

Anthropological Dialectics in Illness and Indigenous Knowledge

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INTRODUCTION

Anthropology is generally characterized as a 'holistic' discipline which emphasizes the total social and cultural context in the explanation of the structure and the behavioural patterns of human groups. Anthropological concerns encompass the study of dialectical relationship between individual and society/culture. As a result there is a great diversity of perspectives within the discipline and a bewildering array of strident disagreements between the proponents of these perspectives. Within Action Theory and Psychological Anthropology among other areas, earnest attempts are made to develop a more sophisticated theoretical apparatus for the study of the relationship between the individual and the 'whole' in Anthropology.

The World Health Organization's (WHO) definition of health reflects this very concept of 'holism'. Accordingly, health is defined as, 'a state of complete physical, mental and social well being of an individual and it is not merely the absence of disease or infirmity'. This exactly is the take off point for Anthropological dialectics in the domain of health and disease.

Two approaches could be easily found in the Anthropological study of the tribal medicine: to consider tribal medicine, as (1) a cultural complex, of material objects, tools, techniques, ideas and values, and as (2) a part of social structure and social organization, i.e., the network of relations between groups, classes and categories. Of late, it is increasingly realized that a knowledge of these two aspects of medicine, in itself and in relation to other aspects of social life such as political economy, religion, magic and law is necessary to understand the culture of any society. These approaches also help us to understand the social dynamics as to why certain elements of modern medicine are easily accepted and why others are rejected.

The social dynamics approach has made some scholars to study the indigenous medical practices in terms of epistemology. Khare (1963), for example, studied the indigenous medical practices in the framework of 'parochialization' and 'sanskritization' demonstrating how the

upper castes try to relate their disease etiologies in terms of great tradition where as the lower castes define them in terms of lesser gods and deities. There were also a few studies which were very critical about the functioning of medical establishments. The 'Theory of Gaze' formulated by Foucault (1975) is one of the most radical theoretical formulations in which he traced historically how the medical system in the west has operated in the feudal capitalist environment and eventually made the medical profession as an industry-by dehumanizing it. More often than not, the physicians tended to reduce the patient as a specimen of laboratory experimentation. Ivan Illich's 'Medical Nemesis' (1974) was the most powerful critique of the medical establishments. Illich challenged the fundamental premise of medical 'progress', arguing that institutional medicine was overwhelmingly pathogenic and actively 'sickening'.

However, a large number of Anthropological works focused instead on the humanistic dimension of tribal medicine opposing the critical stand taken by Foucault and Illich. Some tried to trivialize it by questioning the 'irrational' outlook towards modernization due to their rigidity and faith in tradition and superstitions. But, it may be noted in this context that in many of these studies the socio-political and economic aspects have been grossly ignored with an over emphasis of the cultural descriptions and the role of the supernatural. This trend could be due to the prevailing dominance of the world order in which the 'other culture' is a part of the administrative ideology of the colonial and neo-colonial forces.

DISEASE/ILLNESS DIFFERENTIATION

Anthropological researches around the world have generated a rich body of knowledge concerning health and disease resulting in the delineation of areas critical for our study and further probe. As a first step, differentiating the terms 'disease' and 'illness' from each other has been made, as 'science' demands precision in the universal standardization of the usage of the terms. Disease, accordingly, refers to pathological states of the organism, whether or not they

are culturally or psychologically recognized, where as Illness is culturally or socially defined or refers to conditioned perceptions and experiences of ill health, including some states which may be defined as diseases and others which are not classifiable in terms of medical definitions of pathological states. Accordingly, disease is now universally referred to as a western bio-medical term while illness is culturally defined and identified with the local indigenous knowledge (Fabrega Jr, 1972: 167). Sickness is a general global term which refers to all events involving ill health. This differentiation was made possible by the rich body of indigenous knowledge generated by the countless field endeavors carried out by innumerable Anthropologists all around the world, mostly among the isolated, un/under developed, illiterate, tribal/rural communities since the turn of the twentieth century. Eventually, a new branch of Anthropology, 'Medical Anthropology', emerged.

The Anthropology of illness, influenced by hermeneutically oriented Anthropology of Symbolism, has focused on the symbolic and cognitive dimensions of illness. Good (1977), for example, developed the idea of the 'semantic illness network' which according to him is the 'network of words, situations, symptoms and feeling which are associated with an illness and give it meaning for the sufferer'. Kleinman (1980) developed the 'explanatory models of illness', which were, both models of reality and purposive action. The Anthropology of sickness, on the other hand, focuses on the social relations which 'produce the forms and distribution of sickness in society' (Young, 1982). This approach focuses not on illness experience, but on social systems, power structures, and the social meaning and outcome of sickness.

Each society is characterized by its own set of rules for the transition of signs into symptoms, the definition of illness and the patterns of treatment. Social forces not only affect diagnosis but also the access to different kinds of therapists and their treatment. At the same time, medical practices are also ideological practices, since, as Young notes, 'symbols of healing are simultaneously symbols of power' (Seymour-smith, 1986).

Clinical Anthropology, a branch of Medical Anthropology, may be distinguished here whose primary objective is to increase clinical efficiency, from the type of Medical Anthropology that is

concerned with the analysis of social power relations and the production of medical knowledge. Clinical Anthropology incorporates cross-cultural sensitivity into medical practice and encourages awareness of the patient's cognitive-symbolic organization of the experience of sickness and healing. In the wake of such studies, identification of different medical systems in different cultural systems was made possible, rendering critical evaluation of our own systems against such a background more meaningful.

EMIC/ETIC PERSPECTIVES

These terms were originally coined by the linguist, Kenneth Pike in 1967 which were derived from the words 'phonemic' and 'phonetic'. Phonetic accounts of language are based on the observer's measurement of physical sound differences, where as phonemic accounts are those based on speaker's conscious or unconscious models of sound differences. The distinction between *emics* and *etics* in Anthropology became popular for a time, used for the contrast between the explication and presentation of indigenous models of reality on the one hand and the description and comparison of socio-cultural systems according to the observer's criteria on the other. *Emic* analyses are, therefore, those which stress the subjective meanings shared by a social group and their culturally specific model of experience, while *etic* analysis refers to the development and application of models derived from the analyst's theoretical and formal categories. This contrast is linked to the debate about 'cultural relativism' and opposing positions in Anthropology. However, it is generally recognized that the *emic/etic* distinction is not one that can be too straightforwardly employed in Anthropology, since what distinguishes the discipline is precisely its combination of different kinds of 'native models', including the observer's own native models derived from his culture and society, with a different kind of attempt at theoretical synthesis or generalization. The *emic/etic* distinction, while it cannot be used to classify or divide Anthropological approaches into neat categories, nevertheless points to a crucial area of controversy and of great theoretical importance within the discipline. However, this Anthropological perspective made other social scientists realize the significance of *emic* data collection to occupy a large part of their qualitative research

strategy. The concept *emic* basically refers to the data that reflect the natives point of view, where as the *etic* refers to the language and categories of the researchers, 'the out side' biomedical ways of conceptualizations of health and disease. The *emic* perspective is being widely used in the area of health and disease to construct illnesses in terms of native cultures.

CULTURAL RELATIVISM

The proponents of this theory are the students and followers of Franz Boas in North America. In the works of Boas and many of his students, there was a reaction against 19th century evolutionist theory or 'speculative history' in favour of a *Historical Particularistic* approach, which stressed the need for careful holistic study of each culture's unique features as an antidote to premature evolutionary generalizations. The growth of Anthropological fieldwork tradition, later strengthened by the 'participant observation method' of Malinowski and the emerging Structural-functionalist School in British Anthropology, led to an increased emphasis on the systemic nature of other cultures and other societies. This has focused on the need for Anthropologist as ethnographer to penetrate the inner logic and inner reality of that world view and social system. Thus, Anthropologists on both sides of the Atlantic assumed the defense of indigenous and peasant peoples against the 'ethnocentric' and 'racist' assumptions of much 19th century Anthropology, and assumed it under the banner of 'cultural relativism' arguing that each culture or each society possessed its own rationality and coherence in terms of which its customs and beliefs were to be interpreted. This point is amply reflected in works related to ethno-medicine in different traditional societies of the world.

CULTURAL ECOLOGY

A rich body of 'health data' related to ecological factors is another significant contribution of Anthropologists. Ecologically oriented Anthropologists tend to view environment as a complex system of interacting groups or populations of different plant and animal species living under a limited range of geological and climatic conditions. A human society is regarded as just another group or species within this

complex eco system. Human society has to adapt to environmental challenges: to physical and chemical factors in the environment, to the presence of other species, and to the threat posed by other subgroups of the same species. Alland (1966, 1970) conducted many anthropological studies of disease and illness with an ecological framework.

Cultural adaptation presupposes that man is capable of learning and that he grows up in a human society. Culture is not just the sum of individual behaviours; it is the shared and symbolically transmitted knowledge that is used for interpreting, exploiting, and responding to the environment. On the individual level, humans adapt to changes in the environment by morphological adjustments and acclimatizations. The goal of adaptation is homeostasis within each system and subsystem. A system is in homeostasis if it can maintain its internal composition within certain limits. A human population remains in homeostasis if natality, and morbidity do not seriously threaten its internal complexity and diversity. Homeostasis can be easily upset by interventions originating outside the system, which may bring in new genes, new foods, new ideas, new tools, and new parasites. Even minor and well intended interventions, such as introduction of un-iodized table salt or of non-fortified skim milk have been known to upset previous nutritional adaptations, with serious clinical consequences (Bunce, 1972). Traditional societies are often the target of such interventions. They have to deal not only with the introduction of new cultural elements but also with the destruction or replacement of others.

In the field of medicine the medical specialists or the native healers, and the native medicines administered are important areas carved out by the Anthropologists. Healers include the doctors and his supporting staff, the local mid-wife, the priest, the native medicine man/magician, the shaman etc., and the medicines administered by the local medicine man is dealt with under popular literature as ethno-medicine, ethno-botany, native medicine, traditional medicine etc.

THE NATIVE HEALERS

Rich documentation on the native medicine man in different varieties of cultures is made possible by Anthropological researches. Among the native healers the 'shaman' is the most

popular. Harper (1957), Opler (1958), Freed and Freed (1979), Jilek (1971), Rahmann (1959), Eliade (1974), Rajpramukh (1976 and 2005) and many others documented spirit possession and the role of shaman in warding off the spirits. Explanations offered in the domain of health and disease, according to Anthropologists, are of two kinds viz., scientific and divinatory. The natives' explanation of the etiology of diseases invariably are divinatory in nature i.e., tracing the causes to some divine wrath. The shaman appeases the angry gods and goddesses to restore the health by warding off the spirits. Levi-Strauss placed the role of shaman in the upkeep of social order very cogently, "where as a psychoanalytic cure is based upon the patient's recovery of his individual myth, constructed with his elements from the past, the cure in shamanism is predicted on the patient's receiving the social myth from his collective tradition. The collective myth used by the shaman does not correspond to the patient's personal state but reintegrates his alienating experience of sickness within a meaningful whole.

ETHNO-MEDICINE

Studies in this area focus on non-western medical systems and the beliefs and practices other than those embodied in conventional allopathic 'scientific' medicine. A number of Anthropological studies dealt with the general beliefs and definitions of illness. Khare (1963) dealt with medical beliefs held by Gopalpur villagers and stressed the fact that these beliefs quite often link with contrasting medical systems. Some ethno-medical studies have dealt with the functional role of traditional medicines in particular cultures, others have emphasized the logic behind ethno-medicines; some others have offered the psychological and psycho-somatic implications of these medicines (Bhasin and Srivastava, 1991: 9).

Ackernecht (1942a, 1942b, 1943, 1945, 1947 and 1971) was a pioneer in the study of ethno-medicine. Tracing the relationship between primitive medicine and patterns of culture, he identified three important aspects: (i) there is not one but numerous different 'primitive medicines'; (ii) The differences between the primitive medicines are much less in elements than differences in the medical pattern which they build up and which is culturally contained; and (iii) the degree

of integration of different elements of medicine to the whole and of the whole medicine into a cultural pattern varies considerably.

Field researches in different parts of India have yielded a rich body of data on ethno-medicine. Hemadri's (1994) work on the tribal medicine in coastal Andhra districts is a very interesting and significant contribution.

Tribal Ethno-Medicine as a Science

With the advent of indigenous knowledge perspective, there is a radical shift in the mind set from viewing native systems of thought as naive and rudimentary, even savage to a recognition that local cultures know their plant, animal and physical resources intimately (Nazarea, 1999). If we reflect on the idea that traditional ethno-medicine as science, we must ask how this can be so: scientific principles are constructed through scientific theory and practice where as tribal healing is rooted in the latent knowledge structures and livelihood practices of local people. Both kinds of knowledge are grounded in social practice but very different kinds of practice, based on different categories and assumptions, involving particular experiences, values and cultural definitions.

Atran (1999) maintains that indigenous knowledge structures are like scientific theories in that they generalize from concrete experiences, but unlike theories they are not systematic formulations of laws or methods. Rather, they involve the adjustment of forms of human livelihood to the environment in which they are embedded. The idea that indigenous knowledge must be science because it leads to empirical results consistent with Western Science is based on a concept of nature as a "pre given" and "science" as the only means of discovering its universal laws. However, the nature itself is not perceptually 'given' but 'constructed', in the microscope or in the forest, by 'perceptually guided action', the practices that make up our experience (Nigh, 2002; Varela et al., 1991). Attempting to force indigenous knowledge into the mould of "scientific principles" is to reduce an objective reality independent of human experience.

INDIGENOUS KNOWLEDGE

The study of Indigenous knowledge is a new revolution set in the domain of Anthropology. In

its wake, this new knowledge has created a new awareness on the part of Anthropologists to critically look at their conventional methodological armour. Indigenous knowledge, as an area of anthropological interest, deals with a variety of hybrid studies borne out of a battle of different perspectives, leading to a critique of our understanding of knowledge as such. A holistic perspective on human knowledge would help us understand the implications of indigenous knowledge especially in the areas of health and disease. In this context, of late, Anthropologist's ability to facilitate incorporation of indigenous knowledge into development process has assumed greater significance.

Knowledge and the Development of Indigenous Knowledge

An ideal system of knowledge is generally seen as one that derives its corpus from abstract principles by systematic deduction. Modern academic knowledge is 'a way of knowing' that emerged historically through the union of a number of ideas which are subjected to a global systematization through "centers of calculation", nurturing its spectacular accumulation, scope and power (Latour, 1987).

Such an understanding is questioned with the advent of the recognition of indigenous knowledge as a living and dynamic tacit knowledge interfacing with an all encompassing human activity in all societies, which "scientific knowledge is not always capable of validating" (Brouwer, 1999). The heretical idea gained currency that 'other' people have their own effective 'science' and resource use practices and to assist them we need to understand their knowledge and management systems and "those others" may have something to teach us (Atte, 1992; Barrow, 1992, Fairhead et al., 1991). In his exploration of the ethnography of human knowledge, Barth (2002) maintains that "knowledge in its different modalities can range from an assemblage of disconnected empirical detail to a 'theory of everything' . . . as we are in a world constructed on principles of sociality and morality, not mechanical causality". Indigenous knowledge is explained as "local, orally transmitted, a consequence of practical engagement reinforced by experience, empirical rather than theoretical, repetitive, fluid and negotiable, shared but asymmetrically distributed, largely

functional, and embedded in a more encompassing cultural matrix, that which is not epitomized by being a part of a dominant Western Scientific knowledge" (Ellen and Harris, 1997). By definition indigenous knowledge research is a 'small scale, culturally specific and geographically localized, infrequently encompassing regional ecosystems' (Sillitoe, 1998). This position highlights the centrality of localized socio-cultural context in understanding and appreciating indigenous knowledge.

Barth (2002) presents an analytical framework to distinguish three components of knowledge viz., substantive corpus of assertions, a range of media representation and a social organization. He demonstrates that all the three are interconnected and appear together in particulars of action, in every transaction in knowledge and in every performance. In this context, the tribal cosmology, rituals and religious traditions fall within this concept of knowledge. These traditions also provide the people with a world-view and to act accordingly. They encompass aspects of nature and cosmos, health and life, ethnopsychology, human morality and a panoply of supernatural entities that erratically affect and may even invade and possess human beings.

Indigenous Knowledge and New Applied Anthropology

Indigenous knowledge research sets out explicitly to make connections between local peoples understanding and practices and those of outside researchers and development workers, notably in the natural resources and health sectors, seeking to achieve a sympathetic and in-depth appreciation of their experience and objectives and to link them to scientific technology (Sillitoe, 1998). In this context, participatory research techniques have been generated in different social sciences, thanks to Anthropologist's Participant Observation method, and the main thrust in such an approach is to make the people or the subjects into active collaborators in bringing about desired change. Technology transfer is now considered not as a top-down imposition but as a search for jointly negotiated advances, which results in cost-effective, time-effective programmes generating appropriate insights readily intelligible even to non-experts. Thus participatory approaches seek a more systematic accommodation of indigenous know-

ledge in research and technological interventions (Schaffer, 1989). The demands of indigenous knowledge and participatory research require the establishment of partnerships founded on dialogue. Anthropologists are better positioned to take up the tasks of incorporating indigenous knowledge into the development process as they are pioneers in documenting indigenous knowledge systems through participant observation method that involves living with the subjects for a very long period. This being the hallmark of Anthropological research, the role-play of 'Anthropologists as consultants' in implementing development programmes becomes much more relevant compared to other social scientists.

Haile (1996) proposes that the idea of harnessing Anthropology to technical knowledge to facilitate the development puts the discipline where it should be, at the center of the development process. The focus on indigenous knowledge has already resulted in reappraising theoretical as well as methodological aspects of Anthropology. The liability of indigenous knowledge is reflected in the theoretical shift from a structural to a processual and to a post-modernist perspective. Certain methodological advances to tailor interventions to local conditions have already been put forward by the Anthropologists in 'doing Anthropology' by a very different process.

The process involves the brokering of knowledge in which Anthropologists become researchers for and consultants to indigenous people and traditional communities (community – controlled research). They can also oversee that the indigenous knowledge is not patented for but used in the production of universal medical technologies, not for private commercial benefits. This will establish the 'dialogue' as the cornerstone of a new Applied Anthropology. In this endeavour, the greatest challenge to Anthropology vis-à-vis development debate is to develop criteria and indicators for sustainable development which include health environments, sustainable livelihoods that are based on local, indigenous perceptions, classifications, values, measures of environmental quality and change that reflects local observations and knowledge systems, even if they seem 'magical', whimsical or destructive to the outsider.

INTELLECTUAL PROPERTY RIGHTS

Of late, scientists from other disciplines have

awakened to the clarion call given by the intellectual property rights propaganda in making claims to different areas of indigenous knowledge. Unfortunately, Anthropologists were the last to make such claims although indigenous knowledge, especially related to ethno-medicine, is their forte as their very researches invariably focus on such native knowledge systems universally.

To conclude, Anthropological contributions to the study of health and disease have not been sufficiently acknowledged by other social scientists. Instead, claims and counter-claims have been made by other scientists in acquiring intellectual property rights especially in areas much researched by the Anthropologists. This is highly deplorable and Anthropologists all around the world should question such attempts of hijacking indigenous knowledge which in many places came to light by the laborious and dedicated Anthropological researches.

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KEYWORDS Illness. Ethno-Medicine. Emic/Etic. Indigenous Knowledge

ABSTRACT In the interplay of different disciplines contributing to the domain of health and disease, Anthropological works immensely enriched the knowledge base especially of isolated, remote, pre-literate, tribal/rural people. Of late, it is felt that Anthropological contributions have not been sufficiently acknowledged by other professionals in the area of health and indigenous knowledge. Therefore, an attempt is made to highlight the Anthropological dialectics in delineating concepts and ideas related to the intricate admixture of patterns of human behaviour in the context of health and disease.

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