



# ASIAN MEDICINE NEWSLETTER

International Association for the  
Study of Traditional Asian Medicine

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## *Editorial*

You will have noticed that the IASTAM newsletter was not available for a period of about two years. This is now a renewed attempt to revive this important forum for discussion and networking. Like their predecessors, the new editors, based at the Department of Sociology and Social Policy at the University of Southampton, depend on members' contributions. So, please do send along information about forthcoming events, research interests, book reviews, conference reports, recipes (?) and the like, to help the diverse community of people interested in traditional and contemporary modes of healing in Asia to remain in touch with each other.

We will not set any ambitious deadlines for forthcoming newsletters, but we are aiming at publishing at least one issue per year. So, please send us any material as soon as possible, and we might even get more issues per year going.

Depending on the level of editorial activity in response to the heaps of material you are all going to send us, we might consider getting better publishing facilities. So, if you are keen on a better layout and a more professional and aesthetically pleasing look to the newsletter, start sending us bags of contributions and stop curtailing your literary ambitions.

A great year to everybody!

Eds.

Waltraud Ernst and Kate Reed  
Department of Sociology and Social Policy  
University of Southampton  
Southampton SO17 1BJ  
WER@soton.ac.uk  
C.Reed@soton.ac.uk

## IASTAM and the internet

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Dominik Wujastyk has established an internet discussion group for IASTAM members. To participate, you need to be a paid-up member of IASTAM International (contact [D.Wujastyk@ucl.ac.uk](mailto:D.Wujastyk@ucl.ac.uk) for more information).

We look forward to an active and interesting exchange of ideas in this forum.

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## IASTAM and the World Wide Web

Dominik Wujastyk and Kate Reed are currently working on an update of the WWW Home Page for IASTAM. The address is <http://www.ucl.ac.uk/~ucgadkw/iastam.html>.

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## IASTAM International: WHO IS WHO?

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President	Lawrence I. Conrad Wellcome Institute (London, UK) <a href="mailto:l.conrad@wellcome.ac.uk">l.conrad@wellcome.ac.uk</a>
General Secretary	Kenneth Zysk University of Copenhagen (Denmark) <a href="mailto:zysk@coco.ihl.ku.dk">zysk@coco.ihl.ku.dk</a>
Vice President	Shigehisa Kuriyama Int'l Research Center of Japanese Studies (Kyoto, Japan) <a href="mailto:kuriya@nichbun.ac.jp">kuriya@nichbun.ac.jp</a>
Treasurer	Vincanne Adams Princeton University (Princeton, USA) <a href="mailto:vadams@pucc.princeton.edu">vadams@pucc.princeton.edu</a>
Secretary	Dominik Wujastyk Wellcome Institute (London, UK) <a href="mailto:d.wujastyk@ucl.ac.uk">d.wujastyk@ucl.ac.uk</a>
Editors	Waltraud Ernst and Kate Reed University of Southampton (Southampton, UK) <a href="mailto:wer@soton.ac.uk">wer@soton.ac.uk</a> <a href="mailto:C.Reed@soton.ac.uk">C.Reed@soton.ac.uk</a>

## CONFERENCE TALK

The IASTAM conference on 'Traditional Asian Medicine in the Modern World' was held at the Wellcome Institute for the History of Medicine, London, on 16 November 1995.

One of the presentations focused on 'Ayurveda Today'. The main issues are briefly summarised here.

The practice of Ayurvedic medicine is very much alive in the Indian sub-continent today. Though its popularity is growing even in the urban areas, it is certainly not flourishing and its growth is not taking place in the healthiest of circumstances. The quantitative profile of contemporary Ayurveda in terms of infrastructure and institutions looks impressive as compared to the pre-independence period. But the mushrooming of Ayurvedic institutions is also a story of the butter being spread very thinly and they have been created with sub-critical inputs and resources. Less than 4% of the national health budget is allocated for development of Ayurveda continuing the policies formulated during colonial rule. The reasons for this state of affairs are civilisational, historical, political, economic and, finally, on the surface, sociological in nature. The marginalisation and in effect suppression of traditional systems of medicine in India was done by the British on sheer

political and economic grounds. At the ideological level, traditional medicine was sought to be discredited by compelling traditional practitioners to prove their medical therapies on the basis of the theories and parameters of allopathy. State support for traditional medicine was cut off totally and was diverted for the promotion of allopathic medicine. There exist no reports whatsoever on evaluation of the efficacy of traditional medicine by European professionals justifying such a stand. On the other hand, it has to be confessed that one cannot blame the present decline and the confusion of the traditional medical practice only on the colonial political and economic policies but must also attribute the loss to internal weakness within the traditional medical culture. Indeed, the fact that indigenous medical practitioners and scholars despite their inheritance of a 3000 year old tradition could not defend their knowledge system and practice in the wake of foreign prejudices imposed

on them is often interpreted as the obsolescence of a static tradition that had outlived its time.

Such a conclusion, however, can be arrived at only after a dispassionate study of the foundational theories, functionality and efficacy of traditional medicine. At this stage, the situation can best be explained as a general spiritual weakness of the Indian civilisational process at this stage of its evolution.

If the early European response of appreciation of the Indian medical traditions had sustained to develop a sympathetic attitude encouraging its adaptive growth to the need of the times, we would perhaps, have had a different story to tell. Yet, the fact that the tradition has managed to survive the great vicissitude speaks without words of its inner vitality.

Cultures of the world bear testimony to the varied expressions of human creativity in various domains of human life making human experience all the more richer and

diverse. This creative urge has also found remarkable continuity in some civilisations that have pursued their objectives despite the vagaries of time through periodical phases of renewal and growth.

In this background, the transformation of Western cultural creativity into a power for global domination by means foul than fair is nothing but deplorable ethnocentrism. The rise of European political power sounded the deathknell of older cultures in Asia, going through a weak phase in their expressions, struggling ever since to assert their identity in the most unfavourable of circumstances.

A substantial percentage of the Indian elite has become alienated from their cultural heritage and share the older prejudices of the Western rulers. False social beliefs and myths have become part of the modern social culture having nothing to do with the efficacy of traditional medicine and westernised Indians tend to regard the 'traditional' or more correctly the contemporary indigenous, as backward and modern or more correctly, the contemporary western as forward. The contemporary picture of Ayurveda in India, possessing one of the oldest living cultures of the

world reveals at the same time the unhappy story of cultural domination and unrelenting resistance to external forces.

Efficacy of the Ayurvedic system of medicine is reported in a range of conditions from the common cold to the latest plague of AIDS and cancer. Medical success stories from different regions relating to miraculous healing provided by both the folk traditions as well as the codified traditions abound. Whereas many of its achievements can be backed up by indigenous medical theory and principles, they cannot be justified in terms of modern medical theories. There is no bio-statistical tradition in Ayurveda and therefore no valid statistical inferences have been attempted. Due to lack of epistemological defence and proper research models for validating its practice, all its achievements have been reduced to a string of anecdotes.

The demand for statistical data validating Ayurvedic medical practice comes from people outside the field of Ayurveda, especially those representing the modern scientific community. Lack of seriousness in their attitude is evident as no investments have been made to back up the

demands. Suitable research designs, trained personnel, resources and clinical infrastructure are essential inputs to generate the kind of hard data that is demanded. Without such inputs, the outcomes of any medical practice would be reduced to anecdotal reporting. It has to be pointed out at this juncture that foundational differences become very evident when we compare Ayurveda of Indian origin to allopathy of European origin revealing the fallacy of trying to evaluate Ayurveda on parameters of allopathy.

Any knowledge system, built as it is upon certain basic premises can serve to reveal only partial aspects of nature. The formulation of these premises are in turn influenced by the pressing needs of human society and a knowledge system is sought to solve these problems. Since these needs vary in relation to time and space, it is but natural for people inhabiting different spatial locations and time periods to build up knowledge systems on entirely different premises. The validity of a knowledge system rests in its ability to solve problems that it was created to solve. Universal attributes, however, are likely to be present in any worthwhile knowledge system.

The validity or

obsoleteness of Ayurveda can be decided only after a dispassionate examination of the system in its own

rights and steps in this direction will be crucial in deciding the future course

of development of Ayurveda in the sub-continent and the world.

**Contact address:** Ram Manohar, Darshan Shankar, Foundation for Revitalisation of Local Health Traditions, 50, MSH Lay Out, 2nd Stage, 3rd Main, Anand Nagar, Bangalore -560 024, India.

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## **CONFERENCE REPORT**

### **A Body of Knowledge?: The Relationship between Yoga and Science**

**Cambridge, 1-2 December 1995**

The Dharam Hinduja Institute of Indic Research held its winter conference entitled "A Body of Knowledge?: the relationship between Yoga and Science" at the Faculty of Divinity, University of Cambridge. This conference was the second of a series of regular conferences, seminars, lectures and workshops being initiated by the Institute. Yoga, broadly conceived, is an immensely rich and highly complex spiritual tradition comprising a great many approaches, schools, teachers and technical vocabularies. As a discipline within the Indic traditions which integrates mind and body, and in view of its sheer versatility and long history stretching back nearly three thousand years, Yoga can be recognised as one of the worlds foremost traditions of psychological and

spiritual transformation. By drawing on expertise in the areas of Yoga and Science, the purpose of this conference was to inquire not only theoretically into the nature of Yoga in the context of the relation between Yoga and modern notions of science, but also through group discussion and demonstrations, into the practice of Yoga.

Following the pattern set out in the Inaugural Conference, Part 1 (Day 1) consisted of academic papers which examined the intellectual heritage of Yoga and its relationship with Science, while Part 2 (Day 2) explored the practical/experiential dimension of Yoga. Highlighting the Welcome addresses of the conference, which included introductory remarks by Dr. Julius Lipner (University of Cambridge, and Director of the Institute), was the

presentation of a bronze bust of Mahatma Ghandi to the Faculty of Divinity by H.E. Dr. L.M. Singhvi, the High Commissioner for India. The conference then began with presentation by Dr. Stephen Hunt (Medical Research Council, Cambridge) entitled "Science and Consciousness" in which he spoke on what we can learn from Neuroscience about the conscious brain and our sense of self as well as the contribution molecular biology makes to our understanding of the mind. Critical of the tendency within science to reduce consciousness and warned of making unwarranted distinctions between mind and body, something which Yoga does not do. In his paper on the "Scientific Questions about Yoga", Dr. Fraser Watts (University of Cambridge) discussed various research

strategies on the effectiveness of Yoga. After dealing with "outcome" questions relating to the Yogic discipline. Dr. Watts hypothesised that Yoga is effective and helpful but not uniquely so. He then raised more subtle questions concerning the physical and mental "processes" by which Yoga achieves its effects (including posture and the "somatic focus of consciousness"), alerted us to the need for more sound research on the issue, and brought up some of the critical comments of C. G. Jung about the appropriateness of Yoga in the West.

The next paper by Dr. Ian Whicher (University of Cambridge, and Deputy-Director of the Institute), entitled "Yoga in Patanjali's Yoga-Sutras", centred on the main authoritative sources of Classical Yoga philosophy. His paper was an attempt to counter the radically dualistic and ontologically-oriented interpretations of Yoga given by many scholars and offered a more open-ended, morally and epistemologically-oriented hermeneutic which frees Classical Yoga of the long standing conception of spiritual isolation, disembodiment, self-denial and world-negation and thus from its pessimistic image. Dr. Whicher argued

that rather than culminating in a complete isolation of "spirit" (purusa) from "matter" (prakrti), Patanjali's Yoga can be seen as responsible engagement of these two principles resulting in an integrated and embodied state of liberated selfhood (jivanmukti). Dr. Daniel Mariau (University of Hull) spoke on the history and forms of Yoga showing how the tradition of Yoga has developed in different directions by responding to the needs of the time. He pointed out the centrality of Patanjala Yoga and was careful to distinguish Yoga from Samkhya. Dr. Mariau asserted that Yoga has for the most part stood outside mainstream orthodoxy and that the spirit of Yoga is essentially "heroic", not priestly. He outlined the importance of Shamanistic trance as part of the "roots" of Yoga and highlighted Tantra-Yoga which revitalized the bond between ritual and Yoga practice and states that transcendent Reality and the conditioned world are coessential.

Next came a paper by Dr. Karel Werner (University of London and Masaryk University, Czech Republic) on the goals of Yoga where it was suggested that there is only one goal of Yoga, namely "getting back to the source", a goal which described positively is a

direct encounter or knowledge of ultimate reality, or expressed negatively is liberation from one's dependence on limited forms of existence and on the laws which govern them, i.e. samsaric existence. Other so-called goals of Yoga including bodily health, magic and personal powers (siddhis), gratification of desires and therapeutic effectiveness are, it was argued, either transitory deviations of Yoga or marginal pragmatic approaches to Yoga practice. Dr. Werner explained various terms employed to denote the final goal including: amrta, nirvana, kaivalya and saccidananda. In her paper entitled "The Development of Modern Yoga" Elizabeth De Michelis (research student, University of Cambridge) looked at some of the major differences in how knowledge is transmitted in the traditional Indian context and the modern westernized context. Concluding that the educational approaches in both are quite different, she then contrasted the Indian strand with the Western strand of development in modern Yoga pointing out the powerful influence of western scientific approaches on modern Indians and the interest of Western "seekers" in the spiritual/mystical and the experiential. She concluded

with a look at the development of modern Yoga after World War II. Lastly, Dr. Robin Monro (Yoga Biomedical Trust, London and Cambridge) speaking on "The Scientific potential of Yoga", stated that, as well as being a spiritual path, Yoga is a science because it is grounded in disciplined experience. Dr. Monro discussed the positive effects, physically and emotionally, which Yoga postures and breathing exercises have had on others, effects which include an enhanced control of physiological processes leading to release of tension and greater well being. He argued that the methods of "disciplined subjectivity" in Yoga must be accepted on an equal basis with the objective methodologies of

modern science in the investigation of psychosomatic phenomena and that the potential fruits of such a partnership are enormous in the field of health care and medicine. On the second day of the conference three discussion groups under the headings of: Yoga Tradition, Contemporary Yoga Practice, and Yoga and Science, met in the morning session and were followed by group reports, questions, and an illustrated lecture on the history of Yoga provided by Elizabeth De Michelis. The afternoon session chaired by Dr. Francoise Barbiria-Freedman (University of Cambridge), included three presentations on the practical dimension of Yoga followed by questions and answers.

Here Velta Snikere Wilson (The British Wheel of Yoga), Shyam Mehta (Iyengar Yoga) and Dr. Robin Monro (Yoga Biomedical Trust) all contributed. The afternoon ended with concluding remarks from Dr. Julius Lipner.

The conference demonstrated the rich potential for dialogue between Yoga and science. The enthusiastic gathering of over 180 people each day was a clear indication of a growing interest and participation in such a dialogue- one that is, given a high standard of scholarship and pursued at a practical level, certain to prove very fruitful. The Institute wishes to thank all those that attended the conference for making it such a tremendous success.

Dr Ian Whicher, Cambridge.

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## REFLECTIONS

### South Indian Siddha medicine

The term Siddha means "accomplished", "perfect" or one who has attained supernatural powers of the body and mind. The Siddha system of medicine owes its origin to the concepts of longevity and medicinal practices associated

generally with eighteen Siddhas. The definition of medicine, according to Thirumular, regarded by some as the Father of Siddha system, includes the prevention of mortality as the special goal- a goal ever in sight but never

reached.

"A Physician is the son of an alchemist."

So goes a Tamil adage. In fact the Siddha medical system is an evolute of TAMILIAN alchemy, mainly confined to Tamil Nadu (in South India) with

peripheral interests in the adjoining parts of the three other states of South India, northern part of Sr Lanka, Malaysia and Singapore where Tamilians live in considerable numbers. In effect the Siddha system is the medical system of Tamils, and its entire medical literature is in Tamil.

Tamilian alchemy owes its inspiration to the taoist seed ideas concerning Cinnabar and other mineral elixirs. It would appear that the milieu of Indian tantrism, the Taoist concepts and practices:- male-female symbolism, respiration, sexual, meditational and related aspects- appealed to the tantrik followers, who had similar thoughts and Yogic practices. The Buddhist mendicants and some commercial intercourse between India and China specially during the fourth and the seventh centuries A.D., were instrumental for Indias exposure to Chinese alchemy.

The Siddha system has firm faith in the Taoist alchemical concept, namely, the thought-linkage between aurification and immortality in the sense that if the ignoble metals could be transformed into gold of everlasting lustre, the physical body too could

become immortal or perfect by mercurial and other elixirs. the most important substance in this process of thinking is what the Siddhas call Muppu (an intimate mixture of three natural salts) which is to be added in small quantities to any Siddha medicine to enhance the efficacy of the latter.

An important aspect of the Siddha medicine is its faith in, and practice of, rejuvenation and immortalisation (Kaya Kalpa) of the body, using Muppu and certain plants. The variety of both mineral and animal products, and preparations from metals as well as gems. Broadly there are 64 categories of medicine- 32 for internal administration with dietary regimen and 32 for external application. As for the diagnostic methods, the emphasis in the Siddha system is on the examination of pulse and urine. Nevertheless, at some stage of its development, it accepted the three humoral diagnosis of the Ayurveda along with its postulate of five elements associated with its three humoral theory. Since independence (1947), like the other Indian traditional systems, the Siddha has received a new fillip and special patronage from the

government of TamilNadu. The traditional medicines not only continue to have their appeal but even are being preferred to allopathic medicine by a considerable section of Indian popular in such cases as the maintenance of vigorous health, possible cure of some chronic diseases like gastritis, peptic ulceration, asthma, hypertension, anaemia and skin diseases. While the Ayurvedic medicines hold the fort along with Unani throughout India and even abroad, the Siddha has its share in Tamil Nadu. The Central Council for research in the Indian systems of medicine has been promoting clinical trials of some standardised drugs, but based on traditional Siddha texts. From its esoteric beginnings about 1500 years ago, the Siddha has traversed a long way and has now begun to unfold a transparency which may help us understand its medicinal potentialities on scientific lines. Its relevance and future are interlinked with its ability to have a solid scientific foundation, though its tradition may survive in Tamil Nadu, since any tradition in Indian ethos dies hard.

Contact address: B.V Subbarayappa, Centre for the History and Philosophy of Science, The Indian Institute of World Culture, Bangalore 560 004 , India.



## *FORTHCOMING CONFERENCE*

### **Plural Medicine - Orthodox and heterodox medicine in Western and colonial countries during the 19th and 20th centuries.**

**Southampton, 15-16 September 1998**

This conference will be organized by the Society for the Social History of Medicine and is partly funded by the Wellcome Trust. It aims at bringing together medical historians working on colonial medicine and heterodox medicine in Britain. It is intended to facilitate discussion and exchange of ideas on themes such as the marginalization of heterodoxies/indigenous ways of healing; on how certain medical practices (such as homeopathy, or mesmerism, for example) developed as heterodoxies in Britain, yet as (one) part of 'mainstream colonial medicine' in the colonies; and on whether it is appropriate to talk of global biomedical expansion solely in terms of biomedical 'dominance' and 'power'.

It is also intended to bridge the gap between historians of medicine and social scientists. It is assumed that medical anthropologists and sociologists will benefit from detailed historical analyses, whilst medical historians may derive new insights and theoretical challenges from the major conceptual concerns of contemporary social scientists. The discussion will focus on the nineteenth and twentieth centuries. This will enable consideration of 'indigenous' and 'alternative' medicine to be carried well into recent times. The conference will take Britain and her former colonies (especially South Asia, and the Pacific) as the main areas for analysis.

Research into 'colonial' or 'imperial' medicine has made considerable progress in recent years, while the study of what is usually referred to as 'indigenous' or 'folk' medicine in colonized societies has received much less thorough attention. At best 'indigenous' medicine is looked at as the 'other' or the opposite of Western medicine, in terms of its traditional values (vs modern science), its naivete and barbarism (vs sophistication and progress) and its holistic basis (vs bio-medical individualism). Yet such categorization may be derogatory, and

does not do justice to the complex and problematic nature of both 'indigenous' and 'Western' medicine, for a number of reasons: **First**, 'indigenous' medicine is presented as monolithic, traditional and never-changing. But is 'indigenous' medicine in any one place and colonial period more adequately described as a multitude of beliefs and practices which may be based on a variety of written or oral traditions subject to continual change and adaptation? **Second**, although 'Western' medicine within colonial settings has received much critical attention from

historians. It too emerged as only one of various strands of medical practice, with continuous shifts and fluctuations between 'orthodox' and 'heterodox' practices. **Third**, unlike the global dispersal of Western biomedicine, 'indigenous' medicine is seen as culturally and spatially specific. Yet a focus on the parallels and overlaps between various strands of 'indigenous' medicine in different colonial settings highlights not only the global spread and similarity of some elements of 'indigenous' medicine, but also makes it more

appropriate to think of Western biomedicine as only one among a variety of medical practices.

**Fourth**, the contrasting of 'indigenous' / 'heterodox' with 'Western' / 'orthodox' medicine does not reveal the underlying dynamics which lead to the perceived marginalization of 'indigenous' medicine in

recent colonial countries and of 'heterodox' medicine in Britain itself. The perceived 'rise in alternative medicine' in the former and the flourishing of the latter in ex-colonies attest to their strength, if not power, alongside (rather than only in opposition to) Western biomedicine. We need to

investigate further the complex factors involved in these phenomena - not only in terms of biomedical dominance and colonial power relationships but also in regard to processes of resistance, adaptation, integration and cross-fertilization between different modes of medicine.

**Speakers** will include: David Arnold (UK), Harriet Deacon (South Africa), Waltraud Ernst (UK), Tricia Laing (NZ), Charles Leslie (USA), Kate Reed (UK), Poornima Sardesai (India), Sumit Sarkar (India), Darshan Shankar (India), Ursula Sharma (UK), Alison Winter (USA).

For **further information** contact: Dr Waltraud Ernst, Department of Sociology and Social Policy, University of Southampton, Southampton SO17 1BJ, UK (WER@soton.ac.uk).

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## *NEW CENTRE*

### **Centre for the History and Culture of Medicine, SOAS**

A centre for the History and Culture of Medicine has been established at the School of Oriental and African Studies, London. Its aim is to promote the study of medicine and related fields of science and technology as they relate to Africa, Asia and other parts of the non-European world through the holding of workshops and seminars, publications and by providing a base for relevant research projects. The Centre is attached to the History Department at SOAS, which has a long-standing interest in the history of both Western and indigenous medicine, particularly with respect to health, healing and medical systems in southern Africa, India and China. The Centre will also draw upon the School's wide-ranging interests including anthropology, development studies, geography and the languages and cultures of Africa and Asia.

**Information** about the Centre and its forthcoming activities can be obtained from Dr Christopher Cullen, Department of History, School of Oriental and African Studies, Thornhaugh Street, Russell Square, London WC1H 0XG or on e-mail CC3@SOAS.ac.uk

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## *WORK IN PROGRESS*

### **The eradication of smallpox: India, 1900-1977**

According to one estimate, there were 250,000 cases of, and 64,000 deaths resulting from, smallpox in 1951. This, as in most years, represented over half the smallpox cases in the whole world. The eradication of the dreaded disease was, therefore, not only a triumph for the Indian, but also the international, medical fraternity. At its height more than 150,000 health workers from over 30 countries involved themselves in the eradication programme. Such a massive campaign, not unnaturally, faced multifarious challenges and difficulties, and ruffled many influential feathers. These, as well as the marked social and political effects of forced vaccination drives, tend to be ignored in an otherwise well documented eradication programme. On 23 April 1977, an International Smallpox Assessment Commission declared India to be completely rid of the dreaded scourge. This triumph, rightly portrayed by many being Herculean in character, was a culmination of almost three decades of official initiatives and striking international co-operation

during a period of heightened 'cold war' animosities. However, the process was not a smooth one. Indeed, some of the troubles that punctuated the efforts of the diverse governmental and international medical workers were serious enough to cause facets of the campaign to seem, albeit in hindsight, strikingly disjointed. In fact, seen in this light, the eradication project can be said to be made up of a series of independent initiatives, some of which came to an inglorious end. Nonetheless, it is impossible to question the cumulative value, and ultimate significance, of a multifaceted smallpox eradication programme in the South Asian context. A recent grant by the Wellcome Trust to Sheffield Hallam University has allowed the initiation of a major endeavour to analyse and re-assess the history as well as the political and social aspects of official attempts to prevent the spread of smallpox in India between 1900 and 1977. An examination of the medical initiatives launched in the colonial period - especially during crises like the Bengal Famine of 1943 and

the Second World War - provide a useful backdrop to the Smallpox Eradication Programme launched by the independent Indian government approximately a decade after the British withdrawal from South Asia. As in other aspects of governance, colonial medical and health records very often supplied Indian administrators insights into the organisation, the possible impact and the efficacy of initiatives to counter epidemics. In notable, but rarer, instances, the administrative repositories of the Raj left indelible imprints in the organisation of specific governmental projects. Therefore, a detailed study of the nature and the debates surrounding colonial health measures dealing with smallpox outbreaks remains significant, not merely because they provide us with insights into colonial mindsets, but also as this allows contemporary researchers to locate post-independence health measures more effectively. The current project also hopes to re-assess the developments between 1958, when the Indian Ministry of Health

appointed a 'Central Expert Committee' to suggest means for the eradication of smallpox, and 1977. In doing so, the researchers hope to move away from the valuable - but rather triumphalist - description of the campaign provided by the published reports released by the World Health Organisation. Whereas the extremely important role played by the WHO - and other organisations like the Centre of Disease Control and U.S.Aid - in the eradication programme is never ignored or belittled, treater sensitivity is shown towards the social and political costs of the campaign not only in the urban centres, but also other rural expanses of India. The concepts of 'state power', 'intimidation' and 'coercion' are examined, sometimes re-defined and utilised to understand the far-reaching and often culturally invasive effects of the eradication programme on a linguistically and culturally heterogeneous society.

An attempt will also be made to identify the various practical difficulties encountered by the health workers attached to the eradication programme and the measures utilised to

overcome them. A good example of this was the defective reporting apparatus, through which dependable feedback about the effectiveness of the programme came in irregularly for most of the campaign. The problem was tackled by involving ever-greater numbers of bureaucrats, and also soliciting civilian assistance in the discovery, reporting and limiting of smallpox cases through the provision of very generous cash awards. Another interesting tactic was to encourage school children to report on smallpox cases within their community!

In addition, local - and 'traditional' - medical attitudes towards smallpox and its eradication will also be examined. This will not only allow us to investigate the clash of disparate medical beliefs, but also the not infrequent interaction between knowledge systems like ayurveda and Western allopathic practices. In unravelling this aspect of the eradication programme, a wide range of vernacular sources will be put to use. Local records - written in indigenous languages and dialects - and an ambitious programme of interviews with officials, as well as

civilians, will also be used to elucidate the class, caste and gender based provision of health benefits in independent India. It is in this context that the complex inter-relationship between national, regional and local political practices, and a centrally organised health campaign become very obvious. Indian politics - particularly in the rural areas - has always had a very marked parochial flavour. The reactions towards the eradication programme were thus extremely - sometimes maddeningly-diverse: it provided some politicians with the excuse to complain against forcible vaccinations. In other cases, confrontations - violent or otherwise - occurred between village leaders and spokespeople and health workers. An investigation into these facets of the eradication programme will form an integral part of the current project, and a concerted effort will be made to uncover examples of the anti-vaccination propaganda produced in the localities. Such an expansive focus, it is hoped, will allow for a more comprehensive and nuanced history of one of the greatest medical triumphs of the twentieth century to be written.

For further information contact: Dr Sanjoy Bhattacharya, Department of History, School of Cultural Studies, Sheffield Hallam University, Sheffield S10 2BP, UK

## **WORK IN PROGRESS**

### **"Syncretic" beliefs, "symbolic" behaviours: The health beliefs and behaviours of American and British South Asian women.**

The aim of this essay is to put forward a theoretical argument about the health beliefs and behaviours of American and British South Asian women. The focus lies with those women who are American and British born. More specifically with Hindu mothers with young children. The essay will develop a suitable hypothesis in order to assess the use of Ayurvedic and Allopathic medical discourse in these womens beliefs and behaviours. This will be tested in subsequent fieldwork.

Systematic studies of Asian and black peoples health beliefs and behaviours have been few and far between (Bowes and Domokos 1993, Eade 1997). This has been linked to the failure to provide culturally sensitive health services within the UK (Rocheron 1988) and within the USA (Boyne-Smith 1996). Previous research has been characterised by large scale epidemiological studies. Women of colour have remained exempt from the literature and have remained here as elsewhere objects of the biomedical western gaze (Kjirby 1987). Similarly, minorities born in western countries have been exempt from analysis. Minorities are taken as one cohesive group within research. Research has also tended to be localised and there has been a lack of cross-national comparative research which moves away from the home/host teleology. This has failed to situate South Asian

diaspora within a global context.

Writers on identity (Hall 1992, Parker 1995) have begun in recent years to focus on the unique identity of those diaspora born within the West. They explore the syncretic multiply located and changing identity of this particular generation. This has not been picked up within the health literature. While there are those that recognise the specificity of this generation (Kelleher 1996) and of the dilemma faced by those born within the West to South Asian parents, research has yet to look at how this applies to the use of Ayurvedic and Allopathic medicine among this generation.

Existing studies which have looked at the health beliefs and behaviours of South Asians and other minorities within the west, have tended to find mixed results regarding the use of western and non-western medical discourses. Some have argued that particular

minorities are more likely to use "traditional" folk remedies while others are more likely to use western. Donovan (1986) in her research on women of South Asian and Afro-Caribbean descent argued that while Afro-Caribbean women were more likely to use folk remedies South Asians were more likely to use western medicine. Studies on women of Afro-caribbean descent have subsequently supported the argument (Thorogood 1990). Others have however argued that when looking at minority health one should not focus on the use of "traditional" medicine because to do so is derogatory. Bowes and Domokos for instance (1993) demonstrated in their research on Punjabi Muslim women in Glasgow that these women did not use any "Traditionally" South Asian medicines. They went on to argue that the womens focus was on "ordinary" health care and was comparable to the

white population.

There are also those that argue minorities draw on a plurality of discourses including both western and non-western in their health beliefs and behaviours. As Eade (1997) argues this is part of the dynamic and contested process of cultural construction as traditions are adapted to the conditions of urban life within the west. In his own research on Bangladeshis in Tower Hamlets he argues that a plurality of medical discourse is used. This consists of the use of Allopathic medicine, Unani as well as other folk systems. He argues that these discourses are not completely bounded. It is precisely with this dynamic that the project is concerned. While I feel that by looking at non-western medical discourse one is in danger of presenting minorities as Exotic. I also think that the inability to engage with other forms of discourse leads one to create western medical discourse as somehow pure and as a yardstick to which others must match up. The aim is to explore this plurality of discourse through the concepts of syncrecy and symbolic ethnicity. As I will go on to argue, these concepts have been developed in order to take into account the above problems and come up with a suitable paradigm

within which to research the beliefs and behaviours of American and British South Asian women.

There has been a recognised difference between health beliefs and health behaviours within research. McAllister and Farquhar (1992) in their comparative research on women's beliefs among Asian and white communities in the context of preventative care adequately define and distinguish the two. They define health beliefs as feelings about lifestyles in relation to health and views about causes and symptoms of disease. On the other hand they use Kasl and Cobb's (1966) definition of health behaviour: as an activity undertaken by a person believing themselves to be healthy for the purpose of preventing disease or detecting it at an asymptomatic stage. This definition is situated by many researchers in terms of medically approved practices and the use of health services designed to prevent disease. This research project will draw on this distinction in order to explore the hypothesis that American and British born South Asian women's beliefs are syncretic whilst behaviours are symbolic. Having said that, the two will not be taken as bounded and a reciprocity between the two will be

taken into account.

The idea that beliefs are syncretic plays on the complex interweaving of ethnicity, culture and material circumstance for this generation. The research will draw on the concepts of syncrecy as used in the current theoretical debates on identity (Parker 1995). The hypothesis will be explored that beliefs are drawn from multiple discourses including both Allopathic and Ayurvedic. Although contextual circumstances will be taken into account, it is supposed that, at the level of belief, women are more likely to take from a number of other sources. As such the notion that beliefs will be comparatively syncretic between the two Asian populations will be explored. I have combined and developed two concepts of syncrecy which will be juxtaposed in order to do this.

Fitzgerald (1984) looks at the concept of syncrecy in terms of general lay views about health. He argues that lay views are syncretic in origin in that they originate from distinct and disparate sources and are continually being reworked in the light of experience. This approach overcomes the binary of "minority" versus "white" approach to medicine and replaces it instead with the binary of "lay" versus "biomedical"

(Lambert and Sevak 1996). This model is useful in that it questions the purity of the white western subject. However by erasing cultural difference this conceptualisation leads to an inadequate account of the influence in particular of non-western culture on minority beliefs. The need is to develop an approach which takes into account the multifaceted nature of the beliefs of American and British born South Asians. With the second concept of synecry beliefs would still be analysed within the framework of being distinct and disparate. However this concept takes these ideas and frames them in a global context. This second concept works on the idea of global creolisation. It does not simply reinforce the distinction between the exotic and the domestic, or the west and non-west. Nor does it advocate synecry as synonymous with the spread of the west. It looks at the ways in which the west and non-west are mixed both locally and globally in a reciprocal context. This globalising concept is a useful concept in dealing with the health beliefs of those Asian women born in America and Britain. It recognises the tension held for this group between west and non-west, between roots and routes. Its view is both internal and external and

captures the dilemma of the transnational hyphenated Indian (Sunita Sunder Mukhi 1996).

Such a juxtaposed and entwined positioning of these two concepts of synecry will enable us to develop a suitable paradigm within which to look at the health beliefs and behaviours of Asian women. By situating them within the context of the "lay" versus "biomedical" perspective, then adding both a non-western and global element, we will overcome the two binaries and keep the oxymoron of the local global dialectic in tension. This will enable us to recognise features of both divergence and convergence, the utopic and dystopic within groups and across groups both locally and globally (Eade 1997, Parker 1995).

The idea of behaviours as symbolic focuses on exploring how important ethnicity and non-western medicine are when it comes to health behaviours and practices. The aim is to find out whether when it comes to behaviours and practices ethnicity forms only one point of reference. Previous research on ethnicity and health behaviours has tended to view this as the only, or at the very least primary factor in determining those behaviours. As Bowes and Domokos (1993) argue

much research has focused on culture as a causative factor. They argue this leads investigators to ignore influences on health and health behaviours such as socio economic group, housing conditions and access to health care. This has filtered down to a culture blaming approach in health policy (Ahmad 1992, Rocheron 1988).

This project takes up Ahmad's (1996) call for culturally situated research. Research which acknowledges that culture is materially and locationally situated. As such the research will focus on the importance of other factors such as access to health services, work, material circumstances and location in time and space in determining health behaviours. Whilst acknowledging that health beliefs and practices are shaped by more than ethnic and cultural processes however one should be careful not to move to a position which is overly deterministic. To take the position that beliefs and behaviours are completely determined by external forces leads to an approach which denies agency. It also tends to ignore the influence of other factors on beliefs and behaviours for example the influence of the family and position in the lifecycle. In order to take into account the influence of all

of these factors for this generational group the project will develop Nagel's (1994) notion of symbolic ethnicity. Symbolic ethnicity is characterised as a nostalgic allegiance to the culture of the immigrant generation. However this allegiance is "symbolic" in the sense that other factors such as work, class etc heavily inform identity and daily practice. This symbolic allegiance is not necessarily about choice but is constructed through both internal and external forces.

This notion will be used to explore the argument that while beliefs may be syncretic, drawing from many sources including both western and non-western medicine, and similar in both communities, behaviours, on the other hand, are much more likely to be

grounded within contextual circumstance. As such they are more likely to differ between the two populations. This is not to say that beliefs and behaviours remain completely separate nor that beliefs will be strictly syncretic and behaviours strictly symbolic in the two places. As argued earlier, reciprocity between the two will be taken into account. However, as Ahmad (1996) argues, the notion that behaviours are constructed according to our culturally based health beliefs in a direct linear fashion is pure fiction.

This hypothesis will be explored along a comparative. The comparative will focus on south Asian diaspora in America and Britain. This will enable us to situate Asian diaspora in a global context and move us away

from explorations based on teleological relationships between home/host. It will enable us to explore the links between the two populations which developed during migration, as South Asian migration was rooted and re-routed through these countries. This comparative approach will fit into a framework of what I term a comparative dialectic. This is similar to what Clifford (1997) terms "comparative tension". It involves comparative research which is situated. As Mani (1992) argues analytic concepts must be adequately localised before they are either exported or extended.

This hypothesis will be tested during fieldwork in Leicester, UK and Atlanta, USA later in 1998.

For further information contact: Kate Reed, Department of Sociology and Social Policy, University of Southampton, Southampton SO17 1BJ, UK.

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