



Editorial Introduction

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The relationship between health and identity is of the same dynamic as the relationship between health, culture and society – the biological, social, physical, psychological (and the private and public aspects of these) all weave into a complex fabric defining the individual. This said, such a relationship, or dynamic, is multiplex, where identities and their constituting social, pathological, psychological and historical factors are reaffirmed, undone, or rearticulated. Similarly, experiences of health and illness are important to self and group formation, as are experiences of history, culture and society. The study of subjective experiences of health and illness, within society, and expressed culturally, can at the same time reveal the limits of medical knowledge and underline new needs. Today, our current healthcare research is more than ever before underlining the role of user involvement in the implementation of policy, which at the same time highlights the need for change in health service provision.

Identity, as a social, cultural and historical phenomenon, in the context of health, often draws more from sociological and anthropological research. This enables the researcher to get a handle on the particular phenomena composing a group or an individual. As a logical consequence to this, historical, philosophical and anthropological perspectives dovetail to shed greater light on the compositional factors of an epoch and the realities defining it. This said, identity, is sooner a fluid, complex process rather than a fixed, unilinear state-of-affairs. Let us, for example, consider how indigenous peoples are classified by the World Health Organization. Fact Sheet N°326, released in October 2007, opened with the question, “Who are indigenous peoples?” And rather than seeking to provide an official definition, the fact sheet sooner established a frame within which work and research could be conducted, and within which further questions could be raised. According to Fact Sheet 326, indigenous peoples:

- Are identified, recognized and accepted by their community as indigenous.
- Demonstrate historical continuity with pre-colonial and/or pre-settler societies.
- Have strong links to territories and surrounding natural resources.
- Have distinct social, (micro)economic or political systems.
- Maintain distinct languages, cultures and beliefs.
- Form non-dominant groups of society.
- Resolve to maintain and reproduce their ancestral environments and systems as distinctive peoples and communities.

Although clinical scholarship on pathology can establish particular frameworks and measures (ICD / DSM), diversity within anthropological groups and psychologies (belief systems; traditions of health and healing) mean that the articulation of frameworks, and putting policy into practice, within areas where indigenous systems are maintained and upheld, requires an anthropologically informed approach, in order to facilitate equitable delivery, effective outreach and non-conflictual health education. In this particular context, not only is medical anthropology faced with new demands and challenges, but the notion of *participation* becomes more important than *inclusion*, or rather, *strategies of participation* can enable a more effective inclusion. This is what was evidenced, and indeed voiced with the Cúpula dos Povos which paralleled the RIO+20 Congress earlier this year, namely: *how can diversity not simply be included, but participate in policy strategy and bring legislation closer to lived reality?* With such questions, it is not unusual for the medical humanities and the sociology of health (and sociologists), to raise

the issue of identity and highlight that the full spectrum of subjective experience requires a permanent research. Thus more philosophical approaches are brought to the debate of roles, lived experiences and the society within which these are articulated.

Increasingly, we are seeing interdisciplinary teams emerge, where policy and practice can get a better footing within regional and national realities. At the same time, questions which are raised in these interdisciplinary groups, can gradually sensitize the medical student and health professional to the day-to-day realities of people, and where he/she will not only seek to identify a malady but understand the social frame within which the person *experiences* and *lives* his/her illness in addition to the physical and cognitive limits (or, the social framework within which he/she will seek medical assistance and wellbeing). Indeed the word which has progressively cropped up in discussions over the last decade, in the wake of philosophies of the “new universalism” (circa 1999) and initiatives to increase the population’s knowledge of health practices, is, “wellbeing”. A clinician will understand this term according to his knowledge and working reality, likewise a psychologist, dentist, nurse, psychiatrist, sociologist and anthropologist will enrich the epistemology of this concept with their experiences and the professional ideas which are gleaned therein. Thus survivorship literature, research into sexuality and identity, historical research into health and its institutions, new methods of social wellbeing, all feature as valuable components to our modern reflections on health and identity, to policy design, and consequently to health, culture and society. It is more a fact, than hypothesis, that because of the environmental and economic urgencies hallmarking our epoch, funding frameworks have changed. University education, in the U.K. at least, is becoming more skills based, industry is affirming a more environmentally conscious identity (pro-actively so) and international bridges of collective enterprise, amidst these new defining mechanisms, are becoming a necessity, precisely for the question of policy building, economic renewal, social equity and the progressive assurance of a new working order for the international scenario.

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