BANGLADESHI DIASPORIC CULTURE: Implications on Health care of Elderly Women

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Culture…PASSED DOWN FROM ONE GENERATION TO THE NEXT

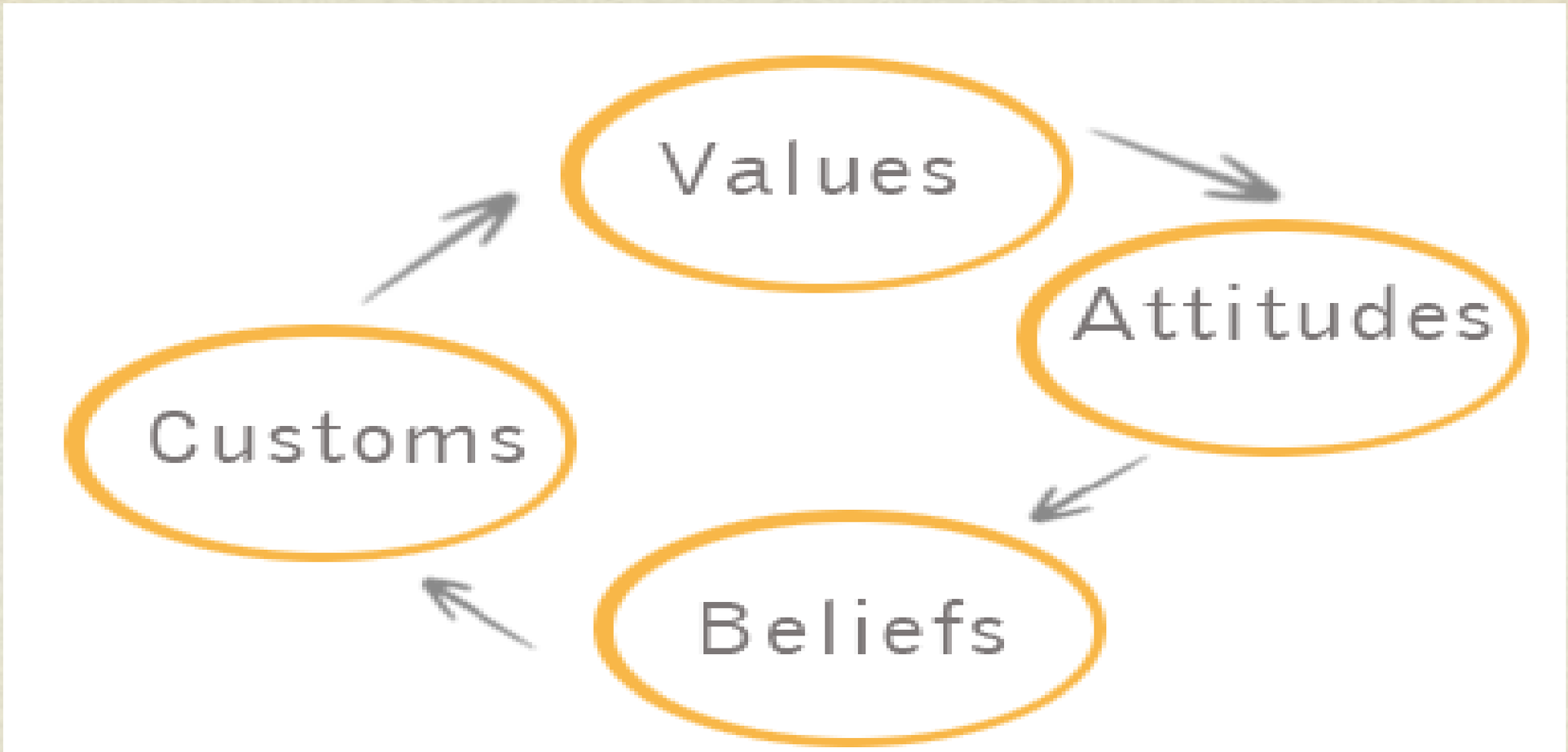
A way of life
A product of collective memories and intellect
The behaviors and beliefs of a particular group

CULTURE IS THE WAY YOU

Think
Act
Interact

There never were in the world two opinions alike, no more than two hairs or grains; the most universal quality is diversity.

The Elements of Culture Include…



USAGE : Language, Religion, Values
Customs & Traditions
Art & Literature
Food etc…

➢Experiencing Old Age….

- not an isolated phenomenon
- life histories and cultural diversities intricately intertwined with histories of families, communities, nations as well as global trends.
- culturally and linguistically diverse background are significant
- diversity of experience shaped by cultural attitudes, family roles and responsibilities, and beliefs

Migration….

Migration…
'… a relatively permanent moving from one geographical location to another, resulting in changes in the interactional systems of the migrants' (Mangalam and Schwarzweller, 1970)

- a major disruption in anyone's life
- not always an entirely free choice (can be both voluntary and involuntary)
- Elderly feel they are ageing out of place (Atwell et al, 2007)
- Traumatic memories
- Undesired circumstances occur

Migration from Bangladesh

Fleeing from their motherland in the face of impending violence and looking for a safe haven, these East Bengali migrants chose West Bengal because of its physical proximity coupled with the ties of language and religion.

According to a survey conducted by the Indian Statistical Institute in 2002-2003, most have religious, political instability and economic reasons for migrating

These migrants generally work as cheap labor in the informal sector, often as domestic helpers, shop helpers, construction laborers, rickshaw pullers, and rag pickers.

Diaspora Formation....

- These Bangladeshi refugees who migrated due to various different reasons like religious persecution and political pressure etc... gave birth to the community under study
- Over the years such migration has impacted the ethnic, linguistic, religious, economic and ecological fabric of West Bengal privileging the ascendance of the DIASPORIC Bangladeshi community of ELDERLY WOMEN residing in the north 24 Parganas in Barasat, on the fringes of Kolkata, West Bengal.

DIASPORA Defined....

For this research, Diaspora has been viewed as communities of migrants settled permanently in and owing allegiance to host countries while at the same time aware of their origin and identity and maintaining varying degrees of linkage with their country of origin and with other diasporic communities of same origin.

(International Organization for Migration, 2002)

Diasporic Culture....

Although every nation has a distinct way of life which is driven by their host culture

- Due to human mobility cultural mixing is a reality today
- Diasporic culture, is thus the product of such constantly configuring process :

•*immigrant or otherwise displaced cultures adapt to host cultures,*

•*intermingling and evolving to form a regenerative new culture,*

•*a culture which is related to both home and host cultures* (Hall, 1990).

Bangladeshi Diasporic Elderly:

- The Bangladeshi Diasporic elderly women respondents of the present study, retained their traditions, religious practices, rituals and festivals, food habits, and
- most importantly used vernacular language for communication (Bangladeshi dialect of Bengali, typical of Chittagoan and Shyllet districts).
- externally, they subscribed consciously to the broad principles of the countries laws, code of conduct, language and public behavior of the local community but indissoluble aspects of Diasporic identity construction were divulged in the field of health care and health care seeking behaviour.

Drawing upon qualitative evidence and quantitative data the paper focuses on strategies and factors determining their health-seeking behaviour.

Objectives:

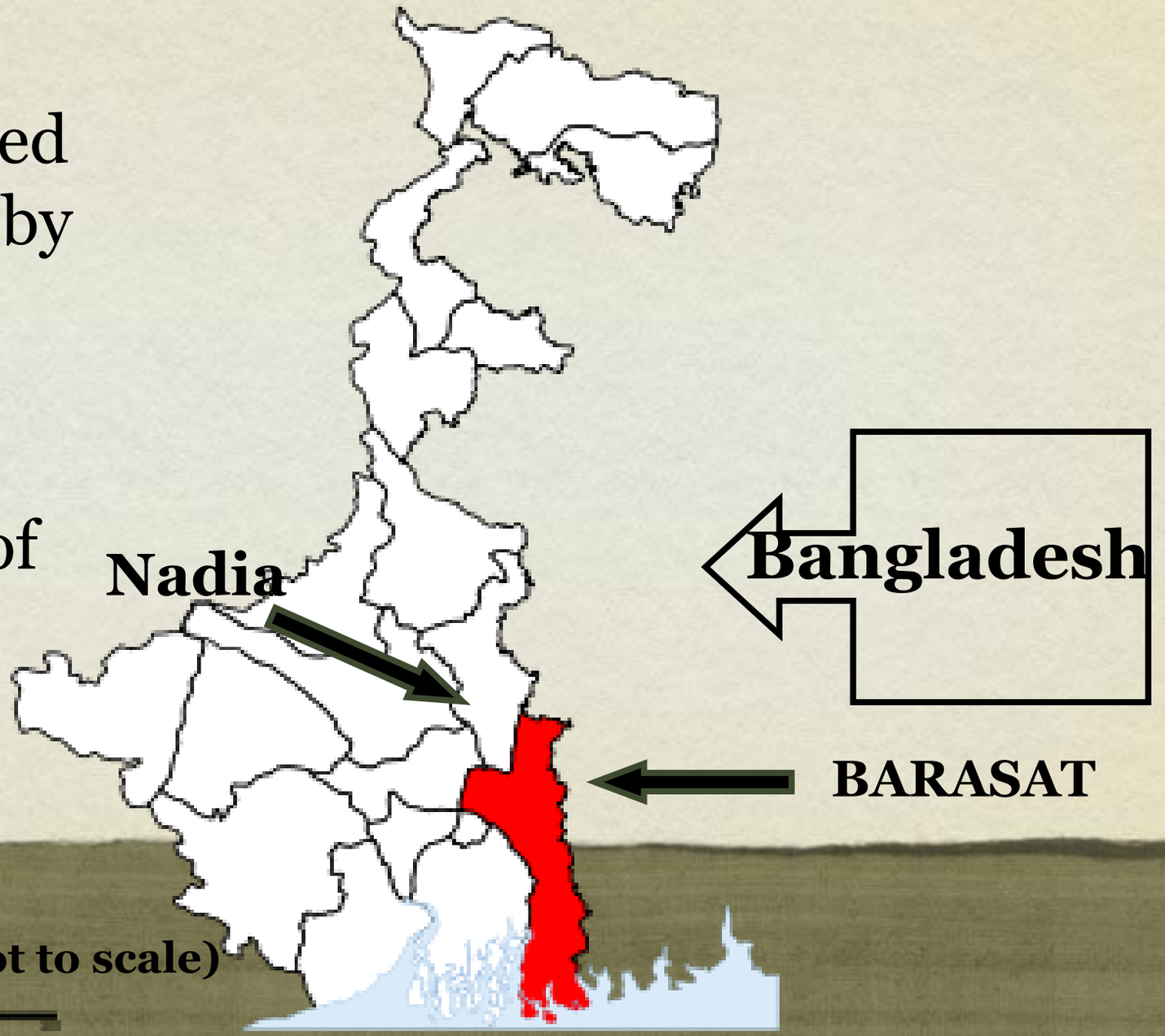
i). to ascertain the nature of problems related to health care among elderly women of the Bangladeshi diaspora living in North 24 Parganas.

ii). to understand the traditional health beliefs and practices among elderly women of the Bangladeshi diaspora living in North 24 Parganas.

Variables: Health Care, Health Beliefs and Health Practices

Map of West Bengal

Area: Barasat, in 24 Parganas North (is bordered by Nadia to the north and by Bangladesh (Khulna Division) to the north and east. Out of the six (6) municipalities consisting of nine (9) gram panchayat, five (5) gram panchayat areas were surveyed.



METHOD

Sample: Data were collected through purposive sampling from 104 elderly women living in North 24 Parganas, (Group:-I, 54 were married when they migrated from Bangladesh and Group:-II, 50 were unmarried when they migrated from Bangladesh) all were aged above 65 when they were participating in the survey.

Tools: General information schedule (containing open ended and close ended question on socio-economic status, attitude and belief system, formal and informal care, intra-generational interpersonal relationship).

Data Collection:

- fieldwork focused on elderly persons' perceptions of health and illness and their health-seeking behaviour in the event of illness. The two main aspects.

i). it illustrated the pathways of health-seeking strategies, which effectively described the decision-making patterns of these elderly women respondents.

ii). it focused on the reasons for their health-seeking decisions.

- The interviews were taped and transcribed afterwards. An interactive process between data collection and analysis was maintained. (Donovan & Sanders 2005).
  - similarities and differences across the respondents .
  - documentation of health-seeking behaviour patterns as well as some individual illness stories were recorded.

Table-I: Socio- Demographic Profile	**Elderly women married when they migrated (N=54) (%) Group-I**	**Elderly women unmarried when they migrated (N=50) (%) Group-II**	**Total (N=104) (%)**
AGE			
65-69 year	**6(11.11)**	**11(22)**	**17(16.34)**
70-74 year	**12(22.22)**	**14(28)**	**26(25)**
75-79 year	**17(31.48)**	**13(26)**	**30(28.86)**
79 and above	**19 (35.18)**	**12(24)**	**31(29.80)**
EDUCATIONAL STATUS			
Illiterate	**19(35.18)**	**14(28)**	**33(31.73)**
Primary	**21(38.88)**	**16(32)**	**37(35.57)**
Secondary	**12(22.22)**	**16(32)**	**29(27.88)**
Graduate	**02(03.70)**	**03(06)**	**05(04.80)**
MARITAL STATUS			
Married	**04(7.40)**	**16(32)**	**20(40)**
Unmarried	**01(1.85)**	**01(2)**	**02(4)**
Widows	**40(74.07)**	**28(56)**	**68(65.38)**
Divorce/separated	**09(16.66)**	**5(10)**	**14(13.46)**

Table-I: Socio-Demographic Profile	**Elderly women married when they migrated (N=54) (%) Group-I**	**Elderly women unmarried when they migrated (N=50) (%) Group-II**	**Total (N=104) (%)**
FAMILY INCOME			
Less than Rs.5000/-	**18(33.33)**	**8(16)**	**26(25)**
Rs. 5001/- Rs.10,000/-	**20(37.03)**	**22(44)**	**42(40.38)**
Rs. 10,001/- Rs.15,000/-	**9(16.66)**	**11(22)**	**20(19.23)**
Rs. 15,001/- Rs.20,000/-	**7(12.96)**	**9(18)**	**16(15.38)**
RELIGION			
Hindu	**35(64.81)**	**38(76)**	**73(70.01)**
Muslim	**19(35.18)**	**12(24)**	**31(29.80)**
CASTE			
General	**23(42.59)**	**19(38)**	**42(40.38)**
SC	**19(35.18)**	**20(40)**	**39(32.69)**
OBC	**12(22.22)**	**11(22)**	**23(22.11)**
FAMILY TYPE			
Nuclear	**12(22.22)**	**32(64)**	**44(42.30)**
Joint	**42(77.77)**	**18(36)**	**60(57.69)**

Table-I Socio-demographic status :

the two groups (the female elderly who migrated with a married status (group-I) and female elderly who were unmarried when they migrated (group-II)) in terms of age, education, marital status, family income, religion, caste, and family type.

the data based facts revealed that most of the respondents belonged to

- higher age group
- widow, divorced or separated
- family income was very low hence low earnings & underprivileged
- concentration of Hindus than Muslims,
- general, schedule caste and OBC categories were present
- group-I lived in joint families and group-II lived in nuclear families mainly

Table-II

Dimensions of Problems Related to Care

	Elderly women married when they migrated Group-I.		Elderly women unmarried when they migrated Group-II	
	Yes %	No %	Yes %	No %
Language Problem				
i) Bangladeshi Bengali not understood by daughter-in –law/care giver	42(77.77)	12(22.22)	30 (60)	20(40)
ii) Pronunciation is not understood by daughter-in –law/care giver due different dialect (Chittagaon and Shyllet)	44(81.48)	10(18.51)	37(74)	13(26)
Cultural background				
Can't accept outsider care giver/ayah/nurse	46 (85.18)	08(14.81)	05(10)	45(90)
Food related problems				
i)Non-vegetarian ship create problem in family	38 (70.37)	16(29.62)	26 (52)	24(48)
ii)Two separate cooking arrangement for veg and non-veg.	26 (48.14)	28(51.85)	16 (32)	34(68)
ii) OCD related to daily food habit (*barbar hat dhoa, bason dhoa* etc.)	30(55.55)	24 (44.44)	22 (44)	28(56)
Intergenerational gap				
Care equal to modern treatment according to children & daughters in law but elderly feel cared for if family members give time and interact with them	16(29.62)	38(70.37)	16 (32)	34(68)

Table II Barriers to Care:

group-I

- limited articulation, understanding and proficiency in local style of language higher due to the non familiar accent of Bengali (77.77% & 81.48%)
- barrier and non acceptance of non family care givers service higher (85%)
- (70.37%) believed care meant family attention, communication and interaction
- food and cooking arrangement linked barriers were higher (70.37%& 48.14%).
- obsessive compulsive habits (55.55%) were profound

group-II

- had better communication and understanding of local language (60% & 74%)
- only (10%) had barrier to service of non family care givers
- only (32%) believed care meant family attention, communication and interaction
- food and cooking arrangement linked barriers were lower (52%&32%)
- obsessive compulsive habits (44%) were less profound

Table-III **Health Beliefs, and Management Practices**	**Elderly women married when they migrated (N=54) (%)** **Group-I**	**Elderly women unmarried when they migrated (N=50) (%)** **Group-II**
Health Management		
Drugs over the counter	**06(11.11)**	**08(16)**
Treat self with herbs and (Jhar phuk)	**02(03.70)**	**0**
Local Quack Homeopathic treatment	**12(25.92)**	**14(34)**
Alternative medical services i.e ; t*abiz*, *kaboj*, *jhar-phuk* (spiritual healing) and *mantra* (incantation) and *holy foods*	**14(25.92)**	**10(20)**
Illness is considered to be ill fate/result of sin	**06(11.11)**	**04(08)**
Pray about it	**03(05.55)**	**02(04)**
Traditional healer (kabiraj)	**05(09.25)**	**04(08)**
Attend public health services	**04(07.40)**	**05(10)**
Sadhu baba/fakir baba gave holy oil	**02(3.7)**	**03(06)**

Table –III Health Belief & Management:

Respondents took to

- alternative medical services (G-I: 25.92% & G-II: 20%)
- local quack homeopathic treatment (G-I: 25.92% & G-II: 34%) most common form of health care
- "ill-fate" (*kopaler dosh*) and result of sin (*paper fal*) (G-I: 11.11% & G-II: 8%) was believed by both groups
- drugs over the counter (G-I: 11.11% & G-II: 16%) respectively
- only (G-I: 7.40% & G-II: 10%) attend public health service

Table-III **Reasons for not Seeking Care**	**Elderly women married when they migrated** **(N=54) (%)** **Group-I**	**Elderly women unmarried when they migrated** **(N=50) (%)** **Group-II**
Lack of money	**06(11.11)**	**08(16)**
Disease due to age (unavoidable)	**12(22.22)**	**17(34)**
Do not want to go out from own living place	**11(20.37)**	**10(20)**
Trust God for healing	**06 (11.11)**	**04(08)**
Old age illness is “*paper bhog”*	**07 (12.96)**	**08(16)**
God’s punishment	**05 (9.25)**	**0**
Nobody to take me to hospital/public/private health service	**07 (12.96)**	**3 (6)**

Table –III Reasons for not Seeking Health Care :

GROUP- I & II

Data revealed that

- the belief that old age and illness are inseparable entities (G-I: 22.22% & G-II: 34%)
- old age illness were the result of sins (G-I: 12.96% & G-II: 16%),
- nobody to take them to the hospital or clinic (G-I: 12.96% & G-II: 6%)
- they did not want to go anywhere from where they were living (G-I: 20.37%&G-II: 20%)
- self- care including self-treatment (or treatment by family members) that is drugs over the counter was common when severity of illness was perceptually low among both groups (G-I: 11.11%&G-II: 16%)

Empirical Facts

1. Health Care

- language barrier in care service
- absence of specialized knowledge in geriatric health care

- multiple sources of quack health care systems

- tendency to avoid going trained medical physicians, commonly known as MBBS doctors,

- formal medical training not consulted unless the situation deteriorates too much.

2. Health Beliefs

- belief that illness and old age remain inseparable
- not completely curable and sometimes even incurable
- demeaning belief about social worth and expectations

- elderly were of less social value hence fewer claims on good quality of life

- internalized the view of old age a period of life with ill health, decreased mobility and decrease of mental faculties.

Older women's, *cultural stigma* visiting a non – family male doctor

As a 76 year old woman respondent **Kamli** put it:

I have pledged ('manot') to God not to be seen by any male doctors... all big doctors (qualified) want to see patients, my family members explained my problems but they demanded to see me...

3.Health Practices

- socio-economic status a strong determinant of health-seeking behaviour (Khe et al. 2002, Ahmed et al. 2003)
  - flexibility of receiving payment by provider
    - flexible cost of treatment

Hence…

- Qualified doctors with formal medical training were not consulted

*quack allopathic care,
*_kabiraji/totka_ (herbalist)
*_jhar-phuk_ (spiritual healing) and
*_mantra_ (incantation) and
*non qualified homeopathic consulted

Final Thoughts

- **Shackles of age old cultural bondage unchanged**
  - limited access to basic health care knowledge and services throughout life course
  - inability to tear asunder the root of the age-old practiced norm of the family system

- **Socio-Cultural belief, predicaments and behaviours**
  - unwillingness to receive services
  - choice of provider
  - behavior of health providers
  - proximity to their residence
  - cost of treatment
  - legal documentation

- **Traditional Health beliefs**
  - no control over health
  - matter of ‘luck’, ‘fate’ or ‘will of God’
  - external health locus of control
  - casting of ‘evil eye’

❖ **Health seeking behaviour associated with**

- type of family setting
  - economical status of the family
    - severity of illness,
      - * source of information,
        - * availability of health facilities,
          - * ignorance of disease
      - * length of treatment process,
        - * cost of treatment,
          - * flexibility in receiving payment
      - * preferring village doctors/ private providers services instead of government services
        - * buying over-the-counter drugs
          - * trust on God for healing

WHAT TOMORROW: There is need to organize for free health services, mobile health providers, proximity of health centres and rehabilitative health care counseling facilities for these elderly within their community to improve their physical, social and psychological understanding & well being.

THANK YOU FOR LENDING YOUR EARS