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Module B3.6 - Immersion communautaire

Abstract - group N°42

How is the family care organized for old people in Santal tribe ?

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Introduction

Worldwide the number of elderly people aged 60 years and over will rise from 900 millions to 2 billions between 2015 and 2050 (moving from 12% to 22% of the global population)[1]. India is not spared by that issue knowing that it is the second largest elderly population in the world. Moreover, it is important to point that, in India, elderly are a particularly vulnerable group because of the low level of social security (only 10% of the 60+ benefit of a social security), the impact of poverty (40% of 60+ are below poverty line)[2] and the lack of old age policies. The Santals are no exception. Santal is one of the largest tribe in India (10 millions people) and they have a long history of marginalization both by the authorities and the colonists. It is a rural tribe and, like in every other rural area, elderly people constitute a large part of the population[3] (66% of the elderly person live in rural areas in India). About the elderly in Santal tribe, there is an important lack of literature. This meant for us that we had to define what old age means in Santal tribe directly from the field (c.f. anthropological method). With the information we collected, we understood that old age is a plural conception. Indeed, while age is defined by the physical aspect of the person and the incapacity of working, it is not defined by the actual age (number). Most of the Santal people are not aware of their own age. Furthermore, it is important to notice that almost all the elderly person we met live with their kin, and like in any other country there is an increasing prevalence of chronic diseases adding difficulties both, for the politics and the joint family. Concerning the care, it is a very large concept. So we decided to stick to the Hesbeen[4] definition which is: « taking care is to pay special intention to a person including oneself in a particular situation to provide well being and to promote health ». Finally, it is significant to reveal how much the care of the family is important in India (including the Santal people). Indeed, as quoted from Park's textbook[5]: « without the support of the family, no amount of medical care can succeed. In India, the joint family provides for such support ». This definition is central in our research because it highlights quite exactly the situation in India and in the Santal tribe: there are almost no policies for elderly people and the family endorses almost their entire care. Having acknowledged all these contextual facts, our objective was to understand how the family provides care for the elderly in Santal tribe and what eases that care for them.

Methodology

In order to fulfill our objective, we used a qualitative and anthropological method[6]. It means that we had an inductive approach: we began from the fieldwork to go up to the theory (bottom up method). We were inspired by the Grounded Theory. This theory is very flexible about the data: we go forward and backward from theory to data during the research, allowing our questions to evolve. The research was then non-linear and our results come from the informations we gathered in the fieldwork. Another aspect of the anthropological method is the immersion in the community. By being immersed in the Santal villages day after day, we could have a better understanding, not only of the health issues, but more largely of the environment and social context. In order to do so, we used two techniques: observation with intensive involvement with people which permitted « a sensitive knowledge », as well as semi-structured interviews with flexible interview grids. In order to have a multiplicity of points of view, a nurse, a doctor, a social worker, an anthropologist and 18 villagers (the elderly as well as their family) were interviewed with a translator.
Another important aspect of our methodology is the pluridisciplinarity of our group, constituted of doctors, a nurse, an anthropologist and a social worker it permitted a skill mix and thus a much broader view about the family care of elderly in a Santal context. In fact, by mixing our different approaches and points of view, we could explore the health not only with the biomedical perspective but also with the anthropological one which is adapted for having a systemic view of it. This pluridisciplinarity is included in a transcultural group and research as well: we worked with French, Indian and Swiss researchers in an Indian and Santal context. We used reflexivity as a tool to better understand this alterity. By being reflexive about the way we entered in contact with Santals as well as our feelings and interpretations in this transcultural context we tend to be more objective. We took into account the fact that we are not neutral because we come from a certain culture with its own representations. In fact, reflexivity permitted to adapt ourselves to the context. We used it during

the fieldwork as well as during everyday debriefings all together. Beside this, we used the rules given by our universities as as ethic guidelines.

Results

From our data we noted three main trends: the elderly person him or herself as the main participant of his/her care, the family sphere and how it has to adapt when talking about elderly care, and the society sphere and how it eases the family care. These three different levels are imbricated when it comes to elderly care.

First of all, it is usually the eldest son who shelters the ageing family member in his own house, until death. It means for the **elderly person that he/she has to adapt** to a new role in the family. As a matter of fact, the elderly person has several roles in the family like transmitting knowledge, taking part in the children care and also working. Indeed, the elderly person has an important financial role because he/she has to help the family by working in the fields or taking care of the cattle. The senior works until it is physically impossible for her to provide that kind of work. But it does not mean that the person completely interrupts his/her activities, as he/she will become householder. In fact, the work will be adapted according to his/her abilities.
As we said before, the eldest son takes charge of his parent. As we saw before, the elderly person is giving but is also **receiving from the family**, which creates new interactions and provides entire care, meaning: basic care, mental care and financial care. For instance, a member of the family will stay at hospital 24/7 with the person until he/she can come home. At hospital, the family member will provide basic care, the feeding and the social support. It is important to notice that even if family care is common and well integrated, we still received some comments from elderly persons telling us to feel lonely and/or isolated. The senior person, even if respected, can also be perceived as a duty for the family and therefore left alone at home while everyone is working. It is important to point that the family is also part of the community. This means that there are shared rituals to improve health of the villagers including the elderly (the daily Puja which is a pray to implore well-being and only practiced by women or the Budna which is a festival practiced once a year to promote health among the Santals). Also, if the elderly person has no family, it may happen that the community will take care of him/her.
Finally, **the society** has an important role to ease the care given by the family. Indeed, the family and the elderly persons have access to the primary health care hospital, which is a free of charge institution for « general medicine », as well as to the Sian Hospital. The latter being a bigger hospital for cases too severe for the primary care hospital to manage. Then, they have access to the NGOs and the general practitioners present there. They also have the possibility to use Ayurvedic, homeopathic and traditional medicine but it depends on which doctor is present in the village. From our fieldwork, we also received a crucial information coming from the general practitioner of a local NGO. He told us that there is a lack of medical education of the Santal population which means they often do not know the threshold between the necessity of hospitalization or not. Also they do not know how to give « specialized » care, needed in a context of increasing chronic diseases (hypertension, diabetes, strokes, and so on). The final point is the lack of available equipment (wheelchair for instance) the elder person and of specific household adaptation to ease the elderly person's life.

Discussion

Through our research we highlighted more than once that the family is the main caregiver for the elderly people and that there is only poor help coming from the social authorities for that category of person. We were surprised by the lack of policies present in the literature (no insurance, no retirement, insufficient pension, lack of geriatric national training, lack of structures for old person). In a context in which joint family is slowly disappearing to become more nuclear, the elderly person will become more and more vulnerable. This particular fact made us think about an observation of the WHO about ageism. The definition of the WHO about ageism is « Ageism – discrimination against a person on the bases of his/her age – has serious consequences for older people and society at large. […] It can obstruct sound policy development, and it can significantly undermine the quality of health and social care that older person receive »[1]. Finding some similitude between our results and this definition we can ask ourselves about a political ageism in India.
A proposition would be to sensitize the health professionals on their training (nurses, doctors, social sciences) when it comes to geriatric care.

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Key words

India, West Bengal, Santal, Elderly, Family care, Pluridisciplinarity

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