

**THE INDIVIDUAL AND LEPROSY: SOME REMARKS ON THE COGNITIVE UNIVERSE OF LEPROSY
PATIENTS IN SOUTH INDIA
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This paper is an attempt to understand some social aspects of leprosy. In particular, it attempts to identify the manner in which members of the agrarian community in South India look upon leprosy. The data for this paper are from two villages in the Chengalpattu district of the State of Tamil Nadu. However logic permits, I have attempted to generalise and extrapolate my observations.

In Section 1, I take up the universe of health perceptions. In Section 2, I discuss perception of leprosy and in Section 3, I draw some inferences for leprosy control programmes.

The basic question with which I am concerned are:

- a) What are the determinants of the, by now well known, cognitive or perception gap between the health delivery system and its recipients (1)?
- b) What are the particular aspects of leprosy, where this gap becomes a problem?
- c) What are the ramifications of this discussion for future research?

1. HEALTH PERCEPTION IN ASTHAPURAM KANTHAPURAM

Asthapuram Kanthapuram is the fictitious name given to two villages that straddle the Chengalpattu Vallipuram road, and located some 13 km from Chengalpattu town. During 1976, I happened to spend nearly seven months in close contact with the people of these villages, doing my field-work for a Ph.D in Economics. Since then, upto 1982 my contacts with the villagers continued to be close and initiate.

The general socio-economic background of the people of the villages, as well as the historical continuities in their socio-economic life have been discussed elsewhere (2). I shall not be discussing them here, not so much because they are irrelevant, but because the way in which I came to be pre-occupied with the health attitudes of these people was not even remotely connected with my research theme at that time.

THE HEALTH CENTER:

During my stay at Asthapuram- Kanthapuram, I set about organising a health centre. The Lion s Club of Chengalpattu was very cooperative and a young member, bright and enthusiastic intern at the Chengalpattu Medical College, offered his services free of cost. He also managed to acquire a fair stock of medicines and drugs to start his work. My friend at Asthapuram Kanthapuram offered to house the centre at the Panchayat building and some of them even loaned some essential items of furniture.

My idea at that time was very much that of a conventional economist interested in developmental issues. I believed that development of rural health care was merely a matter of taking human and material resources to the villagers i.e, transfer of technology which would then provide managerial inputs. This approach, in fact, constituted the very basis of the so called Green Revolution in Indian agriculture since 1965(3).

I also believed that once the villagers understood how easy preventive health care was, they would even take over the financing of it. Towards this end, my intern friend and myself, worked out a Phase II Programme wherein each person in the village would provide Rs.0.25 a month and have the benefit of free medicine and four free consultations a month (every Sunday). On the face of it this was a viable scheme, since this would have meant only 0.05% of the average income of the poorest household. At the

same time, even if 65% of the households contributed, we would have had enough drugs to treat 95% of our cases.

Our emphasis was also on preventive health care. This meant that my intern friend would explain to the patient (with my assistance, wherever possible): (a) the nature of the symptoms; (b) the reason for his diagnosis; (c) the reasons for the treatment offered; (d) how and under what conditions the disease was contracted; and (e) how it was to be averted and what care was to be taken to ensure the non-recurrence of the disease, deficiency etc.

On the face of it, again, this aspect of our approach was perfectly reasonable. It also rested on the Schulzian assumption that people were rational and efficient enough but only lacked superior technology. We were quite hopeful, in fact, since we were going to strike while the iron was hot i.e., when the patient was in the throes of an affliction, and hence most amenable to education.

AFTER THE HEALTH CENTRE

The health centre was very popular. The intern doctor was in undated with patients. With monumental patience and good cheer he went about trying to cure and educate. Soon people of the villages were looking forward to his Sunday visits.

However, the health centre ceased to exist some six months later when the doctor himself took ill and had to go into a long period of treatment and convalescence. For a few months more, the health centre was operated by another doctor, he of course, did not offer either free treatment or consultation. Finally, when the economics of it did not appeal to him any longer, he too would up his practice at Asthapuram-Kanthapuram. An year after the beginning of the entire experiment, the village people were back to square number one.

In a limited sense, some goods had been delivered; a certain number of people had received curative health care. However both our major objectives had been unrealised. Firstly, the maximum collection ever made during the six months of the intern's visits felt miserably short of the needs of the centre. Till the end, the centre remained a venture in charity, even to those who could afford expensive private consultation. The enigma of the result was compounded by the fact that the same villagers did not mind paying Rs.2/ per consultation to the private doctor, while the centre's demands on them was only 12 ½% of this. So much for the self-financing part of it.

The second failing was far more profound. I do not think our health education programme ever took-off. Let me illustrate this. In our first month, we found a predominant number of children suffering from serious vitamin-A deficiency, leading to very poor vision. We kept persuading the parents concerned that the children must be provided greens. We also knew that some varieties such as drum-stick leaves were both liked and easily available. After much effort we did get one parent to regularly feed his child with drum-stick leaves for a month. He came to us one day and announced in an awestruck voice, It is true. This child can see in the dark now! . But even this demonstration did not induce other parents into action. The series of excuses we were given was skin to the old ballad. There is a hole in the bucket .

This was no comment on the doctor's dedication, which was indeed an amazing feat in the light of so much non-response. It was also not a comment on my familiarity and intimacy with the villagers; for when I left the village, there was a large turn-out to bid an unhappy farewell. I was a good man and the doctor had *Kairasi* (healing touch), but still we could not break through into the people's minds.

In the years that followed, two hypothetical explanations came up in my thoughts:

- a) The villagers were proverbial cynics. They never took us seriously just as they do not take any outsider seriously.
- b) The villagers were so irrational that they did not know what was good for them.

Both these hypotheses, soon fell apart. For one thing, the villagers were in fact deeply worried when the doctor missed even a single visit. He had really become a man respected, cared for and looked forward to. For another, the villagers revealed, when they chose to, how rational and clever they could be. Their disputes, their tact and diplomacy in interpersonal relations, their patience and ease in circumventing all forms of bureaucratic interferences, all pointed to a people far from irrational or inept.

Nearly three years later a third and a more viable, hypothesis occurred to me. This was that the *health interventionist and his client meant two different sets of things when they talked about health*. I started gathering materials from my field experience and slowly started putting them together in my mind over the next three years. This third hypothesis began to make more and more sense.

DISEASE AND DISORDERS

To a biological scientist or a medical scientist, the term disease means something very similar to the dictionary meaning, a disorder or want of health in mind or body (4). However, the term disorder has much wider meaning than want of health. The same dictionary tells us that it could mean a variety of things amongst which disease is but one. More interestingly it also means, disturbance, confusion, breach of peace and want of order (5).

To me it seems that, the average villager of Asthapuram Kanthapuram, became concerned with a disease only in as much as it threatened to lead to disorder in a more general sense. Let me illustrate this with the case of D who was a labourer in the villages. During 1978, D came to Madras to see me. He had a badly inflamed cheek and wanted me to take him to a doctor, or at least recommend him one. I took him to see a competent friend who practices medicine as a social service. D's problem was immediately diagnosed as an advanced case of cancer of the cheek. Why did you not seek medical help all these months? asked the doctor. Said D, How could I? I have to work. Anyway it did not cause so much pain as to make me go to a doctor. Even now I am worried mainly that I look disfigured. (I must note, here, that D and his wife were, perhaps, the handsomest couple in the two villages). The doctor exclaimed, What kind of a man are you? You may even die in six months, and here you are. Talking of disfigurement! Let me get you admitted in the hospital. D's plea was as follows: Please let me be. I have no children and so my lineage cannot go on if I join a hospital and die there. Further, who else is there for my wife? Do you think I can go on working till I die? It will be good if I died suddenly, and my wife also had a child by then.

It is clear that D's preoccupation was with a larger notion of order and disorder, in which cancer, and even his possible death, was but a part. Having seen this point, it was easier for me to be more empathetic towards, what I earlier described as hole-in-the-bucket type of excuses regarding vitamin-A deficiency. In particular, I could see that there was a point in what my friend K said, For four days you have argued with me about growing greens in my yard so that our eyesight can improve. You are right in your own way. But look at what will happen: P's chicken will dig up my plants. To make a fence to keep them off, I have to put dried *Veli kathan* thorn shrubs (*Prosopis juliflora*) all around my back yard. After I have worked on that, M's mother or my own wife may pull out the thorn fence to burn it as fuel. After all, where will she go for fuel? It is better that you give us some pills.

I also began to understand why there was so much negligence of child health, in general. A child's sickness causes worry doubtless, but it did not mean loss of earnings! The startling case of R will explain this point. R's son used to hang out with me when I spent long hours interviewing households over my research. Of course, at that time I did not know that the bright faced lad was R's son. The boy had not turned up to see me for a few days, when I went to R's house to interview his family. I asked R about the composition of his family. R started giving me a list, and when he had finished, his wife remarked, My husband has forgotten to mention the son who died last week. You know, the boy called who used to be with you. Not merely was the news a shock, but utterly awesome was the nonchalance with which the news of the recent death of a son was conveyed. Some days later R's wife

rushed to me asking me to help R, who had hurt himself. When I rushed to R's house with a first-aid-kit, I found R nursing a small, but painful cut on his right big-toe. What a thing to happen! lamented R's wife, He had to go and receive his wages from the sugar mill across the river, today. With this cut how can he walk across all that sand in the river bed! So the loss of a son did not occasion as strong an expression of anguish in the presence of a stranger like me, as did the hurt on the husband's big toe that affected the budget temporarily.

Similar was the case of the son of SR. SR was a petty white collared government functionary belonging to a high-caste with a tradition of literacy. However SR's own job was ill-paying, inadequate and a temporary one. He found it hard to feed his own daughters, a son, wife and numerous relatives (whom it was obligatory to entertain well, on grounds of family prestige). SR's frustration was of such an order that he stayed away from home most days of the month and secretly drank himself into inebriation many times during the week. His knowledge that he was more intelligent and that he had a wider knowledge of the world than many others, only added to his torment. In the middle of it all, his young wife came to an arrangement with a rich land owner less than half of SR's age. This, of course, helped the economics of SR's household, but only added to SR the burden of the indignity of a cuckold.

It was during this time that we spotted a leprosy patch on the right cheek of SR's son. We mentioned this to SR who agreed to regularly medicate his son. However, I also noticed that after this disclosure SR became more and more violently disposed towards his son. A year later, SR visited me with his son in Madras. I noticed that the patch had spread considerably all over the cheek. I reminded SR that he might on no account neglect the health of his only son. Is he not your only son? Is he not meant to carry your family line forward? , I pontificated. After a long silence SR said It is true. He is the seed of my *Vamsa* (lineage). But what *Vamsa* is this and what life is this? Each time I see him, I realise that all these are empty words. What future does he have with me as a father and Asthapuram Kanthapuram as a native place? This *Kushtam* (leprosy) is an act of God to put an end to him. I too thrash the boy so that his and our misery may end sooner.

From the two cases of SR, it is clear that even a child's health and well-being are juxtaposed in the minds of the parents with their inner visions of the past and future of the family. In fact, as SR's case clearly shows, *a serious physical disorder may even be considered as a fortuitous occurrence, which alleviates a more general disorder in existence.*

One thing is clearly established. If a health-care system's definition of a disease concurs with that of its recipients, it is no more than a coincidence. The latter frame of reference and the canvas of perspective is infinitely wider. It is a canvas in which health, wealth, human relations, vocation, the past and future are all interwoven in a coherent cognitive perspective. Let us go into some of the determinants of this perspective.

AGRICULTURE AND THE ALMANAC

Since most of the residents in Asthapuram Kanthapuram depend on agriculture for a livelihood, their inner world, is much influenced by the twists and turns of an agrarian vocation. One of the propounded aspects of agriculture is its uncertainty. Not merely do yield levels in paddy fluctuate enormously, but the crop may also entirely fail. At the other end, a bumper harvest may lead to a price collapse, and may therefore even make the farmer worse off. Data on fluctuations in yield levels at Asthapuram-Kanthapuram in the five years leading upto 1976 varied from 15% to 95% in a seemingly random manner (6). What more, all but one of the farmers were victims of this fluctuation and the majority of households moved up and down an economic oscillation, from destitution to reasonable opulence.

It is in this context that the supra-natural becomes central to the lives of the people. We need not argue that uncertainty leads to religious faith, but we may merely accept that it compounds it. In this incredibly uncertain world where the crops, health, wealth, business and political contacts, a daughter's marriage, or son's job and all else is largely in the domain of the unknown, it is logical that

the individual humbly surrenders himself to the unknown . An educated Brahmin calls it *Prorabhdhum* (the result of our past actions) or *Karma* ; yet others may identify it as *Kadavul* (God) or *Vidhi* (Fate). All these constitute some crucial reference points pertaining to an order which is by itself postulated as immutable, inexorable and transcendental of day to day circumstances. It is the most fundamental point of reference in almost everyone s life at Asthapuram-Kanthapuram. Thoughts about this, discussions of this, and speculations in this regard fascinate any villager.

While the civilisation itself has produced some of the finest metaphysical theories, individual members are pre-occupied with rituals, festivals and innumerable speculations and activities that related to spirits, *dosham* (a bad force or consequence), *pavam* (fruits of vice), *punyam* (fruits of virtue), *kan* (evil eyes); and with the appeasement of numerous protective and malevolent deities. The mental universe of a villager dealing with the unknown is the most detailed, has the deepest roots and causes the profoundest of actions (8).

During the eighteenth century, the pests and diseases on the crops were treated with appropriate *mantras*, and *prayers* (9). Every village in the region, also put away a fraction of output for *Varshachalam* or *Varuna Japam* (Prayer for rains)(10). Every village had a *panchangam* (almanac) reader who would indicate the correct celestial confluences, and hence the appropriate time for all activities. Certain villages even endowed a *manyam* (a permanent subsidy) for the *panchangam* (almanac reader)(11).

Today the conditions are vastly different, but uncertainty remains. Even more importantly, the legacy of such information, mythology, ritual practices and beliefs from the past millennium (at least half of the villages in this district are a thousand years old) constitute the cultural foundations for assimilation of knowledge, and rationation today. The great sophistication and myriad detail of this foundation, struck awe in the early English official of this area, as they do in many a visitor today.

It is this legacy that my friend E was communicating to me when he discussed a drumstick tree with me. This particular tree preferred foliage to reproduction there were hardly any drumsticks for two full years from that tree. E said to me, We must put a rock in the lowest fork in the branches of the tree and tie it in place, on the day of solar eclipse. Then it will begin yielding. After all, the people all other living beings are also subject to *dosham*. On either side of E s plot of land, his cousin planted a new variety of paddy, which grew into a lush brilliant green expanse. The day after I remarked upon how beautiful it looked, appeared a cardboard hoarding in the cousin s field. It contained a malevolent and evil looking picture of a half demon-half human face. Below it was the caption *Kannai par siri* (meaning: let the evil eyes be returned to the caster). E and his cousins do not offer a prayer against pests as did their ancestors, but use chemical sprays. However each year they offer a prayer to Lord Murugan at Tiruttani for the safety of their crops.

In the varied circumstances of existence wherein uncertainty is the main feature, the vast and many layered pre-occupations with the immutable order is symbolic of a basic obsession with stability and orderliness. (12).

In the realm of the known, the immense priority given to family, kin-group and jati reflect a similar phenomenon. All these institutions are also to a large measure long lasting; and though not immutable, are certainly free of contingency, in a large measure. (13)

Let us consider the ramifications of all this on health issues.

MEDICINES AND MAGIC

Since the human body and its senses are the repositories of transitory sensations and experience it is not of primary significance; the representation or the manifestation of the immutable in the body is considered more significant. The old Tamil Song.

This body is false, it is merely a bag full of wind, represents the ultimate desideratum in the world-view of most people of Asthapuram Kanthapuram. Thus, even death is not absolute. Among the Vanniya jati people, the funeral rituals contain a joyous dance, called Savu Koothu (death dance), which is actually an erotic and symbolic portrayal of the procreative act. There is much drinking and rejoicing and at the cremation ground a man chants the story of the origin of this universe and the eternal quality of life. (14) Among the Vellalar, the Brahmins, the Yadavas and all other jatis, the belief structure is the same.

What happens to one's body and one's health is also in the ultimate analysis, considered to be a part of larger scheme of things: *Piranda Neram* (the time of birth), *Pendatti rasi* (the propensity of the wife's horoscope to influence one's life), *thalai vidhi* (fate), *thalai ezhuthu* (what is irrevocably programmed at birth) and so on.

All traditional health care methodologies therefore invoke these self-same principles. All of them claim to have come through the *srutis* (original knowledge) as it reveals itself (without any human endeavour)(15). None of them is limited to purely biological phenomena in the Modern Western sense. Tantra and Yoga for instance talk of the Kundalini which is non-verifiable empirically or physically. In Asthapuram-Kanthapuram lives a very old man who is said to be over a hundred years old (16). Although he has none to care for him and is very poor, he is very fit and is reported to have never gotten ill. According to him, in his younger days he had activated all his kundalinis whereby his body became pure and immune to all sources of decay. In Madras, across the street from me, lives a yogi. During times when he is not travelling abroad, he teaches people kayakalpam (or the art of being immortal). As his pamphlets advertise, his disciples can remain youthful as long as they wish. Among his numerous Indian disciples are one former chief-minister and several business magnates.

Even home remedies and Ayurveda and Siddha medicines place much emphasis on manobalam (will power) and prana sakti (soul force).

It is in this background that we must see an allopathic practitioner. Time and again, in our health centre at Asthapuram-Kanthapuram patients would ask us for Pathiyam (diet regulations): if we did not specify any, we received a reproachful look. Traditional medicine is full of pathiyam rules. After a while we also started specifying pathiyam even if it were not strictly necessary. We also had a muscular and well-built woman who kept insisting that we give her an injection every week, although she had no complaints. When turned away, she would feign all forms of symptoms and would not leave us unless we gave a B12 injection. You see this thayathu (talismans)? She asked me, brandishing it on her left upper-arm; This doctor's Oosi (injection has even more power. I never fall ill. Our intern was said to have not merely kai rasi (healing touch), but also much sakti (healing energy power).

The key issue is that health is not an empirical phenomenon to the people of the villages, in the same sense as it is to the practitioners and students of medical science. The statistical canons of medical science will find little to verify among the farmer's ideas on health, because so much of it is non-tangible and qualitative and seemingly a priori. For the same reason health education, as we attempted it, is an exceedingly hard task. What is statistically and empirically a proven causality in medical sciences, is listened to with much respect and awe by the villagers, but it rarely makes a serious impression on them. They are basically on far more secure grounds with their myths and rituals as far as causality is concerned, than is a scientist with his theory.

At the end of one long sermon that I gave on the need to build toilets, my friend K at Asthapuram-Kanthapuram was in total agreement. He said, you should jail everyone who goes to the fields to relieve himself! The next morning he came along as usual to accompany me to the fields. While in the fields he said rather apologetically, what you said yesterday; is true. But is it not a fact that the breeze on one's posterior is the biggest stimulant? He then set forth his theories on the *panchabhoothas* (the five elements of nature) and the need for harmony with them, when the body was performing its most important function.

II. LEPROSY IN SOCIETY KUSHTAM AND KARMA

It is in this context that we must consider leprosy or *Kushtam*. It is taken as being symbolic of a very serious disorder in the larger scheme of things. From my foregoing argument it follows that this is but logical. For, among the various conditions of human existence, there is little that is so visible and (till recently) inexorably a picture of decay and destruction as is leprosy. The slow and insidious method city of its progress is incredibly more awesome than anything that is sudden and quick and hence quickly crazed by the selectivity of memory. Thus it is the *maha rogam or Peru viyadi* (the big disease). Its explanations in terms of the people's casual perceptions must also, therefore, be an eloquent and grandiose one.

One literary work discovered during the eighteenth century in this region, is built up on a huge canvas around the theme of leprosy. It is a Telugu verse-epic about the Raja Bhoja (17). It begins with a description of the splendour of the king's rule and of how beloved he was of his family and his subjects. One day he is discovered to be afflicted with leprosy. Gradually, the curtain of isolation falls around him and eventually he is isolated even by his family. Sick at heart, he proceeds towards a river to drown himself. However, the goddess of the river, fearing that even her sanctity would be ruined by all the *pavam* that manifested itself on the Raja in the form of leprosy, intercepts him in the guise of an old woman. She then derides him for believing that destruction of his body would give him salvation (*vimochanam*) from his *pavam*. On the contrary, she says, You will be born again and again until your *pavam* is dissolved and your *karma* fully undergone. She then advises that he should go to the God of all Gods (Narayana) who could be found in the form of a holy mendicant (called Dattatreya) on a mountain top. When the king finds the mendicant after an arduous search, even the mendicant begins to flee. However, the tenacious king chases him through mountains and forests and eventually corners him and pleads with him to be taught the message of liberation.

In the remaining three-quarters of the epic, the mendicant narrates a series of tales to illustrate the meaning of *karma* and *prarabdha* (the result of past actions). These dozens of tales are woven, one within another, in the classic style of *the Panchatantra* and the Jataka. At length the king becomes enlightened and so is absolved of his *prarabdha*.

There is no *pariharam* (remedy) for leprosy even if the afflicted person is a great and just king such as Raja Bhoja. Let us now consider this in contrast with yet another work discovered in the eighteenth century (18). In that, the Chola king Karikalan is said to have committed the ultimate act of executing his own son, as a result of which he suffers the *dosham* (evil effect) of *brahmahathi* (brahminocide). He redeems himself by constructing more than three hundred temples, towns and villages and bringing in human settlements into the entire eastern Coimbatore district. Thus, there is a *pariharam* for even *brahmahathi* but none for *Kushtam* (leprosy). Such is the place of leprosy in this, the causal universe of culture. It is *poorva Janma karma* (the karma from the previous birth).

LEPROSY AND LEGEND

Not merely in history, but contemporaneously also, leprosy has a legendary quality. In Asthapuram-Kanthapuram people do not use terms such as *prarabdham*, but when they refer to leprosy, they use a similar terminology. SC belonged to the Chettiyar community and was a middle level farmer and a prosperous trader. He had symptoms of fairly advanced affliction of leprosy (some of his fingers had clawed) in 1976. Remarking upon this my friend K said, Poor man! Why should he of all the persons get leprosy? He is not a crook, nor a liar. Were I not an atheist, I might have attributed it to his *vidhi* (fate). A year or so later SC's business was not very good and his crops had failed. K said Look at SC. He is finished. It is all because of his Hippocratic qualities. Do you know that B's wife was seduced by him and abandoned? Now B has also thrown her out. It is his pretence to piety that has destroyed him. I intervened and said, But surely you don't believe all this. You are an atheist. K brushed this aside by remarking impatiently, What has all this got to do with God? He retorted, If I harm you, your *vaithu erichal* (literally stomach burn, metaphorically heart burn) will destroy me. That is a fact, is it not? Now if I deceive someone who is worshipped by everyone, I incur all their heart burns; don't

I? But what can we do? Is there a *nivarthi* (same as *pariharam*) for this? I asked, K's reply was cryptic, Can you put the milk back into the cows udders?

Leprosy also has consequences other than physical. Once MM, the postman was speaking about VM the landlord, A meaner man you will not find. Even though he is my uncle, I am not afraid of saying this. But all actions have their *palan* (fruits), so don't you worry! . Since VM had just then returned from the hospital after a major surgery I asked, Do you think his recent illness was a *palan*? No, no! MM said, that is not what I meant. He was quite a decent person till he seduced the lady with leprosy 10 years ago. What more, she died giving birth to his child. In fact the child also died. It is since then that he has become *vakram* (pervert). His mind is afflicted with leprosy. How could anyone ever do that to a wretched woman with leprosy? So when the leper died she has afflicted his mind with the disease .

Leprosy is by itself also *vimochanam* (absolution). SR, whom I mentioned earlier, met me again in 1979, I asked him about his son. I've left him with my sister he said, let him study or roam the streets, I do not care. As far as I am concerned, his having got leprosy may mean that our *Talai Ezhuthu* (fate) may change. Are our sufferings not like the rains? In a drought some must die, but they are the *bali* (sacrificed) for the rains to come . SR believed that his family might indeed see a better future, now that the eldest child took on the task of suffering on behalf of all of them. This thought process is strangely reminiscent of the *Cholan Poorva Pattaiyam*, which mentions cases of human sacrifice (involving the village leader's eldest son) to appease the malevolent Gods who threatened the entire settlement.

Victims of leprosy are, thus, many things at the same time. They are victims of fate; they are objects of sympathy and pity; yet they have powers, which are not to be tempered with (a la MM). They are also sacrificial symbols who relieve their social group of the burdens of Karma. In other words, leprosy patients are different. They are not like everyone else. How is this difference felt and articulated?

STIGMA AND DISTANCING

At this stage it would be usual for people to say that this difference is articulated through stigmatisations. It seems to me that such expressions as stigma do not really mean anything in contexts like those of Asthapuram Kanthapuram.

To the best of my knowledge none of the Indian languages has a synonym for the word stigma . In fact, as in the case of many other words in modern social sciences, it is difficult for an individual brought up in this culture to make any sense of it, or even translate it without difficulty (19).

The dictionary, gives meanings to the word stigma (20). In a social sense, the relevant meanings are a brand, a mark of Christ's wounds or marks resembling them . In short a stigmatised person is a punished person, and considering the Christian connotations as well, one might even say, a martyr.

From what we have seen earlier it is evident that leprosy patients in a place like Asthapuram Kanthapuram are a lot more than this. They are many things, other than merely punished, or martyred persons; yet among social scientists and leprologists, it is a habit to use the word stigma to refer to the leprosy patient's social conditions (21). The idea at least initially, is to refer to the fact that the society mentally puts them at a distance. But as the word gains currency, many other meanings get attached which are a part of the history of the word stigma, but certainly not that of leprosy as a social phenomenon (22).

Eventually, leprosy as a social phenomenon is given a shape and a character that it perhaps does not possess actually.

Let us consider this in some detail. The only thing I definitely know is that in Asthapuram Kanthapuram, leprosy patients are mentally differentiated from the rest of the population, even if it

happens physically only rarely. In other words, the moment it is known that a person has contracted leprosy there is a way in which he is mentally distanced by others. *This is the only known fact.*

We need to do a lot more research to get some idea about the manner in which this distancing occurs and the factors that influence the process. The fear of being distanced thus, is the basic cause for the tendency in almost all leprosy patients to describe their initial patches merely as *padai* (a patch). Since it is known that there are all forms of *padai* in this area (in Madras and Chengalpattu districts a very large number of people have all forms of skin disease and deficiencies) the patient is able to buy time till more typical symptoms appear (such as clawing, for instance).

However, even if the distancing does occur, it does not necessarily mean that the person is socially rejected, as the use of the word stigma would suggest. In fact there are forms of distancing an individual, which are far more feared than leprosy. There are forms of distancing, which, for instance render a person into a non-entity, and thereby truly reject him or her. To the best of my knowledge no leprosy patient, in this culture is a non-entity. He just acquires a new identity, namely that of a leper.

To make this point clear, it would be necessary for me to go into the phenomenon of distancing in some detail.

HOW ARE PEOPLE DISTANCED?

It will not be an overstatement if the Tamil people are described as the masters in the art of distancing. There are hundreds of occasions of distancing individuals or social groups (i.e. set them apart) temporarily or permanently. There are equal number of reasons and contexts for the distancing process:

- (i) Inter-personal distancing: this involves a basic restraint in all forms of interpersonal relationships, such as father-son, husband-wife, mother-daughter, friend to-friend and so on. The basic feature of this form is a general emphasis on restraint (*nidanam*) in communication as a sign of civilised behaviour. Demonstrative expression of affection in almost considered anaesthetic and vulgar except with very young children. (23)
- (ii) Ritual distancing: There are occasions when people are distanced ritually. These are usually for reasons of ritual purity or pollution. For instance among the Brahmins there is the notion of *madi*; till such time as a person has performed his or her daily religious rituals in the morning, the person cannot come into physical contact with others. Another illustration is that of the menstruating woman. In this case, the woman is literally referred as being in a state of *Dooram* (distance); and because of the context the word also means impure. This is a case of distancing a person in a state of impurity from all the rest, till she has bathed (i.e. undergone a purificatory bath after menstruation). The world of the Tamil-Hindus is packed with occasions of ritual distance based on purity-pollution rules (24).
- (iii) Distances of Consanguinity and Commensality: These are the distances that are most crucial from the point of view of social groups. These distances pertaining to inter-marriage and inter-dining constitute the distances between jatis, sub-jatis and sometimes even kin-groups and lineages. While in Asthapuram Kanthapuram intercaste marriage is a taboo (25), elsewhere (such as among Thanjavur Vellalas) even marriage within the caste but outside one's socio-special zone (known as *nadu*) and lineage group is resented. In fact, these distances constitute an important aspect of the very social definition of man in this region i.e. if one were to ask who is so and so? the answer will be A member of such and such a family of such and such a caste in such and such a village.

- (iv) Occupational and economic distances: These are distances arising out of master-servant, employer-employee, and land owner-tenant relationships.
- (v) Preemptive distances: These are distances that are temporarily or permanently maintained in order to maintain stability or preempt disorder. The distancing of a leprosy patient is of the permanent variety. The distancing of a smallpox or a chickenpox or a measles-patient or an acute herpis (known as *Akki*) victims is of a transitory nature.

Preemptive distances can be of many other varieties as well. In the old days, performing tonsure on a widow, and her consequent disfigurement (along with a ban on all but a few colours of clothing, all flowers and *sindoor*) was preemptive of sexual temptations. An extreme version of this was sati or bride-burning. The depopulation, through the act of desertion, of a harsh king's domain was an act of distancing the kind from his own subjects (26).

Broadly speaking, the process of distancing appears to be a built-in device in society for protection or preservation of stability, since stability is contingent on contexts, so is distancing. The nature, meaning and quality of distancing is often context-oriented. Consider for instance, the case of the menstruating woman. In order that this woman is able to nurse her child, the child is exempted from the general rule. However, in order that the child will not spread the impurity, the child is kept naked during that time. Similarly, in the case of the *madi* woman, nursing her naked child is permissible. It is interesting to note that the nakedness of the child denotes two different things in the two contexts; in the former case, it protects the rest of the household from impurity and in the latter, it protects the mother's purity from the impurity of the rest of the household.

DISTANCE AND HOMEOSTASIS:

The very act of distancing a member or subject of a society is a reflection of its concern for its own organic solidarity. As it may be seen, almost all types of distancing processes involve a threat to solidarity in one way or another. In fact, the social anthropologist Victor Turner, makes a general theoretical postulate that all social process is an oscillation of human conduct between structure (i.e., institutions, norms, established relationships etc.) and community as (i.e., that which is opposed to all structures and the innately anti-structural aspect of humanity) (27). It might be possible to look at the distancing processes as attempts by a social structure to preserve itself constantly from itself. Even more significantly, distancing processes express the homeostatic basis of society (28).

Most of the distancing activities could be viewed through an interesting taxonomy: a) that which protects the individual from his social group; and b) that which protects the social group from the individual. The earlier illustration regarding the *dooram* and *madi* women clearly substantiates this distinction. From this point of view, the distancing process involved in the cases of the mendicant and the leprosy patient are similar. In both cases the social group is protected, in one case from the anomy of mendicancy and in the other from the disorder of deformation. However, the similarity goes much farther. In both cases there is a voluntary element in the distancing process.

In fact, much of the distancing acts are voluntarily undertaken; certainly not voluntary in the sense of a ratiocinative process but more as a spontaneous activity of a person who knows what is expected of him in a milieu. The ultimate act of distancing, is of course, the mendicant's renunciation of all possession and all relations (29). In this search for salvation, the mendicant's code does not permit him to spend two nights in the same place. The householder's ideal type for such voluntary distancing is the idea of karma yoga or the performance of one's duties in a detached fashion (30).

In Hinduism, the classification of the life span of the individual into various *ashramas* is ostensibly at least meant to aid this process. Consider, for instance, the case of SC. Ever since he discovered that he had contracted leprosy, he began washing his own clothes, his own plates, and tumblers;

he would also not allow members of his family to make his bed. This was quite extraordinary since normally a male head of a family of SC s standing and status would loose face by performing even the smallest of these chores. What is equally interesting is that in so voluntarily distancing himself, he had also voluntarily reduced another form of distance between him and his family which was maintained through the sanction against his doing his own chores. A leprologist once narrated to me a similar instance pertaining to an eminent musician who contracted leprosy. This musician once visited the leprologist during the early stages of his affliction. However, although he was a kinsman he refused to enter the house. On being admonished and forced to enter he sat in great discomfort throughout the visit and refused any refreshment of any sort.

Perhaps the most dramatic cases of voluntary distancing are those of the close relatives of the leprosy patient. A distant relative of mine gave up an extremely lucrative and promising career in order to be able to attend on his mother who was a leprosy patient. During this period, he virtually isolated himself and his mother from the rest of the world. He remained virtually jobless for many years, till his mother died. He then took on a relatively low-paid job, since he was, by then, too old to compete for better ones. The other case is that of an entire family in Andhra which isolated itself when the mother contracted leprosy. I was informed that all the girls in the household refused to marry and that they were seldom seen even in the front-yard of their house for all of ten years. Thus voluntary distancing, has elements of both types of our taxonomy; it protects those around an individual, as well as the individual from his environment.

In as much as such distancing is largely voluntary, no individual so distanced loses his roles and functions. Let us consider some illustrations.

KC was a member of the highly placed Chettiyar jati in Asthapuram Kanthapuram. He had fairly advanced symptoms of leprosy including a certain amount of facial disfigurement and clawing of the left hand. He had neither land to cultivate nor any other vocation. A few children used to study with him and his daughter went around in the afternoon selling a few snacks. However, the children s parents did not pay any regular tuition fees and the daughter also could not have earned more than Rs.2-3 a day. Yet KC and his family did not seem to feel the want of food. I discovered that periodically some family or other would provide rice and other articles of food as a loan . I wondered whether such loans would ever be repaid. VM said to me, Of course, nobody expects them to repay. How can they? To do so would be a *pavam* (sin). Isn t be a devotional singer? KC was well versed in devotional songs such as *Thevaram* and spent most his time singing quietly to himself, beetling a complex rhythm in his *Udukkai* (small percussion instrument). Another leading villager KM said, If we give it to him as charity it will be humiliating. And anyway he is a *Thevaram* singer. What has leprosy got to do with it?

Let us also return to SR s son. In 1980 I met SR at Asthapuram Kanthapuram and enquired after his son. SR told me that the boy was still in his aunt s house and that he was now regularly going to a good school. On my asking about his health, SR told me that he was receiving proper medication and that the disease was under control. I asked him if his aunt did not mind the boy s leprosy, SR said, What about it? She says, that as long as he is being retreated let him be with her as one of her own sons. Of course, the other children think it is a *padai* (an ordinary patch). My sister says that the boy should not feel hurt or isolated. So no one except my sister knows . This was a happy ending to a sad story.

In Asthapuram Kanthapuram, of the 17 leprosy patients, only one person lived alone and in isolation. This man, a 55 year old Naidu called NN, had no family or kinsmen in the village. According to my informations, he had been there for about seven or eight years. Somebody built him a hut and helped him grow a small garden around it. Someone or other fed him everyday. In fact, on a rainy day when it had been really pouring heavily, I asked SR s wife where her four year old daughter was. She has taken NN s food to him , she said, It is my turn to feed him . So even NN was not a destitute.

It is in the light of all this that the notion of stigma becomes an enigma. The very idea of stigma evokes moods of isolation, exploitation and undue suffering, none of which I was able to perceive at Asthapuram Kanthapuram.

SUMMING UP:

We are now in a position to sum up the arguments I have made so far.

Since, health as a phenomenon means two different things to the health-care agency and to its recipient, I have argued that there is a need to look at health from the recipient's point of view.

It is evident that the recipient is concerned with the more general phenomenon of order and stability of his or her life, and that not all disease means disorder for him or her. At least in one case it was seen that a serious affliction was even viewed as a redemption from a more general disorder.

On going into the various aspects of the perception of order of the rural based individual, it was seen that it consisted of a many layered fabric that incorporated everything from God to health.

In this context, the health perceptions of a peasant are seen to consist of many elements that lie outside the taxonomy of modern biological or medical sciences. Even the definition of a doctor assumes dimensions that lie outside modern medical sciences.

The incidence of leprosy is viewed by these people in the perspective of this fabric of perception. Thus the notions of *karma* and fate are bound together along with the perception of leprosy as a disease.

A leprosy patient, in turn, becomes the object of varied legends, fantasized or real, all of which make him a different person; somewhat different from any other patient.

This difference is articulated by the distancing process, whereby the person's social roles and functions acquire a new definition. At no point of time does this distancing process involve a rejection or stigmatisation. In fact the very nature of the distancing process is such that, a leprosy patient is rarely rejected by the society; the very process is reflection of the impulse of the society towards a homeostatic solidarity.

My evidence regarding leprosy suggests that leprosy patients continue to possess roles and functions within the society, but from a different perspective. In the light of all these, let us look at the assumptions of leprosy control programmes.

III. LEPROSY CONTROL : LEPROSY AS A SYSTEM

Some time ago, in a conference, I was surprised to hear a bright young leprologist talking about systems approach and operations research analysis. On reflection I discovered that this should not have surprised me at all. For this is the way in which all elements of the development programmes work. In the macro level resource-allocation process, wherein governmental departments compete with each other, claims towards funds and resources are invariably set out in the allocation paradigm of modern economics or operations research.

The department concerned informs the allocating agency that in the previous year so much was achieved at such and such a cost, and therefore so much more should be allocated for the current period. The various agencies in the department are given targets and funds and told to go ahead and maximise results. In short, this is a civilization with the inescapable tinge of economism

(31). That being the case, I realised, it should not come as a surprise if leprosy control becomes an operations research problem or if tuberculosis becomes a linear programming exercise (32).

There are some serious ramifications of this. Firstly, leprosy gets defined as a system. In short, the numerous details of the cognitive universe of leprosy patients are subsumed, pruned, edited and codified into a meaningful system language. It must be clear by now that this kind of exercise can get to be self-defeating (33). It is, of course, assumed that others from say, the Social Welfare Department the Block Development Office, the Religious Endowments Department etc. would take care of the rest. Unfortunately all others are doing the same thing: cutting, pruning, editing storing and pushing a social reality into a system paradigm of their choosing. In this process, no goods are likely to be delivered. If they are, then it is purely fortuitous.

Secondly, some of the essential aspects of the processes of case-finding and case-holding get straight-jacketed into bureaucratic procedures. The sociology underlying the questions, Why do leprosy patients hesitate to come forth for treatment? And when they do, why do they lapse in drug in take or periodic check in? gets side-tracked. In short, sociology of leprosy faces an organisational impasse.

As I said, both these problems emerge from the first assumption of leprosy control programmes, namely that on the whole this is sort of a maximisation exercise. My contention is not that one cannot use, say the PLOT simulation model in leprosy control, but merely that everything has its place. It cannot and should not be used unless the laminal conditions to the system, as well as the characteristics of the subjects are clearly perceived and defined. More importantly, any maximisation exercise can be worked only if the objective and constraints are clearly specified. From the foregoing section, it is clear that these are in fact, the basic problems of the programme.

Another assumption underlying the programme is that the agents of the programme are delivering a particular set of goods; so many cases identified, so many treated and so on. On its own this assumption is all right, as long as it is backed by another one that the division of labour in the Government or similar agencies delivers other goods coordinated with each other. What happens in reality is that the agents of leprosy control programmes find that their subjects make far greater demands than they can match. They demand rehabilitation, jobs, resources, psychological counselling and many other things. The agent is thus torn between two loyalties one to his invisible employer and another to his visible subject. It is quite likely that the agent gradually becomes alienated from his subject and hence possibly, from case-holding.

The very paucity of socio-economic studies today, is an indicator of this alienation. This also results in faulty priorities. If the W.H.O. specifies that x% incidence may be regarded endemic, it does not mean that x% is endemic. Such specifications are, at best, much qualified reference points and no more. From our foregoing discussions it is evident that socially speaking a society might have a tolerance far much higher than x%. It would be interesting to know whether those villages with over 4% incidence in Chengalpattu district have suffered any more socially and economically, than those with less than 1%. My contention is that if a society can take on 4% incidence, let it. There is no statistically valid reason to suppose that through the last three hundred years of human history, 4% incidence areas have suffered any more than 1% incidence areas, or that the contagion does not have its own cycles, simply because such statistics do not exist.

This last point is very crucial from the point of view of developing countries. Suppose, for instance, a country, decides to devote more money on employment guarantee schemes than on (say) cardiac research. It might have more people employed and perhaps a higher death rate. Which is to be preferred? This is a matter of priorities, which comes out of value judgments. Value judgments cannot be meaningful unless there is a sociological apperception underlying them. Such sociological apperceptions cannot come if our programmes (from the start) give preference to maximisation of output rather than to the society that is the subject.

Sociological apperception, will also enable the medical personnel to test the elasticity of many of their statistically given norms. I am, for instance, aware of doctors who are unflustered when a patient in Madras Chengalpattu region shows manteaux= test results with magnitudes much higher than those in the text books used in the Medical Colleges of these regions. According to them, this is normal for this region. However, if the macro system of health delivery continues to be a maximisation oriented one such doctors would only be a minority.

Some very important general observations emerge at this stage:

- i) Society is an organic phenomenon, endowed with a *gestalt* of its own. In this sense, the complex relations among the components of society that constitute the basis of this *gestalt* are more important than the aggregation of the components into the whole.
- ii) The crucial desideratum in matters relating to society will be necessarily in terms of the factors that constitute the basis of its organic solidarity (a la Durkheim). More pertinently, any attempt at changing, modifying, qualifying a component of the society will have to be verified in terms of the effect of such attempts on the homeostatic and homeoerhetic aspects of the society.
- iii) Since, society, as all other complex organisms will be necessarily diversified with respect to the spatial manifestations of its organic solidarity, society itself is best dealt with as disaggregatively as possible. The common social thread that is shared by all the warp and wool of the Indian society, for instance, cannot be postulated apriority but must be only painstakingly and carefully arrived through a study of different regions.
- iv) Thus development as a socio-economic process acquires a very different meaning from its present day one. It is not a maximisation exercise, involving GNP or other variables. It is, a spontaneous process in which the state or any other agency can, at best, intervene in a limited and calculated manner. The limits to these interventions would be given by value judgements that emerge from the perception of society in its organic complexity. The vision of the intervener has to be profound, involve historical dimensions as well as much forethought.

It would appear from all these arguments, that I am raising some basic metaphysical and methodological objections to what goes today in the name of development and such an observation would not be far from being correct. For, after all, what does the study of human civilization tell us about the last three centuries? It tells us that development was rarely engineered by a body of individuals on behalf of a nation. It also tells us that most of theories of development were based on observations after the event. It also tells us that, no two cases were alike. Finally it also tells us that there appears to be a clear-cut positive correlation between degree of disorder or anomy and the rates of growth in GNP, to which different nations and people were forced (34).

REFERENCES AND FOOTNOTES:

1. An elaboration of this theme, is to be found in my paper: Social and Economic aspects of Leprosy Control: Comments Towards a Decentralised and Historically Relevant Mode of Handling the Issue in South India , Paper presented at the WHO-UNIDO Conference on Socio-Economic Factors in Leprosy Control, Kualalumpur, Dec. (1981 a).
2. S.S.Sivakumar, (1978a) Aspects of Agrarian Economy: A Study of Two Villages in Tamil Nadu . *Economic and Political Weekly*, May, S.S.Sivakumar (1989 b) Transformation of Traditional Economy in Tondaimandalam , *Social Scientist*, May, and S.S.Sivakumar and Chitra Sivakumar (1979) Jati and Class at Asthapuram Kanthapuram: Some Comments Towards a Structure of Interests . *Economic and Political Weekly*, Annual Number, February.

3. Theodore Schultz (1965), *Transformation of Traditional Agriculture*, Oxford University Press, New Delhi. 1965.
4. Chambers twentieth Century Dictionary, pp.300
5. *ibid*, pp 303
6. Sivakumar (1978 a).
7. *ibid*
8. It would seem that our Illiterate villagers are in eminent company in this respect; See Max Planck (1936), *The Philosophy of physics*, George Allen and Unwin, London. Since all uncertainty is a function of the future, Time as a metaphysical metaphor is the most profound of the preoccupations. One of the most primordial preoccupations of the people of this region is with the time to do things (Nalla Neram) and the time not to do things (Neram sariyillai). No one barring the very poor is born without a record being made of the exact moment of birth. Most people also record the confluence of planets in the celestial world at that time, and compute the horoscope. The almanac is the major source of information on time as a metaphysical parameter in human action. There is an appropriate time (muhurtham) for everything, from sowing to wedding, from setting out on a trip to doing business. There are inappropriate times as well (Rahu Kalam or the time of predominance of the malevolent planet Rahu). Aside from all this, there are hundreds of omens, the speaking of a gekko the meeting of a lone stranger, a certain remark at a certain juncture and so on.
9. There is an extensive discussion of how village output was allocated in the 18th century, among these and other heads, in Chitra Sivakumar and S.S.Sivakumar, *Peasants and Nabobs: Agrarian Radicalism in Late Eighteenth Century Tamil Country* (forthcoming), Hindustan Publishing Corporation, Delhi.
10. Sivakumar and Sivakumar *ibid*
11. *ibid*
12. *ibid*
13. *ibid*
14. Field notes on Vanniyar Jati Organisation, S.S.Sivakumar.
15. See for instance, a range of literature in Tamil, Nannool Moolamum Kandikal Uraiyun, (ed) T.Chandrasekaran (1959), Govt. Oriental Manuscripts Library, Madras (1952), and Anuboga Vaidiyya Bodini (1978) by Vasudevan, R.G.Pathy and Company, Madras (year N.A.)
16. This man has now passed away. At the time, my friends at Asthapuram-Kanthapuram told me that he is a Siddhar, who can assume the human form at will, any time again. According to them he is not really dead .
17. An English translation of this has recently been made. Unfortunately, at the moment of writing this, I have neither of these works available on hand, and therefore, am unable to give an exact reference.
18. Cholan Purva Pattayam (Tamil), Mackenzie Manuscripts, Government Oriental Manuscripts Library, Madras.
19. See for other such terms and concepts, Chitra Sivakumar and S.S.Sivakumar (1979).
20. Chambers Twentieth Century Dictionary, pp 1084.
21. See, for instance, R.K.Mutatkar, *Leprosy A challenge to social sciences* , Keynote address delivered at the XII International Leprosy Congress, New Delhi, 1984. Mutatkar, in this address finds it important to research into different types of stigma arising out of Race, Sex, Leprosy, etc. He, however, does not ask, What do people mean when they assert that leprosy patients are a stigmatised lot?

22. In the mirage like universe of social science this kind of fait accompli is quite frequent; see S.S.Sivakumar, *Is the Method all Madness?* Social Research, New York, Dec.1986.
23. This is not to say that Tamils are characterised by restraint in behaviour. Tamil films, folk-theatre and drama are, in fact, often full of high melodrama. At the same time, Tamils as a people are considered far more restrained in conduct than, say Punjabis or Sikhs. Be that as it may, the advocacy of restraint in conduct is a part of social norms as well as literature. From the ancient Tirukkural to modern works of Mu.Varadarasanar or T.Janakiraman this moral theme is recurrent.
24. In fact, as sociological literature would have it, the principles of pure and impure constitute the structural basis of Hindu social universe. See, for instance, M.N.Srinivas (1952), *Religion and Society Among the Coorgs of South India*, Clarendon Press, London: and Louis Dumont, *Homo Hierarchicus* (1980), University of Chicago Press, Chicago.
25. For a case study see S.S.Sivakumar (1978a).
26. See Chitra Sivakumar and S.S.Sivakumar (forthcoming) op.cit. For an extensive historical discussion of this.
27. Victor Turner (1977). *The Ritual Process: Structure and Anti-structure*, Cornell University Press, New York.
28. For meanings of the terms homeostatis and homoethesis, see *The New Encyclopaedia Britannica* (1974) Vol.8, pp 1014-1018, and *Dorland's Illustrated Medical Dictionary*, 15th (Asian) Ed. Pp.720. The primordial preoccupation of the Tamil society with order and stability are dealt with in detail in Chitra Sivakumar and S.S.Sivakumar (forthcoming) op.cit. Not merely in day-to-day life, but even in mythology is the Tamil concerned with order and stability; see Chitra Sivakumar *The Lord with a Cockerel Pennant: Power, Violence and Multi-dimensionality in Skandapurana*, (forthcoming) Archives de Social de Religion, Paris.
29. The existential predicament of such a mendicant in a modern day setting is brilliantly portrayed in T.Janakiraman's *Tamil Novel* (1964), Anbe Aramude, Meenakshi, Madurai.
30. As exhorted, for instance, by the much quoted verse 47, Chapter II of the *Bhagavat Gita*.
31. A detailed critique of this process are contained in S.S.Sivakumar, *Poruladara Valarchi Ennum Mana Noi Tamil* (The mental malady called Economic Development), U.G.C. Special Lecture, Madura College, Madurai, and S.S.Sivakumar (1986) op.cit.
32. For a more emphatic assertion of this, see S.S.Sivakumar (1981a) op.cit. Because of their cost-benefit orientatedness, many otherwise respectable agencies are seen to make rather absurd suggestions; see, for instance UNICEF. *Assignment Children*, Spring 1981,pp. 38-40. For an illustration of how such methodologies could cut both ways, see S.S.Sivakumar, *Should the Controller Control Himself? A Heuristic Exercise based on the Piot simulation Models*, Discussion paper, WHO-UNIDO Conference on Social and Economic Aspects of Leprosy Control, Kualalumpur, Dec. (1981)
33. S.S.Sivakumar (1981b), *ibid*
34. This realisation seems to have dawned on even the citadels of present day orthodoxy, see for instance, Wahidul Haque, Nirnanjan Mehta, Anisur Rahman and Poona Wignaraja, *Towards a Theory of Rural Development*, (1975) United Nations Asian Development Institute, Bangalore.