The Health / Illness/ Care Process in the Toba Domestic Groups Settled in the City of Rosario, Argentina

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Abstract

The researcher analyses the health / illness/ care process in the Toba domestic groups settled in the city of Rosario, Argentina. The paper considers the interrelationships between members of the effectors of the health services and the toba people using them, domestic family medicine and toba ancestral medicine, their interrelationships and the belief systems. She also makes critical proposals in this regard.

1. Brief mention of the historical and socio cultural context

In Argentine ethnography, the qom (toba), related linguistically and culturally to the Bolivian and Paraguayan toba, are one of the varieties of the hunter collector cultures of the Great Chaco. Their original habitat comprised from the north of the province of Santa Fe up to Paraguay and from the rivers Paraná and Paraguay westward to the pre-cordillera in the province of Salta.

The first group of toba arrived to the city of Rosario in 1968.

A study performed by the Municipal Bank of Rosario Foundation (1996: 122) gives the figure of 110.212 persons living in "irregular settlements" (shantytowns). According to leaders of these emergency neighborhoods, the number of people living in them reaches the figure of 250.000. The Foundation report states that 47.58% are unemployed (1996: 27) and only 14.06 % are regularly employed. The retired people living there are 3.41% (1996: 29), and the rest of the working population are on occasional jobs, are self-employed, or work as house servants. The 47.44% (1996: 19) of the total population in these emergency neighborhoods are less than 15 years of age. Dwellings are very precarious and few of the inhabitants have access to health services, educational services, and potable water and electric power. By far the larger numbers of these people live in a condition of structural poverty.

The family organization of the toba is typical of the extended family: two, sometimes three generations, live under the same roof. According to our field data: since the year 1968, four fields of socio-ethnical interaction have been forming: the one around the Villa Banana settlement (about 37 Toba domestic groups); the ones around the Empalme Graneros settlement (about 300 domestic groups) and the Cerrito settlement (about 46 domestic groups); and finally the Los Pumitas (370 domestic groups), as well as The Barrio Toba (about 280 domestic groups) developed as a consequence of the implementation of the Municipal Program of Relocalization of the domestic groups of toba in 1996 (Rouillón and Circunvalación).

We have not found new statistics from the government institutions in this regard.

According to the Census of INDEC 2010, the indigenous population of Argentina is of 955.032 people of which 126.000 people are qom (toba). The settlement qom at Empalme Graneros in the North of Rosario is the one that more toba population has received in recent years. "The discriminatory treatment which, by their status as migrants and indigenous people receive the qom from various sectors of society has been revealed in different aspects: education, health, and labor market (Vázquez, H.-Bigot, M. 2015).

2. Economic and social reproduction and health,

The toba domestic groups alternate **"changas"** (occasional jobs), scavenging, and Handicraft Street selling, with **"golondrina"** (swallow) migrations: temporary migration aimed at participating in season crop collection that they take with the purpose of working in the harvest of cotton and sugar cane.

They have built solidarity and exchange nets (especially concerning services) among the toba residents in the different settlements, and these nets also incorporate toba individuals still living in the localities where they came from, as well as individuals dwelling in settlements in other cities, such as Resistencia (province of Chaco), Santa Fe (province of Santa Fe), Capital Federal and La Plata (province of Buenos Aires). The most frequent illnesses are T.B., malnutrition and Chagas. Two members of the research team under our direction hold that according to the Toba concept, health is based on an adequate balance among (a) intersubjective relationships, (b) relationships between men and nature, and (c) between men and the supernatural. There are **sorcerers--brujos**-- (who have the capacity of producing damages) and **healers--curanderos**-- (who can only cure). There are illnesses that must be taken care of by the healers, and illnesses that should be taken care of by "white doctors" (Carracedo, E.-Viglianchino, M. 1996: 45).

In general terms, people older than 30 years of age tend to reject white medicine practiced at medical assistance centers. The toba criticize what they consider to be an excessive delay to produce a diagnosis. They have a contrasting assumption: "The person who knows does not ask; he or she just cures". On the contrary, those who are younger than 30 --mothers especially-- use, as much as it is possible, the services offered by the neighborhood dispensary or the public hospitals. Nevertheless, mutual psychological barriers hinder interactions between toba patients and sanitary agents.(Azcona, S. 2002).

The socio-ethnical communication context is marked by asymmetrical relationships between the toba minority and the majoritarian society that exerts a strong dominance (non-deliberate pressure) because of its linguistic and cultural prestige, and because of the unequal relationships prevailing between a politically and economically dominant society and the excluded aboriginal groups. In the toba settlements of Rosario, the leaving school index is impressively high: about 87% have not followed or finished primary school studies. The lack of an education fit for the needs and expectations of the toba school children in the context of the present situation of contact and socio-ethnical interaction is the main cause of this extremely high percentage of school-absenteeism and repeating of grades. This tendency is reinforced by the exceedingly high degree of illiteracy. Among the toba aborigines the learning of Spanish implies contrasting the referents conditioned by the mother tongue with the referential system conditioned by the Spanish language, an operation that implies a typological change of language --the Spanish language is analytic; the toba, synthetic (agglutinant). (Bigot, M., Rodriguez, G., y Vázquez, H. 2001:12).

The health / illness / care process and the system of social representations of the ethno-medical practices, as well as the selective patterns of demand of medical services offered by municipal, provincial, and national health centers considerably affect the results of the service offered. The most frequent illnesses are: T.B., malnutrition, bronchi and lung diseases, parasite diseases and alcoholism. Different levels of care should be noted concerning ethno-medical practices: The first level is based on the contribution of herbs and some laboratory made medicines- such as aspirins, for instance. In this case, assistance is provided by women belonging to the family. If the patient gets worse, the services of a healer are required. And only if the illness persists, it is possible that the services of a sanitary agent or a doctor be requested. Breaking behavior patterns, as well as not complying with prohibition, could be the cause of damage (Carracedo, E.1995).

It is true that there is not, among the toba, complete homogeneity about the social representation system of the health / illness / care process and the selective patterns for demanding medical and odontological care. The constitution of these patterns organizes a view of the world within which a peculiar interpretation of the health / illness / care system is inscribed. In this way, the relations between the toba cultural tradition and their attitude and value systems are different from the ones prevailing among not aboriginal people. The toba ethno-medical practices cannot be clearly differentiated from the evangelical practices. Herbs and esoteric practices are combined in order to control all kinds of illnesses: from emotional disturbances to tooth-aches. It is interesting to mention that during her pregnancy, delivery and feeding the baby, the toba woman should observe a series of rules, some related to feeding and some about behavior in general. Breaking those rules would harm the baby and also the family.

The elderly women are the ones in charge of "keeping an eye" on the mother to make sure that, the rules are enforced: sexual relations are forbidden during pregnancy, as well as breast-feeding (some informants affirm that this is so during the first year of feeding only). If the mother has had those relations during pregnancy, the baby is born dirty, greenish, and may present malformations. If the mother indulges in intercourse during the feeding period, "the babies get mined, their flesh becomes loose, and they don't grow. The grandmothers tell the mother: "you don't love your child" -an informant's testimony (Carracedo, E. Viglianchino, M. 1996: 30).

Herbs and ritual practices are used to cure illnesses: the holy wood (*delikitk*) is used for certain digestive system diseases, kidneys are purified by means of a potion made with chips obtained from the trunk of this plant. A kind of Carob Tree (*mirasoik*) is used as a cure of parasites. Tooth-ache comes from a little worm (*kochel*) that causes tooth decay: massaging affected dental pieces with urunday (*antaik*) leaves is the treatment prescribed by toba ethno-medicine.

Some members of the toba groups consider that the decay of dental pieces is the result of "biting" (chewing too much) or lack of milk or, in the case of those who have some years of schooling, malnutrition. The criollo shantytown population, on their side, says that it is due to starvation or pregnancy (in women). Young toba women with some schooling are the most worried about dental health. Among the (illiterate) shantytown dwellers it is also the young women who are more concerned about their teeth. Among the members of the social groups belonging to lower-middle sectors interviewed there are not age or sex differences: all of them take the care of buccal health into account. But neither the toba nor the criollo shantytown dwellers are aware of the need of prevention of buccal health. But it mustbe said that the offer of odontolological services does not stimulate it either, (Vázquez, H y Azcona, S: 1999)

In the toba domestic groups, the social role of the woman as the subject of medical and odontological demand is fundamental. It is the woman who stimulates the domestic group to seek medical and odontological care, which finds out about the services and makes the appointments and takes children and adults to the consulting room.
Because of the extended character of the toba domestic groups, different from the nuclear one of the shantytown dwellers, the influence of women takes more importance; they are the "**hard core"** of the solidarity and exchange networks of the domestic group.

In Empalme Graneros, at J.J. Paso 2010 there is a municipal Health Center that offers vaccination and general clinical services. The province has a precarious consultory room on wheels in which voluntary doctors- with no remuneration- give first aid and general clinical services. In the toba neighborhood, which came to being as a result of the resettlement produced by the Town Hall, a dispensary offers general clinical and emergency services. Theseaboriginal people are also assisted in the following centers of health: “Pablo VI,” “Juana Azurduy”, “Juan B. Justo”, and “Centro Comunitario Madre de la Esperanza.”

In Villa Banana there is a dispensary in the settlement that is open on Sundays only. There is also a Health Centre nearby (4.500, Godoy Avenue).Some members of the toba population settled in Empalme Graneros (Northern Sector of the town of Rosario) use the medical services of the Children Hospital "J.J. Vilela". Others go to the Alberdi Hospital. The medical services most used by the toba members of all the settlements are the ones given by the Centenario Hospital. It belongs to the government of the province of Santa Fe, but most of the personnel depend on the National University of Rosario. The toba system of social representation concerning the health / illness / care process takes on a special relevance in what concerns the physician / patient relationship. In fact, the members of the sanitary services tend to perceive habits, behaviors and views belonging to that system of beliefs as strange and impossible to understand. As a consequence the physician / patient relationship is affected by psychological and cultural barriers.

Among the members of the toba domestic groups, there is a general trend to discontinue the treatment of diseases. This interruption of treatments is much more frequent among them than among the non-toba patients. The concept of symbolic efficacy that regulates sanitary practices among the members of the toba domestic groups and the family groups of criollo shantytown dwellers is mediated by the cultural variable. Nevertheless, several factors- such as sex, age, time of residence in the settlement and place of origin- introduce different and decisive shades in what concerns adherence to social representations and practices about the health / disease / care process.

2. Primary Care, Education for Health, and the Toba domestic groups

In the field of sanitary, social and preventive medicine, there has been a tendency to conceive health educations as a series of action organized through Programs with the purpose of producing qualitative changes in the views, habits, customs and attitudes related to the health / disease / care process among the members of one or more social groups.

This kind of programmed action has been understood as part of what hasbeen called "Primary Care Strategy"[1], a concept that suffered a long series of definitions and redefinitions. Nowadays, the sanitary and medical practice is part of a medical model that establishes a hierarchy of different kinds of knowledge centred on specialization and the use of technologies that become the more and the more sophisticated. The core of this model is the hospital model. In effect: "The said medical model is based on the Flexner Report (a North American Model), that privileges specialization and hospital practice as the most appropriate medical practices. Because of this the previously described levels of medical care represent levels of prestige, hierarchy and social status, where the first level of care (health centers) represents the last link in the chain, while the hospitals or research centers constitute the first" (Aguado, J .C. and Portal, M.E. 1992:181).

In general terms, these concepts are applicable to the medical model prevailing in our country. The proposal of Education for Health (understood as a kind of professional practice) has come to being through a process that has progressibly challenged the dominant medical model, opening it to a social model. In spite of this, in the formulation of the Program of Education for Health it is possible to recognize the presence of underlying ideological concepts, dimensions of knowledge, and techniques that reproduce the view of the hospital medical model in three dimensions:

1. - The professional profile designed in the university curriculum.

2. - A view that conceives as excessively homogenous the socio-cultural organization of the groups at which the action of the Education for Health programs is aimed at.

3. - The insufficient participation of different social segments of population in the definition of the objectives programmed for Primary Care and Education for Health.

In areas of extreme urban poverty the principal aspects that the agents tend to privilege concerning Education for Health are:

-Mother- Child care.

-Malnutrition.

-Transmissible infectious diseases.

The three previously mentioned aspects appear with greater intensity -- because of the peculiar socio-cultural characteristics of the population-- in the programs organized to implement action of Primary Care and Education for Health in indigenous populations. Among the ethno-political demands of the toba domestic groups settled in the city of Rosario, that include the rights to Bilingual and Intercultural Education and to be the owners of the house where they live, the toba also stress the need to implement discussion groups organized as an intercultural dialogue with members of the public health services[2].The members of the toba domestic groups in whom the qom population has delegated their representation have a clear view that the relationship between the physician and the members of the toba domestic groups is organized according to differential power relationships. One of the basic aspects to be considered in any Education for Health Program is that the toba population settled in the urban space of the city of Rosario organizes their representation of reality through the mediation of their particular linguistic experience. 77 There is a high percentage of monolingual tobas (Bigot, M. 2007).

The cure of diseases by means of the shamanic ritual has a strong prevalence among the toba population of Argentina (Wright: 1998), and this applies to the toba settled in Rosario too. This is a very important cultural trait, and it must be taken into account when planning any health strategy. There is another basic aspect to be considered in the same respect that seems to be obvious although it is difficult to be taken into account. We refer to different manifestation of resistance. Vazquez, H. (2000) defines the indigenous ethnic resistance as: "both conscious responses (embodied in Indian claims and proposals) and unconscious responses (reflected in attitudes, values and behavioral patterns) that the members of a group build up as a reaction against the diverse specific expressions of restriction to which they are subjected by the dominant group".

[1] Primary Care: "The integral strategies or policies of health that are aimed at the whole population and at the health system in all of its levels. It implies facing sanitary problems by means of specific and appropriate forms of readjustment, recommendation and reorientation of the resources of the whole society in order to satisfy the needs and aspirations corresponding to the area of health" (Primeras Jornadas de Atención Primaria de la República Argentina,1987).

[2] In the city of Rosario, public health services are given by means of a combined action, with the participation of the Municipal Secretariat of Public Health, The VIII Area of the Provincial Secretariat of Public Health and the National University of Rosario.

Besides the need of adding to the clinical files of public health services the name of the ethnic group, the place of origin and the linguistic belonging of the person, other aspects should be considered: there is a well-known overlapping of responsibilities and functions; planners of Education for Health programs frequently have an insufficient knowledge of the epidemiologic profiles of the different sectors of the population according to social and cultural variables. Another very important aspect to be considered is the poverty of knowledge of sanitary agents about:

1. Primary Care Strategy.

2. The cultural conditions of the population.

3. The circuit of medical derivation established among the different health services, considering the levels of complexity of the service offered.

4. The performance of evaluations that make it possible to qualitatively measure the degree of success or failure of the plans of Educations for Health.

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