



Cultural Construction of Health and Health Seeking Behavior in Rural Bangladesh

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Received 12 June 2017; accepted 19 August 2017

Published online 26 August 2017

Abstract

Health is one of the elementary needs of human being. People seek and find out multiple options and practices within and beyond the boundary of the society for healthcare services. There are so many socio-cultural, ideological and psychological aspects to understand health and seeking health. This article investigates on the role of culture in health care behavior. As part of the methodological issues, qualitative approach like informal in-depth interview is applied. The major findings of the research are health behavior 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 once. As well as different beliefs and practices contribute to the causation of diseases as they provide the framework for perceiving causes and seeking treatment. Traditional health behavior is found to exist alongside modern one and an important impact of co-existence.

Key words: Health; Health seeking behavior; Traditional culture; Disease; Moods of treatment

Farhana, S. (2017). Cultural Construction of Health and Health Seeking Behavior in Rural Bangladesh. *Cross-Cultural Communication*, 13(8), 1-6. Available from: <http://www.cscanada.net/index.php/ccc/article/view/9739>
 DOI: <http://dx.doi.org/10.3968/9739>

INTRODUCTION

The role of culture in health seeking behavior is one of the basic themes this paper pursues. Other studies report that the traditional culture is still a dominant factor in health

and demographic behavior in rural Bangladesh (Maloney, Aziz, & Sarkar, 1981). However, role of traditional culture and its implications for health seeking behavior are not studied well. This paper examines the role and verification of different aspects of traditional health behavior, knowledge and attitude to illness and disease.

The empirical context of this paper is rural Sreepur which is a upazilla of Gazipur district in the division of Dhaka, Bangladesh. The context of traditional health behavior and treatment in the Indian sub-continent including Bangladesh is characterised 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 richness of traditional medicines and health behavior is not given much attention by those who have dealt with the intervention programmes of disease and illness in rural Bangladesh. This paper is divided into eight brief sections containing objectives, methodology, literature overview, perception, causes and treatment of illness and disease before the conclusion is drawn.

1. OBJECTIVES

The specific objectives of this study are to examine:

- i. What the rural poor know about the modern explanation of the 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 seeking behavior.

2. STUDY AREA AND METHODOLOGY

Sreepur, as a upazilla does not differ much from other parts of the country in their level of socio- economic

development. Sreepur Upazila area 465.24 m²km, located in between 24°01' and 24°21' north latitudes and in between 90°18' and 90°33' east longitudes. Sreepur has 8 unions. Recent upazilla statistics show that about 58% household depend on agriculture including wage labour for income, 18% trading, 9% salaried job and other 8%. Sreepur had an average literacy rate of 47.7%. Population Total 337,367; male 172,186, female 165,181; Muslim 324,285, Hindu 12,508, Buddhist 331, Christian 8 and others 235. Indigenous communities such as santal, Koch, rajbangshi, Mandi, Nunia and Bhangar belong to this upazila. Sreepur upazilla was formed in 1984.

The researcher of this paper used both primary and secondary data collection methods. The primary data was collected from 40 female respondents. For the secondary information, researcher took the help of both printed and electronic documents. The respondents who gave their consent to provide information were interviewed. Among them, forty women from a poor community were chosen from Kaoraid and Telitati union of Sreepur upazilla by purposive sampling. 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 author along with a field investigator. The investigator had been residing in the area for several months in connection with the data collection for the studies. A checklist was used to conduct the interviews. The study made use of qualitative data analysis to achieve the object of the research.

3. AN OVERVIEW OF RELEVANT LITERATURE AND THEORETICAL FRAMEWORK

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 behavioral outcomes are not always pre-determined. Insightful author Giddens observes that rules and resources at the disposal of a community and informing structural system characterise pre-determination although there may emerge "unintended consequences" out of 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 behavior (Caldwell & Caldwell, 1991; Omorodion, 1993). Cultural relevance to the understanding of health behavior and treatment has been further refined by Klienmann (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 behavior 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 the health transition is not least important (Johansson, 1990).

In popular sector, family is the major arenas of health care consist of non-professionals, non-specialists. Here the process is based on self-treatment, self-medication. Sometimes people take advice given by their relatives. Self-care elements are most practiced in all age categories and female respondents had the highest proportions (Geteri et al., 2013) usually mothers or grandmothers, who diagnosis most common illness and treat them with the materials at hand (Chrisman, 1977). It has been estimated that, about 70%-90% of health care takes place within this popular sector, in both western and non-western societies (Kleinman et al., 1978). Self health care as a "self" that relates to itself freely and transparently, with full knowledge, what proponents of self care do not say is that this self health relation is mediated and highly structured, relying on a cadre of so-called experts and technicians, deploying a vocabulary that is sometimes frightening, alienating and often incomprehensible (Murray, 2007).

Some studies come up with the findings that traditional health care behavior still persists in rural Bangladesh. For example, the study by Aziz, Yunus and Bhuiya (1994) found in Matlab area 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 and 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. They study by Bhardwaj and Paul (1986) in Sirajganj are reported that 51% of the deceased infants were treated by kabiraj.

By analyzing the above literature review, it has been understood the relevance of traditional health behavior and treatment in rural Bangladesh. This research is an attempt to find out the existing healthcare practice on medical anthropological perspective. It is a "contextual study" of health behavior focusing on an "explanatory model" illuminated by the "folk theory" of illness and treatment. "Contextual behavior" 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, p.49).

4. PERCEPTION OF DISEASE/ILLNESS

Local Perception: Disease is a persistent phenomenon for the villagers with an 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 consists of local definitions and terminology. In the name of disease what is conceptualised 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 Lotifa from Telehati union. She is a widow for the last several years. Her husband was an agricultural worker. Lotifa has only one son who is now adult and works in a distant town. His wife and son live with Lotifa. He sends money time to time.

Very few respondents from Telehati union could articulate their views on disease. To many of them disease is nothing but different illness such as lamani (diarrhea), dudher haga (watery white excreta), lunti (measles), pansa (chicken pox), sardi (running nose), or kasi (cough). This is repeated in Kaoraid union too. For example, to Raseda of Kaoraid it is experiencing bad feeling. Raseda is a household maid. Her husband is a day labourer. She

has three sons and three daughters. She is illiterate and extremely poor. In Telehati the discussion about disease never touched on germ theory, both of the union 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 respondents are commonly concerned with, which they call alga batash or invisible wind. By disease many of them mean the catching of alga batash. Such traditional views have bearing on the ways the causes of diseases are perceived or the modes of treatment opted.

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 the adequately washing hands.

The practice of health education, like many other knowledge, was seen to be conditioned by economic capacity too. For the poor village 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. Sometimes traditional behavior is found to be rationalised lending persistence to its duration and informing the cultural specificity of its explanation (cf. Zeitlin, 1994, p.52). Even the systematic health education may not be able to change it. For example, in the two unions 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 behavior because the users strongly believed the water of these ponds were pure.

5. 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, p.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 Telehati union gives us some insights:

The young grand daughter of Kaleda fell sick to dudher haga and lamani (dysentery and diarrhea). 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 diarrhea 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:

Taslima has three sons and a daughter. The eldest son Jasim is married and lives with the parents. He has a toddler. Taslima's husband is a small carpenter. This household does not have any agricultural land. The two grandchildren of Taslima 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 behavior accompanied by wild anger, deranged talk, loud laughter and other unusual behavior 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.

Fatema 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 on 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 behavior like grinning loudly, getting violent to everyone. It was interpreted as the effect of alga batash.

5.1 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 behavior 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 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, pp.250-51).

5.2 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 from it. The superiority of the elderly people sustain their control over traditional knowledge. For a young mother on 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.

6. MODES OF TREATMENT

6.1 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 socio-economic condition, gender relation and other structural features of society.

6.2 Common Traditional Treatments

The common traditional treatments include pani para (water incantation), jhar-phook (oral incantation), tabij (sacred amulet), tel para (oil incantation). Quranle 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 of the union of Sreepur. The following cases

will illustrate different aspects of the observations made above:

Rahela 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. Rahela 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. Rahela has seen her parents, neighbours and others in the village to use traditional medical to treat diarrhea 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. Rahela is least concerned for the qualification of the doctor.

6.3 Mixed Treatment

Mixed treatment is seen in the following case too:

Halima's son, Zakir, fell sick to diarrhea 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 Suraiya Begum of Telehati union, visiting a maulabi or kabiraj to seek treatment is a common matter. Rahela Begum, of the same village, is well convinced that her chronically sick daughter got cured by a maulavi of a neighbouring village. Villagers got confidence on traditional healers still persists.

At one evening Lotifa was feeling pain in her abdomen which led to diarrhea. 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, Lotifa still could not withdraw her belief in panipara or water incantation.

There is a belief 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:

Once Hanufa's grand daughter 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.

6.4 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 Majeda 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.200 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 to work as a day labor 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 has already undergone significant changes. Modern drugs are fairly popular in the two unions. 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 takes 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 behavior persists in rural Bangladesh. Health behavior 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 once. 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 the 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 behavior 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. The issues of evil spirit, open ponds etc. Although the analysis of the cases gives the indication that 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 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 behavior. As a strategy also it will be more standardized to address the wide-ranging culture variations.

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