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Anthropology of Health in the Americas: Contextualizations and suggestions

Antropología de la Salud en las Américas: Contextualizaciones y sugerencias

Eduardo L. Menéndez[1]

In this editorial, I will not make any comments about the texts presented in this issue regarding anthropology of health in the Americas. However, I will mention some aspects and processes that are still connected with said texts, given that such articles reflect the quality and diversification of the current medical anthropology, which is the product of an extensive development mainly related to the impact caused by the historical and social processes, including academic and professional ones, on the formation, development, and reshaping of different sciences and disciplines. I stress this point because, initially, anthropologists – with a few exceptions – were not interested in health/disease/care-prevention (h/d/c-p) processes. However, these processes became known through their fieldwork or their ethnological studies as an intrinsic and inevitable part of every culture and society that they were seeking to fully describe.

This initial encounter led them to work almost exclusively following the "traditional" ways of getting sick and treating the conditions of the participants of the group under study. They adopted such procedures given that, over almost all its history, social anthropology and ethnology worked with societies and cultures where the presence of biomedicine was little to nonexistent, whether in clinical or health terms.

From this perspective, a predominant part of the "routine" ethnographic study was to record data about the health conditions as well as the "traditional" treatments applied without giving much consideration neither to the negative effects resulting from such health conditions at an individual and/or collective level nor to the efficacy – except in symbolic terms – of the the treatments, as these were studied from a cultural point of view without taking into account the negative impact of such health conditions in terms of a disease and, especially, of mortality. The anthropologists were initially interested in the disease and healing insofar as it contributed to the understanding of the cultural rationality in connection with the society under study. Furthermore, they focused on the development and use of ritual practices and they were, generally, much more interested in the magical-religious aspects of such practices than in its efficacy. The anthropologists' interest in the morbimortality of the subjects of study and also in the efficacy, not merely symbolic, of the "traditional" treatments and, eventually, of the biomedical treatments, is much more recent; in other words, upon finding that not only death but also mortality are a part of every culture.

[1]*PhD in Anthropological Sciences. Research professor emeritus at the Center for Research and Further Studies in Social Anthropology (CIESAS). Coordinator of the Standing Seminar on Medical Anthropology (SPAM), Mexico.*

SALUD COLECTIVA. 2017;13(3):353-357. doi: 10.18294/sc.2017.1548

Although this way of working with the h/d/c-p processes corresponds to time periods that go from 1870 to 1880 and from 1920 to 1930, it is important to acknowledge, particularly in the case of Latin American anthropology, that this way of perceiving the previously mentioned processes continues to this day, especially those involved in the so-called "traditional medicines" and "alternative medicines." Moreover, this issue has been considered one of the weak points of an essential part of medical anthropology, which reflects the priority of certain ideological and political goals but, mainly, of melancholic purposes.

As we know, currently there are bibliographic precedents to almost any process. However, I believe that the the developing of an anthropological approach concerned with its own objectives and problems, but also with the integration of the epidemiological dimension and the curative and preventive efficiencies, began to take place during the 1930s; especially, in the case of the anthropology that originated in United States, which, later on, led to the development of medical anthropology. A part of medical anthropology, without excluding the h/d/c-p processes in symbolic terms and later in economic and political terms, became increasingly concerned with the epidemiological aspects as well as the clinical treatments and prevention activities.

The aforementioned development is connected with many processes which came to the foreground throughout the course and end of the so-called Second World War. Such processes were reflected in two complementary "discoveries": the "colonial situation" and the division of the world into "developed" and "underdeveloped" societies. The latter were characterized by a number of features, for instance, they have the highest rates of general mortality, infant mortality, and mortality in relation to the so-called "avoidable deaths," and have the lowest life expectancy rates. However, a significant portion of the vast group of anthropologists who were, and still are, studying these societies were not interested in describing or analyzing the h/d/c-p processes which reflected – perhaps even more dramatically than any other process – the existing inequalities between the "developed" and "underdeveloped" societies. They were only interested in studying traditional diseases, thus intentionally excluding the allopathic diseases.

In the case of Latin American countries, which are mostly defined as "underdeveloped" countries, we can observe that during the 1940s and 1950s, it was beginning to be acknowledged that indigenous peoples were the ones that have the most negative health indicators in comparison to any other social sector, a situation that continues today. Such condition was emphatically acknowledged by the National Indigenist Institutes which were created in many Latin American countries. Furthermore, such institutes place a special emphasis on the development of biomedical, but mostly, public health actions for the health improvement of indigenous peoples. However, this acknowledgement and the actions carried out have shown, until now, that the Latin American governments invested little to nothing not only in biomedical resources, but also in traditional resources which would help indigenous peoples improve their health.

That being said, the anthropological study on the h/d/c-p processes enabled, during the 1930-1960 period, the research and reflection on important aspects of such processes, which were barely discussed by medical professionals, and were instead only discussed by some biomedical theorists. What I mean is the relationship between nature and culture, between the cultural and the biological, and between the normal and the pathological. Nevertheless, it is important to highlight that these matters are currently no longer considered a priority for anthropologists.

The establishment of medical anthropology facilitated the ongoing development of certain basic ideas that were introduced at an early stage by anthropology regarding the h/d/c-p processes. Those ideas were to suggest and prove that diseases are not merely biological processes, but also of social, economic, political and cultural nature. Although certain biomedical trends, such as psychosomatic medicine, developed between 1930 and 1950, or public health, practically since its origins, acknowledged the presence of said processes among the patients and the general population, anthropology highlighted the role of such aspects, especially the

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symbolic aspect, not only in relation to the population but also in connection with the institutions and the biomedical field.

In particular, from the 1960s onward, anthropology studied every medical system – including the biomedical system – from a sociocultural point of view. One of the main contributions made by anthropology involves the structure and functioning of biomedicine, which showed that medical knowledge, as well as traditional healing knowledge, are full to the brim of social, cultural, ideological, and, of course, of power contents.

Moreover, anthropological studies were focused on specific issues that to a certain extent were stigmatized or biased by biomedicine. For instance, in the case of the self-service processes related to health conditions, medicine uniformly dealt with them in terms of "self-care," narrowing the concept down to almost exclusively self-medication. The socio-anthropological study revealed inconsistencies and "omissions" in medical knowledge given that it excludes its own practices when criticizing self-medication. Furthermore, such practices constantly promote certain processes of self-medication, as can be seen through the family planning policies, regarding those treatments applied to chronic-degenerative and infectious diseases, as well as the preventive proposals in connection with obesity and overweight.

However, the anthropological approaches have been questioned or most commonly "brushed aside" by biomedical researchers due to certain trends which they consider to be, at the very least, reckless. At the beginning of the 1980s, while I was interviewing some inhabitants of four colonies located in the southern region of the Federal District and also physicians specialized in problems associated with the consumption of alcoholic beverages, the existence of liver cirrhosis, also known by a large portion of the population as "chopped liver," was persistently mentioned. Given that we were going to conduct a survey, I decided to include questions which would help detect this type of health condition which, as we know, is deadly. While interviewing one of the most important specialists in liver cirrhosis, I told him about my decision to detect cirrhotic members of the population. The specialist asked me: "What are you planning to do after detecting them?" This question led to the thought of where to refer those patients in a context with very few referral institutions that were already overcrowded, which became known through our own research study.

Many anthropological studies are known for researching serious issues but without previously reflecting on the impact caused by such studies, not only on said issues, but also on the "studied" subjects. At least in my experience, many anthropologists have told me about their decision to conduct a study on cancer, depression, schizophrenia or epilepsy. However, when I asked them what they would do if, for example, the subject has an epileptic seizure, which could even be induced by the very interview, they were generally perplexed. Not many can study any h/d/c-p process, given that it is not the same to talk to an interviewee about which plow they use to till the land than to talk about a terminal disease, especially if the plowman is the one who has the terminal disease.

Anyway, despite these frequent slips, I think that medical anthropology has led to significant contributions, not only of ethnographic nature, but also contributions specially regarding approaches, which are particularly useful in theoretical and practical terms whether they are actually used or not. One of these contributions, for instance, is related to the field of prevention. Regarding prevention – which is the main goal of public health – some of the most significant differences are classified around the recognition or non-recognition of popular knowledge as prevention mechanisms, given that biomedicine often considers it as a factor which has a negative impact on prevention. Generally, biomedicine regards such knowledge as erroneous or incorrect, something that needs to be modified. Furthermore, biomedicine explicitly or implicitly considers that the population not only lacks prevention criteria, but also that it frequently misunderstands and/or rejects such criteria.

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Without fully denying these statements, the first thing to highlight is that every social group, beyond its level of formal education, develops and uses prevention criteria in relation to, at least, some health conditions that the subjects and groups recognized as physically and mentally affecting their health, or aspects of daily life related to health. There are no family groups, social or cultural strata lacking this knowledge, given that they are essential for biocultural production and reproduction.

Most prevention criteria used by social groups are sociocultural, and anthropology is not mainly focused on considering such criteria as erroneous or correct behaviors, but in assuming that those groups produce/reproduce social representations and practices of prevention, whether they are wrong or not. The development of the prevention criteria regarding facts, factors, and/or actors which physically and mentally threaten a social group – and, naturally, individuals – is a structural process in the evolution of life of social groups and individuals.

The acknowledgment of these processes by public health would mean a radical change in their approaches, as they would start to believe that social groups are not opposed to nor lacking prevention, given the fact that these social groups produce and use preventive knowledge in their daily life. It would be acknowledged that, although individuals and groups reject or do not use certain concepts and preventive practices, it does not mean that they are against every biomedical proposal or that they do not use preventive knowledge.

A number of public health specialists and physicians complain that individuals do not learn and/or implement medical teachings. Moreover, they consider that individuals may be informed about what is correct in preventive terms but that they do not however implement this knowledge. Therefore, surveys, for example, show that a high percentage of young Mexican individuals forgo the use of condoms, despite being informed of the risks, which accounts for the large number of the so-called "unwanted pregnancies."

These considerations are partially correct, however they will continue to be ineffective until biomedical knowledge seeks the sociocultural logic of such behaviors and also recognizes the progress in the receptiveness of the population – including young people – in connection to their preventive proposals not related to secondary problems but to basic problems of public health. The very data of the Secretary of Health shows that Mexico would have provided one of the highest worldwide vaccination coverages, as over 97% of the population would have been immunized – with the basic vaccination schedule – in the early years of the 21st century, which would at least imply acknowledging that the population does not reject one of the main strategies of biomedical prevention. Although recent data indicates that the percentage of vaccines administered has decreased, this situation should be attributed to the health policies carried out by the Secretary of Health and not so much to the population.

In the mid 1970s, Mexican women had an average of more than six children per woman of childbearing age. Currently, the average is 2.3 children per woman, which indicates a significant decrease of birth rate mainly resulting from the implementation of family planning programs, which offer pregnancy prevention services to the family, and especially to women.

Both of these processes question the biomedical conceptions in relation to the resistance to prevention by the population. Furthermore, Mexican public health specialists know this and, hence, would have to assume that, although sectors of the population may not use or even reject certain preventive actions, most of the population adopts and implements at least a part of the biomedical preventive proposals. Moreover, the change of perspective would help public health specialists observe that a substantive part of preventive knowledge, currently used by social groups as if it was their own, has been produced from biomedicine and standardized by individuals as a daily behavior.

I believe that one of the main tasks should be the description and analysis of the characteristics, meanings, and effectiveness of the preventive knowledge used by the different social groups, in order to build upon such knowledge as well as to articulate it, or not, with

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the biomedical preventive criteria. We need to assume that preventive beliefs and actions are social responses that individuals and groups develop, and that the actual paradox is that this characteristic of social groups has been denied by those in charge of professionally fostering prevention, although it has been demonstrated by medical anthropology.

Almost twenty years ago, several American theoretical approaches, and especially the approach known as critical medical anthropology, indicated that an increasing part of medical anthropology originated in the United States, despite its calls for symbolic order and to social relationships, demonstrated an increasing medicalization, which was mainly reflected in eco-cultural trends and in the so-called clinical medical anthropology. In other words, the basis of such trends was still rooted in social anthropology. However, their approaches became more biomedically-oriented, meaning that what they were producing was similar to what an epidemiologist or even a physician would do.

It is important to accept that, in interdisciplinary terms, every science has developed different points of view in relation to the same problem or process to be studied, and that these differences are, to a large extent, the result of a particular path which helps observe the same process not only in a different way, but also in a contradictory way. If there is one thing that characterizes anthropology – as argued by Ernest Becker – it is the "discovery" of the obvious, what is there, what is standardized, but what we do not see and is, precisely, what we need to detect. This detection can be achieved by adopting a decentralized perspective directed at the obviousness of the processes.

Even though biomedicine may be interested in the fact that some anthropologists used biomedical approaches in the name of their discipline, this process continues validating the medical hegemony and reproducing its approaches. However, this homogenization is not "convenient" for the h/d/c-p processes – and especially not for the subordinate social groups. If a range of disciplines, including social anthropology, has highlighted not only the existence, but also the importance of *differences,* we need to reflect on what differences help anthropology develop theoretical and methodological concepts and instruments, as well as interpretations and even interventions that other sciences do not, even when these sciences certainly develop "other" contributions.

Like the important physician-anthropologists from Latin America, Europe, and the United States, I consider the medicalization of medical anthropology observed in Latin America a serious risk, given that through this "assimilation" – or maybe acculturation? – we may be able to produce worthy products which add, however, very little to what the biomedical knowledge produces. The goal of current sciences is not to create *jacks of all trades*, which was the dream of many initial anthropologists, but to seek the articulation of the different scientific knowledge applied to the same problem. Hence, my proposal is to promote the *differences* among the various scientific approaches as well as to promote their articulation – and not their erasing – but seeking to reduce, and if possible, remove, the hegemony/subalternity relationships which, until now, have dominated the relationships between biomedicine and medical anthropology, to say the least.

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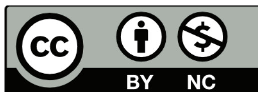

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