Socialization and Well-being: Insights from the Santals

Kumkum Bhattacharya, Professor, department of Social Work, Visva-Bharati

Before I begin my talk I would like to thank all those who have given me this opportunity – I really do not know who to start with. Dr. Widmer, Professor Ilario, Dr. Patrick Ouvrard, Dr. Madeline Baumann, Dr. Sophie Chatelard, Celine, David Nicolet of the University of Lausanne, La Source, the many students for the chance to participate in their intellectual journey through Community Immersion programmes conducted in Santal villages around Santiniketan for the last two years and Mrs Ruby Pal Choudhury, former Chairperson Crafts Council of West Bengal for showing how far encouraging hospitality can foster meaningful interaction and enrichment of the mind. I am grateful to all of you.

I Apologia

I may have some doubts if I am even through osmosis an anthropologist but of this I am sure that I am not a medical anthropologist by any yardstick. As a teacher in the faculty of Social Work with a normal conventional training in mainstream Psychology I have had to re-shape my knowledge, style of work and approach to realities that seem more appropriate to the micro-level insights and understandings evident in the works of anthropologists on ethnology. Social Work as a discipline draws its foundational ideas and concepts from the disciplines of Sociology, Psychology, Anthropology (apart from some other disciplines) giving them their particular perspective rooted in the actual situation within an actual timeframe. More importantly the emphasis of Social Work is in the application of ideas and concepts with a particular view to enhance capacities of exercising individual agency, problem solving and decision making; create appropriate environment; innovate on skills and training and smoothen the process and style of adjustment required in confronting individual differences, social change and demands of the time. In order to prepare myself for a class with students of medical anthropology I have been looking at an array of literature available on the net where I found some questions and indications that attracted my attention. I shall not dare to enter into its subject matter or discourses; however I will try to explain to myself and to you how I see my topic in this mesh of disciplines and what could be its significance in the field of medical anthropology and social science.

II Working definitions

Socialization – ‘The concept of socialization is a scientific construct that describes a portion of reality that is not directly observable for descriptive and analytical purposes…is an object of

investigation…but cannot be materially grasped' (Hurrelmann 1988: 4). 'Socialization is the process, formation and development of the human personality in interaction with the human organism on the one hand, and the social and ecological living conditions that exist at a given time within the historical development of a society on the other. Socialization designates the process in the course of which an individual with specific biological and psychological disposition becomes a socially competent person within the larger or segments of a particular society and dynamically maintains this status throughout the course of the individual's life' (Hurrelmann 1988:2). Socialization then helps in acquiring the littlest nuances of a particular culture, to understand the rhythm and latent grammar of the cultural language and integrating all these, is its influence in the formation of identity and personality. Individuals are born into cultures with a past and future fairly complex in pattern that far outstretches the life span of any particular individual (Linton 1954:16) making socialization complex and intangible in nature.

I take this opportunity to express here my deepest apprehension that social science and its branches are increasingly using the lens and perspective of the individual, individualization and 'global/western' benchmarks for their understanding of multifarious cultures and societies; socialization in different cultures and situations does not have the same pace, pattern or style – the relationship between individual and socialization is diverse; the understanding of individual vis-à-vis community is equally diverse. This somehow gets lost in 'translation' from one culture to another. Srivastava (2015: 3) has indicated the subtle cultural differences that by and large social investigators do not touch upon.

Well-being: the state of health is no longer restricted to the condition of physical or physiological conditions; rather it is an extension of the feeling of health that makes the individual's bio-psycho-social mechanisms capable of meaningful and fruitful interaction with the environment in order to live a purposeful life. According to one of the latest understanding of wellbeing as, '…when individuals have the psychological, social and physical resources they need to meet (social, psychological, biological) challenge…' (cf. Dodge et.al. for Hendry and Kloep 2002).

State of health and the incipient conditions entail an integrated view that is comprehensively offered in socialization studies. However, contemporary societies as results of much cross-breeding of cultures and societies appear to be subject to the laws of 'levelling' and universalizations to a great extent. This makes it problematic to identify the strands by which individuals are guided, directly or indirectly by the society or segment of society to which he or she belongs actually or notionally. Ethnographic studies are imbued with the idea of behaviour and subsequently wellness as being 'rooted in culture' (as if cultures are in isolation); these same studies possibly ignored the many surrounding and impinging factors emanating from other cultures, other societies and contemporaenity in general. Adding to all these are the pre-

conceived notions, stereotypes and prejudices that colour the experiences of diagnosis, prognosis and treatment of general or specific health conditions.

III The questions:

It is through the above that I shall frame my question for which the field of medical anthropology may provide answers. It is important to remember that the bio-psycho-social foundations of behaviour enrich the backdrop against which human behaviour occurs and it is this backdrop that gives us clues to behaviour. However, it is equally important to remember that human beings today no longer live only within their cultures or segments of society to which they belong; they are encultured in and accultured by multiple forces that they adopt, absorb and adapt to in the course of their lives and inter-generational progression.

My question arising out of the discussion of socialization: **What are the elements of the Santal society** that influence the **individual Santal's perception of well-being** within the larger Santal society in general and the segment of society to which the individual specifically belongs? The first part of the question deals with the elements or properties of the Santal society and the second part addresses the strategies and interventions that an individual Santal applies to both perception and management of well-being.

IV Observations:

I shall try to answer the first part of my question. By now the word Santal is familiar to my audience. It is a small, in comparison to the vast population of my country, largely homogenous community estimated at about 1%. The Santals belong to the Constitutional (Indian) category of Scheduled Tribe of which there are around 700 communities estimated at about 8.6% of our total population. The decadal growth trend of the Scheduled Tribes is more or less steady with an upward tendency comparable to the growth trends of the country; and the tribes have a healthy sex ratio of almost 990 girls per 1000 boys (Kshatriya 2014). From the above, it is justified to consider this pattern as applicable to the Santals.

Before I proceed further, (no good social scientist really proceeds very far), let me discuss the implications of the term 'homogenous'. I know that some anthropologists will contest my argument when I say that it is near impossible to maintain homogeneity in these times of 'same brush tarring all' – at best we may say that there is a notional idea of homogeneity that exerts its influence in implicit ways especially in the context of the Santals who are 'ex-situ'.

However, my field observations usually conducted in the villages around my university where livelihood practices are agriculture and labour based, homogeneity among the Santals is not only observable but palpable in their life experiences, interactional range, access to local and

cultural resources, degree of participation in plurality, food and clothing habits and faith in tradition. Some of the remarkable traits of the Santals are their appearance of calm, silence and composure. There is no haste in their movements and the ability to do hard work without show of effort attracts one's attention. One of my Santal students narrating the plight of a family caught in a flood situation described to me how the father let go of his son when he realized the inevitability of his inability to save him and how the surviving father later adjusted to this The element of fun or 'raska' in everyday life is important even when applied to their livelihood of hard labour. The Santal women are indeed very efficient workers. The children in Santal society enjoy their childhood which is not burdened; the children have a tacit understanding of their duties and responsibilities that they fulfill in the course of the day. Routine activities of going to school or enduring the lessons that have practically no connection with their lives and culture does not appear attractive to the Santal children who may drop out of the system and drift into the labour market like his/her parents. Instead, Santals are enthusiastic about community participation, institution of festivals and ceremonies, the cycle of activities traditionally connected with them. The active old have a role in perpetuating culture through their songs, stories, riddles, and knowledge of tradition while the infirm are ignored and neglected to some extent. The old are lonely when their next generations separate; the old women continue to contribute through domestic work. However, I have noticed how even the poorest Santal family lets the ailing family member be and not put pressure on him/her (though mainly him) to contribute to the family income; not that special care or attention is accorded to the sick person. (Cf. Bhattacharya, K 1996, 1999, 2006; Bhattacharya, K and Boro Baski 2002; Baski, B; and K. Bhattacharya 2008). There is one interesting detail that could be relevant in the context of this discussion – the Santals generally avoid consuming the milk of their own cattle because they feel that the calf has first right to its mother's milk. Only when the cow produces more and the calf seems to be able to feed itself, milk is sold to non-Santal households in their neighbourhood. What could have been a source of important nutrients and nutrition remains unutilized. Poultry is reared more for the meat and eggs while goats are reared for the larger market and seldom for domestic use.

Without going into more detailed aspects of cultural and social traits of the Santals I shall focus on the aspects related to wellness or wellbeing in terms of their responses to and perception of illness i.e. the second part of my question.

Now for the second part of my question, my observations are: A pregnant woman, in most cases almost a girl as most boys and girls marry young; is not encouraged to eat eggs, do needlework or close holes and crevices made by rats, snakes or other burrowing animals. About consumption of eggs, the explanations are partly economic and partly to avoid having a hairless child. Closing of holes, pores or crevices is to aid the body be prepared to deliver the child normally. Apart from these there are no restrictions on other activities – the woman is able to do all the tasks of the household and outside till the time of delivery; special mention may be made of the arduous work of transplanting of paddy which is a woman's work. They are not barred

from participating in festivities and taking of the rice beer that they traditionally brew. I have not yet encountered a young Santal girl or woman smoking though the older women do occasionally smoke. Ailments among very small children are a cause of worry but as they grow older and independent parents are not over concerned about the child's physical condition. They are not aware of the connections between body weight and development either during pregnancy or of the child; their food intake is heavy in carbohydrates with little protein on a daily basis. Young boys working as cowherds or 'gupi kora' are adept at catching frogs, small fish, bringing down birds and eating them roasted on a spit fire. During particular seasons, snails are eaten though catching even a small pile can take hours and involve arduous labour. Children are good at gathering seasonal fruits and greens from the fields for their domestic consumption. The Santals do not consume too much of fat either in the form of cooking oil or from flesh. Traditionally Santals love pig meat for which they reared pigs but with the shrinking of habitat and intrusion of non-Santals into their villages, rearing of pigs is no longer feasible. The common illnesses among them is tuberculosis compounded by lack of nutrition, hard labour, alcoholism and inadequate body weight are important precipitating factors. I have encountered many Santal men suffering from back pain and I have wondered why they should have this condition given their capacity for labour and active life. In some cases they may not have sought medical intervention till the condition degenerated to a state of immobility. Lack of health is perceived in magic-realistic terms – the causes are magical and the symptoms are real while remedy is uncertain. In cases of pain, usually the initial causes are attributed to 'evil eye', 'evil intention by person or persons' (it is referred to as '*baan-maara*') for which the service of witch doctors or shamans are required and only much later, would an allopathic consultant be visited or the patient hospitalized.

Incidence of hypertension and diabetes within the reproductive group is on the lower side and is quite below the national figures. However, the picture may change in the case of the present generation with their exposure to modern markets and ready foods right at their doorstep. Anaemia is more commonly found. The condition is hardly addressed unless the woman is pregnant and is administered iron tablets by the state health services with which it is mandatory now to be registered. The level of anaemia is not frequently measured. Tuberculosis is a commonly found condition. The state medical system has factored high incidence in its service delivery by providing free drugs. If the patient continues with the medication and medical advice of food and rest, recovery is fast and sustained but a considerable number of patients discontinue the medicine and are unable to supplement their food adequately. Also, tuberculosis at the early stages remains undiagnosed and untreated for which reason positive prognosis does not show a steady trend towards cure.

V Reflections:

I take this opportunity to describe the work of two partner NGOs – Shining Eyes and Manab Jamin among the Santals in which there has been a happy mix of indigenous knowledge, cultural strengths **and** changing perceptions of the Santals regarding issues of health through which

wellbeing can be achieved. Shining Eyes a German NGO promotes nutrition and health of children while Manab Jamin encourages organic cultivation of plants rich in nutrients, is based in Santiniketan. The founder of Shining Eyes, Dr. Monika Golembiewski has been coming and working with and for the Santals since the last 25 years after which she started a hospital for mother and child health in 2009. She travelled with the Santals to nearby forests collecting their traditional herbs and medicinal plants and observed their medical interventions. More practically she has prepared health records of most of the villagers, especially children of two villages over the years monitored on every visit at least twice every year. She advocates the strong link between nutrition and mental development of children using local and indigenous knowledge while Manab Jamin encourages starting, maintaining, and optimum harvesting of kitchen gardens among those who have very little access to supplementary food. Their experiments with two local plants, Moringa and Amaranthus have borne good and reliable data establishing the fact that proper use of these can take care of multiple micro-nutrients required by a growing child especially in the first two years as well as reduce the impact of anaemia of the child-bearing mothers so that they are able to deliver healthy children systemically prepared to absorb nutrition from their daily diets.

Theirs is a long and arduous journey and the fruits of their work are just beginning to show in small samples. They are now reaching out to larger groups by setting up partnerships with allopathic, homeopathic and ayurveda practitioners for a holistic approach to wellbeing and creating the necessary environment through care and service, to bring about informed awareness and exercise of agency through skill development.

At best, this is a limited presentation of my contention that application of medical anthropology has multifarious means and requires an inter-disciplinary approach with the caution that situations are dynamic and change is almost unpredictable and fast even among very traditional societies.

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