

Chapter 18 Medical anthropology and global health

CASE STUDIES

Case study: attitudes towards contraception of two groups of women in Argentina

Molina²⁰ in 1997 studied attitudes towards modern forms of contraception (the pill, diaphragm and IUCD) among two groups of Argentine women: indigenous Pilagá women in the north-east, and low-income *criollo* (Creole) women who had migrated to Buenos Aires. Both groups rejected modern forms of contraception, but for different reasons. The *criollo* women were used to traditional plant-based methods of fertility control (up to 20 different plant infusions used as contraceptives or abortifacients). Furthermore, unlike the doctors, they did not see procreation as only a biological phenomenon, but as a more mystical process. They believed that any single act of intercourse did not carry with it a risk of pregnancy because pregnancy could only result if the personal 'energy' or 'vital power' of the partners was high enough. 'Stronger' partners could conceive during a single session of intercourse, but most people had to copulate much more very frequently to achieve this result. Both parties also had to optimize their personal 'energy' levels, often with the aid of shamans or herbal medicines. The pill was rejected because it was not plant-based, and could not be classified according to taste – bitter, sour or strong, attributes on which the efficacy of a plant depends. Pills were also seen as dangerous substances that could cause unpleasant physical symptoms, such as bodily swellings, headaches, and liver complaints. Both diaphragm and

IUCD were rejected because, in the *criollo* view, illness was conceived of as a foreign 'substance' located within a particular part of the body, where it causes a dysfunction. As both these internal contraceptives were placed within the woman's body, it was believed that they could therefore cause her to become 'ill', or even to develop cancer. The Pilagá women also believed that fertilization was a mystical as much as a biological event. Pregnancy was also unlikely from a single act of intercourse. Seen as inherently fertile, frequent copulation would not only cause fertilization but was also necessary for the actual development of the embryo and the placenta, for the woman herself 'is a mere vessel and contributes nothing to procreation'. Traditionally, contraceptive methods were unknown, and both abortion and infanticide were used by the Pilagá for unwanted pregnancies. In recent years, they have increasingly adopted *criollo* attitudes towards procreation, and now reject modern contraception for very similar reasons. They now use more plant-based methods, and have less resort to abortion. The Pilagá believe, moreover, that the efficacy of a birth-control method (like pregnancy itself) is not only dependent on human behaviour, but also on the deities 'who ultimately decide whether the process will be effective or not'. In both *criollo* and Pilagá populations, therefore, there is conflict between their own views of fertility control, and those of the biomedical system that they encounter.

Case study: dengue and urbanization in Mérida, Mexico and El Progreso, Honduras

Kendall and colleagues²⁶ study in 1991 of Mérida and El Progreso indicates how an increasing urban population, and especially the growth of slums and shanty towns, is creating new ecologies of disease. In many urban areas of Central and South America and the Caribbean, overcrowding, population mobility, pollution, poor sanitation and the accumulation of garbage are all helping the rapid spread of certain diseases. These include insect-borne diseases such as dengue, and its variant dengue haemorrhagic fever (DHF), malaria, yellow fever, elephantiasis and Japanese encephalitis. Dengue is caused by a virus and transmitted by mosquitoes, especially *Aedes aegypti* (which can also transmit yellow fever). It can cause bleeding disorders and death, and there is no specific treatment or vaccine for it at present. In urban areas, the mosquitoes breed in collections of

stagnant water such as in rainwater pools, barrels, bottles, discarded tyres, flowerpots, vases and animal drinking troughs. However, many people are still unaware of the dangers posed by mosquitoes in an urban environment and of the need to take precautions against them. In Mérida, although most of the population knew about dengue from public health education programmes, some confused it with other fever-producing illnesses such as *derengue* (a disease of cattle), *deshidratación* (dehydration) and 'flu; they were also unaware that insects were its vectors, blaming instead certain 'winds' for carrying it and other febrile illnesses. In El Progreso, too, most people knew of dengue, but many confused it with 'flu, and also believed that it came from the 'winds' or from garbage rather than from mosquito bites. The authors concluded, therefore, that given the growth of urbanization and of these 'new' urban diseases, their control 'will require theoretical knowledge about the

organization of urban environments and its relationship to disease, new methodologies to encourage participation and

social activism in health, and increased knowledge about influencing health behaviour'.

Case study: acceptance of childhood vaccinations in Kéru, Burkina Faso

Samuelsen⁴⁴ in 2001 found a very high acceptance (almost 100 per cent) of childhood immunizations among mothers in the village of Kéru, Burkina Faso. This was largely due to resonances between traditional forms of 'vaccination', practiced in the village for many years, and the modern forms now being promoted by the public health system. Traditionally, mothers in Kéru would bring their babies to a local herbalist healer (known as a *vaccinatrice*) for the treatment, and prevention of a variety of folk illnesses. Using a razor blade to make 30–40 small incisions in a child's skin, she would then rub special herbs into them. Many of these preventable illnesses were believed to be caused by a 'weakening of the blood', so that treatments where medicines were directly mixed with the blood would reverse that process – and help strengthen the blood again. Samuelsen also points out that cicatrization with knives or razors, as well as

scarification followed by 'cupping', is also practiced in many other parts of Africa, and that vaccination against smallpox was actually practiced in West Africa long before it was introduced to Europe. In Kéru there is now a two-way influence between the traditional and the public health systems' for, as Samuelsen points out, 'So-called indigenous practices are not static, but adjust and change continuously in the response to changing social and cultural conditions'. The *vaccinatrice* has integrated many of the approaches and self-presentation of the local public health clinic or Centre de Santé et de Promotion Sociale (SCPS), such as a once-weekly 'clinic day', waiting times, cash payment and the use of imported razor blades and needles. While the SCPS are critical of the healer's treatments and its dangers (especially infections and haemorrhage), these traditional beliefs and practices have actually increased community acceptance of modern immunizations, by reinforcing the idea that disease can be prevented by the process of immunization.

Case study: folk models of tuberculosis in Dongora, southern Ethiopia

Vecchiato⁵⁶ in 1997 described folk beliefs about tuberculosis, and self-treatments, in a farming community of the Sidama people in southern Ethiopia. Despite a high prevalence of tuberculosis in that area, and despite the fact that no social stigma was attached to it, only a fraction of the cases presented themselves to the local clinic. However, most Sidama did recognize the symptoms of the disease, which they blamed either on overwork or on poor nutrition (though some accepted that it spread by contagion, or by 'inhaling dust particles'). However, 52.1 per cent believed that traditional remedies (*Sidama taghiccho*) were much more effective in treating tuberculosis than modern ones, while only 37.8 per cent preferred the latter. Traditional treatments included eating a nutritious diet (especially meat, milk and *ense*)

porridge), ingesting several types of herbal remedies (mostly used as emetics, to vomit out the 'bad blood' that accumulates internally), or getting a traditional healer (*oghessa*) to apply smouldering wooden rods to 'cauterize' the diseased parts of the body, especially the chest. Vecchiato noted that one reason that antituberculosis drugs such as streptomycin were often rejected was that they have no emetic effect, and suggests that future antituberculosis programmes take into account these indigenous beliefs, and work with them where possible. As a starting point, they should acknowledge that the Sindama can accurately diagnose pulmonary tuberculosis, that they do have a sense of diseases being contagious, and that they do see the value of a highly nutritious diet when ill. He also suggests that attempts be made to discover whether traditional herbal remedies are effective in treating tuberculosis, or not.

Case study: symbolism of the motor car in Chaguanas, Trinidad

Miller⁸⁵ in 1994 described how in the town of Chaguanas, Trinidad, the car is 'a vehicle not only for transporting people spatially but also conceptually from one set of values to another'. These new values include notions of individuality, since in contemporary Trinidad 'the car is probably the artefact which

outweighs even clothing in its ability to incorporate and express the concept of the individual'. In conversation, people are sometimes identified not by name, but by the make or number plate of their cars. For young males, particularly, cars have become the means of realizing their inner fantasies of independence from family, successful seduction and sexual attraction (street wisdom insists that 'women will not look at men

who don't have cars'). As a public way of expressing individuality, cars can be 'customized' by special decorations to their upholstery or exteriors, clearly marking the status and character of the owner. One result of this is 'an unwillingness to walk, once in

possession of a car'; huge traffic jams are commonplace as people drive to work or school, even when it is very near to home. Thus, in Trinidad, as elsewhere, the car has become 'as well-established a vehicle for expressive identity, as it is a vehicle for transport'.

Case study: community reactions to Kyasanur forest disease in South Kanara district, southern India

Nichter⁹⁶ in 1987 described Kyasanur forest disease (KFD) in South Kanara District as essentially a 'disease of development' – the result of deforestation and the rearing of cattle in the cleared scrublands between villages and forest. Many of those afflicted were poor agricultural workers, who tended these tick-bearing cattle. In the area, the local cosmology divides the universe into three realms: that of humans, that of the wild (forest) and the realm of spirits mediating between the two. Danger is inherent in any meeting between the human and spirit realms, and when the spirits are not controlled the results may be 'crop failures, epidemics, and the violent death of humans and domestic animals'. Faced with the outbreak of KFD, the villagers in the area assumed that the spirits were punishing some moral transgressions on their part, and tried to placate them by various rituals; their belief in KFD's supernatural causation was reinforced by the failure of doctors to cure it. During the epidemic, many victims refused to go to hospital, for both cultural and economic

reasons, preferring instead to be treated at home by a private Ayurvedic practitioner. They feared that to die in hospital would be to have a 'bad death', and their unsatisfied spirit (*preyta*) would cause problems to their surviving kinsfolk. To appease such a spirit would then entail expensive rituals that they could not afford. Hospitalization also meant the loss of another healthy wage earner, who would be forced to help nurse the patient in hospital. In contrast, the private practitioner, although less (medically) effective, was more sensitive to popular health beliefs than the hospitals, prescribed special diets in keeping with those beliefs and was quite liberal in his administration of diazepam (Valium) to patients having a wide variety of illnesses. By treating them at home, he also helped avoid the expense of a 'bad death'. Nichter points out that, at first, government officials played down the link between KFD and deforestation, and did not sufficiently tap community self-help as a resource in dealing with the epidemic. Despite their belief in the mystical origin of the disease, the villagers' 'effort to appease this spiritual cause of KFD did not preclude an interest in controlling ticks as an instrumental cause of disease'.