Ethnomedicine and Medical Missions

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What does an anthropologist have to contribute to our understanding of medical missions? My initial response was 'little.' Aside from handing out medicines in Indian villages, I have not cured anyone.. On further thought I decided anthropologists do have something to say, because we minister to human beings in their societies and cultures, and lasting medical change involves transforming these systems. Furthermore, anthropologists are students of 'others' and 'otherness,' and can help missionaries involved in ministry to 'others' to understand deal with social and cultural differences.

Global medical programs are facing a major crisis. In one sense they are victims of their own successes. The growing world population and eradication of small pox testify to their effectiveness. In another sense, they have failed to produce deep and self-sustaining transformations to many cultures around the world. The post-war dreams of global development are largely shattered. The South Commission concluded,

> For many, there was the hope born of success in their liberation struggles. Everywhere there was talk of equality and progress . . . It is important to remember this period of progress and its atmosphere of hope now, when there is deep pessimism in much of the third World about the prospects of economic development (Bello 1994, 7).

Despite the investment of billions of dollars and great efforts by tens of thousands of people, we live in a world of increasing global medical crises, dehumanizing poverty, collapsing ecological systems, and deeply stressed social systems (Korten 1990,1).

In part, this failure can be blamed on the continued rapid explosion of the human population due to better medical care. The sheer fact that massive plagues and global famines

I. Different societies define and deal with diseases and health differently, and we need to be aware of these differences.

People in different cultures live in different worlds, not in the same world with different labels attached. Successful communication is not simply a matter of learning a new vocabulary; it requires the mastery of another worldview. This is true with regard to the etiology and treatment of diseases and mental disorders, for these, too, are culturally defined. On the surface, we see the visible manifestations of healing systems--the treatments and medicines of a society. These are based on deep beliefs regarding the causes of disease and the healers who know the remedies. Underlying all is the people's worldview--the categories, logic and assumptions people make about reality--what they think with, not what they think about. Because worldviews are taken for granted, they are largely unexamined and implicit. They are reinforced by the deepest of feelings, and anyone who challenges them becomes the object of vehement attack. People believe that the world really is the way they see it.

All humans have belief systems that help them to deal with the diseases, mental deviations, social pathologies and other crises of life. Most follow the following process:

	CHOOSE A	**DIAGNOSE THE**	**SELECTING A**
ADVERSITY==>	**BELIEF SYSTEM==>**	**CAUSE USING**	**==>REMEDY AND**
	TO EXPLAIN IT	**THIS SYSTEM**	**APPLYING IT**

What is defined as a adversity varies from culture to culture. In many cultures these have to do with abnormal events. People widely believe that there is a 'normal' state which is taken for granted. Abnormal ones must be accounted for and dealt with. Among them are illness, abnormal births, sudden deaths, barrenness, mental deviance, injuries, floods, droughts, earthquakes and the like.

When misfortunes occur, people do not stand by in despair, and do nothing. They try ways to overcome the misfortune and prevent its recurrence in the future. The first step is to find the right belief system to explain the crisis. Most cultures have a 'tool-box' full of different belief systems that they use to explain what is going on. For example, in the West ,we attribute mental depression to biological causes and use medicines to cure it, decide it is a psychological problem and go to a psychologist, or see it as a spiritual problem and turn to the pastor for help. In Osaka, Japan, people go to the Ishikiri Shrine for healing, the Hozan-ji Shine for business success, the Ikoma Waterfalls for power and purity, and the figures of Buddha for help in this life.

The process of healing starts with the diviner or diagnostician. He or she must find out who or what has caused the difficulty and why it has been brought about. Only after this is known can proper restorative measures be undertaken. If a deity or ancestor has been neglected or offended, than a sacrifice must be prescribed; if one has been "bewitched" by a sorcerer, than recourse must be had to counteracting ritual action or medicine; if one has sinned, purification rites must be performed. All people recognize that there are physical symptoms of illness, and the importance of dealing with these is not missed, but this dimension remains a second-order concern to the deeper causes of the ill health (Staples 1982, 71).

The selection of a belief system to explain the misfortune is both a personal and a community decision. A wife suffering from an illness may blame the second wife with putting a curse on her. The second wife denies this and blames the first wife for angering the ancestors by not feeding them each evening. Their husband may side with his first wife, and blame the second for putting secret medicines in her food. Other families in the community gossip that this family is plagued by a cantankerous spirit that needs to be exorcized. The final diagnosis is based only in

part on what really happened, because this is not always clear. It is also based on the social politics in the family and community.

Once a belief system has been chose, the people turn to experts to diagnose the cause and select a remedy. They may turn to medicine men, doctors, shamans, psychiatrists, priests or other technical experts. When missionary doctors arrive on the scene, they are seen as outsiders with foreign explanation systems that cannot be trusted. Moreover, they must be placed in one of the existing cultural categories for the people to know who they are.

We see this clash of cultures in the come of medical missionaries to villages in South India. Traditional village culture defines 'illness' in its own way (Figure 1). Hot diseases bring high fevers and are caused by experiencing too much hot in life--eating too many hot foods (hot spices, meat, eggs, alcohol, tea, unrefined sugar, heavy cereals, foreign foods such as ice cream--generally cheaper foods), having too many hot relationships (quarrels, squandering one's semen particularly in extramarital affairs, high stress jobs), and doing hot activities (hard labor that causes sweating, hyper-activity). To cure them the patient must eat cool foods, maintain cool relationships and rest. Cold diseases are cause by too much cold food (dairy products, wheat flour, sugar, some fruits--generally more expensive foods which only the wealthier high caste people can afford to ear regularly) , cold relationships (store one's semen) and inactivity, and must be cured by adding heat to the patient's life. All people have bad tempers on occasion, but some people are plagued with this and are

Figure 1
Diseases in an Indian Village

- hot diseases (fevers)	- cold diseases (chills)
- boils and cuts	- mental diseases
- bad tempers	- quarrelsome families-
- bad luck	- frequent accidents
- robbed repeatedly	- going broke
- spirit possession	- aches and pains

contagious. A gathering may be peaceful, but when such people arrive the disease soon spread to the whole group.

The most common complaints are of chronic weakness. This cannot be cured by iron tonics and vitamin concentrates. People must make a pilgrimage and bath in one of the sacred rivers which can wash away one's sins, or perform a costly rite of purification conducted by a Brahmin priest.

Indian villagers also have medial beliefs and practitioners to deal with these illnesses (figure 2). When someone becomes ill, the first step is to diagnose the cause--is it due to sin and wrongdoing, spirit possession, a curse, eating hot foods, offending an ancestor, bad luck, or what? If the problem is minor, people generally go first to a person who knows home remedies. If these services fail, they go to more powerful practitioners who use more powerful solutions. The Saint prays to one or more gods, and because they know the cause, he need ask no questions. Moreover, he does

Figure 2
Indian Healers

I. Swami (SAINT):
- deals with diseases caused by sin
- cures by prayer to the gods
- asks no questions, gods know
- charges no fees, a spiritual service

II. *Shaktini* (SHAMAN):
- deals with evil spirits and possession
- cure by battling spirits and exorcism
- asks no questions, he/she knows
- charges no fees, a spiritual service

III. Mantrakar (MAGICIAN):
- deals with black magic, witchcraft
- curse by magic chants, amulets
- asks no questions, divines the cause
- charges no fee, a spiritual service

IV. Vaidudu (MEDICAL DOCTOR)
- deals with medical diseases
- Ayurveda and Unnani medicines
- asks no question, he/she diagnoses
- charges high fee, powerful cures
- gives a guarantee, no cure, no cost

V. Manduvadu (HOME REMEDY, QUACK)
- deals with minor medical problems
- asks many questions, doesn't know
- charges low fees, weak cures
- no guarantee, pay for service

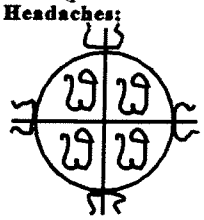
his ministry as a service to God, he charges no fees. Those who are cured, however, give him gifts according to their means to thank the gods, and to make sure the gods help them the next time around. The Shaman, too, asks no questions. He goes into a trance and his spirit enters the spirit world where it finds and recovers the person's spirit that has wandered away, or battles the evil spirit causing the illness. The Magician uses powerful *mantras* and *yentras* (figure 3) to cure the patient after diagnosing the cause of the sickness--a curse, black magic, violation of a taboo or bad stars. These, too, do their service as an offering to the gods, and charge no fees, but accept gifts healed patients give to the gods in thanks.

Figure 3
Mantras and Yentras to Cure Diseases

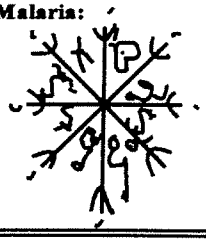
Mantra (powerful chant) to cure a viper bite:
Om namo, bhakagate, sarva peesachi gruhamul nanudzuci, paradzudu, ram, kleem, kshaum, hreem, sam, svaha.

Yentra (powerful drawing) to cure:

Headaches:



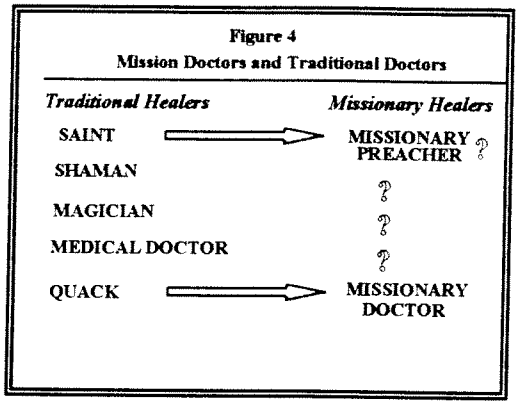
Malaria:



The Medical Doctor uses either Ayyurvedic (Hindu homeopathic medical system), or Unnani (Arabic medical system) to diagnose and cure the patient. He charges high fees because of his great knowledge, but he gives a guarantee. The patient pays nothing if he/she is not healed. Home remedies are prescribed by folk` healers, commonly thought to be quacks. They ask many questions because they do not know how to diagnose illnesses by technical methods; charge low fees because they have little specialized knowledge; and give no guarantee. The patient must pay for the medicine before receiving it, and there is no refund if it does not work.

Given this view of the world, it should not surprise us that when the first mission doctors (practiced western allopathic medicine) came, the villagers saw them as quacks (figure 4). These

foreign 'doctors' kept asking questions when trying to diagnose a disease[2] (why should a patient go to the doctor if the patient knew what was wrong?), and they gave no guarantee. In mission hospitals, patients had to pay for the medicines whether these cured them or not! In the opinion of village Indians, the most important function of the healer is to pronounce the prognosis and declare with an aura of conviction a sure cure--"He will recover." The modern doctor, however, expresses only his or her opinion, and does not speak with the authority of the supernatural power which is the real agent of their cure. For them, healing is not a technical skill, but a supernatural encounter.



It is easy to see that the cross-cultural communication of beliefs and practices as complex as western medicine leads to misunderstandings and distortions. An example of this was World Vision's experience in East Africa. To break the cycle of fly-borne diseases, they introduced windowless latrines with tight doors so that flies could not get into the waste. Months later the public health workers returned, only to find windows cut into the outhouses, the roofs removed, and flies everywhere. On inquiry, they found that the people believed that demons live in dark, damp places, and feared that if they entered the dark outhouses, they would be possessed by evil spirits.

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[2] Russell Staples tells of a Rhodesian tribal who complained after going to a missionary doctor, "How can he help? All he did was to ask me questions" (1982, 70). He believed a proper doctor would have 'divined' the source and prescribed an appropriate remedy--an appropriate ritual plus some medicine, and not wasted time asking seemingly irrelevant questions.

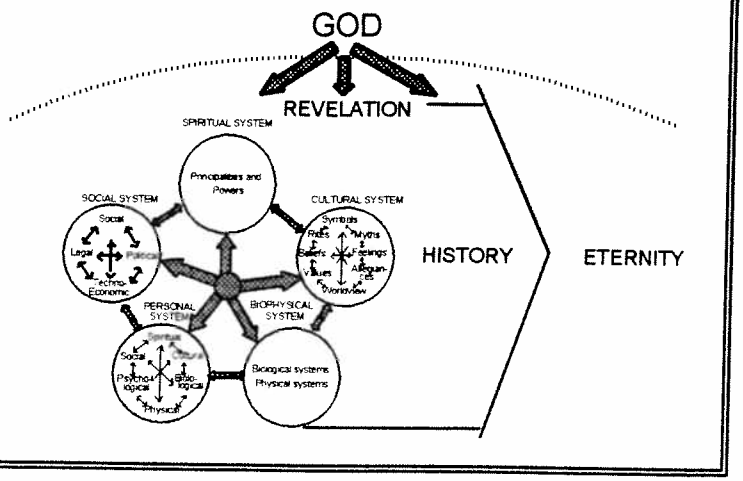
It is important for us to understand ethnomedical systems, for many of the non-Western world's people reside in areas that are not exposed to Western medical treatment. The lack of implementation of modern medical care in these areas is due not only to the lack of funding, but often to the fact that modern medical care is misunderstood and rejected. Determining why the ill choose to accept or reject a system of treatment has to do not only with who they perceive as a proper healer, but also with their native etiology of disease and appropriate treatments.

II. Health and disease are part of larger sociocultural systems, and lasting transformations must take these systems into account.

Every culture defines what are diseases, what causes them, and how to treat them. Every society also embeds these medical systems in the larger social and cultural frameworks of the society. Sociocultural systems define when people are 'sick' and when they are 'well;' who should treat what diseases; who is treated and who is not and for what reasons; and who should pay for treatment. They also defined the social matrix of relationships for support. The resolution of illness is everyone's business in most societies.

Contemporary human sciences study people in terms of a 'system of systems' (figure 5). For purposes of analysis, it is helpful to analyze them as biophysical beings made up of chemicals and biological processes such as blood circulation, nervous system, food assimilation, reproduction and the like. It is also

Figure 5
A Systems Approach to the Study of Humans



important to study them as psychological beings--as individuals with drives, needs and desires; as part of social systems--as groups and institutions based on structured relationships; and as part of cultural systems--systems of symbols [language, behavior patterns, rituals and so on], beliefs [including medical beliefs] and worldviews. To this, as Christians, we must add the spiritual system of humans souls, the work of God in the lives of people, and the conflict between good and evil--God and his angels against Satan and his co-rebels, which included us before we turned to Christ.

It is important to view medical missions in this larger framework for several reasons. First, illnesses generally involve more than one of them. Biologically based diseases can cause psychological problems and social stress. Similarly, spiritual or social conflicts can cause physical diseases which cannot be fully treated by chemical medicines alone. Symptoms may emerge in several of these systems. It is important, and more difficult, to find the underlying causes for the problem.

Second, in medical missions we are concerned with healing the whole person. This includes leading people to faith in Christ, to true fellowship in communities of believers, to full personhood and to biological health. So long as we keep systems distinct, we will not offer a whole Gospel.

III. Sustainable transforming health systems requires a process of participatory/learning in which the outside medical team works with the local community to assess, carry out and evaluate programs of medical transformation.

In the past, we from the west went to other peoples and saw what we believed were problems. We defined these problems, decided on a solution, procured the resources, carried out the work and evaluated the results. When we left, however, often little of what we did continued. It is becoming increasingly clear that sustainable changes require the participation of the people

we serve. The most effective model now emerging is that of Participatory Learning and Action (Raja 1996).

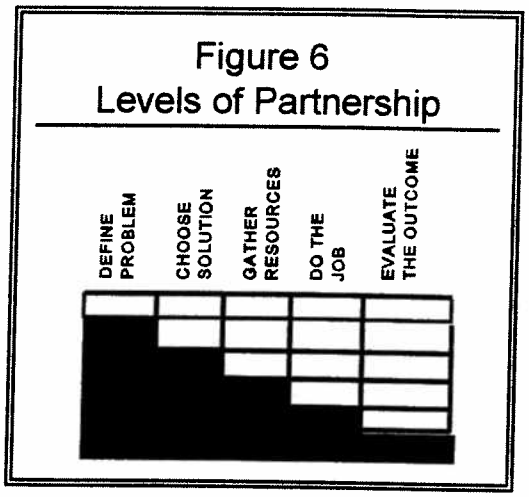
PLA requires joint participation of mission and local community at every step of the medical program. First, the missionary medical specialists gather with local leaders to define their problems. Then they decide together how to solve the problems, how each will contribute to the resources needed, what each will do to carry out the work, and finally whether the project has been a success and how to modify it. PLA involves not only finding a solution to the problem, but also teaching the people processes whereby they can solve their own problems, drawing on outside expertise.

An example of participatory learning and action was World Vision's introduction of clean water in East Africa. Initially World Vision teams determined that the people needed clean water to stop the cycles of disease. Hydrologists came in and determined where to drill, and teams dug wells, but with little success. When they did strike water, the pumps would run until they broke and no one would fix them. When World Vision teams worked with local people to determine where to dig wells, and who would be responsible for maintaining the pumps, the local experts recommended that they drill near by Baobab trees that were green during the dry season [their presence shows deep water reservoirs], near big anthills [ants need moisture in the dry season] and in valleys near irrigated fields. Communities jointed to maintain the pumps so sustained change was effected.

It is clear that the success of medical programs is based to a great extent on our use of participator models that involve the local people, not only in benefiting from the programs, but also in the planning, resourcing, carrying out and evaluating the ministry. This assumes that people have the capacity to solve many of their own problems if they are sensitized, empowered

and organized. The emphasis is on building the community (not only individuals) by seeking consensus through group deliberations and reflections.

Through this process, people participate in their own development, and take ownership for the process of decision-making and change. Partnership takes place only when both parties participate fully in every step of the process (figure 6). By contrast, wholistic programs in which the outsiders distrust the abilities and choices of the people often fail, and are rarely self-sustaining (Ewert 1993).



Participatory learning and action has another benefit. Most people have socially established ways of solving most crises such as droughts, plagues and fires. If we unilaterally intervene too quickly following a crisis we often destroy the people's traditional ways of dealing with it.[3] PLA also helps people from developing a 'harvesting' mentality. Many people now know that they can glean global resources by crying for outside aid.

Cultural Perspectives We bring to Medical Missions

In cross-cultural medical work we need not only to understand the local cultural matrix within which medicine is practiced, but also the cultural assumptions we bring with us as medical missionaries.

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[3] Morris Morris discovered that the people had traditional ways of storing food during good years to carry them through years of drought. Now they realize that when droughts come they simply need to cry 'famine' and the government sends in food. They no longer store up reserves, and spend the surpluses in good years on radios, festivals and cars.

1. Western medicine is naturalistic, reductionistic and mechanical:

Science and modern allopathic medicine emerged in the West with the recovery of the Greek worldview through contacts with the Arabic universities in Spain and Egypt. Fundamental to this worldview is the division of reality in Supernatural and Natural domains. The former has to do with God, angels, spirits, magic, and other 'mystical' realities, the later with the material world and its mechanistic view of disease. This is rooted in the Newtonian assumption that everything is composed of basic building blocks and put together as a machine. This worldview leads to determinism and a engineering approach based on technological solutions. It also leads to the division of the sciences into disconnected disciplines which creates a division of labor and absolutizes the gap between experts and laity.

One consequence of this dualism was to reduce medical causality to natural phenomena. God, spirits, ancestors, witchcraft and magic were eliminated as effective causes. Remedies consisted primarily of biochemical medicines, and vaccines, and physical treatments such as surgery. Another consequence is that we do not use illness and other crises as occasions to present a wholistic Christian response that deals with the spiritual as well as social, psychological and biophysical matters involved, and that helps patients be reconciled with and reintegrated into their clans and intimate communities.

In medical missions it is increasingly clear that the modern enlightenment approach of separating a problem and dealing with it in isolation does not work when it comes to systems of human organization. We cannot go to a people and say they have a 'medical problem,' an 'economic problem,' or a 'religious problem,' and deal with this as distinct segments of human

life. We are increasingly aware that we must see these problems as embedded in the larger systems that make up human existence.

This reductionism robs us of wholeness, and is one of the major reasons for the rejection of our medical systems in many parts of the world. Medical problems are reduced to biophysical ones, and the human to a machine that needs fixing. The people see the healing brought about by western doctors as little more than precarious half-cures because they deal only with the effects of the illness, and leave untouched the spiritual and human forces that have produced it. Where Christian healing ministries try to meet the same needs as met by traditional services, and do so by emphasizing the healing power of God given to the churches, there has been greater success (Berends 1993, 277). It is the religious approach to illness and healing that speaks to the primal need (Staples 1982, 71). Christian medical missions must deal with diseases holistically, integrating the biophysical, psychological, social, cultural and spiritual dimensions of the human dilemma. We fail if we do not show that the gospel has meaning for every dimension of life.

A second reason why modern medicine is often rejected is the different treatment offered by the care givers. In western medicine, patients interact with a number of specialize staff, and relates to the Western doctor in a short, disease oriented interactions isolated from their communities. The traditional healer, on the other hand, spends much time with the patient, seeking out the 'cause' and broader sociopsychological causes of the illness, and involving the community in the healing process. The patient emerges not only with physical health, but also with peace of mind. As Christians, we must involve the communities of those we serve, and the church as God's healing community in treating our patients.

2. We organize our ministries on the premises of individualism and bureaucratic organization.

Our mechanistic, foundationalist view of nature leads us to use bureaucratic principles to organize our corporate activities (figure 7. Berger et. al. 1974, Ellul 1964). The principles underlying these structures often run counter to essential the Christian understanding of the church as a covenant community. We need to recognize that medicine is a community matter, and that healing and ministry are community responsibilities. We need specialists, but they must work in the context of communities of caring.

Figure 7
Bureaucratic Organizations and Covenant Communities

BUREAUCRATIC ORGANIZATIONS	*COVENANT COMMUNITIES*
- mechanistic root metaphor	- organic root metaphor
- human engineering and control	- God's work and leading, human response
- focus on institution, program, outcome	- focus on people, relationships and processes
- stresses uniformity	- recognizes and accommodates diversity
- big is good	- appropriate size, small is good
- centralized and top down control	- decentralized, bottom up and empowerment of the people
- rigid, clearly defined formal structures	- flexible, often informal and ad hoc structures constantly reevaluated
- formal, mechanical roles	- negotiated relationships
- expatriate as leader, manager and trainer	- expatriate as servant leader, catalyst and facilitator.
- professionalism	- mobilize and disciple laity, train leaders
- external inputs required	- self-sustaining programs
- goals, work and evaluation externally determined	- goals, work and evaluation internally negotiated
- time driven	- harvest principle, minister until self-sustaining work is achieved
- western model of organization	- indigenous forms of organization

Many of the problems in current wholistic Christian ministries arise out of the fact that our mission agencies must bridge between two organization worlds. They are organized and funded

in the west, and are their supporters expect them to operate as modern corporate organizations, showing measurable results commensurate to the investment, and giving account for every dollar spent.[4] They operate in societies where organic forms of organization are most effective. We must work with and modify both models of organization. We need planning, financial accountability, good organization and clear visions. We also need flexibility, loving relationships and an openness to the unexpected serendipities of God at work in the situation. We need to wed professional knowledge with lay participation. To do so we need servant leaders. The successes we see in these cases occur most often when this bridge between organizational styles has been built.

Ethnomedicine is an essential ingredient in any medical mission program for it helps us deal with those issues that emerge because of cultural differences, and enable us to communicate with people in other cultures more effectively. Only then are sustainable wholistic medical transformations possible.

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[4] This is essentially an accounting mentality in which responsibility is measured in terms of giving account for each dollar and hour spent. There is little flexibility for decision making in this mentality. It stands in contrast to the biblical ideal of 'stewardship' in which gifts and funds are entrusted to a person who has the right to think and decide creatively in their use, and accountability is measured not in each detail, but in the other all outcome.

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Gunik, on the other hand, are allies with human beings against these dangers, "spirits" o can be called upon to assist the community or individuals, especially in treating ess. *Gunik*, however, were once *mara'*. A *mara'* may come to a person in a dream, ask become kin, and give the dreamer a song. The *mara'*, now a *gunik*, is called "son" or ughter" by its human father or mother, and "sibling" by their children. By singing song, they can call it into the settlement from the forest, to aid its human kin, espe- lly to ferret out and eliminate the sources of their illnesses and to ward off the attacking *a'*. Thus, as inmarrying *mai* become *hii'* by joining the band, contributing to its well- ng, and becoming incorporated into the network of kin relations, so do *mara'* become *ik*. As *mara'* is the malevolence of *mai* given "concrete" cultural form, *gunik* is a reified al image of *hii'*: powerful, protective, and benevolent (if outnumbered) kin. What is ealed by all of this, once again, is a tightly circumscribed world where the only security n *hii'*, in the band and its spirit kin. All else is danger and death.

e Image of the Person

If the foregoing is reality as Semai culture defines it, who are the people attempting to ake their way in it? How do Semai see themselves and their purposes, opportunities, d means in a world so constituted?

Sentence-completion test responses provide some insight into Semai self-concepts.[7] r example, to the item "If (s)he is in difficulty, (s)he . . .," the overwhelming majority id "seeks (or gets) help from others"; to the item "If (s)he is afraid, (s)he . . .," the odal response was "gets a friend/relative to accompany him/her"; and to the item Vhen (s)he is hungry, (s)he . . .," the modal response was "asks someone for food." ie pattern here is quite clear: when stressed, one does not fall back on one's own re- urces. Rather, one seeks (and finds) relief in the security and nurturance of others.

Major determinants of a Semai's (or anyone else's) self-concept are the assessments at others make of him or her and that he or she makes of him- or herself, in terms of me set of culturally defined values. Children, and later adults, come to evaluate them- lves largely in terms of these values, which have become incorporated as components individual self-images, developed and maintained by the continuing reactions of those th whom they are in daily interaction.

Sentence-completion responses also provide some clues to this value set and, thereby, the individual self-images that it helps to develop and sustain. Six test items were di- cted toward eliciting normative conceptions of "goodness" and "badness":

They praise him/her because (s)he . . .
If (s)he is a true friend, (s)he . . .
(S)he is a good person, (s)he always . . .
(S)he is angry with his/her friend/relative because . . .
(S)he is a bad/evil person, (s)he always . . .
His/her kin reject him/her because (s)he . . .

Nineteen informants made 102 value-related statements in response to these items. Only three of those responses were not clearly related to two core values: nurturance and affiliation. Further analysis of the responses revealed that "goodness" and "badness" were not simple negations of one another, but were largely defined on different dimensions, with "goodness" defined positively in terms of nurturance (helping, giving, and so on) and "badness" defined negatively in terms of behaviors inimical to affiliation, especially aggressiveness (fighting, getting angry, quarreling, and so on). These are the standards against which people are judged by their neighbors and by themselves, ideals of generosity, friendliness, and nonaggressiveness—ideals, largely realized in the behavior of most people, that constitute central components of individuals' self-concepts as well (see also Robarchek 1981).

The Image of Nonviolence

These images of self, the band, and the world, incorporated into the personalities of individuals as fundamental assumptions about the nature of reality and, thereby, as components of motivational complexes—the action strategies that they use to operate in such a world—channel and direct individual behavior choices into nonviolent directions. The collective behavior of individuals thus directed in turn constitutes the learning environment of the next generation, an environment where children have little opportunity to learn how to utilize violence. Violence does not come to be seen as a means for settling disputes or resolving difficulties (cf. Dentan 1978).

How does all of this relate to action, to people behaving in the world of occasional pettiness, frequent gossip, inevitable conflicts of interest, evaded obligations, jealousy, anger, deceit, duplicity, in short, to a greater or lesser degree, the human world we all live in? I would like to draw from my field notes a sketch of a scene in a Semai community, a *becharaa'*, a public assembly called to resolve disputes between band members, one thoroughly representative of many that I have attended.[8]

The roots of this particular dispute lay in the changes stemming from the band's increasing involvement in the larger Malaysian socioeconomic system, and the matters at issue in these proceedings were extremely important, either directly or indirectly, to every person in the band.

Recent years had seen a great increase in the volume of trade with the lowlands, especially the sale of durian fruit. This was the major source of cash for most Semai, the money they used to buy sarongs, machetes and axes, radios and flashlights, tobacco and sugar, and all the other luxuries that were rapidly becoming necessities. As the durian trade has become more important, however, there are increasingly frequent disputes over access to territories in the lower end of the valley, nearest to the road and from which fruit could be more easily transported—carried in large backbaskets by people on foot (cf. C. J. Robarchek 1981 for a discussion of the evolution of Semai territorial notions).