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Normal and Ordinary in an Illness Experience: An Anthropological Study

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Abstract: The paper is based on a fieldwork conducted in a village located in the Sirmaur district, Himachal Pradesh. The paper primarily deals with how health and illness are understood and categorised in the cultural context, the contexts in which the terminologies of illnesses are defined and the factors that influence the choices for treatment. The major theorisation of the paper focuses on how illness experiences become normalised and get embedded in the ordinary everyday life of the people, at the same time finer details reveal contingencies of time, economy and survival for those who rely on the labouring body. The uncertainty created by these contingent events does not give leeway to extend the control over body for recuperation well into the future but rather the retained focus is on immediate relief. The study was conducted with an ethnographic approach and the data were collected through in-depth interviews and case study.

Key words : Health, Illness, Normalised, Ordinary, Culture, Himachal Pradesh

> 'Is it necessary to define the terms – illness, disease, diagnosis, health – that provide the scaffolding concepts through which we intuitively come to know the disturbances in our world but which defy any neat characterisations?' (Das:: 2015: 212)

THE CONTEXT

The profoundness of the statement quoted above is reflected from the factual reality that these categorisations are understood and used as measures to observe, acknowledge and probably work upon the discrepancies that shift or tilt the balance between health on one hand and illness/disease on the other hand. These categorisations have been variedly understood, compared and presented based upon contextual requirements.

Biological rationalities or the biomedical paradigms are based upon physiological, genetic, biological component of human existence with disease, and knowledge production about diseases, including identification of certain populations as susceptible to certain diseases[1] and thus marking itself as an aloof, neutral, universal and technical field, However, this claim for neutrality and universality stands questioned on many grounds (Gordon, 1988). Public health relies upon biomedical discourses for information production, dissemination and consumption to facilitate behaviour change or to promote certain health practices through various means available at disposal, including epidemiological studies (Ahmed, 2011). Economics of/in health focuses primarily on the inequity and inequalities in health care systems experienced

by people in terms of proportions of various indices on health and related variables and economic parameters and the ways to counter these inequities in terms of resource allocation and distribution as matters of demand and supply (Jacobs and Rapoport, 2004; Folland *et al.* 2013). Anthropological and sociological dimensions project the pluralities of beliefs, practices, health seeking behaviour of the people and the structures and institutions that produce or accentuate sufferings and vulnerabilities for the people owing to unequal availability and utility of health care focusing upon how these macro processes impact the lives of people at micro level (Farmer 2001, 2003).

This paper focuses on the experience of illnesses at the level of the ordinary. Furthermore, it tries to project the hybridity regarding the notions of health, illness, disease, diagnosis, treatment embedded in local social institutions and that is what holds significance beyond the time frame.

The word *ordinary* here refers to the existence that is lived as everyday life, without being put into question or most often eventually accepted as the *normal*. It differs from the eventful[2] in the sense that experiences of the *ordinary* do not create ruptures even if they tend to dislocate the *status quo*. Illnesses, as experienced by people often tend to become *ordinary* whereby they become part and parcel of everyday life. Diagnosis of a disease at clinical level might trigger an imbalance in the *status quo* leading to abrupt changes over a short period of time in lives perceived as *normal*. It may continue its earthquake like shocks and aftershocks in lives of the people concerned or it may get subsumed under the rubric of ordinary everyday normality of life. This paper attempts to present this movement into the *ordinariness* of illness as experienced by the people and recourse(s) that they take while coping and moving from disease diagnosis to illness acceptance and towards a reconciliation of it all being part of their routinised life. Hence, as Green (1998: 3) puts it, '... to focus on examining the meanings and complexities of the lived experience... and reveal the extraordinary and subtle by which people ...' come to live with the realities of their lives either by acceptance, appropriation or dejection. The theoretical orientation of the paper is premised upon the concepts of "everyday, ordinary and normalisation" as problematised and explained in the works of Das (2015), Kleinman *et al.* (1998) focused more upon the experiences and the realities of people embedded in their everyday lives and struggles, which get subsumed in the idea of *normal* and hence often remain unquestioned. The focus is on experiences "and suffering that is assimilated within the normal and yet not fully absorbed in it..." (Das::2015:I)

THE LOCALE

The paper is based upon a fieldwork conducted in a village named Lathiana, located in the hilly terrain of district Sirmour, Himachal Pradesh. The fieldwork was conducted in the month of October, 2015. The data were collected through

interview guide. In total, 25 in-depth interviews were conducted and 6 case studies were collected. 15 females and 10 males aged between 20 and 57 years were interviewed. These respondents were selected based upon their willingness to participate. These respondents were spread across 25 households in the field area, and an attempt was made to include at least one respondent from each household. Two case studies which were directly related in the context of the present paper have been presented in the text. With the publishing of the book *Writing Culture: The Poetics and Politics of Ethnography* (1986), there was a turn in the ways and means of writing ethnographic papers which began to focus upon lone voices and subjectivity of the researcher which otherwise might get subsumed under the objectivity of majority responses and experiences. Janice Boddy's (1998) paper on *Remembering Amal* published in an edited volume, Vincent Crapanzano's (1980) seminal book *Tuhami: Portrait of a Moroccan* are examples of where single experiences were analysed to put forth the hidden structural and institutional forces that perpetuate marginalisation. Also this kind of approach "…defeats categorisation of such issues as principally psychological or medical and, therefore, *individual*. Instead, it points to the often close linkage of *personal problems with societal problems*." (Kleinman *et al.*, 1998::ix)

The village under study falls under block Sangrah, Himachal Pradesh, under the jurisdiction of Jamu-Koti *panchayat*. The village is located at a distance of 11 km from the holy place of Renukaji. The holiness associated with this place is attributed to the celebration of Renuka festival. It is believed that during the period of Renuka festival, Lord Parshuram resides in the famous Renuka temple located in the town of Renuka ji. Lord Parshuram is the deity of not only Renuka ji, but of all the villages in that area. Esoterism of religious occult is a part of life of the people.

The people of this area, including those from the village Lathiana, are mainly dependent upon subsistence based agricultural practice and the extra agricultural produce is sold in the local market of Dadahu town. With the implementation of the 73rd amendment, political emancipation of historically marginalised castes[3] by holding positions in village *panchayat* is also observed in the village. However, this political emancipation stands countered by caste based segregation (among Rajput, Koli and Mochi caste groups) of dwellings in the village. There is also restriction in the entry at the village temple by the members of the Koli and Mochi caste groups and in the practice of food commensality between castes. The road divides the village into two sections. The Rajput households are located on the upper slope, and those from the Koli caste groups on the lower slope. At the end of the village there are two houses of the Mochi caste.

The Rajputs are the dominant caste and have larger landholdings. Next in the scheme of hierarchy are those from the Koli caste, who for a long period of time used to serve the Rajput landowners as agricultural labours. With the

changing political and economic scenario over the years, the Koli caste group also gained some economic and social benefits in terms of small landholdings and participation in village political life. The members of the Mochi caste group people are engaged in skinning dead animals. Although they have very small landholding, yet they rely on the upper castes of the village for their survival. The two households are also the caretakers of the village *gharat* (water mill run on the power of the village stream to grind corn, wheat and other crops into flour). Each house takes turn for every round of grinding the flour and on each occasion they are offered a small portion of the produce in return.

Athough the state of Himachal Pradesh fares better in comparison to many other Indian states, yet the typicality of overstressed state health system is also observable in the area (Himachal Pradesh HDR Govt. of Himachal Pradesh, 2002; Mukherjee et al. 2014)[4]. There is no school or health clinic within the village. The children of Lathiana go to schools that are located in the villages Galja and Bhatgarh, situated uphill at distance of about 15 km. The health sub-centre of the village is also located in Bhatgarh village. Dadahu is the nearest town located at a distance of 15 km from the village of Lathiana. The referral hospital is situated in this town. There is a bus service which plies thrice a day between Lathiana village and Dadahu town. This small town has a bus terminus from where bus service is available to reach to other places. Owing to the limitation in daily bus service in Lathiana, any exigencies including medical emergencies are catered by private transport services, like jeeps or cars which the villagers often hire for service from Dadahu town. Apart from the government sector health services, there are three other (informal) health practitioners in Dadahu town. The people of this locality refer them as doctors. Their qualifications and practice are typical to formal health practitioners located in other small towns in India. One was a Bachelor of Ayurveda Medicine and Surgery (BAMS) and the other two received education up to the second year of bachelor course and were trained as Multipurpose Health Worker (MPWH). These practitioners consider themselves to be competent in treating common ailments. Administration of injections was the preferred mode of treatment for both the private practitioners and their patients. These health practitioners prescribe allopathic medicine, but nonetheless share the aetiology of traditional categories of hot and cold for diagnosis and advice on diet. The repertoire of their treatment includes giving basic first aid in case of any minor injury, administering injections and medications for minor ailments. They do not perform any surgeries. The people of this area including those from Lathiana frequently visit these practitioners. The reasons are easy availability and accessibility to these health practitioners, getting the preferred mode of treatment (administration of injections) and less waiting time. Added to it, is the relationship of camaraderie beyond typical client doctor relation. The doctors of the referral hospital are transitory in their station, and are considered as *bade saab* (the powerful) who are city based,

dressed up differently, scold the patients when treatment is not followed properly. There is a clear power dynamic between the doctors of the referral hospital and doctors of the town, and also between local people and hospital doctors.

EXPERIENCING ILLNESS AND DISEASE

Every step towards recourse to one or multiple modes of seeking treatment for any anomaly commences with the recognition and acknowledgement of deviation from what is perceived to be a normal way of existence including bodily understandings of the normal and the healthy, at both individual and collective levels. Recognition of symptoms, associated diagnosis and treatment(s) are based upon the subjective meanings associated with health, illness and cure. In order to understand how these seemingly three distinct entities become enmeshed and overlap in the understanding and explanations for the people, response was sought for simple yet nuanced questions on *aap sehatmand kisko samajhte hain*? (who according to you could be considered?), and the dichotomy to it was *app ke hisab se koi bimar kab hota hai*? (who according to you could be considered suffering from an illness?). These questions while trying to address the categories of health and illness, also revolve around the notion of who is the subject of these categories and how he/she is located in the local social cosmology of understanding of these issues. The premise of these queries has been derived from Kleinman's explanatory model that gives emphasis upon narratives of illness[5]. The focus of these queries is to bring forth the experience or explanation of an illness as felt or understood by a sufferer and his/her family, thus in a way giving words to their experiences through simple yet profound questions and articulating how illness is perceived. Based on these primary queries, further questions were extrapolated to understand the perceived and experienced knowledge about health and illness through 'notions of complaints, symptoms and diagnosis in the narratives and see what light these notions throw on the construction of illness, local ecology and the subject' (Das:: 2015: 87).

The subjectivity of identifying with health involves active participation in everyday life chores, be those at individual, familial or social levels. This invokes the concept of what Veena Das (2015: 41) refers to as the labouring body[6], where the health of an individual is associated with active labour whether in the field or at home. Health is a matter of age and the state of health is reflected from the *freshness on the face.* Illness as opposed to this is inability to fulfill expected activities or is a matter of old age. These subjective understandings reflect the routine transitions in life caused by various factors ranging from change in weather to ageing and hence are perceived to be a part of the normal experiences of everyday life transitions. Within these explanations, emerged narratives such as *chhote mote dukh mein sona nahi*

chahiye, hum zimidar log hain (we cannot afford to take rest for minor bodily ailments, we are farmers). Here, it is not just the labouring body of an individual who is dependent upon agricultural activities but that of his family as well whose survival cannot afford the luxury of being confined to the category of 'rest'. Since illness may complicate the matters of everyday survival, these in many cases are passed off as *routine* and *normal*. This exemplifies in a sense how the *normal* is located in the event of any form of illness owing to fulfillment of other forms of more contingent requirements. Injuries due to fall are commonly occurring and acceptable as normal physical issues owing to the terrain of the area and work in the fields. The terrain of the area and the lack of carpeted pathways on the slopes of the hills accentuate the risk of fall and injury, especially during the rainy season. Women are often found traveling up and down the hilly slopes carrying loads of grass (for animal fodder) on their head, with young children on their arms. Falls and injuries are not given much significance and are rather treated as part of the *normal*, *chot to lagti rehti hai* (injuries are common, not to worry about them). Presented below is a case study, which depicts how an illness gets normalised, without referring to the medical causation. It reflects the process of acceptance and continuation.

The incident refers to the case of a 23 year old K.S., who lives in a joint family. The family members comprise his spouse and child, his parents, two other siblings and their spouses and children. The interview was conducted in the small courtyard of the house. During the interview session, K.S. fainted. He was immediately taken inside, given some water to drink and was rested. K.S was neither offered any medication nor was he taken to the doctor in the Dadahu town. Next day on enquiring from his wife it was learned that K.S. has been suffering from such bouts of fainting since the age of 18 years. Over the years he lost his body hairs. Many treatment modes were followed, ranging from leech therapy of *ayurveda* to *jhada* to western medical practice. While there was no linearity in the follow-up of these modes of treatment, the explanatory factors for diagnosis differed in each. The *ayurvedic* treatment was administered by a local BAMS at Dadahu, who had placed leeches on his head to suck away *kharab khun* (polluted blood) from the body. On the other hand, the *tantrik* smeared the blood of a local bird on his head and offered him *mantar vala pani* (water made sacred by recital of sacred verses) to drink. In case of encounters with western medical practitioners at hospitals, two referrals were made from Dadahu to Nahan to Postgraduate Institute of Medical and Education Research (PGIMR) to PGIMER, Chandigarh (located at a distance of about 130 km. from Renukaji). Since no medication was administered to K.S during the last three year period, his wife said *sar par baal nahi hai iss liye dhup zyada lagne ki vajah se usse fit padh gaya tha* (because of his baldness and over-exposure to the sun he suffers from sudden bout of fainting) and hence there is no need to consult a doctor further.

This case represents how the deviance from what is considered as healthy oscillates between the established constructs of illness (a supposed cultural

construct) and disease (a supposed biomedical concept). But what needs to be constructed out of this narrative is how eventually and ultimately a *normal* is established in the event. This established normality hides the fact that rest and continuation of treatment at a premier hospital is not possible owing to distance, time, infrastructural constraints and the struggle of everyday livelihood of farming. This problematises the very premise of *normal* and the learning to live with it narrative because the definition of *normal* is established in such struggles. The incidence also implicates not only the individual sufferer but also the kin members and familial relations.

Paradoxically to the support base of the familial and community care during an illness episode, there are explanations where these support bases are rendered as cause of the problem being faced. Thus, the institutions of kinship and neighbourhood lie in an ambiguous zone. This generates the complexities regarding kinship relations and neighbourhood cordiality, where these very relations might be held responsible for jealousy and evil intention. The idea among people for sudden body ache especially headache, illness of a child or consistent crying of a child were all attributed to the concept of *baan laga hai* or *kisi ki nazar lagi hai* (effect of evil eye). In order to get rid of these health problems, they sought help from the village *tantrik*. Another commonly used concept was of *upari kasar* (black magic) usually practiced out of jealousy against someone especially by neighbours or relatives. These too were managed by the *tantrik*. The diagnosis and treatment for such cases often involves use of biomedical system as well as the occult power.

In such scenario, the role of a healer also projects an ambiguity between the one who protects and the one who is also capable of causing harm. Hence, the identity of a healer is not only viewed in contestation with that of modernity, but one with that of healer who causes illness as well, as Das (2015: 134) puts it, '... practitioners of occult are transgressive figures within both tradition and modernity....'

These cases exemplify how the local and medical cosmologies of illness and disease understandings intersect in everyday experiences for the people. It is not about the traditional or the rational dichotomy but rather the hybridity of the systems in lives of the people.

TERMINOLOGIES OF ILLNESS

Each culture has its way of recognising and naming of an illness, thereby, opening an analytical window into how the knowledge of differentiation and typification of illness is understood, maintained and passed on and becomes part of everyday communication. Each illness is diagnosed based on the description of symptoms located in the local cultural terminologies. The diagnostic categories also form the part of this cultural repertoire and these categories together determine the process of treatment. Nonetheless, cultures are not closed off boxes where rigid boundaries are maintained between

various sections. As Das points out, '... there are no hermetically sealed cultures, which can provide fully constituted and coherent cosmologies within which illness is experienced, diagnosis made, and therapies are sought' (Das:: 2015: 29).

At the same time the categories of various illnesses as understood or experienced by people are based upon admixture of two processes: through the lens of cultural standards as well as through personal experiences with illness. There are illnesses, like cold, cough, body ache, insect bites which are understood as *chhoti bimariya* (minor illnesses) and could be treated through home remedies. *Antar dosh* (dysentery), physical injuries due to fall, illnesses which tend to become acute or chronic are referred to as *badi bimariya* (major illnesses) and are contingent for a visit to the doctor. Head ache is specially associated with the concept of evil eye requiring a *jhada* from the *tantrik*. On the other hand, *Budri mata* (chicken pox) is considered as a part of the sacred and is believed to be caused by the action of goddess. Rather than treatment, precautions are observed in terms of intake of less spicy food, hygiene of the patient and his/her immediate surroundings. Reverting of *budri mata* without any harm to the person is thanked with presenting of sweetmeats to goddess in the village temple. However, such linearities in terms of choosing one system after another does not follow a fixed pattern. The case study below explicates the point in the discussion:

The case relates to middle aged R.S., who was detected to be suffering from 3+ stage of pulmonary disease of TB and pneumonia in the year 2003. Prior to the diagnosis of the disease, the only symptom was continued cough. R.S. used to take *ayurvedic* medicines from a local health practitioner of Dadahu town. Seeing no improvement in his case, the doctor asked him to consult the western medical practitioner in the Dadahu referral hospital. In the hospital R.S. was diagnosed with TB. The doctors of the referral hospital administered treatment of anti TB Schedule II for six months. Back home in his village, he also consulted the village *tantric* to ward off evil. R.S. further sought blessing of the village deity, and sacrificed a black goat in a session of special prayer organised at the village cremation ground at mid-night. At the time of conducting the interview, R.S. was free from TB. In this case both magical and the technical, weave together in the cosmology of acceptance and treatment. It presents a scenario where the sense of understanding an illness moves through two systems which are otherwise thought to be in contestation with one another as modernity vs. tradition. But within the cosmology of everyday life and its fragility the two come together, even if they fail to make sense or are bound to create a feel of bewilderment for those who stand outside that person's sphere of everyday life. Bringing in the conceptualization of liminality[7] in this context, an extension of time is experienced, marked with specific intervals, which may reflect transition from the state of illness to the state of health or an oscillation between the state of illness and perceived state of

health. Hence, "here liminality appears to have been 'stretched' and temporally fragmented" (Prout:: 1989: 351)

A local traditional healer of the village, locally known as the *tantrik* was seen visiting a western health practitioner in Dadahu town. The *tantrik* said that his wife was seeking treatment from the doctor (a BAMS) for the problem of *fit* (the word here does not refer to the condition of fits suffered in epilepsy, but rather it is a localised term for a condition in which a person tends to faint all of a sudden) for which he had learnt the art of healing in the first place. The doctor administered allopathic medicines and injection. Administration of injection as a method of treatment is a well accepted therapeutic method by the people. Another doctor (a graduate and Multipurpose Health Worker) also confirmed that common people of the area appreciates administration of injection for getting immediate relief. Administration of injection symbolises the fastness and efficacy of biomedical treatment. This is viewed as something more powerful than the regular course of medication, because administration of injection is generally done by a qualified doctor, unlike oral administration of medicine, of which was left to the discretion of the patient. Hence, a linear progression in terms of causes attributed and treatments sought cannot be established. At times the categories of symptoms and diagnosis utilised by people and practitioners cut across other explanatory systems. The perceived rigidity between various forms of medical systems lays unbraided and open at the level of the *ordinary* resulting in hybridisation of various modes of therapies and treatments.

These categorisations and meanings attached by the people of Lathiana give a sense of what happened and how it happened. Thus, folding over an event which otherwise is capable of dislocating the *ordinary* and gives it a semblance of *normality*. However, reading between the lines reflects the precarity of survival. Most of the informants are involved in agriculture and rely on the produce for self consumption and selling at the local market in Dadahu town. The locale and geography of hilly terrain compounded by slippery pathways adds to chances of fall and injuries implying lack of infrastructural facilities available for safe commute for the people. Even though the area is not marked by a sense of remoteness, nonetheless, accessibility at ease of medical facilities is difficult.

CONCLUSION

The narratives cited above depict how an illness experience is located within the institutions of family, kinship, economy and state agency, like referral hospitals. Located within these institutions, the illness is understood and defined and hence becomes part of the *ordinary* and the *normal* everyday life of the people. In one context the illness may become a critical event bringing in rupture and change from the established routine and in the other context it may get embedded eventually in the ordinariness of the everyday life. In

both the cases illness located in the body as a discomfort is a result of many factors and implicating in itself many other domains and institutions. These experiences hence, oscillate between the extraordinary and the ordinary. In the cases narrated here is an element of temporality involved where the illness experienced in a particular moment fluctuated between the past and the present and how the knowledge becomes a part of the cultural lexicology.

The temporality is also induced in the form of contingency associated with the illness in terms of a labouring body involved in work for survival and the precarity of falling ill and losing out on precious time of work and survival. It also speaks about how combination of being bedridden, requirement of work, choices for practitioners, categorisations of illness and actual experience of illness place emphasis on immediate relief; thus, leaving the future at a distance and focusing more on the immediate effect. Temporality also involves in terms of past experiences or local cultural knowledge about an illness.

Even if the illness gets subsumed in the assumed normalcy of ordinary, there are instances where the available repertoire of knowledge limited to the individual or the family or the kinship network gets exhausted without producing the expected results. In such scenarios, illness goes into the realm of expert advice, diagnosis and treatment either in form of a doctor or a *tantrik*. Also people hybridise the vocabularies of multiple medical systems to make sense of the situation.

The paper hence attempted to understand the meanings and answers about illness experiences located in questions like who has the knowledge of a particular illness, who defines the steps to deal with illness, who diagnoses the illness, who treats it and how, what strategies are to be adopted and why, were these actions successful or not. In an apt conclusion to this, '... illness is made knowable in the course of clinical and social transactions' (Das:: 2015: 26) and so are the associated notions of health and disease.

NOTES

1. The power associated with biomedical knowledge production as the science of dealing with health issues from the aspects of Cartesian dualism of mind and body separation has been questioned on the premise that body, culture, society, politics, history are all entangled and are capable of bringing about changes in human existence leading to "biosocial transformations" (Lock and Nguyen, 2010).
2. Veena Das (1995) in her acclaimed book Critical events refers to critical events as opposed to the uneventful as 'new modes of action came into being which redefined traditional categories..., new forms were acquired by variety of political actors' (p.6). In her another seminal work Afflictions she refers to Povinelli's (2011) conceptualisation of illness experiences as a quasi event, which she defines as "... quasi-events never take the status of having occurred or taken place. They neither happen nor not happen". Her focus is on how these events get noticed or are not noticed in the moral, political or market domains as opposed to the eventful which demand attention. Das, however, noting the importance of this concept states that larger political and economic changes simply cannot be juxtaposed into lives of people

because simple juxtaposition 'cannot do the work of showing the pathways through which the larger changes are absorbed in individual lives' (p 15).

3. Even though through the 73rd Amendment of the Constitution and the constitutionalisation of the Panchayati Raj Institutions, a way for political and ultimately social emancipation of these castes was paved but social forces played a significant role in maintaining the caste hierarchy.
4. According to the calculation made by the authors, Himachal Pradesh ranks 3rd in Human Development Index (HDI) for 2011-12 amongst various states in India.
5. For further details and explanations see Kleinman (1988) *The Illness Narrative.*
6. Das refers to the labouring body in terms of intermittent employment that people in poor neighbourhoods in Delhi sought and the precarity of this labouring body when the threshold of not finding work and falling into an illness complicates the matter further for them.
7. For further details refer to Victor Turner's essay on liminality and communitas (1969).

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