Antrocom Online Journal of Anthropology vol. 15. n. 2 (2019) 167-175 – ISSN 1973 – 2880

Antrocom Journal of Anthropology

journal homepage: http://www.antrocom.net

Medical choices of a disaster-prone Bangladeshi village: An ethnographic study

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KEYWORDS

Medical choices, Disaster, Ethnography

ABSTRACT

A highly advanced contemporary health system exists in Bangladesh and provides health services to all tiers of Bengali society. However, because of the insufficiency of medical infrastructures and shortage of manpower, the benefits of modern health care did not exist in the study area (November 2010 to June 2011), albeit highly needed. Culture of poverty, remoteness, lack of professional physician, cost of health care, lack of transport facilities, and lack of knowledge, superstition strongly influenced to take decisions for choosing sectors of health care in Char Majhira.

Introduction

Health care sectors are the accumulation of existing therapeutic facilities within the livelihood system of a community that provides goods and services to treat illness. Diverse health care services vary in their thinking and idea as to the reasons of illness, their methods of healing, techniques of treatment, and composition and grounding of medicinal products. The native term meho is used to say what white discharge is in medical terms or padda phool for uterine prolapse. In fact, without establishing the exact meaning of local terms or by linking its symptoms one cannot guess a person's illness in rural Bangladesh. What is conceptualized in that term is often something close to the notion of illness and mostly touches to the functional knowledge's of the body. However, in the study area, the sectors of health care were classified by the respondents as

- The popular sector
- The folk sector and
- The professional sector

The researcher has tried to sketch out the sectors of healthcare of Char Majhira based on the following findings.

Objectives of the study

The objective of the research was to understand the medical choices of a disaster prone village that is

Please cite this article as: Uddin N., Rahman M.,Khatun M., Medical choices of a disaster-prone Bangladeshi village: An ethnographic study. *Antrocom J. of Anthropology 15-2 (2019) pp. 167-175.*

to investigate how socio-economic, geographic and other factors contribute to the health hazards of this disadvantage people. To achieve the objective of the study, the researchers identified three specific objectives:

- To know about most common severe illness of the village.
- To explore the number of ill people of the village.
- To explore the medical choices of the village.

Methodology of the study

The qualitative research was conducted by using both emic and etic approaches. The researchers used participant observation, and administered in-depth interview and FGD for data collection by using purposive sampling of 250 households during November 2010 through June 2011. The head and aged people of the households were considered as the key respondents. As a head and aged member of the family, they have an adequate knowledge as well as a vast experience regarding health problems.

Study area

Char Majhira, under the Sariakandi Upazilla of Bogra district in Bangladesh was selected as the study area, because every year this village is frequently affected by the natural disasters such as river erosion, flood and is remotely situated in the upazilla (sub-district).

Findings

Most common illnesses in the study village

The villagers identified the following most common illnesses ranked according to severity. The illnesses mentioned here report symptoms or names mentioned by the respondents themselves. The name of a mentioned illness was not validated by a physician. However, when labeling the Bengali terms or symptoms described by the participants by a medical name, a physician was consulted.

Table 1: Most common illness in the study village

Most Severe Illness					
Severity ranking	Newborn (1-6 Months)	Children (4-8 Years)	Adolescents (9-16 Years)	Adult (17-55 Years)	Aged (56+)
1	Convulsion	Malnutrition	Malnutrition	Ulcer	Stroke
2	Pneumonia	Rickets	Gastric	Asthma	Paralysis
3	Jaundice	Pneumonia	Malaria	Diabetes	Asthma
4	Measles	Diarrhoea	Typhoid	High Blood Pressure	Arthritis
5	Breathing Difficulty	Measles	Diarrhoea	Arthritis	Memory Loss
6	Loose Motion	Breast Feeding Child Diarrhoea	Tonsil Infection	Ear Infection	Ear Infection
7	Fever	Fever	Skin Illness	Gastric	Lower Back Pain
8	Skin Illness	Cold	Fever	Weakness	Toothache
9	Excessive Crying	Mouth ulcer	Growing Pain	Headache	Hearing Difficulty
10	Cold	Fungal Infection	Conjunctivitis	Fungal Infection	Blurry Vision

Number of ill people during the study period

Among 250 households, 219 had at least an ill person during the study period while the rest did not have any problems. The numbers of ill persons were 316 of which 297 received treatments from different options while the rest did not seek any options. As to the table 6.1 among the ill persons 194 were females and 122 were males. The researcher has found that, among 316 sick persons adolescent people were in great number, that is 123, among them males were 44 and females were 79, newborns were 27, among them males were 15 and females were 12, children were 49, among them males were 27 and females were 22, adult were 89, among them males were 26 and females were 63 and the elderly people were 28, among them males were10 and females were 18. Total numbers of ill persons of landless households were 153, among them males were 56 and females were 97. Ninety-seven people of small peasant households were affected by illness, where the number of medium peasant and rich peasant families were relatively less affected than others, that is 54 and 12 respectively. This means that the conditions of females were severe in the village and household's assets have a great impact on illness in this village.

Table 2: Number of households based ill persons during the study period

Landless			Small peasant			Medium peasant			Rich peasant		
Newborn (1-6 moths)	Male	5	Newborn (1-6 moths)	Male	4	Newborn (1-6 moths)	Male	3	Newborn (1-6 moths)	Male	3
	Female	5		Female	3		Female	3		Female	1
Children (4-8 years)	Male	13	Children (4-8 years)	Male	8	Children (4-8 years)	Male	5	Children (4-8 years)	Male	1
	Female	9		Female	9		Female	3		Female	1
Adolescent (9-16 years)	Male	23	Adolescent (9-16 years)	Male	11	Adolescent (9-16 years)	Male	9	Adolescent (9-16 years)	Male	1
	Female	54		Female	17		Female	7		Female	1
Adult (17-55 years)	Male	11	Adult (17-55 years)	Male	9	Adult (17-55 years)	Male	6	Adult (17-55 years)	Male	0
	Female	23		Female	27		Female	11		Female	2
Aged 56+	Male	4	Aged 56+	Male	2	Aged 56+	Male	3	Aged 56+	Male	1
	Female	6		Female	7		Female	4		Female	1

Social and cultural aspects of health care pluralism: perceptions of the study people

Anthropologists have pointed out that the health care system of any society cannot be studied in a manner isolated from other aspects of that society, especially its social, religious, political and economic organization. It is interwoven with these, and is based on the same assumptions, values and view of the world. Landy points out that a system of health care has two interrelated aspects: a cultural aspect, which includes certain basic concepts, theories, normative practices and shared modes of perception; and a social aspect, including its organization into certain specific roles (such as a patient and a doctor) and the rules governing relationships between these roles in specialized settings (such as a hospital or a doctor's office). In most societies, one form of health care, such as scientific medicine in the West is elevated above the other forms, and both its cultural and social aspects are upheld by law. Besides this 'official' health care system which includes the medical and nursing professions – there are usually

smaller, alternative systems, such as homeopathy, herbalism and spiritual healing in the UK, which might be termed a health care sub-culture. Each has its own way of explaining and treating bad health and the healers in each group are organized into professional associations, with rules of entry, codes of conduct and ways of relating to patients. Medical sub-cultures may be indigenous to the society, or they may be imported from elsewhere; in many cases, immigrants to a society often bring their traditional folk healers along with them, to deal with their ill health in a culturally familiar way. In the UK, examples of these are the Muslim hakims or Hindu vaids sometimes consulted by immigrants from the Indian sub-continent. In looking at health care pluralism, wherever it occurs, it is important to examine both the cultural and social aspects of the types of health care available to the individual patient.[1] In this text, the researcher has examined the pluralistic health care systems of the village, in order to illustrate the range of therapeutic options available to this community.

The popular sector

This was the lay, non-professional, non-specialist domain of society, where ill health was first recognized and defined and health care activities were initiated. Most people told us it included all the therapeutic options utilized, without any payment and without seeking an advice from either folk healers or medical practitioners. Among these options there was self-treatment or self-medication or treatment given by a friend, relative, neighbor, etc. Most villagers said that the main area of health care is our family. The key health care providers were women, usually mothers, sisters or grandmothers, usually relying on a set of beliefs about the disease described in the table's one and two. These were usually a series of guidelines, which were specific to their cultural group, about the correct behavior to prevent illness in oneself and in others. It includes beliefs about the 'healthy' way to eat, drink, sleep, cress, work, pray and generally conduct one's life. The researcher has observed that in this area an illness-affected person has to observe a little food prohibition. There was a familiar belief in the village that a pregnant mother should eat less to keep small the size of the baby for easy delivery. In the village a typical taboo was that newborn babies were not given colostrums because this fat material might upset their stomachs. It is worth mentioning that almost all the mothers of landless, small peasant, medium peasant and rich peasant households observed a few taboos about infant illness thus perpetuating cultural beliefs, norms, values, customs and so on.

Table- 3: Food prohibition for mothers whose baby's were illness affected[2]

Disease	Name of food	Causes of food prohibition
Convulsion, Pneumonia, Jaundice	Papaya (Carica papaya), Banana (Musa paradisiaca)	These food may be increased the pain of patients
Measles, Skin Illness	Beef, Mutton/food of animal organ	Increasing Morbidity

In the village, children, adolescent, adult and aged who were affected by a disease had experienced a food transgression. The researcher has taken the following notes about these cultural practices.

1 C. G Helman, *Culture, Health and Illness* (London: Butterworth-HeinemannLtd, Oxford 0X28DP, 1994): 63-64.

2 Primary Data.

Table-4: Food prohibition of illness affected age groups[3]

Age Group	Disease	Name of food	Causes of food prohibition
Newborn/ Children	Diarrhea, Measles, Fungal Infection	Coconut water, Sugar, Beans, Cabbage and Its Cousins, Beef, Mutton/food of animal origin	Increasing Morbidity
Adolescent	Malnutrition, Diarrhea, Skin Illness,	Milk, Eggs, Fish, Beef, Mutton/food of animal origin, Sugar, Pulses and legumes , Rice, Cereals, Grains	Increasing Morbidity
Adult	Asthma, Diabetes, High Blood Pressure, Fungal Infection	Milk, Eggs, Fish, Beef, Mutton/food of animal origin, Sugar, Pulses and legumes , Rice, Cereals, Grains	Increasing Morbidity
Aged	Stroke, Paralysis, Asthma, Toothache, Blurry Vision	Milk, Eggs, Green Vegetables	Increasing Morbidity

The folk sector

The villagers shared the innate religiosity or even fatalism observed among all sectors of the society. A bout of illness in the family would prompt a prayer or a special invocation to the family deity or the almighty for a benediction. This may involve a Hujur (religious leader), or a Fokir or any similar person who would also use their, 'Unconventional' treatment method (s) which the householders would accept because they believed themselves presumed helplessness and trusted the practitioner's ability to achieve the desired result. The therapists treating an illness caused by supernatural factors looked for religious leaders or priests supposedly in possession of a supernatural healing power. They also used herbal ingredients in their treatment. A traditional practitioner usually acquires his/her knowledge from other practitioners. The following local methods were used to prevent illness in the studied society.

In the village, folk medicine was made of both material and non-material elements. The material elements consisted of curative preparations from plants and animal products. These were applied habitually in their raw forms and were used in treating ailments such as cold, fever, skin illness, loose motion, diarrhea, paralysis, arthritis, lower back pain etc. The non-material components were formed by religious and spiritual items. The religious items comprised

- Gifts and offerings given in the name of supernatural entities i.e. Allah/deities;
- Holy verses from Quran written on papers and given as amulets, or painted on the face or body of the patient, or on water to be drunk, or on food to be eaten;
- Spiritual items included communicating with spirits or ancestors through human media to ask about the illness and its remedy, performance of incantations to drive away evil spirits, and many other similar methods.

Non-material elements, either independently or together with material components were usually applied in the treatment of all types of illnesses but especially in the treatment of patients with physiological problems such as malnutrition, headache, paralysis, blurry vision, etc. Sometimes, their use widens to the treatments of illnesses like rickets, ulcer, asthma, memory loss and even convulsion

3 Primary Data.

as well as jaundice in newly born children.

Folk medicines were attached to folk modes of healing and established perceptions about illness and health prevailing among common folk. The researcher has observed that a number of contagious and non-contagious illnesses in the village were explained by people with an approach notably different from modern medical science.

The table 5 offers a list of important plants which were observed in the study area. These plants were favored by the villagers generally for two reasons such as (1) their adaptability to the climatic conditions of the locality and (2) the varied use of many of them in different medicine preparation as the 'basal' component.

Table 5: List of the major medicinal and spice plants/ animal products commonly observed in the study area[4]

Vernacular name	Scientific name	Therapeutic use
Garlic	*Alliaria petiolata*	Convulsion, Breathing Difficulty, Gastric, Headache, Toothache, Hearing Difficulty
Onion	*Allium cepa*	Convulsion, Gastric, Toothache, Hearing Difficulty
Olive leaves/oil	*Olea europaea*	Hearing Difficulty
Basil/Mint oil	*Ocimum basilicum*	Headache
Salt water	-	Loose motion, Tonsil Infection, Toothache
Lemon	*Citrus limon*	Convulsion, Loose motion, Toothache
Green Spinach (Vegetables)	-	Rickets, Ulcer, Blurry Vision
Got/ Cow Milk	-	Convulsion, Measles, Gastric, Blurry Vision
Cabbage	*Brassica oleracea*	Blurry Vision
Broccoli	*Brassica oleracea*	Blurry Vision
Corn	*Zea mays*	Blurry Vision
Peas	*Pisum sativum*	Blurry Vision
Carrots	*Daucus carota*	Blurry Vision
Mustard Seeds	*Brassica nigra*	Loose motion, Diarrhea, Growing pain
Mango/Mango Leaf	*Mangifera indica*	Pneumonia, Ulcer
Guava	*Psidium guajava*	Gastric, Ulcer
Flax seeds oil	*Linum usitatissimum*	Arthritis
Ginger	*Zingiber officinale*	Breathing Difficulty, Gastric, Arthritis
Turmeric	*Curcuma longa*	Measles, Mouth Ulcer, Gastric, Arthritis
Cinnamon	*Cinnamomum verum*	Arthritis
Coconut water/oil		Measles, Mouth Ulcer
Tulsi Juice/leaf	*Ocimum santalum*	Penumonia, Mouth Ulcer
Honey	-	Measles, Breathing Difficulty , Mouth Ulcer
Potato juice	*Solanum tuberosum*	Gastric
Fenugreek seeds	*Trigonella foenum-graecum*	Breathing Difficulty, Loose motion
Sugar	-	Pneumonia, Loose motion
Pomegranate seeds	*Punica granatum*	Loose motion
Licorice	*Glycyrrhiza glabra*	Measles

The village people have their personal terms and forms of treatment. For example, they have coined numerous homely names to state different forms of diarrhea/ loose motion like dudher haga, patla paikhana, and breathing difficulty – Dom Bandho, Skin illness – gha rog etc. Someone's inconsistent behavior like hearing difficulty, blurry vision, memory loss was called batash laga or alga batash, and was due to an intangible spirit or to a disembodied soul devoid of any hylic spirit. The villagers said that such spirits actually wander through the wind and enter the human body through its orifices. The researcher asked the villagers which way does the alga batash responsible for illness? The rural people

4 Primary data.

told stories to exemplify its working. They said the batash does not always enter the body instantly. It comes through another person and then it attached itself to a patient.

The researcher observed that illnesses involving one's reproductive health in the village was not independent from the cultural influences that control their livelihood. Reproductive health problems and vaginal discharge in particular were illustrated in numerous ways by the native medical belief system. The villagers believed that vaginal discharge is often caused by extreme heat inside the body. Child-birth was another field where the conventional interpretation was widespread. An layer of prevalent local beliefs was connected to women's monthly cycles. Menstruating women were not permitted to bathe in water bodies such as in ponds or in rivers. Village traditions do not have the facility to have pregnant women commonly examined by trained people. The delivery of a child in most cases took place at home under scarcely hygienic conditions. Most deliveries were home affairs usually carried out by the pregnant women's relatives. Just in dangerous cases a dai (birth attendant) was called in. Gender discrimination was guessed from overall conditions in the village. Most mothers said that their child's as well as husband's health was more important than her own. A husband's prolonged sickness was sometimes blamed on the wife who is then marked as sinister person. It was believed that women may contaminate husbands during menstruation and at childbirth.

A woman was therefore separated and there was also a taboo for man during such situations. Inferior status, opaque, purda system, and the customary feminine image forced women to take the option of folk health treatment. According to the village people, a healthy person is one who is sturdy, looks youthful, and shows energy in physical work. Slight ailments such as a headache, cold, fever, and stomach upsets do not bother them. An ill person does not look for any treatment unless the illness becomes serious enough to stand out from reputed minor illnesses. The villagers' explanations regarding illness generation consisted of several fabulous perceptions, including improper food intake, influence of an evil eye or spirit, God's will, divine punishment for wrongdoing, etc.

It was generally believed in the village that one has to take the help of backdoor powers to treat illness, that is persons believed to have occult powers such as fakirs, pirs, hujurs (folk healers) and others. General folk treatments generally used in the village were telpada (oil incantation), panipada (water incantation), jhad phook (oral incantation), and tabij (sacred amulet). Religious practitioners were invited to perform exorcisms whenever a person was possessed by a zin or bhut (spirit).

The villagers offered Bhoge (offering a feast to deities) to the nearest Dhorgabari or Mosque (a Dhargabari is a place where live deity, ghosts, witches and ancestors) to please their deities or the almighty. They offered sacred food as milk, curds, banana, batasha (one kind of sweet), hens etc, and prayers to recover from illness under a big old banyan tree at a Dhargabari. A priest or hujur patronizes the Mosque or the Dhargabari, and is also the representative of the almighty or a deity dealinmg with the villagers, who accepts the Bhoge and forwards the prayer to a deity or Allah.

The customary therapeutic system of rice processing treating jaundice, convulsion, stroke, ulcer were applied to 5 % mothers. The patient is to keep some rice's under the patient's pillow to establish whether he or she is affected by jaundice, convulsion, stroke, ulcer or not. If the patient is really affected by those diseases, the rice color would become reddish and the folk doctor treats the patient with traditional homely plants, tree roots, etc. Hindu people believed that the evil deity Kali visited the village and a number of illness were caused by Kali's touch. So, they looked for the assistance of fakir to chase Kali from the village.

The professional sector

The villagers have badly suffered due to lack of proper treatment facilities. "We are underprivileged of free health care services as there is no government clinic or medical centre here. We have to rely on kabiraj (herbal medicine practitioners) and medicine shops for treatment. Villagers go to the government hospitals in the mainland only when a patient's situation gets serious," said all the villagers. "We took an emergency patient to the government doctor's in the mainland a couple of days ago. We had to do the difficult job of carrying him, walking for over one and half hour on the sandy char. Still, we perceive ourselves fortunate as the ill man could be admitted at the Upazila hospital," they added. The people of the char have urged the government to set up clinics there to ensure healthcare services to them. The researcher has found that the professional facilities were comprised of both government and non–government facilities within and without the village. These are as follows:

Medicine shops

In the village, there were three medicine shops where medicines were purchased by the villagers. 87 % people turned to medicine shops for primary health care for both prescribed medicines and medicines without prescription. The medicine shops also provided medical advice to people for all health issues described in the table's one and two.

Satellite clinic of NGO's

As for the villagers the satellite clinic is funded by the non-governmental organization World Vision. The clinic was helpful way to provide basic primary health care services to people living in the village, particularly women and children. The satellite clinic consists of a team of one paramedic, one pep educator and a medical aide or nurse (all routinely supervised by a medical doctor) who join with the educated community member, the World Vision Community Medic-Aide (WVCMs), to set makeshift camps on the village to treat the isolated population. Satellite clinics were held at weekly in a particular location via boats/van with regular intervals (fortnightly or monthly depending on need and funding).These groups set programmed weekly clinics in a selected area of the village through World Vision Community Medic-Aide (WVCMs) or trained society health workers.

The satellite clinic dealt with rural community education, primary health care, maternal and child care, diet and nutrition, particularly centered on pregnant women and children, family planning, offered subsidized medication and recognized needs for secondary care interventions and many other issues. It is important to mention here that, only the members of World Vision were getting medication from the clinic by paying 15 taka while the rest spent 35 taka to pay within two weeks.

Majhira community clinic

The people of the village were fond of modern medical facilities like the satellite clinic of the NGO's but the Govt. community clinic failed to start its activity as it was under construction during the study period.

Union health and family welfare center (UHFWC) and upazila health complex

These were all located outside the village. People seldom visited these services for first aid, medicines, minor testing and education. These facilities all provide the same care but were monetarily differently supported. The Union Health and Family Welfare Center (UHFWC) are funded by the government. The UHFWC and Upazila Health complex was the only healthcare service where Government doctor work a few times per months and all the other services work with paramedics.

On the other hand, villagers selected to visit the Union/Upazila health complex for major health problems in need of specialized treatment, extensive testing (such as X-rays) or operations. Since these health centers were located outside the char, they were only reachable by taking a boat during the rainy seasons and walking for the rest of the years.

Conclusion

A highly advanced contemporary health system exists in Bangladesh and provides health services to all tiers of Bengali society. This system does not limit itself to simply remedial treatment of the patient, but also attempts to extend its services to the prevention of illness by vaccination and improving the individual and ecological hygiene of the patient and the community. Well-educated and proficiently trained experts carry out this system of medical treatment. Scientifically advanced as well as decidedly sophisticated apparatuses and methods are used in this system to attain accurate diagnosis and treatment of illness. Planned and well-equipped hospitals and clinics have been developed successfully to offer healthcare services to people in this system. However, because of the insufficiency of medical infrastructures, apparatuses and shortage of manpower, the benefits of the modern system of health care services did not exist in the study area though it is highly needed. The cost involved in offering health care services under professional sectors was also much higher than that of folk health treatment available in Char Majhira.

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