Sociology 31 – 41

Health Awareness Patterns

A Cross-Cultural Comparison between Muslim and Horizon Communities in Rajshahi Metropolitan City of Bangladesh

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Abstract. *Health is one of the very important elements of human capital. The knowledge of health awareness enhances human being to get proper healthcare facilities all over the world. In Bangladesh health is one of the main fundamental rights of every citizen, which is ensured by the constitution. The present study, the author tried to find out health awareness patterns between the two communities (Muslim and Horizon). The purpose of the study was to examine and compare how health awareness knowledge influences on health outcomes between Muslim and Horizon communities. In this study, total number of 275 (150 for Muslim and 125 for Horizon) participants were interviewed by the author during April to July, 2012 in the Rajshahi Metropolitan City of Bangladesh. The simple random sampling technique was applied when sample size selected. Various statistical techniques were used during analyzed data with SPSS software in version 15. The present study showed that health awareness knowledge was greatly influence over the healthcare outcomes. The author found that Muslim community dominated the minor community (Horizon) in the various sphere of life. Most of the participants studied up to primary level which was 45.09%. 83.46% participants seemed that proper health awareness knowledge positively enhanced to get healthy life style. 49.10% participants seemed that communal destitution is existed to get educational attainment and take healthcare facilities. 87.28% participants argued that they were concern either permanent or temporary family planning methods. 79.35% participants showed their opinion that health awareness knowledge made conscious about primary diseases, how and where to take diagnosis and treatment of their suffering diseases. 83.23% participants expressed their fillings that health awareness and educational knowledge enhances to get better healthcare facilities and lead a better healthier life.*

Keywords: Health, Awareness Patterns, Cross-Cultural Comparison, Muslim, Horizon, Bangladesh.

Introduction

Health status attainment is the universal phenomenon all around the world. This is the achieving mental aspect of human behavior across the social systems. Health care services in our country are not adequate enough to provide treatment facilities of the total population. Moreover, poverty, illiteracy and lack of health awareness knowledge cause miserable sufferings and premature death to our people. The quacks and village doctors are aggravating the situation (BPHMS: 2011). An individual with his or her personal education and health status attainment not only occupies certain status in the family, group, community or wider society but also acquires certain prestige through which s/he meets his or her day-to-day human needs and solves personal physical, mental and social problems faced in a particular environment(Uddin:2009). In Bangladesh, according to constitution section-2, article-15, the government ensures free medical care (Bangladesh constitution: 2011). Likewise education and health status attainment refers to the achievement of persons' relative position of

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education, occupation and income within that particular social system (Hossain: 2012). This paper focuses on cross-cultural comparison of health awareness patterns and health status attainments and its interrelationships between Muslim and Horizon communities in Rajshahi metropolitan city of Bangladesh. In Rajshahi Zila (district) the literacy rate is 53.0% and school attendance rate (5 to 24 years) is 58.9% (census report: 2011). Where the national literacy rate (7 years and above) is 51.8% and ethnic population is 1.10 %(census report: 2011).

The World Health Organization defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"(WHO: 1948). Health is the quality of life that renders the individual fit to live most and serve best. But attainment and maintenance of health may not be easy in the world when lives have become so complex and the environment so hazardous. Because of improper living the result of either ignorance or carelessness, the health of many even in the developed world is below the desired level (Rashid, Khabiruddin and Hyder: 2004). The eight essential component of health awareness patterns are: (i) Education and information about prevailing health problems and methods of preventing and controlling them; (ii) Promotion of food supply and proper nutrition; (iii) Adequate supply of safe water and basic sanitation; (iv) Maternal and child health care including family planning; (v) Immunization against infectious diseases; (vi) Prevention and control of endemic diseases; (vii) Treatment for minor ailments and injuries, and (viii) Provision of essential drugs (Rashid, Khabiruddin and Hyder: 2004). The knowledge of health awareness patterns status persons singly or collectively attain is socio-culturally constructed and modified in every society. Social scientists separately suggest three approaches to study health awareness patterns status attainment: Prestige approach by National Opinion Research Center, Functionalist approach by Duncan and others, and Class approach by Marx and Weber, including its categorical and numerical variables. These approaches generally assume that health awareness patterns status attainment may vary across the class, caste, sex, religion, race, region etc. due to inequality in property, power and opportunity distribution in the hierarchical social structure in every society. Based on the assumption relevant cross-cultural comparative studies conducted across the cultures reveal that health awareness patterns status attainment widely varies people in the dominant market economy compared to the non-dominant ones achieve high status. These studies argue that without high status achievement people in the highly modernized market economy cannot fulfill their human problems like health awareness faced in that environment. Other comparative studies reveal that this health awareness patterns status achievement also varies among the different classes, castes, religions, races, regions within a given culture, because dominant class or cultural group always dominates, deprives and exploit non-dominant classes or cultural groups within a society. Regarding this several researches investigated in multicultural societies indicate that every parental health awareness patterns status attainment of the cultural groups is transformed into the next generation. As health awareness patterns status attainment of minority parents or non-dominant groups (Black, Hispanic, Asian and African born) compared to the majority or dominant ones (White) is low, so their children's health awareness patterns status attainment is also low. In addition, it is widely reported that males' health awareness patterns status attainment compared to the females within the family and other formal organizations also varies in different cultures. Health awareness patterns status attainment of males is higher than the females. These health awareness patterns status attainments education, occupation and income are cyclical process in which low educational attainment by someone influences his or her low prestige job involvement that in turn influences low income rate in the particular social system in Bangladesh report that health awareness patterns status attainment of the dominant group (Muslim) is higher than the minority groups of Horizon in Bangladesh (Hossain: 2012). In Bangladesh patient doctor ratio is 2773:1 and the available pure drinking water user 85% and the available of sanitary latrine is 87 %(Bangladesh Economic Survey: 2012). Where pure drinking water user is 82.55% and the user of sanitary latrine is 77.45% in study area.

Background and Methodology

Background

Community is a group of people who not only share the same believe system but also acquire more or less the status in a particular environment. This community status may vary from other community. A community is a group or a collection of groups that inhabits a locality. The residential tie to an area is one attribute that distinguished a community from other groups. Another distinguished feature of a community is the total organization of social life in the area (Ogburn and Nimkoff: 1960). Bangladesh is an agrarian economic based

rural country where various religious and ethnic communities, especially Muslim and Horizon, live in the same geographical location, and involve in the historical and social processes for livelihood (Uddin: 2009). The Muslim in this country is the dominant group, while the Horizon (Ancient believer) is non-dominant group. Religiously, the former believe in Monotheism, but the later believe in animism (Bongas). The former speak in Bengali language with the mixture of Arabic-Urdu preference. On the other hand the later speak in Austric-Mundary, and sometimes speak in Bengali version with the other Bengali-speaking people. Based on their respective fundamental believe system both the communities interact with agriculture economy for their livelihood. Although about 75% of the rural people live in subsistent economy in which most of them are poor, minority groups such as the Horizon are the poorest of the poor. One report indicates that 53% of the rural peoples are poor and there are 55 million food insecure households and 62% adults are illiterate. In Bangladesh current total fertility rate (TFR) is 2.3%, child mortality rate is 53 per 1,000 and current use of contraceptive instruments is 56.9% (BDHS: 2011). It is more interesting that although main occupation of the rural villagers is agriculture, man-land ratio is very low and many of them are landless or near the landless due to law of inheritance, land fragmentation and over-population. Some reports indicate that about 62% of the rural households are functionally landless. In the education and health status attained by the Muslim, Horizon is embedded in Rajshahi city of Bangladesh (Hossain: 2012).

Objectives of the Study

The study is based on the health awareness patterns between Muslim and Horizon communities of health in Rajshahi metropolitan city of Bangladesh. The main objectives of the study are as follows:

To closely know the health awareness patterns between Muslim and Horizon communities.

To find out and compare the situation of the health awareness patterns and healthcare facilities attainments between Muslim and Horizon Communities in Rajshahi metropolitan city of Bangladesh.

To know what types of diseases and health hazards faces and where treatment the diseases by the respective community people.

Hypothesis of the study

Hypothesis 1: Health awareness patterns attainment of the Muslim community is higher than Horizon community in the Rajshahi metropolitan city of Bangladesh.

Hypothesis 2: There are positive significant relationships between health awareness knowledge on healthcare attainment of the Muslim and Horizon communities in the study area.

Hypothesis 3: Better quality of health awareness knowledge enhances the better quality of healthcare outcomes.

Hypothesis 4: Health awareness people are very much conscious about various diseases, cured system and prevention than unawareness people of the study area.

Methodology

This study was conducted during April to July, 2012 in the Rajshahi Metropolitan City of Bangladesh where Muslim and Horizon community people live side by side. Three villages like Hetem Khan Pan Bahar, Methor Para and Karigar Para, ward no. 11 under the Rajshahi City Corporation in Boalia Thana (Police Station), were purposefully selected for this study. Muslim community people live in Hetem Khan Pan Bahar, and Karigar Para village and Horizon community people live in Methor Para village.

Features of Sample

There were total numbers of participants 275 (Muslim no.150 and Horizon no.125) who were enlisted in this study. 275 participants were selected by using simple random sampling procedure whose age ranged 10 to 40 and above years and male (200) and female (75). Most of them were day laborers (23.63%) and rests of them were Sweeper (22.92%), Rickshaw puller (24%) and small Shopkeeper (11.27%). Most of the participant's monthly income was Tk.5000 to 7500 (34.55%), (1 U.S Dollar = 79.75 Taka in Bangladeshi currency).

Variable and Measure

Community was nominally measured and coded as 1= Muslim, 2= Horizon. Sex was nominally measured and coded as 1= Male, 2= Female. Age was numerically measured in years. Family structure was nominally measured and coded as 1= Nuclear, 2= Joint. Family authority was nominally measured and coded as 1= Parental, 2= Maternal. Occupation was nominally measured and coded as 1= Job holder, 2= Sweeper, 3= Rickshaw puller, 4= Small shopkeeper, 5= Day laborers. Education was nominally measured and coded as 1= Primary level, 2= Secondary level and 3= Tertiary level. Knowledge of health care facilities were nominally measured and coded as 1= Yes, 2= No, Health Awareness Patterns measured and coded as 1=Good, 2=Moderate, 3=Poor, Knowledge about Safe Drinking Water measured and coded as 1=Good, 2=Moderate, 3=Poor,, Knowledge about Hygiene measured and coded as 1=Yes 2=No, Types of Latrine measured and coded as 1=Sanitary, 2=Unsanitary, Knowledge about Safe Delivery and Maternity measured and coded as 1=Govt. Hospital, 2=Mother and Child Welfare Center, 3=Private Hospital, 4=Own Home, Using Family Planning Methods measured and coded as 1=Permanent , 2=Temporary, 3=None, Communal Destitution to Get Healthcare Facilities were nominally measured and coded as 1= Yes, 2= No.

Relationship of health awareness patterns, here awareness pattern was independent variable and healthcare outcome was dependent variable.

Instrument and Procedure

The data of this study were quantitative in nature of health awareness patterns between Muslim and Horizon communities. In order to collect data semi-structured questionnaire with close and open ended questions was made in Bengali language version, because of these communities participants did not understand English. After collecting necessary data, it was converted into English version. In order to ensure reliability and validity of the data rapport was build up and followed with the participants from initial stage to last stage.

Data Analysis

Based on author's objective, the collected data were analyzed by descriptive statistics, presenting frequency distribution, percentage and grand total was applied to measure the relationship about health awareness patterns. The author used the SPSS software version 15 to analyze the necessary data. Especially different statistical techniques were applied to find out similarities or differences and associations in the health awareness patterns attainment on healthcare outcome between Muslim and Horizon communities in the three villages like Hetem Khan Pan Bahar, Methor Para and Karigar Para, ward no. 11 under the Rajshahi City Corporation in Boalia Thana(Police Station). These statistical techniques to find out cross-cultural differences and interrelationships for the health status attainment variables included were more relevant, because most of the variables used were numerical (quantitative) in nature (Uddin : 2009).

Results

In order to find out and compare health awareness patterns by Muslim and Horizon communities people in Rajshahi metropolitan city of Bangladesh, education, various healthcare awareness ingredients , occupation and the income in the study area were measured and compared. In addition, this study also analyzed and compared how health awareness patterns influences each other between the Muslim and Horizon communities. The findings of the comparative analysis are given in below the tables no. I-XV

Table I
Sex of Community between Muslim and Horizon

Sex of the community	Muslim	Horizon	Total
Male	107 (38.91)	93 (33.82)	200
Female	43 (15.63)	32 (11.64)	75
Total	150	125	275

Note: Percentage in parentheses

Table I shows that (72.73%) is male and rest of the female (27.27%). Maximum sex of the community is male.

Table II
Occupational Attainment between Muslim and Horizon Communities

Occupational Attainments	Muslim	Horizon	Total
Job Holder	37 (13.45)	13 (4.73)	50
Small Shopkeeper	23 (8.36)	8 (2.91)	31
Rickshaw Puller	34 (12.36)	32 (11.64)	66
Sweeper	0 (0)	63 (22.92)	63
Day Laborers	56 (20.36)	9 (3.27)	65
Total	150	125	275

Note: Percentage in parentheses

Table II shows that most of the Muslim participant's occupation is day laborer (20.36%) and most of Horizon participant's occupation is sweeper (22.92%). The occupation of Muslim community is better than that of Horizon community.

Table III
Age of the Muslim and Horizon Communities

Age of the Participants in Years	Muslim	Horizon	Total
10-20	12 (4.36)	8 (2.91)	20
20-30	78 (28.36)	62 (22.55)	140
30-40	41 (14.91)	35 (12.73)	76
40^{+}	19 (6.91)	20 (7.27)	39
Total	150	125	275

Note: Percentage in parentheses

Table III shows that the maximum Muslim participants are (28.36%) and Horizon (22.55%) of age group of 20-30 years.

Table IV
Educational Status Attainment between Muslim and Horizon Communities

Educational Status Attainments	Muslim	Horizon	Total
Primary Level (i-v)	66 (24.00)	58 (21.09)	124
Secondary Level (vi-xii)	52 (18.90)	43 (15.64)	95
Tertiary Level (xiii-xvi)	32 (11.64)	24 (8.73)	56
Total	150	125	275

Note: Percentage in parentheses

Table IV shows that the maximum primary educated Muslim participants are (24.00%) and Horizon participants are (21.09%). Muslim community is dominant in educational status attainment.

Table V
Monthly Income of Participants between Muslim and Horizon Communities

Monthly Income of Participants in Tk.	Muslim	Horizon	Total
2500-5000	31 (11.27)	30 (10.91)	61
5000-7500	49 (17.82)	46 (16.73)	95
7500-10000	42 (15.27)	32 (11.64)	74
10000^{+}	28 (10.18)	17 (6.18)	45
Total	150	125	275

Note: Percentage in parentheses (1 USD=79.75 Tk.)

Table V shows that the maximum monthly income of Muslim community that is (16.73%) and Horizon community is (17.73%). In monthly income perspective Muslim is dominant than that of Horizon community.

Table VI
Knowledge about Healthcare Facilities of the Participants

Knowledge of Healthcare Facilities	Muslim	Horizon	Total
Yes	112 (40.73)	85 (30.90)	197
No	38 (13.82)	40 (14.55)	78
Total	150	125	275

Note: Percentage in parentheses

Table VI shows that knowledge about healthcare facility of Muslim community is (40.73%) and Horizon community is (30.90%). Knowledge about healthcare facilities perspective Muslim community is ahead than that of Horizon community.

Table VII
Health Awareness Patterns of the Participants

Health Awareness Patterns	Muslim	Horizon	Total
Good	48 (17.46)	45 (16.36)	93
Moderate	82 (29.82)	53 (19.27)	135
Poor	20 (7.27)	27 (9.82)	47
Total	150	125	275

Note: Percentage in parentheses

Table VII shows that moderate health awareness patterns of Muslim community is (29.82%) and Horizon community is (19.27%). Health awareness patterns aspect Muslim community is ahead than that of Horizon community.

Table VIII
Knowledge about Safe Drinking Water of the Participants

Knowledge about Safe Drinking Water	Muslim	Horizon	Total
Good	84 (30.55)	69 (25.09)	153
Moderate	52 (18.91)	34 (12.36)	86
Poor	14 (5.09)	22 (8.00)	36
Total	150	125	275

Note: Percentage in parentheses

Table VIII shows that good knowledge about Safe drinking water perspective Muslim community is (30.55%) and Horizon community is (25.09%). Knowledge about safe drinking water perspective Muslim community is dominant than that of Horizon community.

Table IX
Knowledge about Hygiene of the Participants

Knowledge about Hygiene	Muslim	Horizon	Total
Yes	94 (34.18)	64 (23.27)	158
No	56 (20.37)	61 (22.18)	117
Total	150	125	275

Note: Percentage in parentheses

Table IX shows that knowledge about hygiene perspective Muslim community is (34.18%) and Horizon community is (23.27%). Knowledge about hygiene perspective Muslim community is ahead of Horizon community.

Table X
Types of Latrine by Use of the Participants

Types of Latrine	Muslim	Horizon	Total
Sanitary	135 (49.09)	78 (28.37)	213
Unsanitary	15 (5.45)	47 (17.09)	62
Total	150	125	275

Note: Percentage in parentheses

Table X shows that types of latrine by use perspective Muslim community are (49.09%) and Horizon community is (28.37%). Types latrine by use perspective Muslim community is ahead than that of Horizon community.

Table XI
Have Any Knowledge to Get Proper Diagnosis of Diseases the Participants

Knowledge to Get Proper Diagnosis	Muslim	Horizon	Total
Yes	77 (28.00)	58 (21.09)	135
No	73 (26.55)	67 (24.36)	140
Total	150	125	275

Note: Percentage in parentheses

Table XI shows that knowledge to get proper diagnosis of diseases perspective Muslim community is (28.00%) and Horizon community is (24.36%). Knowledge to get proper diagnosis of diseases perspective Muslim community is ahead than that of Horizon community.

Table XII
Have Any Knowledge to Get Proper Treatment Plan of the Suffering Diseases of the Participants

Get Proper Treatment Plan of the Suffering Diseases	Muslim	Horizon	Total
Yes	99 (36.00)	90 (32.73)	189
No	51 (18.55)	35 (12.72)	86
Total	150	125	275

Note: Percentage in parentheses

Table XII shows that knowledge to get proper treatment plan of the suffering diseases perspective Muslim community is (36.00%) and Horizon community is (32.73%). Knowledge to get proper treatment plan of the suffering diseases perspective Muslim community is ahead than that of Horizon community.

Table XIII
Knowledge about Safe Delivery and Maternity of the Participants

Place of Delivery	Muslim	Horizon	Total
Govt. Hospital	80 (29.09)	53 (19.27)	133
Mother and Child Welfare Center	31 (11.27)	39 (14.18)	70
Private Hospital	20 (7.27)	10 (3.64)	30
Own Home	19 (6.91)	23 (8.37)	42
Total	150	125	275

Note: Percentage in parentheses

Table XIII shows that knowledge about safe delivery and maternity maximum go to Govt. hospital Muslim community is (29.09%) and Horizon community is (19.27%). Knowledge about safe delivery and maternity perspective Muslim community is ahead than that of Horizon community.

Table XIV
Using Family Planning Methods by the Participants

Patterns of Family Planning Methods	Muslim	Horizon	Total
Permanent	56 (20.36)	49 (17.82)	105
Temporary	79 (28.73)	56 (20.37)	135
None	15 (5.45)	20 (7.27)	35
Total	150	125	275

Note: Percentage in parentheses

Table XIV shows that using maximum temporary family planning methods perspective of Muslim community is (28.73%) and Horizon community is (20.37%). Using family planning methods perspective Muslim community is ahead than that of Horizon community.

Table XV
Have Any Communal Destitution to Get Healthcare Facilities of the Participants

Communal Destitution to Get Healthcare Facilities	Muslim	Horizon	Total
Yes	62 (22.55)	73 (26.55)	135
No	88 (32.00)	52 (18.90)	140
Total	150	125	275

Note: Percentage in parentheses

Table XV shows that communal destitution to get healthcare facilities perspective Muslim community is (22.55%) and Horizon community is (26.55%). Communal destitution to get healthcare facilities perspective in some cases Horizon community is destitute by the Muslim community people.

Discussion

Purpose of the study was to explore and compare Health awareness patterns status attainment between Muslim and Horizon communities in the Rajshahi metropolitan city of Bangladesh. Health awareness patterns status attainment of Muslim community people was higher than the Horizon community people. Occupational status attainment of the Muslim is batter than Horizon community. The findings of study suggest that there were significant differences in Health awareness patterns status attainment, occupation and income and others some variables between the Muslim and Horizon community in the study area. In addition, these variables of Health awareness patterns attainment were significantly related to each other. Previously the author formulated four hypotheses: (1) Health awareness patterns attainment of the Muslim community is higher than Horizon community in the Rajshahi metropolitan city of Bangladesh; (2) There are positive significant relationships between health awareness knowledge on healthcare attainment of the Muslim and Horizon communities in the study area; (3) Better quality of health awareness knowledge enhances the better quality of healthcare outcomes and (4) Health awareness people are very much conscious about various diseases, cured system and prevention than unawareness people of the study area. However, the findings of the study confirm the hypotheses previously determined in the study area.

In order to examine and compare the hypotheses 275 respondents (Muslim =150 and Horizon =125 participants) from the three villages, Hetem Khan Pan Bahar, Methor Para and Karigar Para, ward no. 11 under the Rajshahi City Corporation in Boalia Thana(Police Station), Bangladesh, were randomly selected by cluster sampling . The selected respondents were singly interviewed with semi-structural questionnaire method. The finding of the study suggest that there were significant differences in health awareness of participants on healthcare outcomes and also various socio-economic attainment were significantly related to each communities people. However, the findings of the study confirm the hypotheses previously settings in the study area. Health awareness patterns attainment of Muslim community was hither than that of Horizon community that was 54.55% and 45.45% respectively. There were 86.43% Muslim and 73.55% Horizon community were argued positive significant relationships between health awareness patterns on healthcare outcome attainment in the study area. There were 82.75% Muslim and 69.28% Horizon community people expressed their opinion that better quality of health awareness knowledge enhances the better quality of healthcare outcomes. There were 75.54% Muslim and 66.35% Horizon community people deeply believed that health awareness people are very much conscious about various diseases cured system and prevention than unawareness people of the study area.

Conclusion and Recommendations

Health awareness patterns status attainment of Muslim and Horizon communities are the significantly correlated. People of the two communities were said that the knowledge of health education positively influences over healthcare facilities and attainment not only occupy certain statuses and prestige in the family and the community but also meet human needs and solve familial problems faced in a particular socio-cultural environment. In order to compare health awareness patterns status attainment, including education, occupation, health awareness knowledge and income in this study Muslim and Horizon communities were considered. The results of the study are supported by several studies conducted in abroad and Bangladesh. Based on these studies' findings the present study argues that inequality, deprivation and dominance between the two communities influence variations among the health awareness patterns status attainment in the study area.

Further cross-cultural study should conduct on how inter-community relations of Bangladesh influence their health awareness patterns status attainment.

1. Government and policy maker should made a holistic syllabus up from the class one can be framed out to give suitable information about health awareness, healthy habits, medicine and uses of indigenous locally herbs etc.

2. Government should ensure in getting health awareness and healthcare attainment of the given communities.

3. Government should be given extra priority towards Horizon community on health educational and health related activities attainments.

4. Non-Government organization should be conscious as minor Horizon community primary diseases of the study area.

5. Local and national leaders should be taken necessary steps to change their fait and luck through given proper health educational and health related scheme of Muslim and Horizon community.

6. Various workshop and training program should be arranged to make them conscious and enable to prevent their primary and daily diseases through proper and working education.

7. Ensure the proper schooling and healthcare attainment between the Muslim and Horizon communities.

8. Improve and provides the community healthcare facilities by the Bangladesh Government

9. Community people should awareness about basic and universal health education and healthcare knowledge and

10. Finally electronic and print media can play a vital role to ensure the health awareness knowledge through their different health conscious program.

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