
Disease and Social Diversity is the harvest of wide experience in medical practice, acute intelligence, and deep research and reading in the social and natural sciences. Stephen Kunitz observes that the development of physiology and bacteriology transformed the practice of medicine by revealing universalistic ‘natural histories’ of germs and bacteria. He proposes that these insights be tempered by renewed attention to individual, cultural and institutional circumstances. Cross-fertilization between biomedical (universalistic) and anthropological (particularist) models of causation is now essential: each approach yields insights into lives and deaths, but each is dangerously incomplete without the other. Mere fame and fortune attend those who adopt extreme positions. Kunitz’s aim is more ambitious: to alter the agenda of epidemiology and public policy by charting the fruitful middle ground where he is liable to be attacked from all sides.

His argument is sustained by ‘comparative studies at increasingly more refined levels of analysis’. A survey which ranges from the Americas through Polynesia to Australia deserves to be reviewed as a whole — but multiple reviews underline the fact that few scholars match Kunitz’s range. One specific audience for this book is the (mainly Anglo-Saxon male) community of historians of Pacific Islands, transfixed by epidemics and devastating depopulation in the aftermath of ‘contact’ with the outside world. The terms of the debate were set by colonial writers who suspected that the population decline might prove inevitable and irreversible, and were inclined to incriminate the victims as well as the infections. On the other hand the ‘new Pacific History’ has resisted the ‘fatal impact’ syndrome, arguing with the benefit of hindsight that island societies were highly resilient. A particular argument now rages about the pre-contact population of Hawai’i, estimated variously between 250,000 and at least 800,000 (Stannard 1989). The precise figure is significant because numbers tumbled over the first hundred years of interaction, to a nadir of about 40,000. Innumerable studies have not produced agreement on the scale, timing or causation because this demographic collapse...is the most important ‘fact’ in Hawaiian history. As disease destroyed their numbers, it destroyed the people’s confidence and their culture; finally, it was the most important factor in their dispossession: the loss of their land and ultimately their independence (Bushnell 1993: 162).

On these and parallel issues, Kunitz throws clear light. First he shows that depopulation was very uneven among Polynesian societies, despite generic and cultural homogeneity; then he suggests a correlation between the extent of early depopulation and the frequency and intensity of shippings. The most arresting element of the discussion is that the later loss of land was an acute health risk. This analysis neatly reverses the chain of causation proposed above:
it seems likely that the impoverishment resulting from the destruction of subsistence agriculture would have made people more susceptible to respiratory diseases and gastroenteritis, which flourished under conditions of poverty, crowding, and malnutrition. Moreover, the expropriation of land resulted in removal and very likely in the disruption of social networks which provide both instrumental and emotional support... Observations of epidemics in virgin soil populations, suggest that social disruption is at least as significant in causing high mortality as is the virulence of the infectious agent itself, and many contemporary studies suggest an important role for social support in reducing the risk of death from a wide variety of causes (p. 51).

Kunitz emphasizes long-term population trends, whereas historians who lack knowledge of the natural sciences are drawn to dramatic episodes such as the Fijian measles epidemic of 1875, or West Samoa’s exposure to Spanish influenza in 1919, from which societies recovered if other circumstances were favourable. What becomes urgent therefore is to investigate resilience rather than catastrophe. There are, of course, awkward exceptions. Even within Kunitz’s sample, the Marquesas demand further explanation to account for their steep collapse and the unusual tardiness of their recovery. Going beyond Polynesia to Micronesia and Melanesia, there are convincing records of depopulation in the Marianas in the seventeenth century and in parts of New Guinea and Vanuatu in the twentieth, often associated with missionization, which involved the concentration of rural societies into villages where they were more accessible to Christianity — and infection. Some nineteenth-century New Caledonians gave the name cristiano to tuberculosis, acknowledging the source of the problem. Perversely, tuberculosis became a disease of development rather than a disease of poverty. These and similar episodes do not falsify Kunitz’s argument. Rather they gain significance from the broad context which he sketches.

Twentieth century demographic evidence often turns conventional wisdom on its head. Historians have usually concentrated on infections or contagions, treating other causes of morbidity and mortality as somehow beyond the realm of social explanation. Kunitz compels us to broaden our vision beyond the natural history of infections to individual (and perhaps collective) patient careers. Again, despite their comprehensive dispossession, Hawaiians enjoy longer lives than other Polynesians, including Maoris, an outcome deeply disconcerting to Maori and pakeha self-images. American Samoans live longer than their cousins in independent (and culturally conservative) Western Samoa. When Kunitz places these data together with the evidence for native Americans, they support a strikingly counter-intuitive argument that universal health services may not best serve the needs of ‘fourth world’ populations. They also underpin the profoundly unsettling thesis that many problems do indeed respond to the therapy of throwing money at them.

This important book bristles with arresting observations which serve as persuasive arguments for blending biomedical and ‘social’ perceptions. It should be required reading for policy-makers, and social scientists will find it disconcerting and liberating.

References


Donald Denoon
Division of Pacific and Asian History
Stephen Kunitz, of the Department of Community and Preventive Medicine, University of Rochester, New York, writes extensively on demography and epidemiology and contributes significantly to the understanding of the health of indigenous people in the United States and Australia (Kunitz 1983; 1986: Kunitz et al. 1994). In the book under review, he has studied an epidemiological and demographic topic that has long awaited attention. Previously, it was assumed that the health patterns of indigenous peoples would reflect those of the general population, that is, they would follow the models described as the demographic and epidemiologic transitions (Omran 1971:533). Populations pass through a number of stages in the decline from high to low mortality: the first stage is that of pestilence and famine; the second, of receding epidemics; and the third is the stage of degenerative and man-made diseases (Hugo 1986:23). Kunitz rejects these models, however, because he believes that it is likely to be more useful to understand in detail the myriad ways in which different causes of morbidity and mortality in populations are affected by social processes, rather than to strive to build grand theories (pp.4-5).

Kunitz develops his own theory to explain changes in indigenous people's epidemiological and demographic patterns over time. Disease and Social Diversity explores the impact of European contact on the health of the indigenous peoples of North America, the Pacific and Australia. Kunitz theorizes that disease patterns in populations may be understood by recognizing not only the social, political and cultural contexts but also the biology of the diseases in the peoples studied. In rejecting heuristic models Kunitz focuses on local-historical knowledge of time and place, claiming them to be crucial in understanding the morbidity and mortality of particular groups and diseases.

The book is designed to study the importance of federal structures (both macro- and micro-social structures) balanced against a set of criteria. Kunitz’s major contribution to an understanding of indigenous health is that European impact on the health of the indigenous peoples in America, Polynesia and Australia varies widely. I look at how he constructs his theory by examining briefly the presentation of material on the United States, Polynesia and Australia.

Data used by Kunitz from the United States reveal that early records are sparse. The paucity of records meant that he resorts to archaeological evidence as a means of establishing the ethnological past. Demographic assumptions, likewise, are used to bridge the lack of written documentary sources. Elements of the pre-contact social structures, such as habitat size and location features, are adopted as a way of explaining group partnership pairing, kinship arrangements, modes of producing group livelihood and, finally, group mobility.

Kunitz compares the Navajo and Hopi peoples, two groups that were in contact with each other for two or three centuries before the mass European immigration of the eighteenth and nineteenth centuries. In comparing the two indigenous groups the author shows that the Navajo are special because they exemplify the fact that disease did not afflict all populations in the same fashion or to the same degree and that to invoke disease as the cause of the universal decline of New World populations in the absence of other factors is to oversimplify (p.142).

In various Hopi and Navajo groups Kunitz searches for diversity. Using comparative methods, he focuses on indigenous culture and group health, but ‘...holding constant the
political, economic and physical environment and... differences in culture [between the two
groups](p. 120). Now living on Indian reservations in Arizona and Utah, the Hopi
population increased from 2,500 in the mid-nineteenth century to 3,000 in 1930. (Kunitz re-
employs this feature when observing the resurgence of the Queensland Aborigines from the
1820s to 1950s.) No movement off the reservations occurred until after World War II, and
6,601 Hopi Indians were counted in the United States census of 1980 (p.127). By 1990,
7,061 Indians were enumerated on the Hopi land. The author declares that
despite the difficulties of enumeration and definition, the pattern of population
growth over... 150 years is reasonably clear: stagnation and even decline through
the second half of the 19th century followed by a fivefold increase from about
1900 to 1990 (p.127).

Kunitz dismisses fertility decline as both a route to nineteenth century stagnation and the
cause for population decline (p. 142).

The Navajo, Kunitz explains, have a different past from the Hopi. For example, in the
late nineteenth century, an estimated 10,000 Navajo remained free. In 1930, the population
had doubled and by 1960 had further increased to 90,000. In 1990 the total was 215,000,
showing that they differed in their demographic history from all other Indian groups; there is
no evidence that the Navajo ever suffered the population decline of other Indians. The
reasons include stable food supplies, early cessation of hostilities from other Americans,
geographical dispersion and, finally, social stability related to their return to homelands as
early as the 1860s (Johnston 1966, cited in Kunitz, p. 129). This form of diversity can be
shown in other aspects of Hopi and Navajo social structures over time.

The Navajo and Hopi exhibit different patterns of fertility, morbidity and chronic
disease. For example, the Navajo increased tenfold while the Hopi increased fivefold in the
past century. In addition, although Hopi fertility in the nineteenth century was higher, child-
survival rates were lower: infertility and subfertility can be dismissed as a factor in population
decline (p.132). Similarly these two groups were affected differently by epidemics, at least in
the late nineteenth century (pp. 132-134, Tables 5-3 and 5-4).

Moreover, differences in habits associated with human waste and hygiene practices
meant that

Different living conditions accounted for the differences in mortality from both
epidemic and endemic infectious diseases...patterns of child mortality and
fertility varied in ways...associated with ecological adaptations ...

The fertility differences do not accord with the high levels of sterility suggested
as being among the major determinants of population decline, for the population
that was declining had a higher fertility rate than the one that was increasing
(pp.134-135).

Cultural factors, old and modern, influenced fertility. Traditional contraception was not
a factor in itself, but with modern contraception, and the number of mothers reaching higher
levels of school, effected fertility decline, in particular after the Second World War.

Following the Second World War, mortality declined markedly in Hopi and Navajo
groups, so that ‘...noninfectious and man-made conditions... [came] to dominate the
epidemiological regimes of each population’ (pp. 136-137). In addition, infant mortality
dropped dramatically. For example, the Hopi infant mortality rate had declined significantly
to 11.4 per 1,000 live births by 1968-69 and the Navajo rate was 31.5 per 1,000 live births.
At the same time accidents accounted for half of all deaths in each population, perhaps half of these being motor vehicle related. And liver diseases caused by alcohol consumption played an important role. Kunitz discusses the complications of cirrhosis and epilepsy by alcohol addiction (pp.137 - 141). The Hopi and the Navajo themselves present different ideological explanations for these chronic conditions.

According to Kunitz, this is where cultural factors that influence disease ideologies take on a life of their own:

The contrasting historical and contemporary experiences of these two neighboring peoples therefore indicate that in regard to both acute infectious diseases and chronic diseases, the concept of 'natural history of disease' may be misleading. The epidemiology of acute infectious diseases, whether epidemic or endemic, and chronic diseases, whether infectious (tuberculosis) or noninfectious (epilepsy) all are shaped in important ways by the social context in which they occur. It is only by understanding this context that one can understand morbidity and mortality in their full complexity (pp. 143-144).

I now turn to the Pacific to see whether, in the face of European contact, epidemiologic and demographic structures influenced Polynesian peoples as they did the Hopi and Navajo. There is little doubt that European contact had some immediate impact on the population, but there is evidence that the population decline was under way before European contact. In any event,

For more than a century there has been a conviction that the peoples of the Pacific have experienced major losses at least since the time of first European contact [or] ...even before contact...Explanations have varied. Epidemics introduced into virgin-soil populations by European explorers and colonists are common to virtually all of them. Declining fertility as a result of declining...[social morale due to] disruption of traditional social organization and culture, or as a result of venereal diseases...(p.44).

Here the author covers the contradictions inherent in the historic models of traditionalism and modernism (such as the Mead and Freeman debate); the different experiences of the Maoris and native Hawaiians which affected mortality and, finally, the differences in social and economic arrangements leading to similar health outcomes.

Similarly, Kunitz combines Tongan, Samoan, Maori, Hawaiian, Tahitian and Marquesan population trends as a way of comparing total populations over time. The demographic trends indicate that population decline was not universal. There is wide agreement that the large decline in the Hawaiian population took place after 1780. The estimates are disputable, the contact population being placed somewhere between 250,000 and 1 million. Kunitz errs on the side of conservatism and prefers the lower figure. Whereas warfare, epidemics, and subfecundity due to venereal diseases are blamed for the decline of populations, he asks how the demographic patterns from 1790 to the 1980s can best be explained and favours an explanation that earlier population declines are not supported by evidence. ‘The Hawaiian, Maori, and Marquesan populations dropped , and the Samoan, Tongan, and Tahitian populations stagnated but did not fall substantially if at all’ (p.49).

Further distinctions are that the European and American settlers ‘dispossessed and demographically overwhelmed’ the indigenes of both Hawaii and New Zealand, while Samoa, Tonga and Tahiti were colonial outposts only, with larger indigenous than European
populations (p.49). Settler capitalism\textsuperscript{1} epitomized New Zealand and Hawaiian settlements, which began as garrison outposts of Europe. Also, neither had a dependable product with which to exploit indigenous labour. Incidentally, these two indigenous groups found it impossible to prevent settlement occurring, for with the settlers came pastoralism followed by power over land and an administration that protected the new status quo. Prosperity for both settlers and their administration was greater than expected and was supported by a market based in Europe. In additions, plantations and sheep grazing standardized production with imperial control dominated by class structures, and production that engendered dependence on imperialism. And, finally, they both expanded their colonies to cash cropping and agriculture, thereby creating new forms of peasantry (pp. 49-50).

Migration of Europeans and Asians triggered a catastrophic population decline by introducing exotic diseases such as influenza, measles and tuberculosis, and creating new epidemic infectious pools where none previously existed. These two models combined to change social conditions that affected Polynesian population and, coupled with the loss of land, directly affected women's fertility and fecundity. What were the consequences of these historical population and health patterns for traditional and modern life?

Kunitz rejects, to some degree, the Toennies sociological model which explains the transformation from Gemeinschaft, typified by face-to-face relationships, to Gesellschaft or impersonal mass society, typified by bureaucracy, standardization and mass political structures (Nisbet 1967; Grew 1977). He is concerned that the indigenous island groups he deals with suffer from the problem that the model presented does not account for the lack of transformation. For example,

The problem is that the communities that are said to be traditional do in fact depend heavily on subsistence activities similar to those practiced in past times, but the whole context in which these activities occur is so changed that to describe the villages as traditional may be misleading (p.56).

These perspectives, he declares, are underpinned by social evolutionist assumptions. The difficulty of using the dialectical model of modern and traditional occurs because ‘...what we may be seeing instead is two different patterns of adaptation to two different forms of colonialism and social and economic change’(p.61). Kunitz then looks at what he calls 'distinctions in the Fourth World' where he highlights sub-differences between Hawaiians, Maori and other Polynesian experiences with settler capitalists, health and emergent dependence resulting from incorporation into the 'Welfare State'. In concluding, he focuses on theories of biological, social and economic determinism.

In doing so, Kunitz rejects William McNeill's claim that ‘...the impact of European contact on the peoples of the Americas and Oceania was uniformly cataclysmic in regard to population size’ (pp.72-73). Similarly, he points out the unreasonableness of leading his readers to conclude that contact with Europeans did not lead to widespread population decline (p. 73). He then turns to an analysis of 'settler capitalism' in Australia and its impact on indigenous health in three periods, 1820 to 1900, 1900 to 1967 and finally, from 1967 to 1989.

Abandoning the comparative model, Kunitz maintains his particularism toward Aborigines in Queensland (pp. 82-120). He investigates first, the idea that it was not disease acting alone that reduced the population but conscious genocide, destruction of indigenous mainlanders' habitats, starvation as well as disease; and secondly, that life expectancy and health failed to follow Amerindian and Maori trends because of Australian colonies' dynamics.\textsuperscript{1} For the term ‘settler capitalism’ Kunitz acknowledges Denoon 1983: 217-224.
monopoly over the lives of Aborigines. After 1901 the member states of the federation maintained that monopoly. Kunitz provides evidence of environmental destruction and genocide caused by starvation and introduced diseases (pp. 82-114).

This is an important book because it brings indigenous people into the debate about colonialism, imperialism and historiography. In this regard Kunitz opts for a perspective from which indigenous people are seen as more self-contained than in other models or previous sociological accounts. He attempts to explain, through the examples of health, what happened to indigenous people as Europeans came to dominate their worlds; and he rejects large models which, he argues, fail to account in a standardized way for the differences in culture and geography that safeguarded populations against epidemics and decline. There are problems in the way in which the author has rejected certain established paradigms that have previously been used to explain social processes. Nevertheless, this should provide for lively exchanges between scholars who, in the Kuhnian sense, maintain them as the accepted paradigms (Kuhn 1970). The book has scholarly footnotes, appendices and an index; it would be ideal as a university text for students studying history, anthropology, demography or epidemiology.

References


Gordon Briscoe
History Program, RSSS
Australian National University.


Health Care for the Poor and Uninsured is based on papers prepared for the Second Annual Conference on Health Care for the Poor and Uninsured in the United States and originally published in the Journal of Health and Social Policy, Volume 3, Number 4. It is a very slim monograph but, nonetheless, an important one which focuses on the promotion, coordination, and financing of health care services for poor and uninsured people. It provides information on strategies and programs that really work, and describes techniques to promote access to health services, innovative approaches to public-private collaboration in the delivery of services, financial strategies of health maintenance organizations, and the formation of foundations to fund health-care delivery. The concentration is primarily on successful programs for pregnant women, infants, and children.

This is a successful monograph on many levels. However, the one that appeals to me most is its open and frank discussion of the lessons learnt from programs and strategies developed to alleviate somewhat the problems of health care accessibility and affordability. This is refreshing and makes a significant contribution both to the literature and to current debate on those issues in the United States, as opposed to simply providing further diagnoses of the problem of the lack of health care for the poor and uninsured.

Some of the topics addressed in the monograph include the effective use of nurse-practitioners and midwives to provide prenatal care, referral systems which promote the coordination of public and private-sector service delivery, hospital financial support of State screening programs, aggressive outreach programs to reach special populations, factors influencing family selection of a health care provider, new approaches to funding long-term care, and the use of outreach clinics and a co-ordinated referral system.

This is a solid monograph and I highly recommend it as required reading to all policymakers and professionals interested in developing effective programs to help alleviate the health-care problems in the United States, particularly by implementing strategies for delivery of health care services to the poor and uninsured.

The text of Health Policy and the Disadvantaged was originally published in a slightly different form as Volume 15, Number 2 of the Journal of Health Politics, Policy and Law. The text is a series of essays on the soft underbelly of the American health system, the treatment of that country’s disadvantaged. These essays examine public responses to health crises and they attempt to chart the immobility of United States health policy in the recent past and point to its disastrous consequences for the 1990s. The essays focus on particular needs of some of the disadvantaged groups in American society: the elderly, children, people with AIDS, the mentally ill, the chemically dependent, the homeless, the hungry and the medically uninsured.

Taken as a whole the book boldly points out the serious problems related to health care for the disadvantaged in American society and the inadequacies of the American health care system that contribute to a continuously worsening situation in the delivery of health care to disadvantaged groups. It is a depressing story, but nonetheless a compelling one that provides, in a single place, solid analyses of the direct correlation between low socio-economic status and lack of political influence on the one hand and health care access on the other.

This book is essential reading for all parties interested and concerned about health care delivery and policy in the United States, particularly as it relates to the disadvantaged. Perhaps the only shortcoming of the text is its lack of specific recognition of the issue of race, although race is indeed the hidden story in the text. However, some attempt is made to deal with this shortcoming through the book’s epilogue which states, among other things, that:

In every chapter, the data create the same portrait: there is deprivation in many quarters, but ‘minorities’ suffer a disproportionate share. Here is a potent
American dilemma which is often obscured (as it is here) by the functional
categories of our policy discourse. Whether the topic is poverty among the aged,
the risk of homelessness among children, the incidence of drug abuse, or the raw
statistical probability of ending up in jail (now approaching 3 percent for males),
the portrait of black America that leaks out of collections such as this is
extraordinarily grim (p. 194).

This accurately captures both the book’s contents and the issues related to health policy
and the disadvantaged in American society.

Kempe Ronald Hope, Sr
UN Adviser and Professor of Development Studies,
University of Botswana

Knowledge, Power and Practice: The Anthropology of Medicine in Everyday
Life. Edited by Shirley Lindenbaum and Margaret Lock. Berkeley: University
of California Press, 1993. xv + 428pp., plates, index. [awaiting price info from
publishers.]

This book of essays is edited by two anthropologists whose writings have made a major
contribution to integrating the subdisciplinary area of ‘medical anthropology’ with theoretical
developments in the discipline as a whole. Knowledge, Power and Practice is based on
papers presented at a 1988 symposium sponsored by the Wenner-Gren Foundation for
Anthropological Research, the aims of which were to evaluate the development of medical
anthropology and to explore the possibilities of using health-related research to link ‘three
domains of anthropological inquiry which are often treated separately: human biology, the
cultural construction of knowledge, and relations of power’ (p.ix). In their preface, the
editors suggest that medical anthropology has not fulfilled its theoretical promise because
practitioners have been uncritically wedded to biomedical categories of thought. This volume
endeavours to define medical anthropology in a way that places it in the mainstream of
contemporary social science and cultural studies. Thus the subject matter of medical
anthropology is restated as ‘a study of the creation, representation, legitimization, and
application of knowledge about the body in both health and illness’ (p.x).

The book is organized in five parts which encompass this scope of interest. In the first
part, ‘The Cultural Construction of Childbirth’, cultural constructionist approaches are
broadened to include discussion of contested notions of risk in childbirth and of the power
relations in which childbirth practices are embedded. The papers focus on Northern Indian
village midwives (Jeffery and Jeffery), isolated Inuit communities in the Canadian Northwest
(Kaufert and O’Neil) and a New York prenatal diagnosis laboratory (Rapp).

Part 2 is an exploration of ‘The Production of Medical Knowledge’, with papers that
well exemplify the power of ethnographic methodology to penetrate the micro-worlds of
medical school (Good and Good), post-traumatic stress disorder clinic (Young) and
emergency psychiatric unit (Rhodes), and engage with knowledge production as practical
understanding in these ‘fields of power’ (p.80).

In Part 3, ‘Contested Knowledge and Modes of Understanding’, the emergent themes of
difference and contestation in medical knowledge become a primary focus. In two papers
which substantively deal with widely differing contexts of action, psychiatrist as expert
witness, and researcher in a New Guinea village, the physician-anthropologists Fabrega and
Lewis discuss the contradictions of medical objectivizing and cultural relativizing engendered
by their different sets of professional practices. The chapter by Frankenberg throws another light on these contradictions by reflecting on the differences between epidemiological and anthropological approaches to health and illness, and the possibility of a common ground between them. Pearce's chapter, which could have more effectively concluded this section than begun it, provides a foil to the ‘difference and contestation’ scenario by describing the Yoruba (Nigeria) situation where lay medical knowledge is creatively reworked through networks and groups which may at various junctures include specialists who do not have radically different frameworks of understanding from their clients (p.157).

Certain theoretical traditions in medical anthropology have long been concerned with the experience of illness in relation to medical categories, and the two papers which constitute Part 4, ‘Constructing the Illness Experience’, take up this problem with quite different material. Estroff argues for the ‘fusion of identity with diagnosis’ (p.245) that constitutes chronicity, and the implications for the social identity of the patient when intersecting with institutional health and welfare arrangements. Briceno-Leon describes a community-based intervention for Chagas disease that is based on residents' understanding of their problems rather than disease categories.

The last part of the book, ‘Body Politics - Past and Present’ provides the most thorough engagement with post-modernist thought, which surprisingly is somewhat neglected in earlier chapters. The essays on colonial medicine in nineteenth-century South Africa (Comaroff), ideologies of the menopause in North America and Japan (Lock), and recent scientific discourses about body, self and the immune system (Haraway), all provide compelling arguments for ways in which the body is contested in medical practice, as well as for the cultural construction of the ‘biological facticity’ of the body.

While there is some unevenness in the various authors' execution of their original brief to theoretically integrate biology, culture and power, this is only to be expected in a volume of this type. All the papers are interesting and of high quality, and the volume is well edited with succinct introductions to each section. The extent to which some of the papers were able to bring an anthropological understanding to biological knowledge was impressive. As the editors point out, this proved the most difficult achievement for the authors (p.303), a not uncommon problem in medical anthropology generally. The discussion of power relations from various theoretical perspectives was another significant contribution, redressing the inadequacies of much of the earlier work in this field. This volume fulfils its aim of furthering research on health, illness and the body which is at the forefront of critical thought in the discipline of anthropology.

Linda Connor
Department of Sociology and Anthropology
University of Newcastle NSW.


A reviewer concerned with the policy implications of social science research on sexual behaviour inevitably views a collection of papers by demographers and anthropologists with priorities and biases different from those of the authors' disciplinary peers. Thus, where demographers are particularly concerned with numbers of sexual partners and anthropologists with the cultural shaping of sexual behaviour, someone asking about the policy significance of their work may come armed with a critique based on other concerns.

Health Transition Review
The 18 papers published here are a selection of those presented to a seminar in November 1990 organized by the Committee on Anthropological Demography of the International Union for the Scientific Study of Population. This was apparently the first gathering of demographers concerned with the study of sexual behaviour related to HIV, though it was merely one of many on the same subject which have brought together anthropologists (e.g., those edited by Ralph Bolton and by Gil Herdt and Shirley Lindenbaum) and wider groups of social scientists (e.g., the series edited by Peter Aggleton).

The papers vary widely in their focus. One deals with epidemic modelling and another with historical comparisons of stigma attaching to previous epidemics of STDs. Three are broad ‘situation reports’ on India, Sudan and Uganda. The other 15 are concerned with varying mixes of quantitative and qualitative data on sexual networking, ranging from shallow KABP surveys to studies with considerable ethnographic, historical or analytical depth.

Tim Dyson’s introduction provides brief summaries of the papers and draws out five common points. He argues the need for ‘broad country situation assessment studies’, but those presented here are based on generalizations and assumptions which offer only a very superficial foundation for policy prescriptions. Second, he signals the presence of significant methodological contributions in the quantitative material, but these are not specified. Third, he states the need for marrying quantitative and qualitative approaches, and fourth, the need for focusing on communities as well as individuals. Finally he notes the tendency to increased linkages between research and policy and program development.

Dyson also discerns in several of the papers evidence of a global trend in the last 40 years towards greater coital frequency and more lifetime sexual partners, and speculates on the impact of increased human mobility, urbanization, the decline of customary restraints and ‘the rapid and sustained communication of new ideas on what constitutes acceptable patterns of sexual behaviour’. All of these speculations deserve further attention.

Roy Anderson’s paper sets out a model of the transmission dynamics of STDs with an assertion of the responsibility of social scientists to gather quantitative behavioural data to fit the models of epidemiologists. In relation to HIV, epidemiologists have made signal contributions to understanding the history of transmission, but have not provided useful guidelines for anticipating future developments. Some of the assumptions built into Anderson’s model, about the static nature of sexual behaviour within any given population and the ‘extremes’ within which behaviour might vary, raise doubts whether social research is best guided by epidemiologists.

Many of the other papers by demographers are largely concerned with quantitative presentations of sexual networking, defined by I.O. Orubuloye and Jack and Pat Caldwell as ‘the number of different sexual partners of each individual’. Where, as in their paper, there is a historical dimension available, there is evidence of the rapid change in behaviour in recent years which is only surmised in other studies. Where there is merely counting of behavioural instances without an underlying body of theorized cultural and historical understanding, as in the WHO/GPA surveys, there is little useful information and only paltry conclusions to be drawn despite a very considerable investment of resources.

Those studies which are informed by substantial ethnographic research are of greater interest since they invoke the cultural contexts within which sexual activity takes place, and the changing meanings of sexual relations. Here the papers on homosexual men in urban Brazil (Parker) and Chicago (Herdt and Boxer) are particularly informative, because of the cultural analysis on which they are based and their awareness of policy implications. They also have the advantage of drawing on a theoretically informed discourse which has developed among social scientists concerned with both homosexuality and HIV. These are presented in the publications of the annual conferences on Social Aspects of AIDS in London.
and the widely circulated monographs of the Social Aspects of the Prevention of AIDS project and its successors at Macquarie University in Sydney, which have set new standards for research into sexual behaviour, standards now being applied in the later series of WHO/GPA studies being co-ordinated by Aggleton.

The broad approach taken by some anthropologists concerning sexual transmission of HIV is best represented in this collection by Brooke Grundfest Schoepf, who reports on the work of a team of medical anthropologists, CONAISSIDA, in examining the sociocultural, economic, political and cognitive aspects of gender and sexual relations in two cities in Zaire. Her review of the literature on sex in Africa provides a lucid critique of the predominant single-discipline approaches and the superficiality of many assumptions and inferences. Her discussion of the complex meanings of commoditized sex in Zaire is particularly useful in displaying the limitations of simple quantitative surveys of ‘prostitutes’ in African cities. Her paper, placed at the end of this collection, may provide an appropriate introduction to the next generation of studies sponsored by WHO/GPA and reported by IUSSP’s Committee on Demographic Anthropology.

J. A. Ballard
Department of Political Science
The Faculties
Australian National University

Caring for Health: History and Diversity. Edited by Charles Webster.
Paperback A$39.95.

This collection of essays forms the sixth book in a set of eight serving an Open University course on the history of health and ill-health. It covers the period 1500 to the 1990s, with about three-fifths of the contents weighted towards the twentieth century. English experience predominates, but there are useful discussions of health problems in central Africa and India.

The essays are contributed by experts in their fields: the information and interpretations are crisply presented and up-to-date. The coverage is remarkably extensive, given the small size of the volume: voluntary hospitals, domestic treatments, sickness insurance, pharmacy, infant mortality, smallpox, salmonella. Only two issues seem to be underplayed: one is the role of basic demographic factors, particularly in the chapter on the Industrial Revolution; and occasionally authors have yielded to the weight of evidence and say more about doctors and sanitary officials than about patients.

Readers of this journal will be struck by the many contrasts the authors note between health policies in different nations over time. The tables in Chapter 9 are especially instructive; not least that at page 179 showing Australia way above its OECD partners in the proportions of appendicectomies performed in 1980.

F.B. Smith
Research School of Social Sciences
The Australian National University

In terms of this journal, this book is both exciting and frustrating. Its interest derives from its thorough exploration of traditional interpretations of health and illness in rural Egypt and its demonstration that these explanations are still believed by most people. Clearly, they must militate against the effective use of modern medicine.

The frustration comes from Soheir Morsy’s failure to devote much attention to modern medicine. There is a brief mention of modern private doctors and a government clinic in a large village only three kilometres away, and nothing more until modern medical services are briefly discussed on pp. 173-176. Yet the Egyptian infant mortality rate has dropped from 200 to 65 per thousand births over the last 40 years while expectation of life at birth has climbed from 42 years to 59 years. It might be assumed that modern medical services (called ‘cosmopolitan medicine’ in the book) had something to do with it. Indeed, we are suddenly told on p. 176 that modern medical services are the first choice, following home treatment, in three-quarters of the cases of sickness. The villagers choose it because they believe that it is the most effective and they manage to reconcile the way they think it works with their old belief system. One would like to know if these ancient explanations for disease slowed down the seeking of treatment or made its use less effective. If Morsy’s villagers had fully concurred with the biomedical explanation of disease and sought modern medical treatment at once, would they now have a life expectancy ten years greater, and half the mortality rate? The vaccination of children is apparently almost universal, but the explanation for its acceptance is inadequate.

The treatment of traditional health beliefs and behaviour is extremely good and entertaining. Of particular interest is how ancient beliefs were said to have support from the Koran, and how 1,400 years later they were similarly reconciled with the modern world. The treatment of gender is particularly good, and there are fascinating accounts of how the powerless improve their position by becoming possessed by certain forms of ill-health. A contemporary parallel to this is women rejecting the national family-planning program by forgetting to take the pill, for they know that the only way they can establish a nucleus of power is through motherhood. Interestingly, both the circumcision of boys and the clitoridectomy of girls is referred to in Arabic as ‘purification’. Although the author refers to clitoridectomy as a way of controlling female sexuality, it is not clear from her own evidence that this is quite the way the villagers see it.

Egyptian females are certainly disadvantaged. The author attempts to provide quantitative proofs of this by demonstrating an infant mortality rate for females 18 per cent above that of males. This is achieved by showing that during the year eleven more girl infants died than boy infants, but the proof depends on our acceptance that 48 fewer boys were born during the year than girls. One wonders whether there was greater shame in admitting the birth of a baby whom they failed to keep alive in the case of males. For anyone who has carried out field work in Sub-Saharan Africa and south Asia, there are haunting similarities in explanations of ill-health, even in such specific matters as the ‘evil eye’. One is left wondering whether such explanations are the obvious ones in a non-scientific culture, or whether there was an ancient system of beliefs that encompassed much of the Old World.

Pat Caldwell
Health Transition Centre, NCEPH
The Australian National University

This is a fascinating book which should be compulsory reading for everyone engaged in the effort to reduce Third World mortality levels. It is written with an identification with the kind of health activities which are likely to be most effective in reducing mortality levels in poor countries, namely grass-roots-level, free or cheap, community-based and democratic health services often described as primary health care. It is edited by three of the great figures in the field: Jon Rohde of UNICEF, known for his work in Bangladesh, Indonesia, Haiti and India; Meera Chatterjee with her interests in women and health in India; and David Morley, with a long subsequent career, but remembered in Nigeria and elsewhere for his under-seven child health clinics in Ilesha. They are joined by 25 other authors who form the backbone of the attempt to achieve good health for all by 2000 or whenever. The book is full of prescriptions for what will probably work, and honest, ruthless analyses of why they did not work better.

Yet, for a social scientist and an editor of this journal devoted to examining the social and behavioural contribution to health, the book is fascinating too for its assumptions and omissions. It is written, perhaps understandably in view of an authorship which is almost entirely medical, from a medical viewpoint. Good health is to be attained by better medical, hygiene and sanitation programs, usually designed elsewhere even if the collaboration of the community is earnestly sought. The approach is largely top-down, even if disguised by the fist being in a kindly, caring and co-operating glove. Cultures are not treated as being significantly different. Traditional medicine is rarely mentioned. The kind of thing dealt with in Health Transition Review and in the Forum in this issue does not appear. Little appears about individuals' behaviour, motivation and health philosophy, and nothing on the locus of responsibility, even if there is much about co-operation, collaboration and the galvanizing of community effort. Education is treated as children's right but usually not as something that will produce a different sort of adult with major implications for the health — even in the absence of health services — of themselves and their children. Cultural change is rarely seen as going beyond participating in health provision, digging wells and disposing of waste and not as a process — for good or ill — of Westernizing the world. Some of the more radical authors deal with change or desired change, but their interests are confined largely to the revolutionary political changes that will share wealth and opportunity. The major theme of the book, and not one to be undervalued, is how to have the people with us rather than against us or indifferent.

For the health transitionist, the most interesting part of the book is the first section, a quarter of the book, on community health and development. Anthony Klouda, drawing on his experience in Tanzania and Malawi, maintains in the first chapter that 'Prevention is still more costly than cure'. This may well be so, but prevention in his terms is removing the risk-creating conditions of poverty, landlessness and unemployment. These are ultimate aims to which most of us could subscribe, but he has no half-way house and offers an analysis which would have forbidden Sri Lanka or Kerala to achieve the low mortality they now enjoy. Being a humane person, he points out that growth surveillance programs embarrass families by singling out those who have children with unsatisfactory growth (pp. 17-18), but little attention is given to the fact that this embarrassment may be the key factor in reversing the situation. Admittedly, the author later argues that it is usually impossible to reverse the situation, because the family is so poor that the extra food cannot be afforded or the mother cannot spend time at home with the children, and hence the programs are useless (pp. 24-26).

Many of the self-help community projects concentrate on matters that produce better environments. Mary Johnson's chapter on Indonesia is of a directed-democracy program.
typical of that country, although in this case the work of a non-government organization which encouraged ‘self-introspection’. Toilets were dug, fences erected, fruit trees planted and roofs repaired. At least from the author's — and the reviewer's — perspective the village became a pleasanter place to live in and probably a healthier one. One wishes that figures would substantiate the last assumption. Patricia Nickson's description of community development in Zaire is not dissimilar.

Edgar Mohs's record of Costa Rica's achievements over the last 80 years is accompanied by figures. Costa Rica's achievements in education, economic development and health have been impressive. It is difficult to disentangle these three elements, but clearly a democratic efficient health system has been an essential part, but so, as he points out, has been social development which he identifies with peace and democratic stability and programs of social aids (p. 385), but which may well have had increasing education levels as its most health-effective force.

A fascinating bonus, only partly linked to the main theme, is Alfred Sommer's account of the battle against professional conservatism and the bureaucratic timidity of WHO, reluctant to bring recognition for the research showing the full role played by vitamin A and hence the possibility of intervention programs where many suffered from its deficiency.

This is, in terms of the establishing of grass-roots, caring, effective Third World health programs, a splendid book. The authors are interested in specific programs of induced social change, but surprisingly uninterested in the broader currents of cultural and social change as we move inevitably towards a global society, and extraordinarily uninterested in the spread of schooling and its implications for health.

John C. Caldwell
Health Transition Centre, NCEPH
The Australian National University, Canberra


This edited volume is the tangible outcome of a conference on women’s health that was organised by the National Council for International Health in 1991. Chapters deal consecutively with health and poverty, health and women’s roles, nutrition, infection, family planning, abortion, mortality, violence, mental health, access to care and quality of care. A concluding chapter discusses how to learn from women themselves. The emphasis is largely on poor countries, where women’s health is worst. Many useful references are given and the subject index is comprehensive. Too many references, however, are unpublished conference papers.

The full catalogue of horrors is here laid out: dowry deaths in India; female genital mutilation in parts of Africa; unsafe abortion everywhere. Yet to conclude, as the book does, that an answer lies in (to use the current jargon) ‘bottom-up’ rather than ‘top-down’ programming, is to ignore many uncomfortable realities. Female genital mutilation, for example, is portrayed as a male plot which African women themselves have begun to organise themselves to oppose. Yet, this ignores the fact that women themselves are able to marry off their daughters and granddaughters. If one asked ordinary women themselves, this is part of what they would say; and would one then decide to leave this difficult topic alone?
The weakness of the book’s conclusion results in part from its structure as a compendium of behaviour or experiences that Western or Western-educated women find shocking. Thus, the short account of female circumcision appears in the chapter on violence against women, sandwiched between sections on violence against refugee women and discrimination against girl children. This mode of organization has rhetorical power, but leads nowhere but to calls for action, for further research, and for listening to the women involved. It does not enhance our understanding of the social and cultural environments that support or promote such diverse acts of ‘violence’.

The collection has another basic flaw, which is that it describes a world populated only by women. Men, where they are mentioned at all, are agents; otherwise, they are largely invisible. Presumably, the logic of their omission is that the topic was the health of women, not men. Yet, there are at least three problems with ignoring men completely. The first is that, even in the poorest countries, it is getting harder to find any instances where age-specific mortality rates are higher for women than men. Women do generally live longer than men; and to counter this observation by describing the often unenviable plight of, say, the Bangladeshi widow, ignores the basic fact that she is alive and her husband is dead. Secondly, we cannot understand the world by focusing our attention on the unpleasant experiences of only half its inhabitants. Thirdly, men have a pretty tough time too. This fact is most irritatingly ignored in the first chapter whose logic seems to be that, since ill-health is an outcome of poverty, and women are commonly assessed as poorer than men, then poverty is a specifically female disease.

This ideological stance, although by no means unique to this compendium, is scientifically unhelpful. The reality is that, in many countries and even for the most abused wives and daughters, widowhood and orphanhood are likely to be catastrophes. Deploring these facts will not make them go away, nor will writing about health as though it were salient only to half the population. The end result is the sort of lobbying that now occurs in the rich countries, with interest groups declaring that breast-cancer research, for example, is poorly funded in comparison with AIDS research; or that men’s health has been ignored while health centres have been established specifically for women. Such divisiveness is unproductive, and it would be a pity to export it to the Third World.

In search of solutions we need to focus not on common outcomes, as this book does, but on common causes and precursors. This we cannot do unless we try to understand why certain modes of action make sense to the principals involved. We need to study not just women but societies. A volume such as this one needed the contributions of a few more social anthropologists.

Gigi Santow
Health Transition Centre, NCEPH
The Australian National University