Cultural Construction of Health and the Institutional Measures of Change in rural Bangladesh: The Cases of the BRAC Village Organization and ICDDR,B MCH-FP Programmes in the Selected Villages of Matlab

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Foreword

Empirical evidence point to a causal relationship between the socioeconomic status of individuals and communities and their health. Indeed improvement in health is expected to follow socioeconomic development. Yet this hypothesis has rarely been tested; at least it has not undergone the scrutiny of scientific inquiry. Even less understood are the processes and mechanisms by which the changes are brought about.

The Rural Development Programme (RDP) of BRAC is a multisectoral integrated programme for poverty alleviation directed at women and the landless poor. It consists of mobilization of the poor, provision of non-formal education, skill training and income generation opportunities and credit facilities. The programme is the result of 20 years of experience through trial and error. However evaluation of its impact on human well being including health has not been convincingly undertaken.

The Matlab field station of ICDDR,B is an area with a population of 200,000, half of whom are recipients of an intensive maternal and child health and family planning services. The entire population is part of the Center’s demographic surveillance system where health and occasionally socioeconomic indicators have been collected prospectively since 1966.

A unique opportunity arose when BRAC decided to extent its field operations (RDP) to Matlab. ICDDR,B and BRAC joined hands to seize this golden occasion. A joint research project was designed to study the impact of BRAC’s socioeconomic interventions on the well being of the rural poor, especially of women and children, and to study the mechanism through which this impact is mediated.

In order to share the progress of the project and its early results, a working paper series has been initiated. This paper is an important addition in this endeavour. The project staff will appreciate critical comments from the readers.

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Introduction

The role of culture in health care behaviour is one of the basic themes this paper pursues. Other studies report that traditional culture is still a dominant factor in health and demographic behaviour in rural Bangladesh (Maloney, Aziz & Sarkar 1981). However, changes in traditional culture and its implications for health behaviour are not studied well. This paper examines the role of development interventions to facilitate such change in addition to verification of different aspects of traditional health behaviour, knowledge and attitude to illness and disease.

The empirical context of this paper is rural Matlab which gives a unique opportunity to investigate how health intervention by the International Centre for Diarrhoea Disease Research, Bangladesh (ICDDR,B) and the socioeconomic intervention that of the Bangladesh Rural Advancement Committee (BRAC) brought about changes in the intertwined context of culture and traditional health behaviour. This paper elaborates this complex relation in the context of selected diseases and illnesses in rural Bangladesh.

What follows is divided into eight brief sections containing objectives, methodology, literature overview, intervention programmes, perception, causes and treatment of illness and disease before the conclusion is drawn.

Objectives

The specific objectives of this study are to examine:

i. what the rural poor know about the modern explanation of disease (such as, disease is a pathological condition of human organisms) and their notions of illness;
ii. what they know about the scientific causes of diseases and their indigenous understanding;
iii. how socio-cultural elements of society determine their health behaviour;
iv. finally, how far the interventions by BRAC and ICDDR,B have brought about changes in the traditional health behaviour of the rural poor and influence the socio-cultural elements in it.

1 The context of traditional health behaviour and treatment in the Indian sub-continent including Bangladesh is characterized by multiple facets. For instance, with regard to treatment there are well known practices of ayurveda, unani, hekimi and others (Kakar 1982). However, the issue of modern intervention is not given much attention by those who have dealt with the richness of traditional medicines and health behaviour.

2 The wide-ranging disease context of the rural area is noted in different studies, for instance (Chen, Rahman and Sardar 1980). The observed variability of treatments has been called ‘medical pluralism’, (Bhardwaj & Paul 1986), such ‘pluralism’ cut across developed societies also as an example of an African -American woman from Miami, Florida shows that she has almost simultaneously consulted the ‘root doctors’, ‘sanctified women’ as well as the modern hospital technician (Heiman 1995), similarly the Kleinman’s notion of ... EM (explanatory model-added) is based on an understanding of health care systems as pluralistic system’ (1979 : 89). The renewed interest in traditional health regimes has been seen as ‘medical revivalism’ (Leslie 1976).
Methodology

It is a ‘contextual study’ of health behaviour focusing on an ‘explanatory model’ illuminated by the ‘folk theory’ of illness and treatment. A comparative framework is introduced here which consists of the BRAC, non-BRAC, ICDDR,B, non-ICDDR,B villages among the DSS and non-DSS villages. All are located far from Matlab, at least five kilometer away and selected purposively.

Background Characteristics of the Selected Four Villages

<table>
<thead>
<tr>
<th>Village Background</th>
<th>Name of the Village</th>
</tr>
</thead>
<tbody>
<tr>
<td>With BRAC Intervention &amp; non-DSS</td>
<td>Uttar Nalua</td>
</tr>
<tr>
<td>Without BRAC Intervention &amp; non-DSS</td>
<td>Rasulpur</td>
</tr>
<tr>
<td>With ICDDR,B’s MCH-FP &amp; DSS</td>
<td>Narayanpur</td>
</tr>
<tr>
<td>Without ICDDR,B’s MCH-FP &amp; DSS</td>
<td>Sarkarpura</td>
</tr>
</tbody>
</table>

Ten women from a poor community were chosen from each village and in the BRAC village all respondents came from the beneficiary households. The respondents’ were wives and/or household heads thus facilitating more reliable information.

The major data collection technique was informal in-depth interview conducted by the first author along with a female field investigator. The female investigator had been residing in the area for several months in connection with the data collection for other studies. Where needed assistance was taken both from the BRAC and ICDDR,B to be introduced to the respondents. A checklist was used to conduct the interviews.

An Overview of Relevant Literature

Culture and social structure are believed to determine individual behavior and such belief is reflected in the postulates of structural-functional school in anthropology (Hammel 1990; Lockwood 1995). Behavioral traits significantly emanate from the congeries of beliefs, norms and morals that society approves of while the distribution of wealth; power relation and kinship inform the structural features. However, the postulates of structural functionalism are not universally binding for practical situations and individuals’ preferences may override it. The duality of structure and agency explains why the behavioural outcomes are not always pre-determined. Insightful author Giddens observes that rules and resources at the disposal of a community and informing structural system characterize pre-determination although there may emerge ‘unintended consequences’ out of

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3 ‘Contextual behaviour’ and ‘explanatory model’ have carved attention in health research for various reasons. Explanatory models focus attention on systematic information that includes ideas about causes, types of, symptoms of, and various alternative treatments, for specific illnesses, as experienced and perceived in particular populations (Gittelsohn et.al. 1994: 49).

4 Since 1966 the ICDDR,B has been conducting Demographic Surveillance System or DSS in the selected villages of Matlab sub-district, Bangladesh. It gathered information on vital events like pregnancy outcomes, death, in-migration, out-migration, internal movement, changes in marital status. It started with 140,000 people in 132 villages. In 1970 the number of the villages rose to 232 but reduced to 149 in 1977. Meanwhile seven other villages were washed away by the surrounding rivers rendering a population of 200,000 in 147 villages. The Female Community Health Workers (CHW) of the ICDDR,B visit all households of the coverage area every fortnight to update their records on vital events (Razzaque et al. 1987)

5 The DSS villages of Narayanpur and Sarkarpura came from two of the four sets of villages the BRAC - ICDDR,B research project has designed, which focuses on the impact evaluation of the intervention. Other two villages, Uttar Nalua and Rasulpur, were selected upon discussion with the BRAC area manager to obtain adequate cooperation from the respondents and to ensure the absence of the BRAC’s RDP.
the acts of ‘reflexive’ human beings (Cassell 1993). In the context of ‘health transition’ the relevance of the difference between individual and society is underlined since one cannot be always extrapolated from the other (Caldwell 1990).

Cultural factors like ethnicity; religion or gender norms produce differential health behaviour (Caldwell & Caldwell 1991; Omorodion 1993). Cultural relevance to the understanding of health behaviour and treatment has been further refined by Klienmann (1979; 1980) by introducing the concepts of ‘popular sector’, ‘folk sector’ and the ‘professional sector’ in health care and the notion of ‘explanatory model’ which defines in broad terms the process the etiology of a disease is perceived, symptoms construed, response occurs and communicated as well as management takes place. He focuses on the comparability of ‘medical and cultural systems’ by identifying the cultural expressions of ‘clinical realities’ as well as the differences of ‘disease’ and ‘illness’ with the former being pathological dimension of the phenomenon while the latter being the socio-cultural and psychological dimensions of the problem.

Health behaviour change correlates with other important factors like education, income, living condition, health facilities and policies of the state (Bhuiya, Streatfield & Meyer 1990; Caldwell & Caldwell 1991). Attempt has also been made to build a health transition model (Frenk et.al. 1991). Health and its transition are not free from conceptual ambiguity as there is the need to distinguish ‘health transition’ from other related concepts like ‘mortality transition’ or ‘epidemiological transition’ (Caldwell 1990). Health advocacy sometimes contains hegemony also in the modern world at the cost of individual choice and autonomy (Das 1990), while the material background of health transition is not least important (Johansson 1990). Macro factors like a society’s equity distribution, welfare services or political commitment to achieving good health for the people largely the prospect and reason for success of the micro programmes (Elling 1978; Janzen 1978).

Different intervention programmes have been implemented in rural Bangladesh in order to change the socioeconomic and health conditions of the people. Further the impact of the interventions is not precisely known. Rather, some studies come up with the findings that traditional health care behaviour still persist in rural Bangladesh. For example, the study by Aziz, Yunus & Bhuiya (1994) found in Matlab area as recent as 1990 that about 86% of the selected respondents washed faeces-soiled clothes in the pond, 87% did not use latrine, 85% use incantation/amulet in milky diarrhoea. The study by Bhuiya & Streatfield (1995) found in 1987 in Matlab area that only 41% of the sick children were brought to health care providers by their parents in a span of fifteen days from the onset of symptoms. These providers are distributed in different backgrounds. For example, more than 23% of the diarrhoea affected children were taken to traditional and religious practitioners while 29% were treated by homeopath practitioners. The study by Bhardwaj & Paul (1986) in Sirajganj area reported that 51% of the deceased infants were treated by kabiraj. Above scenario taken together affirms the relevance of traditional health behaviour and treatment in rural Bangladesh.

Matlab and the Intervention Programmes

Matlab, as a thana or sub-district does not differ much from other parts of the country in their level of socioeconomic development. It locates about 50 kilometers south-east of Dhaka while marked by the extensive presence of rivers and canals in and around it with country boats and motor launch as the common means of communication. Recent thana statistics show that about 89 % households depend on agriculture including wage labour for income, 8 % trading, 3 % salaried job. The size of the landless households is 48 %. The literacy level is 26 %.
BRAC commenced its development programme implementation in Matlab in 1992 and so far expanded into 72 villages with 132 Village Organizations and the number of the members is about 6,000. The development package of BRAC is called Rural Development Programme or RDP. In the following the activities of BRAC under RDP in the year 1995 is shown.

**BRAC Activities in Matlab in RDP 1 Area in 1995**

<table>
<thead>
<tr>
<th>Categories</th>
<th>Amount/Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Loan Disbursed (Tk.)</td>
<td>1,53,05,000</td>
</tr>
<tr>
<td>Loan Disbursed Per Capita (Tk.)</td>
<td>3611</td>
</tr>
<tr>
<td>Total Training Delivered</td>
<td>40</td>
</tr>
<tr>
<td>Health Issues Meetings &amp; Orientations</td>
<td>600</td>
</tr>
<tr>
<td>Slab Latrine Sold</td>
<td>378</td>
</tr>
<tr>
<td>Hand Tubewell Sold</td>
<td>25</td>
</tr>
</tbody>
</table>

Source: BRAC MIS, Matlab

*: Training was given on leadership development, credit management, chick rearing, cow rearing, horticulture nursery, vegetable garden and sericulture.

The commencement of the ICDDR, B’s MCH-FP programmes in 150 villages of Matlab dates back to 19776. Activities covered under this programme in 1995 are shown in the following table.

**MCH-FP Programmes in Matlab in 1995**

<table>
<thead>
<tr>
<th>Services Provided</th>
<th>Persons received</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contraceptive (married women)</td>
<td>13,346</td>
</tr>
<tr>
<td>Tetanus vaccine (Pregnant Women)</td>
<td>3,151</td>
</tr>
<tr>
<td>Measles vaccine (Children)</td>
<td>2,698</td>
</tr>
<tr>
<td>BCG (do)</td>
<td>2,636</td>
</tr>
<tr>
<td>DPDT1 (do)</td>
<td>2,667</td>
</tr>
<tr>
<td>DPDT2 (do)</td>
<td>2,626</td>
</tr>
<tr>
<td>DPD3 (do)</td>
<td>2,438</td>
</tr>
<tr>
<td>Malnutrition management (do)</td>
<td>2,079</td>
</tr>
</tbody>
</table>

Source: MCH-FP Rural MIS, ICDDR,B.

**Perception of Disease/Illness and Health Education Implication**

Local Perception: Disease is a persistent phenomenon for the villagers with occasional outbreak of epidemics, sometimes resulting in death. However, the long exposure to disease does not enable them to capture a scientific explanation of it as propounded by the modern ‘germ theories’ or reflected in the pathological perceptions of human organs. The discourse on disease circulated in four study villages consist of local definitions and terminology7. In the name of disease what is

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6 BRAC’s recent activities are published in its annual reports and the MIS database for Matlab RDP keeps track of its course of programmes. ICDDR,B’s programmes are updated in the Annual Report too. One can know more about these organizations and the programmes from the latest Annual Report of 1994. To learn more about the MCH-FP project by ICDDR,B in Matlab one may see (Fauveau, V. et al. 1994). Besides, there are a large number of published papers and research reports incorporating the description and analysis of individual programmes of these two organizations.

7 The wide-ranging use of folk terminology in rural Bangladesh to denote diseases - for example diarrhoeal - has been already reported in earlier studies, for instance (Chowdhury & Vaughan 1988; Chowdhury & Kabir 1991).
conceptualized often more close to the notion of ‘illness’ since it largely refers to the functional experiences of the body. For example, if a person cannot eat or walk indicates disease or *ashuk,* as observed by *Lutfa,* a member of the BRAC Village Organization (VO) from Uttar Nalua. Very few members from Lutfa’s VO could articulate their views on disease. To many of them disease is nothing but different illness such as *lamanai* (diarrhoea), *dudher haga* (watery white excreta), *lunti* (measles), *pansa* (chicken pox), *sardi* (running nose), or *kasi* (cough). This is repeated in non-intervention villages too. For example, to *Khoteja* of Rasulpur it is experiencing bad feeling. In Narayanpur (a MCH-FP village) the discussion about disease never touched on germ theory, in Sarkarpara (non-intervention village) the discussion showed mixed interpretation - i.e., mere names of disease and dysfunctional state of the health. However, there is another group of illness the villagers are commonly concerned with, which they call *algā batash* or invisible wind. By disease many of them both from the intervention and non-intervention villages mean the catching of *algā batash.* Such traditional views have bearing on the ways the causes of diseases are perceived or the modes of treatment opted.

**Health Education:** The health education programmes of both the BRAC and ICDDR,B give special importance to the dissemination of knowledge about diarrhoeal diseases. The villagers’ occasional reference to the effect of germ in the causation of diarrhoeal diseases actually shows some effect of health education. But they did not mention the germ theory in connection with other communicable diseases like chicken pox, measles or jaundice. Therefore the knowledge they gather through health education remains partial and descriptive although the horizon of their cognition is widened than earlier. Their descriptive knowledge included the information like excreta as a source of diarrhea and dysentery, fowls or flies as a cause to spread diarrhea from open latrines. They also know about the health risk of keeping food open or not taking food after adequately washing hands.

**Importance of Intervention:** How far the health knowledge of the villagers of the BRAC and ICDDR,B intervention villages are unique in the sense that they know more than the villagers of the non-intervention villages? There is uniqueness, which cannot be exaggerated because nowadays radio, television, or the expanded immunization programme cover these information widely and the exposures of the villagers in general to the above is substantial. Villagers’ visit to thana health complex or district hospitals also widen their exposure to such knowledge. However, such exposures are common both for the intervention and non-intervention villages. Then what is the uniqueness of the intervention villages? It is the frequency of interaction between the health workers and the villagers in the intervention villages what makes the thing different. The continuous rather than intermittent exposure to the systematic health education create a better opportunity to influence the health behaviour at the group and individual levels in the intervention villages.

**Intricacy of the Intervention:** Yet the changing process of health behaviour is not always very smooth. Why it is not smooth is to be understood for an objective analysis of the impact of health intervention. The case of soap using to wash hands after defecation may be illustrative here. *Lutfa, Khairunnesa* and a few other members of the BRAC VO had occasions when the soaps were consumed in their respective households and not bought again. It was an outcome of the workload of these households.

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8 Lutfa is the president of the BRAC VO at the village Uttar Nalua. She is a widow for the last several years. Her husband was an agricultural worker. Lutfa has only one son who is now adult and works in a distant town. His wife and son live with Lutfa. He sends money time to time. Lutfa is a chick rearer as well as an active worker of BRAC VO who is spirited to undertake new business.

9 Khoteja is a household maid. Her husband is a day labourer. She has three sons and three daughters. She is illiterate and extremely poor.

10 BRAC VO member from the beginning. She has seven children and some are married, live separately. Husband is a small carpenter. The present household size is six. Two daughters are still unmarried and the youngest son lives with the parent with his wife and a very young baby. Both Khairunnesa and her husband did not receive formal education.
For Lutfa - the household head - it is not always possible to remain aware whether or not the soap is bought again after its consumption.

The practice of health education, like many other knowledge, was seen to be conditioned by economic capacity too. For the poor villagers it is not easy to buy soap or slab latrines when three simple meals a day are uncertain. Here culture mingles with economics and a right balance between the two is needed. The BRAC has attempted to strike such a balance. It has incorporated into its credit programme the loan for slab latrine alongside health education on the use of open latrine. Already the use of slab latrine is increasing in Uttar Nalua. Many of the BRAC members either already possessed it or in the process of buying with BRAC credit.

Rationalizing Traditional Behaviour: Sometimes traditional behaviour are found to be rationalised lending persistence to its duration and informing the cultural specificity of its explanation (cf. Zeitlin 1994: 52). Even the systematic health education may not be able to change it. For example, in all four villages the use of open ponds for bathing and washing utensils and clothes is a case in point. The ponds are called bandha pukur with the implication that they are not connected with canal or river. Respective health education which advocates not to use pond water for household chores could not influence this aspect of behaviour because the users strongly believed the water of these ponds were pure. Occasional flood carries wastes from open latrines of the villages to these ponds is yet to be admitted rather the receding flood water is believed to wash away the polluting agents.

Causes of Disease

Belief in Invisible Spirit: The villagers, in their part, pose the question why do diseases occur? Or why does a person fall ill? Answer is sought in their terms. They talk about, in this context, alga batash (cf. Patel 1994: 63) It is attributed to various diseases. What is meant by alga batash? It is intangible spirit, sometimes disembodied soul devoid of any corporeal existence. It wanders through wind, penetrates human body through its unlimited apertures. But they are not so keen to give it a clear meaning as much they are eager to see it as a cause for various diseases afflicting them. For a few diseases it is identified as the central cause while for the others it is ancillary.

How does alga batash catch a person to cause disease? The villagers will be found to weave motley stories to illustrate the episodes of catching such diseases. Not always batash penetrates the body of a sick directly. It may come through another person linked to a patient. The following case from the BRAC intervention village of Uttar Nalua gives us some insights:

‘The young grand daughter of Khairunnesa fell sick to dudher haga and lamani (dysentery and diarrhoea). How did it happen? Once the mother of that girl visited a village wood around noon, seen as bad time to go to a wood. From the same afternoon the suckling daughter fell sick to diarrhoea and dysentery. It was interpreted as the influence of alga batash which penetrated the body of the young girl through her mother’s breast milk.’

Another case to demonstrate how does spirit wanders through one person to another:

‘The two grand children of Taibunesa fell sick to measles who were two and four years old respectively. The younger one was still breast-fed. When they were ill for about five days a neighbour died and the mother of the children visited the house of the deceased person. From
that day the condition of the younger child began to deteriorate very quickly. By the time the
night was over the child died. It is now believed that in the house of the deceased neighbour
the mother caught bad spirit and through her breast milk it got into the body of the ailing child
causing his death.'

Communicable diseases are believed to be less influenced by alga batash than the diseases like
convulsions or hysteria, closely related to the domain of psychology. Violent behaviour
accompanied by wild anger, deranged talk, loud laughter and other unusual behaviour are seen
to be the manifestations of alga batash. The following story brings home another fact that the
bad spirits are more comfortable to descend on a forlorn
women.12

‘Amena13 was sitting on the bank of a canal with a fishing rod in the water. She saw a
wavering lotus on the water calling towards it. Out of fear she started running back to her
home. A spirit grabbed her and threw into the air. She fell on the ground and could not move.
The sun disappeared in the horizon. Her brothers found her lying on the ground under a semi-
conscious condition. That was the first day she began to make erratic behaviour like grinning
loudly, getting violent to everyone. It was interpreted as the effect of alga batash.'

Social Structure and Gender Relation : The range of stories woven about bad spirit and
disembodied soul is not narrow. The essences of these stories also illuminate on the socio-
cultural aspects of rural society. Gender relations, predominant norms or the structural features
embedding the power relations are seen to inform the construction of these stories. For
example, if an unmarried young woman roam outside the house, in the market places or in a
quiet wood in violation of the norms prescribed by purda she runs the risk of attack by bad
spirit. Activity or behaviour against the predominant norms of society allows bad spirit to act
upon. Disregards of a murrubbi (elderly person) or a matbar (village leader) makes bad spirit
revengeful. Thus alga batash is not only the cause of many diseases but also infused with the
power of cleansing the so-called social ills. The body of society and individual overlaps in this
context since social ills are seen to lead to individual ills (cf.Comaroff 1978 : 250-51).

Role of Traditional Community : Traditional knowledge, including those of diseases, originate from
different sources. It includes old people known as murrubbi, traditional healers called kabiraj and
oja, religious healers known as fakir, pir, maulavi and imam. The above people command respect
and authority. For instance, the role of the imam of a mosque is widely acknowledged. On the other
hand, the predominance of community life over individual life makes the community belief binding
for others. Oral culture quickly spreads traditional beliefs leaving little opportunity to remain
isolated of it. The superiority of the elderly people sustains their control over traditional
knowledge. For a young mother the principle of conformity is unbreakable due to their inferior
gender status, even if they learn something new there is little scope for its implementation. The
words of mother in-laws are often sacrosanct for them. When a child falls ill the mode of
treatment is often the decided by the mother-in-law. These are the intricacies of the process, which
accounts for the coexistence of traditional and modern beliefs about diseases together. The health
education by BRAC and ICDDR,B are silent about such misconceptions of the rural people about
the causes of disease. Villagers’ notions of evil or bad spirit are not contested probably to avoid
conflict with them.

12 Women’s greater vulnerability to invisible spirit has been noted in other studies also (cf. Blanchet 1984 : 52).
13 Amena is now married with a young son. Her husband is an agricultural worker. They are poor and illiterate.
Modes Of Treatment

Traditional Treatment: The modes of treatment opted by the villagers also combine traditional and modern elements. For some diseases the treatment is exclusively traditional, while for others it is mixed. The way diseases are explained by the rural people influence their choice of treatment. They are influenced by their socioeconomic condition, gender relation and other structural features of society.

The common traditional treatments include pani para (water incantation), jhar-phoo (oral incantation), tabij (sacred amulet), tel para (oil incantation). Quranic verses or other sacred books supply the material for incantation. They are believed to infuse spiritual power into the body of a patient. However the use of traditional treatments is noticed both in the intervention and non-intervention villages. The following cases will illustrate different aspects of the observations made above:

‘Setara Begum’s’ son Monir fall sick to diarrhoea more often than not in the recent time. He is usually given traditional treatment first followed by allopathic medicines if it is not cured. The traditional medicine is pani para. Setara has seen her parents, neighbours and others in the village to use traditional medicine to treat diarrhoea as she has also seen to take oral saline. Allopathic medicines were collected from the medicine shop located in the village market. It was not prescribed by any qualified doctor instead by the dispenser. This man is now called as daktar or doctor. Setara is least concerned for the qualification of the doctor.’

Mixed treatment is seen in the following case too:

‘Hanufa’ is another woman from the non-intervention village. Her son, Jewel, fell sick to diarrhoea and dysentery for a number of occasions in recent time. She first gave him oral saline. When it relapsed she brought herbal medicines from a kabiraj. It failed to heal the young boy. Finally, the boy was given allopathic medicines by a village dispenser.’

For Mafia Begum of Rasulpur, visiting a maulavi or kabiraj to seek treatment is a common matter. Setera Begum, of the same village, is well convinced that her chronically sick daughter got cured by a maulavi of a neighbouring village. Villagers confidence on traditional healers still persist.

The above cases and observations refer to the non-intervention villages, let us see the condition of intervention villages in this respect. A few cases will apprise us about it:

‘At one evening Lutfa was feeling pain in her abdomen which led to diarrhoea. Its intensity increased. Her son quickly brought some water incantation for his mother. But it was of no use. The condition of the patient deteriorated further and she was removed to a hospital. Interestingly, Lutfia still could not withdraw her belief in pani para or water incantation.

There is a belief at the village Uttar Nalua that a very young boy (less than three months old) shouldn’t be taken out of the house. It has serious implication for treatment reflected in the following case:

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14 Setara Begum is a wife of a rickshaw puller. Her husband sometimes works as a porter also. The household size is seven. Economic condition is bad. She is a housewife and illiterate.
15 The wife of an agricultural worker, Hanufa, is now a mother of two children. Both husband and wife are illiterate and their economic condition is bad.
16 Mafia has two children and her husband is a porter. They ar e poor. Owns a tiny agricultural land which is used for kitchen gardening.
‘Once Khairunnesa’s granddaughter was caught by 

hara-bera or scabies. She could not dare to take 

the baby out of the house to see a doctor although she felt the need. Some of her neighbours suggested 

not to do so because alga batash would inflict the baby. She faced a dilemma due to the contradiction 

between two sets of knowledge - traditional and modern. Some murrubis advised her to take the baby 

to the imam of the mosque who would perform ritual to let the Allah protect the baby from the 

influence of evil spirit outside the house. She followed the suggestion and took the baby to a preacher 

of a mosque.’

Economic Condition and Modern Treatment: It is not only belief that matters, one’s economic 

condition also plays a role to make the choice of treatment. The following case would illustrate the 

point:

‘The poor woman Marium could not afford an allopathic doctor for her ailing son although she 

wanted it seriously. She did not have the necessary money. Her son was suffering from stomach pain 

for a long period. Once she took him to an allopathic doctor who took as much as Tk.70 only for the 

prescription. The money she had was not enough to buy all the prescribed medicines. He was still 

suffering. Then she took him to a kabiraj without having any result. Now she has begun a plant nursery 

making loan from the BRAC and expects that one day she will be able to collect money to provide 

allopathic treatment to her son.’

The choice of treatment on the part of the villagers have already undergone significant changes. 

Modern drugs are fairly popular in the intervention and non-intervention villages. However, the 

villagers are more interested to heal the diseases than being obsessed with any particular mode of 

treatment, although there is priority in certain cases. The limitation of the traditional treatment take 

them to allopathic treatment when they can afford it. As the community does not stop the spread of 

modern medicines it does not discourage the prevalence of traditional treatment either.

Conclusion

This micro-level study sought to know, among others, why traditional health care behaviour persists in 

rural Bangladesh and how intervention programmes change them. Health behaviour is found to be a 

complex phenomenon since it is subject to a number of determinants ranging from psychological, 

biological, cultural, social to the economic ones. Further, all determinants are not measurable in 

quantitative terms rendering the precise evaluation of intervention impact a difficult task and moreover 

all determinants do not change in same magnitude.

Different beliefs and practices contribute to the causation of diseases as they provide the framework 

for perceiving causes and seeking treatment. Traditional health behaviour is found to exist alongside 

modern one and an important impact of such co-existence is the delay to obtain modern treatment 

when it is urgent. Does it mean that the intervention measures by BRAC and ICDDR,B fall short of 

the target? While dealing with this question it should be considered that the intervention programmes 

of the BRAC and ICDDR,B do not cover all aspects of traditional health behaviour. The issues of evil 

spirit, open ponds etc. Although the analysis of the cases gives the indication that the intervention 

villages have been benefited (e.g., using more slab latrine, following more systematically hygiene 

advises) what should really be attempted in this respect is to increase "scientific commitment of a

17 In this context a relevant observation underscoring the importance of economic factor is worthnoting: ‘...cultural 

research rarely expects to find major cultural changes unaccompanied by substantial economic changes’ (Johansson 

1990 : 69).

18 Marium is a widow. Does not own any land other than for the homestead. Economically hard-pressed. Illiterate and a 

mother of three children. Active BRAC VO member.
culture’ through health education. Such inclination, once achieved, would help create a scientific frame of mind to dispel, for instance, the misconception like there can ever be any perceivable link between the so-called social ill and sickness of an individual. Likewise in hygiene practices attention may also be given to the issues of scientific definition of disease or the importance of ‘germ ‘ in causing various contagious diseases at the household level. A simple but effective orientation to ‘health knowledge’ in addition to advocating ‘health practices’ would result in the increase of general awareness than particular diseases or behaviour. As a strategy also it will be more standardized to address the wide-ranging cultural variations.

There is one more element that contributes to the continuation of traditional health regime, which refers to the dominance of the elders, religious leaders, traditional healers and sometimes the community leaders. Through the perpetuation of traditional health behaviour their ideological dominance in society is consolidated so they are reluctant to ignore their valued beliefs and attitudes. Traditional social structure accommodates scientific health notion owing to its larger effectiveness, of course not always, but retention of the traditional ones more owe to certain belief and social relations. Material gain by the traditional healers is no less important in this respect. Now the question is how to control such negative influence? It is through further empowerment of the rural poor by intensifying intervention programmes, which will increase their individual rights and awareness and reduce the overriding importance of the community and other traditional social groups. It will also improve their economic condition to obtain expensive modern treatment when necessary.

In addition routine monitoring of the programmes may also be considered to ensure that the programme inputs reach the poor properly and practiced subsequently. It will also help identify the shortcomings of the programmes and re-design it.

Against the background of widespread rural poverty, illiteracy, and mortality there is little scope to underestimate the importance of the interventions by BRAC and ICDDR,B. Even if it is found that the results are not coming as quickly as expected the present thrust shouldn’t be reduced for it might affect the positive results already achieved 19.

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19 Authors are aware of the complexity of the health intervention, particularly with respect to singular cause determination of mortality, interaction between infection - nutrition or infection - infection (Chen 1986). However, the issue has not been dealt with within the scope of this paper to keep it focused on the relation between cultural construction of health behaviour.
References


