from the wider society for an appreciable period together lead an enclosed and formally administered round of life.

1.3.6. Labelling Theory

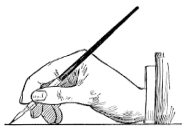
Howard Becker has used the labelling theory in explaining health-related issues. Becker holds that no human behaviour is inherently deviant but that social groups create deviance and deviant behaviour is that which is labelled by society. Labelling theory is closely related to social-construction and symbolic-interaction analysis. The theory focuses on the tendency of majorities to negatively label minorities or those seen as deviant from standard cultural norms. The theory is concerned with how the self-identity and behaviour of individuals may be determined or influenced by the terms used to describe or classify them. The social construction of deviant behaviour plays an important role in the labelling process that occurs in society. This process involves not only the labelling

of criminally deviant behaviour—behaviour that does not fit into the socially constructed norms—but also labelling that reflects stereotyped or stigmatized behaviour of the "mentally ill". Hard labelling implies that mental illness does not exist; it is merely deviance from the norms of society that cause people to believe in mental illness. According to it, mental illnesses are socially constructed. Soft labelling, on the other hand, implies that mental illnesses do exist and are not entirely socially constructed.

Labelling theory was applied to the term "mentally ill" when Thomas J. Scheff published *Being Mentally Ill: A Sociological Theory* in 1966. Scheff challenged common perceptions of mental illness by claiming that mental illness is manifested solely as a result of societal influence. He argued that society views certain actions as deviant. To come to terms with and understand these actions, society often places the label of mental illness on those who exhibit them. Certain expectations are placed on these individuals and, over time, they unconsciously change their behaviour to fulfil them. Criteria for different mental illnesses, he believed, are not consistently fulfilled by those who are diagnosed with them because all of these people suffer from the same disorder. Criteria are simply fulfilled because the 'mentally ill' believe they are supposed to act in a certain way. Another issue involving labelling was the rise of HIV/AIDS cases among gay men in the 1980s. HIV/AIDS was labelled a disease of the homosexual that further pushed people into believing homosexuality was deviant. Even today, some people believe contracting HIV/AIDS is punishment for deviant and inappropriate sexual behaviour.

Labels, while they can be stigmatizing, can also lead those who bear them to proper treatment and recovery. The label of "mentally ill" may help a person seek help such as psychotherapy or medication. If one believes that being "mentally ill" is more than just believing that one should fulfil a set of diagnostic criteria, then one would probably also agree that there are some who are labelled "mentally ill" who need help.

CHECK YOUR PROGRESS



1. Who is the author of *Being Mentally Ill: A Sociological Theory*?

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2. Name the book of Goffman discussing Hospital as an example of 'Total Institution'.

1.4 POSTSTRUCTURAL AND POSTMODERN THEORIES ON HEALTH AND ILLNESS

Each of these more recent contributions to defining the field of sociology of health and illness has emerged in the wake of the post-modern/post-structuralist turn in western thought in which old principles of structure, stratification and division have been merged with pluralities, mobilities and differences, and each in its own way reflects varying degrees of embrace of, or resistance to, this trend. Indeed, perhaps the very emphasis on a tougher concept of social structure is a response to the post-structuralist turn in intellectual life. Holding firm to the social structure is now not only an important defence against medicine's biological reductionism but also a form of resistance to poststructuralist subjectivism.

1.4.1 The Feminist Theory

Feminist writers have focused on the male domination of the medical sphere and the adverse impact this has had on women. Pregnancy and childbirth are regarded as medical issues and sometimes even as an illness

rather than a natural process. Feminists believe that the exploitation of women by a patriarchal society has contributed to the fact that more women suffer from depression, anxiety and stress than men. Marxist theory has been criticized in particular for its almost exclusive emphasis on the economic determinants of social relationships and the resulting primacy of social class in any analysis of inequality. Feminist theory from the 1960s onwards sought to challenge the invisibility of gender in sociological theory. It began to oppose patriarchy and sexism and sought to eliminate violence against women and to give women control over their reproduction.

There are three variants of feminist thinking:

- Liberal feminism seeks equal opportunity for all, irrespective of their gender in the existing society
- Socialist feminism advocates abolishing private property for establishing social equality
- Radical feminism seeks to create a gender-free society.

The feminist theory thus makes a substantial contribution to the understanding of health and illness. It provides an analysis of gender relations based on how female inequality has been structured and maintained in society. It explores the gendered nature of the definition of illness and treatment of patients. Its main concern is the way in which medical treatment involves male control over women's bodies and identities. Ann Oakley (1984) has argued that a woman's life has been subject to far better control and regulation through the medical profession than through men. Particular examples can be seen in the context of pregnancy and childbirth.

Stop and Read

Ann Oakley's work *Essays on Women, Medicine and Health* is a collection of essays, lectures and papers written between 1981 and

1992 which brings together the best of Oakley's work on the sociology of women's health

1.4.2 Michel Foucault

The book *Birth of the Clinic: An Archaeology of Medical Perception* by Michel Foucault has much implication on sociology of health and illness. Foucault's work focuses on the history of the medical profession, medicine, and disease. Besides, it also explores the history of human experience- the experience of politics, bodies and systems. Michel Foucault concentrates on the dominant medical discourse which has constructed definitions of normality (health) and deviance (sickness). This discourse provides subjects in modern societies with the vocabulary through which their medical needs and remedies are defined. The source and beneficiary of this discourse is the medical profession. Foucauldian theorists also argue that medical discourse plays an important role in the management of individual bodies (what Foucault called 'anatomo-politics') and bodies en masse (bio-politics). Medicine is not just about health and illness as it is conventionally understood, but also about wider structures of power and control. A major contribution of Foucault to medical sociology is his study of the social functions of the medical profession. In his study on madness, clinics and sexuality, he has used medical knowledge as a means of social control and regulation.

Foucault found two distinct trends in medical practice:

a. medicine of species where he discusses the classification, diagnosis and treatment of disease

b. medicine as social spaces where he discusses the prevention of diseases

His main analysis of these two trends is that the former defines the human body as an object of study subject to medical intervention and control, the latter makes public's health subject to medical and civil regulation. In his work, *The History of Sexuality*, he categorically discusses how the state regulates physical health and human sexuality that affects population control. Therefore, the body itself has become a subject of the state. Foucault's analysis of the body also led to the development of a new specialised field, the sociology of body (Cockerham, 2001:14). We will discuss this in detail in a different unit.

Stop and Read

Biopower is a term coined by Michel Foucault. It relates to the practice of modern nation-states and the regulation of their subjects through several diverse techniques. Such a regulation exercised by the state ensures the subjugation of bodies and the control of populations.

Postmodernist understanding of health and illness refers to the present historical period characterized by the globalisation of the economy and culture. It shows fragmentation of individual identity such as the old categories of class, nationality and gender identity. Individuals need to think of new ways of accessing healthcare provisions and perhaps even explore nontraditional options such as alternative medicine. The uncertainty of life in postmodern society can lead to growing health problems. Postmodernists believe that people should challenge conventional views on health and ill health. Postmodernists are concerned with the 'deconstruction' of meanings. In other words, they challenge (or deconstruct) the claims made by certain theories. In the sphere of health and social care profession, they challenge the claims made by health and social care professionals.

1.4.3 Pierre Bourdieu

William Cockerham (2001) observes that Bourdieu has become fashionable in sociology of health and illness and his concepts 'social capital', 'habitus' and 'lifestyles' are the most popular in this regard. Bourdieu's concepts appeal to medical sociologists who wish to move their thinking from 'methodological individualism' to focus on the relationship between health and social structures. His book *Distinction* (1984) is an important work pertaining to sociology of health and illness. His theory serves as a bridge between mainstream sociological theory and sociology of health and illness. Bourdieu has theorised lifestyle practices. His understanding of the ways in which these practices are embedded within and enact class culture helps researchers to explain the prevalence of unhealthy lifestyle practices in an era in which rich nations have unprecedented access to health and education. He incorporates the idea of how patterns of cultural consumption and competition depend on class-oriented habitus. This, in turn, shapes particular aspects of health lifestyles. He argues that patterns of cultural consumption (food habits) also determine the longevity of individuals. Thus, from Bourdieu's analysis of health behaviour, it can be said that there is a close relationship between class and health lifestyles.

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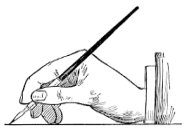

1. Who is the author of *Essays on Women, Medicine and Health*?

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2. What does Foucault mean by Biopower?

1.5 SUMMING UP

We can sum up the discussion into the following points:

- Health and illness are not merely biological and medical phenomena, but also important sociological phenomena.
- Talcott Parsons (1951) was the first to discuss in terms of the **sick role**: patterns of expectations that define appropriate behaviour for the sick and for those who take care of them. This was for the first time that sociological theory included an analysis of the function of medicine in society.
- Medicine is a major social institution, and in capitalist societies, it is shaped by capitalist interests. Marxists also claim that health problems are closely tied to unhealthy and stressful work environments. Rather than seeing health problems as the result of individual infirmity or weakness, they should be seen in terms of the unequal social structure
- Developed by sociologists during the 1960s, the labelling theory focuses on the tendency of majorities to negatively label those seen as deviant from standard cultural norms.
- Feminist theory explores the gendered nature of the definition of illness and treatment of patients. Its main concern is the way in which medical treatment involves male control over women's bodies and identities.
- A major contribution of Foucault to sociology of health and illness is his study of the social functions of the medical profession. In his study on madness, clinics and sexuality, he has explained medical knowledge as a means of social control and regulation.
- Bourdieu theorised lifestyle practices, and his understanding of the ways in which these practices are embedded within and enact class culture helps researchers to explain the prevalence of unhealthy

lifestyle practices in an era in which rich nations have unprecedented access to health and education.

1.6 QUESTIONS

1. Discuss the functionalist perspective on illness in society, specifically the role the sick play in society and how that role affects others.
2. Examine conflict theory on health and illness focusing on Karl Marx and Max Weber.
3. Explain and give examples of social constructions of health according to the symbolic interactionist perspective.
4. Discuss the contribution of Foucault towards sociology of health and illness.
5. What is the importance of Labelling Theory in understanding health and illness? Explain.

1.7 RECOMMENDED READINGS AND REFERENCES

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UNIT 2: DEFINING HEALTH AND ILLNESS

UNIT STRUCTURE

2.1 INTRODUCTION

Health and illness are facts of life and change over the life course. Everyone experiences illness sooner or later and everyone must eventually cope with illness and death among close friends and relatives. To the ill person, illness can often seem a purely internal and personal experience, and to some degree it is. However, it is also a psychological, social, biological, and cultural phenomenon, both in its causes and consequences. The sociology of health and illness studies the interaction between society and health. In particular, sociologists examine how social life impacts morbidity and mortality rates and how morbidity and mortality rates impact

society. This discipline also looks at health and illness in relation to social institutions such as the family, work, school, and religion as well as the causes of disease and illness, reasons for seeking particular types of care, and patient compliance and noncompliance.

The sociology of health and illness requires a global approach of analysis because the influence of societal factors varies throughout the world. Diseases are examined and compared based on traditional medicine, economics, religion, and culture that are specific to each region. For example, HIV/AIDS serves as a common basis of comparison among regions. While it is extremely problematic in certain areas, in others it has affected a relatively small percentage of the population. Sociological factors can help to explain why these discrepancies exist.

2.2 OBJECTIVES

By the end of this unit, you will be able to:

- Explain the meaning, aim, objectives and scope of sociology of health and illness;
- Analyse the concept of health and illness and different social determinants of it;
- Discuss major studies on illness;
- Discuss contributions of sociology towards understanding health and illness.

2.3 SOCIOLOGY OF HEALTH: AN INTRODUCTION

Health is the basic human right of all human beings. Health contributes to a person's basic capability to function. Denial of health is not only a denial of 'good life-chance' but also a denial of fairness and justice (Sen, 2006). 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 (Desai, 2007). 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 injurious to health. Definitions and conceptualization of health may vary systemically among various social groups and it is likely that different accounts of health are drawn according to social circumstances.

Heath is a metaphor for well-being. To be healthy means to be of sound mind and body; to be integrated; to be whole. Over time and across societies, influential theorists have emphasized that health consists of balance, of being centred. One's perspective on health is oriented by 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 the individual.

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". This definition underscores the major theme of this unit:

- Health is not just a matter of personal choice, nor it is only a biological issue; patterns of wellbeing and illness are rooted in the organization of society.
- This definition also confirmed health as a social issue and this is borne out by evidence which demonstrates that standards of health

have varied over time and also from one society, culture and country to another. For example, what is considered as good health in a low-income country such as Sri Lanka is very different from what is considered good health in the high-income UK.

- The biomedical approach which dominated the medical thought till the end of the nineteenth century and based on the 'germ theory of disease' views health as an 'absence of diseases'. This approach almost ignores the role of environmental, psychological and other socio-cultural factors in defining health. The ecological approach views health as a dynamic equilibrium between man and his environment. For them, the disease is maladjustment of the human organism to the environment. The psychological approach states that health is not only related to the body but also to the mind and especially to the attitude of the individual. The socio-cultural approach considers health as a product of the social and community structure. A functional definition of health implies the ability of a person to participate in normal social roles.
- A sociological understanding of health considers structural and social factors, rather than simply biological explanations of health and disease. It describes the complex relationship between structural factors and personal choice in relation to health inequalities.

2.3.1 Dimensions on Health

While many people associate their wellness to their physical health it can also be used to describe one's environmental, mental, intellectual, occupational, emotional or spiritual well-being. These different dimensions of health interact together to help determine one's full quality of life. Following are four major dimensions of health:

1. Physical:

Physical wellness can refer to any of the aspects that are needed to keep the body in top condition. It is the ability of the human body to function

properly, the body's capacity to carry out everyday activities and be free from illness. It includes fitness, weight, body shape and ability to recover from illness. Consuming a healthy diet and getting an adequate amount of exercise to build cardiovascular health, endurance or flexibility are essential to this goal. One is responsible for his or her health care which means treating minor conditions and consulting a professional to manage more serious conditions. On the path to good physical health, one should monitor warning signs so that one understands when one's body is not getting the nutrition it needs or establishing an unhealthy state. One's physical health helps to improve determination, self-control and self-esteem. Sufficient amount of sleep, avoidance of harmful substances like tobacco products, and annual physical examination are some of the tips for maintaining good physical health.

2. Social:

Building and maintaining satisfying relationships comes naturally to us as we are social animals. Being socially accepted is also connected to our emotional well-being. The ability to make and maintain healthy relationships with other people is included in this dimension. It also includes accepting social standards/norms of behaviour, for instance, waiting in queues, behaving appropriately at the cinema. This dimension of health focuses on the process of creating and maintaining healthy relationships that provide support, such as from friends and family. Making time for positive experiences with friends and family can build emotional reserves and strengthen social connections for times of need.

Social wellness is an ability to interact with people, respect oneself and others, develop meaningful relationships and develop quality communication skills. This allows one to establish a support system of family and friends. The social dimension of health is made up of the cultural and social aspects of the relationship between patients and health professionals. This relationship is a social negotiation affected by beliefs, practices, interests, and power dynamics. Communication within this

relationship can have a powerful impact on health outcomes. The influence of this relationship upon health is not limited to Western, allopathic, biomedical systems but is equally as important in other medical systems throughout the world. The stark fact is that most disease on the planet is attributable to the social conditions in which people live and work. The socially disadvantaged have less access to health services, get sicker and die earlier than the privileged. Despite impressive technological advances in medicine, global health inequalities are worsening. There is no single definition of the social determinants of health, but there are commonalities, and many governmental and non-governmental organizations recognize that there are social factors which impact the health of individuals.

Stop and Read

The WHO later developed a Commission on Social Determinants of Health, which in 2008 published a report entitled "Closing the Gap in a Generation". This report identified two broad areas of social determinants of health that needed to be addressed. The first area was daily living conditions, which included healthy physical environments, fair employment and decent work, social protection across the lifespan, and access to healthcare. The second major area was the distribution of power, money, and resources, including equity in health programmes, public financing of action on the social determinants, economic inequalities, resource depletion, healthy working conditions, gender equity, political empowerment, and a balance of power and prosperity of nations.

3. Emotional

Emotional wellness focuses on ensuring that one is attentive to one's feelings, thoughts and behaviour. This includes both positive and negative reactions, though overall one should seek an optimistic approach to life, enjoying life in spite of occasional disappointment and adjust to change and express one's emotions appropriately. This dimension of health focuses on

awareness and acceptance of feelings and stressors. Emotional well-being includes the ability to manage one's feelings and related behaviours, the ability to cope effectively with stress, and the adaptability to change. Just as it requires effort to build or maintain physical health, the same is necessary for emotional health. Emotions contribute to almost all aspects of our life, at times, even setting the course of actions. Symptoms of emotional problems, such as hopelessness, depression, anxiety, and even suicidal tendencies are not always easily detectable but can lead to dire consequences. Awareness and acceptance of our strength and shortcomings are essential for our emotional wellbeing.

4. Spiritual:

Spiritual wellness involves discovering a set of beliefs and values that brings purpose to one's life. While different groups and individuals have a variety of beliefs regarding spiritualism, the general search for meaning for our existence is considered essential to creating harmony with ourselves and others regardless of the path to spirituality we choose to follow. It is considered healthier to find one's own path to the meaning of life that allows one to be tolerant of the beliefs of others and live a life that is consistent with one's beliefs.

However, these dimensions interact and overlap. They also complement each other to form the whole person. Similarly, change in one dimension affects the other dimensions. For example, a person who begins an exercise programme to lose weight (physical) may also improve his or her self-esteem (emotional). A college student studying philosophy to fulfil university requirements (intellectual) may discover meaning in life, a purpose for living (spiritual). When someone is ill (physically), he probably doesn't feel like spending time with his friends (social).

2.4 HEALTH: A GLOBAL SURVEY

As mentioned in the above points, health is closely linked with social life. Research shows that human well-being has improved over the long course of history as societies have developed economically. For the same reason, there are striking differences in the health of rich and poor societies today.

2.4.1 Health in Low-Income Countries

Severe poverty in much of the world cuts life expectancy far below the seventy or more years typical of rich societies. People of most parts of Africa have a life expectancy of barely fifty, and in poorest countries of the world, most people die before reaching their teen. The World Health Organization reports that 1 billion people around the world—one in six—suffer from serious illness due to poverty. Bad health results just not for eating only one kind of food but more commonly, from simply having too little to eat. Poor sanitation and malnutrition kill people of all ages, especially children.

In impoverished countries, safe drinking water is as hard to come by as a balanced diet, and bad water carries a number of infectious diseases, including influenza, pneumonia, and tuberculosis, which are widespread killers in poor societies today. To make matter worse, medical personnel are few and far between so the world's poorest people – many of whom live in central Africa- never see a physician. In poor nations with minimal medical care, it is no wonder that 10 per cent of children die within the year of their birth. In much of the world, illness and poverty form a vicious circle: Poverty breeds disease which in turn undermines people's ability to work. Moreover, when medical technology does control infectious disease, the population of poor nations rises. Without resources to ensure the wellbeing of people they have now, poor societies can ill afford population increases. Thus, programmes that lower death rates in poor countries will succeed only if they are coupled with programmes that reduce birth rates as well.

2.4.2. Health in High-Income Countries

Industrialization dramatically changed patterns of human health. By 1800s, as the Industrial Revolution took hold, factory jobs took people from all over the countryside. Cities quickly became overcrowded, a condition creating serious sanitation problems. Moreover, factories fouled the air with smoke, which few saw as a threat to health until well into the twentieth century. Accidents in the workplace were common. But industrialization gradually improved health by providing better nutrition and safer housing for most people. After 1850, medical advances began to control infectious diseases.

It's a fact of modern times that the wealthy in all societies have better physical, mental and social health than the poor. This starts at birth with the poorest members of society having the highest infant mortality rates and continues throughout life as the wealthy enjoy better access to healthcare thus having a better chance of recovering from serious illnesses and major trauma. The present world average life expectancy is 67.8 years. In the most developed societies, it is 78 years plus. However, in the lowest income countries, health is undermined by lack of food and poor sanitation and the average life expectancy is below 50 years. Approximately, half the children born in these countries do not make it into adulthood.

Sociology assumes that a functioning society depends upon healthy people and upon controlling illness. Although many believe that science alone determines illness, the sociological perspective points out that society determines sickness as well. For example, the culture defines diseases as legitimate if they have a clear "scientific" or laboratory diagnosis, such as cancer or heart disease. In the past, society considered conditions such as chemical dependency, whether drug- or alcohol-based, as character weaknesses, and denied those who suffered from addiction the sick role. Today, drug rehabilitation programmes and the broader culture generally recognize addiction as a disease, even though the term "disease" is medically contested. In today's culture, addicts may take on the sick role as

long as they seek help and make progress toward getting out of the sick role.

Stop and Read

The 2011 World Conference on Social Determinants of Health brought together delegations from 125-member states and resulted in the Rio Political Declaration on Social Determinants of Health. This declaration involved an affirmation that health inequities are unacceptable and noted that these inequities arise from the societal conditions in which people are born, grow, live, work, and age, including early childhood development, education, economic status, employment and decent work, housing environment, and effective prevention and treatment of health problems.

2.5 SOCIOLOGY OF ILLNESS

By contrast to health, illness refers to imbalance. Something out of sync. This can be understood in terms of judgments about what constitutes normal and abnormal (Lock, 2000). These judgments are made in terms of biomedical tests, individual perceptions of 'I do not feel well' and the social construction of the abnormal. As the analysis of health, an examination of illness can take place on the level of the diseased organ, the individual, the community or the nation. While discussions of pathology dominate the medical literature, social scientists point out that illness is culturally constructed and closely associated with the dominant social, political and moral order (Turner, 2000). Their argument is that regardless of the organic basis of disease, the cultural context and interpretation of illness has profound implications for an individual's sense of well-being and perceived attribution of responsibility.

When we say, ‘He is sick’, we employ a rich metaphor which means much more than the person has been judged to have an organic pathology determined by biomedical tests. We mean that the person is out of balance judged from our perspective. Theories of illness have been based on imbalances in the body, in the person or in social relationships. The great healing systems of India, China and Europe, for example, are based on the analysis of and interventions in such imbalances. Ayurvedic medicine is based on the Hindu belief that the body contains three elementary substances representative of the three divine universal forces they call spirit. These forces are comparable to the Greek ‘humours’ of blood, yellow bile, black bile and phlegm grounded in the four elements of fire, earth, air and water.

In traditional Chinese medicine, there is a dualistic cosmic theory of the yang (the male force) and the yin (the female force). The body is made up of five elements: wood, fire, earth, metal and water. In these systems, specific illnesses were attributed to an inordinate amount of one force, element or humour. For instance, in the Greek system, colds in the winter were due to phlegm and diarrhoea in the summer to bile. In these three theoretical systems, illness depended on the preservation of the balance between these forces and it was the task of the healer to bring these forces into equilibrium. In a review of ethnographic data from 139 societies intended to sample the world’s cultures, Murdock (1980) argues that an understanding of illness and by implication of health, across cultures can be based on theories of natural and supernatural causation. According to Murdock (1980: 9), theories of natural causation consist of ‘any theory, scientific or popular, which accounts for the impairment of health as a physiological consequence of some experience of the victim in a manner that would appear reasonable to modern medical science’. Natural causation explanatory frameworks include theories of infection, stress, organic deterioration, accidents and overt human aggression. The germ

theory of illness, for example, which drives Western scientific medicine, would fall under a natural causation model emphasizing infection. The theories of the supernatural causation of illness rest on assumptions that scientific Western medicine does not recognize as valid. According to Murdock's (1980: 17–27) analysis, there are three general types of theories of supernatural causation:

- Theories of mystical causation
- Theories of animistic causation
- Theories of magical causation.

Theories of mystical causation are "any theory which accounts for the impairment of health as the automatic consequence of some act or experience of the victim mediated by some putative impersonal causal relationship rather than by the intervention of a human or supernatural being" (Murdock, 1980:17). Some examples are the notion of 'fate' among the Romans and the breaking of food or sex taboos among the Tonga. Theories of animistic causation are 'any theory which ascribes the impairment of health to the behaviour of some personalized supernatural entity – a soul, ghost, spirit or god' (Murdock, 1980: 19). An example is the concept of soul loss among the Tenino Indians of Oregon State in the United States. Theories of magical causation are 'any theory which ascribes illness to the covert action of an envious, affronted, or malicious being who employs magical means to injure his victims' (Murdock, 1980: 21). An example is the concept of the 'evil eye' invoked in Mediterranean cultures to explain illness and death. Each of these theories deals with the issues of:

- Agency: Who or what is causing the illness?

- Social role: What is the role expected of the patient and of the healer?

-Symbols of knowledge, power and healing: What is the knowledge base of the healer? What symbols distinguish the healer from others in the community?

-Structure, process and outcome: Where should one seek help when ill? How does healing take place? And, how should the healers be treated if they succeed or fail in their endeavours?

2.5.1. Some Studies on Illness

- Murdock (1980: 88–95) found that nearly 80 per cent of his sample had a notion of mystical retribution expressed through a sense of sin; the belief that acts in violation of some taboo or moral injunction would be followed by punishment of the individual or group which is the cause of their illness.
- Malinowski (1944, 1948) made a major contribution to our understanding of theories of illness and help-seeking by analysing how individuals seek help for an illness or seek to restore balance when things are out of sorts in his examination of the workings of magic, science and religion,
- Malinowski concluded that individuals seek help for maladies according to their cultural and societal frames. What they have learned and experienced gives meaning to and a sense of control over their illnesses. Malinowski and others also discovered that people can use multiple frames of reference in understanding disease and seeking help. For instance, among the Wakomba of Kenya, individuals would often seek help from their medicine man if they were ‘sick’. But if that did not work, they might visit a health clinic to try Western scientific medicine delivered through a coloured pill or injection by a doctor in a white coat. If the intervention of the medicine man and the doctor did not work, they might turn to their indigenous belief system or to the Christ of the missionaries. Often these approaches for help and interventions are blended, with no one healer knowing that the others are being simultaneously invoked.

2.5.2. Subjective Illness

While health is defined either as an ideal state or absence of disease, illness is the subjective experience of feeling unwell. Defined by Radley, "Illness can be taken to mean the experiences of disease, including the feeling relating to changes in bodily states, and the consequences having to bear that ailment; illness, therefore, relates to a way of being for the individual concerned". Illness, therefore, is what the individual senses as 'wrong' with him or her, and may lead to making an appointment to see a doctor. Disease is what the individual has wrong with her/him on the return from that appointment. According to Cecil Helman (2007), a wide variety of subjective evidence is involved in the process of defining oneself as ill. These perceived alterations can be in physiognomy (for example, loss of weight), bodily emissions (for example, urinating frequently, or diarrhoea), the working of specific organs (for example, heart beating fast, or headaches) or the emotions (for example, depression or anxiety).

The term 'sickness' denotes the amalgamation of the two processes of feeling ill and being diagnosed as diseased. It alludes to the existence of a social role especially following a diagnosis, and that are obligations and rights that society confers on diseased individuals

2.5.3. Social illness:

The social features in the maintenance of health and the manifestation of the disease are irrefutable. Marx described that appalling social conditions are experienced by the poor living in the large industrial cities of that age. He connected the cause of morbidity and mortality among the inhabitants of the slum areas, factory workers, and the unemployed to these social conditions. Engel's treatise accounts of how disease cannot be simply understood in terms of biology and pathology. Engels lays the blame for illness on the way in which (capitalist) society is structured, and in particular on the bourgeoisie. A study conducted in the late 1990s of the Indian city of Mumbai recorded how the systematic clearance of slums

areas for new commercial and residential developments was responsible for the eviction of 1,67,000 people. The children of these slum dwellers have protracted nutritional deprivation, diarrhoea, respiratory disease, and skin infections, which were linked to the transitory nature of their residence and the effect this has on the family finances. The relationship between socioeconomic inequalities and disease inequalities within rich countries are reified in the life expectancy figures with those at bottom of the socio-economic hierarchy dying younger than those at the top, children born into families of low socioeconomic status having a much higher risk of death before five years ago. The social selection perspective suggests that the lower classes those with meagre employment and educational, material deprivation contain most of the unhealthy people in society. Those with physical and mental disease will 'drift' into the disadvantaged stratum of society as a matter of course. Physically and mentally advantaged will maintain good health and gain social superiority. Self-evidently, the uneducated and unemployed, living within poor housing within disruptive communities, are more likely to be ill than are people with high educational and occupational attainment living in expensive and gated residential areas.

Sir Michael Marmot, professor of Epidemiology and Public Health explains the interplay between structural condition and illness. According to him social conditions such as education, nature of jobs, living conditions like housing and availability of adequate nutritious food, quality of healthcare are the determinants of health and illness.

People with mental illnesses equally struggle for recognition and understanding. Although treatment conditions and understanding of mental illness have drastically improved, critics and mental health providers argue that considerable work remains. Prior to the 1960s, most mentally ill patients were locked away in places referred to as "insane asylums," in which patients were often sedated for easy control. Because of new drugs that reduce or eliminate many symptoms and changed attitudes toward mental illness brought about by the work of sociologists and psychologists,

many asylums closed and thousands of patients were released to community group homes, halfway houses, or independent living. This movement toward community care produced mixed results, with most mental health professionals concluding that the majority of deinstitutionalized patients adapt well with appropriate community placement and follow-up. Critics point to an increase in homelessness coinciding with deinstitutionalization. They claim many homeless are mentally ill patients who need institutionalization or at least better mental health care. Communities now face a number of issues due to deinstitutionalization because many localities object to group homes and halfway houses being located in their communities. Many wrongly believe that the mentally ill are more likely to commit crimes. Because of this misperception, as well as others, recovered mentally ill people, as well as those diagnosed and in treatment, are still stigmatized and discriminated against. In addition, turf wars can exist among mental-health professionals and over the use of drugs to control problematic behaviours.

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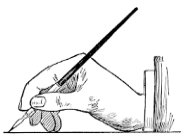

1. What is social illness?

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2. Fill up the blank: Weber's study of Health Sociology is related with the study of_____.

2.6 CONTRIBUTIONS OF SOCIOLOGY TO HEALTH AND ILLNESS

Inequality in health has also been a dominant theme of the sociology of health and illness which has evolved from a consideration of differences in behaviour and material circumstances to a complex consideration of how health behaviours and material and social resources interact to produce differences in health outcomes both on the individual and community levels. Researchers in this area have illustrated the importance of social capital in dealing with health issues.

Social capital refers to the social resources and networks available to individuals that help them define and cope with health problems. Consistent findings show that larger amounts of social capital are predictive of less disability, more support and a higher quality of life. Research on social equity has also highlighted the need to do multi-level analysis; to consider individuals in their environments and as members of a community and nation. Each layer of relationship is likely to explain some of the health outcomes and considering individuals in context permits a more fine-grained analysis of health and disease realities. The work on health-related quality of life has also drawn renewed attention to the concepts of normalcy and deviancy.

The women's movement and interest in international health have illustrated how white male norms established at one point in history in post-industrial countries do not serve as useful reference points for the behaviour of all people Most research has been traditionally done on men by men and for men. Yet, recent research clearly demonstrates that women's health experiences and issues are different from those of men, requiring considerable changes in the conceptualization and delivery of health care for women and children. In fact, one of the major factors in improving the health of a nation is to educate women and make health

resources available to them, for women are usually the people who care for children, older parents and disabled people.

Sociological Perspective on Health assumes that a functioning society depends upon healthy people and upon controlling illness. Although many believe that science alone determines illness, the sociological perspective points out that society determines sickness as well. For example, the culture defines diseases as legitimate if they have a clear "scientific" or laboratory diagnosis, such as cancer or heart disease. In the past, society considered conditions such as chemical dependency, whether drug- or alcohol-based, as character weaknesses, and denied those who suffered from addiction the sick role. Today, drug rehabilitation programs and the broader culture generally recognize addictions as a disease, even though the term "disease" is medically contested. In today's culture, addicts may take on the sick role as long as they seek help and make progress toward getting out of the sick role.

2.7 SUMMING UP

- Health is a social issue because personal well-being depends on society's technology as well as its distribution of resources. Culture shapes definitions of health and patterns of health care. Historically, human health was poor by today's standards.
- Health improved dramatically because of industrialization and later because of medical advances. Poor nations suffer from inadequate sanitation, hunger, and other problems linked to poverty. In the poorest nations, half the children do not survive to adulthood.
- The sociology of health and illness requires a global approach of analysis because of the influence of societal factors which also varies throughout the world.
- Diseases are examined and compared based on traditional medicine, economics, religion, and culture that are specific to each region.

There are obvious differences in patterns of health and illness across societies, over time, and within particular society types. There has historically been a long-term decline in mortality within industrialized societies, and on average, life-expectancies are considerably higher in developed, rather than developing or undeveloped, societies.

- Patterns of global change in health care systems make it more imperative than ever to research and comprehend the sociology of health and illness.
- There are enduring differences between social classes in relation to health. In terms of early mortality, morbidity and a range of other health indicators disadvantaged groups have considerably poorer outcomes than advantaged groups.
- There are four dimensions of health e.g. physical, social, emotional and spiritual. All these dimensions interact and overlap. They also complement each other to form the whole person. Similarly, change in one dimension affects the other dimensions.

2.8 QUESTIONS

Short Questions:

1. What is Health according to the World Health Organization?
2. What are the two broad areas of social determinants of health according to 'Commission on Social Determinants of Health', 2008 developed by WHO?
3. What is Social Wellness?

Essay Type Questions:

1. The dimensions of health interact with each other. Elucidate
2. Discuss the Sociological perspective on Health.
3. Discuss the contribution of Sociology to health.
4. What are the different kinds of illness? Explain.

5. Explain the social determinants of health.

2.9 RECOMMENDED READINGS AND REFERENCES

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UNIT 3: CULTURE AND DISEASE

UNIT STRUCTURE

3.1 INTRODUCTION

By now you have learnt in detail about health and illness in a sociological context. In this unit, we are going to cover the relevance of culture in the context of health and illness. We are going to learn why it is important to look at health and illness from a cultural perspective. Therefore, this Unit analyses why it is necessary to discuss health and illness in the realms of culture. There is a co-relationship between culture and health. A worldwide academic framework is necessary to understand these interrelations from the sociological lens. Different sociologists and scholars have worked upon these areas of sociology where they have shown the influences of culture in health-related behaviours. You might have also noticed that, with the passage of time, healing systems to cure diseases have also changed with the introduction of various advanced scientific technologies. Today, people

mostly rely on highly specialized health-related technologies. With the influence of various factors like education, health awareness, etc. such significant changes can be seen. In this unit, all these various aspects will be discussed in detail.

3.2 OBJECTIVES

By the end of the unit, you will be able to:

- Explain the relation between culture and health;
- Understand some theoretical frameworks on culture and health;
- Analyse health-related human behaviours.

3.3 CULTURE: FROM THE CLASSICS TO CONTEMPORARY RESEARCH TRENDS

In this section, we will learn how different sociologists and anthropologists have looked into the influences of culture on health and illness. Culture has its own understanding and definitions across the world. It is highly contextual and the meaning varies from various disciplines to conceptual perspectives. Therefore, to keep it simple and intact for your understanding, we will only focus on the contributions given by different sociologists and anthropologists. For better analysis and conceptual clarity, we will begin from the historical glance to understand culture. Tracing back to the classics, Emile Durkheim has proposed the concept of "social facts" in his book *The Rules of Sociological Method* published in the year 1895. He argued that social facts are the representations of our society in the minds of the individuals. He further added that they are the ways of thinking, feeling and acting that are external to an individual. These "facts" might include moral and social beliefs, myths, religious conceptions, values, etc. By treating values, beliefs and customs as social facts, he, therefore, introduced a systematic and a scientific study of culture. Durkheim's concepts of collective social consciousness and social solidarity also encompass culture. He saw social solidarity and collective

consciousness as reflective of culture and those are present external to the individual (Cockerham, 2001). These ideas can be applied to sociology of health and illness to study the various changing forms of social solidarity and various other perceptions like disease, medicine and health.

Similarly, Max Weber's works in the 20th century marked the initiation of the sociological analysis of culture. In his two popular books *The Protestant Ethics and the Rise of Capitalism* (1905) and *Economy and Society* (1968), he has highlighted the significance of culture as values and beliefs that influences social action. To be specific, his concepts of ethnic group and traditional action provides primary bases relevant to study culture. Weber's analysis helps us to understand culturally inspired and culturally sustained health practices because of his profound influence and incorporation of his conceptual insights into the general knowledge of sociology. Weberian contributions are directly applied even today in sociology of health and illness. Many sociologists and anthropologists have put forward different definitions on culture. However, some common strands have been used collectively to define culture. Kluckhohn (1951) has summarized culture in a wider sense as a community's "design for living". For him, culture must be used as a "map" or an "abstract representation" of distinctive features of a community's way of life.

A direct relation between culture and health was analysed by Bronislaw Malinowski. He considers culture as an "integral whole" and also as a response that functions to satisfy the organic and the basic necessities of man and of the race. He proposed "hygiene" as the cultural response to health. Another contribution to the understanding of culture was given by Talcott Parsons. Parsons have conceptualized social action as taking place in the context of culture, personality and social action. He defines culture as ordered systems of symbols that guide social action and is

internalized components of the personalities of individual actors and institutionalized patterns of social systems. He identifies three important features of culture- culture is transmitted, learned and shared. Therefore, culture is a product as well as a system of human interactions. (Cockerham, 2001).

Till now, we have discussed some of the classical contributions that lead to the foundation of our understanding of culture and its influence on human behaviour. The area of research on culture in the field of sociology and anthropology is expanding rapidly. Neo-classical approaches have emerged out of the classical understandings giving new ways and perspectives to the introduction of contemporary understanding of culture and health. In the context of contemporary research, we have to bring in the works of Michel Foucault. His works on *Order of Things* (1970), *The Birth of a Clinic* (1973) and *Discipline and Punishment* (1977) provide various assumptions by awakening alertness to the symbolic and perceived meaning of the body.

To elucidate how culture affects human behaviour, Erving Goffman is another prominent sociologist who works on symbolic interaction. He focuses on a person's subjective definition of the situation and the concept of stigma. Multidisciplinary approaches also constitute some new contemporary research that unfolds the relation between culture and health. So, till now you have learnt some of the theoretical understandings on the influence of culture and health from the classical to contemporary times.

Stop and Read

Multidisciplinary Approach: This approach is an amalgamation of various disciplines to redefine problems external to the normal boundaries and come up with solutions based on new understandings of

complex and complicated situations. It is a curriculum where a same topic is studied and analysed from different disciplines. It involves several professionals with their own expertise and inputs for more holistic outcomes.

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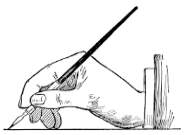

1. Fill up the gaps:

a. The book *The Social System* was written in the year___.

b. For Malinowski_____is the cultural response to health.

c. Durkheim has discussed the concept of "social fact" in which book_____.

3.4 CULTURE AND HEALTH BEHAVIOURS

Every culture worldwide has systems of health beliefs to analyse and explain the cause of illness, how it can be cured or treated, and who should be involved in the process. The extent to which patients perceive patient education as having cultural relevance for them can have a profound effect on their reception to information provided and their willingness to use it. Mostly, in the western societies, the cause of an illness or an epidemic is believed to be the result of some natural scientific phenomena but again, some societies believe that illness is the result of some supernatural phenomena. Therefore, cultural issues play a very significant role in patient compliance.

Culture influences the perceptions of health, illness and death, beliefs about causes of diseases, approaches to health and so on. In this section, you will be learning on culture and health behaviour. As we can see that culture acts as a part and parcel of everyone's lives and therefore, it has a great influence on human behaviour which cannot be overemphasized. For a more holistic understanding, we will be discussing health behaviour by categorizing them into three types- preventive health behaviour, illness behaviour and sick-role behaviour. The two former concepts were put forward by Stanislav V. Kasl and Sidney Cobb, and the concept of *sick-role* was formulated by Talcott Parsons. In the latter part of this unit, we shall discuss various health behaviours in detail.

3.4.1 Culture and Preventive Health Behaviour

Preventive health behaviour refers to the activity where an individual believes that s/he is healthy to prevent any illness or disease. Kasl and Cobb have labelled this health behaviour which is very different from the other two types of behaviour which we will discuss in the later sections. In addition to the study of healthy individuals, other significant studies are also made to understand preventive health behaviour like addiction or substance abuse that focuses mostly to analyze the path or the process of an individual towards addiction. It also tries to identify the factors involved in the process. The subjective evaluation of one's own health status may propel or retard preventive action against diseases. It was found that there are many reports or data regarding the self-evaluation of one's own health status but fewer data regarding the cultural meaning attached to one's own health status. Evidence of such cases is found among the Chinese. It must be noted here that, it is not very easy to study culture and health. There are difficulties that one has to encounter to study preventive and other types of health behaviour like alcoholism and other health disorders among immigrants and others.

M.C. Guttman has studied about the immigrants in the United States and he has found that the presence of multiple cultural identities has not

created further any identities. But a significant outcome that he has found was *pragmatic acculturation.* It is the borrowing of different cultural factors or elements of different societies and adapting them for a practical purpose. It is a practice to search for preventive ways to prevent illness or it searches for different remedial measures to deal with diseases or illness and also seeking expert suggestions to treat any illness or disease. To put into simple words, individuals borrow healing ways and practices from different cultures other than their own. However, they might not incorporate those healing practices taken from others in their lives permanently. The borrowing and adopting process is an ongoing process of dealing with health and illness. Another way to look at culture and health is the identification of cultural differentiation in health behaviour (Cockerham, 2001). Differences must be seen in a sub-group of a community or a country that is assumed to be homogenous.

3.4.2 Culture and Illness Behaviour

Illness behaviour refers to the activity undertaken by a person who feels ill for the purpose of defining the illness and seeking for a solution. How people behave when they feel unwell or how they deal with illness symptoms, and also the meaning they attach to these symptoms varies across culture. Cultures are so distinctively different that there is no demonstration required to show the differences in illness behaviours among different cultures. Documentation on the relation between culture and illness behaviour is rapidly increasing. It may be noted here that the reaction towards a symptom differs among family and people close to the ill person. Different understanding of a person being ill also varies. For instance, the Vietnamese only considers a person as ill when he or she threatens the social order or the safety of people which is quite different from the other cultures (Cockerham, 2001). Illness behaviour involves the attitude of waiting and observing the symptoms and the

reaction to them which is followed by self-medication. If the problem aggravates, expert advice is sought.

3.4.3 Culture and Sick-Role Behaviour

Sick-Role behaviour is the activity undertaken by an individual who considers himself or herself ill for the sake of getting well or cured. It is the manner in which persons monitor their bodies, interpret and define their illness symptoms, take some remedies to cure diseases and also use and seek more formal healthcare systems. However, before discussing sick-role behaviour, it is very necessary to understand what actually sick-role is. The term "sick-role" was first coined by Talcott Parsons in his book *The Social System* in the year 1951. He considers that being sick means that an individual enters into the role of a "sanctioned deviance" because a sick person is not a productive member of any society. He argued that the best way to understand illness from the sociological lens is to view it as a form of deviance which brings disorder and instability in a given society. According to him, 'being sick' is not simply a fact or a condition but, it also contains some rights and obligations. There are three rights and two obligations. These are-

- Customary Rights:
    - The sick person is not allowed to perform her/his normal daily social roles.
    - The sick person is not responsible for her/him getting sick or her/his condition.
    - The sick person has the right to be taken care of.
- Obligations:
    - The sick person must try to get fit and healthy.
    - The sick person should seek technically competent help and cooperate with medical professionals.

Mark Zborowski analysed the influence of culture on sick role behaviour for the first time focussing on cultural differences in response to pain. Recent studies and publications have addressed the significance

of physicians and other healthcare professionals to be informed on the importance of cultural differences that might impact the relationship between the doctor and the patient. Some of the excellent works like *The Cultural context of Health, Illness and Medicine* (1977), *The Handbook of Diversity Issues in Health Psychology* (1996) and *Culture and Health* etc. all of these books have in detail discussed illness behaviours, the medical profession and introduces some of the important conceptual discussions. While we are discussing sick role behaviour, it must be noted that an informal social support network is also very significant for the sick person.

Stop and Read

A person's sick role behaviour is significantly influenced by culture. For instance, machismo may discourage a man from seeking prompt medical attention.

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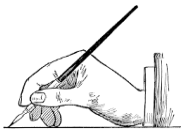

1. What is preventive health behaviour?

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2. What is sick-role behaviour?

3.5 SUMMING UP

We can summarise this discussion as:

- There is a very close relationship between culture and health

- From the classical ages to the contemporary times, we have seen that sociologists and anthropologist have shown keen interest in analysing and explaining the influences of culture on health. Therefore, culture is a significant factor that impacts health, wellness and illness.
- Again, we have learnt that the meaning of culture is highly contextual. One cannot easily define what actually culture is.
- Culture plays a very significant role in human behaviour. It impacts the way people perceive illness or any disease.

3.6 QUESTIONS

1. What is Culture? Support your answer with proper theoretical discussions from the classical ages to our contemporary times.
2. Discuss culture and the various health behaviours. Give proper illustrations to support your answer.
3. What is Sick Role? Write a note on sick role behaviour.

3.7 RECOMMENDED READINGS AND REFERENCES

Cockerham, W.C. (ed.). (2001). *The New Blackwell Companion to Medical Sociology*. Blackwell Publishers Ltd., Oxford.

Deborah, L. (2012). *Medicine as Culture: Illness, Disease and the Body*. SAGE, London.

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UNIT 4: ILLNESS NARRATIVES

UNIT STRUCTURE

4.1 INTRODUCTION

By now, we have learnt in detail about culture and its influence on health in a sociological context. In this unit, we are going to cover the relevance of narratives in the context of health and illness. It is universal that people talk about their experiences in life. The language here plays a very significant role to convey and share one's experiences. The development of language has led to the extensive use of various metaphors and speech and therefore, the narrative form. All societies are somehow dependent on these narratives, at least to maintain some social integration. Therefore, narratives bind together the cultural and individual levels of human existence. Today, studies on narratives have gained much attention, in both the social and physical sciences and also in the field of literary criticism. In this unit, we shall learn about illness narratives, that is how sick people narrate their illness and their experiences. These narratives are often in oral form and also in written autobiographies and biographies. Many authors and scholars have put a keen interest in understanding these narratives of

sick people and use them in research works. We will discuss this in detail below.

4.2 OBJECTIVES

After going through this unit you will be able to:

- Discuss illness narratives;
- Explain the significance of illness narratives;
- Explain the use of illness narratives in research.

4.3 UNDERSTANDING ILLNESS NARRATIVES

In this section, we will try to understand what illness narrative is. It gives us an opportunity to look into the uncovered and unexplored areas of life. They also help to construct a new context that encompasses both the illness event and surrounding life events to recreate new social relations. Illness narratives are commonly thought to be the narratives of the sick people about their illnesses and also their impact on their lives. Illness narratives can also include the narratives of relatives, the effects of the illness on their relationships with the sick people and also on their own lives. As mentioned in the beginning, these narratives can both be oral and written. They help to configure and articulate experiences and events that change one's life and its prerequisites as a result of illness (Ritzer, 2007).

In the late 20th century many studies and research have been done to understand the forms and functions of illness narratives. Patients' illness narratives concern about the individual's suffering at a micro level that stands in contrast to the medical narratives which reflect the needs of the medical professions and institutions. The research on illness narratives is marked by diversity in the theoretical perspectives and methods. The field covers interview studies of patient narratives of illnesses, as well as studies of the way narratives, are used in the interaction between medical staff and

patients. Medical sociologists and anthropologists (among others) have attempted to understand suffering and illness as they are experienced by ill persons and how their daily lives are affected by illness – this in opposition to describing the illness from the perspective of the medical profession and institution (Ritzer, 2007). This approach has been conceptualized by Mishler in the year 1984. According to him, there is a conflict and struggle between the ‘‘voice of the life world’’ and the ‘‘voice of medicine”. Many researchers have tried to examine the ‘‘voice of the life world’’ extensively and in that context has used narrative both as an analytic and theoretical concept.

There are three main areas of research: illness narratives and identity, illness narrative and medical knowledge, and the functions of illness narratives. The first area focuses on the ways in which individuals reconstruct their identities in the face of chronic illness through narratives. The second area of research looks at the narrative as primarily focusing on the illness, that is the narrative conveys knowledge and ideas about the illness. The third area of research looks at the functions of the narratives in various contexts. Research on illness narratives is still growing. In contrast to the verbally performed narratives, new areas focus on the ways illness narratives that are represented through various media’s like photos and films and also through bodily performance.

CHECK YOUR PROGRESS

1. How do illness narratives help us?

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2. Fill up the gap: Narratives can be both_____and_____.

4.3.1 Arthur Kleinman's Views on Illness Narratives

So far we have understood what are illness narratives and their relevance in an individual's life. Now we shall look into Arthur Kleinman's views on the illness narratives. Kleinman has extensively worked on illness narratives. His book, *The Illness Narratives: Suffering, Healing & the Human Condition* was written in 1988, where he has extensively discussed the illness experiences. This book deals specifically with the chronic illness, that is how it is sometimes not treated, how it affects the individual and other social networks all are being discussed in this book. From different cultural backgrounds of the doctors and patients, this book is a fusion of many case studies, historical studies and also anthropological studies. Kleinman has attempted to criticize the western biomedical model and also brings the various perspectives of the non-western doctors and also the patients. He was much concerned about the psychosocial aspect of the patient. For him, 'illness' is different from 'disease'. Illness is an individual's subjective experience of their symptoms and the illness problems are those that the patients bring to the doctor.

Disease is a medical term. It means that there is a pathological change in the functioning or structure of the body. He also talked about sickness. Sickness can be described as a disorder from the generic sense. It can be applied to a group or a population. However, illness can be contextual. Kleinman views chronic illness as one of the most complicated forms of illness which have several meanings. He also looks at the importance of culture that influences the various meanings of illness. He also looks at how the medical professional acts to illness. The neoliberal medical healthcare system was also being criticized by him.

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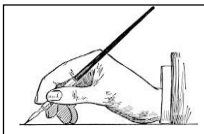

1. **Fill up the gap:**

a. For_____, 'illness' is different from 'disease'.

a. Kleinman views_____as one of the most complicated forms of illness

4.4 NARRATIVE DIMENSIONS

When a person is healthy when s/he is able to perform all the duties and responsibilities properly expectations surely come that their lives would continue tomorrow in a likely manner as today. We believe that our bodies will function the same from one day to another. However, chronic illness destroys such expectations. Such kind of illness does not go away easily and creates havoc in people's lives. A body affected by a chronic disease is felt like an enemy as it disrupts our day to day life activities. Many people see it as a split in their lives as before and after. For some such suffering never goes away and no way is discovered. But again, others view it as a type of journey whether it is emotional, spiritual or others. Through this, they try to convey their stories and choose it as a platform. Their purpose is to make people understand that their illness has changed them and these stories manifest ways to let people discover how they have changed.

Sharing illness narratives and conveying their illness experiences help the ill person in several ways. *Firstly*, the creation of illness narratives to describe ones illness helps the ill person to bring stability and order to the chaos. If the illness is a journey, it is one that makes a mess of the planned route. Describing what it is like to take that trip helps people remember

significant points along the way that when looked back on, can add up to a coherent story. Telling the story in effect takes the disconnected fragments of the illness experience and creates a story out of them, one that points to a new destination (Greenhut, 2018). As said by Roger Schank, a psychologist, we must share our or tell someone else's story that describes our experience because the process of creating a story also creates memory structure that will contain the gist of the story for the rest of our lives. Telling the story helps create a new map for the ill person, a picture of what happened, when it happened, who was there, and how the ill person responded to it all because without the story there is no map (Greenhut, 2018).

Secondly, an illness narrative provides values to others (those suffering from a chronic illness). The affected person undoubtedly gets a detailed analysis of their disease from the medical health team but the patients also have other needs like emotional, side effects of the treatment, living with uncertainty, etc. which are catered to by illness narratives. We must also understand that there is no replacement for hearing an illness story as someone speaks realistically about what the experience with the illness has been like. Apart from the people with chronic illness others like physicians also get benefitted by hearing to these lived experiences. However, it takes a long time to educate healthcare professionals about ways in which they can communicate with patients suffering from chronic diseases.

Thirdly, illness narratives reduces the isolation that is felt by the ill people. Medical professionals never teach the patients how to incorporate their illness in their day to day lives. Sharing illness narratives further helps to understand ill people at the micro-level, that is their lived realities. These help them to open up new contacts with people suffering from the same illness. Narratives also help the ill person to confront the stigmas and challenge the stereotypes and societal assumptions. There are also people who suffer from chronic illness in an invisible manner. Therefore, many a time they may not appear sick.

Today, it is very rare that in this modern society where people barely get time for themselves, would listen to the stories of others. As such, it is very rare for a person suffering from a chronic illness to get an opportunity to speak their heart out without any interruption. For a healthy listener, s/he may cut short the story. Also, in many cases, the listener may find some solutions to offer that may help with the illness but it may as well end with a misinterpretation or false narrative for the ill person, making her/him more isolated.

(Referred from- "Narrative Dimensions: Re-Envisioning Health and Illness, Honouring Life's Experiences" by Janet Greenhut (2018) https://www.narrativedimensions.org)

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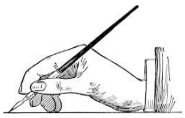

1. **Fill up the gaps:**

a. Telling the story helps create a_____for the ill person.

b. _____have said that, the process of creating a story also creates memory structure.

c. Sharing illness narratives further helps to understand ill people at the _____.

4.5 SUMMING UP

In this unit, we have explored the significance and role of illness narratives in sociology of health and illness. In this context, we have learnt that language plays a significant role in the lives of people. In general, narratives bind people together through sharing of their thoughts and

experiences. Narratives are one's own personal realities. As discussed above, there are several significant uses of illness narratives which cannot be overemphasized. Studies on illness narratives by different professionals show the significance of it in the lives of individuals.

4.6 QUESTIONS

1. Elaborately discuss what is illness Narratives?
2. Write a note on Arthur Kleinman's views on illness narratives.
3. Discuss how illness narratives help the ill person and its usages.

4.7 RECOMMENDED READINGS AND REFERENCES

Kleinman, A. (1988). *The Illness Narratives: Suffering, Healing and the Human Condition.* Basic Books, the U.S.

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MODULE II: MEDICAL PLURALISM AND ALTERNATIVE MEDICINE

UNIT 5: ALTERNATIVE MEDICINE

UNIT STRUCTURE

5.1 INTRODUCTION

The term 'alternative' in alternative medicine suggests that it consists of those medicines and healthcare systems that are seen as an alternative to biomedicine or allopathic medicines. The various national and regional studies have pointed out that in developed countries, the importance of alternative medicines has been growing. The studies show the increasing usage of alternative medicines in those countries. The increase in OUP (out of pocket expenditure) in the government healthcare system has also been one of the factors that have made people incline toward alternative

medicines. In this unit, we will discuss the importance of alternative medicines. The unit will cover the different types of ethnomedicine. You will get an overview of the concept of alternative medicine that is considered as a substitute to biomedical medicines.

5.2 OBJECTIVES

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

- Explain the importance of the alternative medicine;
- Discuss the different forms of alternative medicine.

5.3 IMPORTANCE OF ALTERNATIVE MEDICINE

Good health is prerequisite for the adequate functioning of any individual within a society. If our health is sound, we can engage in numerous types of activities. For the smooth functioning of society, illness should be healed out. In this case, medicine has been playing a significant role to heal the different diseases. However, within medicine, there are two major divisions. One is dealing with the diseases and the other section is known as social medicine. The social medicine indicates social and environmental factors influencing human disease and promote methods of prevention of disease. The earlier one is mostly based on allopathic and traditional medicines.

Howard Rasmussen (1975) made an argument regarding the alternative medicine. He says, it can either redefine diseases and restrict its treatment to specify different medical conditions or it can accept a broad concept of disease and change medical education programmes to deal effectively with the wider spectrum of illness.

Alternative medicines are mostly used for curative purpose. The alternate medicines operate mostly outside of the healthcare system. Since the 1990s, there has been widespread sociological support for viewing non-biomedical practices as ‘complementary’ rather than

'alternative'. The term complementary and alternative medicines have been commonly used in both the biomedical and social sciences literature. However, most of the scholars have pointed out that alternative medicine carries a holistic aspect of health that takes care of both the mind and the self. One of the major criticisms against the biomedicine is that in most of the cases, it fails to interpret the holistic aspect of health. The people's socio-cultural dimension of health is mostly undermined in allopathic medicines.

The emergence of alternative medicines has been the product of enlightenment. However, it is itself a critique of modern allopathic medicines that fails to introduce the transcendentality of the health of the people. In the nineteenth century, the work of Louis Pasteur and other prominent scientists ensured that 'modern medicine' would be the new orthodoxy, and this would be informed by an allopathic principle. The triumph of modern medicine has been attributed more to the incorporation of scientific medical practices into powerful professional groups than to the inherent superiority of knowledge claims (Easthope, 1986). The various alternative healthcare systems such as homoeopathy, acupuncture, hydrotherapy, botany, osteopathy and mesmerism have been growing popular at different places. Emerging numerous medical practices lead to the state of medical pluralism. Medical pluralism has been quite relevant in the public discourses for which people get different options to determine which one will be their preferential healthcare system.

5.4 CONCEPTUAL UNDERSTANDING OF ETHNOMEDICINE

The concept of ethnomedicines is based on people's lay understanding of health. Culture plays a significant role in the emergence of ethnomedicines. Ethnomedicines rely on empirical knowledge for managing practical problems of sickness. In most of the cases, certain predominant superstitious beliefs have also been playing a significant role in terms of

shaping the different ethnomedicines. Different magical and rituals beliefs are constantly shaping the conceptual understanding of illness and these are based on empirical, real and adaptive effects (Winkelman, 2009). The concept of ethnomedicines is mostly interrelated with the lay understanding of health. Lay understanding of health indicates people's understanding over their own health. This lay understanding has been developed over time through socialisation. However, in most of the cases, it has been observed that a portion of lay understanding of health can also have the possibility to become a part of professional medicines. The Professional care of medicines is mostly dominated by biomedicine. In the context of India, the practice of ethnomedicines is quite common mostly among the different tribal communities.

Culture has been playing a significant role in terms of development and practice of the ethnomedicines. Ethno-medicines have been an example of new paradigm that could be considered as different from the allopathic medicines. Both allopathic and ethnomedicines have been analysing the concept of the body differently. Ethnomedicines usually have been the root cause of different cultural interpretation of diseases. Ethnomedicine is a study or comparison of the traditional medicine that is practised by various ethnic groups, especially the indigenous people. The word ethnomedicine is sometimes used synonymously with traditional medicines. Often the concept of ethnomedicine is seen as interdisciplinary, where both medical anthropology and ethnobotany have been considered significant.

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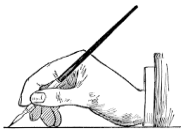

1. What do you mean by alternative medicine?

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2. What is ethnomedicine?

5.5 FOLK MEDICINE

The folk medicine is based on people's traditional understanding of medicines and that is why it is also mostly addressed as traditional medicine. Before the invention of modern allopathic medicine, the medicinal aspect of traditional medicines has been passing from generation to generation in society. The World Health Organization (WHO) defines traditional medicine as "the sum total of the knowledge, skills, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness. Folk medicine includes the cultural interpretation of healing" (WHO 2005). Midwives, traditional healers, spiritual healers, diviners, faith healers, herbalist have been categorised under the folk medicines.

The origin of traditional medicines has been the reaction of primitive men to natural events. In this context, magic and witchcraft have been significant phenomena of society that became an important method of healing in society. Again, people's belongingness toward the traditional healers has one of the significant factors that make alternative medicines even more popular. However, in most of the cases, it has been observed that the different healers who practice the traditional medicines are mostly the insider of the particular family and with whom the people of the villagers could maintain a close affinity. In most cases, the health providers belong to a larger kinship network of the villagers that have indirectly enhanced the relationship between the health providers and health receivers. Research on medical sociology has pointed out that the patients' relationship with the traditional healers is relatively satisfactory compared to the relationship with the allopathic doctors. In these cases, the patients

hardly hesitate to reveal their health problems to the traditional healers as they are often an insider of their community.

Within the folk tradition, there are mostly two kinds of healers- midwifery and herbalism. In most societies, women have their own mechanisms and local traditions that are practised during the time of pregnancy. These practices have more or less universal acceptance across various places. On the other hand, within the traditional medicines, herbal medicine practitioners have also been playing a significant role. All societies have also developed traditions regarding the use of local plants as an essential aspect of health maintenance and disease treatment. These traditions are widespread, where different plants have been used for medical uses for medical purposes. This empirical knowledge is developed through various clinical experiences (Winkelman, 2009).

The folk sector is not the dominant health sector for a nation. It may not play a significant role in terms country's economic and political scenario, but it has been considered as one of the useful healthcare systems. However, folk health care system comes under the informal health structure, which has not been considered significant as far as the country's revenue generation is concerned.

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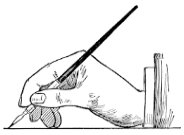


1. Fill up the gap:

Within the folk tradition, there are mostly two strata of healers-_____ and herbalism.

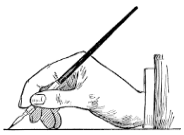
5.6 SOCIAL MEDICINE

Even though we are discussing social medicine as alternative medicine, it is pertinent to note that modern allopathic health practitioners also consider the importance of social medicines as a healing method. In the 19th century, social medicine emerged as a movement to investigate medical problems through the lens of social science. French physician Jules Guerin introduced the term 'social medicine' (Cockerham and Ritchey, 1997). The idea of 'social medicine' spread throughout Europe after the First World War. The importance of the social aspect of health has been popularised after the industrial revolution. During that time, an attempt has been made to understand how the socio-political condition affects one's health. Scholars and policymakers have tried to understand how the marginalised people's health condition has been influenced by the existing socio-political scenario of the nation and such consciousness came after the First World War, which made severe damage to people's health. Such political condition has been more harmful to the socio-economically marginalised people and to understand their condition, branches like social medicine emerged.

Social medicine is not a new branch of medicine but somewhat an extension of the idea public health, reflecting the strong relationship between medicine and social sciences or a new orientation of medicine to the changing needs of man and society. According to Cockerham and Ritchey (1997), social medicine is a broad field embracing the social and behavioural sciences, along with humanities in the analysis of the relationship between society, health and medicine. Social medicine also studies the social effects of medical knowledge, social origins of health and diseases, health lifestyle and social and political philosophies that are underlined in terms of healthcare delivery system. The goal of social medicine is to produce knowledge enabling health practitioners and policymakers to make informed and effective decisions reflecting the social and cultural realities of the people. Thus, social medicine has been

significant not only in the study about the health behaviour of the people, but it helps to study the health policies and programmes of the society. However, it studies the importance of environment on one's health. Ecology is one of the important phenomena as per health is concerned.

CHECK YOUR PROGRESS



Fill up the gap:_____introduced the term 'social medicine'.

5.7 UNANI MEDICINE

Unani medicine first emerged in Greece. From Greece, it travelled to Arabia and then to Persia and finally penetrated to the Indian system of medicine. The Unani medicine system is very close to India's Ayurvedic system. Most of the Indian scholars recognised it as one of the indigenous systems of medicine. The Unani system is based on the humoral theory (Mishra, 2007). Borins (1987) stated that the Unani system has been playing a very significant role in terms of health treatment. Unani practitioners in India have started to use modern techniques such as microscopic examination, chemical analysis, radiography and electrocardiography for treating patients. In the Unani system, treatment like regional therapy, diet therapy and pharmacotherapy are included (Akram, 2014).

5.8 SIDDHA SYSTEM OF MEDICINE

The Siddha system is based on the principle of the free flow of pranic energy (life) all through the body. When the flow is stopped, diseases

take their roots. Restoring the free flow of energy is restoring the health of the patient. In this case, no specific medicines are used. The treatment can be done through yoga and meditation. The Siddha practitioners mostly examine the patient's tongue, nails, eyes and lips (ibid).

The Siddha system of medicine is very popular in South India but these days, it has been promoted by the government of India. It is known to be one of the earliest traditional medicine systems in the world. This method treats both the body and mind. Siddha means perfection through which one can attain bliss. It is related to the ancient Tamil culture and civilization.

Siddha medicine is believed to invigorate and restore the dysfunctional organs that cause the disease. This method follows Kayakarpam, which is a special combination of medicine and lifestyle along with Pranayamam. Thus, Siddha tries to connect both spiritual and physical aspects of a person. It aims at the physical, psychological, social and spiritual wellbeing of an individual.

5.9 YOGA THERAPY

Yoga therapy refers to the treatment of diseases through application of yoga practices to alleviate physical and mental health. It uses *asana* (the physical postures) and *Pranayama* (breathing exercises). This mode of treatment has been practised across different parts of the world. Different scholars have pointed out that yoga therapy originated in India. Over some time, this kind of treatment has been popularized all over the world and is considered as one of the important branches of alternative medicines. Yoga therapy has emphasised on exercise, pranayama and meditation. Of late, yoga therapy has also been included in the curriculum of most schools and colleges in India.

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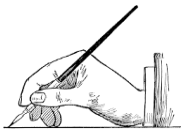

Fill up the gaps:

a. Unani medicine first emerged in_____.

b. The_____is based on the principle of the free flow of pranic energy (life) all through the body at every time.

c. Of late,_____therapy has also been included in the curriculum of most schools and colleges in India.

5.10 SUMMIMG UP

In this unit, we have learnt about the importance of alternative medicine and its different branches. The main reason for the emergence of alternative medicines has been a response to the dominance of modern allopathic medicines. In most of the cases, allopathic medicines are relatively costly and that compel certain sections of people to go for alternative medicines. Again, some people seek different methods of treatment after not getting good results from the use of allopathic medicine. Alternative medicines have made an alternative paradigm that indicates the counter-narratives of the modern allopathic healthcare system. Allopathic medicines are known for their different side effects. This is also another factor contributing to the growth of alternative medicines. Most of the people prefer alternative medicines to allopathic medicines as the former usually do not have side effects. Thus, the popularity of different types of medicine has been increasing in the public discourse.

5.11 QUESTIONS

1. Write a note on the importance of Alternative medicines.
2. What is ethnomedicine? Examine its importance as alternative medicine.
3. Discuss the different types of alternative medicine.

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UNIT 6: MEDICAL PLURALISM

UNIT STRUCTURE

6.1 INTRODUCTION

The presence of multiple therapies is a reality for most of the countries. These multiple therapies are generally divided as codified and non-codified system. The codified system of medicine is, where the knowledge is codified either in the form of pharmacopoeias or ancient script. (Ruhil, 2015). Whereas in the non-codified system of medicine, knowledge is transferred through oral means like folklores etc. and developed through local needs and resources available. Therefore, the non-codified system of medicine varies from society to society. However, their co-existence is equally affected by an unequal distribution of power. This unequal distribution of power derives its legitimacy from political patronage, cultural ideology, revivalist movements, and competition among the different medical therapies for the growing international market.

6.2 OBJECTIVES

By the end of the unit, you will be able to:

- Explain the meaning of medical pluralism;
- Explain how medical pluralism is being used to project the other therapies as a replacement of the official therapy of the state;
- Analyse the differences between theories of illness among various therapies present in India.

6.3 MEDICAL PLURALISM

The term "medical pluralism" was first used by social scientists in 1970s to denote a situation in third world countries where people resorted to other therapies apart from state-sponsored bio-medicine (Sujatha, 2009). These third world countries have many local health traditions along with bio-medicine. Therefore, medical pluralism can be defined as the presence of multiple systems of medicine, like Unani, Ayurveda, Siddha, folk medicine, homoeopathy and allopathy. It might also be referred to as multiple choices in a system. So within the system, she/he may go to a private practitioner or may go for the services at a hospital. Medical pluralism gained prominence in the 1990s when demand for alternative medicine for a various range of health conditions started growing. So, in the present situation, state-sponsored medical pluralism is a reality which came up as a result of public demand.

6.4 MEDICAL PLURALISM IN INDIA

Medical pluralism in India grew due to the contribution of western and Indian system of medicine. Each of these therapies assigns different theory of diseases and their therapies are equally diverse. Allopathy in India arrived with the arrival of Britishers. Before the arrival of allopathy medicine, India was home to many other medical practices, all of them either originated in India or travelled to India at various point of time. Some of these practices have a magico-religious base as well, where the

disease was considered as a curse by evil spirit or wrath of a deity and the disease alleviation was possible only through appeasing the concerned deity through prayers and *other* religious practices as suggested by religious gurus. In opposition to this, Ayurveda presented a physical basis of disease where the disease is considered as a result of an imbalance between the three humours or *tridosa* viz *Vatta, Pitta and Kapha*. *Vata* corresponds to all the movements in the body and mind like respiratory, reproductive, excretory, circulatory digestive and it co-ordinates and sustains all organs of the body, sensory faculties. The *vata* is again divided into different types mainly-

(a) *Prana* –It maintains senses organs like heart, mind, breathing, intellect.
(b) *Udana* –It controls speech, strength, awakening if minds, nourishes tissue pores.
(c) *Vyana* –It controls the movement of the eyelid, blood flow, contraction expansion, upward downward movement.
(d) *Samana* –It controls the digestive system
(e) *Apana* –It controls the elimination of faeces, urine, foetus, menstrual blood (Caraksamhita cited in Jayasundar, 2012).

The function of *Pitta* is related to regulate the metabolism and to sustain heat, desire, hunger, complexion and memory. The *pitta* has many classifications

(a) Pachaka –It controls the movement of the food and elimination of excreta.
(b) Ranjaka –It imparts red colour to blood.
(c) Sadaka –It has a psychological function with its association mainly to intelligence, pride, enthusiasm.
(d) Alochaka –It helps in vision.
(f) *Brajaka* –It is associated with skin and complexion (Caraksamhita cited in Jayasundar, 2012).

Kapha is responsible for lubrication of joints and provides a structural basis for body cohesion and nourishment. Kapha is classified on the basis of

(a) Avalambaka – It is associated with heart and body fluid namely fluid in the shoulder, arm and neck.
(b) *Kledaka* –It controls the lubrication of food in the digestion.
(c) *Bodhaka* –It controls taste and saliva
(d) *Tarpaka* –It is associated with fluid in the head and nourishment of sense organs
(g) *Slesha* – It controls the lubrication of joints and joint movements (Caraksamhita cited in Jayasundar, 2012).

Since the theory of illness according to Ayurveda is the imbalance between the three *dosa* the identification of the dysfunctional *dosa* is the main focus of diagnosis. The recommended treatment would aim at curing the disease by restoring the balance without causing any side effect or creating any new disease. Treatment in Ayurveda generally is a combination of medicines, medical procedure (*panchakarma)*, diet and mental and physical activities (Sujatha, 2012).

Siddha medicine is mainly practised in and around Tamil Nadu and in some countries where the Tamil community is in sizeable number. The word *Siddha* in Sanskrit means 'to realize'. Siddha medicine is a branch of Siddha tantric yogi, who has obtained the supernatural power through yoga and alchemy. The basic texts of Siddha are mainly in Tamil and Telugu. Siddha and Ayurveda shared many common features like physiological theories, diagnosis, and therapeutic methods; however, it uses more metal and minerals in its medicine as compared to Ayurveda. According to Siddha, the body is made up of substrata or sheaths known as *utampu*, which is nourished by many *dhatus* (Sujatha, 2012).

Unani in contrast to Ayurveda's civilizational origin came to India with the Moghul occupation. Unani is derived from the word *Unan*, which means Greece in Arabic term and *Unani Tibb* means Greek medicine (Browne,

2001; Khan, 1986; Meyerhof, 1984; Rosenthal, 1990; Ullman, 1978 cited in Alter, 2008). The language of reference of these Greek medicine is in Arabic and the ample amount of the prevalent knowledge of Greek medicine is known by the Arabic and Persian writings, so, Unani Tibb is often referred to as Islamic or Arabic or Greco-Islamic or Greco-Arabic medicine. *Unani Tibb* received patronage from Hippocrates in Greece during the fourth and fifth century BC (Khaleefathulah, 1991). However, before the advancement of western medicine, Unani medicine was considered more of a secular medicine with it being practised and used by many non-Muslims.

According to *Unani Tibb*, the human body is considered to be made up of seven components (Ummor-e-Tabiya) and each of them has a close relationship with each other and affect the health of an individual. These components are-

(a) *Arkan* –It means the human body according to Unani Tibb is made up of four elements- air, water, earth and fire. They represent four states of matter, as in air is hot and moist, water is cold and moist, the earth is cold and dry and the fire is hot and dry.

(b) *Mizaj* – It represents temperament. The collaboration of different elements (*Arkan*) creates various states which in turn produces various temperaments in an individual.

(c) *Akhlat* – It denotes humours. Humours are the essential fluids which the body gets from the food and the fluid intake.

(d) *Aza* – It signifies organs. The health of the whole body is dependent on the health of each organ.

(e) *Afal* – It means functions of the various organs of the human body.

(f) *Arwah* – It implies spirits. *Arwah* or spirits are considered to be the forces that carry different power.

(g) *Qwa* – It connotes faculties or mental and physical power (Khaleefathullah ,1991).

According to Unani Tibb, the body has the power of self-preservation and in cases of any disturbance, the defence mechanism of the body tries to adjust and restore the body. The role of the physician in Unani Tibb is, therefore, to help and guide the body in the self-preservation. Drugs in Unani Tibb are mainly made up of plants, minerals and animal sources. Practitioners of Unnai Tibb in India gave special emphasis to locally available medicinal plant for drugs.

Yogasanas or Yoga according to the Hindu ideology is not merely an exercise but a union of body, soul and mind. Proper *asana* or posture is the first step in yoga and through these postures or *asana*s, the function of different organs are carried from *chitta* (mind) to soul and thus, the union of mind, soul and body.

As India is home to many systems of medicine, there was a bureaucratic need to put a bracket between ISM and other indigenous systems of medicine. So, ISM stands for Indian System of Medicine and includes Ayurveda, Unani, Siddha and Naturopathy. The reason behind selecting only these systems of medicine among all other indigenous systems of medicine is that these systems of medicine have textual evidence and are well documented and do not rely on oral tradition to pass the knowledge (Banerjee, 2000).

In contrast to all the codified systems of medicine, India has been a cradle of many “folk medicine”. Usually located in villages, these folk healers are frequented by a large number of population. Their preference for folk healers reflects the diverse health culture of the people. Folk medicine includes all form of herbal medicine, traditional birth attendant, faith healing, religious therapies, specialists for diverse disorders like dog-bite, snakebites and bonesetters. These healing practices rely largely on supernatural power as resources for knowledge. Along with its dependency on religious dimensions, the healer has a social function and a social role to play. It is therefore not uncommon for a healer to sometime treat a disorder that affects the social life of a person, such as lack of employment, discord

between a married couple, dispute related to property. Folk medicine includes such a large array of practices that the use of the term 'medicine' in its relation to bodily ailment would be quite contested.

Western medicine namely, bio-medicine came to India with the arrival of Britishers. Hippocrates, the father of bio-medicine, brought in the concept of logic, reasoning and observation that challenge the magico-religious concept of illness. Hippocrates' lecture as complied by his disciple talks about all branches of medicine. He believed that matter is made up of four elements, namely- earth, water, air and fire. These elements embody being hot, cold dry and moist and are mainly denoted by four humours- phlegm, yellow bile, black bile and blood. He ascertained that the health of an individual depends upon the perfect balance between these four humours. Just like Unani Tibb, the human body is believed to be capable of restoring the balance in case of any disturbance and the role of the physician is to help in the restoration of the balance. Along with Hippocrates, another Greek philosopher and physician, Galen emphasized the importance of human anatomy which was prohibited during that time owing to religious reasons. He, however, dissected pig considering its anatomy to be similar to that of human beings. It was during the sixteenth century, that a Belgian physician Andreas Vesalius corrected the wrong conception of human anatomy by Galen and conducted the first dissection on the human body to study the human anatomy. With this development, the theory of Hippocrates on humour was also started getting refuted, but nevertheless, the contribution of Hippocrates towards bio-medicine cannot be disproved.

The period preceding the sixteenth century was marked by revolution. Out of which the political revolution of France and America and the industrial revolution resulted in the rise in the standard of living along with advancement in science and technology. The industrial revolution along with technological advance brought many problems like the creation of slums, overcrowding, and filth. This caused many diseases like cholera, tuberculosis which were the main reasons for the death and ill health

among children and women. During that time, there were many theories to explain the situation. One of them was the Miasma theory. This theory ascribes noxious fumes or vapours as the main reason for diseases, especially cholera. The theory ascertains that the gases or miasma coming out of filth or decomposed organic matter are the causes of disease. It explains why population residing in the filthy, stinky area are more vulnerable to disease, especially cholera. This theory was supported by many sanitary reformers like Edward Chadwick, William Farr, Florence Nightingale, Sir John Simon (Park, 2005).

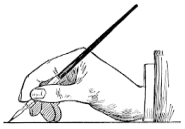
Another theory which gained prominence during that era was the spontaneous generation theory. According to this theory, disease is spontaneously generated within the blood it denies the contagious nature of disease (Park, 2005).

The third and most successful theory is the germ theory of disease. Louis Pasteur (1822-1895) demonstrated the presence of bacteria and Robert Koch (1843-1910) showed anthrax was caused by bacteria. These findings of Pasture and Koch established the germ theory of disease. Eventually, the germ theory for chorea was established and accepted worldwide. However, the sanitary reforms following the miasma theory had already done much in containing cholera before the development of the germ theory (Park, 2005).

With the gradual shift from acute to chronic disease, the germ theory was proving unable to give a causal relation with diseases like cancer, obesity, diabetes, heart disease, etc. Thus, a new theory known as a web of causation was propounded that ascertains a host of causes that interact among themselves, rather than a specific cause for the disease. Some of these causes are immediate whereas others are more distal causes for the disease. For example, in case of heart diseases, the immediate or proximate cause could be obesity, lack of physical activities, alcohol, and smoking whereas age, income and occupation could be distal causes (Park, 2005).

Another western medicine, Homeopathy came to India during the nineteenth century and was developed by a German physician. It follows the theory of 'like cures like', i.e. a single treatment for a particular type of symptoms. It also believes in treating the entire body rather than only treating the specific ailment and therefore it advocates the tiniest amount of dosage for a specific symptom (Bhardwaj, 1980).

CHECK YOUR PROGRESS



1. What is medical pluralism?

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2. What are included in the Indian system of Medicine (ISM)?

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3. What is the germ theory of disease?

6.5 WHY MEDICAL PLURALISM?

The dominant system of medicine in India during the early 19th century was the indigenous system of medicine which also included many folk medicines (non-codified system of medicine). With the advancement of the century, the Britishers have started to endorse biomedicine as the official system of medicine through policies and creating a discourse for its people. The health policy reflected their priority towards the health of their army and European settlers. Thus, in 1764, the East India Company instituted Indian Medical Services that instituted bio-medicine as the state-sponsored

medicine system. After the Indian Mutiny of 1857, the East India Company was taken over by the Queen and India came under the control of the crown. In the 18th and 19th centuries, India saw many wars that affected the mortality of European soldiers along with many diseases like fevers, dysentery, diarrhoea, liver diseases and epidemic cholera. So In 1859, the Royal Commission was appointed to enquire about the poor condition of health of the soldiers. The Commission reported that among the total number of deaths during the period of study, only 6% was due to war and the rest were due to major diseases like fevers, dysentery, diarrhoea, liver diseases and epidemic cholera. The report recommended cleanliness of the environment with better water supply, removal of miasmatic release from the soil, water, and air. Based on the recommendation of the report, norms were laid down for the creation and development of European civil areas, military areas, hill stations segregating them from civil areas. Thus, the cantonment area and European civil areas were created keeping in mind the environmental condition of the area rather than strategic locations (Ramasubban,1982).

Even though the state officially promoted biomedicine, the colonial state also encouraged ISM on many occasions integrating them with western medicine. During the end of the 19th century, the indigenous system of medicine was part of medical services in India. In many instances, the indigenous system of medicines was considered as a replacement of western medicines and people trained in indigenous system of medicines constituted the support staff of the western medical practitioners. Clearly, the indigenous system of medicine was used as a carrier of modern biomedicine to make it more acceptable. However, the situation changed with the start of the 20th century. With the start of the century, biomedicine not only got the official patron but also a discourse has been established in favour of bio-medicine. On the contrary, the indigenous system of medicine which was till the last century got some favour from the British government, and it was mostly, neglected. From denying medical registration to the indigenous practitioners to deregistering allopathic

medical practitioners associated with the indigenous system of medicine, this discourse was successful in establishing allopathic medicine as "scientific". The neglect of indigenous medicine by the colonial government, the subsequent humiliation meted out to its practitioners and the "unscientific status" assigned to them led to the formation of political organization as All India Ayurvedic Mahasammelan (Ayurvedic congress). The Ayurvedic Congress felt that all the issues are politically motivated and hence need to be addressed categorically. Along with addressing these political issues, the Congress also realised that to reclaim its status, it is important to institutionalize the training, train personals into a particular system of medicine, establish research organization to facilitate research. And hence, subsequent attempts were made to modernize the indigenous systems of medicine (Sujatha –Abraham, 2009)

The era of post-independence had many debates about the indigenous system of medicine and the committees that were formed in and around that period of time reflected those debates. The health policies of the British government were mainly for their troops and to save their trade from any kind of losses. And whatever they did for the general public it was under the international pressure. And under such international pressure '**Health Survey and Development Committee 1946**' was formed which is popularly referred to as the **Bhore Committee** with the view to look into the prevailing health conditions and health organizations in British India and give recommendations for future development. But it did not give due importance to indigenous medicines. It termed it as unscientific and the subsequent committees only emphasized the need for indigenous medicine to be streamlined along with biomedicine. Meanwhile, **the Chopra Committee** was formed in the year 1946 to look into the indigenous system of Medicine. The committee which submitted its report in 1948 suggested integration of the indigenous and western system of medicine through education and research. Even the National Health Policy of 1983 also proposed the same and asked for integration of the indigenous system of medicine with the overall health service system.

Stop and Read

'Health Survey and Development Committee' was formed in the year 1943 with Sir Joseph Bhore as its chairperson to prepare the blueprint of the health service system of India. The term of reference for the committee was: (1) survey of the present health conditions and health organization in British India. (2) Recommendation for future development. The committee submitted its report in the year 1946 and came up with long term and short term goals. Some of the long term plans are-(a) Health as an integral part of the overall development. (b) Services to be placed as close to people as possible. (c) Cooperation between health personals and people. (d)Laboratory facilities for diagnosis, treatment, consultations. (e) Inability to pay should not prevent anyone to secure adequate medical care. (f) Emphasis on proper sanitation measures. (g) The district as a unit of health scheme planning and co-ordination. (h) To provide curative, preventive, promotive services. (i) The long term plan talks about the three-tier medical system. (j) Primary unit with 75 beds for a population of 10,000-20,000 people doing curative and preventive works, secondary unit with 650 beds which will act as a first level referral, tertiary units with 2500 beds with modern medical facilities and administrative staffs. (k) Abolishing of licentiate medical courses.

The short term goal- Setting up of one primary health unit for a population of 40,000, one 30 bedded hospital for two primary health units. Secondary health centre with an initial capacity of 200 beds to be raised up to 500 beds by 10 years leading up to DHO at the district level, it also recommended about the mobile medical clinic.

An attempt was made to integrate the traditional system of medicine along with allopathic medicine at the medical college and at the service delivery level department of Indian System of Medicine and Homeopathy (ISM &H) was formed in the year 1995, which was later on named as AYUSH (Ayurveda, Yoga, Unani, Siddha and Homeopathy) in the year 2003. These attempts towards the indigenous system of medicine were vehemently opposed by the allopathic practitioners. Their concern was that it would dilute the 'scientific knowledge' and give an opportunity for a back door entry in allopathic medicine.

With the pressure exerted by the allopathic practitioners, the integration of the allopathic and traditional system of medicine was abandoned and separate colleges were set up for them. With the recommendation of Central Council for Health and Family Welfare posting of one ISM&H practitioner in every primary health Centre became compulsory, however, the colonial ideology of biomedicine's supremacy remains same and ISM&H practitioners were used as a replacement to fill up posts of allopathic medicine practitioners in health centres and the budget allocation remains very less as compared to the total health budget.

Despite such odds and a conscious attempt by the government to project these therapies as "alternative" to bio-medicine, the registered AYUSH practitioners have increased enormously. The impetus for this goes to WHO for coming up with a strategy on traditional medicine and the consequent "National Policy on ISM &H". With the launching of National Rural Health Mission (NRHM) 2005, provisioning of AYUSH practitioners at the PHC and CHC level became mandatory, every PHC should have one and CHC should have two AYUSH practitioners. The department of AUYSH was upgraded as "Ministry of AYUSH" in the year 2014 and National AYUSH Mission was launched in the same year. The subsequent Draft National Health Policy 2015 and Rashtriya Bal Swasthya Karyakram (RBSK) emphasized the importance of AYUSH (Ruhil, 2015). These moves are aimed at providing with the choices to the patients with different

therapies. But these moves were not based on equality. AYUSH practitioners were only used as a replacement to allopathic practitioners who refuse to go to the rural area, the AYUSH medicines are found in short supply. Thus, the image of AYUSH was consolidated as an "alternative" to allopathic medicine.

6.6 SUMMIMG UP

The choice of medical pluralism is restricted owing to the matter of availability, accessibility, affordability of services. In the Indian context, the integration of the Indian system of medicine into the state health service system is only at the infrastructural level. Further, the modernization of the Indian system of medicine within the framework of biomedicine already puts them at the backseat, projecting them as "unscientific". The adherence of people to biomedicine is also related to the romanticising of the "scientific" value associated with bio-medicine. This integration of Indian system of medicine into the state health service system is itself against the ethos of medical pluralism. Medical pluralism implies the co-existence of multiple systems of medicine without interfering into each other but in reality, practitioners of Indian system of medicine are only used as a replacement of biomedicine practitioners and this ultimately reinforces the supremacy of biomedicine and places the Indian system of medicine as a cheap replacement.

6.7 QUESTIONS

1. Define medical pluralism. What are the differences in the theory of disease according to bio-medicine, Ayurveda and Unani Tibb?
2. How does the state sponsored medical pluralism reinforce the dominance of bio-medicine? Explain.
3. The present status designated to Indian system of medicine is a colonial legacy. Explain..

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UNIT 7: GENDER AND HEALTH

UNIT STRUCTURE

7.1 INTRODUCTION

By now, you have understood that sociology of health and illness looks at the medical tradition, human health and sickness through sociological lenses. In other words, the problems related to human health and sickness are defined in sociological terms. We are social beings. We live in a society and our actions and their outcomes all are influenced by society. Needless, therefore, is to mention that our health condition is somehow related to the material and social environment that we are associated with (Lewis, 1953). A female body differs from a male body biologically but how the female body gets objectified depends on the society one belongs to. If the male sex is considered stronger and the female sex the weaker one, it is because of the society and its recognition of the sexes. When one talks about gender, most of the times we draw in our minds a picture of the men and the women, failing to realise that there exists another category of human sex, which has long been isolated and considered as deviance. It is a category which stands in the intermediate level. The main aim of this unit is to link

the relationship between health and the social environment, focusing on the concept of gender to study how society influences our conception of 'health'.

7.2 OBJECTIVES

By the end of the unit, you will be able to:

- Explain gender as a construct and its impact on access to healthcare;
- Explain the health inequalities among male, female and the third gender.

7.3 UNDERSTANDING GENDER AND HEALTH

Gender is a social construction, a man-made construction of individual roles and unequal statuses. To be born as a male or female or as eunuchs is a biological reality but when we say that females are inferior to men, we are then making assumptions which are the outcomes of a gendered mind. To be born as a male with male organs is a biological fact but when one says that a man does not cry, it is an outcome of gendering the sexes. Gender is the modification of the characteristics of the sexes by society. These discriminatory changes are made by the society, the living environment of an individual. Issues related to gender are debated everywhere but why is it so? It is because the construction of gender has led to many adverse and undesirable changes to the human existence, the construction has led to differences, inequalities which, in almost all cases, are destructive and unacceptable.

'Health is Wealth', this is probably the most common saying every person must have heard, we are our own bodies and it is one important identity of our existence. Every person deserves good health, a healthy lifestyle, a proper diet, and proper health facilities but what if one's health is affected because of one's socially constructed status? Gender discrimination can be

one very significant reason leading to health problems for women. Women are victims of both improper health as well as technological dominance. We will find numerous women opting for plastic surgeries in order to stay beautiful and at the same time, we will also witness cases of women suffering from malnutrition.

There are pieces of evidence that women outlive men by many years in many countries but it far more evident that women mortality rates are higher in many countries. Can the reasons behind women's deaths be only a biological reality? No, not certainly.

As Leela Dube (1988) argues, the birth of a girl child is considered unfortunate in many societies as against the birth of a male child. People celebrate the birth of a baby boy but feel disheartened when a girl child takes birth. Girls are regarded as burdens by those societies, more importantly, the families. For a country like India, it becomes very tough for women to stand up, live a life equal to that of the men, and enjoy the same lifestyle privileges, tougher enough to even get the basic needs to live a healthy and dignified life. The men are considered the bread-winners of the society and that is one reason why they claim to the right to have better food. In almost every family, where undue importance is given to the male members of the family, we are certain to find that in the dining table, the best of the food is served to the male members. The explanation that is given is that men are the ones who go out in the rain and the sun to earn for the entire family. They do the tougher job and so they deserve healthier food. These inequalities have not have been there since long past and are continuing to a great extent in many societies. Further, this unequal distribution of food within the family, unfortunately, stretches too far and does not limit to only food but touches every single aspect of a woman's life. When a woman is not given adequate food, how can she be expected to be given other facilities that would build her identity and life chances? Patriarchy is then inextricably linked with property rights too. (Priyam et

al, 2009). Generally, women are not considered the heirs of their family's property. Daughters should be married off so they are considered as the temporary members of the family. Therefore, it is thought useless to invest in the daughters because after all, they would not be bringing home money. Even if their parents educate her, she will be married off and serve her marital family with the money she would earn. When a girl is not allowed to go to school when she is not allowed to do jobs when she is forced to do only household work which is not given any admiration, how can she be expected to live a good life? When she does not have the money to invest on her health when she is socialised in a way to think that she deserves lesser than her male counterpart, how then do we expect equality among the males and the females? Gender inequality in income and wealth distribution proves to be disadvantageous to women as they are thrashed into poverty. It becomes difficult for them to fulfil their daily necessities.

When one talks about gender, most of the times one restricts its meaning to the male and female members of the society but there is another category of humans who are now known as the third gender. When we call heterosexuality as a norm, we are entitling it to be normal and anything which stands against it is viewed as deviance. The society has designed its norms in such a way which privileges men and which privileges sexual relationship between only a male and a female. Homosexuals are sexually attracted to people of the same sex. Even though now things have changed a lot yet in many societies, homosexuality is still considered something 'abnormal', 'deviant' or sinful behaviour. This leads to stigmatization of the homosexuals, where they feel estranged from society. This estrangement leads to isolation, loneliness and so on. Thus this affects the physical and mental health of the stigmatized category.

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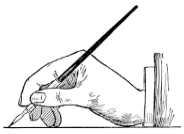

1. How does one's sexuality affect one's access to healthcare?

7.4 SOCIAL CONSTRUCTION OF GENDER AND HEALTH

By now, you have understood that gender is a social construction. As students of social sciences, we seek to understand our society and the way it functions. When we discuss gender, some important terms need to be addressed. For instance, gender equality, gender discrimination and so on. If gender is a construction, it implies that there is some sort of power relationship involved which shapes the relationship between the genders. This power relationship among the individuals brings inequality and discrimination as one group of individuals enjoy superior control over the other group. Patriarchy here becomes important to be discussed because it works as an important institution of power, the dominance of the male minds over the other sexes. It becomes very important to study patriarchy in order to understand how the society functions, in which way is the distribution of power, opportunities and resources carried out. It is furthermore important to observe how the exertion of power by one group over the other is justified. For instance, in most societies, if a girl is raped, the society questions the raped woman rather than questioning the rapist. It does not, however, end here because, the woman after the accident is not situated under the 'normal' category of girls because once raped, her body, which is her physical entity, is also a social one, comes at stake. The society neglects that 'raped body' as if it is a diseased body. The woman, thus, has to live

with a stigmatized identity. Thus, we see how these aspects are related. The female sex is often considered weak and the female body comes under the critical gaze.

The concept of health has also turned out to be a social construction. The following part will be explaining how and why health has undergone a social and cultural construction. But before discussing health as a concept let us first try to unfold some important elements of the society which manipulates the understanding of health.

We live in a society but in a stratified manner. A society may be stratified by social class, gender, language, region, etc. This stratification becomes important to understand because a stratified social class leaves its mark on the people's access to resources. Our choices, options and opportunities are to a great extent influenced by the class we belong to. Our status, our income, our educational career is referred to as 'life chances'. Our life chances determine our living standards. For instance, we can make out the difference between the health facilities enjoyed by people from high social and economic class to a lower one. For a fact, a person with low economic class would not have access to better resources. One's health, survival, mortality differs by social class. The social and economic relations between men and women affect their health conditions. The ill impact of discriminatory actions between the sexes as well as the unequal distribution of economic resources between men and women affects their health (Gabe, 2004).

One's health condition can contribute to making the social world of that person because one's health, one's normal behaviour is prescribed by society. If a person does not belong to the category of 'normal' which the society decides, one is boycotted or left to live alone, her/his social world gets affected or shattered at once. This phenomenon is called stigmatization. Erving Goffman has contributed substantially to the

concept of stigma. Socially stigmatized people are those that do not have full social acceptance and are constantly fighting to adjust their social identities.

Now you may wonder who is stigmatized? The physically deformed person, mental patients, drug addicts, prostitutes and so on come under the fold of stigmatized people. We must have heard and seen the negligence of a physically deformed person faces. To be born with one leg or one hand or to lose a leg or eyesight in an accident can never be out of choice. These are accidental outcomes. The person who goes through such deformity in their body brings them a lot of health-related problems but because our body, our health condition is a concern of the society, people with deformity undergo a situation of stigma where they are not accepted and welcomed in the society. According to Goffman, these people strive really hard in order to derive the larger society's acceptance. They are not welcomed because they are considered sinful. Illness, health all are social and cultural constructs. Goffman discusses a number of responses that stigmatized people take in order to correct their identity or manage their stigma. For instance, a lady who has a dark complexion and feels stigmatized for it might nowadays undergo a skin peeling surgery, or skin bleaching in order to overcome the stigma. This shows how in order to gain acceptance and be appreciated, one needs to alter one's natural biological body into an artificial one which would give them the tag of a 'normal' or 'desirable'. According to Goffman, those people might also make extra efforts to compensate for their sigma, for instance by shifting people's attention to another area of the body or to an impressive quality they have. It might also happen for a person to use their sigma as an excuse for their lack of success, they either see it as a learning experience, or they use it to criticize 'normals' (Goffman, 1963).

Michel Foucault looks at the concept of knowledge and power. He posits when one has the knowledge about a particular phenomenon or a person, that person tries to force upon a dominance which flows through the knowledge of the phenomenon. When we have knowledge about something, we can then claim authority over it. Foucault argues that this knowledge and the power which flows after it, are a source of discipline. When one has the power and the knowledge, one gets the power to control, to discipline or to punish. Foucault talks about the dominance of medical knowledge over people who do not own such knowledge. The increasing dominance of medicine and medical gaze scrutinizes the health of the population. This knowledge brings them to a privileged position where they hold the power to state normality and abnormality in the health behaviour of an individual. He discusses how medical discourses construct knowledge about the body including diseases. Foucault discusses in his work, *The Birth of the Clinic* (1973) how scientific knowledge, medical training and clinical practices press control over the human body. He termed the word 'clinical gaze' in order to explain how illness and the body can no longer be reduced to a physical reality instead it has turned into a consequence of the clinical gaze which is practised by the physicians in order to clinically control the bodies (Gabe, 2004).

7.5 CONCEPT OF WOMEN'S HEALTH

The status of health has been different on the basis of gender. Women and men are biologically different, as a result, health-related problems or risks and even health-seeking behaviour among them are also different. A Review of research from the United States of America shows that women are significantly higher risks of autoimmune diseases as compared to men. The incidence of hip fractures is much higher among women than men. On the other hand, men are known to have a higher blood pressure than women throughout middle age, but after menopause systolic pressure increases in

women to even higher levels than in men. In addition, biological factors, control over resources, decision-making abilities, gender-based division of labour all these have implications for women's and men's health. Gender-based division of labour has been seen within households and labour market also. As for instance, poor women, especially in developing countries, are engaging with the cooking process and smoke that comes from cooking fuels has an adverse impact on her body.

Research has shown that life expectancy among women is higher than men. But always longer life need not necessarily translate into a healthy and good life. Women's longer life expectancy may underline the higher burden of chronic and degenerative diseases and their lack of resources to care for themselves contribute severe impact in such situations. Therefore, it could be said that girls and women have to bear negative health and which is the outcome of gender inequalities. Various patriarchal values as for instance preference for a son, devaluation of a daughter, negligence of women's non-reproductive health issues have initiated to grow the negative health situations for women. In the year 2004, a study in 16 Indian states shown that girls were five times less likely to be fully immunized than the boys (*Gender policy*. Geneva, GAVI Alliance, 2008). However, it has been seen that health-seeking behaviour among men and women are also likely to vary.

Indeed health-seeking behaviour is also affected by the patriarchal notion of thinking. Studies have shown that women generally neglect their health unless and until they suffer from a severe illness. However, their lack of economic resources also stands as a hindrance in terms of their access to healthcare facilities. Women's economic dependency also underlines a major impact on their decision making qualities. It is seen that women have to seek permission from their husbands in terms of healthcare for themselves. Data from demographic and health survey show that in some

countries of sub-Saharan Africa and South- Asia, women were not in decisions concerning their health in 50% or more of the households and Burkina Faso, Mali & Nigeria almost 75% of women reported that their husbands alone took decisions concerning their healthcare. Therefore, health disparities have been seen between men and women.

Inequality based on gender is standing as a stumbling block in attaining equitable healthcare system. To attain equity in the healthcare system, both men and women should be able to access and participate in the public healthcare system. In this context, the public health approach has played a significant role and in the year 1978, it took 'health for all' approach. And this approach tried to link between health and development and promote health equity through policies and programmes. Equity means social justice and health equity means to give importance in terms of one's own health need. During the year of 1970 and 1980, an attempt has been made to highlight the negligence of women's health issues and women's health movement also played an important role in this context. However, later it has been realized that the concept 'health for all' only covered a small portion of women, where a large number of women has to remain as exclusive of this process and after that, the need of 'mainstream gender' has come out in terms of healthcare facilities. The two international conference Population and Development (1994) and the Fourth World Conference on Women (1995) has helped to initiate the idea of mainstream gender. There are two dimensions of gender mainstream that were identified by WHO, i.e. programmatic gender mainstreaming and institutional gender mainstreaming. Both dimensions have focused on the equitable healthcare system. However, equitable health care system has holistic meaning and it is somehow similar to inclusive health development. Again, gender is one of the important components of Social determinants of health. Socially constructed masculinity underlies serious health threat to the women. In many societies, girls and women suffer systematic discrimination in access to power, prestige and resources.

Therefore, it could be said, that without proper concern on gender, the health system fails to be inclusive in nature. Inclusive health development means the incorporation of people's participation irrespective of gender, caste, creed, class and ethnicity.

7.6 SUMMING UP

In this unit, we have learnt how gender and health are interconnected. We have understood that the term gender does not merely translate into the issues pertaining to women, even though the focus is primarily on them. The unit explores how the stratification based on gender along with the roles attached to each gender have an impact on the access to healthcare. The stigma factor associated with the third gender also affects their access to healthcare.

7.7 QUESTIONS

1. Analyse the relationship between the gender and health.
2. How has the concept of health been an important topic to understand the social reality? Explain.
3. How is access to healthcare related to one's gender? Explain.

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UNIT 8: GENDER AND SOCIOLOGY OF BODY

UNIT STRUCTURE

8.1 INTRODUCTION

In this unit, we will discuss in detail the relationship between the sociology of body and gender. Based on gender, one's body might be experiencing different life worlds in everyday life. The concept of the body is not merely biological. Different cultural, social and economic phenomena are also significant factors in shaping the concept of body. We consider our bodies as natural and free that belong to us. But in reality, our bodies are also socially constructed. How our bodies behave, function, are all determined by the social relations we enter into. From the moment a child is born, its body comes under the process of socialization. The mothers generally try to make their girl children like them. A young girl takes her mother as her guide, she follows the way her mother behaves, how she talks, how she dresses, and how she walks because that is what is expected of her by

society. A girl needs to grow as a woman and her mother is the best person to make her a socially acceptable 'woman body'. A mother always likes to dress her girl like a princess, in fancy frocks and everyone admires it. Hardly do we get to see a girl child being dressed by her mother in clothes that are "meant for boys", like shirts and trousers. Girls according to their bodies are supposed to wear "their dresses" and boys are expected to wear "theirs". This was just one example to make you understand how our bodies are taught to be socially acceptable.

Some human bodies are considered "polluted" by society. Sex workers are one such category whose bodies are considered "polluted" as their work is not considered decent and is looked down upon. Female bodies are expected to exhibit shy and docile behaviour and anything that goes against this is a compromise on the image of "an ideal female body". Similarly, the concept of heteronormativity makes the heterosexual body as "normal". Thus, by now, we have understood that our bodies are socially constructed. We will discuss further this topic in the subsequent sections.

8.2 OBJECTIVES

By the end of the unit, you will be able to:

- Explain the concept of the body;
- Explain the concept of sociology of body;
- Analyse the domination of medical knowledge over women's health.

8.3 HUMAN BODY AS A SOCIAL CONSTRUCT

Norbert Elias, Michel Foucault, Marcel Mauss are some of the thinkers who have contributed to the study of bodies, how they are controlled and constructed. Norbert Elias gives a clear picture of a socially constructed human body. He points clearly to the fact that the disciplining and controlling of one's body and impulses can be seen as inextricably

linked to the way power is exercised over the minds and bodies of others through an internal form of policing and self-control rather than overt forms of external coercion. This, according to him, is more prominent in the context of modern democratizing society (Adelman and Ruggi, 2015).

Societies have evolved and so have techniques of rewards and punishments. For instance, in societies long back, the forms of punishment used to be very different, very brutal but now we have prisons for the criminals. A prison is an institution where criminals are not brutally killed but are kept in isolation, aimed at self-realization and correction. This is more a democratic way of punishing a criminal. Similarly, schools serve as another institution for disciplining human bodies. One has to dress and behave in a prescribed manner in a school or any other educational institution. For instance, in most schools, students are made to wear uniforms. Similarly, the students are taught to speak politely, keep their nails trimmed, respect the elders, etc. in schools and anyone failing to adhere to these are punished. Hostels, boarding schools, libraries are all institutions which work towards disciplining and controlling human bodies and actions.

8.4 THE DOMINATION OF THE MEDICAL KNOWLEDGE OVER WOMEN'S HEALTH

The female body has always been under critical gaze. Here, we need to understand that femininity implies learning restrictions, be it related to the female body, a woman's behaviour or her mind. Laura Mulvey writes on how in the virtual side of the world, in cinemas, the female body is subjected to the male gaze, how the female body is seen as an object of seeking pleasure. In movies and advertisements, we see how the female body and its parts are objectified and commodified at the same time (Mulvey, 1975).

Our bodies are subjected to continuous regulation, monitoring and surveillance and Foucault has explained this in his works on sexuality, asylum, clinic, and prison. According to Foucault, the power that controls our bodies sticks its gaze on us, monitors our bodies and acquires the control to discipline us. For instance, in a medical encounter, the patients are expected to tell everything about their bodies to the doctors to be cured, the patients are demanded to reveal all the secrets of their bodies to the doctors, this is one form of control which the medical encounter has over the bodies of the patients. Foucault has worked immensely on the dominance of medical expertise and discourse, how they set the boundaries for what is pathological and what is normal. In his work on Governmentality, Foucault discusses the media and ways through which the modern state controls the human body. He argues how in a democratic setup, the welfare state functions, where, the individuals' minds are manipulated in such a way that they discipline their bodies and their minds themselves without being coerced (Nye, 2003).

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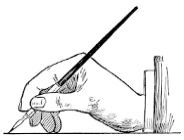

1. Fill up the gap: In movies and advertisements, we see how the female body and its parts are _____and commodified at the same time.

8.5 FOUCAULT ON CREATING MEDICAL DOMINATION OVER WOMEN'S HEALTH

Foucault explores the state's micro-power relations that control one's body. According to Foucault, the State has been controlling the human

body through local institutions and authorities. Foucault's Governmentality has been defined as "the ensemble formed by the institutions, procedures, analyses and reflections, the calculations and tactics, that allow the exercise of this very specific albeit complex form of power, which has as its target population, as its principal form of knowledge political economy and as its essential technical means apparatuses of security" (Foucault, 2001).

In the popular discourse, the body has often been considered as something without agency or subjectivity. Before Foucault's insights on the concept of body, classical thinkers like Marx, Weber and Durkheim have given their insights on the concept of body. Marxist thinkers study body along with social relations and groups. Karl Marx states the concept of body in his work *Economic and Philosophic Manuscripts of 1844*. Here, Marx says, "The universality of man is in practice manifested precisely in the universality which makes all nature his (sic) inorganic body- nature, that is, in so far as it is not itself the human body. Man lives on nature- means nature is his body, with which he must remain in continuous intercourse if he is not to die. That man's physical and spiritual life is linked to nature means simply that nature is linked to itself, for man is part of nature" (Marx, 1959 [1884]).

However, Marx tried to establish a link between capitalism and the concept of body. In terms of establishing the link, Marx was influenced by Engels's work. Engels in his work, *The Condition of the Working-Class in England* has explored the poor health condition of the marginalised body. The socio-economically marginalised people have been compelled to live in very unhygienic health conditions.

Durkheim states about the concept of body in the essay "The Dualism of Human Nature and its Social Conditions". In this essay, Durkheim unequivocally considers that the body and soul are interrelated. He also

interlinks it with his idea about sacred and profane. He states that body and soul are interrelated. The body is an integral part of the material universe and it is experienced through sensory observations.

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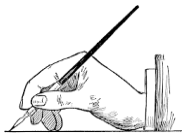

1. Who is the author of *The Condition of the Working-Class in England*?

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2. How does Durkheim explain the concept of body?

8.6 THE CONCEPT OF SOCIOLOGY OF BODY

Recently, the concept of body has been popular in the academic discourse. The emergence of sociology of body has been one of the contributions that indirectly enhance the popularity of body in the academic discourse. Sociology of body suggests that the body should serve as an organizing principle for sociology. Following this, Bryan Turner coined the term 'Somatic Society' to describe how the body in the modern social system has become "the principal field of political and cultural activity" (Turner, 1992). The body has been an important topic for both the electronic and print media. Newspaper and television have been constantly working on body image, plastic surgery to keep the body looking young and beautiful. In the era of high modernity, the body has gained much prominence. Modernity can be understood roughly as the 'industrialized world'. According to Anthony Giddens, modernity has led to an increase in the degree of control that nation-state

in general, and the medical profession in particular, have been able to exercise over the bodies of the citizens. Further, it also resulted in a reduction in the power of religious authorities to define and regulate bodies (ibid).

The concept of the lived body has been developed from the people's everyday experience of their life. The lived body is such an idea where human beings and their consciousness is invariably embedded within the body (Nettoleton and Watson, 1998). People have relatively less idea about their bodies unless and until they are asked about it. The human body is an embodied one. Maurice Merleau-Ponty (1945) in his book *The Phenomenology of Perception* argues that all human perception is embodied. Therefore, the lived body is constructed by the life world and there is a constant interaction going on between the lived body and the existing social world.

Csordas (1999) stated body is "the existential ground of culture and self". The body has been internalising different notions through everyday interaction with the world. These different notions might be varied in terms of gender, class and creed and race. On the basis of social position, one experiences the body differently. Thus, the concept of the body is not only biological but also social. The importance of the social aspect of the body leads to the subjective interpretation of the body.

CHECK YOUR PROGRESS

1. Who is the author of *The Phenomenology of Perception*?

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2. Who has coined the term ‘Somatic Society’?

8.7 RELATIONSHIP BETWEEN BODY AND HEALTH

There is a close relationship between the concept of body and health. One’s perception of body and health are influenced mostly by one’s gender. Both men and women experience health differently. Due to the socially achieved superior status, the male members of society get privileged access to a range of valuable resources. Generally, in Indian families, the male members are given more importance and therefore they enjoy all sorts of facilities in their life, including access to healthcare. But there is one negative side to it which adversely affects men’s health. The men who bear and maintain the heterosexual male identity often prefer to do risk-taking jobs which they feel would prove their masculinity and this attitude may lead to serious health problems.

Evidence proves that in factory workplaces, many men feel compelled to engage in risky behaviour in order to prove their masculinity (Doyal, 1995). Men are likely to be victims of sexually transmitted diseases because they are more inclined towards having unsafe sex than women. Sometimes it also happens that the desire to portray a strong masculine identity, they remain reluctant in taking healthcare seriously. Often they are seen to have the notion that if they go for healthcare, they would be considered weak like the women. It is observed that most men do not feel like seeing a doctor unless severely ill and the illness cannot be ignored.

Phenomenological understanding has been one of the most relevant schools of thought on the study of sociology of body. Some of the scholars want to address sociology of embodiment rather than discussing sociology of health. The concept of embodiment refers to the experiences of

everyday life that are based on mostly gendered socialisation. Embodiment can be understood as the lived experience of gender (Hughes & Witz, 1997). It is crucial to the experience and perception of gender identity (Thapan, 2009). As Lois McNay (1999) puts it, "At the point of overlap between the physical, the symbolic and the sociological, the body is a dynamic, mutable frontier. The body is the threshold through which the subject's lived experience of the world is incorporated and realised and as such, is neither a pure object nor pure subject" (McNay, 1999).

The concept of the body is understood as both object and subject. Moreover, it is argued that the body and its image are part of 'formally identical objects interacting in the infinity of space and time", and as subjects, "the same body and body image is immeasurably enriched with the inner content of lived experience" (Ferguson, 1997). Thus, lived experience is essential as far as the embodiment is concerned. Paul James (2005) states that embodiment is lived across all forms of communities as a deeply embedded social-relational category. It is an ontological category that is constituted by various social practices and meanings (James, 2005), which have been generated through socialisation over a period of time. Veena Das (1995) states that the study of the embodiment includes the various activities, social relationships, and impacts of culture that occur in one's everyday life.

The concept of body and mind are mostly explained by the idea of nature and culture. There is a dualism between body and mind and that has been more popular in the western discourse. This dualism dominated the western thought in terms of favouring logic and reason on one hand and conceived body as mechanistic and peripheral on the other hand. Further, the body is not only the subject matter of sociology, but anthropology and feminist theory also consider the body as an important subject of discussion. The binaries of nature-culture are used to relate with the body and mind concept, where the body has been considered as inferior to mind.

Similarly, women's body is considered as inferior to the male body, while males are considered as a representation of the logical mind. The body has been regarded as a source of intrusion in, and a danger to, the operations of reason. In the *Cratylus,* Plato claims that the word *body (soma)* was introduced by Orphic priests, who believed that man was a spiritual or non-corporeal being trapped in the body as in a dungeon *(setna)*. In his doctrine of the Forms, Plato sees matter itself as a degraded and imperfect version of the idea. The body is a betrayal of and a prison for the soul, reason, or mind. Later Descartes distinguished mind (res cogitans) as thinking object from the body (res extensa). The body is a self-moving machine, a mechanical device, functioning according to causal laws and the laws of nature (Grosz, 1994).

The lived body or embodiment has been the idea of post-structuralism, which denied the mind-body dualism. The concept of the embodiment has been growing with the help of everyday life, which is based on the agent's subjective interpretation. Everyday experiences of body denied the pre-existing binary notion of mind-body. In the late 1970s, the poststructuralist school of thought raised a critical challenge to the dichotomous nature of the body. It also questioned the physical, mechanistic, constructed and passive characterization of body. In this line, the paradigm of embodiment or living body has been developed as a principal characteristic to the collapse of dualities between mind and body, subject and object (Csordas 1990 and Lock 1993). Rethinking the body through embodiment has been one of the major epistemological upheavals for the natural and social sciences. The epistemological understanding of the body is itself a challenge to the prevailing models of the body (Grosz,1994; Lock, 1993).

Thinkers like Merleau Ponty and Pierre Bourdieu emphasised on the integration of the mind and body for the collapse of the binary between mind and body. Merleau-Ponty (1962) elaborates embodiment in the

context of perception, and Bourdieu (1977, 1984) situates embodiment in an anthropological discourse of practice. Both attempts not to mediate but to collapse these dualities and embodiment is the methodological principle invoked by both (cited in Csordas, 1990). Merleau Ponty emphasised on the duality of subject-object, while Bourdieu studied about the binary concept of the structure and practice. For Merleau-Ponty, the body is a "setting in relation to the world," and consciousness is the body projecting itself into the world; for Bourdieu, the socially informed body is the "principle generating and unifying all practices," and consciousness is a form of strategic calculation that is attached with a system of objective potentialities (Csordas, 1990).

8.8 SUMMING UP

In this unit, we have discussed the concept of the body through sociological analysis. We have understood how the body is not only biological but it also has a social ensemble. We have also seen how the experiences of health differ based on one's gender. Just as gender is socially constructed, the body is also the outcome of social construction. Again, the unit has also touched upon Foucault's concept of governmentality in the relation of surveillance of the body. The unit also provides an overview of the phenomenological understanding of the concept of body.

8.9 QUESTIONS

1. Using Foucault's concept of knowledge and power, analyse how human bodies are controlled.
2. Write a note on the democratic mechanisms of control of the human body.
3. Critically examine and analyse the concept of lived body.

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UNIT 9: MEDICALIZATION AND DE-MEDICALIZATION

UNIT STRUCTURE

9.1 INTRODUCTION

Medicalization is a social process which brings human problems under the jurisdiction of the medical profession (Conrad 1992). This also comes under the purview of the dominance of the biomedical model. Because it is through the medicalization process that even some natural instinctual behaviour of the human body can be labelled as sick or deviant behaviour which requires medical assistance. The concept of medicalization traces its beginning with the writings of Foucault and Ivan Illich. The term had its beginning in academics in the 1970s. Some other thinkers who have contributed to this concept are namely, Ervin Zola, Peter Conrad, and Thomas Szasz. Increasing dependence on medicine has expanded the level of medical authority into the areas of everyday human life. As Foucault argues, the medical encounter is the most influential form of surveillance of the human body because a sick person under a treatment seems to know

less about his own body, sometimes the patient's own experience seems to have no importance during the treatment as the doctor's analysis and medical reports prove to be more trustworthy.

9.2 OBJECTIVES

By the end of this unit, you will be able to:

- Explain the concept of medicalization and de-medicalization;
- Analyse the advantages and disadvantages of medicalization and de-medicalization;
- Explain the concept of stigma in relation to de-medicalization.

9.3 CONCEPTUAL UNDERSTANDING OF MEDICALIZATION AND DE-MEDICALIZATION

According to Conrad (1975), "By medicalization we mean defining behaviour as a medical problem or illness *and* mandating or licensing the medical profession to provide some sort of treatment for it". He adds, "Medicalization consists of defining a problem in medical terms, using medical language to describe a problem, adopting a medical framework to understand a problem, or using a medical intervention to 'treat' it".

Most of the scholars treat medicalization as a state of the category. Various scholarly works try to define whether a problem is being medicalized or de-medicalized. The treatment of medicalization possesses three analytical problems. First, it entails the analyst to establish a threshold for determining how much medicalization is required before a problem is 'medicalized'. Second, it minimizes the importance of significant increases or decreases in medicalizations that are too small to produce a categorical change. Third, it obscures the fact that medicalization and de-medicalization often occur simultaneously. These two processes are contradictory to each other, where one considers the importance of medical

sciences' intervention on the body, the other refused such intervention. In a nutshell, medicalization enhances biomedical practices. However, medicalisation increases when biomedical vocabularies, models and definitions become more prevalent in discourses about social problems.

Both the process of medicalization and de-medicalization have been dynamic and not static. However, the growth of the consumerism in the health marketplace and the emergence of a more egalitarian style of doctor-patient relationship have been continuously affecting the process of both medicalization and de-medicalization. By medicalization, the medical professionals get the legitimacy to provide some sort of treatments. For instance, pregnancy and childbirth which were earlier considered natural processes are now being medicalized.

According to Conrad and Schneider (1980), medicalization can occur at multiple levels—the conceptual level, the institutional level (which they call the organisation level) and the level of doctor-patient interaction. In the conceptual level, 'a medical vocabulary (a model)' is used to 'order or define the problem in hand' but medical professionals and treatments may or may not be involved (Conrad and Schneider 1980). At the institutional level, organisations 'adopt a medical definition and approach to a problem'. Finally, at the end of the 'doctor-patient interaction', a physician defines a problem as medical (i.e. gives it to medical diagnosis) and treats a social problem with a medical form of treatment (Halfman, 2011).

However, it has been observed that medicalization is not a continuous process as it may keep changing over time. There is a chance of de-medicalizing of certain medicalized problem. Therefore, most of the scholars pointed out that the process medicalization is not static. But the question arises as to when a problem is medicalized. Halfman (2011) has pointed out that there are three important analytical steps necessary for medicalizing a problem. First, it requires the analyst to establish a threshold for determining how much medicalization is required before a problem is 'medicalized'. Second, it minimises the significant changes that are

important to observe the increases or decreases in medicalization. Third, both the medicalization and de-medicalization often occur simultaneously.

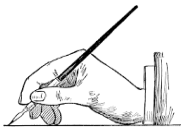
This was a brief explanation of what medicalization means but now let us understand what de-medicalization mean. De-medicalization refers to the process by virtue of which a problem which was earlier medicalised is no longer considered a medical problem. For instance, in the late 19th century, masturbation was considered a disease that required medical control but by the 20th century, it was no longer considered as a medical problem. We can also take the example of disability. The various movements associated with disability emphasises that it must be kept outside the medical purview. It is at the fore a personal matter and secondarily, a medical matter. Again, in the case of homosexuality, as a positive response to the movements and gay liberation campaigns, it is now no longer considered an illness instead, it is a matter of choice of living; it is more of a human rights issue at this period of time (Conrad, 1992).

Most of the scholars define de-medicalization as the opposite of medicalisation. De-medicalization limits the process of medicalization. One specific medicalized problem might be turned into the de-medicalized in a certain period of time. Anti-abortion movement in the 19th century has been one of the examples of de-medicalization. Before the 19th Century, abortion was considered morally and legally unproblematic. Gradually this idea has been losing its significance in the post 19th century. In the late 18th century, many regular physicians argued that foetuses were alive the moment of conception and killing the foetuses is itself problematic both morally and legally. The dynamic nature of social structure and people's awareness have been playing a significant role in terms of medicalization and de-medicalization. From being morally accepted to being legally prohibited, the idea of abortion has been changing with time and space.

Both the processes of medicalization and de-medicalization have typically sought to access the normative implication of the processes. Though they

depend on the dynamic social structure, they put emphasis on the continuation of the existing functions.

CHECK YOUR PROGRESS



1. Define medicalization.

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2. What according to Conrad and Schneider are the levels at which medicalization can occur?

9.4 THE PROCESS OF MEDICALIZATION: ADVANTAGES AND DISADVANTAGES

Illich defines medicalization by attributing to the increasing professionalization and bureaucratization of medical institutions associated with industrialization. According to him, people's ability to take care of themselves has declined as modern medicine has created increasing dependence on doctors (Gabe et al, 2004). Zola has defined medicalization in the same line. He too argues that increasing technological and bureaucratic system lies in the roots of medicalization which proposes an undue reliance on the medical experts (ibid). Many have portrayed medicalization as a negative thing which enhances medical and social control but there were also some who pointed out the benefits of medicalization. For instance, when a disorder is medicalized and is labelled

a disease, it can be treated through medical intervention. Social beliefs which can call it a deviant behaviour can be removed and this ultimately saves the person from being called abnormal. When the health condition is given an objective explanation, people begin to understand why the person with that condition is different from others. But there is a negative side to it too because labelling a person with the disease might also associate a stigma to the individual. For instance, in the case of depression, medicalization has helped in understanding it as a disease that needs medical intervention as against a mere feeling of sadness. It has helped in understanding depression as a big disease burden which is a leading cause of disability worldwide that can also lead to suicide. Medicalization has undoubtedly helped people with depression to seek medical help but at the same time, due to the label of mental illness, often they have to deal with the stigma associated with it.

Medicalization came to be discussed widely in the 1970s when it was linked with ideas such as social control. Let us try to analyse medicalization in the way Conrad and Schneider have put forward. According to them, medicalization occurs in a three-level process. Firstly, medicalization can be said to have taken place when a medical terminology is used to define a problem. Secondly, it occurs in the institutional level where organizations adopt a medical approach to treat a problem in which they specialize and thirdly, they see medicalization at the level of doctor-patient interaction when the problem is defined as medical and eventually medical treatment starts (ibid). But it is also important to note that in most cases, medicalization is not complete. Medicalization works in different degrees, for instance, there are certain medical problems where the degree of applied medicalization is greater, death and childbirth for that matter come under this category. In the same way, opiate addiction and menopause are certain problems where the degree of medicalization is less (Conrad, 1992).

It is also pertinent to note that excessive reliance on medicines can be harmful because of the side-effects they have on the body. With the increase in medical dominance, people have come under the control of the medical profession. This also, as a result, helps in augmenting the profit that the drug companies make because people are so eager to use the drugs in order to get cured faster.

Medicalization has changed our perception regarding certain things which we would in other cases view as normal behaviour. For instance, shyness was never a disorder earlier, it was just human nature but now shyness is labelled as a disorder which needs to be cured. It has been named as an avoidant personality disorder.

9.5 THE CONCEPT OF STIGMA

The concept of stigma is closely related to medicalization and de-medicalization. You have already understood this in the example of depression or medicalization of sadness. Let us now try to understand a little more on the concept of stigma. There are certain diseases to which people associate some sort of stigma. These are called stigmatized illnesses. People ignore mental patients because they bear some sort of stigma. Some kind of fear is sensed in the presence of mental patients whom the normal people try to avoid.

Stigma is a mark of disgrace. When a person is labelled and recognised as mentally ill, they are categorized under a stereotyped group. The people outside that group create prejudices against those stereotyped people.

Again, another example of people who are stigmatized is women who fail to become pregnant. This condition is commonly known as female infertility. In our societies, married women are expected to have children soon after marriage and if women are unable to give birth they become

victims of stigma. They face ‘name-calling’, they are verbally abused by their natal as well as maternal family members, they are most often not welcomed in public gatherings or auspicious occasions as marriage and so on, where their presence seems to be a threat or a sign of misfortune. A woman need not necessarily be always responsible for failing to give birth to babies but often, it is the woman who is blamed, neglected and abused and the man is freed from any blame. This shows how the gendered mind and thinking affects the physical as well as social life of women.

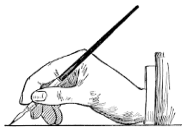
Similarly, people who are HIV positive or people suffering from other sexually transmitted diseases are often looked down upon. The cultural and social dogmas do not approve of these illnesses. Generally, when someone suffers from AIDS, the person is considered to have an ill character, someone who must have had several sexual relationships with different people. These people are then not considered as ‘decent’. Such a stigma also hinders the process of their treatment. Thus, from these examples, we can make out how illnesses have cultural meanings attached to them, how illnesses are not the concern of only doctors but the society equally takes part in labelling these diseases as culturally acceptable or unacceptable.

While talking about the social construction of illness, we cannot leave behind the meanings which people associate with disability. A person who is physically disabled is mentally and spiritually paralyzed by the negligence of the society. The society is not all welcoming towards a disabled or physically deformed person. The behaviour towards these people results in dreadful consequences. The people with some disability fail to face the outside world and also themselves at the same time, which is even worse. The ‘normal’ of society humiliate them and try to make them feel low. This avoidance makes those people feel low

about them and they eventually view their life as a curse rather than a blessing.

In cases where the disorder or disease is stigmatised, people hardly prefer to go to the doctor for the treatment. Some even end up using the different magical or home-based treatment for getting cured. In these cases, people deny the importance of medical expertise and try to de-medicalize the health problem by themselves.

CHECK YOUR PROGRESS



1. What is stigma?

9.6 SUMMING UP

In this unit, we have discussed the conceptual understanding of medicalization and de-medicalization. The chapter tries to give the advantages and disadvantages of both the concept of medicalization and de- medicalization. The concept of the stigma that has a close connection with medicalization and de-medicalization has also been covered in this unit.

9.7 QUESTIONS

1. Define the concept of medicalization . Elaborate your answer with the help of examples.

2. Elaborate the advantages and disadvantages of the concept of medicalization and de-medicalization.
3. What is stigma and how does it affect the mental and physical health of an individual?

9.8 RECOMMENDED READINGS AND REFERENCES

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