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Anthropo-Medical Orientation: Reflections on Medical Anthropology and Cultural Riddle

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Cultures globally are man-made survival strategy based on responding to various environmental, ecological, demographical, topographical, geographical, political, social, psychological and economic factors for diversity. The point raised here is if the nature accepts the diversity due to which the living styles, languages, dressing, and other related aspects of aesthetics then why don't human accept socio-cultural diversity. The paper focuses its discussion on medical anthropology. Anthropologists have long been involved in studying the health systems of various societies that they choose for research. The understandings of various cultures and its medical practices helped anthropologists to understand why people prefer to have a unique and indigenous thought patterns as regards health notions and practices. Pakistan being a member of third world brethren still holds its position among the conventional medicalization. National life is divided into various strands of medical belief system and thus practices regarding diagnosis, curing, treatments, rehabilitation. Health bureaucracy blindly follows the Western medical approaches upon which there are intellectual debates internationally to accept the cultural notions in order to improve the global indicators while accepting the local cultures and their interpretations on such vital aspects of man's civilized life. There is a need to reiterate the health policy as well as the brain set of medical care systems to give the cultural perceptions and thus medical anthropology a due role in deciphering the dream into a reality. This paper attempts to educate the readers about the importance of cultural factors in understanding the disease, illness and healing in cultural settings and also to discuss the role of ethno-medicine that has been acknowledged throughout the world.

Keywords: traditional medicine, indigenous knowledge system, health care system, disease, illness, healing, medical anthropology.

Anthropology traditionally claims to be a discipline of studying man from four standpoints that largely make up main sub disciplines. Out of four, Cultural Anthropology or Social Anthropology is a contemporary discipline studying the mankind in the 'present'. Health is main developmental issue of any community, culture or current day modern and developed nation. Every society is generally concerned about the general welfare and wellbeing of its population as it is related to the development, betterment and progress of people and thus community. Health issues remained a major developmental challenge for Pakistani nation as well. It is a fact accepted universally that health population leads to health nation. A nation that is capable to compete with others round the globe.

Pakistan is a developing country of third world and cognizant of the realities associated with better health indicators. The overall health status of Pakistani nation is not satisfactory when the position of Pakistan is compared with other sister countries in South Asia. The reasons may be many, among them, poverty, access to health facilities; social stratification system and illiteracy count the most. As regards the role of Anthropologists in health domain in country concerns, the national picture cannot be defended with satisfaction.

The present work investigates the traditional and cultural heritage of Indus valley to highlight health perceptions of people from anthropological point of view and thus inviting a brethren of social scientists especially anthropologists to contribute in favor of our centuries old repertoire of knowledge including faiths and practices held by local people over centuries. Most alarmingly, researchers round the globe work on the credibility of traditional medicine whereas this important issue still needs advocacy regarding its validity in Pakistan. This issue goes graver when it is found that internationally reputed organizations like World Health Organization also recognizes the importance of the local medicine and treatments patterns. On the other hand, there is lack of awareness and also strong resistance from the medical personnel who oppose the local treatments and deny its credibility what so ever. The paper is a conscious attempt to study the local and traditional medicine from Anthropological perspective.

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Anthropology and Health

The Social Science Encyclopedia (1989) throws light on a number of scholars who worked for the development of anthropology in nineteenth and twentieth centuries were physicians like Rudolph Virchow, Paul Broca, W. H. R. Rivers, etc. It is also mentioned that

Over the past decade the field underwent a period of explosive growth in America so that at present nearly one out of five anthropologists there regards himself as working in this subfield (The Social Science Encyclopedia, 1989)

As per the role of anthropologist in applied settings, various scholars have opined about applied anthropology's utilities as also indicated by Kluckhohn (1949) says 'It is obvious that anthropologists have special knowledge and special skills for assisting governments in administering primitive tribes and dependent peoples. They have been employed by the British, Portugese, Spanish, Dutch, Mexican, French, and other governments. An understanding of native institutions is a prerequisite for successful colonial government, though, thus far, anthropologists have been used more to implement policies than to formulate them' (Kluckhohn, 1949).

He further comments that "the broadcast utility of cultural anthropology to medicine consists in the anthropological faculty for swiftly apperceiving the principal currents of a culture as they impinge on individuals. Carefully designed quantitative studies to give a cross cultural testing of theories on mental health are just beginning to emerge". Another important view is presented by Kessing when he talk about the role of applied anthropology and anthropologists in utilities of it compared to other disciplines while saying 'Just as they have looked to geology, entomology, and the other physical and biological sciences in handling the resources of the territories concerned, and to tropical medicine in meeting health problems, so they have drawn on anthropology to throw light on the exceedingly difficult problems of human relations, especially the adjustment of the so called native or indigenous people to modern civilization' (Kessing, 1945).

Unlike other academic disciplines, Anthropology talks about Health in a broader perspective and deals with it as a complete code held by any population including perception about wellbeing of population, notions on curative and preventive aspects of treatment, treatment patterns according to the severity of diseases and set of practices and associated faiths. Hahn (1984) has made a similar comment which is also supported by Mechanic while commenting 'Anthropologists generally see "health" as a broad construct, consisting of physical, psychological, and social well-being, including role functionality' (Mechanic, 1962). Both scholars have opined about the perception of illness as something that is not physical rather a philosophical issue that contains and carries perception of ill health. They say:

'Illness' is the culturally structured, personal experience of being unwell and it entails the experience of suffering (Hahn, 1984; Mechanic, 1962)

Another scholar Sobo (2004) also verifies that illness is a broad term that acquits a particular state of belief system in particular socio-cultural systems. According to her 'Illness can refer to a variety of conditions cross-culturally. In some cultures, it is limited to somatic experiences; in others it includes mental dysfunction; in others it includes suffering due to misfortune, too. That is, some medical systems deal with human struggles related to love, work, finances, etc. Social, somatic, emotional, and cognitive troubles often are not separated at all but quite intertwined and even fused together.' Eisenberg and Kleinman (1981) define 'patient-hood' as 'a social state and not simply a biological one'. Both scholars discuss about social and cultural factors involved in the risk of becoming sic, how sickness is defined and symptoms interpreted, and response to those symptoms. People decide to become (or remain) patient, as well as being defined and labeled as patient by doctors. Another illustration has been made by Cassell (1976) that 'illness is what the patient feels when he goes to the doctor, disease is what he has on the way home.' Schulze and Angermeyer (2003) define illness as 'patient's subjective experience of physical or mental states, whether based on some underlying disease pathology or not. But illness can also be social: the experience of some illness is not limited to the symptoms but includes a 'second illness' – the reactions of the social environment, for example the stigma associated with the disorder. Stigmatization is an additional dimension of suffering added to the illness experience' (Schulze and Angermeyer, 2003). According to Eisenberg (1977) stresses upon the distinction developed by the social scientists to understand disease and illness. The distinction is as below:

1. *Doctors diagnose and treat disease – abnormalities in the structure and function of organs and body systems*

2. *Patients suffer illness – experiences of malfunction in states of being and social function.* (Eisenberg, 1977)

With this recapitulation of illness and disease discussion to conceptualize the relation, a strong criticism has been raised over the finding which is also discussed by Hahn that 'This underscores a major criticism of the disease–illness dichotomy: that it recapitulates the mind–body dichotomy that biomedicine has been criticized for trafficking in. 'Disease', as the dichotomy defines it, is anchored in the body; conversely, 'illness' may be seen as anchored in the mind. Disease is thus attributed a real, concrete, scientific factuality or objectivity that illness, as a subjective category, may be denied' (Hahn, 1984).

In the initial days of Anthropologists studying the medical systems, practices and faiths was not graded as something

grave and worth of grandness because of indecisiveness of anthropologists themselves upon work done and formal labeling of researches conducted under banner of medical anthropology. This was so because the development of demographic anthropology and likewise research trend in post World War II scenario emphasized upon the quantitative analysis and descriptions. The stance of demographic anthropology largely was regarding quantitative description as agreed by Scupin and De Corse (1992). The demographic anthropologists were more concerned with the population statistics with more intensive data collection techniques to ensure reliability among the traditional troika of birth, death and migration factors within a population. Kreager states that 'A stereotypical quest of the social demographer, after all is for generalizations which hold true at higher levels of aggregation, whilst anthropologists sing a no less perennial song about the peoples they study being really diverse in a way that escapes deterministic models' (Kreager, 1997).

The statement above clearly denotes the high reverence allocated to the sciences that quantify objects of study rather than the one that talk of diversity. Despite the fact that Lorimer's (1954) findings amply justified role of anthropology while studying the population issues. He advocated a vacancy for anthropology to be best suited to explain the 'demographic transitions' and thus assuring anthropological data to be complementing quantitative approaches. Whereas rightly observing the situation Kreager commented that 'The marginalization of culture in postwar demography gave decidedly secondary place to anthropology in the emerging field of population and development research, the sources of this relegation derived less from any specific attitude to anthropology than from a wider consensus against taking culture as a major force in modern history' Kreager (1997).

The reason why medical anthropology took so long to develop as a scientific domain of inquiry was the internal disagreements of anthropologists upon the subject matters and methods of data collection. Pool and Geissler made an indication in their words as 'one of the most important objections to this type of field research in that the data that it produces might be biased'. *They* elaborate another objection on medical anthropology that 'The problem of 'informant accuracy' – the fact that different informants may say different things about the same topic' (Pool & Geissler, 2005). Foster and Anderson (1978) have also thrown light on another vital aspect of invaluableness of data collected. They are of the view that 'with the end of World War II, medical anthropology (still at that time an unnamed specialization) received impetus and support from foundation- and government funded applied work in the arena of international public health. The data collected by anthropologists in earlier times for non-medical purposes proved invaluable; anthropologists helped ensure that social and cultural aspects of health and healing were taken into account in ways that promoted international health program success' (Foster & Anderson, 1978). Probably the most important contribution was made by Clifford Geertz (1973) who defined anthropology in following terms to resolve the brain-teaser for anthropologists by noting that Anthropology is 'not an experimental science in search of law but an interpretive one in search of meaning' (Geertz, 1978). Pool and Geissler (2005) have also added in favor of ending this debate in words that 'these differences are not trivial and they have consequences for any attempt to apply anthropology practically, for example in public health. They are grounded in fundamental epistemological questions: What are the limits of what we can know about human society? How reliable is this knowledge? Do the things we know about exist separately and independently of our knowledge of them? What kind of knowledge should anthropology seek, and what kind of knowledge can attain it? Is this fundamentally different from, say, medical knowledge?' (Pool & Geissler, 2005).

The Evolution of Medical Anthropology

The Social Sciences Encyclopedia edited by Kuper and Kuper (1989) have referred Kleinman's work who talks about 'anthropology of medicine' as the 'sub field' of anthropology that takes as its subject matter the cultural context of health, illness and healing". According to him this subfield has distinctive areas of research including cross cultural comparisons of medical systems (for example; in small scale preliterate societies, post-traditional, ethnic and mainstream Western societies), anthropology of nutrition, population problems, birthing, ageing, and substance abuse, ethno-psychiatry, social epidemiology, clinically applied anthropology, bio-cultural research on socio-somatic interactions in health and illness and most recently, cultural analysis of biomedicine itself. Both social and biological wings of anthropology actively contribute to the field; to do so, to a lesser extent ethno-historical studies of disease and paleo-pathology. Kottak (2000) defines Medical Anthropology as amalgamation of 'academic/theoretical' and 'applied/practical'. He further elaborates that 'it is a field that includes both biological and socio-cultural anthropologists'. As per views of Kottak, medical anthropology ponders upon the various aspects like specificity of diseases regarding particular populations, how illness is socially constructed and how does somebody adopts appropriate measures to treat an illness while remaining in a particular culture. The emphasis here is on culturally defined methods and treatments patterns. The acknowledgement given by the Social Science Encyclopedia about the notes that:

Contemporary medical anthropology took its origin from the work of Clements in the 1930s on presumed universal categories of disease aetiology, from Ackerknecht's reviews of primitive surgery, primitive prevention, primitive psychotherapy in the 1940s and 1950s to construct an historical anthropology of ancient systems of medicine. Other important contributions were the study of ritual healing in the anthropology of religion, fieldwork in ecological anthropology that examined cultural-biology interactions,

and applied anthropological contributions to international health research (Social Sciences Encyclopedia, 1989).

Unlike other social sciences having their specializations in health studies and medical sciences has dramatically responded to the challenges posed by the post World War II's scenario. Among several disciplines, anthropology also contributed justifiably. Hendriks and Nowak (1993) gave a similar citation regarding the development of different fields like medicine, biology, microbiology, and chemistry. On global scale, the world's community, nations and respective governments were more concerned about the reconstruction of national infrastructure surviving the World War. Another causing move was the governments' increased recognition to deliver the inherent rights to their citizens as citizens and under the grown acceptability of newly emerging concept of basic human rights as it was observed with development of United Nations Universal Declaration on Human Rights (UN-UDHR) in 1948. With this natural development that led for the development of new disciplines an important issue was also raised by Hendriks and Nowak (1993) who express that:

Progress in medical sciences and advanced treatment methods involves new challenges to humanity and the traditional regulation of societies. With the biomedical development, new opportunities and life perspectives have been created for those with previously intractable complications of health programs. Not only have the boundaries of life and handicaps been removed but, at the same time, new forms of procreation have been developed which have an enormous impact on our definitions of parenthood, family, descent, heredity, titles and other concepts (Hendriks and Nowak, 1993).

This seems to be a confession on the part of people who underestimated the role of anthropology in bringing new orientations to understand the importance of cultures and cultural responses to newly emerged challenges in health domain globally. Good (1994) refers 'to medical anthropology in the 1960s as a 'practice discipline,' dedicated to the service of improving the public health of societies in economically poor nations'. It was first time when the journey of medical anthropology as a full-fledged profession got started and well perceived by Anthropologists within the discipline. The quote underneath qualifies that:

Indeed, initial efforts at organizing a medical anthropology interest group occurred in the late 1960s under the auspices of the Society for Applied Anthropology (Todd & Ruffini, 1979).

Sobo (2004) also confronts another misconception with the gradual emergence of medical anthropology that initially the term medical was so narrow to accommodate the new visions put forth by anthropology. She says 'Technically speaking, the term 'medical' refers only to those curative practices engaged in by Western trained, allopathic, biomedical physicians (and when hairs are split, surgeons are not included here). As effective as this type of curing may be, it is asocial and highly technologized, bureaucratized, and industrialized. It deals with body parts and systems rather than individuals. It values quantitative over qualitative data' (Sobo, 2004). Steve Ferzacca (2004) in his paper 'Post Colonial Development and Health' adds that Medical anthropology found itself as a sub-field of anthropology at this historical moment of post-coloniality. The research concerns and methodological approaches of medical anthropology emerged within a post-colonial context for which "development" and the urge to develop were integral features of political and social life.' In the newly emerging nation-states poised between remedying the health hazards of colonialism and traditional lifeways, most Westerners began practicing what was to become medical anthropology (Janzen, 2001).

Medical anthropology while focusing on socio-cultural systems is especially interested in seeing and studying the socio-cultural context of phenomenon of disease and its relative specificity with a given population. It also studies conceptualizing illness and its implications. Few reflections have to be understood in great deals of depth so that stepping in of anthropology is medical studies is made easier to understand. Chrisman (1978) referred to recognition of symptoms:

The recognition of symptoms is generally the first step in what Noel Chrisman (1978) long ago termed 'the health-seeking process' (Chrisman, 1978)

Why this recognition was made possible so late is also apprehensible because of early disagreement upon the place of anthropology in health studies especially medical as well as by the time evolved and refined vision of anthropology in medical. The recognition of potential share of anthropology towards better understanding of health systems including faiths and practices allowed researchers, practitioners, and academicians to accept what Sobo says 'symptom recognition depends on cultural definitions of normal well-being, and understandings about the causes and contexts of sickness. Owing to cross-cultural differences, symptoms are not always grouped together in the same way cross-culturally. However they may be grouped, some of the important factors that people in all cultures consider when evaluating symptoms include how dangerous to life they are suspected to be, and the degree to which they interfere with lifestyle or function' (Sobo, 2004).

New Reflections and Medical Anthropology

Culture being at the heart of Anthropology made easier to understand between what is a disease and what is an illness. How both concepts are essential to be understood in the same place? How these two are reciprocal to each other. According to Young 'One simple model casts illness as either 'internalizing' or 'externalizing'. Internalizing systems focus on proximate physiological mechanisms. They give primacy to biological or physical signs that can mark a disease's

progression' (Young, 1976/1986). He further states 'Illness is an individual problem, not a social problem. In contrast, externalizing systems ascribe importance to events outside of the ill individual's body. Such systems view pathogens as purposive; often they are human or anthropomorphized. Diagnostic activity focuses on discovering what brought the (now ill) individual to the pathogenic agent's attention, provoking the attack. Externalizing systems focus on ultimate causes, not proximate ones. Using the externalizing–internalizing model, Young offers some interesting suggestions regarding the evolution of health systems. He holds that internalizing systems evolve from externalizing systems when societies grow complex' (ibid). He says that 'externalizing systems focus on social and cosmological relations. They are interlinked with other cultural domains, such as religion, and have little conceptual autonomy.' While describing the small scale societies that has been a major area of interest for the early anthropologists, he explains that:

In small-scale societies, specialization is uncommon and the division of labor is low. Young (1976/1986) argues that this explains the overlap between healing and other cultural domains. Large-scale societies have complex labor division patterns that include specialization and engender distinctions between cultural domains. The conceptual autonomy of internalizing systems is linked to this. The fragmentation of cultural realms in large-scale societies supports internalizing systems, which focus on the body, paying little heed to legal, religious, and other dimensions of life (Young, 1976/1986).

The Social Science Encyclopedia (1989) highlights the conceptual and methodological breakthroughs of medical anthropology as firstly, analytical frameworks for explaining and comparing medical systems in non-Western and Western societies; secondly, a distinction between illness[1] and disease[2]; thirdly, social influences in terms of production and construction of disease and illness; fourthly, evaluation of culture specific and universal aspects of help-seeking process, practitioner and patient relations and healing; and fifthly, strategies employed to reduce cultural miscommunications. This is an understood fact that socio-cultural system had successfully sustained before 'scientific revolution' through their uniquely evolved indigenous knowledge systems. The indigenous populations as defined by Ferraro (2008) are:

The original inhabitants of a region who collectively wield little political power, and whose cultures and ways of life are threatened by the forces of economic development (Ferraro, 2008)

What is required most essentially is the recognition that all societies do have their unique health care systems which includes a complete belief system and a set of practices to gauge the health related issues and anticipating the possible causes and thus proposing a culturally appropriate treatment method. Kottak (2000) defines the health care system as comprising:

Beliefs, customs, specialists, and techniques aimed at ensuring health and preventing, diagnosing, and curing illness (Kottak, 2000)

Martin (1992) also contended that incidences of diseases vary from society to society and the cultures have their own pattern of construing and devising the curing plan. It is now accepted globally that socio-cultural systems have their own methodologies of recognizing and evaluation of disease and illness. This phenomenon has been recognized by scholars including Kottak (2000).

Gaines and Davis-Floyd (2004) state that 'the designation 'Biomedicine' as the name of the professional medicine of the West emphasizes the fact that this is a preeminently biological medicine. As such, it can be distinguished from the professional medicines of other cultures and, like them, its designation can be considered a proper noun and capitalized.' It is therefore the term of 'biomedicine' was coined by Gaines and Hahn (1982, 1985) after Engel (1977) on what had previously been termed 'Western medicine', 'allopathic medicine' or 'medicine' (Engel, 1980; Kleinman, 1980; Leslie, 1976; Mishler, 1981). The problem with the term 'medicine' was that it simply equated 'biomedicine' as unscientific or 'folk' (Good, 1994). The works of Hahn and Gaines (1982) envisage 'biomedicine' as 'socio-cultural system' as a system of beliefs along with rituals and practices in which biomedicine acts as 'ethno-medical system' Hahn & Gains, 1982).

Gaines and Hahn (1985) also discovered three features 'biomedicine' as a socio-cultural system. Firstly, it is an institution that is erected upon a complete set of cause and effect principles on the basis of observations and practices (Gaines, 1979, 1982a, 1982b; Lindenbaum & Lock, 1993). Secondly, it also hires the services of specialized labor available within a culture but it involves no internal differences and inequalities (Gaines, 1992d; Hinze, 1999). On the other hand, the modern medicine where the paramedical staff is highly specialized as discussed by Johnson (1985). The preferential treatment patterns and gender orientation of biomedicine (Hinze, 1999; Ginsburg & Rapp, 1995; Martin, 1994) factors of ethnicity, economic status and age groups (Baer, 1989, 2001; Gaines, 1982a, 1986, 1992d, 1995; Good, 1993; Hahn, 1992; Nuckolls, 1998). Land marking studies conducted by Foucault (1975) and Gaines (1992c) were conducted to see biomedical orientation to treat human physiology as a socio-cultural product that affects medical practices and understandings. The biomedical system of knowledge does contain a complex whole of practices and

[1] Encyclopedia discusses illness as learned and shared patterns of perceiving, experiencing and coping with symptoms.
[2] Encyclopedia describes disease as understanding of illness within systems of beliefs and practices of particular groups of practitioners

argots and treats human body as 'local biology' (Gaines (1992b, n.d., b). Thirdly but most importantly, bio-medicinal paradigm frames the role of practitioners as most vital in its continuous updating.

This particular paradigm is unique in its nature because of the fact and understanding the human biology is a product of its bio-cultural realities due to which the spatial differences require these differences to be kept in frame of reference as discussed by Kleinman (1980) and Unschuld (1985). Good and DelVecchio Good (1993) also discuss that 'its biological focus is complemented by a strong focus on energy. The same is true of Unnani, the professional medicine of the Middle East derived from Greek Classical medicine. Unnani and its Greek predecessor are involved in the somatic domain, but may add to it energetic and cosmological elements and interpretations that make their reading of human biology unique'. G. Devereux was the scholar who investigated the impact of biomedical system under the socio-cultural system to state that certain psychological diseases are cultural products and carry diverse notions about it if analyzed from culture binoculars (Devereux, 1944, 1949, 1980). For instance schizophrenia is a biological factor in western tradition (Gaines, 1992a; Kleinman & Good, 1985; Marsella, 1980) but not in other non-western cultures (Blue & Gaines, 1992; Devereux, 1980; Kleinman, 1988b).

Disease Theory System

Another important aspect of medical anthropology is what called "Disease Theory System" as termed by George Foster and Anderson in 1978. This system is the one that identifies, classifies, and explains illness. Foster (1976) commented that 'the contrast between 'naturalistic' and 'personalistic' medicine focuses directly on social relations' (Foster, 1976). According to Foster and Anderson (1978) in a joint research chore revealed that there are three basic theories about the causes of illness.

Personalistic Disease Theories

These theories visualize malicious agents to be responsible for illness. These agents might include sorcerers, witches, ghosts, ancestral spirits (Kottak, 2000) and other super natural elements.

Naturalistic Disease Theories

These theories explain illness in terms of impersonal factors like the non-local treatment methods. Similarly, the classification of food as containing the environmental effects like 'hot' and 'Cold'. All these could be termed as impersonal factors of illness.

Emotionalistic Disease Theories

Illness is explained from the point of view of psycho-emotional factors. Kottak (2000) has described a clear example discussed by Bolton (1981) and Finkler (1985) of Latin American experiencing *susto* which is equivalent to soul loss. This illness is said to be caused by the anxiety or any other kind of fright. Sobo (2004) mentioned the same models explaining sickness and illness that 'Naturalistic models explain sickness as due to impersonal forces or conditions, including cold, heat, and other forces that upset the body's balance. Personalistic approaches, however, ascribe illness to active external agents. The agent involved in a given case may be human (such as a sorcerer), or non-human (such as an evil force or ancestral ghost). Accident or chance has no role in illness here as they do in naturalistic explanations; in personalistic systems, illness is the direct result of an agent's purposive act. Therefore, people need to be certain that their social relations, with the living and the dead, and with deities and other agentic forces, are well maintained. If not, others may be provoked to take actions leading to one's ill health' (Sobo, 2004).

Bioethics and Health Care Systems

Bioethics is a growing sub-discipline within the larger domain of anthropology that combines various interpretations regarding medical anthropology to understand the cultural importance of understanding the perceptions on health system and remedial measures. This is especially true in terms of cultural relativism (Crigger, 1998; Kleinman,1995a, 1995b; Marshall, 1992; Muller, 1994). The regional perspective is also added (Fox and Swazey, 1984). Kleinman (1995a, 1995b) though comments that it is limited in scope as regards non-Western moral traditional because its orientation is too narrow that does not accommodate its non-Western theoretical foundations. The anthropological contribution in bioethics is now focusing on the impact of technological innovations in biomedicine or traditional medicine (Brodwin, 2000; Lock, Young, & Cambrosio, 2000).

The maturating bioethics concentrates various themes as major area of inquiry within itself. Bioethics brings into its direction themes like: Death; Organ donation and transplant; disclosure of terminal diagnosis and prognosis; end-of-life care; beginning of life decision-making; reproductive ethics; and bioethical view on genetics, race and identity. As regards death perspective, the stance of bioethics concerning indicators of biological and social death is purely cultural upon which various societies reveal considerable diversity of opinion for instance the works of different scholars (Lock, 1996, 2002; Lock & Honde, 1990; Ohnuki-Tierney, 1994; Lock, 2002; Lock & Honde, 1990) can be quoted. The stand-point of bioethics on organ donation and transplant to explore the cultural stance on gift-giving between the donor and recipient has also been studied by scholars like Fox & Swazey (1992); Fox, Swazey, & Cameron (1984); Ikels (1997); Joralemon (1995); Sharp (1995, 2001, 2002) because of variety of cultural differences (Siminoff & Arnold, 1999; Lock & Honde, 1990). It is therefore many anthropologists have attempted to study the public policies on organ transplant and donation in various nations (Das, 2000; Joralemon, 2000; Marshall & Daar, 2000; Scheper-Hughes, 2000; Siminoff, Arnold, Caplan,Virnig, & Seltzer, 1995).

Bioethical sub-discipline regarding the issue of 'truth-telling' about particular diseases like cancer is also full of

diverseness and requires attention to be dealt while keeping in perspective the need to study this cross-culturally. Countries like Japan, China and Italy, physicians hold their view from patients to avoid the possible dearth of hope and further cause of depression among patients as studied by Gordon (1990, 1994); Gordon & Paci (1997); and Long (1999, 2000b). Whereas, in US, physicians believe in disclosing the terminal diagnoses but many physicians carry a spiritual view in hiding it to justify the 'hope' among patients to live (Christakis, 1999; DelVecchio Good, Good, Schaffer, & Lind, 1990; DelVecchio Good, Munakata, Kobayashi, Mattingly, & Good, 1994; Blackhall et al., 1999; Muller & Desmond, 1992; Orona, Koenig & Davis, 1994). Side by side there are views on using a family-centered model of medical decision-making (Blackhall et al., 1995; Marshall et al., 1998; Muller & Desmond, 1992; Orona et al., 1994).

The position of bioethics in anthropology related to 'end-of-life care' is also focus of interest as it also help to understand several ethnic and cultural perspective which surely is embedded in particular cultural, ethnic and religious traditions for example hydration, nutrition, artificial oxygen support (Crawley, Marshall, & Koenig, 2001; Hern, Koenig, Moore, & Marshall, 1998; Koenig & Gates-Williams, 1995; Long, 2000a, 2001; Marshall et al., 1998; Slomka, 1995). All such studies conducted to understand 'end-of-life care' in its cultural uniqueness. In this connection, some anthropologists have also studied the socio-political dimensions to develop insights to engulf policy directions made for Para-medical staff to implements 'end-of-life care' decisions for patients (Muller, 1992; Muller & Koenig, 1988; Slomka, 1992). Another focal point in bioethics is 'beginning-of-life decision-making' to understand medical assessments about the climacteric medical conditions of newly born babies as well as many closely knit domains of special persons' rights and duties of health professionals as done by Levin (1988).

Reproductive ethics is one of the most vital areas of bioethics as cultural beliefs associated with it are perplexed and deeply rooted in religious, moral and historical grounds. Anthropologists (Bosk, 1992; Browner, Preloran, & Cox, 1999; Franklin, 1998; Press, Browner, Tran, Morton, & Le Master, 1998; Rapp, 1999) have attempted to study the prenatal practices. Similarly, the decision-making regarding child delivery at home (traditional methods) or hospital (reproductive technology) also carries cultural importance especially in South Asian perspective (Kaufert & O'Neil, 1993; Beeson & Doksum, 2001; Price, 1999). This field of studies emphasizes the worth of understanding the role of 'risk' in making decisions about reproductive health.

As regards, the ever-in topics of race, genetics and identity in anthropology in addressing ethnocentric views on all of these concepts to remove the non-scientific superiority concepts among nations. All of these non-scientific superiority concepts forge the specific world views of different ethnic groups. The aim of this sub-discipline is to address the importance of cultural understanding regarding these concepts as evident in the works of Brodwin (2002), Gordon (2002), Wolpe (1996), Wailoo (1997) and Lee, Mountain, and Koenig (2001). It is therefore role of anthropology is crucial in studying the culture-bound notions regarding health. Anthropologists are thus busy in conducting researches on targeting all major themes in bioethics (discussed above) to interrelate these concepts in their cultural settings (Jecker, Carrese, & Pearlman, 1995; Carter & Klugman, 2001; Koenig & Gates-Williams, 1995; Orr, Marshall, & Osborn, 1995; Crawley et al., 2001; Kaufert & Putsch, 1997; Hern et al., 1998; Marshall, Thomasma, & Bergsma, 1994).

Anthropologists have also identified cultures with having their own Care Systems based on culturally evolved unique strategies. The health care systems in one place do have their own system of faiths and practices similarly they do have specialized practitioners (also indicated by Foster and Anderson, 1978) having their curing methodology. Kottak (2000) also referred 'health care systems' to be containing beliefs, customs, specialists, and techniques for diagnosis and cure. These practitioners also possess particular calculations and anticipations about the cause and effect relationship of specific illnesses.' Loustaunau and Sobo (1997) say:

Medical systems generally include a diverse array of practitioners, such as herbalists, chemists, surgeons, bone setters or body workers, midwives, sorcerers, priests, and shamans (Loustaunau & Sobo, 1997).

On the other hand, Kleinman (1978) has talked about the common typology that aims to explain complex medical system in tripartite scheme comprising popular, folk, and professional. Another model is Bonnie O'Connor's (1995) having two parts including *conventional medicine, and vernacular medicine. Vernacular medicine* colligates Kleinman's (1978) folk and popular types whereas *conventional medicine* having formally trained and centrally controlled staff.

Global Recognition of Traditional or Ethno-medicine

WHO (2000) defines ethno-medicine as 'Traditional medicine has a long history. It is 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 illnesses. The terms complementary/alternative/non-conventional medicine are used interchangeably with traditional medicine in some countries.'

The case of recognition of traditional or ethno-medicine is again of great importance. The vitality of it goes stronger because of cultural factors and their indispensability in lives of folks-men. The local populations and communities adhering to their legends and cultural life thus make the

importance of understanding the cultural notions of sickness and illness necessary to understand. It is also because local populations usually have a non-favorable attitude towards medical practices and explanations having no roots in recent or even remote history of a particular region. The role of local practitioners including herbalists, traditional birth attendants, faith healers, spiritualists comes to be dominantly occupying the place and winning trust of people for consultation. Lieban (1977) also pleaded for understanding to eradicate the biases held for western medicine against scientific medicine.

As a matter of fact, to evaluate why locals always are distrustful of innovations that are not originally based in their socio-cultural systems is because people experience and often complain about the medical product being inappropriate and methods of diagnosis as against the local norms and lack of client or 'patient centered approach'. The local medical systems and its practitioners well rooted in local cultural systems and enjoying a trust worthy relationship with community make them for more effective in their locally evolved methodologies. In addition, role of local methods being effective for centuries is not simply because of mere preference of indigenous methods but because of the case histories that a community is learning from day to day contacts and sharing. The community also recalls collective experiences happened in past within the population. On the other hand, it is only few decades ago when the modern western medicine and its brain set has reached out to them in parts not as a whole. The communities especially in rural and remote regions in third world still have to rely on their local medical practices and indigenous health belief system. The main actors of local medical systems are very much part of indigenous populations and issue of accessibility is no more an issue. In spite of huge development interventions, local populations still manage to retain their local faiths and practices because it is a trust game. In this regard, the words of Routledge Encyclopedia of Social and Cultural Anthropology (2005) reinforces:

Since the 1970s, increasing levels of dissatisfaction with Western medicine among patients, and communication difficulties between doctors and patients of culturally diverse backgrounds within North American society, have led medical professionals to take a more direct interest in the possible contributions of anthropology to clinical practice. This includes the recognition of cultural variability in the expression of signs and symptoms of distress and disorder through a focus on meaning and symbolization.

Advances in medical anthropology's concerning cause and effect relationship of illness are evident in Kleinman's (1980) delineation of 'Explanatory Models' as:

Conceptual templates variously constructed by individual patients and practitioners to explain episodes of illness – has been widely utilized in clinical settings and in academic medical anthropology (Kleinman, 1980)

Recently, WHO has acknowledged the dominant role of traditional medicine all around world and thus commenced worked for its formal acceptance at international level. In this regard WHO has also prepared a strategy for local medicine. WHO (2002) comments that 'Traditional complementary and alternative medicine attracts the full spectrum of reactions — from uncritical enthusiasm to uninformed scepticism. Yet use of traditional medicine (TM) remains widespread in developing countries, while use of complementary and alternative medicine (CAM) is increasing rapidly in developed countries. In many parts of the world, policy-makers, health professionals and the public are wrestling with questions about the safety, efficacy, quality, availability, preservation and further development of this type of health care. It is therefore timely for WHO to define its role in TM/CAM by developing a strategy to address issues of policy, safety, efficacy, quality, access and rational use of traditional, complementary and alternative medicine' (WHO, 2002).

WHO (2002) classifies Traditional Medicine (TM) as a comprehensive term used to refer both to TM systems such as traditional Chinese medicine, Indian ayurveda and Arabic unani medicine, and to various forms of indigenous medicine. TM therapies include medication therapies — if they involve use of herbal medicines, animal parts and/or minerals — and non-medication therapies — if they are carried out primarily without the use of medication, as in the case of acupuncture, manual therapies and spiritual therapies. In countries where the dominant health care system is based on allopathic medicine, or where TM has not been incorporated into the national health care system, TM is often termed 'complementary', 'alternative' or 'non-conventional' medicine' (WHO, 2002).

WHO estimates are based on neutral observations, systematic data from all member state which qualifies the existence and social approval of traditional medicine thus recognition of widespread traditional and local medicines. WHO states that 'TM is widely used and of rapidly growing health system and economic importance. In Africa up to 80% of the population uses TM to help meet their health care needs. In Asia and Latin America, populations continue to use TM as a result of historical circumstances and cultural beliefs. In China, TM accounts for around 40% of all health care delivered. Meanwhile, in many developed countries, CAM is becoming more and more popular. The percentage of the population which has used CAM at least once is 48% in Australia, 70% in Canada, 42% in USA, 38% in Belgium and 75% in France. In many parts of the world expenditure on TM/CAM is not only significant, but growing rapidly. In Malaysia, an estimated US$ 500 million is spent annually on this type of health care, compared to about US$ 300 million on allopathic medicine. In the USA, total 1997 out-of-pocket CAM expenditure was estimated at US$ 2700 million. In

Australia, Canada and the United Kingdom, annual CAM expenditure is estimated at US$ 80 million, US$ 2400 million and US$ 2300 million respectively' (WHO, 2002).

WHO further comments on the global acceptance and utilities of local medicine practitioners and traditional medicine in following words that 'In developing countries, broad use of TM is often attributable to its accessibility and affordability. In Uganda, for instance, the ratio of TM practitioners to population is between 1:200 and 1:400. This contrasts starkly with the availability of allopathic practitioners, for which the ratio is typically 1:20 000 or less. Moreover, distribution of such personnel may be uneven, with most being found in cities or other urban areas, and therefore difficult for rural populations to access. TM is sometimes also the only affordable source of health care — especially for the world's poorest patients' (WHO, 2002).

Eisenberg's work (1977) on ethno-medicine is worth studying that brings more insights in understanding ethno-medicine. Eisenberg discusses that 'the term 'ethno-medicine' is frequently used to characterize the object of study in ethnographic research on indigenous, usually non-Western, forms of healing and classifications of disease. Such research is often, though erroneously, itself designated as 'ethno-medical' since the focus of enquiry is the elucidation of emic or indigenous concepts of sickness and its treatment' (Eisenberg, 1977).

Anthropological researches on indigenous populations have thus made significant contributions in formal recognitions for local medical health systems as well as the inevitability of ethno-medicine in lives of communities. 'The ethnographic investigation of indigenous modes of healing and their relationship to underlying conceptualizations of sickness and health as part of a particular worldview has continued to be one of the three major orientations historically identifiable in medical anthropology' (ibid., 1977). Eisenberg comments on the critical acceptance of disease and illness dichotomy which was previously not taken into account is a magnificent contribution of medical anthropology in bringing indigenous notions and explanations to global attention. Further added by the same scholar that 'efforts to characterize non-biomedical views of ill health and approaches to its treatment in relation to the biomedical paradigm led to the development of the single most utilized analytic dichotomy in medical anthropology as a whole: that of the disease/illness distinction' (ibid, 1977).

Routledge Encyclopedia of Social and Cultural Anthropology (2005) discusses about medical anthropology and its applications regarding clinical medicine and public health for its appropriateness about corrective measures. 'The application of anthropology to clinical medicine and public health is ultimately a means for increasing the appropriateness, and thus effectiveness, of biomedicine in a variety of settings from the clinic to the community. In contrast, more academically oriented medical anthropology critically examines biomedicine itself as a form of ethno-medicine' (Routledge Encyclopedia of Social and Cultural Anthropology, 2005). Not only anthropology has studied the importance of local system but also the modern medicine and the infrastructure spread over beyond borders as Justice (1986) says 'research in this vein ranges from the study of international health institutions and bureaucracies.' It is now an accepted fact that Ethno-medicine is becoming globally recognized and according to situation of third world countries especially India and Pakistan the widespread of ethno-medicine is also due to many obvious reasons out of them one is most important that they are cost effective and locally produced with the assurance of no side effect. The wide spread utilization is realized by WHO in the year 2000 by citing that 'During the last decade, use of traditional medicine has expanded globally and has gained popularity. It has not only continued to be used for primary health care of the poor in developing countries, but has also been used in countries where conventional medicine is predominant in the national health care system. With the tremendous expansion in the use of traditional medicine worldwide, safety and efficacy as well as quality control of herbal medicines and traditional procedure-based therapies have become important concerns for both health authorities and the public' (WHO, 2000). Seeing the social approval and acceptance WHO recommends that:

> *The challenge now is to ensure that traditional medicine is used properly and to determine how research and evaluation of traditional medicine should be carried out. Governments and researchers, among others, are increasingly requesting WHO to provide standards, technical guidance and information on these issues* (Ibid)

It is since 1991, that World Health Organization developed Guidelines *for the assessment of herbal medicines*; *Research guidelines for evaluating the safety and efficacy of herbal medicines*; and *Guidelines for clinical research on acupuncture*. These guidelines were though not fully capable of covering all major fields of ethno-medicine yet they proved to be a yardstick in progressive journey towards positively increasing social awareness at a global scale. Towards the end of same decade of 90s, National Center of Complementary and Alternative Medicine[3] in collaboration with National Institute of Health, USA worked to prepare guidelines for methodology the research and evaluation of ethno-medicine that later on approved in 2000 after considerable refinements. The approved guidelines discuss the safety and efficacy of traditional medicine and may also be used to evaluate the results of clinical research in traditional medicine.

[3] The term of Complementary and Alternative Medicine is frequently applied to Traditional Medicines that are developed according to the local indigenous knowledge elsewhere but non-local to a specific country. For example Indian Indigenous Health Practices are local to South Asian context but non-local to non South Asian countries and regions.

Role of Cultural Brokerage

To reduce the gap and gulf between modern and traditional medicine the role of cultural brokerage may be very effective. This is so because there is a need of bridging the gaps in order to prioritize the local notions in order to empower the communities to be really proud of their contribution in such grave issues. Van Willigen has in his book Applied Anthropology while discussing the idea of *'Cultural Brokerage's'* utilities raises the issue of increasing accessibility of basic medical care in the United States. He acknowledges that besides the centralized and bureaucratic health systems in current day's world, there seems to exist a parallel system of health beliefs and practices. He sees a competition between both systems because the traditional system also exists and operates throughout the world I isolated rural areas as well as the densely populated urban settlements. Van Willigen has cited Weidman (1979) who states:

The position of Western medicine in this competition in unique. Since it emerged in Western world, that social institution called 'scientific' or 'modern' medicine has been sanctioned internationally as being ultimately responsible for the health of national populations (Weidman, 1979)

Weidman (1973) also emphasizes that *throughout the world much health maintenance behavior is based not on 'scientific' medicine but on traditional health culture.* As a matter of fact, Weidman (1973) discussed her concept of 'Cultural Brokerage'[4] and its applications in what she called 'health care context'. The lag that remained between the medical sciences and anthropology that former's research dominantly relied upon the statistical and numerical presentations of data, in doing so the most of the part of interest was on cause and cures. On the other side, the later largely studied the perceptions of people in populations about illnesses, diseases, notions about body and soul, and preferring the ecological approaches deeply rooted in the socio-cultural systems to come up with explanations that were suited according to the notions and belief system of populations that were studied. Weidman (1975) discussed the culture concept along with the 'health culture concept' which is defined as 'all the phenomenon associated with the maintenance of well-being and problems of sickness with which people cope in traditional ways within their own social networks'. She opines that 'health culture encompasses both the cognitive and socio-system aspects of folk therapies.' On *Cognitive* side, it covers health values and beliefs, guides for health action and the relevant folk theories of maintaining the balanced form of health, diagnosis, prevention, disease etiology, treatment and cure (Weidman, 1975). The social side comprises structural functional aspects of health related social statuses and roles.

As per the paradigm of Weidman are regarded, if one analyses it from functional utility approach, it can safely be enough to say the applied anthropology and the concept coined as 'cultural brokerage' seems to be more effective and required because of the professional gulf existing between modern medical science approaches and medical anthropological understanding of local health systems all over world. Modern health studies excluding medical anthropology as representing one co-culture and medical anthropology the other. The role of cultural brokerage is of grandness to make it more human like in a sense that people always attach high attachments to a system of knowledge that is intellectually theirs. Culture as a learned behavior, including patterns of thought and behavior is a typical feature of people inhabiting a specific geographical area as well as specific eco-environmental conditions is a man made living strategy that has and is still supporting man's survival possible. This centuries old interaction of humans with the physical realities including; environment, eco system, demographical factors, topography, geographical landscaping, ecologically and geographically interpreted political and social systems, etc also bring forth explanations for population bound diseases and its remedies. Area and population bound diseases and conceptualization of illness and health can better be studied and understood in a locally specific area through drawing detailed case studies. The international mingling of nations and spread of new diseases is also discussed by De Lancy (1978):

'Beyond the possible introduction of new diseases, however, European colonialism caused major disruption by forcing large groups of people to work on plantations in areas distant from their homes, usually under unhealthy and unsanitary conditions (DeLancy 1978).

Ferzacca, (2004) Medical anthropologists often operated as cultural brokers, bridging gaps of translation thought to plague interactions and development efforts taking place between the modernity of aid and assistance and the traditions of the needy. Moreover, as advocates, medical anthropologists often reified these distinctive features of contact and change when calling attention in relativist terms to the logic of native medical perceptions and practices. In what follows, post-colonial developments are explored in terms of continuing health conditions, emerging health issues related to development, and the conceptual schema of development that continued to locate that "external discourse" (Gupta, 1998) of modernity based in "western

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[4] Cultural Brokerage is a concept of role that forms the basis of the cultural brokerage model. The concept of the broker role is supplemented by other ideas that are essential to the approach. Cultural brokerage is an intervention strategy of research, training, and service that links persons of two or more coequal socio-cultural systems through an individual, with the primary goals of making community service programs more open and responsive to the needs of the community, and of improving the community's access to resources. While other types of intervention affect the community is substantial ways, cultural brokerage substantially affects the service providers. In other words, the focus of change processes is the agencies themselves. The cultural brokerage approach to intervention is a way of restructuring cultural relationships not so much to resolve cross cultural conflicts, but to prevent them.

experience" (Escobar, 1994) within images, activities, and associations related to health and health care.

Anthropo-Pathological Understanding and Cultural Change Perspectives

Another face of anthropology is basically an attempt to focus man when pathological interpretations are sought. The unlike of other explanations that merely focused the causes and effect relationship in terms of bacteriology and virology, etc. Improved means of communications and journey has realized the dream of man increasing per unit productivity as well as enhanced man's control over his innate natural and physical resources. The medical revolution, revolutionary innovations and innovations in telecommunications and Green Revolution have in total changed the meaning of social and cultural life of today's world.

A bit before the global trend of colonization on behalf of resource poor and civil war stricken European nations who had to move in search of resources for improved livelihoods. Post World War II scenario, when global restructuring of nations and reconstruction, rehabilitation of basic infra structure was main challenges faced by several nations economy centered approaches articulating development were on the boom. Green Revolution[5] was taken as a promise to compensate the food shortages. The promise did not turn up as per social estimates rather widened the gap between rich and poor classes within a society as evaluated by several scholars like Palanianppan and Annadurai (2003), UNECA (2003) and Dewalt (1984). Similarly, the growing world's population could not be controlled and remained a threatening problem for land lock countries and resource poor regions as also discussed by UNECA (2003).

The particular regions and nations of the world where the colonizers moved was not a merely geo-political and military issue rather they took along with them a radical package of change. An across oceans migration was started thus allowing the diffusion of ideas and cultures possible. The Europeans while using their newly exposure also took along with them new constructions of meanings of what was called Development. A perplexing phenomenon that surely not suited with the circumstantial realities of colonized world as added by Dube (1995) in his book states 'The naiveté of the earlier developmental strategy is now apparent and the Third World is left with the sober realization that the process of development is infinitely complex and involves a wide range of interpenetrating variables. Development is not a simple matter of making calculated inputs to raise the output to the desired level. The transfer of technology bristles with difficulties: the transfer of institutions, even if desirable, is almost impossible to accomplish. The adaptation of technology is a time-consuming process that needs patient innovation involving a great deal of trial and error. The institutional and motivational frameworks, propitious for development, pose a series of puzzling paradoxes and baffling problems. Countless alibis for failure can be offered, but they are at best a poor consolation, for they do not illuminate the path to attainable progress in a predictable period of time. It is essential now to look retrospectively on the causes of the failure of the western paradigm for development and prospectively to viable alternatives. This task involves serious rethinking of the concept of development itself as well as of its strategies.' In this respect, De Silva, et al, (1988) argues that:

The process of economic growth as it has been unfolding in the past quarter century has multiplied the problems of both the industrialized and the Third World countries, as well as those of individuals within each group. In both groups of countries the creativity and potential of people is unlimited, yet life lacks fullness, resources continue to be misused and major social and political contradictions remain unresolved (De Silva: 1998).

Though some times, one can get the impression that International and national development agencies have recognized the value of participatory approaches to decision-making for sustainable approaches to development. During the past decade a rapidly growing set of evidence indicates a strong relationship between indigenous knowledge and sustainable development. In this regard Posey (1985) opines:

Serious investigation of indigenous ethno-biological/ethno-ecological knowledge is rare, but recent studies show that indigenous knowledge of ecological zones, natural resources, agriculture, aquaculture, forest and game management, to be far more sophisticated than previously assumed. Furthermore, this knowledge offers new models for development that are both ecologically and socially sound (Posey: 1985).

Development activities that work with and through indigenous knowledge and organizational structures have several important advantages over projects that operate outside them. Indigenous knowledge provides the basis for grassroots decision-making, much of which takes place at the community level through indigenous organizations and associations where problems are identified and solutions to them are determined. Solution-seeking behavior is based on indigenous creativity leading to experimentation and innovations as well as the appraisal of knowledge and technologies introduced from other societies. On the other hand, I observed that during the planning phase of contact changes, the planners and policy makers ensure the inclusion

[5] The Green Revolution, which took place in Asia (India, Indonesia, Taiwan, Philippines, China and Japan) during the 1960s, is a major global scientific and technological achievement towards increased food production. Improved crop varieties, irrigation, pesticides and mineral fertilizer were introduced, which contributed to substantial improvement of food production. With this technological advancement in agriculture it was possible to develop varieties, which have contributed to higher food production and improved the returns to costly resources used by poor farmers. As a result, increased productivity has decreased food costs, in general, and thus improved food security, particularly for vulnerable sections of society.

of participatory approach in the work plans but during the real operations being taken place, the real spirit of participation is always felt missing. This version is again reinforced by Kunitz (2003) that 'ecology has made a difference to survival, but the isolation that sheltered the forest-dwelling Indians of the Amazon region when more accessible tribes were being conquered is no longer sufficient to protect them. Despite efforts to provide some measure of protection, we see in our own time the same sort of process at work that has already destroyed indigenous peoples and their cultures in the Americas and Oceania for the past five centuries.' (Kunitz, 2003).

The discussion threw light on the different perspectives in development sector while keeping in view the importance of the non-economic factors in development practices. It is worth noting that current world has started recognizing the vitality of social, economic and cultural impediments in launching sustainable development in the society. The literature surveyed successfully highlighted the importance of development as perceived by the local people after realizing the local needs and priorities. On the basis of scholastic reviews of the development professional and theorists, it can safely be concluded that development that is perceived, managed and administered locally can be sustainable. In fact, what lied in the term development was precisely denoting economic development though indirectly related but not in total. All change is not for the sake of betterment of humanity; one has to bear the expenses of it as well. The mixing of races also brought impacts and sometimes effects like as discussed by Kunitz (2003):

Long-distance trade and troop movements became increasingly frequent. And the shift from subsistence farming to the monocropping of cash crops for sale in the world market led to landlessness, urban migration, and deteriorating nutritional status. Though adequate registration data are not available, the far from unanimous consensus is that the colonial period beginning in the nineteenth century saw a deterioration of the health situation in southern Africa (Kunitz, 2003)

The adverse impact of colonization upon the indigenous population in almost all aspects of socio-cultural life has also been discussed by Goonatilake as 'In the past, colonial and semi-colonial countries and peoples were conquered and exploited as sources of raw materials and markets for manufactured goods. In the process, their traditional values and knowledge systems were transformed into a colonial culture that could not be much more than dependent and imitative.' (Goonatilake, 1984). It was during the mid of nineteenth century when most of the colonies got independence. The knowledge elites globally were mostly American and Europeans in origin. Their theories were adopted as milestones for development especially for sustainability. The development models non-local to indigenous circumstances did not meet the promise rather situation went dismal. Hughes and Hunter (1970) point out:

Moreover, during the post-colonial era attempts at economic development have often had the paradoxical and untoward effect of worsening the health situation in ways not unlike those of the colonial era. For example, damming rivers in Ghana has expanded the zone of river blindness (onchocerciasis). Road construction in Liberia, migrant labour from Upper Volta, Mali and Niger to Southern Ghana, and settlement relocation from high plateaus to lowland agricultural areas in northern Nigeria have all been implicated in the dissemination of sleeping sickness (trypanosomiasis) (Hughes and Hunter, 1970)

Similarly, findings presented by Kark (1949) and Kark and Cassel (1952) highlight that 'the construction of irrigation systems has resulted in the spread of *schistosomiasis* and malaria. Diamond and gold mining in South Africa have caused the spread of venereal disease and tuberculosis, as well as the disruption of families' (Kark 1949, Kark and Cassel, 1952). United Nations being the failure of League of Nations is the only representative organization for humanity on the face of earth verifies that 'despite the facts that disease control programs have had an impact on improving health in some regions, and that one major killer—smallpox—has been eradicated, life expectancy has increased only modestly since the Second World War, and infant and child mortality remain extremely high' (UN 1982:95-6).

The scholars have also depicted a cause and effect relationship while finding out and documenting that the incidence of more acculturated life raises the percentile probabilities of diseases spread. Finau (1982) argued in this respect after conducting an empirical research that 'the appearance of non-infectious diseases within indigenous populations does not affect everyone equally but occurs first among those becoming most acculturated to European ways of life' (Finau *et al.* 1982). Kunitz (2003) worked out the impact of European contact with indigenous people by citing 'magnitude of the impact of European contact on indigenous peoples depended largely upon whether or not they shared a common microbial environment before contact occurred. Indigenous peoples in the Americas and Oceania had been isolated from Eurasian sources of infection, so that when contact was made the consequences were catastrophic.' (Kunitz, 2003) and Crosby (1986) who worked on Siberian Indigenous Populations and came up with reasons similar to Kunitz.

It is evident from the discussion above that Western paradigm on Development did not reflect and bring the results as promised. The recipients populations are neither mere robots not the development itself can stand anywhere without blending of cultural factors into it. No doubt, it is a human aspiration to progress and develop the surrounding realities but without understanding of cultural factors and deliberate ignoring of the historical event of a particular

society cannot fulfill the dream as a reality. The Social Science Encyclopedia (1989) favorably gives its remarks that:

Anthropology of medicine has disclosed that the orthodox profession of Euro-American medicine is as pluralistic as folk healing; that certain of its categories and practices are as magical and ritualized as traditional therapies; that its system of manufacturing knowledge and passing it on to trainees is infiltrated with cultural norms, and that its diseases and clinical realities of practice are socially constituted and negotiated (Social Science Encyclopedia, 1989)

The crux and climax of the discussion is to generate a fruitful discussion to remove doubts and biases existing against the medical anthropology and its potential roles in refining the health care systems so that concept of disease and illness may also be understood in clinical settings in which understanding of cultural backgrounds may be helpful for better prevention, diagnosis, treatment and rehabilitation of people with cultural understandings and its covers under which illness and disease is guised. It is also another aim of paper to register to people about medical anthropology's role to bring cultural notions of pathology on the anvil. This is an established reality that role of culture as defined by Robarchek and Robarchek (1998) as 'a society's theory about the world and how it works' cannot be denied at all. The modern world has experience a number of examples where cultural factors and realities when undermined failing to bring the fruits of even the noblest causes. The dignity and respect extended for any local culture may encourage local people to participate in any planned change program since they believe to be a part of decision making regarding their own lives thus allowing them to think that they have opportunities to plan for themselves as well as their native science i.e., their indigenous knowledge system including their indigenous faiths, believes, worldviews, and practices are as valid, verifiable and authentic as current and modern world.

Conclusions

The paper attempts to highlight that medical anthropology though a bit new in Pakistani perspective may not be termed as something out of medical context as is common in health domain in Pakistan. The survey of global literature available on medical anthropology helps to bridge the gap between the patient and the medical practitioner. Medical anthropology can serve as a mean of interpretation of cultural elements in public health program. As regards, the massive campaigns on public health, there is a necessity to understand and get help from the cultural perceptions on disease, illness and healing. Failing to which the world has experienced massive failure of financial resources made on improvements in health indicators. Health may not treated solely as something from biological and physiological point of view, rather the applications of health in deeply rooted in culture as it is very much understood and cured in native cultures as well. Similarly, the rise of modern medicine has its roots in ancient mythology and refinements of ancient curing concepts and practices. How could simply, the contemporary cultures and their interpretations of disease, illness and healing is ignored. As regards the cure, the cultural context is mostly undermined due to which person hosting a disease is cure physically or may be psychologically but not culturally unless there is a level of social recognition on behalf of health bureaucracy in Pakistan and other likewise a third world developing countries. Though clinically proven, the successful medical interventions and strategies cannot simply be imposed upon people especially in a socio-political scenario where the native are always fearful of the malafidies of capitalistic ethos and rumors of snatching the cultural uniqueness of indigenous cultures in terms of their independence.

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