RF_COM_H_75_SUDHA

Summary: W medicine in India and its effect on the social and cultural structures of a village.

To introduce W.med. into the villages.

(i) treatment should be brought to the village.

(ii) W medicine ~~driver~~ should be divested of its cultural accretion but retain the technical know-how.

(iii) Greater understanding into the social structure and the indigenous medical services.

(iv) Willingness on the part of the doctor to work in the villages esp. as he is used to a different standard. and to fit into the inner realms of the society.

(v) Education of the populace — not just literacy but knowledge. with the idea of giving the villager a ~~better~~ ~~newer~~ ~~bold~~ different outlook.

out the medicine.

(iv) Payment before cure.

Correlation, Conclusion

– The difference bet. Indigenous & WM shows why WM has failed.

– Retaining the technical knowhow but doing away with cultural accretions may be more profitable.

– The analysis therefore shows the social & cultural problems involved and also a possible means of fitting WM into the villages.

Regarded as an outsider but handles it by.

(i) Creating an aura of superior & penetrating knowledge about him. Result. — he need not be told, he knows.

(ii) Emphasizes that hes practising medicine for the sake of enhancing his own religious merit. Villager feels safe being dealt by a rich physician who is also pious.

(iii) Prepares his own medicine. & sells at high prices. — "hiring". If prices are too high, takes part payment causing a dependance. May not take money if the person is poor — " He never takes money only interested in curing people.

Points to notices

(i) not to be too technical.
(ii). Include the family & if they can make the pay.
(iii) Snake bites & priests bend more difficult.
(iv). placing above people, preparing own medicine & gaining trust.

(9) Western Doctor.

(i) Outsider speaking English — "Sahib" — exploiter.
(ii) Equalitarian bedside manner not appropriate to social organization.
(iii) Individual rather than family considered.
(iv) technical competence is highly regarded in IOM. but is not the only basis for interpersonal security in villages.
(v) Only prescribes on a piece of paper & does not dole

(8) WM in 3 realm as Indigenous medicine but how has I.M. flourished.

Practices are.

(a) Magical. – charms, protecting things etc. – Charm ~~g~~, the performance & the technique have an objective existence. (appeals to the individual.) – Subjective improvement immediate & also helps to get rid of spirits which. medication angers it. But since it is technical it is rejected & despised as a low craft.

(b) Religious Exorcism:

Highly religious & track on their talents to impress clients. ~~Case~~ Effectiveness of cure is quickly known & the family assist in it. – "The more you pay the more its worth." As a doctor who gave Pencillin injections only to patients who needed it, was branded as corrupt & unhelpful.

(c) Priests: of high Brahmin caste. – only advises to perform rites, not only for good health & posterity ~~of~~ the patient but also himself as in his "prescrip-tion" he includes a charitable gift – food, money or a cow – for him self.

(d) Snake biting: Highly respected as they undergo fasts, sleep on the floor & cook their own food. Not allowed to eat till the patient is cured, cannot accept payment

(e) Secular Medicine. Hakims & Vaids – different schools.

Western Medicine in India.

(1) Most villages away from industrialization, education, town life and community developement.

(2) Mostly self-sufficient but hygeine lacking eg. drinking water, flies & other pests in abundance

(3) Indigineous practioners serve their medical needs — no need for W.Med.

(4) Though attempts have been made, found to be highly unsucessful. — Reason! why did they not trust the doctors? not pay for their medicines? revert back to indigenous practioners?

(5) ~~Adequat~~ Adequate facilities, village reached, doctors worked, peasants were in no fear of techniques, but still a failure.

(6) Look into inter personal relationships — Trust, responsibility, charity, power respect. — may explain.

(7) Social structure.

(a) Kinship.

(i) Trust.

ie outside the family things are to be made doubly sure — "The village is full of thieves dishonest people."

(b) Caste.

- 4 castes.
- ~~Several~~ Several kinships in a local caste.
- wealth & power.
- ~~be~~behaviour.
- Dependance, but higher asks favour first.
- within family allowed.

(c). Outsiders.

(i) in family.
(ii) intercaste.
(iii) by previous exp. Friends money & power counts.

Date : 18/9/81

Socio-Cultural Factors

1. What is culture?
2. Cultural Synthesis - Modern Phenomena
3. <u>Cross cultural outlook in Medicine.</u>
   a) Unavoidable reality.
   b) understand pt behaviour
   c) Effective application of technique
   d) Problem solving
   e) Communications.
4. <u>Understanding Culture.</u>
   - Observation / Reading literature / Meeting people
   - Interviewing patients.

   Not '<u>what</u>' but 'why'?
5. Continous Process - Both sides constantly adapting

—

Family Size/Composition
Sex Status - esp of Women
Marriage - Age/Stability

Inheritance
Education
Caste
Religion.
Occupation

Areas of importance

Concept of Etiology
Env Sanitation
Food Habits
Personal Hyg
MCH ..
Sex/Marriag.

Culture of Medicine

1. Attitude to Health/Disease.
2. Importance of Diets.
3. TBAs & IM Practitioner
4. Folk Medicin
5. Attitudes to western Medicine

Observational Logic vs Intellectual /Scientific or Experimental Logic

=

Sociology and Medicine

Known	To be known
Age and disease	Attitudes and expectations of status groups
Sex and disease	Attitudes of private patients vs general patients
Socio-economic status and disease	Patient response to different type of illness
SES and attitudes and information about illness	Functional disability ↓ Physiological lack of function Behavioural/attitudinal inadequacy
Educational level and attitudes and information about illness	
Ethnic backgrounds and reactions to pain	

Information about health personnel

1. Roles health professionals play
2. Selection of Health Professionals — Criteria
3. Objectives of education of Health Personnel
4. Points of view of roles of health professionals.
5. Patient expectation of roles.
6. Which role performance is most effective for a particular result.
7. Methods of orienting medical/nursing students constructively towards difficult patients

Nature and organisation of Medical Care

1. Relationships of staff
2. Staff-student relationship
3. Staff patient relationship
4. Method of supervision provided.
5. Forms of organisation
6. Measurement of Quality - Evaluation indices

"Medicine is a social science and politics nothing but medicine on a grand scale"

Virchow 1848

"For if medicine is really to accomplish its great task, it must intervene in political and social life. It must point out the hindrances that impede the normal functioning of vital processes and effect their removal." Virchow 1849

SOCIAL AND CULTURAL FACTORS IN HEALTH AND DISEASE

SEMINAR

1. The Cross-Cultural Outlook in Medicine - Dr. Ravi Narayan

2. 3 project Reports

   i) Medicine and Faith in Rural - Rajasthan - Miss V. Bhateja

   ii) Western Medicine in a village of North India - Mr. Ajoy Krishnamurthy

   iii) Concepts of Health and Disease in Mysore, Kerala and Goa - Miss Mary Prem Pillai

3. Summary of Cultural Factors in India relating to Health and Sickness.

   a) Concept of Etiology and Cure

   b) Environmental Sanitation

   c) Food habits

   d) Mother and Child Health

   e) Personal Hygiene

   f) Sex and Marriage

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RESOURCE MATERIAL

(1) The Cross Cultural Outlook in Medicine (Chapter 4)

of Medical Care in Developing Countries - Ed. Maurice King.
Oxf. Univ. Press 1966

(2.) Health, Culture and Community by Benjamin D. Paul
Russel Sage Foundation, 1955

a) Medicine and Faith in Rural Rajasthan (Chapter 4)

b) Western Medicine in a Village of Northern India (Chapter 9)

(3) Concept of Health and Disease
- a diagnostic study
by D. Anand, A. Ahluwalia and
C. M. Kapoor.
Lady Hardinge Medical College
New Delhi
Reports of Mysore, Goa
and Kerala only,

(4) Textbook of Preventive and
Social Medicine by J. E. Park

Cultural Factors in Health
and Disease - p 84-90

The Cross Cultural Outlook in Medicine

- Definition: Culture is the sum total of the customs, beliefs, attitudes values, goals, laws, traditions and moral codes of a people

It includes their language and their art as well as everything they make, be it a stone-axe or a space-craft. It includes their views of the universe and also their attitudes to health and disease.

- Each culture has two aspects.
  i) Visible - language, dress, education, art.
  ii) Invisible - values, attitudes, traditions, morals.

- Value of Cross-Cultural outlook

1. Few of us even in the most developed countries can practise among patients who are always culturally similar to themselves
2. If this difference between the doctor and his patient is granted - than it is obvious that he needs to understand their culture and hence he must have this cross-cultural outlook.
3. Very often we know the solution to a medical problem but when it is applied it doesn't work. In such cases we need the understanding of a patient's culture which modifies his attitude to the treatment offered. (Effective application of technique)
   e.g. Why is a child malnourished though protein food sources are readily available?
   Why are a couple loath to accept family planning?
4. Overall view of culture is necessary if views relating to health care to be understood in the right context.

- Obtaining a 'cross-cultural' outlook

Observe the society closely. Use what is visible to lead to what is invisible in terms of attitudes, values and goals

Read Some Anthropology

Read what novels and plays may be relevant.

See if there have been any specific studies of the villages in the area and read them.

Make the acquaintance of any anthropologist working in the vicinity

Obtain an insight into the local culture by carefully questioning some of the more educated members of the local community

Follow this up by obtaining more information in routine case-histories taken from the patients

Take at least some steps to learn a local language, even if it is only the greetings and the necessary clinical questions and imperatives.

What should you know:

- The Family — Common patterns of Family Composition. What is the age of marriage and how stable is it? What are the strongest emotional ties within it? What are the obligations towards the extended family? What is the status of women?
- What other important associations are there? Political Parties, Guilds, Agricultural Cooperatives, Initiation groups; Religious communities.
- Who are the influential members of the community? Chiefs? Party officials? School teachers? Ministers? Hospital assistants?
- What are the values of a community? Leisure? Conformity? Happiness? Fulfillment of the personality?
- What accords status in the community? Cattle? Wives? Children? Land? Money? Education?
- What are the customs of the community over the use and ownership of land and money? How is the land inherited? What is the income of the average family? Is money the common property of the family? Is there money available in the community for medical expenses?

- What are the attitudes and practices of the Community in matters of health and disease? What is the traditional system of medicine? Do people consult their healers first or only after scientific medicine has failed? What are the concepts of causation of the common diseases? Does the indigenous system include the idea of prevention? What are the local names for the common diseases?

Classification
- Harmful — to be changed
- Harmless — to be left untouched
- Beneficial — to be used as a bridge

e.g. Harmful —
- Eggs & dal forbidden.
- Cow dung on umbilicus.
- opium to child

Harmless — Premastication, puncturing nose & ears
Castor oil for purgative.

Beneficial — Neem paste
Prolonged breast feeding
Oil baths and massage

Summary of Cultural Factors

① Concept of Etiology and Cure

1. A person is considered health — if good muscular body; — can work hard.

2. Illness is considered a matter of chance.

3. Minor illnesses are not cared about. People like to proudly claim that they have never seen a doctor.

4. Causes of disease may be

Supernatural — a) Wrath of Gods and godesses. e g Smallpox (Goddess Mata or Sitala Devi)

b) ∴ instead of treatment c̄ drugs Pujas are performed.

b) Breach of taboos — venereal disease due to illicit sex

c) Past sins — e.g Leprosy & TB due to past sins

d) Evil Eye — esp Children's diseases. eye of a barren woman particularly potent
— therapy consists of wearing charms and amulets recitation of incantations by exorcist, and blowing on the face

e) Spirit or Ghost intrusion — Fevers, Epilepsy and Hysteria. Therapy — Services of an exorcist

Physical a) The effects of weather.

b) Hot and cold foods
meat, fish, eggs, jaggery — curd, milk lemon, vegetables

c) Wrong foods. — combinations.

d) Impure blood — cause of skin diseases
Eat neem leaves & flowers to purify blood

② Environmental Sanitation

1. People in rural areas go to fields to defecate.
practice time-honoured and considered harmless

2. Excreta of children is harmless ∴ children permitted to defecate in the back yards or close to home

3. Womenfolk go in small intimate groups. Thus combine physiological function c̄ a social one.

Why does the Average Indian Villager refuse to accept a latrine.

a) Location close to house — considered unhygienic because bad smell
 — In cities — alright because absence of fields

b) Going to fields — additional advantage of a morning walk.

c) Small houses — no spaces for latrine.

d) Going to fields is cheaper.

e) Total ignorance that faeces is infective.

f) Cleaning of latrine to be done only by low castes ∴ physical restrictions

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Disposal of wastes

1. No awareness that mosquitoes breed in dirty water ∴ pools allowed to collect c̄ sullage.

2. Household refuse thrown in front of house - permitted to decompose

3. Cow dung used as fuel - in the form of cakes

Water supply

1. Well is a place for
 - bathing
 - washing
 - animal washing
 - meeting.

2. Tanks & ponds used similarly.

3. Some rivers considered holy ∴ raw water is drunk.

4. Holy water bottled and carried long distances to relatives & ffriends. — Reported spread of cholera and gastroenteritis

Housing

1. Small windows for reasons of security
2. Absence of seperate kitchen & bathroom
3. Animals in the same room often
4. walls and floor plastered with cowdung

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③ Food Habits

1. Hindus do not eat beef and muslims - pork.
2. Adulteration of milk common - because pure-milk if boiled - produces drying up of mammary glands of donor animal.
3. Fasting important feature
4. Country liquor consumption
5. Use of Ganja, bhang & charas - religious significance - Association c̄ Sadhus.
6. Eating & drinking from same vessels sign of brotherhood among Muslim
7. Who prepares food - very important.
   - Eating in hotels not common

④ MCH - discussed in detail

⑤ Personal Hygiene

1. Personal cleanliness - immense amount of ritual.
2. oral hygiene - twigs of neem tree
   Charcoal.
3. Bathing naked - is taboo
4. Baths - ritual bathing on special days
   - after period
   - after child birth
5. Shaving - done by traditional barber who does not sterilise instruments - ignorant of ko

6. Smoking hookah - common use
7. Smoking chutta - (reversed) - Oral cancer.
8. Purdah - high incidence of TB in such women
9. No shoes - because contact with mother earth' essential - ~~Good~~ vibrations

⑥ Sex and Marriage & Family

1. Early marriage.
2. Universality of marriage.
3. Polygyny and Polyandry — Todas of Nilgiri
   Kulin Brahmins of Bengal
4. Joint family — Disease is a Family problem
5. Very little privacy or individual possession
6. Mother-in laws authority
7. Husband answers in the clinic
   wife answers at home

Treatment

1. Pulse. taking.
2. Elaborate restrictions of food.
3. History taking.
4. Ritual of drug intake
5. Preparation of own medicine
6. Payment after cure

Maternal Care

Magnification

Bed bugs

DDT

& many realise its significance
recognised ~~but m y feel apprehensive~~
& ~~approve of it as an economic measure~~
, But in Goa the idea receives opposition

(7) Insects :- The mosquito was mostly associated with malaria & the flies with disease. Yet the significance of eradication programmes such as D.D.T. spraying is not ~~fully~~ ~~good~~ known because no attempt has been made to ~~expla~~ make them understand

(1) The survey is based on interviews of folk dances, in Delhi on the occasion of / Republic Day celebrat^ns.

(2) ~~Atoll~~ Four topics relating to medical care ~~[illegible]~~ were chosen:

A) Mother & Child care

B) Small pox Vaccin^n

C) Family Planning

D) Insects

(3) 3 States have been selected - Goa, Kerala & Mysore

(4) Mother & Child Care → The expectant mother usually delivers at her parents place. No food restrictions are observed, except avoidance of oily or food rich in chillies; ~~we observe~~ The evil eye is believed to play an important role in ~~children~~ childhood diseases

(5) Small pox - Most of the know about vaccination but in ~~most cases~~ the belief that Small pox is due to divine wrath is widespread

(6) Family planning:- The red triangle is

Influence of Social + Cultural factors on Medical Service Facilities in Rural Rajasthan.

1) Differing ideas & beliefs among villagers of sickness, cure & etiology — cure by individuals "possessed" by gods.

2) Different conception of the role of the healer: Physician is a prophecizer, a link between mortal man + the purposeful cosmus.

3) Techniques of inspiring confidence — use of showmanship, value of taking pulse, giving injections; & of predicting recovery.

4) Belief of villagers in devils + witches as causes of disease, Lack of scientific understanding. Use of pulse mainly for diagnosis ~~for~~ & charms for cure, strange dietary restrictions etc.

5) Role of faith in Curing.

6) Conclusions — Summary of ways to improve effectiveness of medical services.

(1) The African Mind in Health & Disease.
J.C. Carothers - Consultant in Mental Health WHO.
Worked in Kenya.
Writers quoted - military psychiatry
General Hosp service
Rural Service
Mental Hosp. records

(2) Search for Security - Dr. Margaret J. Field
- Study of Rural Ghana among the Shrines
- Study of patients in Mission Hospitals

(3) The Human Factor in Changing Africa by Mr M. J. Herskovits.
colonial Africa 1931
Nigeria, 1960 Kenya Ghana, 1957 Senegal 1961
Field Research in Anthropology

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1. Different Races
2. Geography
3. Climatic, Infective, Nutritional factors underlying any condition
4. Socio economic & cultural factors
5. Idealogical background
6. Studies in Psychiatry — Problems faced
1. Studies on African brains
2. Studies in general psychology
3. Studies on diseases of stress
4. Studies on US Negro psychology
5. Studies on Mental Health
- general
- specific disease

Conclusions

1. Importance of further study and research.
2. Mental evolution in all societies in transition.
3. Mental Health problems increased if transition is hastened.
4. Highly developed areas reactive conditions increased.
    i) Greater competition
    ii) Use of reason only.
    iii) Higher rates of suicides

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1. No std. 'metre' for measurement.

1. African - large family
2. ______.

British & American attitudes to Drug Addiction.
— Drug pusher

Africa - SOCIOECONOMIC & CULTURAL BACKGROUND

(6)

1. Mainly Agricultural community apart from few big urban cosmopolitan centres.
2. Democratic gerontocracy till very recently
3. Village & country-town
4. Traditional households - large family units
5. Mens quarters and women's quarters especially in "home-town"
6. Class hardly exists. Rank does exist but its attainment is the reward of individual merait. (Indigenous democracy)
7. Infant & toddlers are always indulged and petted.
8. Older children harshly disregarded.
9. Any food which fills the belly is considered good enough for the child.
10. "Cocoa" has not shown us the good man".
11. Women have nearly always equal economic status as men. They can earn money and own their own property
12. Life at bare subsistence level is not difficult to maintain since population sparse, land rich & wellwatered & free, no warm clothing necessary, houses easily built, staple starchy foods easily grown and stored.
13. Problem: Many young unemployed literates supported at expense of elder illiterate relative.
14. Money is a great luxury and meant to spend on life's greater gratification and enhancement of prestige — not squandered on basic necessities.

15. Money spent on funerals, litigation, cars and lorries, travelling about country to shrines and medical men, land-buying.
16. Concept of good nourishment completely absent.

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(5) IDEALOGICAL BACKGROUND

1. Witches & witchcraft – "Obayi"
2. Types of obayi – Transferred and Congenital
3. Kra (soul) – sunsum (mind, spirit)
4. Magic or "medicine" – good and bad involves forces which man commands
   - therapy of illness – immunity to harm
   - divining. – illness or harm or death to enemy
5. Magic record books
6. Relevant mythology i) Fairies – aboatia (sing.) / mmoetia
   ii) Sasabonsam – forest monster.
7. Theological dogma – god.
8. The cult of the dead
9. The popular assessment of Christianity
10. Spirit possession – dissociation. hysterical stigmata
    – similarity c̄ hebrew religion and descriptions in the old testaments
11. Belief – The primary vulnerability of a patient to the disease is of supernatural origin and until redemptive ritual has been performed the hospital efforts are futile.

Chapter: Troubles & desires of ordinary people.

1.) Different races of Africa
- Some insignificant in number.
- African Negro → Negroid, Nilote, Bantu. (110 million)

2.) Geography. Inaccessible by sea, cut of by desert, shifting cultivation, lack of river communication, hostile countryside monotony, low density of population.
- personal Insignificance plays a part in African attitude to Life.

3) Cimatic factors - African economy and rhythm of life closely identified c̄ coming of rain

3) Infective Factors

15-30% of admission to mental hospitals — Syphilis. Trypanosomiasis (Tooth - Gold coast) (commonest cause of mental derangement) organic & schizophrenic components)

Carothers — Malaria (3.4% of admissions to M.H)

Pneumonia (25%)

T.B. Encephalitis, Cerebral Sepsis

Worm Infestations, Relapsing fever, Yellow fev

4.) Nutritional factors - defficiencies of proteins Vit A & Vit B complex Kwashiorkor

Changes in behaviour & personality due to semistarvation

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6) Cultural Factors

a) Infant - excessive affection & indulgence
- abrupt weaning → relative emotional shock
- forced supplementary feeding from first few weeks of life against will

b) Child
↓
i) Large family - many relationships
ii) Parental influence not exclusive or continous
iii) conditioned morality c̄ in family situation
? iv) Reputation for lying - arises from excessive desire to avoid rudeness or discourtesy of speech
v) Discipline - by threats of bogey men etc.
- immediat. punishment

vi) Early responsibility and contribution to life of family
vii) Variety of persons play several roles in education

c) Adolescent - Puberty obvious milestone - elaborate initiation - intensive education, sex c̄ out conception encouraged.

d) Adult - Family
- Ibolo (brideprice), polygamy is rule
- Children born out of wedlock "always belong"
- Specialisation of work
- economic autonomy

e) aged - honoured place

(9) Diseases of Stress - far less common, eg peptic ulcers occurs 6 yrs after moving to Industrial town

(7) Studies on African brain - less wt - frontal & occip regions smaller & size ↓ - though characteristic relation to function not known.

(8) Studies in Psychology

-ve	+ve
1. Highly dependent on Physical & emotional stimulus	Cheerful.
	Self confident
2. Conventional	Sociable, loyal
3. Lacking in foresight, judgement	emotionally intuitive
4. Inapt for sound abstraction.	bearing no grudge
5. Living in the present c̄ out ambition.	excellent memory
6. Unstable, impulsive.	large vocabulary
7. Nor regard for rights of people outside his circle.	Aptitude for music & dance
8 Given to phantasy & fabrication	

Intelligence - compared c̄ Europeans
No definite results

(10) Studies on Psychology of Negroes in USA
- no scientific proof of innate racial differences
- differences explained in terms of factor in social & educational environment
- as the environmental opportunities became similar & [illegible] diff. tended to disappear

African Psychiatry

1. Gene dependent conditions uncommon ∵ exogamy.
2. African culture
   i) behavioural conformity.
   ii) Frowns upon expression of originality
   iii) " profundity of reason
3. Man in Africa is buffered from reality by a cultural machinery which can cope c̄ most exigencies
4. Misfortune → bewitchment → witchcraft
5. Incidence 0-3/1000 Gold Coast (Tooth) 0·06/1000 Nyasaland (Shelly & Walson) 0.1/1000 Kenya (Carothers)
   — difficulties in case finding & case record
6. More men — difficult to control. Women more circumscribed life
7. Age incidence 10-40 — (78%) — Age ??
8. Detribalization — whether imp factor ??
   i) Not always first contact c̄ best representatives of western Civiliz.
   ii) Swamped c̄ new ideas
9. Insanity incidence much less — studies on employed natives.
10. Studies difficult.
    i) Incidence in rural & detribalised situation not real due to differing opportunities for care.
    ii) mental derangement more amenable forms in rural life
    iii) African Negro ↓ — American Negro ↑ — Westerners ↑↑↑
11. Diagnosis difficult
    i) Poor histories. — or unreliable accounts
    ii) Diversity of cultural experience —
    iii) No standardised tests for Africans
    iv) Presence of other diseases.
12. Hysteria very common.
    Anxiety — assoc c̄ bewitchment

Writers quoted

1. military psychiatry.
2. General hosp. experience.
3 Rural survey.
4. Mental hospital studies

Conclusions

1. Bewitchment takes place of conscienc
2. Disavowal - not looking back.
3. Certain reactions developed c in the framework of local culture - acceptable
4. Concious factors play large role in Production of reaction
5. Emotion dominates entire mind.
6. Neuroses resolved on social lines
7. Psychoses takes amorphous or abortive forms.

Negro - intermediate between rural African and White - - excessive liability to breakdown. As time passes - cultural experience converges and contrasts progressively diminish.

Transition

Preliterate group - meticulous rules - Stamp on independent thought & ~~meticulous rules~~ personal initiative.
↓
Social evolution ⟶ Literate group.

African mind - use of phantasy & reason.
European - Reason - phantasis relegated
— to darkness & dreams

Colonial situation

i) Freedom of action as defined by cultural norms denied
ii) (i) by own people / imposed by foriegn ruler
iii) Racial differentiation