What is Anthropology? Why should you study it? What will you learn? And what can you do with it? *What Anthropologists Do* answers all these questions. And more.

Anthropology is an astonishingly diverse and engaged subject that seeks to understand human social behaviour. *What Anthropologists Do* presents a lively introduction to the ways in which anthropology’s unique research methods and cutting-edge thinking contribute to a very wide range of fields: environmental issues, aid and development, advocacy, human rights, social policy, the creative arts, museums, health, education, crime, communications technology, design, marketing, and business. In short, training in Anthropology provides highly transferable skills of investigation and analysis.

The book will be ideal for any readers who want to know what Anthropology is all about, for school leavers seeking exciting and rewarding career directions, and for students coming to the study of Anthropology for the first time.

Veronica Strang is Professor of Social Anthropology at the University of Auckland. An environmental anthropologist, she has written extensively on water, land and resource issues in Australia and the UK, and is the author of *Uncommon Ground: Cultural Landscapes and Environmental Values*, *The Meaning of Water* and *Gardening the World: Agency, Identity, and the Ownership of Water*. 


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HEALTH IN A CULTURAL CONTEXT

Nothing is more fundamental to human life than health; there are major cultural variations in how people think and act on health issues, and all aspects of health—from the cradle to the grave—have an important social dimension. This is, in consequence, one of the major areas in which anthropology is applied.

Anthropological interests in health span both time and space: they focus on temporal change with studies of evolutionary biology; ideas about human genetic development; and analyses of the effects of historical changes on health and well-being. For example, Chapter 4 noted some of the health issues that arise when people shift from nomadic patterns of movement to settlement (Green and Iseley 2002). Boyd Eaton and Melvin Konner’s (2003) work looks back even further, to consider the mismatch between the diet and lifestyle of prehistoric humans (adapted genetically over millennia), and modern diets and lifestyles, which are the result of very recent and rapid changes. We need to understand ancestral lifestyles, they say, to see why modern humans suffer from chronic illnesses:

We have been investigating the proposition that the major chronic illnesses which afflict human beings living in affluent industrialized Western nations are promoted by a mismatch between our genetic constitution and a variety of lifestyle factors—diet, exercise patterns, and exposure to abusive substances... The genetic constitution of humanity, which controls our physiology, biochemistry and metabolism, has not been altered in any fundamental way since *Homo sapiens sapiens* first became widespread. In contrast, cultural evolution during the relatively brief period since the appearance of agriculture has been breathtakingly rapid, so that genes selected over the preceding geologic eras must now function in a foreign and, in many ways, hostile Atomic Age. (Eaton and Konner 2003: 52)

Other lessons can be learned from the past, too. Payson Sheets notes that archaeologists have found prehistoric crops, agricultural technologies and even medical remedies that can help to cure illnesses. For example, an archaeological analysis of ancient Mayan stone tools in El Salvador revealed that obsidian knives were 100–500 times sharper than the modern surgical razor blades and scalpels, creating cleaner incisions and causing less tissue damage. Archaeological knowledge about ancient Mayan production skills has therefore been drawn upon to make obsidian blades for delicate eye surgery (Sheets 2003: 108).

The application of anthropology in health is also spatial, with specialized research areas such as epidemiology, which considers how diseases spread through populations, and more generally, with the cross-cultural comparisons that are central to the discipline. There is much useful knowledge about health and medicine that can be shared cross-culturally. Although health care in the twenty-first century is heavily dominated by Western sciences, there are many other cultural models about what constitutes good health and how this can be achieved and maintained. Anthropology is therefore useful in translating and communicating different ideas about health between cultural groups, in a variety of contexts. For instance, Andrea Kielich and Leslie Miller work in the area of immigrant health care in America (where 800,000 immigrants arrive each year), and note the importance of understanding diversity in ideas about sickness and health. America absorbs over 800 thousand immigrants each year. ‘Each group of new immigrants brings a unique set of cultural beliefs about sickness and health, a vocabulary of medical terms, and, often, a medicine cabinet of folk remedies, challenging American physicians to use skills not typically taught in medical school’ (Kielich and Miller 1998: 32).

In the course of their work they run into Asian ideas about health as an equilibrium between yin and yang; African and Native American ideas about wellbeing as a form of harmony with nature; and, among immigrants from Spanish-speaking countries, ideas about good health as a correct balance of hot and cold. And, returning to the point that Eaton and Konner made about contemporary ‘modern’ lifestyles, they also find that ‘contrary to popular belief, most immigrants arrive here
in better health than their US-born counterparts — but their health deteriorates in
direct proportion to their length of stay’ (Kielich and Miller 1998: 38).

FROM THE CRADLE TO THE GRAVE
Anthropologists are involved in studying health at every stage of human life,
even before it begins. A fast-growing area of research is concerned with human
reproduction, in particular where this is technologically assisted, for example by
in vitro fertilization. This practice raises a number of complex social issues, as do
reproductive controls, such as contraception and abortion. In such areas, sensitivity
to diverse cultural beliefs and values is very helpful — one might say vital. For example,
Catherine Chiapetta-Swanson conducts research with nurses in clinics specializing
in genetic termination (an abortion that is carried out when genetic abnormalities
are found in a foetus). As she points out: ‘GT nursing is intense. It is one-to-one care
across a range of extremely sensitive procedures, which are emotionally and morally
charged for both patient and nurse’ (Chiapetta-Swanson 2005: 166). Her research
helped hospitals to improve their structuring and management of the process,
and to assist the people involved with more effective coping strategies. Human
reproduction raises other complex issues too, particularly when it is assisted, thus
Charis Thompson’s work in fertility clinics in California examines some of the tricky
questions raised about kinship and ‘chains of descent’ when egg or sperm donation
or surrogacy creates ‘third party reproducers’ (Thompson 2006a: 271).

Cultural differences are also the focus of Brigitte Jordan’s studies of women and
birthing practices. Her work with four different groups showed how these practices
depend on a range of cultural ideas about life and death, gender, power and authority,
and religion:

Jordan’s work opened up a whole area of research in applied medical anthro-
pology and, equally importantly, provided women, their families, and their
medical assistants with knowledge of alternative ways to situate the birth…
For many women, this research transformed the birth experience into a positive
and emotionally significant moment in their lives. (Jordan, in Whiteford and
Bennett 2005: 126)

As noted in Chapter 2, cultural variations are equally evident in approaches to
child rearing, and this is also an area in which ‘the long view’ is informative. Some
researchers look not only at the prehistoric, but also at the pre-human. For example,
Sarah Hardy (2003) works with primates in considering some of the fundamentals
of human behaviour in child rearing. She suggests that the stereotypical ‘Flintstones’
view of early humans, in which men are presented as ‘the hunters’ and women as ‘the
nurturers’, is wrong, and that the evolutionary record actually points to biological
and cultural mechanisms that engender cooperation in child rearing. She also looks
at contemporary human cultures where this model pertains, and extended family
members — both female and male — have a major role in raising children. Her
research emphasizes the importance of social cooperation in child rearing, both for
individuals and for society as a whole.

BUILDING BODIES OF KNOWLEDGE

Patricia Hammer

Center for Social Well Being, Peru

I first encountered anthropology by chance. I had enrolled in a body-building class at the local community
college, with the idea of getting into shape to apply for a job as a firefighter. While waiting to sign up for the
course, I began to peruse the teaching schedule, and was attracted by an offering entitled ‘Chinese culture’.
Although I had very little idea what anthropology was, I decided to take the class. The professor was Chinese
born and, faced with rural conflict, had fled to Hong Kong as a refugee. Eventually the family immigrated to
California where she studied anthropology.

In this initial exposure, I was amazed at the breadth of the discipline. With an interest in music I focused
my class paper on the history and styles of traditional Chinese music. My classmates selected themes that
included Chinese cultural systems of healing, early education, calligraphy, fishing and dinghy construction. Our
professor insisted that gaining a sensory understanding of a culture required that ‘you eat it’, therefore, after
our final exam, we all went out for a Chinese meal, with the professor guiding us through the dishes as well as
explaining Chinese dining symbolism and etiquette. The course was a fulfilling introduction to anthropology.

Extinguishing my firefighter ambitions and applying myself to undergraduate study, I resumed an earlier
interest in Spanish. I became aware of opportunities for ‘study-abroad’ programmes that would combine my
ambitions to acquire language skills and to experience a different culture and society. In my third year in
Courage is not the absence of fear, but the triumph over it. The brave man is not he who does not feel afraid, but he who conquers that fear.

During my graduate study I also looked at the work of other social science professionals, with an eye to developing a career outside academia. I was pleasantly surprised to find that when I inquired about projects with international non-profit organizations, as well as with state institutions, they were enthusiastic about my research, often inviting me to speak at workshops. I began sending my CV to international health organizations. Early one morning I received a call from a women’s reproductive health project coordinator in Lima. We spoke at length about effective participatory research, and soon I was flying off to Peru to start my first job as an international health consultant.

Since 1996, I have worked as an applied medical anthropologist, with ministries of health and education, and NGO projects, primarily in Peru and Bolivia. I am also the director of a rural institute dedicated to the promotion of indigenous healing knowledge and practices in the north-central Peruvian Andes.

Learning from other cultural groups allows us to question the practices that our own culture regards as ‘normal’. Elizabeth Whittaker observes that, ‘culture determines the way we have children and how we raise children… Rarely do we question our cultural traditions, especially when there are experts and expert opinions’ (Whittaker 2003: 38). Using evolutionary, biological and cultural perspectives, her work examines breastfeeding practices across cultures, and suggests that American approaches fail to acknowledge that mothers and infants form a biological pair not just during pregnancy, but also in the child’s infancy.

Mothers and infants are physiologically interconnected from conception to the termination of breastfeeding. While this mutual biological relationship is obvious during pregnancy, to many people it is less clear in the period following birth. In Western society, individuals are expected to be autonomous and independent, and this idea extends to mothers and their babies. Individual autonomy is a core value in our economy, society, and family life: even to our understanding of health and disease. However, it is not a widely shared notion, as more socio-centric concepts of personhood are very common in other cultures. (Whittaker 2003)
Many transitions in life have cultural importance, and there is a wealth of ethnographic research considering the diverse ideas and rituals that surround shifts into puberty, adulthood, marriage, birth, 'mature' status, professional advancement, retirement, and of course death. Each society handles these life stages differently, but all mark important transitional points, often with elaborate ceremonies that reveal core cultural ideas and values. These influence how groups manage not only childbirth and parenting, but also later stages, for example the care of the elderly. With the 'baby boomers' born in the 1940s reaching retirement age, greater attention is being given to the issues surrounding geriatric care. Anthropologists have been closely involved in work examining how old age is imagined and experienced in different groups; how people think about ageing; what kinds of activities they undertake in old age; and how different generations interact.

There is also considerable ethnographic research on institutions for the short- and long-term care of the elderly, such as nursing homes and hospitals. Robert Harman (2005: 312) comments that 'nursing home treatment is frequently unsatisfactory and sometimes inhumane', and he notes that a number of anthropologists have acted as advocates for the inhabitants of such institutions, or worked to influence policy. They have also contributed to the education of carers in institutions and at home, producing guidance videos and manuals, and organizing seminars and workshops for them.

LONG-TERM CARE

Sherylyn Briller

Assistant Professor of Anthropology, Institute of Gerontology, Wayne State University

I come from a family of urban teachers. My father taught for thirty years in the New York City public school system. While he truly made a difference in his students' lives, this job was very demanding. He often came home bone-weary and said, 'You can pick any profession you like, just don't be a teacher. It's too exhausting.'

Today, despite my father's warning, I teach anthropology at Wayne State, a large urban university in Detroit. However, I really love the job, especially teaching applied anthropology and preparing students for their future professional roles. On the first day of each course, I always tell students 'my story.'

As a twenty-one-year-old undergraduate anthropology major, I did not know what I wanted to do after I finished college, but I thought that I might work in a field related to aging. In my family there were many elders, including grandparents and great aunts and uncles. Some were childless and my nuclear family served as the 'children' and 'grandchildren' in their lives. I relished spending time with them and hearing their stories.

This strong interest in working with elders and oral history pushed me in the direction of gerontology, and my first job after college was working in a nursing home as an Activities Assistant. This was very anthropological,
It is also useful to understand social beliefs and values in relation to the diseases that often accompany (and sometimes precede) ageing. Ideas about cancer, disability, and dementia are critical in defining how these are treated or managed at a social level, and an awareness of 'under-the-surface' beliefs can often help in developing new ways to cope with health problems in these areas. Thus Jeannine Corell's (2004) work looks at different cultural models of illness, and how these affect recovery in breast cancer support groups.

Because of the discipline's cross-cultural utility, anthropologists are often employed to assist in the health care of elderly refugees and immigrants. Robert Harman notes research in several related areas: Elzbieta Gozdziak working on problems specific to older refugees and programmes designed to support them; Neil Henderson's development of ethnically specific Alzheimer's support groups for Hispanic and African Americans; and Kay Branch's work as an Elder Rural Services Planner for a Native Tribal Health Consortium in Alaska (Harman 2005).

As noted in earlier chapters, anthropologists also work with aid agencies, many of which focus on bringing medical aid to parts of the world (and diverse cultural contexts) where health care systems are failing. More often than not, a lack of resources for health care is coupled with difficulties in the provision of sufficient food and clean water.

**FOOD AND LIFESTYLE**

The anthropology of food has long been a major area of research. Ethnographers have focused on the social and cultural diversities with which human societies approach this central aspect of life, looking at the history of food; how food is produced, cooked and shared; what foods mean in different societies; how food is used in rituals; how food contributes to the construction of social identity and status; the use of food for medicinal purposes; and of course the various health issues relating to food security, nutrition and diet.

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**AN ANTHROPOLOGICAL JOURNEY**

Nancy Pollock

*Victoria University, Wellington, New Zealand*

My anthropological journey began in the Caribbean, but led me to establish my research in the Pacific, where I have been fortunate to benefit from the hospitality and tolerance of many host families who put up with my seemingly inane questions, fed me a range of foods, and shared times of shortage and times of relative plenty.

Many flights and boat trips have taken me through the skies and waters of the Pacific to islands that are each beautiful in their own way. The environment of each atoll and island provides a setting that challenges an outsider's understanding and necessitates local explanation. My fieldwork has followed two overlapping research interests, food habits as they affect health, and development. These two areas of research have led me to exchange information with many non-social scientists, particularly nutritionists, epidemiologists, lawyers and health physicists.

Food consumption was not a popular or accepted area of anthropological research when I wrote my Ph.D. dissertation in 1969, but it has come to the fore in the last 20 years. For me, collecting dietary data in an atoll community in the Marshall Islands provided a platform for subsequent field research and yielded a rich source of ethnographic data about social life on an atoll still under US jurisdiction. The data also presented interesting contrasts with later research on food habits in other Pacific island communities.

In the 1990s, a Wallisian colleague and I conducted research on Wallis and Futuna for the South Pacific Commission (as it was then) and the New Zealand Medical Council. One project focused on understanding obesity from a local perspective, where body mass index (BMI) is considered large by Western medical standards. One informant told us she would feel weak if she lost any of her 96 kg, and this 'comfort size' was an important consideration for her health. Contributors also asserted the strong focus on food as a social pathway to integrate communities. The islands of Wallis and Futuna are still heavily reliant on local root crops and fish they provide for their families, and so represent an economy that is 'pre-commercial'.

A second project undertaken at the suggestion of French Medical officials looked at the drinking habits of young Wallisian men, some of whom had injured themselves and others when driving cars. The close restrictions on social life and lack of alternative 'entertainment' were revealed as major reasons for binge parties in the bush, together with ready access to alcohol at any corner store.

These two projects, and a subsequent one in Fiji, became training exercises in anthropological fieldwork with local researchers. In Fiji we collected data on food consumption and then, working with Samoan and Moari students from Victoria University, we demonstrated ethnic differences in food selection, timing of eating and tastes. This led to a project in Wellington sponsored by the Ministry of Social Development, focussed on the criteria participants used to select foods at the supermarket when they had $100 a week (or less) to spend on food. From this I went on to investigate the social issues around use of food banks in New Zealand, and this work became part of a series of studies assessing poverty in New Zealand society.

Working on food consumption in Pacific communities also drew me into two major projects focussed on the aftermath of nuclear testing in the Marshall Islands, where the US exploded Bravo and other nuclear devices...
Cultural beliefs and practices around food are critical in defining what people eat. David Himmelgreen and Deborah Crooks point out that many anthropological studies of food have practical applications in dealing with nutrition-related problems: for example, a study examining the high consumption of Coca-Cola in the

Yucatan revealed a belief that it is healthy, and the importance of local perceptions of it as a Western (and therefore high-status) item. As they say: 'anthropological studies on the marketing of fast-food chains like McDonald's are especially relevant today' (Himmelgreen and Crooks 2005: 155). In more general terms:

Applied nutritional anthropology has the potential to make significant contributions in addressing the nutritional problems of the twenty-first century. These problems include the global obesity epidemic, the intersection of diet and physical activity in the development of obesity related diseases (eg, type 2 diabetes), the continuing problems with undernutrition and micronutrient deficiencies, the ongoing problem of food insecurity in a food-rich world...[And] the contribution of globalization on food consumption patterns. (Himmelgreen and Crooks 2005: 178–9)

Anthropologists often find themselves working in regions where food security is major issue: for example, David Pelletier’s (2000, 2005) research in Latin America, Vietnam and Bangladesh is concerned with how malnutrition affects levels of child mortality, with a view to improving policies in this area. Ann Fleurent (1988) researched food aid and its implications for development in Kenya and became involved in the American Anthropology Association’s Task Force on Famine. In research on health there are often intersections with other issues: for example, Mike Mtika’s (2001) work illustrates how, in poor countries, the AIDS epidemic has had major implications for household food security.

Researchers also work in areas where the over-consumption of poor quality food along with sedentary lifestyles creates obesity. Nurgül Fitzgerald, David Himmelgreen and their colleagues (Fitzgerald et al. 2006) became involved in developing educational programmes to promote better dietary habits through nutrition in impoverished American communities; Barry Popkin (2001) has been tracing dietary changes and a shift towards higher levels of obesity in the developing world; and Hannah Bradby’s (1997) ethnographic study on the dietary choices of Punjabi women in Glasgow highlighted the social issues that contribute to a relationship between health, eating and heart disease.

There is also a growing anthropological literature on health foods, their meanings and what they reveal about the concepts that people use in thinking about their health. Thus Rosalind Coward’s work on health foods also points to growing concerns about the inclusion of undesirable substances in modern food production:

The pursuit of a healthy diet is the principal site where we can exercise conscious control over our health. Diet is the privileged arena where the sense of personal responsibility for our health can be worked out. No wonder there has been such panic as the facts about adulteration of food at source have become widely
This work resonates with my own research on drinking water, examining why many people are willing to pay vastly more for bottled spring water rather than drink tap water that they fear may have been chemically polluted in the course of its treatment, and during its journey through an industrial farming landscape (Strang 2004).

Anthropologists can therefore provide insights into many aspects of food use and into wider behavioural issues, such as the way that people think about physical exercise, and the extent to which this is encouraged or not in their economic and social practices. And as mentioned in Chapter 5, in relation to social marketing, anthropologists are well situated to work in areas such as health education, where the major aim is to understand cultural beliefs and values with a view to encouraging behavioural change. Some culturally embedded ideas encourage people to adopt habits that are harmful, and the only way to combat such problems is to understand the underlying factors. Thus Florence Kellner’s research (2005) seeks an in-depth understanding of how the processes of self-construction and self-presentation that are part of ‘coming of age’ in most Western societies actually encourage many young women to take up smoking.

UNDERSTANDING DISEASE

Behavioural change is also, quite literally, a matter of life and death in responses to infectious diseases, and in this area, as in others, local understandings are critical. The comparative nature of anthropological research underlines the reality that there are many specifically cultural ways of handling epidemics, some of which may be better suited to a particular context than imposed Western models. Curtis Abraham (2007) describes how Barry Hewlett’s work illustrates this point. Hewlett examined some of the problems that arose following an outbreak of the Ebola virus in central West Africa in 1995 and 1996. Medical aid was sent, but there was little communication or coordination with the local community, and people became so suspicious of outsiders that when they returned with the second outbreak, there was armed resistance to their activities. The research showed how the problem lay in the aid agencies’ lack of understanding of local history, how diseases were perceived and also how they were managed. They were also misled by stereotypes about African medicine. ‘Western public health officials ignored the fact that indigenous people have their own strategies for disease control and prevention’ (Abraham 2007: 35). Partly as a result of this work, the World Health Organisation (WHO) revised its guidelines for responding to Ebola outbreaks.

Curtis Abraham also points to Ted Green’s work, which further affirms the need for treating local understandings with respect. Green has spent several decades working in sub-Saharan Africa, and is familiar with indigenous contagion theories. He notes that people are well aware of the causes of disease, and how contagion spreads, and have specific protocols for quarantine. Programmes that cohere with local methods and actively support and make use of them are far more likely to work. WHO has also taken this advice on board, and is now directing its efforts towards
working with and incorporating indigenous medical practices into aid programmes (in Abraham 2007).

Understanding local perspectives is particularly critical in dealing with issues such as the AIDS epidemic, which has been so devastating in Africa. Adam Ashforth's work looks at how the spread of this disease is entangled with ideas about witchcraft, which has been, traditionally, as a central factor in illness. 'Cases of premature death or untimely illness in Africa are almost always attributed to the action of invisible forces, frequently those described as “witchcraft”.' Thus the HIV/AIDS epidemic is also an epidemic of witchcraft (Ashforth 2004: 147). Because of the distrust engenders, the disease therefore poses a threat not only to human health, but also to the stability of democratic governance in the region:

The implications of a witchcraft epidemic are quite different from those of a ‘public health’ crisis … when suspicions of witchcraft are at play in a community, problems of illness and death transform matters of public health from questions of appropriate policies into questions concerning the fundamental character and legitimacy of public power in general – questions relating to the security, safety and integrity of the community. (Ashforth 2004: 142)

**DRUG CULTURES AND CRIME**

Understanding local cultural perspectives is vital in considering how best to combat AIDS, wherever this disease occurs. Merrill Singer, Ray Irizarry and Jean Schensul (2002) conducted research into AIDS prevention in America, looking at needle sharing among drug users. Their central question was whether this group would use free needles if these were made available, and whether this would be an effective way of slowing the spread of HIV/AIDS. However, they also had to consider anxieties in local communities that handing out needles might increase intravenous drug use, and the political realities that surround policy making: 'Needle exchange is one of a number of controversial strategies that have appeared in recent years (widespread street distribution of condoms and bleach for needle cleaning are others) in an effort to halt the spread of AIDS to the drug-using sector of the population' (Singer, Irizarry and Schensul 2002: 208).

Their research showed that concerns about needle exchanges increasing drug use were unfounded, and that the scheme had some potential as an effective measure against the spread of infection.

As these examples imply, anthropologists tend to ask why people do what they do, rather than merely condemning what many people regard as antisocial behaviour. Like other social scientists, they think that getting under the surface to see the cause of problems is more likely to lead to effective solutions. Researchers bring this approach to investigating a range of difficult social issues, such as the use of drugs and alcohol, prostitution, violence and crime, which have major effects not only on social life in general, but more specifically on people’s health and wellbeing. Linda Bennett’s (1995) work, for example, looks at different cultural perspectives on alcohol, and the impacts of alcoholism on families. Linda Whiteford and Judy Veltucci (1997) have examined the effects of substance abuse in pregnancy, and how this might be prevented and Philippe Bourgois’s (1995) investigations in New York’s Harlem reveal the subaltern economy surrounding crack dealing.

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**THE QUALITY OF PUBLIC HEALTH**

Richard Chennah

Menzies School of Health Research, Charles Darwin University, Northern Territory, Australia

I became involved in the evaluation of residential treatment centres, through my Ph.D. studies. After completing an undergraduate and postgraduate degree in anthropology, my first 'proper' job entailed teaching and doing research in a public health research institute. As the only social scientist working in this centre, I was bewildered by the language spoken by public health researchers, who were mostly epidemiologists. I did not know anything about the bacterium Burkholderia pseudomallei; I was not too sure what a chronic disease actually was and I knew that public health was something that dealt with the health of populations and mainly used statistics. Everyone talked about some doctor who, in the 1840s, halted a cholera epidemic by sealing a particular water pump in London. So I stumbled my way through various lectures and discussions with medical doctors, and often felt pretty silly as I rarely understood what they were talking about.

I found that public health researchers were quite interested in the kind of information they thought an anthropologist would be able to provide, but in a research context dominated by epidemiology (which relies mainly on statistical data), qualitative methods such as participant observation were unfamiliar. Complex social analysis does not fit easily into public health models designed to provide very specific interventions. Anthropological research seeks to expand understandings of health issues by going beyond clinical knowledge and statistical comparisons, to examine a range of social and cultural influences in people's lives: these aspects of illness and treatment which cannot be reduced to variables and measured. However, in understanding population health we need to tackle the more complex aspects of human behaviour and the social systems within which we are enmeshed.

Things have moved on since I first began working in this area, and qualitative research and anthropological methodologies have become increasingly popular in the health sciences. I now teach in a public health postgraduate degree programme, and the majority of students go on to work as project managers or research assistants in health-related projects, or find employment in government departments. Many make use of the methodological tools of anthropology, finding their training in qualitative research methods to be one of the key skills they use in their workplaces.
Drug and alcohol abuse and prostitution often occur in the same socio-economic arena. Pamela Downe's work involves both advocacy and research with prostitutes in Costa Rica (1999) and Edward Laumann's (2004) research in Chicago considers the complexity of 'sex markets' and how these intersect with social networks and sexually transmitted diseases. He also considers sexual violence and its social and cultural context.

Many social problems are related to mental health issues and, while these are often regarded as an individual matter, how they are dealt with at a social level is critical. There are wide cultural variations in how mental health problems are understood and encompassed, and anthropological insights into these variations are useful in informing both the management and treatment of problems. They also reveal changing attitudes: for example, Emily Martin's work examines attitudes to mental conditions like manic depression and ADHD (attention deficit hyperactivity disorder). She observes that, because ideas about 'what makes an individual' are becoming more open to constant change and fluidity, these conditions 'have been undergoing a dramatic revision in American middle-class culture, from being simply dreaded liabilities, to be especially valuable assets that can potentially enhance one's life' (Martin 2006: 84). Cultural attitudes to mental health also have to be considered in relation to physical issues: not just genetic, diet and lifestyle factors, but also wider social, cultural and ecological influences requiring what Roger Sullivan and his research collaborators have called a 'bio-cultural analysis'. Their research in Palau was directed towards trying to discover why there was, most particularly among the men in the population, one of the highest incidences of schizophrenia in the world (Sullivan et al. 2007).

More extreme mental health issues often intersect with crime, and there has been considerable media interest in analyses of the social causes of crime, and, more particularly, in the solving of crimes. Forensic anthropology features regularly in novels, television programmes and films, and has been made famous by programmes such as Silent Witness. The role of the forensic anthropologist is usually to identify bones and determine the cause of death: she or he will begin by determining whether the bones are human, and will then look for indications of age, gender, and ancestral origin. Dental records are useful, as are old fractures and signs of diseases, hair samples, blood type, and of course DNA. In general, this work is not as dramatic as that depicted on television, but there are some famous cases: for example, Alfred Harper (1999) describes the role of forensic anthropology in identifying tiny bone and tooth fragments and thus solving a case in Connecticut, after a murderer had disposed of his wife's body in an industrial woodchipper. In recent years, forensic anthropologists have also been involved in identifying the victims of genocide in countries such as Rwanda and, unfortunately, the need for this kind of work is increasing.

It will be plain from the above account that there is enormous diversity in the range of work done by anthropologists in relation to health, and a range of sub-disciplinary areas of expertise have emerged – for example, medical anthropology, biological anthropology, nutritional anthropology and forensic anthropology. Because anthropology invariably considers the context of social behaviour, there is also a considerable body of work concerned with the institutions that deal with health issues.
NURSING A HOLISTIC UNDERSTANDING

Marion Droz Mendelzweig

Chargée de Recherche, Haute Ecole de la Santé La Source, Lausanne

I have always wanted to know about what people do and why they do it. Sometimes I want to ask 'how do they manage to behave like this? I guess being an anthropologist implies a capacity to preserve a childish curiosity.

My research is oriented towards the past rather than towards an ethnological 'other'. I did my first degree in history but moved to studying anthropology when, while working for the International Red Cross in 1994, I was faced with the abomination of the genocide in Rwanda. As a member of a family that, like so many others, was subjected to the genocide perpetrated by the Nazis, I found that the Rwandan experience resonated with my own history and shed new light on the relationship between individuals and the societies that determine their identity. After seeing the results of genocide in Rwanda, I turned to anthropology hoping for an explanation to keep me from despairing about humanity. I can't say that it has given me more optimism, but I am convinced that gaining anthropological tools in order to look at humankind helps us to be more intelligent in considering what is going on in the world, and in imagining the future.

To study anthropology, I joined the Ethnology Institute at the Neuchâtel University in Switzerland. It was a very attractive place for young scholars eager to learn about the infinite richness of human cultures. My studies there were a continual voyage of discovery, not so much from the topics we studied, but rather from the way I learned to look at them. Each new research perspective was a trigger to more exploration: would I continue in the anthropology of religion; in the anthropology of food; or in the anthropology of material culture? Among so many possible avenues, the word 'health' acquired new meaning and complexity.

The subject of my MA thesis — on medically assisted procreation — opened a door for working in the medical realm as a research fellow in a school for nursing. Broadly, the difference between nursing and a medical approach is that the first is centred on the person and the second on the disease. From the nursing point of view, the interest lies not so much in the biological causes for a disease, but in the ill person's understanding of it and on the social and environmental conditions that affect its progress and treatment. It is therefore not surprising that nursing schools include in their teaching programmes anthropological approaches to health, culture, kinship and social groups, or that nursing as a discipline is keen to draw professional knowledge from anthropology. There is a common objective: gaining the capacity to understand 'the other'.

My tasks at the school are twofold: I teach anthropological approaches to students and conduct research projects, for example looking at health networks for migrants. I see anthropology's major contribution to nursing as providing a holistic understanding of the social phenomenon around health and medical care.

MANAGING HEALTH

I noted earlier the utility of anthropology in considering health institutions such as nursing homes, where anthropologists consider the issues surrounding the long-term care of elderly or disabled people. Some researchers have also turned an analytic eye on the health professions themselves, examining their political, social and economic dynamics. Elizabeth Hart, for example, is particularly interested in the anthropology of organizations, and has turned her attention to the way that the institutional cultures of health care facilities enable some people to have more 'voice' than others. She looks at people's experiences of speaking in organizational contexts where they feel themselves to be in some way suppressed, or marginalized, or even describe themselves as 'invisible' — as nurses often do when speaking of their caring skills' (Hart 2006: 146). Hart works mostly with women in the British National Health Service, but also with senior male managers, who she found face similar dilemmas in speaking up, being required sometimes to profess confidence in the policies they were implementing, despite serious misgivings regarding their efficacy.

Gender issues also surfaced in Joan Cassel's (2003) research, which considered the realities for women surgeons in a male-dominated area of health care, where metaphors about practice are highly aggressive, employing images of war and invasion, and valorising courage and rapid decision-making. Her research raises questions about whether women actually display the assumed 'traditional' female characteristics, such as sensitivity, warmth, compassion, and whether (and how) this affects the operating theatre.

The research also made it plain that women are often not welcome as equals in this arena, which — as comparative ethnographies have shown — is a far from unusual