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Daily health concerns in Kakabo

Anthropological explorations in a Bangladeshi village

Edited by
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Anthropological explorations in a Bangladeshi village

Daily health concerns in Kakabo: Anthropological explorations in a Bangladeshi village is a collection of essays written by students of BRAC James P Grant School of Public Health in 2005, 2006 and 2007. These essays are the results of exploratory studies conducted in a village named Kakabo, about twenty-five kilometres from Dhaka, the capital city of Bangladesh. The students came from varied backgrounds and different countries in Asia, Africa, North and South America.

The essays deal with diverse, obscure topics and unexplored areas in the field of rural public health in Bangladesh. This book includes chapters on oral health, personal hygiene, mental health, disability, elderly well being, sexual and reproductive health, traditional healers, local concepts of illness, occupational health, environment, smoking, and health information.

This book also contains an elaborate overview of social science studies of health and health care in Bangladesh (see Appendix 1). For local terms, see footnotes and the glossary (Appendix 3).

Editors

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Dedicated to the people of Kakabo

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Acknowledgments

We are grateful to the people of Kakabo, who shared with us their experiences and the stories of their lives. We thank the BRAC James P Grant School of Public Health students of the past three years for their contributions.

Special thanks to Sabina Faiz Rashid, Anthropologist and Assistant Professor at James P Grant School of Public Health, BRAC University, for her advice and support to the students during the writing of these essays. Thanks also to Haily MacEachern, Mahrukh Mohiuddin, Faisal Karim, Tapan Biswas, and Shahanoor Akter Chowdhury for being involved in copyediting and proofreading the manuscript at different phases.

Introduction

Sjaak van der Geest & Nasima Selim

Public health and curative health care interventions should be inspired by and built on ideas and practices embodied in the community. This is the basic philosophy of applied medical anthropology. But there would be no medical anthropology without ethnography. The respectful, intelligent and sensitive description and understanding of people's daily lives are the beginning of a humane health care system.

Here are questions that individuals involved in policymaking and actual interventions in the field of public health and clinical health care should ask themselves: What factors contribute to the acceptance of community health financing or a vaccination programme? What social and cultural factors should be taken into account to operationalise all ambitious plans to improve reproductive health care? What cultural assumptions of health care workers hinder or facilitate communication with members of the community? What are the needs of a growing group of elderly people or psychiatric patients? These are only some of the many questions with which health professionals and health planners are confronted. Anthropological research can be a tremendous support to health programmes by giving insights to the perspective of recipients and providers of health programmes and health care and by providing managers and implementers of health programmes with mechanisms and strategies that facilitate a reorientation of health care programmes and policies towards the actual needs of the target group. In addition, such research helps health workers reflect on their own roles in public health and critically assess their contribution in the field of health and health care.

The anthropological approach needed to investigate the above questions is characterised by at least three important concepts and values. First, we can only gain an understanding of people's ideas and practices if we view them in their own daily *context*. Participant observation and conversation-like interviews are, therefore, the favourite tools of the anthropological researcher. It is only by seeing how people practise their ideas and think about their practices in 'real' life situations that we are able to come anywhere near what these ideas and practices mean to them.

This brings us to the second point: the aim of the anthropological researcher is to *understand* people's way of life by capturing *their* ideas, their *emic* point of view. Their views are important, not only because they steer people's actions (and perhaps their resistance to health care interventions), but also because they are valuable in themselves. Members of a community are experts in their own lives; they have lived for many years in that particular community. They are used to the social, economic and climatic conditions, and they have learned how to cope with them. The researcher knows much less about these conditions and needs their information. In other words, the researcher is the student, and the members of the community are the teachers.

Thirdly, and logically following from the previous point, the researcher respects the culture of the informants. He or she should enter the field without preconceived value judgements about other ideas and practices and avoid judging other cultures with criteria derived from his/her own culture. It does not mean that the researcher must approve of everything. Cultural respect or 'relativism' implies that the researcher takes other people's culture seriously and is open to their views and arguments. If,

in the end, s/he disagrees or disapproves of certain ideas or practices, it will be on the basis of a proper understanding. Moreover, if s/he wants to contribute to changes in that culture s/he will be able to enter into a dialogue armed with correct information and will be more successful. The members of the community will know that her/his views about their culture are not the result of misunderstanding or ethnocentric prejudice. They will be more prepared to listen to her/him and respect her/his opinion. The advantage of this mutual respect for public health policy is obvious.

Medical anthropology is a unique approach with its focus on *understanding* the human experience of health and illness. We know that full understanding will never be achieved but we can make some headway by the use of qualitative research methods, such as participant observation and informal conversation (as opposed to formal interviewing). The underlying philosophy of these 'soft' approaches is, as we said before, that people express their concerns best in their own style and environment. The fieldwork that led to this collection of essays was only a modest beginning of spending time with the villagers, listening to them and showing respect for the way they were managing their lives.

In 2004, the James P Grant School of Public Health was established in BRAC University as a logical outcome of BRAC's work on issues surrounding the health of the poorest and most disadvantaged groups over the past thirty years. The courses at the School have been designed to train public health professionals in a developing country setting with a relevant and responsive curriculum. Students of the School devote a great deal of their course work to acquiring a better understanding of community perspectives on health, illness and health care. During one course focusing on the anthropological approach to public health and qualitative research methods, they were required to carry out a short exploratory study in a nearby rural community about local beliefs and practices related to health and health care. That study was the completion of a field exercise to apply the ethnographic and qualitative research tools learnt in the classroom. This book presents a selection of the essays that resulted from that field exploration.

For most students the field visit to a nearby village was an eyeopener. For the foreign (non-Bangladeshi) students this was to be expected. Being received into the houses of rice farmers, factory workers, rickshaw pullers, and their families gave them the opportunity to get to know a less visible part of Bangladesh. For many of the Bangladeshi students the village life proved an unknown reality as well. Education in Bangladesh is unevenly distributed, favouring the urban middle-class young people at the expense of their rural age-mates. Very few school pupils from rural areas make it into university.

During one of these courses, one of us asked the eighteen Bangladeshi students if any of them had grown up in a village. None of them had. Only one or two knew relatives who lived in the countryside. The large majority belonged to a family that had been urbanised for several generations. The alienation from village life of the future Bangladeshi public health experts is both alarming and ironic. The Public Health students are preparing themselves for a profession that will take them to a wholly unknown society: the rural communities in their own country. That awareness made the however brief field experiences in the village even more meaningful. This enabled the students to discover for the first time their own country and to see themselves in a new light: at a long distance from their rural countrywomen and men.

The researches were carried out in the village of Kakabo, near the campus in Savar where students resided during the first part of their training. Students had visited this village regularly for the last

four years as a part of their course curriculum. Kakabo provides a 'social laboratory' to apply the lessons learnt in the classroom. Kakabo is a semi-urban village with about two thousand people and around three hundred households. It is one of the two villages in the eighth ward of Birulia Union, under Savar Police Station in Dhaka district. Situated just about twenty-five kilometres away from central Dhaka, the capital city of Bangladesh, Kakabo harbours people from all over Bangladesh who often migrate and make their home here. The place is quite near the capital but the living cost is surprisingly low and job opportunities are abundant. Many find work in the thriving ready-garments industry in nearby town Savar. People have been expecting a bridge connecting Kakabo and the Mirpur area in Dhaka over a long stretch of water for quite some time. Once it is done, this village will undergo very rapid urbanisation.

In Kakabo, there are several clusters of households, known as *para*: Rishi *para,* Uttar *para*, Dakshin *para*, Kha *para*, Pashchim *para*, Nager Agey *para* and Kheyaghat *para*. The majority are Muslims with few Hindus and even fewer Christians. Most of the people living in Kakabo are poor or ultra poor. Only a few households can afford buildings made of brick and *pucca*[1] latrines. There is one primary school, four non-formal BRAC schools, one private school and one *madrasa*[2]. The nearest health centre is the Union Health Complex in Birulia, one and a half kilo metres away from the village, . Men in Kakabo are mostly factory workers or fishermen during rainy season, and farmers, agriculture labourers or vegetable sellers at other times. There is a marked seasonal variation in their livelihood. A day's income for a hired labourer is about one hundred to hundred and twenty taka[3] (less than two USD). Many work in Dhaka and travel home at the end of the day. Most women are homemakers. Many tea stalls have television sets or radios. Kakabo villagers have celebrations during the Bengali festive seasons (e.g., *Nabanno*[4]), religious festivals (i.e., *Eid*[5], *Durga Puja*[6], *Bishwa Ijtema*[7] *etc.)*, family and social gatherings (e.g., weddings, name giving ceremonies etc.), and often invite strangers and outsiders. A number of NGOs work in Kakabo with various micro credit schemes, e.g, BRAC, Grameen Bank, ASA, SSS[8], and Swadesh. Since 2004, BRAC has maintained poverty alleviation and development programmes in Kakabo.

Because of limited space, not all student reports could be included in this volume. We selected fifteen out of thirty-eight ethnographic essays. The selected ones are the more relevant and interesting essays, dealing with less known topics. Those that were *not* selected were about health seeking for respiratory infection, gastric illness, pregnancy care, breastfeeding, weaning practices, antenatal care, school environment, ageing, the local health centre, pharmaceuticals, and local medicines.

Originally, each essay contained extensive discussions on relevant literature and sections on theory and methodology, plus various annexes, acknowledgments, etc. Most of this had to be taken out in the present selection, which focuses on the ethnographic and qualitative findings. All names of Kakabo inhabitants that appear in the text are fictitious to protect their identity.

1 *Pucca* means brick built.
2 *Madrasa* is the Islamic religious school.
3 Taka is the Bangladeshi currency.
4 *Nabanno* is the harvesting celebration, held in *Poush* the first month of the Bengali winter.
5 *Eid* is the most important festival for Muslims, celebrated twice a year.
6 *Durga Puja* is the most important festival for the Bengali Hindus, celebrated once a year.
7 *Bishwa Ijtema* is the second largest gathering of Muslims in the world held every year in nearby Tongi.
8 In Bengali, ASA means hope. SSS is a local NGO, Society for Social Service.

Each essay was written by two students, one from Bangladesh and one from another country. The Bangladeshi researcher helped the foreign one to communicate with the people in the village. The James P Grant School of Public Health has a diverse student body drawn from all over the world. Each student shares his or her learning with the other and experiences public health in practice together.

We decided to produce and publish this collection because of the high value of the essays and the dearth of qualitative ethnographic work on health and illness in Bangladesh. Ethnographic studies on health issues that have been published so far are mainly in the field of women's health, reproductive health, mother and childcare, nutrition, environment and health services. Many aspects of rural medical culture that are presented in this book are virtually nonexistent in the current Bangladeshi literature (for an overview of social science studies of health and health care in Bangladesh, see Appendix 1). Moreover, very few of the existing studies are based on the participatory type of approach that was used by the authors in this book. We believe that this collection of short exploratory studies will be a welcome addition to the existing body of knowledge about local perceptions and practices in the field of health.

Some readers may wonder what the practical relevance of these essays is. As we stated in the beginning of this introduction, a humane and effective public and clinical health practice must give highest priority to the views and concerns of those for whom it has been designed. The chapters in this book do not provide 'prescriptions' for better policy and practice but they do draw attention to the social and cultural issues to which health professionals must be sensitive to be successful in their work.

We thank the authors who allowed us to use and edit their essays, Shahduz Zaman and Sabina Faiz Rashid, the supervisors who contributed to the quality of the papers and the inhabitants and health workers who enthusiastically cooperated in the research. We dedicate this book to the people of Kakabo with gratitude and respect.

Hygiene

Personal hygiene of women

Emilita Monville Oro & Taskeen Chowdhury

This chapter explores the perceptions and practices of personal hygiene of women in the village. Data were collected from six women through observations, free listing of personal hygiene practices, household mappings of resources and in-depth interviews. Triangulation method was used to crosscheck the findings. Six married women aged from eighteen to forty-five years were selected to participate in the Participatory Rapid Appraisal (PRA) exercises and ethnographic interviews. Three were married and young (eighteen to twenty-three years old), without or with one or two children; the other three were middle-aged married women (twenty-five to forty-five years old), with two or more children.

Meanings of personal hygiene

There are varied meanings attached to personal hygiene: religious, social and health related. The emphasis on maintaining personal hygiene as a part of religious belief is vividly expressed by the women. This is demonstrated by the practice of washing hands, face and feet before saying the five daily prayers[9]. The concept of personal hygiene seems mostly related to purifying oneself after being in an 'unclean' state, e.g., after having sexual intercourse or menstruation, when one becomes a 'pollutant'. As some women put it:

> When you have sexual intercourse, better take bath right after, but if you are not able to do so, you have to take it early in the morning before you hear the crow. You cannot do your household work without taking a bath first. It is considered a sin. It is in the *Hadith*[10]…

> Taking a bath after sexual intercourse... It is better to do *Ozu*[11], and saying the prayers for bath. We do not put our hands in the rice pot without taking a bath.

Personal hygiene is also related to social order. For women, it is very important what people say, what people think and how society judges them. Being called *Khachchor*[12] is a disgrace. Being unclean is more than a function of physical appearance. One woman said that if she is dirty, people may think that, "…since she is dirty outside, she must be dirty inside too." Being clean then, saves them from being negatively perceived by other people. She said:

9 For Bangladeshi Muslims as well as Sunni Muslims across the world, saying prayers (*salaat*) at least five times a day is mandatory (*farz*).

10 *Hadith* or *Hadis* is a compilation of recorded words and deeds of Prophet Muhammad.

11 *Ozu* is the Islamic practice of ablution with water before saying prayers or reading the holy texts.

12 *Khachchor* is referred to a very unclean person. The word is often used as slang.

> To me, if unclean, what will people say: Look at this girl! She is dirty. People will say bad things about you. Even if your clothes are torn, if they are clean, then people say good things.

Personal hygiene is also a health promoting activity. Three out of the six women, both young and middle-aged, associated personal hygiene with disease prevention. Being clean is being healthy. As one of them said, "If you maintain cleanliness, you do not get sick." Being unclean is believed to predispose one to illness:

> If you are dirty, for example, if your hands and nails are dirty, the dirt will fall into the food you are preparing and when this dirt goes into the stomach, you get sick.

Practices of personal hygiene

Findings from free-listing activities, as well as the ethnographic interviews, provide us very useful information about the day-to-day activities performed by the women to maintain personal cleanliness. The ethnographic interviews reveal that personal hygienic practices include brushing teeth; taking a daily bath after sexual intercourse and after menstruation; washing hands with soap after defecation, after urination, after handling dirt and before eating; washing clothes and cutting nails. During the free-listing activities, taking a bath after menstruation, washing hands with soap after urination, after handling dirt, and before eating were not mentioned. They were asked about excreta (e.g., children's stools) disposal during the interviews, as this is not usually mentioned. We validated results through observation. Below are some excerpts of discussions of each personal hygienic practice that we identified.

Brushing teeth

All respondents mentioned that they brushed their teeth one to three times a day using toothbrush or *meswak*[13], with toothpaste, toothpowder, charcoal, 'mud' (from stove) or salt. During a period of observation, a woman was seen brushing her teeth with a bamboo shoot. One respondent expressed special preference for *Neem*[14] bark:

> I do not like brush. I use *Neem* stick (laughed)…because the juice of the *Neem* is so bitter and so powerful that even if a snake bites you, the snake will die and will not be able to harm you.

Taking a bath

Five out of six respondents mentioned a daily bath with soap. One woman confessed that she does not use soap when in a hurry. They used different brands of soaps, e.g., *Lux*, *Keya*, *Lilly* or *Lifebuoy*. One of the respondents said that she "combed her hair every morning with *Jui* (a local brand) coconut oil…and washed it once a week with *Sunsilk* (a local brand) shampoo." Women were

13 *Meswak* is the practice of using twigs of *Neem, Motkila* trees or bamboo shoots instead of toothbrush.

14 *Neem* (*Azadirachta indica*) is a tree in the mahogany family. It is known for its numerous medicinal properties, to alleviate conditions ranging from digestive disorders to diabetes and high cholesterol to cancer. *Neem* twigs are used for brushing teeth across the Indian sub-continent. This is perhaps one of the earliest and most effective forms of dental care (Ciesla 1993).

observed to take a bath with their cloths on. Out of the five women, we observed two of them taking a bath at the tube-well nearby the road without using soap. Those who used soap also used a sponge to scrub their arms and legs. Four women spent a maximum of five minutes taking a bath. Only one woman spent more time taking a full bath, as described below:

> The old woman had her turn at the tube-well. She removed her blouse, leaving her *achol*[15] to cover her body. Using a sponge with bath soap, she scrubbed her arms, her face and then washed with water. Next, she scrubbed her legs and feet thoroughly, using the sponge with bath soap and washed with water. She also washed her hair with soap and water. She finished off with pouring water all over her body…
>
> Women looked fresh, wearing fresh cloths in the late afternoon around 4:30pm. (Observation notes)

The three middle-aged women, with whom we established better rapport, readily shared with us the practice of taking a bath after sexual intercourse. This was the first thing they mentioned when asked to enumerate their personal hygienic practices. They described the following ritual:

> …after being with your husband[16], you have to take bath. You should say *Bismillah*[17] three times and pour water on the head at least three times with small pots so that all of your body parts get wet. If any part is dry, even your earrings, it is not proper bathing. You also have to wash your cloths three times (immersing in water) saying *Bismillah*.

Young married women did not talk about these issues. According to one of the respondents, men also wash after sexual intercourse. For them, it is the *niyom*[18]. They take a bath at night or after waking up in the morning, before breakfast. Two respondents, one young, and the other middle-aged mentioned bath after menstruation. The practice is more of a ritual cleansing. One narrated the following procedure:

> After menstruation, we clean our whole body…we shave our private parts and underarms with blade…..we wash our hair with soap and after that we become clean and *pak*[19]….as said by our Prophet.

Washing hands with soap

All respondents claimed that they wash their hands after going to the toilet. They said they use soap, soil or ash after defecation. Wiping with *dhila kulukh*[20] or pieces of paper is common practice. A grandmother who joined our free listing emphasised this practice:

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15 *Achol* is the long end of a traditional *saree* worn by women.

16 Women refer to sexual intercourse indirectly, e.g., they call it "being with husband".

17 *Bismillah* = In the name of *Allah*, the almighty God in Islam.

18 *Niyom* is the local norm or usual custom.

19 *Pak* means pure.

20 *Dhila kulukh* is a small mud ball (used to wipe oneself after going to the toilet, an early Islamic practice that isstill prevalent among village Muslims).

> After defecation, if you do not wash hands with soap, then you are not clean….we use soap, or ash or mud and water from tube well. If we do not use soap, our hands smell.

Only one woman mentioned washing after urination. Washing hands is practised but use of soap is not regular. She described it as follows:

> After urinating we use water and wipe with small clothes…we keep the cloths in the toilet and everybody has their own clothes. We sometime wash our hands with soap but …if I am in a hurry (laughs)…I do not always do that.

We had very little chance to observe this practice and were not able to crosscheck this piece of information. We were able to observe one woman who went to the toilet with a water pot. She came out after a minute or so and washed hands using only water.

Dirt seems to be treated differently by these women. Mud and cow dung were handled without much concern with bare hands. They washed their hands only with water after handling dirt. Nasal secretion, especially of children, was not of much concern either. We observed a mother wiping the nasal secretions of her son, first with her hands, then with leaves, then with her *dupatta*[21]. Excreta (e.g. children's stools) disposal was described as the process of letting "children defecate in the courtyard wherever they want to...we throw the stools away afterwards". According to one of the women, they believed that, "from birth up to the thirty-ninth day, faeces and urine of children are not dirty…from the fortieth day onwards it is dirty because the mother is eating a lot of things. She can pass these on through breast milk".

Two out of the six respondents mentioned that they do wash hands before eating. One mentioned that she washed with soap. This practice was not mentioned during free listing, nor was it observed.

Washing clothes

Five out of the six respondents mentioned washing clothes as part of personal hygiene. Most of them used soap while washing clothes, but not regularly. Women who were observed taking a bath, washed their clothes at the same time, and none of them used soap. Children's clothes are treated differently. As one of them recounted:

> I wash my clothes with soap once in a week, but wash them with water everyday. Children's clothes are washed with soap everyday because they do not understand and they make clothes dirty all the time.

Maintaining trimmed and clean nails

Based on the interviews and free listing activities, we found out that cutting nails was done once a week. We observed the young married women to have clean fingernails (no mud under nails), while most children and middle-aged women had mud under fingernails.

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21 *Dupatta* is a long scarf like traditional piece of clothing, usually worn by adolescents and young women with *shelwar* (trousers) and *kameez* (long tunic).

Facilitating and hindering factors to personal hygiene

From in-depth interviews, observations and household mapping we derived factors that facilitated or hindered practices of personal hygiene. Findings show that these factors included: perceived benefits in terms of health, economic and social aspects; access to sanitation facilities and materials; awareness on personal hygiene brought about by religion, media and health education through school or medical practitioners; women's heavy workload; safety and financial constraints.

Facilitating factors

Our findings reveal that practices of personal hygiene are motivated by perceptions of social, economic and health benefits. Only half of our respondents related personal hygiene practices with maintenance of health; disease causation is more associated with beliefs in *Bao batash*[22]. Respondents mentioned that pregnant women and young children are most vulnerable. Three women remarked that keeping children clean by "using *lifebuoy* soap" would help prevent diseases like diarrhoea and skin infections. Preventing bad breath was a benefit also mentioned.

Three women suggested that practicing personal hygiene brings economic benefit to the household. Someone said:

> If you take care of your body, you become healthy. If you have a healthy body, you can work well. You will not get tired easily.

Furthermore, they related being sick with spending money and becoming a burden to the family. As expressed by one of the women: "We are poor people. We cannot spend much money when we are ill. The cost is high, so we just suffer". The women also mentioned that being sick leads to dependency on others for work and makes one feel unwelcome. As one put it, "If you are sick, you have to ask other people to help you with your work and they may not always agree."

We also found that women gain social benefits from personal hygiene. Our respondents related personal hygiene with self-esteem described as feeling good about them:

> If you stay unclean… you will feel bad about yourself. You will smell your own body and will feel bad about it.

One of our respondents mentioned how cleanliness promotes self-esteem among young school going children. According to her, "In school, if children have dirty clothes, the teacher makes them sit at the back. If their clothes are clean, then the teacher put them in front". That is one reason why women teach children to have clean personal hygiene practices from the very beginning of life.

Every one of these women said that not practicing cleanliness could bring chaos in their personal as well as social life. They viewed hygiene as a reflection of both inner and outer cleanliness. One of the women remarked that a badly kept household would also create problems among neighbours as their livestock and poultries would damage the neighbour's gardens and trees, resulting in conflict. One

22 *Bao batash* is evil air, believed to cause different kinds of problems and health conditions.

woman shared with us that if they did not maintain the household properly their husbands would be angry at them and it would start a dispute:

> If you do not clean the house, you'll always have a fight. If you do not wash the clothes, then he will say, let me wash it!

Information we gathered also showed that access to sanitation facilities and materials facilitated practices of personal hygiene. Household maps indicated that sanitation facilities like toilets and tube wells are accessible and available. All respondents confirmed this. Half of the respondents had their own tube well in the courtyard. A common tube well, which was set up by the government, was shared by three respondents, along with six other families for those who could not afford to set up their own water facilities. One household had two toilets, with slab-type ring latrines. One of those was designed for children's use while adults used the other. The two latrines we observed were clean. There were no faeces around them and they did not smell.

The women mentioned that soap was always available for the toilets and that they used a separate soap for bathing. They also mentioned that other cleaning materials like toothpaste, tooth powder, and blades were available and that their husbands bought them whenever needed.

The women were aware of the importance of being clean. Media played a major role in increasing their level of awareness. All of them mentioned that they learnt about cleanliness and cleaning materials, such as soap and shampoo, from television and radio advertisements: "I have seen their ads on TV and heard about it from people."

Health education also increases the awareness of the importance of health and personal hygiene. One woman, who studied up to class eight, mentioned that she had learnt about hygiene in school. Religious teachings also increase awareness of personal hygiene. Another woman said that the *Imam*[23] from the local *madrasa* taught the women how to become *pak* after menstruation or sexual intercourse, and about the consequences of becoming impure. Another woman mentioned that she had learned the importance of personal hygiene, particularly washing hands, from medical advice related to worm infestation of young children.

Hindering factors

Three obstacles to personal hygiene that the women mentioned were their heavy workload, safety concerns and financial constraints. Three women emphasised that their heavy workload prevented them from maintaining personal hygiene. One of them stated:

> When there is heavy workload, for example the next month is the time for harvest…..we will not have time for lunch…let alone being clean.

When they have many things to do, whether in the house or in the field, it is not always possible to practise cleanliness and they sometimes even skip meals or have to go out of the house with an unclean body. Having small children is also considered a barrier to practicing personal hygiene. Two

23 An *Imam* is an Islamic religious leader who leads in a *zamat* (congregational prayers) in a mosque; also acts as teacher in the religious schools (*madrasa*).

women, each having two children, said that it is difficult to maintain hygiene with young children around as young children play with dirt and frequently come up to their mother in soiled clothes.

Another hindering factor was concern for safety. Many of the households had illegal electricity connections and none of them had electricity in the toilets. Therefore, even though they had the toilet just behind their house, they were afraid to go there in the dark. One of them said:

> At night, we just use torch to go to the toilet. I am afraid that somebody or something would be sitting there. I become very much afraid, especially after I have heard crime stories.

Lack of money also hindered women from maintaining personal hygiene. While discussing the household maps during our ethnographic interview, one of the women expressed her wish to change the location of the toilets and have easier access to water facilities. She wanted it to be twenty to twenty-five feet away from the main house and thought that it would be "healthy" to have it far away from the household. Both women, with whom we did household mapping, stated that having water facilities inside the toilets would be very helpful:

> We do not have water in the toilet, so we have to go near the tube well to wash our hands after going to the toilet.

Another woman wished to divide the toilets into two rooms, one for urination and one for defecation. During discussion of the household maps, both women said that they would like to change the location of the kitchen, cowshed and garbage ditch. According to them, the current locations were not healthy because the soot, dust and smell entered their house. Since money was a constraint for them for the time being, they expressed the wish to make these changes in future.

Conclusion

Perceptions of personal hygiene among the women in Kakabo village reflect more of cleanliness than of asepsis or removal of germs. What is clean and what is dirty is comparable to what is pure and what is polluted. Religious beliefs, social thinking and perceived health benefits influence meanings associated with hygiene. Understanding hygiene has "more to do with morality and social values than with a scientific analysis of the paths of disease transmission" (Curtis 1998: xx). Disease resulting from a lack of personal hygiene is not associated with the presence of germs as much as it is with religious concerns.

The women of Kakabo perform certain hygienic practices. Generally, brushing their teeth, taking a bath, washing their hands using soap (mostly after coming back from the toilet) and maintaining trimmed clean nails are tasks done daily or regularly. It was noted though that actual practice may be different from what they said, for example, they may say they use soap after urination, but in practice, they may not do so regularly. A number of factors motivate hygienic practices. For instance, hygienic practices strongly supported by religious beliefs are more likely to be maintained by various methods, e.g., by taking a special bath after menstruation is over or right after sexual intercourse. Perceived benefits of health and social harmony also provide strong motivation to maintain personal hygienic practices. Again, these benefits must be understood within the context of their beliefs: health and social harmony as a reward for moral obedience, while disease and social conflicts as consequences of immoral acts. This study was done only among Muslim women. Conducting a similar study with

women belonging to other religions, such as Hindus or Christians may illuminate other aspects of personal hygiene.

For the women in Kakabo, it is not an issue of non-practice but how they practise, as well as, their ability to maintain personal hygiene. The ways in which they conduct personal hygienic practices do raise questions. For instance, taking a bath outside the house with one's clothes on brings about the issue of privacy and risk to women's health. How can a woman bathe and clean herself, especially her private parts, in front of strangers? For women, things scientifically considered dirty are handled without much concern. Cow dung, mud, a child's running nose - are just parts of their lives. How can we expect women to treat these things as dirt, or even agents of disease? These areas need to be explored further.

Our findings complement those of Ahmed et al. (1997) concerning sanitation emphasised by the three-pronged intervention of providing accessible safe water, appropriate and sanitary methods of excreta disposal and hygiene education. As revealed by our findings, access to sanitation facilities like a toilet and tube wells is an important facilitating factor in the practice of personal hygiene. More work has to be done on excreta disposal, as children's stools do not concern the women much. In this study, we also found that health inputs through media, health education and medical advice helped in improving hygienic practices. We firmly believe that for permanent behavioural changes to occur, an internal driving force, such as personal beliefs and philosophies need to be taken into account. We recommend to health promoters (government and non-government organisations, health practitioners, media, schools etc.) to consider the perceptions and meanings attached to hygiene by the rural people when developing health messages and frameworks and strategies on health education. The concept of workload affecting self-care and personal hygiene (Afsana et al. 1998) also came out in this study. This, as well as the safety issues must be analysed and well considered while promoting personal hygiene.

Hygiene

Menstrual care of adolescent girls

Ayesha Sania & Laksmi Durga Chava

The aim of this chapter is to understand issues related to menstrual care of adolescent girls in the village. Qualitative techniques such as individual ethnographic interviews, focus group discussions, case studies and PRA tools, such as body mapping, were used for data collection. The respondents of the study were seventeen adolescent girls and four mothers from Muslim and Hindu families. Menarche marks girls' transition from childhood to womanhood. As the topic of menstruation remains taboo, many mothers often communicate nonverbally and as a result most girls do not get adequate information before menarche. Menstruation is viewed as an expression of woman's fertility. However, menstrual blood is considered impure and girls take special care to keep clean using 'old cloth' as absorbents. Women believe that menstrual problems can lead to infertility and often link infertility to evil spirits. Therefore, they seek health care from traditional healers and not biomedical practitioners. Menstrual care practices and care seeking during menstruation are shaped by socio-cultural norms, traditions associated with gender relations and economic status.

Meanings and understandings of menstruation

During our fieldwork, we became familiar with the local terminology used for menstruation such as: *mashik*, *menses, shorir kharap*[24], and *rakto bhanga*[25]. The adolescent girls also shared a cryptic language for menstruation when they discussed it among themselves. Some of these secret codes are *isti asha*[26], market opened, and *kala kapar*[27]. The meanings of menstruation for mothers are related to womanhood and fertility. A fifty-five -year-old Hindu mother said:

> The intrauterine blood of the mother taken by the foetus comes out at menarche to indicate the girl's readiness for fertility. Without flowers, we cannot get fruits. Therefore, girls menstruate every month to keep up their fertility.

For both mothers and adolescents menstruation is something given by God. They said, "Allah has given it to every woman who is supposed to give birth." They think regular menstruation is necessary for good health. According to the girls, "menstruation happens every month; stays for three to seven days and to maintain good health it is essential to have regular menstruation."

24 *Mashik* literally means monthly, *menses* is the shorter version of menstruation. *Shorir kharap* means having one's body in bad condition (feeling out of sorts). All these words refer to menstruation.

25 *Rakto bhanga* means passage of blood (rakto).

26 *Isti asha* means visits by guests.

27 *Kala kapor* is a black piece of cloth.

A feeling about menstruation expressed by all the girls was embarrassment due to restricted mobility and tension that the stains might be visible to others. Menstruation is a monthly hassle to them. A Hindu girl narrated, "Once my friend got *menses* in the school and she had gone home to change her clothes. When she came back, boys in the class started making fun of her, saying that in dry season she got wet in the rain!"

The adolescent girls have some idea about the menstrual process, especially the source of menstrual blood. It was interesting to look at their drawings during the body mapping exercise. It helped illustrate their perceptions of the menstrual process. A few girls said, "It comes from lower abdomen so we keep some cloth there to absorb it". One of them elaborated the idea: "blood comes from kidneys, gets stored in the lower abdomen and sheds out every month." Their explanation of monthly shedding of blood was, "blood is collected from the body during the whole month, is stored in a sac and the sac overflows when it is filled up (i.e., menstruation)". To them menstruation is a process of purification of the body. As one girl said, "impure blood stored in the body during childhood comes out every month in the form of menstruation which makes the body lighter." Though they mentioned the collection of blood in some sac in the lower abdomen, none of them named the sac as uterus.

The meaning of 'menstrual care' among the Hindu and Muslim families was mostly related to aspects of 'taking care of impure blood'. For example, it required personal hygiene to purify themselves from the impure blood that comes out during menstruation; proper washing, storing and disposal of the cloth used to absorb impure blood; restriction of foods especially during menarche to control flow and stop spreading of the smell of impure blood.

Access to information

"When I saw blood on my *shelwar*, I was scared and started to cry. I thought I had cut myself. Then I went to mother who informed me that I had grown up," said one girl. Similar to her, most of the girls were scared at menarche by experiencing sudden bleeding because they had very little or no idea about menstruation before menarche. A twelve-year-old girl, who had not reached her menarche yet, said, "I came to know by seeing my sisters' stained cloths being dried on the roof. But I am not aware of the details of menstruation".

None of the mothers we interviewed talked to their daughters about menstruation before menarche. They never considered giving prior explanation to girls about menstruation. Two mothers who have adolescent daughters told us, "It is not necessary to inform in advance what is common in every woman's life. The girls will come to know when they grow up." The adolescent girls usually learn about menstruation from their sisters, cousins and friends. The thirty-year-old Muslim mother of a girl of pre-menarche age said, "I am not going to tell my daughter directly, rather I expect my brother's daughter who is grown up to inform my daughter about this." The daughter also confirmed that: "My mother did not tell me anything about menstruation so far." A few girls informed us that they are aware of the advertisements of sanitary napkins on TV and in newspapers but they are too shy to watch them in the presence of other family members, especially in front of their father and brothers. All the school-going children mentioned that they did not get any information from the school curriculum or from their teachers about menstruation.

Practices of menstrual care

Personal hygiene

"As I am not pure during menstruation, I take a bath early in the morning and then my mother allows me to enter into the kitchen", said one girl. To maintain personal cleanliness girls take daily baths during menstruation. Hindu girls commonly take their bath immediately after they come to know that they have menstruated irrespective of the time of the day. Until they take their bath they are not allowed to come into the house. This is their way of taking immediate action to remove impurity from their bodies.

Girls use old cloth as absorbents during menstruation. The cloths used are torn pieces from old *sarees*[28], *lungis* or *dupattas*[29]. Some girls, especially the school going ones, use a panty for holding the absorbent cloths in position. Other girls use strings for that purpose. They usually change the absorbent two to four times in a day. A few girls who experience excessive bleeding may need to change these cloths five to six times daily. Girls have to stay quite a long time in school and it leads them to take extra protection. A school going thirteen-year-old Hindu girl said, "I use more cloth before going to school as there is no opportunity to change."

We found a Muslim woman (thirty-five years old) who use sanitary napkins while her daughter uses old cloth as absorbent. The woman expressed her satisfaction saying, "I use sanitary napkins brought by my husband. I find them more convenient to use and dispose of. There is no need to wash them. Nobody will come to know that I am menstruating." During the later part of our discussion, it came out that due to high cost of sanitary pads not everybody can afford them. The woman told us, "It is costly. I need only two pads as I usually have bleeding for two days. But my daughter needs more pads as the flow is generally more among girls." The daughter however said, "I do not know what my mother uses for herself during menstruation."

Most girls wash their cloths when they change them during the course of a day. Some find washing these cloths inconvenient in front of others at daytime and they wash all used cloths at night. A fourteen-year-old Hindu girl remarked, "I keep all the used cloths at one place and wash them at night. Nobody will come to know it. I will feel less embarrassed." The girls either used washing powder (*wheel*) or kept a separate soap.

In Muslim families, drying of cloths is always done inside the house, behind cloth stands or under the cot on a string. The women and girls ensure that the cloths are not seen by anybody else, especially men. Hindus also try to dry the cloths in a hidden place but they will dry them in the sun when the men are not at home. A fifteen-year-old Hindu girl stated, "We spread them on tin sheets and it gets dried properly under the sunlight, but nobody can see them as we spread on the highest part of the roof." The washed and dried cloth is kept at a secret place, for example, behind the lower part of an almirah. All the girls except one said they dispose of the cloths every three to four months and then replace them with other pieces of an old *saree*. A fifteen -year-old Muslim girl said, "I have been using the same cloths for two years." Every one of the girls said they themselves collect and throw away cloths when they want, but a Muslim mother said: "I myself throw my daughter's used cloths away every month as they become dirty. My daughter does not know how to wash them properly."

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28 *Saree* is the traditional long piece of clothing worn by women in Bangladesh.

29 *Lungi* is traditional skirt-like piece of clothing worn by men in Bangladesh from their waist to feet.

There is a notion among both Muslims and Hindus that disposal of used cloths is related to the fertility of women. Every respondent we interviewed mentioned that they take great care to dispose of the cloths in such a way that crows, dogs, pigs, snakes and evil spirits are unable to smell them. The strong notion expressed by all the girls and mothers is that if any of these animals or beings smells their cloths, it can lead to irregular periods and pain in the lower abdomen and eventually, infertility. A few of the mothers mentioned that they bury the used cloths.

Seeking health care

Every girl we interviewed had menstrual problems, such as abdominal pain, especially during the first days of menstruation. A few girls also mentioned problems of excessive bleeding, prolonged bleeding and irregular intervals of bleeding since the onset of menarche. None of the girls however mentioned the signs of reproductive tract infections like itching or white discharge. It is evident from the discussions that the mothers are not aware of the menstrual problems of their daughters and even if they know, think these are not health problems and common to the life of every woman. The Muslim women who had eleven and fifteen-year-old daughters questioned us: "Why go to hospital? Anyway, it is cured after seven days of menstruation. We do not seek the help of doctor for such problems before marriage". However, a few Hindu girls mentioned that they were taken to a *fakir* (local healer) after complaining to their mothers of abdominal pain and were relieved of the problems by the chanting of the *fakir*.

Case 1

Reba lives in Kakabo. She is sixteen and has two sisters and two brothers. Her father is a mason. Five years ago when she was a student in class four, she gave up her studies. Her father said that if young girls are sent to school they will be spoiled because they will mix with so many boys.

One day when Reba was playing with her friends in the school compound she realised something warm was coming down between her thighs. She became frightened thinking that she had cut herself somewhere in her groin. She ran from the school to her older sister. Her sister smiled at her, assured her that it was a normal thing, and explained how to take care of it.

After a few days Reba realised her menstrual periods were more frequent than that of the other girls. She also thought that she was losing more blood compared to the others. She had to change cloths (absorbents) 5/6 times a day and could hardly come out of the house during her periods.

When she told her sister about her problem, her sister replied, "You must have stepped over a crab's nest when you went to the field to bring the cattle home," and she did nothing. Then, one day one of Reba's aunts noticed her sufferings during menstruation. The aunt advised her to talk to her mother and to see a doctor immediately. Finally, Reba talked to her mother about her menstrual problems (which she found shameful to share with her mother) but her mother again did not take any action.

It has been three years since Reba's menarche and she is still bleeding excessively during each menstrual period. On our second visit, she told us, "I know I should see a doctor." At last, Reba went to the nearby Akrain *bazaar*, but the only 'lady' doctor was not available on that day. On our last visit, Reba tried to tell us something but she seemed very hesitant. Finally, she asked us to give her some medicine or at least a prescription for her problems.

Girls were aware that they could get treatment for their problems from the female doctor in the local health centre. However, all of them mentioned that they could not go there alone because they are not allowed to or because of shame.

The role of fathers was hardly mentioned except in the case of a fifteen-year-old Hindu girl who suffered from prolonged bleeding. She said, "I informed my mother who told my father to get some medicines from a medical shop. My father brought the medicines from Akrain *bazaar*. I got some relief but I do not know what those tablets were."

During the focus group discussions, all of these girls expressed that they feel weak during menstruation. Some girls mentioned that they need good food but their 'illiterate' mothers often do not consider this. The girls expressed their inability to get any additional nutrition: "We do not get or take any special food, though we feel weak during and after menstruation". Most girls said that their brothers are always served first after their father. Some added casually that their brothers *should* get the first share because that is the norm in their family.

Socio-cultural norms and traditions

We observed a large number of traditional beliefs and restrictions surrounding menstruation. Most of the restrictions are based on concepts of pollution and much of the 'information' about menstruation imparted to young girls is in the form of restrictions on their movements and behaviour. This is one reason why after menarche some girls are withdrawn from school. In our study we found four girls left school just after reaching menarche.

Case 2

Anju has three daughters and two sons. Her husband, a cobbler in Savar *bazaar*, is the only earning member in the family. A few years ago when the older two daughters were young, Anju was very careful about their activities and always kept them under many sorts of restrictions. At that time both daughters were regularly menstruating. One day Anju noticed that Mala (the second daughter) had not had her menses for two months. Anju became worried thinking that Mala had a secret relationship with a neighbour boy. She asked her daughter several times but every time she denied a relationship.

Anju took her daughter to a *fakir* who applied *jhara* (local practice of healing). But Mala's menstruation did not resume. By that time, Anju stopped worrying because found no sign of pregnancy.

Mala continued to experience amenorrhoea for six months despite the treatment of the *fakir*. The neighbours told Anju that she would not be able to find a match for her daughter if she was not menstruating regularly. Then, Anju took her daughter to a homeopathic doctor. Mala received homeopathic treatment for four months and her menstruation resumed. Now, Anju is happy that both her grown up daughters are married. She felt that as long a woman's menstruation is regular and she is able to conceive there is nothing to worry.

Parents feel that norms are essential to keep their daughters under control, because they worry that their daughters will have pre-marital sexual relations. A Muslim mother shared her opinion with us: "It is not a good age and they (girls) tend to talk or go with the boys. If people in the community see this, they will make comments and it will be difficult for me to get a match for my daughter." Girls

are not allowed to play outdoor games and have a special dress code. Parvin (sixteen years old) says, "Nowadays we can not wear frocks and need to wear *shalwar-kameez-dupatta*[30] though we feel very hot and uncomfortable in this during summer."

The traditions are also linked with beliefs about the possible harmful effects of 'pollution' through menstruation. A few girls mentioned, "We are not allowed to go to an ill person or an ill person should not come into our shadow while we are menstruating as it deteriorates their health."

Some religious activities are also restricted during menstruation. Girls are not allowed to touch the *Qur'an*, to say prayers or to fast during this period. Hindu girls also said, "We do not perform *puja*[31] and do not go to the temples during menstruation as we do not want our shadows to fall on our *thhakur*[32]." Hindus do not allow menstruating girls into the kitchen. At times, restrictions become a blessing to the girls. One of our respondents (married just ten days ago) said, "I do not have to cook during menstruation. It's good in a sense. At least I can get some rest!"

All respondents mentioned that many dietary restrictions are imposed on them during menstruation. They informed us: "Our sisters and friends told us not to eat fish during menstruation as it gives a fishy odour to the menstrual blood." A few girls mentioned that they avoid sweets because they make bloodstains stick to the cloth. A thirty-five-year-old Muslim mother said, "Sour food makes the blood thin and increases the blood flow. So, I forbid my daughter to take sour foods during menstruation." Hindu mothers mentioned that their daughters *usually* avoided non-vegetarian food during menstruation.

Girls seemed to find their own way of following restrictions. At the end of one FGD, we heard an assertive Muslim girl mention tactics to play with the food restrictions: "We just follow these food restrictions only for the first few months and then we start taking all the foods without our mother noticing it. Nothing happens."

Different religions have different practices bound to their cultural norms surrounding menstruation. In Muslim families, mothers inform girls not to tell anybody about menarche and menstruation. Whereas in Hindu families the community is informed by celebrations at menarche like giving a special bath to the girl with turmeric, a variety of grass and five types of fruits. The girl is asked to look at the fruits before she is given a bath to make her future life fruitful and fertile.

Discussion and conclusion

We found that young girls were not prepared for their menarche. They were frightened, embarrassed and disturbed due to their ignorance of this natural process. Sexuality, fertility and pollution are strongly associated with menstruation, which makes menstruation a shameful and hidden subject. Even after reaching menarche, young girls get little information about the physiological changes taking place and the required hygienic practices. There was a general opinion among the girls that menarche would have not been so painful and disturbing if they had prior knowledge about it.

30 *Shelwar* (trousers), *kameez* (tops) and *dupatta* (piece of cloth that goes with the tops) are three pieces of the same traditional dress.

31 *Puja* in Bengali means praying and offering to God. Usually it means the Hindu mode of worship.

32 *Thhakur* is how Hindus often call upon their God(s).

Irrespective of religion, girls take special care to maintain personal hygiene in terms of cleanliness of their body as well as the absorbent cloths and the disposal of the cloths. They assume these things will affect their fertility. As long as menstrual problems do not lead to irregular/missing menstrual cycles and infertility after marriage, they do not seek health care. The common notion is that the menstrual problems and infertility should be dealt with by traditional healers and not by bio-medical practitioners.

Most of the norms practised in the village restrict girls' movements and food intake. Restricted foods during menstruation include fish, sour foods and sweets as these are thought to affect menstruation in various ways. In a study conducted in Bangladesh, Blanchet et al. (1984) wrote that women avoid all kinds of fish to stop the spread of the fishy smell of menstrual blood and also because *bhuts* (ghost spirits) are fond of fish and bloody life matter. The dietary restrictions practised during menstruation do not really affect a girl's nutritional status provided she receives sufficient nutrition outside the menstrual period. Girls like to practise certain norms like not doing household chores, which allows them to rest during menstruation. Girls with excessive bleeding prefer to stop attending school to avoid the embarrassment of bloodstains that may be visible to others, especially boys.

Girls from both religious groups in the village talked about gender disparities in their families and the community. At the onset of menstruation, parents focus on the protection of the girls against sexual abuse or pregnancy but do not teach them skills to meet the demands of their future life. A teenage daughter reaching menstruation becomes a problem and burden for many parents in Bangladeshi society because preservation of virginity is the greatest concern for a bride (Aziz & Maloney 1985).

Some girls discontinued school just after menarche. Studies show that in many developing countries the onset of puberty results in significant changes in school participation for girls. Socio-cultural norms and traditions cause withdrawal of adolescent girls from school after menarche and restrict their exposure to the outside world. In addition, poverty and gender disparity cause ignorance and poor health for girls during this crucial period of their life.

In conclusion, this study explored adolescent girls' perspectives and practices of menstrual care and the influence of socio-cultural factors in their lives. Cultural silence around menstruation keeps the girls unaware of biological process before menarche. Socio-cultural norms and taboos strongly influence the decision not to seek health care. Lack of awareness and communication between mothers and daughters puts the girls at risk. Orientation to proactive groups of adolescent girls on topics like menstruation can be an entry point activity to educate them about their reproductive health.

Hygiene

Kitchens and health

Susan Nakuti & Tanveer M. Kamal

This chapter explores the emic perceptions regarding environment and health in two rural kitchens in Kakabo. One kitchen was that of an ultra poor family and a wealthier household owned the other. Both were 'congested' and 'closed' kitchens. The researchers conducted participatory observations. The interview settings varied to include both the formal and informal, with interactions both inside and outside the kitchen (and even outside the household). Kitchen and household mapping was done to help identify the *emic* perceptions about such concerns, e.g., what should an ideal kitchen look like, and what should be the distance between the latrine and tube well etc. An FGD was conducted with the women and children in the 'poor' household kitchen.

The key approach in this study was the application of the 'observer as participant' technique. The researchers took active roles in the kitchen, as if they were part of the family and went through 'just another day's work' following a successful rapportbuilding. The entire day's work was termed as 'a cooking session'. The session involved actively performing the chores involved in the afternoon's cooking, such as sweeping the floor, fetching water from tube well, disposing of waste/peels and serving the food. During this time, food preparation practices and the kitchen surroundings directly linked with health and hygiene were observed. In-depth interviews were conducted with the women in the kitchen both during and after cooking.

An ultra poor household

The house belongs to Kapil Das, a blacksmith, and his wife. They have three daughters, all married but with little education. The eldest daughter (Neela) lives next door, in one small room, with her husband, who works at a nearby shop, and two children. The second daughter is married to a man in Savar town and stays there. The youngest one (Arunima) was visiting her father's house with her son at that time. They are a Hindu family.

Socio-economic situation

Kapil Das's household was built on a piece of land that belonged to someone else. The home that they lived in, and the one where Neela lived, both consisted single rooms built with clay, had thatched walls and tin roofs. With limited income support from the two husbands of the respective households and frequent taunts from neighbours about not owning the land they built their house on, both families lived in a sense of insecurity surrounding their day-to-day lives. With no standing assets and obvious exclusion from any development programme, this family fits the profile of the ultra poor of Bangladesh (Zaman et al. 2004). Wife of Kapil Das exclaims:

> "Lunch…? Whatever God provides today!"

The kitchen

Neela's kitchen was just the clay stove built at a corner of the *uthan* (courtyard) of the one room house. The cooking space, or kitchen, measured about four by eight feet. The stove was about six to ten inches away from the thatched wall at one end of the space. Neela sat with a pail of water, instinctively, whenever she was cooking, as a safety measure in case the thatched wall caught fire. Mrs. Das's kitchen was similar, except that it had a roof and thatched walls on two sides. Neela's kitchen had better ventilation, more light because of its location out in the open.

The latrine for the household was located as an attachment to Mr. Das's home. They complained about the smell, which was particularly unpleasant and difficult to bear while cooking. They did not have the money to construct a new latrine at some distance. Their key complaint was regarding the bad smell and the flies that resulted from the latrine's proximity. However, these nuisances were not necessarily perceived as health threats. The source of water was a tube well in the next *para,* since their own tube well broke down about a month ago. They were not aware of any arsenic contamination in the water.

Chore burden

The women of the household bear the entire chore burden involved in providing the meals of the day for the whole family. Women also rake leaves, collect figs and twigs. The daily chores involved in preparing meals are as follows:

Sweeping the yard and kitchen floors, before and after cooking
Preparations for cooking, e.g., peeling and cutting vegetables
Fetching water (at least four pails, i.e., four trips a day) to the water source
Fetching leaves/biomass for cooking (about four baskets for each pot of cooking)
Winnowing the rice on a flat basket
Cooking itself
Several wash-ups of utensils during cooking
Disposing wastes/peels (in a designated spot at one end of household land)
Serving food
Dishwashing

The only help the women receive is from the children but even that is infrequent, for minor tasks only, and depends on whichever child is (playing) nearby.

Neela's inputs in conversations were usually in relation to the fatigue and exhaustion that marked her typically overburdened days. Interestingly enough, Neela did not complain about the kitchen smoke and said she could not be at risk from the smoke from cooking because she was "used to it by now."

Seasonality

During the monsoon, Neela cannot cook in the open kitchen and has to cook indoors, inside her (bed) room, on a makeshift clay stove. This causes excessive smoke inside the room. During the rains, the collection of usable biomass poses a special problem because the leaves and twigs are all wet. This necessitates a search for alternative fuel. Hence, the women rely on cow dung and whatever dry twigs and wood chippings that they have stored for this time of the year in large sacks at one end of their *uthan* (courtyard).

Gender

Men in general are not involved with the kitchen chores. Every attempt of the male researcher to get involved in sweeping, spicegrinding or waterfetching faced with resistance. Women felt these attemepts were a strange and unusual instance of male labour in the kitchen. Neela, who bears most of the chore burden for this family, summed up the sentiment regarding male labour with a decisive remark: "Men's business is to be in the marketplace and to bring food. They have no place in the kitchen!"

Fuel

Women, men and children all revealed unexpected and in-depth understanding regarding different types of biomass/fuels. The children were thrilled to lead the researchers around the yard and explained the properties of different types of leaves and twigs. They could all offer advice on which type of fuel burnt the longest or emitted more smoke.

We noticed that the thatched walls were constructed with woven palm leaves (*taal pata*), which are reported to be highly flammable. When asked why they chose such material for construction of the walls in the kitchen (given the associated risks of fire), the men responded with a saddened smile that silently alluded to their economic hardship. It was obvious that they could not afford any other material.

Cow dung was considered precious and low in supply. Average livestock ownership is very low in this village due to pervasive poverty. Also because the cow dung available is used primary for maintaining and layering the mud floors (*ghar lapa*).

Cooking

The researchers gradually became engaged in the chores of the kitchen during the preparation of lunch. Susan started with the peeling, cutting and washing of the vegetables, in preparation for cooking, while Tanveer took on the task of sweeping the premises, going to the *bazaar* to get spices, fetching water and gathering leaves in piles next to the stove.

The direct involvement in kitchen helped the researchers to observe the people in action more closely. The use of water was noticeably systematic. Women of the household fetched a bucket of water and placed it near the kitchen to use for the entire set of activities during the cooking process. Wastewater was disposed near the same location. A basket was placed as a lid on top of the bucket. Incidentally, it was the same bucket used to fetch and pile the leaves for the stove. The peels and garbage remains of cooking were disposed to a more or less designated area of the yard. The women said that the peels blended into the soil over time and that it was considered good for the soil. Noticeably, though, very little care was taken with the cooking utensils. They were often kept without lids on the floor.

We observed that children enjoyed the process of opening the grocery bags, when the researcher came back from the *bazaar*. They ate raw tomatoes, unwashed, as they arrived straight from the market. Meanwhile, the women of the house insisted that Susan wash the vegetables at least twice after peeling and cutting: "If the vegetables are not washed well, they'll give you stomach troubles!"

The wealthier household

Fahima and Ismail live on their own land in a three-room house. Ismail runs a shop. Fahima adopted her brother-in-law's son a year ago but she is now three months pregnant.

Chore burden, fuel, gender and seasonality

Some of the conditions surrounding this household (with respect to chore burden, fuel perceptions, gender and seasonality) were largely similar to those of the ultra poor family. The differences are as below:

Socio-economic situation

Fahima and Ismail's family receive additional support from their wealthy in-laws who live nearby. Ismail's brothers live in the neighbourhood as well, in a joint-family set-up spread over several households in the *para*. Three square meals are cooked daily in Fahima's kitchen. The family has livestock, chickens and ducks. Clearly, they are not short of food.

The kitchen

Fahima had a standalone kitchen outside her house with a mud floor, a tin roof and two thatched walls. The kitchen space was a bit too cluttered and congested, and the ceiling was too low for anyone to stand up to full height. The ceiling appeared to be smeared thickly with moist soot. When asked, Fahima said that it was an annoyance when the soot occasionally got on her face. During this conversation, her brother-in-law (Azad) added that it could be a menace if the soot fell on the food. Regarding smoke from the stove, Fahima did not see any danger to her own health (or to her pregnancy) because she is also "used to it by now!"

Household and kitchen mapping

Mapping exercises were held with the respondents to explore their perceptions regarding good and optimum environments with respect to the household and the kitchen. The household mapping exercise focused mainly on men while the kitchen mapping exercise mostly included women. The mapping exercises revealed that:

> Men have a clear set of requirements for a "good household environment", marked by economic considerations, e.g., the need for space for farming, future expansion of family, livestock, and more income-generating activities such as building shops.
>
> Younger men think more in terms of securing assets (e.g., land) for the future and for their children.
>
> Women feel a greater necessity to have more *space* and *fire-safety* in their opinion on what a "good kitchen" should look like.
>
> However, women did not request a window to be placed or built next to the stove, in the kitchen.
>
> Women have a better awareness than men do in planning for water supply in the household. They placed at least one bucket of water next to latrines. This also indicates a better understanding regarding hygiene requirements.

> Women show a certain pride in their roles in the kitchen. Consequently, in planning a household, they required more space to keep the utensils and to serve food - this is reflective of their pride.

Discussion

Three major issues become apparent as a result of this short exploration. First, the emic perspective on environmental health does not always meet the scientific standards. Second, where the local ideas concerning environmental health are in tune with the scientific standards, they may not be utilised to the maximum benefit because of other (e.g. economic) factors. Finally, valuable local concepts of hygiene and environment must be studied in-depth to bring about more effective environmental health solutions.

Emic and etic perspectives

Our observations revealed that the congested kitchens are located too far away from water and fuel sources. Studies have shown that the chore burden and energy expenditure is greatly reduced and work efficiency markedly increased if the location of the kitchen is optimised in relation to the water and fuel sources, washing facilities and storage areas (Nystrom 2003). However, in our study, it seems that the sheer chore burden on women desensitises them against developing perceptions regarding their own efficiency and energy expenditure. Thus, they are not in a position to make certain important decisions to improve their situation. This is a case where traditional attitudes and socio-economic constraints are the main obstacles to developing adequate health perceptions among rural women.

We also observed that women did not identify any direct health impact of smoke from biomass. The second kitchen session revealed that the soot on the kitchen ceiling was considered a nuisance for the fact that it could contaminate food. However, women did not realise that the ceiling was an indicator of the condition of their own lungs, because of the kitchen smoke. Many studies consistently show that passive smoke inhalation through kitchen smoke is the leading cause of Chronic Airway Diseases (CAD) in women and Acute Respiratory Infections (ARI) in children (Ekici et al. 2005). The lack of disseminating such scientific findings by the health professionals and policy makers keep the women and children in dark about the dangers of kitchen smoke, and continues to leave the rural women and children at risk of respiratory health threats. No wonder Neela is oblivious of such dangers when she says:

> "The smoke can't hurt me anymore…; after all these years of cooking, I am now used to it!"

Emic at par with etic

Women illustrated adequate planning of water supply sources (in the household mapping exercise) with regard to latrines, even though they failed to see such an association with respect to the kitchen. Also women are acutely aware of the connection between their physical ailments and their working position in the kitchen. It goes along with the finding that the kitchen fixtures, fittings and equipments should be built around the most comfortable and healthy work position (e.g., sitting versus standing) in the kitchen (Nystrom 2003).

Furthermore, the findings of the first cooking session revealed that women and men are both aware of the fact that a latrine located too close to the kitchen may cause health problems because of the menacing flies. However, constructing a new latrine is expensive. Here again, economic constraints make it impossible for the poor to access what they already identify as an "optimum environment". As Azad says:

"I will have to sell a cow to construct a new latrine!"

The best example of a situation where the *emic* perspectives are in keeping with the *etic* standards is in the well-articulated fuel perceptions of the community. Men, women and children all know that leaves burn most quickly and emit most smoke. They even specify further that jackfruit leaves burn the longest and they emit more smoke than any other leaf, while palm leaves burn the quickest and emits the least smoke. Furthermore, they know that hay, figs and cow dung burn longer and emit less smoke.

Studies have showed that increased exposure to wood smoke increases the risk of respiratory infections (Ekici et al. 2005). However, such scientific findings are far removed from the traditional knowledge or education of the poor. If such scientific information are shared with the people and incorporated in their fuel perceptions, they may actually help them in making more conscious and informed decisions regarding their fuel choice and thereby safeguard their health.

Regarding the chore burden of women (and children), in both cooking sessions, it is evident that Fahima's work burden is greater than that of Neela's, because the former has no children to help, while the latter has two. Studies show that the work and contribution of women and children is not taken into account in the national economic planning of poor countries (Warwick & Doig 2004). Consequently, there is a great possibility of ensuring poverty alleviation through ensuring improved planning and work efficiency and reduced chore burden in the rural kitchen. Neela retorted when we asked her about health problems:

"You talk about health or gastric problems in this village? Talk about my backaches!"

Recommendations

Every day modern science and research continues to find new information on the correlation between environment and health. More often than not, these findings fail to reach the poor and those who need it the most. The kitchen environment provides an exemplary location where several environmental and health factors are tied together in a way that has significant impact on the poor. However, most interventions to improve the health of women working in their kitchen, such as improved stoves and ventilation, are designed without simultaneously raising awareness. If the women were better aware of their own situation, they could perhaps see through the eyes of scientific development. Then, they could be empowered to make improvements in their environment on their own, which would then better safeguard their health.

In tune with what is revealed in the discussions above, there is an existing need for in-depth qualitative research for a better understanding of the Environmental Health field. Such studies may help us understand the gaps between the *emic* perspectives of rural people and the *etic* views of science to help bring about improvements in the environmental health through more conscious choices and informed decisions in their everyday life. In this regard, an anthropological approach may offer the appropriate perspective by asking, "Why do people do what they do?"

Coping with ill health

Rickshaw pullers

Jawaid Stationwala & Shamim Ahmed

In this chapter, we shall describe the health problems of rickshaw pullers in the village. We interviewed three of them. One was a twelve-year-old child, and the others were middle aged and older adults. Two FGDs were conducted with three to five people in each group. They shared the following characteristics: they used rickshaw pulling as their primary source of income; they fell within the age range of twenty-five to thirty-five and had migrated from either Natore or Sirajganj, leaving behind their families. A mapping exercise was also done to illustrate how these rickshaw pullers perceived the conditions of the roads and the distances they had to travel. We also observed a typical workday of rickshaw pullers: the hours worked during a day, routes taken, road conditions, clothing, dietary pattern, housing conditions, family life, interaction with customers, and recreational activities.

Painting a picture: Where they work and who they are

The intersection of four roads paved by dust and pebbles called Akrain *bazaar*, is the meeting place for crowds of rickshaw pullers. The bodies of the rickshaw pullers are covered by dingy white shirts torn from overuse. Their feet are partially covered by cheap spongy sandals that are used to push plastic bike pedals. The white part of their eyes appears bright, reflecting off the colour of their burnt skin. At the intersection, they wait for customers, sitting in the back seat searching for shade with their legs dangling in momentary freedom. Around them are shops and tea stalls, motorcycles and cement trucks, pedestrians and animals, all of which must be circumvented on their frequent rides. One of these dusty roads runs over a small bridge into Kakabo village, where we met our first respondent sitting on the bench of a local tea stall.

Rafiq, a twelve-year-old boy, who had migrated with his father from Natore, came to Kakabo to pull a rickshaw. It was only his tenth day on the job. He introduced us to his uncle, a thirty -year-old lifelong rickshaw puller by the name of Mohammed Monirul Islam, who became one of our key respondents. The other respondent was Morshed *Chacha*[33], a sixty-five -year-old rickshaw puller supporting a family of five, including his grandchild. We also conversed with Harun, a thirteen -year-old rickshaw puller working to repay his parents' debts.

Falling into rickshaw pulling: Hardly a choice

Early parental loss and family obligation

Morshed *Chacha* shifted the gaze of his sunken eyes toward his feet, and lowered his head and said, "I feel like crying whenever I tell my history." With a few words, he expressed the pain of many

33 *Chacha* literally means uncle and is usually the term to address a much older man with respect. Here the 65 -year-old man is called *Chacha* by everyone as a sign of respect for his advanced age.

rickshaw pullers we came across. *Chacha* recalled that his father died when he was three years old, leaving his widowed mother to support the family. At the age of ten *Chacha* began managing cattle as his late father had done before. Unfortunately, *Chacha*'s story is not unique. The following day we met two other rickshaw pullers who had lost their mothers before the age of three months. These two young men from Natore and Sirajganj, landless and homeless, also began farming and pulling rickshaws since the age of five. Our observations showed that early parental loss places pressure on children to take up income-generating jobs from an early age.

This pressure to be a contributing member in the family was however not limited to children who had suffered the loss of a parent. Rafiq, twelve years old and less than four feet in height, had insisted on coming to Kakabo to work alongside his father. He said to us, "I wanted to come and help my father earn money for the family." When Rafiq complained that pulling rickshaw was too painful, his uncle told him, "Just go back home, we will earn your bread." Rafiq did not listen to them. Instead, he just rested for two days, and started to pull rickshaw again in order to send money home to his mother in Natore. *Chacha,* who is now a sixty-five-year-old man exclaimed in much the same way as Rafiq did, "I do not want to pull a rickshaw anymore, I do not even want to touch the handle bars, but I have to feed my family!"

What else would I do? Limited opportunities and accessibility

Every rickshaw puller we came across complained that the job was far too strenuous. This raises the question: what entices someone to do such hard labour? One rickshaw puller explained, "I used to work on other people's land, but a housing society bought out most of the land to build a *Model Town*. Now there is no more land for farming. That is why we started pulling rickshaw." Other rickshaw pullers who had migrated mainly from Natore said, "We have fewer opportunities in Natore, so we must come here to earn a living."

Local townspeople mentioned that many of these migrants did not pull rickshaws in their own towns to avoid the shame and disparagement associated with rickshaw pulling. *Chacha* introduced yet another dimension stating that, "I am a poor man. Poor people do not have many options. Besides, I have grown old. No one will hire me elsewhere."

Another common reason mentioned by rickshaw pullers for choosing this job was the accessibility factor. Harun, the twelve -year-old boy said, "It only costs twenty-five taka to hire a rickshaw, and anyone who wants to can pull it." He added, "I am poor, my parents are poor. School is not for someone like me." Here he was referring to the fact that due to lack of marketable skills and education rickshaw pulling was a suitable job for people like him.

Managing life as a rickshaw puller: Income, expenses, saving, and debt

The average income of a rickshaw puller varies somewhere between a hundred to hundred and fifty taka per day requiring over thirty to forty short but excruciating trips. Harun mentioned that on Wednesdays and Sundays he earned two hundred to two hundred and fifty taka (less than four USD) because many people went to the *bazaar* to purchase and sell groceries. During the rainy season, the income decreases to between sixty to eighty taka (little more than one USD or less) per day. When asked how they coped with the decrease in income *Chacha* responded by saying, "We eat less!"

Beside living expenses, often times the men's income is used for maintaining the source of their livelihood, the rickshaw. Ishaq *bhai*, a seasonal rickshaw puller who supplemented his farming income by pulling rickshaw, informed us that, "The frame of the rickshaw sometimes breaks, the tyres get punctured, in general it costs four hundred taka (about six USD) every two months or so to keep the rickshaw going." Rafiq one day cracked the side frames of his rickshaw by carrying cement bags. The next day the owner of his rickshaw told us that Rafiq had grown anxious because he would be unable to pay for the damage, so both he and his father took their belongings and returned to Natore (a town about a hundred kilometres away from Kakabo) that same afternoon.

Often times, when the income is insufficient, the rickshaw pullers resort to borrowing money. Harun said, "I am working to pay off the debts of my parents." *Chacha* said, "I have been sick for the last few days so I took one sack of rice on credit from the *bazaar*. It makes me feel anxious and tense when I borrow." The respondents made it clear that borrowing and indebting oneself was a vicious cycle they fell into. Often they pull a rickshaw today to pay off what they borrowed to survive yesterday. *Chacha* said that because of rickshaw pulling he got sick every few days and tried hard to save money for food and medicines. We asked when he would stop pulling and he said with a long face, "I do not know. Allah knows. I do not have savings or investments. I do not know what to do." Another rickshaw puller added, "I cannot do this for much longer, I need a way out."

Daily pains: Commonly perceived injuries and illnesses caused by rickshaw pulling

This section is comprised of the health conditions, in order of frequency and gravity, described by nearly all of our respondents. We will use one story or a few core quotations for each of the health problems to illustrate the experience of multiple respondents.

The burning sun: Heat exhaustion

The afternoon sun was finding its position in the sky, beating down and warming the earth below it. Slowly sweat dripped off *Chacha*'s face and droplets of perspiration lingered on his skin. His shirt stuck tightly to his body, his weight continued to push the rickshaw forward, with us sitting snugly behind it. When we asked *Chacha* what it felt like he said, "The heat stays inside my body. No matter what I do I cannot get the heat out of my body."

Round and round spinning sensations

Harun, a thirteen-year-old boy about the size of a standing guitar, begins his workday at seven in the morning and continues most days until seven in the evening. When asked what was most troublesome in his job he said without hesitation, "My biggest problem is head-spinning. It is so painful when I get home, I do not know my right arm from my left." He described how the spinning continued throughout the evening, leaving him at times completely disoriented and bewildered.

It hurts everywhere: Body aches and sleeplessness

Monirul *bhai* is a thirty -year-old man who has been pulling rickshaws since his childhood. He said,

> I have constant pain in my fingers from gripping the handlebars. The pounding from the uneven roads gives me pain in my chest and shoulders. I have pain in my knees from pushing the pedals. In my calves and joints, there are deep pains as well.

> I also have pain in my back and waist, it hurts when I sit. Therefore, I have to stand, and it hurts when I stand. Then I have to sit. At night my body continues to ache, so I have to change positions every few minutes just to move the pain from one place to another.

When asked which part of the rickshaw caused these pains he responded by saying, "The seat is the most dangerous. In fact, the whole rickshaw is harmful. Pedalling is hard - it takes a lot of pressure. The handlebars bruise my hands, and cause me very painful blisters."

We need more blood: Malnutrition/weakness/fatigue

Sitting together huddled in a circle alongside the paddy field with five rickshaw pullers we asked about their general well being. One puller mentioned, "I think rickshaw pulling is deteriorating my health. I work very hard, but I do not have enough nutritious food. I went to the doctor and he gave me vitamins because I am weak." Another puller commented, "If you cannot drink milk then you cannot get blood properly. If you drink milk, you get more blood. We do not get enough blood, so we are weak." Others joined in and said, "We need one litre of milk a day, but we cannot afford it. We need bananas, grapes, and oranges. If we could afford it we would have chicken and rice three times a day."

The acid burns: Gastritis

"If I eat breakfast at eleven in the morning instead of eight in the morning, and lunch at four in the afternoon instead of twelve, then I get gas. The gas comes from not eating on time or not eating when I am hungry. This causes my gastritis and then I have even less appetite."

Rise in temperature: Fever/cough

Ejaj Molla said, "When I have a cough I continue to pull rickshaw, but when I have fever, I have to stop. I get fever three to four times a month. This is probably caused by working under the burning sun and drinking water right after returning from the sun."

My uncle told me not to pull rickshaw: Sexual problems

The particular topic of sexual problems never came up during the in-depth interviews. During the FGDs, we obtained most information regarding the sexual problems. They freely talked to us:

> If you ride a rickshaw then you have sexual problems. Rickshaw pullers get paralysis caused by excessive weakness due to their work. When we are pulling and while we urinate, we have white discharge. Going uphill or pushing hard also causes the white stuff to come out. This is a sign of weakness.

Another commented that, "I feel intense pain during intercourse. It feels like fire - *jala pora*, and I cannot continue for very long." To add to this, another puller recited a Bengali proverb "*Jar meho nai, tar deho nai*" (If there is no sperm, there is no body). The consensus among the group was that, "If you pull the rickshaw for long you will grow weak and have no sex power. If you have adequate strength, you will have no sex problems. However if you are weak, then you will discharge more *dhatu* (white discharge).

The flippant swing of a hand: Psychological pressures

Beside these physical problems, many of the rickshaw pullers expressed frustration, anxiety, and unhappiness. In general they suggested that the weakening body caused a weakening mind, "If you are physically ill then you are mentally ill." There was a morale attached to weakness as many of them said, "If you are a good person then you will be strong, and if you are a bad person then you will be weak." Moreover, they gave concrete examples, e.g., "Men from upper class treat me badly, they bargain with me waving their hands at me - telling me to go away." Another mentioned that, "You see the sweat all over my body, I am used like an animal, and it makes me feel ashamed." *Chacha* said with sadness in his voice, "I am a sixty-five -year-old man but these people refer to me as *tui*[34], and if I do not do what they want, they slap me." Harun, the child rickshaw puller said, "Once a *chokidar*[35] slapped me just for touching his shoulder. He said, "Do not touch my body!" My father was nearby but he could not do anything because we are migrants. I wanted to cry." Others mentioned sleepless nights worrying about debts they had to repay, and the uncertainty of being able to provide for their families. These internal anxieties influenced their rickshaw pulling as Ishaq *bhai* stated, "When I feel sad or upset the rickshaw pulling feels like hell."

Survival by coping

Self-treatment

For daily work related health conditions, rickshaw pullers have devised a number of ways to self-treat. Earlier we mentioned that heat exhaustion and head spinning were among the most pressing concerns for rickshaw pullers. To remedy this Monirul Sheikh said,

> I take tasty saline usually everyday at lunch. It usually comes in orange and mango flavours. It makes me feel cool, healthy, energised, and tension free. It makes me feel cool! What we actually do is pour two saline packets into a bowl, add six glasses of water, and four of us take it together.

A number of rickshaw pullers stated that they used saline to take the heat out of their body, and to make themselves feel cooler. Almost all of them agreed that it was a widely used practice. One went as far as saying that sometimes when he went home to Natore he used intravenous saline to energise himself. The saline is used in conjunction with both sugarcane and molasses juice. Other methods for re-energizing and cooling down are seeking shade under a banyan tree, and pouring cold water over the head.

For body aches Mohammed *bhai* said, "I go to the pharmacy and take tablets called *Diclofen*[36] that cost one taka per tablet (less than two cents). I take one after dinner when I feel severe pain." While he mentioned it another rickshaw puller remarked, "*Diclofen* causes leaks in your stomach. Two guys back home died because they took *Diclofen* during *Ramadan* (month of fasting)." When asked why they did not use muscle relaxants they replied, "It only cures the pain on the skin, but not the pain in the bone." To help with the body aches, pains during sleeping. Many rickshaw pullers have their

34 *Tui* literally means 'you'. It is a derogatory word if addressed to an elderly man. Usually *tui* is used to address younger people, children or someone who is very close.

35 *Chokidar* is the local guard, a village watchman.

36 *Diclofen* is the commonly prescribed painkiller Sodium Diclofenac.

children, and grandchildren perform full body massage. However Harun, the child rickshaw puller said, "There is no medicine for body pain."

While discussing another topic, one rickshaw puller brought up the element of time and said, "I am busy and cannot wait at the (nearby) Samair Health and Family Welfare Centre forever. Therefore, I send a woman in my place, telling her about all my symptoms, and she tells the doctor that she is feeling those things. She then brings me the medicine."

Clinical treatment

Two migrant rickshaw pullers told us, "The doctors we go to do not have degrees, we call them doctors because they are experienced." The rickshaw pullers emphasised that they wanted doctors who were familiar with their illnesses. Ishaq *bhai* mentioned that, "Doctors do not treat or know about my problem, they give me whatever cost the most."

Most of the time, decisions on which doctor to choose are based on the severity of the problem. In most cases, if rickshaw pullers experience what they feel is minor (that which does not prevent them from working) then they go to Samair Health and Family Welfare Centre. One rickshaw puller said, "For poor people it is good, the medication is free." *Chacha* however mentioned that, "When I feel severely sick then I go to Akrain Medical Pharmacy or even to Savar Medical Centre."

Some of the migrant pullers we observed even took a bus to cross a hundred kilometres just to treat their medical problems back home. We ran into two of our respondents who were returning to their home in Natore because they were unable to urinate.

Traditional healing and faith in Allah

In general, the rickshaw pullers thought that sexual problems fell within the domain of the *kabiraj* (local healer). One rickshaw puller told us, "Last time I went to the doctor was four years ago for *jala pora*. He said I had stones inside my penis. I had to spend three-thousand taka. Then I went to a *kabiraj*, and he prepared medicines from plants, spices, and milk. He did not take any money from me. After twenty days of treatment I felt better." Another respondent confirmed this saying, "I know a rickshaw puller who cannot have intercourse for long. He goes to the *kabiraj* who gives him *halwa*[37], spices, and plants. We think only a *kabiraj* can treat these problems." However, when asked whether they visit the *kabiraj* for other problems they said, "No, because the other problems are related to the body."

The main source of spirituality is the relationship rickshaw pullers have with God. One mentioned that, "Allah pulls the rickshaw. Without him, I cannot do anything. It is because of him that you and I met today." Similarly, while talking about the time when earnings diminished, they said, "If you earn less in one day, it is because you have sinned."

Recreation

The rickshaw pullers commonly relieved them from daily stress by going to teashops, gossiping, watching television and resting. In response to whether rickshaw pullers usually went to the cinema

37 *Halwa* is local sweetmeat made from fruits or vegetable mixed with sugar, oil and condiments.

one respondent plainly stated, "If you are weak and not feeling good, a cinema will not help you." They also engaged in risky habits for recreation that included smoking, drug abuse and visiting prostitutes. The focus group respondents said that, "Some people take *taari*[38] for thirty taka (about forty cents), *bangla mod*[39] for three hundred taka (about four USD), *ganja*[40] for ten taka (about one and a half cents), and *bidi* (local cigarette) for five taka (about seven cents). It was also suggested that, "they take these drugs to fight and quarrel with others." Our respondents repeatedly claimed that they participated in none of these activities, nor did they associate with those who indulged in such practices.

Discussion

So far, we have presented the perceptions of rickshaw pullers on three distinct but inter-related topics: the socio-economic context, common health problems, and coping mechanisms. In this section, we will focus on specific findings, relate them to relevant literature, and link them among the three established themes.

A poem by the Bangladeshi national poet Kazi Nazrul Islam (translated and cited by Anwar 2004) captures in many ways the struggle of rickshaw pullers:

> Oh my child, my darling one
> I could not give thee even a drop of milk
> No right have I to rejoice
> Poverty weeps within my doors forever.

In earlier sections, we mentioned the plight of rickshaw pullers as they try to support their families, often starting from a young age. Like in Nazrul's poem, many of our respondents mentioned that they endured the rigors of rickshaw pulling so that they could bring "milk" to their families. This notion of the man as "the bread winner", or in Bangladesh, as "the rice winner" is deeply rooted in Bangladeshi culture. Deeply ingrained in the minds of the young boys who pull a rickshaw is the notion that they have to earn no matter what, and it remains with them until they die. Their roles as providers continually affirm their sense of manhood.

According to Begum and Sen (2004), rickshaw pullers provide full support for 4.4 persons and partial support for 0.5 persons. Thus, they bear the burden of an additional half a person on average beyond their immediate family members. The authors claim that the rickshaw pullers come from very poor origins both in terms of 'household human capital' and 'physical capital' and rickshaw pullers belong to one of the most deprived social categories. In other words, rickshaw pullers come from the country's poverty pockets, the areas with economic depression, places of river erosion, and underdeveloped areas with 'limited work opportunities' (*ibid.* 2004). We found this to be true among our respondents as well, particularly those who had migrated from other villages and complained of 'limited work opportunities'. More importantly, migrant rickshaw pullers fall within an even lower class, because they lack the networks that native rickshaw pullers have. Therefore, when a passenger someone cheats them of money or slaps them in the face as someone did to Harun, they cannot even act in their interest or negotiate their rights.

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38 *Taari* is locally made liquor from *taal* (a blackish-brown round shaped fruit) extracts.

39 *Bangla mod* is the local brew.

40 *Ganja* is a popular addictive substance (known in the west as marijuana/hashish/smoking pot); scientific name, *cannabis indica*

A large majority of rickshaw pullers according to Begum and Sen (2004) are uneducated (58%) or semi-educated (17%) having never completed primary level education. Only one out of our ten respondents was able to read and write, and many had mentioned this inability as a factor contributing to choosing rickshaw pulling as a career.

It is evident that the economic conditions and family obligations of certain individuals led them into rickshaw pulling as an occupation. This cannot be neglected in a study evaluating health conditions of this group. The choice of rickshaw pulling presents a number of occupational health hazards. The economic situation of rickshaw pullers determines largely how they cope with these ailments.

Our respondents reported aches in almost all regions of their body. Most of their complaints were related to road and rickshaw conditions. In the focus group mapping exercise, the respondents were asked to draw the roads as they perceived them. In most portrayals, they drew roads as windy, uneven, earthy, and with slight gradients. Since we were unable to find specific health hazards for rickshaw pulling, we resorted to comparing the injuries sustained by rickshaw pullers to those of mountain bikers and off road cyclists. In an article called Cycling and Your Health (Benjamin 2004) , we found references to posture, road conditions, and bicycle equipment. For mountain bikers the forward bent position increase speed. For rickshaw pullers they too use this position not only to maintain speed but also to pull the weight of the passengers. It is nearly impossible for rickshaw pullers to sit in the recommended upright balanced position, since they need to pull the rickshaw frame continually forward to move the weight behind them. The literature substantiates the complaints of rickshaw pullers regarding their hands, elbows, wrists, shoulders, back, and neck. The article (Benjamin 2004) reads:

> In the forward bent position continual tension is placed on the muscles, tendons, joints, and supporting ligaments, from the hands through the shoulders, and to the back. Because these structures are under tension, bumps in the road send shocks of stress through the elbows, shoulders, and the very sensitive wrist ligaments and joints making all of these areas more vulnerable to injury.

Like mountain bikers, rickshaw pullers navigate through terribly rough terrain leaving them wide open to sprained wrists, and damaged muscles. Most of these injuries are hardly addressed by rickshaw pullers, and are often treated as routine bodily pains.

In our FGDs, rickshaw pullers mentioned diminished "sexual power" and difficulty urinating because of rickshaw pulling. Other studies have linked genital numbness to cycling. According to Benjamin (2004), the numbness can

> ...interfere with sexual functioning and can indicate more serious medical problems, such as, genital pain, urinary tract disorders, erectile dysfunction and localised atherosclerosis. When sitting on a chair most of the weight is distributed to the ischial tuberosities, essentially the bottom portion of the pelvis. However, due to the shape of a bike seat, the weight shifts to the internal part of the genitals. Studies at Boston University have shown an association between erectile dysfunction and extended athletic cycling.

Rickshaw pullers spend on average six to seven hours a day on the seat of a bike. Their problems with urination and erectile dysfunction are confusing because their symptoms are also suggestive of

sexually transmitted infections, in particular the white discharge reported by the rickshaw pullers. Therefore, their sexual problems may have more than one cause.

Another important observation is that rickshaw pullers attach moral values to weakness and sexual dysfunction. Being weak is not simply a matter of diminished physical activity, but it is also considered a sign of diminished moral value. The belief is that weakness is for sinners.

The most commonly reported complaint from our rickshaw pullers was heat exhaustion. A recent article (Rafoth 2006) on cycling performance states that heat stress during exercise on a particular day may cause sudden death the next day. A number of military recruits and professional athletes have died due to heat exhaustion. The conditions of heat, humidity, and direct sunlight coupled with dehydration and excessive strenuous activity pose one of the most significant dangers for rickshaw pullers.

Due to the strain of rickshaw pulling, many of our respondents indicated that they could not sustain this livelihood for much longer. They mentioned that the pressures keeping them within the occupation, and the health hazards associated with their occupation, were seriously deteriorating their health and their future earning capacity.

The economic situation also forces rickshaw pullers to become creative and cost effective in the ways they cope with their occupational injuries. We would like to re-visit four simple coping strategies that help rickshaw pullers recuperate and re-energise. The first is the usage of *Diclofen*. The tablet is an anti-inflammatory painkiller and has dangerous side effects. Rickshaw pullers take them frequently to alleviate body aches. It can cause gastric ulcer and perforation of the stomach. If this tablet is taken too often, there is an increased chance of acquiring gastritis. Irregular eating habits combined with the usage of *Diclofen* render rickshaw pullers quite susceptible to gastritis, according to the local doctor. No wonder, a large number of our respondents suffered from gastric complaints. The problem is that these drugs are readily available at pharmacies and rickshaw pullers can self-prescribe. Most of the time they are not aware of the health risks associated with the medication and can further complicate the problems they seek to remedy. Pharmaceutical drugs in Bangladesh are largely unregulated, so rickshaw pullers often exchange their short-term pain for future long-term pain without knowing it.

Another coping mechanism is the usage of oral re-hydration solutions traditionally used for diarrhoea patients. Rickshaw pullers use the solution everyday during lunch to cool down and replenish themselves. The oral saline was not created to serve this purpose. Among rickshaw pullers it has become a common source of revitalisation. In essence, the solution is being used as a sport drink and if the rickshaw pullers are not actually losing salts, they might be unintentionally creating an electrolyte imbalance for themselves.

Though seemingly simple, shade is the most readily available and most widely utilised mechanisms for re-energizing. Our respondents said that shade was their source of energy and the remedy they most sought for their suffering. Seeking the shade of a banyan tree was their escape from the burning sun.

There seems to be an association between rickshaw pulling and using illicit drugs. Though none of our respondents admitted to drug abuse, which was clearly a sensitive issue, they did mention that their colleagues used drugs as a way to release pressure and stress from quarrels with others. Warren (1986) mentioned in his book on Singaporean local history that rickshaw coolies were exposed to the

daily use of opium, as it was a necessary drug to ease the physical pains of rickshaw pulling and as one of the four sources of pleasure for them. Labourers looked to opium as a painkiller and the fact that it is an addictive drug implied that once a market was found for it the demand could only increase. Since much of the Singaporean labour force was dependent on opium rickshaw pullers as well as other working class people - it became a necessity for the capitalist development of Singapore. Rickshaw pullers were exploited then on two fronts; first as human horsepower and, then, as agents for establishing opium as a commodity to build the Singaporean economy. Rickshaw pullers earned money by pulling a rickshaw and, then, through purposeful design of government officials, spent their money on opium to lessen the pain caused from their labour.

The lesson is that rickshaw pulling and the health risks associated with it are conditions created by the historical exploitation of poverty. Today, conditions of poverty lead individuals into labour-intensive careers, such as rickshaw pulling, and unequivocally result in chronic occupational health hazards. In order to cope with these health hazards rickshaw pullers are often innovative and resourceful, sometimes to their own detriment. The purpose in mind for these impoverished men is always quite clear, “We have to feed our families.” Yet the trouble with their employment is that it is unsustainable. The child labourers grow fatigued and unhealthy with age and the already aged rickshaw pullers are not adequately equipped to deal with the pressure of their job. Though the job sustains a regular income for a certain period of time, the health hazards caused by the intensity of the job eventually makes the work-life of these men shorter.

Reflections

Some men cannot carry their own weight, thus other men have to carry the weight for them. With clenched fists gripping the handlebars and trembling legs pushing forward, the veins of these men bulge and battle, supply and surrender, in a fight for survival. The body bends and weakens, slows and aches purposefully, yet this is always the better kind of pain. This can diminish with time, with the help of painkiller tablets and syrups. Yet this pain is also a reminder of one's place in the world, a reminder of deeper pains. A place where one suppresses frustration, anger, and exercises submissiveness daily and regularly.

The men who pedal and pull the weight of others on unpaved roads, these men who travel their lives on the sidelines of main streets, always whisper a prayer in their minds while their passengers gossip and gaze. They keep saying to themselves, "May God gives me enough today to feed my family".

Therefore, the next time we ride a rickshaw may we all remember that in front of us there are two unseen passengers: a man's dignity and his humility.

Coping with ill health

Oral health

Bethuel Mbugua & Mahjabeen Ahmed

In this chapter, we explore the perceptions of oral health and health seeking behaviour of both men and women and determine how these perceptions influence their health seeking behaviour. We chose from middle-aged men and women between twenty-five to forty-five years of age to be our respondents. We observed their brushing behaviours, habits of chewing *paan-jarda* and tobacco products. We also observed the insides of their mouths during conversation (to see if there is any discolouration, missing teeth, caries etc.). We conducted two FGDs for both men and women but separately, with four people in each group from rich, middle and poor households. We also conducted four in-depth interviews with two men and two women, drawing from both rich and poor sections. The women were homemakers and the men held occupations, such as, farmer, shopkeeper and technician. Two men were unemployed.

Oral health practices

Cleaning teeth

We asked all our respondents about how they kept their teeth and mouth clean. Their occupations varied, but their socioeconomic status varied from rich to poor. Their oral health practices also varied but it seemed to have little to do with their socioeconomic status. Most men and women used toothbrushes. Some women used their fingers and toothpowder instead of a toothbrush as a matter of habit and comfort. Some men used or preferred to use *Neem* (local medicinal tree) twigs instead of toothbrush or in addition to the toothbrush.

Those who used toothbrush also used toothpaste and women who used their fingers, also used toothpowder. The duration and the frequency of brushing per day was relatively the same (at least once a day) among women but men tended to brush more than once a day. Information on the respondents' gender, socioeconomic conditions, choice of brushing methods, and duration of brushing are summarised in Table 1. This information highlights the prominent use of *Neem* by men, toothbrush and fingers by women, although toothpaste use seems to cut across gender and class.

Religious perceptions also seem to play a role in choosing the method of brushing. All our respondents were Muslims. They told us that Islam stresses good breath in the context of oral health because of similar practices by Prophet Muhammad (Peace be upon him). It is commonly believed that the prophet used *Neem* twig to brush his teeth and therefore all Muslims are taught to emulate him in all possible ways. Regarding oral health, most perceptions are based on the *Qur'an,* various *hadiths* as well as the various interpretations of certain beliefs regarding oral health. Men brush with *Neem* much more during their fast in the month of *Ramadan,* while the use of toothbrush and toothpowder declines during that time. Women said that their brushing habits did not change during *Ramadan*. When asked how many members of their household used a toothbrush, most respondents answered that the majority of their household members used toothbrush with toothpaste.

Our observations revealed that men were brushing with other men in groups outside the tea stalls, but we had a hard time locating a woman cleaning her teeth in public. We later learned that men tended to brush in the open, mostly when chatting with other men and at a much later hour than the women did. A woman's domestic work begin before dawn, especially if she is married. Therefore, she tends to take care of her personal hygiene before starting her daily chores. Most women brush at that time.

Table 1: Socioeconomic conditions, gender, methods and time spent cleaning teeth

Gender	Socio-economic condition	Methods of cleaning teeth	Timing
Women	Rich	Toothbrush and toothpaste	Once in the morning
	Rich	Toothbrush and toothpaste Sometimes finger and toothpowder	Once in the morning
	Middle class	Toothpowder and finger	Once in the morning
	Poor	*Neem* twig and mango leaf	Two to three times per day
	Poor	Toothpowder and finger	Once in the morning
Men	Rich	Toothbrush and toothpaste	Twice morning and evening
	Rich	Toothbrush and toothpaste *Neem*	Twice *Neem* twig morning Tooth brush-night
	Middle class	*Neem*	Twice morning and evening
	Poor	Either Toothbrush & toothpaste or *Neem*	Once in the morning
	Poor	*Neem*	Once in the morning

Gender differences

When asked to respond to several questions related to their knowledge and practice of cleaning teeth, both men and women had similar answers to questions regarding brushing methods and causes of oral health problems. When asked about brushing, all respondents said it was a good habit. When asked about what they thought of toothbrushes, they defined a good toothbrush as *Neem* or *Motkila* stick.

The older poor woman said that use of a toothbrush for "brushing is a new conception (that) people should try to use *Neem* and other natural means" because they are best for cleaning the mouth, also because it was mentioned in the *Qur'an*. The middle class technician said that some people believed that a toothbrush caused erosion of gums. He said he would rather use *Neem*. When a shopkeeper (middle class) was asked the same question, he said that using a toothbrush thinned the gums and caused gum problems, so he would rather use *Neem*. Men gave similar answers in the FGD. The importance of *Neem* as a better method of brushing was highlighted by some women in the FGD as well, when they said that brushing is good, but "*Neem* is very good (and that) it is good for health and teeth."

All women in the FGD defined oral diseases as those accompanied by pain, swelling of gums, ulcers, bad breath and tooth problems, such as, toothaches and *daate poka*[41]. When asked what caused these problems, the women did not have an answer. When the same question was posed using local

41 *Daate poka* literally means there is an insect (*poka*) inside the tooth (*daat);* usually refers to dental caries.

terminologies of dental caries (e.g., what happens when there is *daate poka* or *daate gorto?*), the older rich woman responded: "It is when you have food and you do not clean the teeth, the insects grow in your mouth and cause pain." She went further by adding, "When young kids with teeth are breast fed their teeth are destroyed, their teeth are spoiled."

On the other hand, men in the FGD said that the mouth problems consisted of swollen tooth, root pain, bad breath, bleeding during brushing and teeth sensitivity. When asked what caused these symptoms, they said they did not know. When the same question was asked to shopkeeper (middle class) during the in-depth interview, he said that tooth problems consisted of swelling, mouth ulcers, and pain (which made it hard to chew food). We asked him what caused these mouth problems. He said it was because of a dirty mouth due to lack of cleaning. Unclean mouth, he said, was a result of "food impaction between teeth (that has)…not been cleaned off." This, he added, caused caries, *'poka,'* among other oral health problems. The technician listed similar oral problems. He also gave a similar answer as the shopkeeper by saying that the cause of the problems was due to lack of brushing. The poor older woman said that the problems occurred when "people do not clean their mouth."

A few men gave an interesting response. They told us that brushing for a period of twelve years with *Neem* could build resistance against snake venom.

Chewing of *paan-jarda,* betel nuts or other substances

Jarda is processed tobacco and people usually chew them with *paan* (betel leaf) and *supari* (betel nut). Two women (rich and poor) and three men (two middle class and one poor) told us that they chewed *paan* and *jarda*. The rich woman chewed five times a day, and had a history of teeth mobility. Her teeth were straight but coloured red from years of chewing betel leaves. The poor older woman chewed whenever she felt nauseated and when she could not sleep. She had toothaches and mobility of teeth. Presently, most of her teeth were gone. The only teeth left were all blackish and yellow. She suffered from swollen gums.

Out of six men, two middle class and one poor men chewed *paan* and *jarda*. One middle class man chewed at least three to four times a day, but he had no history of oral problems, although, his teeth were discoloured. The other middle class man responded that he chewed twice a day, and had some oral cavities. His teeth were heavily discoloured and slightly crooked with one chipped front tooth. The poor man also chewed twice a day. Once he had abscesses in his teeth. His teeth were discoloured and she had one front tooth missing.

When asked about what was so good about *paan* and *jarda*, the older rich woman said that it made teeth stronger and purified the blood, while the poor woman stated that it prevented bad breath and acted as a food substitute when food is scarce. When we asked the men who chew the same question, one of the middle class men had no answer while the other said that it prevented bad breath and was good for toothaches. When the same question was posed to the other respondents, the men said that it discoloured teeth. Only three respondents said that they ever had any history of oral problems, but our observation revealed that only three of all respondents had a straight series of unstained teeth.

We found that chewing *paan* and *jarda* had an impact on oral health. Men and women who chewed had discoloured teeth, had either lost one or more of their teeth, and had a history of much more serious oral health problems compared to those who did not chew. Their present tooth condition showed that chewing had a big impact on their oral health irrespective of their daily brushing habits.

Factors relating to brushing and macro culture

The biggest change that all of our respondents mentioned was the environmental change that Kakabo village had undergone within the last ten years. All of them stated that Kakabo used to be a dense forest, but now houses and people outnumbered the remaining trees. When asked how this affected them, they responded by saying that due to reduced number of trees, use of *Neem* and *Motkila* for brushing had significantly decreased.

Another change noted was the use of other tobacco products such as *gul*[42]. Many respondents who chewed *paan* and *jarda* would not respond to the question of whether they chewed *gul* or not. The process of stuffing raw tobacco between the lips and the lower gums was perhaps not very attractive to them. It may very well be that admitting a habit of *gul* was not a popular response because of the extremely addictive nature of this habit. The process of chewing *paan* and *jarda* enjoyed evident popularity. It was more of an elaborate ceremony where several different shaped nuts and other additions were used. The men and women wrapped the green leaf into a small cone around various ingredients and chewed to relish.

A Bangladeshi tobacco company, incidentally the third highest taxpayer in the country, process the tobacco that is used to make *jarda*. Its impact on the development of Bangladesh's economy is crucial because business transactions that take place between the north provinces, producers of 'good' *jarda*, and the consumer southern states, are large.

The fact that Bangladesh is so densely populated makes it an ideal place for tobacco sales. We found that the majority of men who chew were young, but women chew when they were older. In a village, these findings show the behavioural changes brought by outside forces, such as, tobacco companies, the government and the media.

Oral health seeking behaviour

Available services for oral health care

Men and women across gender and socioeconomic classes responded similarly to questions regarding oral health problems. A similar pattern was found in their health seeking behaviour. Their preferences revealed a great deal in terms of their treatment choices, methods, knowledge and perceptions of oral health and problems.

When asked where they went when they first noticed the oral problems, the women said that they first self-treated, and when it did not work, they went to a traditional healer, a local *kabiraj*. When asked why they did not go to a dentist, many respondents said they only knew about the *kabiraj* who treated many health conditions including oral problems. Most of them did not know that there was a professional oral health specialist called dentist.

The men responded in a similar fashion, but they added that another option was just to ignore the problem. The poor farmer said that he would go to a healer first. Shopkeeper retorted, "What will the healer do if someone has a tooth problem?" The shopkeeper was knowledgeable about the role of the dentist, as he had had his teeth extracted in Saudi Arabia.

The farmer's thinking was that if both the healer and the local 'doctor' gave fresh plants, and the 'real' doctor gave tablets made from such a plant, why not just take the fresh plants from the healer

42 *Gul* is a black powder made of burnt tobacco; used as toothpaste (very addictive).

instead. In the case of *Neem* use, this 'naturalistic' thinking seems to be an important factor that influenced the choice of oral cleaning methods and treatment. The older rich woman repeated this when she said that she self-treated using treatments based on natural remedies because it was mentioned in the *Qur'an*.

The farmer went on saying that a couple of months ago when he had a severe toothache, he went to see a doctor (not sure if he was a professional doctor or not). The 'doctor' told him he had a severe infection and he needed medication before the tooth could be removed. He took the medication but when the pain went away, he never went back to the doctor. This finding is crucial as it describes instances when the respondents required further treatment by a doctor but decided against it. Respondents chose home-based treatments and sought medical attention only when the problem became serious, i.e., unbearable.

Socio-economic factors were commonly cited as deciding factors while choosing treatment methods. One younger woman said that she usually did nothing: "Since this problem does not make you bed-ridden and does not make you weak I do not go anywhere" for treatment. If the problem persisted, she would self-treat like gurgling with hot water because seeking medical help cost money to travel and also for treatment. The older poor woman said that in the past, she had to use a brew made from boiled guava leaves to alleviate toothaches and other oral problems. She did this before she considered seeking help from a *kabiraj*.

Lack of oral health care service

Perception of a tooth specialist called dentist was overwhelmingly absent in all the respondents' responses except those of the rich shopkeeper who had been to Saudi Arabia. The tooth specialist was not well defined but the respondents often confused him with the local 'doctor' in Savar who treated oral problems in his office. Those who had seen this man described him as a 'doctor' who had an office, a desk and a wooden chair for patients.

People often said they went to a 'tooth doctor.' In reality, they hardly knew who a dentist was, but to them, since there is a doctor for the eyes, for ears, etc… then it seemed possible that there could be someone 'out there' who was responsible for fixing teeth and other oral problems. Some of them felt that the 'tooth doctor' was a more specialised doctor than that of the MBBS doctor. As the rich woman put it, "There is not even any MBBS doctor, and you are talking about a dentist!" Most respondents did not know anyone who had ever been to a dentist or had oral surgery. Many thought that the *kabiraj* in Savar was the real 'tooth doctor' who could be consulted if self-treatment failed, or if the oral problem became too severe to ignore.

Discussion

Studies conducted on the health seeking behaviour of the poor have shown that socioeconomic status is an important factor in choosing the method of medical treatment. What we found was that brushing habits however were not always related to their socioeconomic status. All respondents owned a toothbrush and brushed at least once a day with toothpaste or toothpowder. Most men and women had a history of oral health problems, although their socioeconomic status seemed to have some effect on their health seeking behaviour, although not as much as their cultural beliefs played a role. Most of them treated themselves first before seeking the help of a *kabiraj*.

In a four-year long study by Ahmed et al. (2003) that explored the patterns of health seeking-behaviour over time, it was found that although there was tentative evidence of greater gender equity in choice of treatment, preference for professional medical care was not apparent. In another study

(Ahmed et al. 2005), it was found that a household's poverty status emerged as a major deciding factor of health-seeking behaviour. Both studies emphasise the influence of socioeconomic status in different settings, but in our study, as stated above, socioeconomic status did not seem to have any effect on brushing although it had some effect on the health seeking behaviour.

Cultural belief played a big role in brushing practices. These practices were tied to both tradition and religion. Religious beliefs seem to have a lot of influence on people's perceptions of oral health. The religion of our respondents is Islam, which focuses on cleanliness, and gives instructions for how to maintain good oral health. According to certain *hadiths*, Prophet Muhammad (Peace be upon him) used *Neem* and he expected others to keep their mouths clean. Furthermore, he described the process of cleaning one's teeth as "purification of one's mouth, and an act that is pleasing to the Lord". He further emphasised the importance of good oral health when he said, "Clean your gums from food and brush your teeth," (Mazhar 2006). Therefore, brushing as a means of maintaining good oral health is a practice that has been around for ages, but through time, it has become more of a traditional practice based on religious beliefs in Bangladesh.

Traditionally, *Neem* is still a remedy used by the *kabiraj* for oral problems. A *kabiraj* applies *Neem* extracts to cure various bodily ailments. Brushing with a *Neem* stick is perceived in religion and culture as good for oral health, and traditionally *Neem* has become part of herbal medicine. This could be one reason why toothbrush as a tool for cleaning one's teeth and mouth is perceived as an intrusion, a new concept that had nothing to do with tradition.

Yet, the toothbrush in Kakabo is seen as a necessary 'substitute' to *Neem* which is natural. Fewer *Neem* trees mean fewer *Neem* users, but brushing is perceived as a must. Without *Neem*, people know that to maintain good oral health, as is prescribed by culture and religion, one must have a toothbrush. This is one other reason why use of a toothbrush is partially accepted as a *Neem*-substitute. Other factors that can explain why the toothbrush is slowly being culturally accepted are availability, affordability, and accessibility. As outside information and knowledge on oral health continues to become more available through the media, we can expect a gradual change of oral health behaviour to toothbrush use in Kakabo.

Having seen how keeping one's mouth clean by brushing is part of Kakabo culture, it was ironic to see that people chewed *paan* and *jarda* even with the knowledge that it 'dirtied' the mouth by causing teeth discolouration and oral cancer. *Paan* and *jarda* use, like brushing, is a common habit in Bangladesh and many South Asian countries. Chewing *paan* and *jarda* is accepted in Bangladesh as smoking is (or used to be) in many western cultures. According to a survey conducted in Bangladesh by the WHO, half of Bangladeshi men and one-fifth of women use tobacco in either a smoking or smokeless form (WHO BAN 2006).

We noted that men and women who chewed had discoloured teeth and a history of oral health problems. Despite their daily brushing rituals, the present (observed) condition of their teeth was bad. The addition of *jarda* further increased the likelihood of developing oral cancers. The duration and daily frequency of keeping *paan-jarda* and betel nut inside the mouth increase the risk of cancer (Warnakulasuriya 2002). It is not surprising, therefore that in Bangladesh where so many men and women use tobacco products, thirty percent of all cancers are oral cancers (Sadique 2005).

The habit of chewing *paan-jarda* along with other harmful oral practices is a cultural phenomenon and requires dissemination of information to the public, especially the poor, about the harmful effects of tobacco. The government needs to pay more attention to tobacco use in order to prevent oral cancer. Public education about these harmful cultural practices will help people to develop a better understanding of oral hygiene.

Coping with ill health

'Mental' illness perceptions

Nasima Selim & Priya Satalkar

This chapter discusses the 'mental' illness perceptions in the village. Observations, responses and narratives include the perspectives of caregivers and patients. Some illnesses were believed to be present from birth and mostly incurable. Supernatural causation and local cures were mentioned for a particular category of illness. There were very few instances when respondents accessed the existing mental health care services in the big city. Widespread abuse of various substances was reported. In general, the respondents showed broader acceptance of these conditions, except for certain forms of substance abuse. These findings are discussed in relation to defining respondents' perceptions in terms of explanatory model(s). Our analysis is also concerned with the way people 'embody' their 'illness experience', and how this is made relevant for the process of coping with 'mental' illness in the family.

First day at Kakabo

A man came running down the middle of the road, covered with dust, with only a worn-out chequered lungi on him. Young men sitting at the nearby roadside tea-stall kept yelling at him, "Aye adha-pagla[43]…langra[44]...come here…are you happy today?" Their tone was condescending, yet mixed with affection and concern. The man they addressed did not seem to mind the language. He was about five feet tall, a small head, all skin and bones, a rough beard and a moustache. He had hazy eyes, looking straight ahead but responded whenever people called him. We learnt that his name was Ainal, the village pagal[45]. We asked him if he would like to eat some moori[46]. He started undoing his lungi, seemed restless and uncomfortable with us. We made a paper cone to give him some moori. He took it and went away happily. We met him again in the evening when we were having a discussion with the men in the village. He was running towards his house with a small packet of turmeric[47] and some money. People again addressed him as langra, or Ainal and had small talks with him. He only uttered certain sounds in response, and occasionally made gestures to reply to their queries about his recent whereabouts. Ainal obviously has a place in the village social life. People were affectionate, at least while we were around the place. We do not know how it might be at other times. When we called him, he came and sat with us for a while, ate biscuits like a child, and seemed to be enjoying the attention. Someone said we should not make him stay longer. His mother must be waiting for him. Ainal looked better, cleaner. He looked like he had a place among the others. He was a son who had a job to do for his mother.

43 *Adha Pagla* means halfwit. In this case people used the term affectionately for addressing *Ainal*.

44 *Langra* usually refers to a disabled person; often used as a derogatory term for someone who either does not have a limb or has trouble walking properly.

45 *Pagal* is mad man (or woman). Most commonly used term for the deranged and the mentally ill.

46 *Moori* is puffed rice.

47 *Turmeric* is the paste made from the rhizome (roots) of a plant, used in Asian countries for culinary purpose e.g. to add yellow colour.

This is our first experience with a person who appeared to be mentally ill and for whom the villagers had several names, e.g., *pagal, adha pagla, brain out, mathhay chhit*[48] etc. Soon we came to know more…

'Mental' illness and perceptions

In the absence of reliable data, but based on global estimates, there are supposedly fourteen million people with some kind of mental illness in Bangladesh but less than a hundred qualified psychiatrists (WHO BAN 2006). In this country, as in most of the other developing countries, mental health is a low-priority area, compared to physical health needs (Jacob 2001). The fact that there is no baseline estimate or exploratory study on mental illness in the community leaves us far behind in the process of incorporating the mental health component into primary health care, as recommended by the World Health Organization for almost two decades (WHO 1990).

For any mental health intervention to be successful in a rural setting, or even before that, for any problem definition to be *valid* and *reliable* within the community, local beliefs need to be elicited and discussed, prior to any training in the biomedical model of mental illness. Studies repeatedly emphasise on the need to explore indigenous belief systems and explanatory models (EMs) (Joel et al. 2003). Kleinman (1973) defines EMs as people's perceptions of illness and treatment in a given society, in the context of their cultural beliefs and norms, and employed by all engaged in the clinical process, including the healer-patient interaction. The 'view-from-nowhere' objectivity of biomedicine and science's discouragement of narrativity (Wilce 2005: 134) is problematic, because "narratives offer a method for addressing existential qualities such as inner hurt, despair, hope, grief, and moral pain which frequently accompany, and may even constitute, people's illnesses" (Greenhalgh & Hurwitz 1999: 48).

Not much has been published about mental illness perceptions in Bangladesh. Jim Wilce's seminal work, *The Poetics of Madness* (2000), in a Bangladeshi village, looked into the naturally occurring speech involving elements that the Bangladeshis call *pagal,* focusing on the method of 'discourse analysis', the relationship between language, society and culture. It offered valuable insights on this relationship but not as much on illness perceptions per se, and therefore it has less to offer in terms of our current study objectives. In this small-scale study, we were unable to do justice to the unexplored terrain of such linguistic explorations.

To find their world

Our goal was to explore people's perceptions of mental illness in the village: 1) to find out the local terms for conditions that people consider to be "mental illness", 2) to understand their explanatory model(s) of such illnesses, and 3) to understand the 'embodied experience' of the people with mental illness by listening to and going through their 'master narratives'.

The research included patients, caregivers and other villagers, men as well as women, young as well as older people. Our approach was a mix of observation, informal conversations, FGDs, illness narratives and free listing of illness terms. The most important 'tool' was our intuition and openness to what happened during our field visits.

48 *Mathhay chhit* = crack pot (derogatory)

Turning the tables

After meeting Ainal, the village *pagal,* we thought about the encounter in retrospect: the way we approached him and reacted to his presence - our own taboos and fears. Listening to the villagers also stirred our emotions and brought forth materials from recent and distant memories that proved relevant to our study as well. Our discussion revealed our mindset before and during the study.

Both of us are medical doctors. One researcher had some training in psychiatry, she was interested in the patients' narratives while seeing them in clinic, and she made efforts to look beyond the biomedical model. Here she had an opportunity to do exactly that, i.e., listen to stories and try to understand the 'embodied experience' through this study but ironically she was now struggling with her psychiatrically trained mind that compelled her to think about the diagnosis and treatment. She was now aware of this feeling of being trapped in the middle, between the ground perceptions and the biomedical model during the course of the research. For the other researcher who had no background in psychiatry but three years of work in public health sector, the struggle was different. Apart from the research questions, she was keen to dig deeper into these stories and wanted to know more about the every day life, personal challenges, joys and sorrows of people with mental illness that could have profound effects on them and the people around them.

Their terms and our models

By gathering people's experiences in discussions, narratives, stories and anecdotes, we discovered many local terms for 'illnesses of the other kind', perceived causes, manifestations, outcomes, and treatment seeking patterns. We present our findings from the different perspectives of women and men, some of them being caregivers, with sections on access to mental health, stigma, myth and social acceptance.

The Women

There was initial reluctance and little discussion from the women until an elderly widow, looking tired and worn-out, responded to us. Earlier we had asked them if they knew about any kind of illness in the village that was not physical. At first she said, "*shoreer chhara ashukh hoy?"* (Is there any illness that does not have its place in the body?). Another woman, in her late thirties, picked up the hint and said that they did not have that many *moner ashukh*[49] in their area but heard that it happened in other far-off places. A gradually growing enthusiasm on part of the women overrode the initial denial of the existence of such illnesses. A number of women already gathered in the courtyard and they opened up a wide vista of rich experiences and interesting details.

During our discussion, they frequently used the term *pagal*. Other terms to describe people who wandered aimlessly were, *Mental, Brain Out, Matha Out, Mathar Brain Nashto, Mathay Chhit.* According to the respondents, these people were often very dirty and urinated or passed stool wherever they liked. They would not eat or sleep properly and were often aggressive. They cried or laughed for no reason. *Dhoom pagal* was their term for the most severe kind, those who stayed naked on the streets. *Adha pagal* were those who stayed at home and did not bother their family members or neighbours. Most *pagal*, they believed, had this condition from birth. For example, *Ainal* was like that from his

49 *Moner ashukh* is illness (*ashukh*) of the mind (*mon*).

childhood. But according to the women, some became *pagal* because of torture or certain life events. One woman told us about a *pagli*[50] who lived in a nearby village: "It was marriage that made her like this. She was all right before marriage. Then her mother-in-law used to torture her." Most of the respondents believed that a *pagal* could not be cured while a few commented: "Who knows what would have happened if they had been treated! If they could spend enough money, maybe…" Some, however, believed that even if families could afford to take the *pagal* to the doctors, they would hardly get better.

Paye dhan harailo/Guptadhon paye haraile (Found the treasure but lost it) is a particular condition within the indigenous category of *pagal* or *brain out* mentioned by the villagers. Some villagers believe in the popular myth that 'finding treasure' (*Paye Dhan*) and then 'losing it' (*harailo*) could make someone *pagal*. One of the women recounted a folk tale to illustrate this:

> Lalu's father, Azam, was a farmer. Near *dakaat mora,* a place that is not far, he saw a hawk that used to come to this hole in a small hill under the big Banyan tree. He went to see what it was and found a heavy piece of shining metal. He thought it was *gayebi maal*[51] and did not dare touch it. Instead, he went to his uncle and asked him to come with him. His maternal uncle declined but later went by himself without his nephew and took it all. Since then, Azam has been *pagal* and *matha out,* breaking everything, hitting people for no reason. No treatment could cure him. The *kabiraj* tried *jhar fuk* and doctors gave medicine but nothing worked. He gradually went worse with these thoughts and wandered around, lamenting: *Mamu*[52]*, amare dila na!* (O maternal uncle! How could you deprive me).

The women agreed that *paglami*[53] was not as common as *batash laga,* by far the most common condition of 'the other kind' that was not physical. They thought that *bhut dhora, kalay dhora, batash laga, shapa batash*[54] were caused by *jinns* or local *bhuts* who were around at certain times during the day or night. According to them, newly wed brides were particularly vulnerable and the *batash laga* illness made them behave strangely (e.g. vocal abuse, breaking objects, disrespect to elders, uninhibited show of emotion, and convulsions). This condition was not limited to young women alone. Men and women of all ages could also be affected. They attributed this to supernatural causes, but the common belief was that these conditions were usually curable if the afflicted people were taken to a *fakir* early, while there was still time to drive away the evil spirits.

The women also talked at length about *chinta rog*, the worry illness and *Kheali bhab*, absent-mindedness. One of the women claimed that she had been suffering from both these conditions. She told us that she did not feel like eating, could not sleep properly, had *buk dhak dhak*[55], sweating, and that she was always worried about the future of her family. Her constant worries were mostly related to the repayment of the loans she had taken. She attributed the cause of *chinta rog* to this excessive

50 *Pagli* usually refers to a woman considered mad by the community; although the term is often used as an endearment.

51 *Gayebi mal* are objects thought to have supernatural origin.

52 *Mamu* is maternal uncle.

53 *Paglami* is madness, the condition of being a *pagal*. All kinds of major mental illnesses are lumped together and considered as *paglami*.

54 These are considered as 'conditions of the other kind' attributed to the works of the evil spirits.

55 *Buk dhak dhak* refers to anxious palpitations.

worry and thought that *chinta rog* resulted in the other illness named *kheali bhab*. She felt that there was no real cure for her worries. Doctors were of no use. Sometimes treatment by a *fakir* reduced her sufferings but the symptoms never went away completely.

A few women came up with the term, *pratibandhi* for children with a low level of intelligence compared to other children of the same age. They said that there was no cure for such children and they were bound to grow up to become useless.

Men and *nesha paani*

With the men, we sat under the shade of a big *Koroi* tree in late afternoon. They were very interested to talk to the women researchers from BRAC. They held animated discussions among themselves and even shared with us that they had 'mental' problems themselves. Most of these village men were at first amused watching two city women coming and talking to them but we were able to move beyond the stage of mere curiosity and in the end established a good rapport with them.

The men brought in a very different perspective on 'mental illness.' Just like the women, they began with discussions about *pagal*, *matha olotpalot*[56] and *batash laga, shaapa batash, bishakto batash* but at some point, they started to speak about *nesha paani*, the various forms of substance abuse in their community. We found that *nesha paani* was a common practice among men from age twenty to fifty. We asked them if they considered *nesha paani* to be a mental illness. A businessman said that it was *moner byapar*[57], *hoite pare moner ashukh* (maybe, illness of the mind). He said,"If you do *nesha paani* for many years, when you go past the age of fifty you will become 'mental', you become a *pagal*. You wander around doing nothing, engaging in abnormal behaviour." Others told us that along with pethidine, heroin, phensidyl, and various *nesha tablets* (sleeping pills) - locally made products, e.g, *bangla mod*, *ganja*, and *taari*, were all available and extensively used. One man even offered us a bit of fermented *taal* extract/juice (*taari*) but then they thought it was better not to, thinking that we might get drowsy, or even intoxicated.

The men came up with a few perceived causes, e.g, emotional hurt, devilish thoughts inside the mind, or just *moja*[58]. According to them, people who were dissatisfied with their work often did *nesha paani* if there was nothing better to do. They said, "Look, if someone is hurt emotionally, he takes *ganja*. If someone wants to harm someone else, he will make him take heroin. That is dangerous." They described the various modes of taking drugs (*nesha paani)*: "When they do it for fun, they do it together, with friends. When they take it to relieve pain, they do it alone." Most of them had some idea about the short-term (forgetfulness, sleepiness, fatigue etc.) and long-term (e.g., mental illness, physical problems) effects of *nesha paani*. They thought that there was no cure but 'self-cure' ("Only if someone really wants to, he can stop.") One man cracked a joke to which everyone laughed. He said, "It does not cost much to be good. Being bad is costly" (*Bhalo hoite paisa lagena. Kharap hoitei khorcha kora lage*).

A contradictory view emerged when they were discussing how others feel about those who take *nesha paani*. Some admitted that people considered them bad, as people who had gone astray. They said they were often beaten up and sometimes parents would hand them over to the police. But this habit

56 *Matha olotpalot*=turmoil inside the head

57 *Moner byapar*= matter/affairs related to the mind

58 *Moja* is enjoyment.

of taking *nesha paani* did not seem to be always looked down upon. It was also regarded as manly. One man summarised a male-centred attitude towards *nesha paani*:

> A man is not a man without *nesha paani*. A man has to have some kind of *nesha* to get him through life. No man in this world can be without *nesha*.

Awareness of mental health care

None of our respondents felt any doctor could cure these conditions. They mentioned that they frequently went to Savar or Dhaka for seeking treatment for their physical illnesses, but they did not do so for the 'other' kind of illnesses. They had never heard of a psychiatrist. They hardly knew anything about the existing mental health care facilities in Dhaka. A few of them had heard about the big Mental Hospital in Pabna, which they thought was the ultimate place for *pagals*. During our discussion, an adolescent girl laughed aloud and sang to us:

> *Jar jato bhabna, she jay Pabna.* (Those who worry, they go to Pabna)

Mirgi Rog

An independent source was an unmarried adolescent girl who acted as our guide in the village. She mentioned *mirgi rog*[59] and we later followed it up by visiting the house of a ten-year-old boy suffering from repeated convulsions (*khichuni*), who was known to have this *mirgi rog*. His mother, in her thirties, without formal schooling, gave us a graphic description of what is known in biomedical terms as Epilepsy:

> When he was about two years old, we thought it was *batash laga*, that evil air touched him. Since then he occasionally had *khichuni*, sometimes he fell on a cooking pot and hurt himself. When he has *khichuni*, froth and sometimes blood come out of his mouth. He clinches his teeth, loses his senses completely, sometimes he urinates and passes stool as well. He has fanning of toes and claw hands with jerky movement.

She said she did not know why her child had this, and shared with us what she heard from others. The villagers told her that this happened because she ate *mirgi machh*[60] or had *megher paani*[61] on her head after delivery. The mother had earlier taken her son to a city doctor who told her that it was because she took some medicine to kill the baby inside her. The mother took her son to see many doctors in Dhaka, who did X-Rays and prescribed medications. They told her to keep him away from fire, water and sharp objects. The villagers suggested that she should eat the head of that *mirgi machh* which she tried as well. Nothing worked. Even *jharfuk* could not cure her son. She had asked her son if he had seen a ghost or something, but the son said that he felt something was shaking inside his head. That is why she thought it had nothing to do with the spirits or even the mind. It was just *mathar rog*[62]. The mother was very protective about her child and resented the comments by some villagers who told her that she should keep her other sons separate from the boy, implying that *mirgi*

59 *Mirgi rog* is Epilepsy like sickness.

60 *Mirgi maachh* is mirgi or mrigel fish, a big fish not liked by many.

61 *Meger paani* is rainwater.

62 *Mathar rog* is disease inside the head, usually associated with mental illness. Here, however, the mother was not associating this with the mind although the villagers did.

rog could be contagious. The mother said that it made no sense. None of the members in the family ever got it although they drank from the same glass or ate from the same plate her son used.

Stigma, myth and acceptance

We found that the villagers talked openly about what they perceived to be 'mental' illness. There were some evident social stigmas and few myths about 'mental' illnesses in the community but beyond that, we found a greater social acceptance of 'mental' illness in the village. A young woman told us that mentally ill people kept their emotional sufferings to themselves. Although women often talked to other women, believing that it would bring them some relief. They also told us that both men and women with *batash laaga* had difficulty getting married. Women were afraid to stay close to men who were *pagal* or *matha out*, because they were aggressive, sometimes loud, and indecent. But they also said that they were more tolerant to the *pagli,* the mentally ill woman and regarded her as harmless. They would take her to their house and even let her sleep in their inner courtyard. We felt that there was more sympathy in their voice and attitude than scorn or ridicule. One of the women said affectionately: "They are *pagal*, they have their own mind. We let them be."

The experience of a father

The most striking experience that we had in the field was when we met Ainal*'s* father, a seventy-year-old man, father of seven children. He was resting in his thatched house at one end of the village, facing the green horizon of paddy fields. A seller of trinkets and mud jewellery, he had seen better days and now appeared to live in extreme poverty. We saw him with a wide grin on his worn-out but still spirited face. He told us what it meant to be taking care of a son who was not like other children, who could not speak or think for himself at times, who had a tendency to get lost and was regarded by everyone to be the village *pagal*. He had tried whatever he thought was useful, spent as much money as he could, and made efforts to get his son married. In the end he had accepted his son's condition. We 'edited' his tale slightly to provide the reader with a direct experience of what he told us:

> Ainal is *Pagal, mathay chhit*. I have wasted so much money, went to India, to *Ghutiari sharif*, of a *Jinda Pir*[63]. I did *manat*[64] in all the *mazars*[65] in Bihar, Kuch Bihar, Jalpaiguri, Siliguri[66]. I went to all the *Alga doctors*[67]. I will tell you the truth. I have never tried to take Ainal to a hospital. Never. I never sent him to a school…Few days after his birth, he was touched by a *batash*, he would not crawl, could not walk…No one in this village is like him. He cannot speak but he understands everything, and he works very hard. He can feed himself; he can take care of himself. He takes care of things in the house…Sometimes he is angry, gets cranky, and starts crying. He makes a lot of sound…*Aaaa*…without any reason.
>
> I know, his brothers or sisters will not take care of him. I am worried about him… Last year he got lost after *Eid*. I went to many places, near and far, to *Tangail,*

63 *Jinda Pir* is believed to be a holy man whose presence is felt even after his death.

64 *Manat* is the pledge made by people to give something in return if the blessing they received in the holy places actually brought in results.

65 *Mazar* is the final resting place of the *Pirs,* the holy men.

66 Places all over India.

67 *Alga Doctors* are non MBBS village doctors.

> *Narayanganj, Tongibari*[68]. I went and looked in certain areas where the *pagals* lived and searched for Ainal. I almost spent ten thousand taka. I saw many *pagals* but no sign of Ainal. It was the worst time in our lives as if the sky has fallen on our heads…. After three months and eleven days, he finally returned…
> The villagers like him, and they never scold him. Every one loves him and he is like that. Even if there is lump of gold on the street, he will never take it... We never have enough to eat because I have spent so much money on him and the other children. Now I am old, I cannot earn the way I used to… I have no land of my own. I worry about his future. *Pagaler mon, dariyar dheu* (The mind of a mad man is like the waves of the ocean). Ainal is not a *dhoom pagal*[69], but we worry about him all the same…
> We tried to get him married…a villager got a beggar girl from Mirpur and we married them off. We thought if he had a family of his own, he would do better, there would be someone to take care of him but it did not work…The girl was disrespectful, she did not listen to any one. Villagers said that Ainal was not a proper husband and I did not argue with them. Ainal did not like his wife in any case. They used to fight. She left…
> It is difficult, but I never lose hope. I always try everything people tell me to do. I always have some hope [sigh]. Not every one is the same. God has given unique power to every one. His mercy is on every body. People need help. Without help where would they go? I am a disciple of the *maiz bhandari*[70]…
> I believe that life has a place for everyone**.**

Discussion

We will discuss these findings in relation to people's explanatory model(s) and the way they 'embody' their 'illness experience', and how they cope with 'mental' illness in the family and the community. We will also make efforts to understand how poverty and the transitional state of a village like Kakabo, its gender difference, shift in the status of women, role of media, and lack of access to mental health care affect the 'mental illness' perceptions of its inhabitants. We will end with a short inquiry into the existing general acceptance of these conditions among the villagers.

Illness categories

Among Kakabo villagers we found at least six different types of 'mental illness', e.g. *pagal, bhut dhora, chinta rog, pratibondhi, mrigi rog,* and *nesha paani.* Respondents' everyday knowledge provides them appropriate explanations, relieves their anxieties and offers them hope. People are mostly unaware that biomedicine has something to offer to illnesses such as *mirgi rog*, certain *nesha paani*, e.g., heroin abuse and a number of *paglami*, similar to mental illnesses, e.g, schizophrenia, bipolar mood disorders, or brief psychotic disorders. We realise that we were always in a double bind, trying to interpret their local terms with 'western' biomedical concepts. We did not always try to find equivalent biomedical terms for these conditions, knowing very well that it would not always be

68 Places near Dhaka.

69 *Dhoom pagal* means completely deranged and insane.

70 *Maiz bhandari* is an unorthodox Islamic sect originating from the village of *maiz bhandar,* Chittagong, in the Southern part of Bangladesh. They believe in religious tolerance and unconditional love for all beings through devotional songs and mystical practices.

accurate. Each society has a different way of thinking and classifying their experience, and they express these in their culturally specific language. Kakabo is no exception.

A village in transition, a village in poverty

Kakabo village and its inhabitants live within an hour's drive from the capital city of Dhaka. A short stroll around the village is enough to make one realise that this is not a completely rural community. Most roadside tea-stalls have televisions with cable network. People watch foreign movies, take interest in the latest international news, and are not immune to the consumerism spread by the advertising industry. What they called *Paye Dhan Harailo* (Found the treasure but lost it) was a recurrent theme in our discussion.

The young men we talked to were not happy with their lives. They said they were involved in work they did not like. Through international TV channels and cheap video CDs, they are exposed to the lifestyle of the 'rich and famous'. Living close to the culture of the rich in Dhaka city raises false hopes and unrequited dreams of making quick money, adding dissatisfaction to their lot. This feeling of social deprivation can be directly linked to the widespread drug abuse. While discussing *nesha paani* with the men, we also felt that the 'manly image' of film stars, the glitters of showbiz and media personalities could have influenced the behaviour of these people which led them to experiment with smoking, alcohol and drugs like heroin. Non-judicious use of such substances can be attributed also to the availability and legally sanctioned access to sedatives such as diazepam (Seduxen), flurazepam (Aluctin) etc. causing detrimental effects to the overall well-being of the young men in the village.

Kakabo is far from resolving its poverty. Our respondents expressed a guarded hope when they said that spending money might have cured the ill people. They expressed frequent worries that can be correlated with the increased stress due to disintegration of joint families and loss of traditional values because of rapid urbanisation, which does not necessarily reduce poverty. Profound commoditisation of daily life has led to increased material desires among the rural people of Kakabo. Micro credit is assumed to have reduced vulnerability by increasing income generation (Chowdhury 2002); but in Kakabo, it seems that it has also become a source of constant worry. One self-reporting patient of *chinta rog* and *kheali bhab*, told us that she and many other women like her worried about their future and their families, mostly because they were in debt and had to continually worry about repaying the loans.

Finally, we should note that, contrary to our urban preconceptions, the Kakabo villagers do not believe in supernatural causation of mental illnesses alone. They also attribute importance to individual choices, life styles and the nature of associated life events. It seems modernity is slowly creeping into this village.

The gender question

We have seen a significant difference between the perceptions of women and men. Men spoke elaborately on *nesha paani*, while women were mostly preoccupied with *chinta rog, kheali bhab* etc. It seems that men tend to take up *nesha paani* to deal with their emotional pain and are more affected by it than women are. It brings to mind the question of greater mobility and financial capacity of men compared to women, a possible reason why men have more access to such addictive substances. Women, however, seem more prone to distress and worry for which there is no relief other than talking among each other or taking occasional help from the *kabiraj* or *fakir*.

Traditional healing works

There is need for more research to explore the role and efficacy of traditional healing in 'mental illness' and to assess the need for mental health interventions, e.g., anti-epileptic drug for *mirgi rog*, psychotropic medications for the *pagal* and detoxification services for those who are habituated to *nesha-paani*. For example, the common condition of *bhut dhora* is believed to be curable and most traditional healers seem apt to identify and treat such conditions. In many cultures spiritual healing has been found to be more effective for such conditions because the healers explained the treatments in familiar terms, mobilised social support, took into account the core values, and comforted both the patients and their families. However, with the exception of *bhut dhora,* the Kakabo villagers keep their mental illnesses to themselves and their families. It is obvious that although the Kakabo villagers felt the need to seek treatment for their physical illnesses, they were not keen to do so for the 'other kind' of illnesses. The nearby Savar Ganashasthya University has a practising psychiatrist and the nearby capital city of Dhaka has three hospitals with tertiary mental health care facilities. Yet it is surprising that the villagers we talked to had never heard of a 'psychiatrist' and they categorised illnesses as various local conditions of 'the other kind', or as the 'not physical kind' - rather than putting them all under one category of 'mental illness'. In that case, the question remains whether there is a perceived need for 'mental health care' in Kakabo.

Life has a place for everyone

The attitudes and narratives from the villagers illustrate a broad level of social acceptance of the 'mentally' ill. People like Ainal have their social space among men and women. Villagers are not very secretive or ashamed of the 'mentally' ill among them. Marginalising the sick is not evident, and certain forms of substance abuse are accepted or condoned. Centuries of living as a community may have made people believe in an inclusive world-view, they do not always seem prone to reducing people to their functional status alone. Is it because the villagers expect little from life, and are satisfied with less? Many hold fast to their spiritual beliefs that God created all and that life has a place for everyone.

Concluding remarks

We have explored the 'mental' illness perceptions in this village. The emerging patterns illustrate there is a hidden body of knowledge that needs further investigation. Not much is known and little effort has been made to incorporate indigenous knowledge with the existing body of knowledge of mental health in Bangladesh. There is a paucity of studies on this particular research topic, and we believe that even this small-scale study can point towards a direction for future wide-scale investigations and intervention research in mental health.

Coping with ill health

Physical disability

Ilias Mahmud & Ramiro Llanque

This chapter explores the emic views of physical disability in Kakabo to identify the beliefs and attitudes of the villagers, perceived causes of the disability, available treatments and the consequences of disability on the individual, family and the community. The study explored the understanding of the community about its role and the government's responsibilities for the welfare of the disabled people.

Data were collected with a triangulation of strategies including individual in-depth interviews, FGDs, and observation. Nine men and six women participated in the FGDs. One woman, two adult men, a disabled elderly man and a family with a disabled child were interviewed. The men and women in this study were married and aged between twenty-five to fifty years. Most of them had never received any formal schooling. Only a few had been to school and completed primary level education. Men were farmers except one who was a bicycle mechanic. Women were homemakers. One woman was also a traditional birth attendant with no formal training. Parallel to the FGDs and interviews, we continued with observations in the community: if disabled people were visible, and the presence or absence of facilities for the disabled people in public places, e.g., health centre, mosques, local markets etc. and the attitude of the community towards disability.

The disabled in the village

We will take the readers through two stories of disabled people in this village in order to give a sense of the experience of being disabled and the effect of disabilities on families. Abir's story will elaborate the experiences of a family with a disabled child. Jamir's story will spell out the consequences of his own disability.

The disabled child and his family

Abir is eight years old and cannot speak clearly. He only makes certain sounds. During our visit, he was drooling excessively. He soiled his hands while eating. There was rice was on his hands and all over his face. He could not walk on his feet. He had to drag himself to move from one place to another. He is a child with cerebral palsy.

His parents and two sisters were living with him in a mud-walled, tin-shade house. His father is an agricultural labourer and does not earn enough to cover the family expenses and Abir's treatment. The family is desperately seeking for ways to cure Abir. They took him to the *fakir*, *kabiraj*, medical doctors and therapists, but they did not find a cure. In the end, they stopped the medical treatment and prayed for a miracle by seeking help from *fakirs*. The parents blamed each other for lack of care and discontinuation of therapy.

Villagers have sympathy for the family but they also tease the family during any kind of dispute. They try to avoid the boy because they consider him 'dirty'. They think that the family has to accept and bear with this condition. They believe that it is because of some past misdeeds by the parents that God has punished them with such a child. When we were leaving Abir's house, the father asked us why there was no drug or injection to cure his child. We had no answer to that

An old and lonely disabled man

Jamir Uddin cannot tell his exact age but he thinks that he is in his mid seventies. He wears thick glasses. He used to work on someone else's land as a day labourer. Many years back he got an infection in his left foot. He did not seek medical treatment because he could not afford it. He was also very confident about the effectiveness of traditional medicine. He received treatments from *kabiraj* and *fakirs*, but nothing worked. Last year he went to a public hospital where his left leg was amputated below knee to stop the spread of infection. He and his wife strongly believe that because of *chokh laga*[71], his infection did not improve. Now he uses old metal crutches to walk.

Even with the infected foot, he used to work hard to feed his children. Now, his three daughters are living with their husbands in other villages and his three sons are living separately near his house. His children cannot help him since they are also struggling to support their own families. He lives with his wife, an aging woman with her own sufferings. His bamboo made house is very small and messy. Tree branches keep falling down in their yard. The old couple have no strength to clean up the yard regularly.

A narrow path connects the house to the nearest shop. Jamir Uddin finds his only joy here, watching television and talking to people. Lately, he has become dependant on his wife for almost everything, even bathing, urination and defecation. He fell dawn many times on the narrow path trying to collect water or going to the shop. He cannot participate in any social activities because he does not have any money. Furthermore, it is difficult for him to walk some distance on his own. Villagers are friendly to him and feel sorry for him, but they have no idea how to help him. These days Jamir Uddin prays to God so that he can die and escape from his extreme suffering.

In these two case studies, we see how disability has significantly influenced the lives of common people, both young and old, and their families.

The village

Most of the houses in this village are made of mud with a tin roof, very few are brick built. The paths connecting the households are narrow, muddy and become very slippery during the monsoon. The homesteads are usually situated on high ground, making things doubly difficult for the disabled people to move from one place to another. Public structures e.g., mosques, schools, and shops are built without any consideration for the access needs of disabled people. Even the local government health centre does not have a ramp and the entrance steps are very high.

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71 *chokh laga*= evil eye; common belief is that an enemy (or a jealous neighbour) is believed to have cast an evil glance to cause harm or disability.

Perceived meaning of disability

When we asked the villagers about their definition of disability, the bicycle mechanic said,

> They [the disabled] have problems in their legs, hands and face…they have a *khut*[72] in their body.

The rest of the respondents also identified disability as a physical impairment. Few related disability with the inability to perform everyday activities. They considered the disabled people as different from the rest. Karim said, "Disabled people are not like us". The terminologies that they used to identify disabled people signified that they were either deficient in one or both limbs (*Langra, Khora, Atur, Pongu, Lula, Nula)* or weak (*Atur*) and useless (*Ochol*). Disabled children were identified as fools and lazy bones (*Habagoba, Labra* etc.). Almost all respondents tried to deny the presence of a disabled person in their community. They said,

> Actually, we do not have any disabled people in our village. Those who are disabled, come from outside.

Perceived causes of disability

The respondents mentioned a variety of causes for disabilities. Everybody mentioned supernatural causes, such as, *batash laga, chokh laga, asar*, *chorai dhora*[73], and *atonker batash*. A man during the FGD mentioned,"*Batash laga* is the prime cause of disability". The rest of the group unanimously supported his statement. Most respondents, especially the women mentioned supernatural causes during pregnancy to explain disability in children. A thirty-five -year-old homemaker said during an FGD:

> Tuesday and Saturday the *jinns* always move around with air. We like to eat fish with eggs inside and the *jinns* are similar. They also like pregnant women because they think these women have their eggs inside. That is why they practise *Asar* on pregnant women and eventually harm the child.

The respondents, both male and female also related disability with immorality, such as, inappropriate sexual behaviour, cruelty and other *khaslot*[74]. Regarding inappropriate sexual behaviour they mentioned extramarital sex, *swapna dosh*[75], uttering slang during intercourse, having sex in the evening and during pregnancy. In this regard, Helal said, "If the father or mother has had extramarital sex, their child will be disabled." Cruelty and misdeeds to them meant quarrelsome behaviour, betrayal and cheating. According to them, such behaviours could result in a curse by the victims so that God might punish the perpetrators by causing disability to them or to their children. Karim said,

> If I commit a sin, my children will definitely suffer…as this is the most horrible punishment. Allah said if you commit any crime, you would be punished.

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72 *Khut* is a defect, flaw or blemish.

73 *Chorai dhora* means that the devil has got hold of someone.

74 *Khaslot* here refers to misdeeds which are part of someone's own nature.

75 *Swapna dosh* usually refers to night soiling. They also used this term to mean masturbation.

In this context Rashida added,

> Near to our house there is a woman…she was cruel to her father- in- law. One day the father-in-law became very angry and cursed her…The following day she became *Lula*.

Astrological influences were also identified as a cause of disability. Men in the focus group discussion mentioned the influence of the planets and stars on disability. Women referred to lunar eclipses that affected the pregnant women. They said, "During the lunar eclipse if the pregnant woman lies down on her bed, her child will be *Nula*."

Poverty was often blamed for disability. Respondents said that a person might become disabled if he/she did excessive physical work (e.g., they said, "If anybody works very hard, he may become *Pongu*"), if the mother or the child suffers from malnutrition and lack of treatment. Rasida mentioned,

> If the pregnant woman eats too little, the child's head become big. It might create problem during delivery and the child may become *Lula*.

All women related disability with pregnancy and delivery care. They referred to the child's positioning in the mother's womb and to poor delivery care. The women in the FGD said, "If the child stays in a wrong position in the mother's womb, the child would be born as a *Nula*". The TBA mentioned,

> If during delivery the child touches the anus then he/she may become *Nula*. During delivery, it is necessary to press away the anus….if the birth attendant is not competent; the child may receive some injury and become *Nula*.

The villagers perception of what caused disability was dominated by traditional beliefs, such as, supernatural, spiritual, astrological factors and moral concerns. Few also mentioned accidents and diseases as the cause of disability, but with a traditional interpretation:

> If the child suffers from a fever, he gets convulsion. Because of repeated convulsions, the child may die or become *Nula*. This might be because at that time, excessive blood goes to its head.

Differences were noted in the responses of men and women. Men mostly mentioned about sexual causes such as extramarital sex, masturbation, time of having intercourse and using slang during intercourse; while the women talked about pregnancy and delivery related factors. However, both the groups equally emphasised supernatural causes. If adults suffer from disability, they are held responsible for their misfortune and disability. If children suffer from any kind of disability the villagers believe that the parents are to blame.

Perceived treatment of disabilities

The villagers mostly rely on indigenous herbs and spiritual treatments for disabilities, and they seek help from the medical doctors as well. As with many other conditions, medical pluralism exists in this case. Rafique said,

> We often use traditional herbs to treat disabled persons. *Tel pora*[76], *jhara*, body massage with special oil and *tabij*[77] given by a *fakir* is the treatment for this type of problem. We also go to the doctor. If the cause of disability is *Atonker Batash,* the person will not be cured with medical treatment. A *fakir*'s treatment will be more effective for him.

Villagers have more confidence in indigenous herbs and spiritual treatments than in biomedicine. Rafique expressed his doubt about the outcome of biomedical treatments. He said, "I did not find anyone with disability got cured". Some of them mentioned that even though some kinds of disabilities were treatable, affected people still had residual problems, e.g, difficulty in walking. None of the respondents said anything about the possibility of rehabilitating the disabled.

Perceived consequences of disability

Respondents named a wide range of consequences of disability that affected the individuals and their families, but none of them mentioned any social consequences for the community. They told us that disabled people become dependent on their families. They are a burden because they cannot earn an income. Furthermore, taking care of them involves high economic costs. Often no one is available to assist them. Losing an income and/or bearing the expenses of a disabled member may create poverty for the whole family. This may lead to the deprivation of basic rights, e.g., education and health of the other members. This view was clearly supported by Rafique. He said, "Their [disabled persons'] children cannot receive education and treatment if they are sick because of financial problems."

Disabled people are also stigmatised and discriminated by the larger society. The villagers show little respect and gradually become indifferent to them. Very often, they are able to earn nothing but sympathy from others. That is why Helal said, "The family suffers a lot as they have to take care of the person. It is not possible to throw him/her away." Stigmatisation, discrimination and indifference are also reflected in the views expressed by a woman about a disabled man in a focus group discussion:

> He (the disabled person) is dirty. It is very difficult to keep this type of person clean. Nobody likes a dirty person. Sometimes he drags his feet and comes to our house. We get disturbed about this. We know that we should not neglect him but we also do not like him…If somebody comes to your house you cannot chase him away but we try to avoid him as much as possible.

People often tease the disabled person and his/her family. Disabled persons also face problems in marriage and if the person is a woman, it is extremely difficult, if not impossible, to arrange a marriage for her. Even if it is possible, it often involves a huge amount of dowry.

Facing all these adversities disabled persons and their families often get frustrated and even desire death! A desperate claim of a disabled person we interviewed shows the extreme frustration and anxiety that disability can cause. He said, "I pray to God: please do not give me these extreme sufferings, rather take me away."

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76 *Tel pora* is the ritual of preparing enchanted oil, to keep the evil spirits away.

77 *Tabij* is an amulet to keep the evil spirits at bay.

In contrast, some opinions were favourable to the disabled. For example, the women in the focus group mentioned that the presence of a disabled person could bring fortune to the family and that his/her absence could represent a disaster. One woman cited an example and said, "The family was well-off when she (a disabled child) was with the family. After her death the family became very poor".

Perceived role of the community

Most respondents believed that the community should help disabled people. In most cases, they said that the community could play a big role but did not specify the nature of that 'big' role. Some mentioned that they should provide money and food to the disabled person. If possible, in some cases, they should also take care of them, especially if the disabled person has no family. Men in the focus group discussion came up with the concept of more sustainable help. They said,

> Nobody is going to feed him/her for his/her whole life. It is better to arrange something so that he/she can earn his/her livelihood.

There is also a belief that if someone helps a disabled person, a reward for doing so awaits the helper after death. A woman said, "If I help them [the disabled] I will be rewarded by God." But another woman expressed her indifference with adults who, according to her belief, had disability due to their own action. She said,

> If a child suffers from disability we should help him/her as it is not his/her fault. But if the *Lula* becomes a *Lula* because of his/her misdeeds we should not help him/her. We should let him/her suffer.

This clearly indicates how beliefs about the causes of disability might influence the attitudes towards a disabled person.

Perceived responsibilities of the government

Some villagers believed:

> The government is even unable to look after the normal people [non disabled]! It is not possible for Government to help all of them [disabled] even if they want to do so.

At the same time, the men insisted in the focus group discussion that despite the resource constraints, the government should do something about it. They expected that the government should help the disabled by providing education, treatment, as well as, financial support. One of them emphasised the need for ensuring treatment at the doorstep. He said,

> Think about polio vaccination. I need not to go anywhere to vaccinate my child. They bring this to my doorstep. That is how we were able to vaccinate our child. Otherwise, it would not have been possible for a person like me to vaccinate my children. Similar things need to be done for the disabled people.

Discussion

Disability results from social and other disadvantages imposed by the society on the people with physical impairments (Oliver 1990 as cited by Helman 2001: 23-24). Perhaps it is because there is no rehabilitation facilities that the villagers have seen generation after generation of the physically impaired lose their ability to work. Often this is because of the inability to bear the costs in order to shape the environment to cater for the needs of the disabled. This allows a person with impairment to gradually become disabled. That is why impairment has become a synonym for disability in this community. This belief is so deeply rooted that even a person with a physical impairment himself could not believe that he could be independent in everyday activities.

The villagers relate a variety of causes to disability, but traditional beliefs, such as, supernatural, spiritual, astrological and moral concerns dominate over the physical and other causes. Traditional beliefs are embedded in daily life. People mainly rely on these beliefs for the interpretation of the causes of the disability. To the villagers disability is more than a specific clustering of symptoms and physical signs. It also has a range of symbolic meanings such as moral, spiritual and social (Helman 2001: 25). Sufferings of disabled people can be linked to changes in the natural environment or to supernatural forces.

There were differences between the explanations of women and men. Women associated the causes of disability to reproductive conditions, while men to sexual behaviour. Since the role of women and most of their responsibilities, especially in rural areas, are framed within the bounds of their reproductive functions, this may explain why most of the causes for disability in children mentioned by women were related to the pregnancy and delivery period. In traditional Bangladeshi Muslim families, most women stay at home and are in charge of taking care of the infants and children in the family.

People suffering from any illness usually have a number of ways to help themselves or seek help from others. This includes resting, taking a home remedy, asking advice from others, consulting a local holy man, a traditional healer or a doctor. Treatment seeking of these villagers seems to be influenced by their notions about what caused disability. If the causes are perceived to be supernatural they tend to rely on *fakirs* for spiritual treatment and *kabiraj* for herbal treatment. Sometimes they also consult a medical doctor. Yet, one may question why they would seek help from biomedicine? This may be because they are desperate to find a cure, and that is why they would try every possible solution. The villagers are pro-active, rational decision makers. They choose a method of treatment from a range of alternatives sources, depending on their knowledge, resources and other relevant factors. The villagers do not usually seek help for rehabilitation of a disabled member; they look only for a cure.

Perceived causes of disability also seem to influence the consequences of disabilities. When the cause is attached to a stigma, the disabled person's life also becomes stigmatised. This may be the reason that the community wishes to deny the presence of disabled people because their presence may stigmatize the whole community. The disabled people lose their identity and these words (*pongu, lula, langra, atur* etc.) are used to address them instead of their names.

Even though the villagers express sympathy for the disabled people, in many cases they try to avoid any responsibility by saying that they should encourage the 'community' to help the disabled people. But who is this community that they talk about? They describe community as if it were another entity, independent of them, of individual responsibilities. This makes the community looks like a passive actor comprising of members who shun responsibilities and look away from the problem by thinking it comes from outside.

People also have a deep-rooted assumption that disabled people are unable to earn their livelihood and will always be dependent on others for their survival. That is why they emphasised on curing physical impairment and if that is not possible, financial support. They hope that the government will take these responsibilities although they are doubtful about this. Impairment automatically assumes the meaning of disability to them.

Coping with ill health

Health problems of older people

Geoffrey Mabuba & Tanvir Ahmed

In this chapter, we shall explore the community perceptions of older people, their health, the illnesses they suffer from as well as their health care seeking behaviour and barriers. We conducted two FGDs, four in-depth interviews and several informal conversations with the people in the village. One of the challenges of the interviews was to determine the age of the interviewees. For this, we used an event calendar with dates such as the liberation war of Bangladesh, the language movement in the fifties, or the partition of the sub-continent etc. During the FGDs and in-depth interviews, we asked the respondents to do free listing and severity ranking of the commonly occurring illnesses among older people.

Five men from different occupations and six women (all homemakers) participated in a FGD. We interviewed a seventy-six-year-old man who had completed secondary school. He was living with his wife, five children, sons, daughters-in-law and grandchildren. We also interviewed one of his daughters-in-law. Another interviewee was a sixty -year-old woman who did not have any formal education. She had seven children and was currently living with one of her daughters, grandson and daughters-in-law. We talked to one of her daughters-in-law. All these interviewees considered themselves relatively well off. We also interviewed others who considered themselves poor. Among them were a sixty-year-old man without formal education with four children, who was living with his son and his twenty-four-year-old daughter-in-law; and a sixty-year-old woman without formal education, and with six children. She was currently living with one of her sons. We also interviewed her thirty five-year-old son.

Definitions of old age and older people

The community defined old age and older people from two perspectives: according to age and according to appearance. They produced different definitions with regard to both aspects. People also tried to define older people according to their position in the society focusing on the societal context. There was another, gender-based definition. People defined an older female according to the number of children she had. They also tried to relate the definition of older people with religion. Clearly, the community had their own categories of older people.

When people defined old age and older people according to their age, the onset varied from forty to seventy years. When they chose appearance as criterion for old age, people focused on either the physical attributes or the social position of the older person in the community. Then again, the community perceived the physical attributes in two ways, e.g, bodily changes and changes in behaviour. Physical attributes of an older person according to the community are: a) bodily changes, and b) changes in behaviour.

An older person gradually encounters these bodily changes in the course of time. Usually people referred to the young age as a scale to compare the changes in old age and pointed out the contrasts. These changes included grey hair, reduced or loss of mobility, wrinkles and loose skin, deepening of the cheek, reduced strength resulting in weakness, laziness, loss of eyesight and hearing, loss of facial glamour, loss of teeth, altered accent of speech, forgetfulness, soiling of cloth by urination or defecation, walking with a stick or leaning forward etc.

Changes in behaviour are the phenomena described by people as part of family or social interactions in everyday life. These include repetition of words, behaving like a child, lack of judgement, increased complaints, inflexibility, stubbornness, impatience, leaving the responsibilities to the daughters-in-law etc. The sixty-year-old poor woman said,

> I do not know why an old person keeps on repeating the same word, but it is true that they repeat the words… They lose their consistency. They become inflexible and stubborn, like a child.

All these characteristics were not always considered present in old age. Respondents were quite aware of the presence of some characteristics, particularly the bodily changes, which according to them, might or might not be related to old age (such as, grey hair, walking with a stick, loss of teeth, loss of strength etc.).

Position of the older person in the community

Some respondents defined an older person by his or her social context. To them the term 'older' refers to a title expressing honour and responsibilities, an older person is someone to be respected. The older rich man informed us that, "In a community, the oldest person is called the elder." Some defined an older person according to how 'familiar' he or she was to the community:

> …We call a person old from our social interactions. There is no particular method or any grammar to call someone old. If we know the person long enough and he is well known, he might be an older person. Just age does not make someone older. (A male respondent in the FGD)

Gender bias

The variation in defining old age and older people in terms of gender was evident. The age varied from as high as forty-five years to as low as twenty in case of females, whereas for the males the variation described was much less, between forty to seventy years:

> There are different ages for men and women to become old. A woman becomes old when her age is around forty to forty-five years, while a man gets old when he is at or above sixty. (A male respondent during the FGD)

> …*'Kurite buri'* - the women start growing old at the age of twenty… those who do not grow old after twenty usually deviate from the path of religion. They are known

> as *Dauss*. No matter what happens, even the *Dauss* women lose all their power and strength after forty. 'Good' women get old at the age of twenty and in case of *Dauss* it is forty. Only thing left after that age (of forty) is their tongue, their language. (The sixty-year-old man who considered himself poor)

A poor, older woman expressed a contrasting view. She emphasised that there was no gender difference in terms of age.

Definition of the older people and number of children in case of women

In case of women, one interesting observation was that the number of children was taken into account to define old age:

> I do not know whether they are old or not but all of them are having three or more children…A group of older people of different ages are those who have so many children…All of them must be elderly (The sixty-year-old woman who considered herself rich)

> …In case of women, the number of children they have is important. (The sixty-year-old woman who considered herself poor)

Definition of older people and religion

There is yet another perception available and that is how respondents linked the definition of old age to religion. The sixty-year-old rich woman in the interview said:

> Old is the person who is at the end of his/her life, someone who is supposed to be abiding by the religious norms, saying his/her prayers and remaining faithful to Allah.

Older people and their categories

Our respondents evidently had their own categories of older people. Some of these categories were based on the ability to work (mobility) along with the degree of assistance needed as well as verbal expressions. The categories were:

Category A (according to working ability and mobility)

1. Those who can work properly and are fully mobile
2. Those who can only perform moderate work and are moderately mobile
3. Those who cannot move or work: These people are regarded to have reached the stage where death is just a matter of time.

Category B (according to age and need for assistance)

1. Older persons: They are considered to be just above fifty to sixty years who can somewhat help themselves.
2. Very old persons: They are considered to be above eighty years and are mostly confined to bed. These people need constant assistance.

Category C (according to the verbal expressions)

1. Expressive: Those who describe themselves as old people
2. Non-expressive: Those who do not describe themselves as old people

Perceived definition of elderly health in the community

The community perception about elderly health was found to be somewhat similar among the people except for one or two variations. They defined elderly health in terms of *tagod* (strength). To them, *tagod* is the ability of a person to work or to be mobile. They think that an older person having *tagod* enjoys good health. They consider young age as a scale to compare the present status of an elderly man:

> This *tagod* has a good connection with the body. There are materials in the body like calcium, vitamin that deplete in the course of time and age. This results in loss of strength and the person becomes weaker. (The seventy-six-year-old rich man)

An interesting finding was the contrasting perception of *tagod* between the rich and poor group. The rich group thinks that the reason for losing *tagod* is none other than the decaying process of the human body whereas the poor group's perception is linked with lack of food. For them lack of a balanced diet is the major reason for losing strength.

Another interesting finding was the difference in the perception of *tagod* between men and women. From the abovementioned findings, it is clear that men mean by *tagod* the ability to work or move. Women have a different perception. In addition to the ability to work or move, by *tagod* they also refer to the sense of humour and appreciation of beauty that they had during their young age:

> An older woman who has a sense of humour (*rang*) and a *kashma* (firm) figure is called a healthy person. It is all due to *tagod*, just as we had it when we were young. (The sixty -year-old rich woman)

Relating elderly health to strength was a clear indication of the degree of involvement of an older person in the society. According to them, one has to work and move to live in the society. Any condition preventing someone from doing so is therefore regarded an effect of ageing. Many respondents defined health as the ability to work freely. The contrast between the rich and poor group was remarkable but not surprising. The rich wants to live free of anxiety. On the other hand, the poor have little qualms about their willingness to work hard even in an advanced age, as they still

feel competent enough to challenge the young. They worry about the lack of food. According to them, adequate nutrition is the only way to enjoy a healthy elderly life.

Perception of the common illnesses

Definition of illnesses

Most respondents shared the same perception about the definition of illnesses. The FGDs and the in-depth interviews revealed that the community takes illnesses in old age for granted. The social adaptation to illnesses and old age leads to the perception that an old person is supposed to suffer. There was, however, some variation in the explanation of what caused the illnesses. At this point respondents came up with different ideas, such as, the *heat* theory and *blood* theory.

With the *heat* theory, they explain that in old age people lose heat, a major factor in the causation of illnesses. The *blood* theory is mainly focused on the gradual decrease in the volume of blood in the course of time and age; as a result the natural defence against illness is somewhat lowered. On further probing, we found that both theories were connected to the gradual loss of strength.

Another important finding regarding the definition of older people's illness by close kin was the link between behaviour and illness:

> She says many things when she feels sick. She calls for Allah and her parents. Sometimes we neglect her illnesses as she talks too much. (Daughter-in-law of the rich older woman)

Categories of common illnesses

Our respondents had their own list of common illnesses:

Type 1 : Related to breathing [*Hapani*[78], Difficulty in breathing, Cough, Sneeze, TB]

Type 2 : Related to digestion and defecation [Lack of strength of digestion, Diarrhoea, Dysentery, *Gastik* (Gastritis like illness), Stomach ache]

Type 3 : Pain [Pain in the back, Pain in the whole body, *Baat* (arthritis)]

Type 4 : General [Poor eyesight, *Chhani*[79] (cataract), Lack of hearing, Spinning of the head, Headache, Loss of appetite, Lack of memories]

Type 5 : Fever (*jor*)

Type 6 : Jaundice (*jondis*)

Type 7 : Heart disease

78 *Hapani* usually refers to Asthma or simply difficulty in breathing.

79 *Chhani* refers to cataract

An interesting finding about the common illnesses involves diabetes and *presar*[80]. Almost all respondents were aware of the fact that these two diseases might occur at any age. In addition to this, they mentioned that these diseases increased the suffering of the older people. These two diseases were also perceived to be related to income and lifestyle:

> Those whose lifestyle or way of earning is not approved by the religion, will definitely get diabetes and *presar*. (The sixty -year-old poor man)

Ranking of the common illnesses according to severity

Almost all respondents varied in their response while ranking the illnesses. The idea was to rank the illnesses according to the amount of attention each should receive from the community. But people ranked according to their own perception, whether or not they had any direct experience of the illness themselves or among close kin. Severity varied according to individual and family experience. The community ranking provided by the respondents is as follows:

Rank 1: Most serious. Many of the respondents mentioned breathing illnesses such as *'hapani'*, cough and difficulties in breathing.

Rank 2: Moderately serious. In this group, people mentioned illnesses related to digestion and defecation such as *'gastik'*, abdominal pain, diarrhoea and dysentery.

Rank 3: Least serious. This is all about pain, whether it is in the whole body or a headache. Many of them also mentioned *baat*.

An interesting interpretation of severity came from a close kin of one of the respondents. She said, "Any disease that confines an older person to bed is serious."

Health care seeking behaviour

The health care seeking behaviour of the older people can be described in two steps:

Step 1: Waiting

All respondents stated that there was a waiting time for every illness. In most cases, people waited for a spontaneous cure. The length of the waiting time depended on the severity of the illness. The idea of severity was linked to how bearable the condition was. It also varied according to the perception of close kin and community, and sometimes resulted in negligence of the health conditions because of ignorance. In addition to this, financial ability of older people or their kin also contributes to the length of the waiting time. A common practice is to take medicines (biomedical or herbal) during this period. One older woman said,

80 *Presar* usually means hypertension or a fluctuation in blood pressure.

> I wait because of the lack of financial support and my children's negligence. Sometimes I keep waiting until it is severe. May be one day I will die like this. (The sixty -year-old poor woman)

Step 2: Perceptions of illness and preference

Important, with regard to health care seeking is people's own categorisation of treatments:

> Category A: Herbalist or spiritual healers are usually consulted to treat certain illnesses, such as, jaundice, fever, *batash laga*, *dor khawa*[81], *jinish* such as *pori* or *petni*[82].
>
> Category B: Medical doctors are consulted to treat certain other illnesses except the abovementioned ones.

Barriers to health seeking

Nearly every respondent stated that ignorance and negligence, lack of money, and a communication gap with the doctor are barriers to health care seeking. In addition, the lack of efficacy of medicines, biomedicine or herbal, in old age also discouraged people from seeking help. Finally, barriers may arise because of the individual's dependence on his/her family:

> If he has monetary freedom and power, he can look after himself. Otherwise, he has to depend on his children and their financial capacity. If they do not take it seriously, he is left to the mercy of God. The health care seeking in illnesses is dependant on either the individual abilities of the old man or the abilities of his children. The abilities of the children are their patience and attention towards the elderly and their financial capacity. (The sixty -year-old poor man)

Discussion

It is evident that the calendar age of an older person hardly mattered to the community and the definition of old age and older people was based on their involvement and contribution to the society. While the UN and the rest of the world tend to define older people on the basis of a particular cut off age, for example people over sixty (WHO 2007), the Kakabo community categorises older people by taking into account social criteria.

Studies have suggested that 'old age' and 'ill-health' are often inseparable entities in the community, even in developed countries (Biswas et al. 2006), but this study illustrate a slightly different scenario. In this community, people perceive 'ill-health' and 'illness' as inseparable entities, whereas in 'old age', the only thing they are concerned about is their *tagod*, which is directly related to elderly health. Obviously, *tagod* in their culture is the ability to work, which is an expression of the quality of a person's social existence.

81 *Dor khawa* refers to sudden fright (*dor*).

82 *Jinish, e.g. petni* as an evil spirit (female).

Health care seeking and its barriers have a complicated relationship. Financial constrains, ignorance, negligence, and perceptions of illness are major barriers to health seeking in the village, as they are in other parts of Bangladesh (Biswas et al. 2006). In rural Bangladesh, kinship also has major impact on elderly health (Rahman, Menken & Kuhn 2004). These barriers are also linked with literacy, poverty and government policy.

The results from our short study indicate that the definition of older people and old age lies in the community and that it is not always the age that makes a person old. There are many barriers to health care seeking, but financial constraint is the strongest. Our exploration provides us with enough insight to conclude that it is time to consider the health problems of older people from the community perspective. Further study will however be necessary.

Coping with ill health

Smoking

Dauod Khuram & Mejbah Uddin Bhuiyan

This chapter explores the prevailing smoking perceptions and practices in the village of Kakabo. Observation of smoking behaviour, FGDs and in-depth interviews were conducted. The timeline method was used in FGDs to explore and compare the time utilisation of smokers and non-smokers. The respondents included men who never smoked, currently smoked and those who gave up smoking as well as a few non-smoking women. In total, fifteen men and five women participated in our study. Men were aged from thirteen to thirty-five years and only one was older than that. Most of the women were middle aged ranging from thirty-five to sixty years. Eight men were smokers and only one was a former smoker. The rest of them had never smoked. Nine of our respondents did not attend school. Only seven completed secondary schooling.

Perceived factors that influenced people to smoke

Availability of tobacco, limited opportunity for productivity

Every adult man we came across, without exception, complained that a job was hard to get and one had to go too far away to get one. Being poor and unemployed, most of the adult men felt social pressure to earn a livelihood and expressed deep insecurity about their future. Their perception was that this insecurity might have led them to start smoking in most cases:

> In our village, the main reason for smoking so many cigarettes is unemployment. If there were employment, if people would have been busy with work, there would be no tension, no problem in their minds. It is to get rid of these problems and tension they usually start smoking. (Twenty-eight-year-old smoker)

Another common reason mentioned by all respondents for choosing this habit was the availability of tobacco products and of course affordability as well. Although most respondents (smoker) came from poor families, the price of the cigarettes and the locally made *bidi* was so cheap that anyone could afford at least one brand. Badol, a twenty-eight-year-old man, said, "A single piece of *Scissor* cigarette costs only one taka twenty-five paisa (about two cents) whereas you can buy a whole pack of *bidis*, consisting ten pieces, with only three taka (about five cents). How can you prevent smoking even if you want to?"

During an FGD, the non-smoking group also considered this unemployment issue as one of the major factors behind smoking. However, they had different perceptions about the availability factor. One of the respondents named Saiful argued, "Whoever develops this habit will go and get it wherever it is and whatever the cost is."

Most respondents also highlighted the role of the marketing policy of cigarette manufacturing companies. We observed that each roadside tea stall or shop had at least four to five types of cigarettes. Shopkeepers stated that the cigarette companies regularly supplied them with these products. Zahid, a shopkeeper, informed us that when a shopkeeper sold the highest number of cigarettes in a particular location, the company would award him with cash. Cigarette manufacturing companies are successful through such marketing policies, and thus they make cigarettes widely available.

When time stands heavy

During the FGDs with both the smoking and the non-smoking group, we gave them an exercise to draw a timeline. By comparing these two timelines we observed that the smokers were blessed with abundant leisure time throughout the day. They could roam around, gossip, and pass idle time sitting and chatting in tea stalls. At every step, they were exposed to smoking. Whereas the non-smokers' timeline showed how busy they were, with study or work. They had no time to sit in the tea stall or gossip. The only time they had was in the afternoon and they spent it by playing in the field. It was obvious from the timelines that productive timing and having less leisure time (although none of the respondents mentioned this) played a vital role in preventing a smoking habit.

A friend in need is a friend indeed

We were cycling slowly and observing the surroundings while heading towards Badol's tea stall where we planned to conduct a FGD. Reaching there, we found that everybody was looking at Shihab. Shihab was taking his first puff of a cigarette in front of his peers. He was looking very curious. Badol was guiding him on how to smoke properly. After two to three trials, he succeeded. By the time we finished our FGD, we saw that Shihab had smoked two more cigarettes. While chatting with the respondents we came to know that Shihab was here because he had trouble with his family last night, and he came to his friend's house. His friend gave him shelter and within thirteen hours, taught him how to smoke.

Smokers and non-smokers both agreed that the most influential factor for smoking is peer pressure. All respondents (smokers) had their first puff of a cigarette from their friends. Even respondents who were non-smokers had smoked a cigarette once in similar situations. It is a matter of shame if someone who belongs to a smoking group is himself a non-smoker. The popular perception was that initially everybody started smoking because of the influence of friends as a hobby but after some time it became a habit:

> First, my friend offered it (the cigarette) and I took it as a hobby. Soon it became my habit. Some of my friends were providing me cigarettes free of cost during the first few days, and afterwards I started to purchase it myself. Now it has become such an addiction that unless I smoke, I do not feel good. (Karim, twenty-six-year-old smoker)

In some cases, a young man had to start smoking to stay within the same group of friends. It helped him shed his 'baby-boy' image. The smokers group said that the peers were not only involved in the "inauguration of the royal route of addiction" (i.e., smoking) but also to shift the practice to secondary addictions:

> After smoking cigarettes for a few years, I started to smoke *ganja*. My friends influenced me. First, my friends offered me a single puff of *ganja*. After having two to three puffs I felt that it tasted fine. Then slowly and steadily, I started to smoke *ganja* all the time. (Badol, twenty-eight-year-old smoker)

Peer pressure seems to be one of the most dominant causes for smoking. Most respondents who were smoking said that they developed the smoking habit under the influence of their friends while they were in their adolescence. Ehsan stated that his smoking friends were usually offering him cigarettes whenever he was meeting them. They were forcing him to have a taste by saying, "just take a puff!" They had been telling him repeatedly that it would not matter if he took one or two puffs. He felt that if he rejected their offer it would be a matter of shame. That is how slowly smoking turned into an addiction for him. Now he does not feel good without smoking and he smokes all the time. Respondents who were non-smokers, and aged between fifteen to nineteen years, admitted that they might also develop a smoking habit if they mixed with friends who were smokers:

> If I enter into a new friend's circle where most of them are smokers then I may also start smoking. I will never smoke unless I am under the influence of bad boys. I strongly believe that. (Khaled, eighteen-year-old non-smoker)

Learning from the family

Almost all respondents expressed the importance of the family in smoking. Khaled said, "In my childhood I lit up a cigarette for my grandfather and it tasted good". Khaled's father learned smoking from his grandfather, while his grandfather learned to smoke *hukka*[83] from his father many years back. He said that some fathers were still asking their children to light cigarettes for them. Most respondents stated that if the head of the family was smoking, other family members especially wives had to bear with his smoking behaviour. However, the wives did not approve and were annoyed whenever the head of family developed such addictions. Some of the women responded that those who were smoking rationalised their smoking habit by blaming their families and saying that they had not paid enough attention to their education and instead they were now encouraged to work far away from home to earn money. These men regretted working under tough conditions and started smoking because of various tensions.

Saiful, an HSC[84] student, said that if his family ever came to know that his friends were smokers they would become very angry. All the non-smokers strongly believed in the importance of family culture and norms to keep their members away from developing a smoking habit.

It was a common perception that most often children learn smoking by observing their older family members smoke or by participating in the process of smoking (e.g., lighting the cigarette) with their elders. Almost all smokers had at least one elder family member who had been smoking for a long time.

Social acceptance

We were waiting for our FGD respondents in the corner plot of the local primary school. A ten-year-

83 *Hukka* is locally made smoke-pipes (smoke if filtered through water).

84 HSC examination is equivalent to the high school diploma.

old boy was passing by with questioning eyes. He had four cigarettes in his right hand. We asked, "Whose cigarette is this?" He replied, "It is for my father." He also added, "It is my daily duty to bring him cigarettes in the afternoon." Thus, we came to realise that the family as well as the society might play an influencing factor for developing a smoking habit.

When we brought up the same issue with the respondents during the FGD, one of the respondents disregarded the fact of social influence and said, "Society has no control over the smoking habit". The respondents (smoker) also said that they had no specific choice of place for smoking. Badol was laughing when he told us, "We can smoke wherever we want". Badol also stated that when they were young, they used to hide the cigarettes from the sight of the elder people and that they followed the practice to this day. This was perhaps the only cultural taboo against smoking:

> If I am walking with cigarette in my hand and any elder happens to come the same way, I just hide it from his sight and continue smoking after he passes by. He never asks me why I am smoking. (Badol, twenty-eight-year-old smoker)

The non-smokers were more concerned with the impact on society. They stressed that it was the smokers who made the society disorganised with their activities. Khaled said, "They have to manage money for their addiction and that is why they become involved in illegal activities, which makes the society violent."

Both groups mentioned the lack of education in the village as another factor. During our fieldwork, we found a good number of teenagers sitting in the tea stall for two to three hours while some of them were smoking continuously. We wanted to know about the daily activities of non-smokers (most of them were busy with their study), to find out about their leisure time. As mentioned earlier, we found that the non-smokers had very little leisure time to roam about and gossip.

Perceived factors that influenced smokers to quit

Family factors

Family motivation is an essential factor for smokers to quit smoking. Each family puts some efforts into encouraging their family members to discontinue their smoking habit.

A father who could not quit

Khaled told us that people could quit smoking because of family pressure. If the parents become very strict with the children, it was not difficult for the children to quit. Moreover, he believed that wives could also put pressure on their husbands to quit. A non-smoking respondent who had smoker parents or elders stated that they did not feel good when their parents or elders smoked inside the room. They believed that smoking inside the house was the main reason for diseases, such as, common cold and cough, especially for children.

Khaled, an eighteen-year-old non-smoker, also told us that sometimes his mother rebuked his father when he smoked inside the house. But his father does not care because he is the head of the family and he thinks that everybody should just tolerate whatever he chooses to do. When Khaled's father began to suffer from excessive cough that was the right time for his mother to raise her voice against his smoking habit. Khaled said that her mother often used a sarcastic tone to reprimand the father:

'Khao aro khao. Moro. Tobuo cigarette chairo na. Jiboner moja niya nao (Please smoke more and more and die but do not give up your smoking and have the fun of life!)".

Khaled's father once gave up smoking because his wife motivated him, also because his elder brothers were non-smokers. It lasted only a few days and he started to smoke again to relieve tension and due to peer influence. Khaled cannot ask his father to quit smoking, as he is still young but he will do it, he says, when he grows up and takes responsibility for the family.

Young respondents think that some people may quit smoking when they get married and become intimate with their wives. Usually their wives do not like the smell that results from smoking and, therefore, the men quit smoking for a while after marriage:

> A man quits smoking for six months and then, when the honeymoon period is over he again starts smoking because of various pressures and tensions. (Jasim, twenty-eight -year-old smoker)

All respondents agreed that family pressure to quit smoking depended on the number and position of the family members who were smokers. If the head of the family is a smoker himself, then the family is more passive and just tries to encourage him to quit. Whereas if the smoker is a younger member of the family the parents and older siblings adopt a very strict approach.

Policy factors

Most respondents emphasised the role of government policies to curb smoking practices. Badol, despite being a smoker, thought that if the government could ban cigarette smoking it would help people to quit smoking, and thus people would be better off financially and psychologically. Saiful believed that if the government took necessary steps to ban cigarette smoking, the young generation would not be able to do it as freely. Zahid, a seventeen-year-old non-smoker, stated that, in order to control smoking and protect the young generation from smoking, the government should stop the production of cigarettes and provide job opportunities for those who are jobless. Most of the respondents we met told us that if the government made the cigarettes unavailable then people would not be able to access them.

Peer pressure

Some respondents believed that the influence of friends could also encourage smokers to quit. Mamun believed that if a smoker had friends among non-smokers, he could be encouraged by the non-smoking friends to quit smoking in order to keep the friendship going. He told us that he had a few friends who were smokers and they were advising him not to smoke cigarettes, to stay away from this poisonous habit. Khaled always preferred to have friends who were non-smokers. Sometimes his new friends offered him cigarettes. He refused strongly and later avoided them.

Physical perceptions

Mamun, a seventeen-year-old non-smoker, said with a smile in his face when we asked him about the factors that influenced one to quit smoking:

> I am watching my father smoke from my childhood. We, the other members of our family, are telling him to give up smoking for a long time, but he did not pay

> attention to us. Recently he has been suffering from breathing difficulties. The doctor advised him not to smoke any more if he wished to get better. Now he is thinking of quitting smoking.

Although they were smoking ten to twenty cigarettes a day, the smokers also wanted to quit. The main reason behind this was their health. Health problems were primarily problems for the smokers, according to the non-smoker group. When we asked the reason why they had never smoked, all of them replied with a single reason, i.e., to stay healthy. Smoker respondents were also aware of the disease burdens like cancer, black spots on the lungs, TB and other *jotil*[85] diseases because of smoking. The smokers who planned to give up smoking would do that only to be physically fit.

Perceived impact of smoking

Most respondents from the non-smoker group confidently stated that smoking was an antisocial act. Smoking to them was the first step towards developing other dangerous addictions. They believed that smoking might lead smokers to be involved in some illegal activities once they became addicted:

> To manage money for smoking and other addictions, smokers get involved with some unlawful activities. That is how they create chaos in the society. (Saiful, eighteen-year-old non-smoker)

Badol has been smoking for the last seventeen years and he spends a quarter of his daily income on smoking, and sometimes even more than that, when his friends come to meet him. Another young respondent from the smoking group did not consider the smoking expenditure as a big financial burden.

Almost all respondents agreed that smoking was bad for one's health. Murshid, eighteen-year-old non-smoker teenager, believed that while the smoke was getting into the body it could create problem and said, "Even on the packets of cigarettes it is written that smoking is injurious to health".

One of our young non-smoker respondents believed that smoking was not only harmful for the health of a smoker but also for the other family members who were inhaling cigarette smoke passively. Most respondents believed that smoking could lead to cancer, tuberculosis and heart problems, which sometimes made people quit smoking. They believed that smoking affected the physical and mental power of their body.

All respondents from the smoker group addressed the harmful effects of smoking on physical and mental health but at the same time, they were also saying that it was a habit for them, as drinking tea was for others. They did not feel good if they could not smoke cigarettes.

Discussion

Poverty, unemployment and marketing polices of cigarette manufacturing companies seem to be the major factors for promoting smoking habits among villagers. Teenagers who are not going to school,

85 *Joti*l means complicated.

those who also have a family member who smokes are especially susceptible to developing a smoking habit, as they have more free hours to spend which could lead them to mix with peers who are smoking already. Meanwhile, they are influenced by tensions resulting from poverty, unemployment and the clever marketing strategies of the cigarette companies.

A large majority of smokers emphasised that lack of entertainment alternatives led to smoking. This supports similar findings by Bancroft et al. (2003). We came across the same feeling among the people in Kakabo when they said, "Smoking is my only pleasure". They are used to smoking cigarettes that provided them relief from family stress, the tension of being jobless, unfulfilled dreams of life among other things. All these reflect on the unemployment problem in Bangladesh. This perception was most common among respondents who were jobless and were suffering from various tensions due to poverty and unemployment.

Our study also explored the importance of age in smoking. We observed that the smokers who were between twenty-five to more than fifty were the largest consumer group of *bidi,* cigarettes etc. Efroymson et al. (2000) reported similar findings: they found that the highest percentage of consumers belonged to the thirty-five to forty-nine year age group. However, it is also true that age makes people think about quitting smoking. Age seems to influence the cultural acceptability of smoking as well, especially because of the respected status of the elders. Respondents view it as more acceptable for older men to smoke. In contrast, smoking by young people is regarded as disrespectful to the elders. Thus, the smoking habits of young people are supposed to be hidden from the older members of the community. Younger people are viewed as being more likely to smoke because of the influence of peer pressure and to project a manly image. Bush et al. (2003) reported similar findings.

According to them, smoking by men in Bangladesh is accepted as a "normal part of their life." We found that a similar attitude was present in this rural setting. Men are the usual smokers in this society and smoking is an integral part of their lives, just like regular meals. New smokers follow the trend and this has become a tradition now. The scarcity of female smokers in the village however supports the finding of Efroymson et al. (2000).

From the 2001 year data available from UIS (2007) the adult literacy rate is estimated to be approximately forty-seven percent among people aged fifteen and above in Bangladesh. However, the literacy rate in this village is not that high. The villagers told us that only five percent people were literate. The fascinating issue regarding this poor literacy rate is that we found most of the smokers were illiterate. Being illiterate, these people felt insecure and inferior. They found some relief in smoking and became addicted.

Because of unemployment, some of the young people are frustrated. They think they are wasting the most energetic period of their life. To overcome this frustration and stress the only entertainment they can think of is to meet with their friends. Usually, the unemployed people in the community gather in front of tea stalls and small shops in the village, where they can watch television and gossip. This is the usual time and place for peers and friends to encourage each other to smoke.

The most remarkable thing that we observed was the use of cigarettes by teenagers. Their number is not that high but it looks alarming. Teenage boys sit in the tea stall, in front of the girls' school, and try to create an impression with a cigarette in their hand. It is an attitude that they think might establish their manhood. Acting *macho,* projecting a fashionable image are all associated with their

smoking habit. Sometimes we got a quite different opinion from the non-smoking group. They mentioned that smoking had nothing to do with being *macho*. Even when the smokers realised this they were too addicted to keep themselves away from this habit.

There are social taboos against teenagers who smoke, sometime challenged by the teenagers. On the other hand, after smoking for a long period, smokers over thirty years are afraid of the health hazards of smoking and try to quit smoking. Some of them succeed in their mission, but some resume smoking faced with the various tensions in life, most of which being financial in nature.

Tobacco products especially *bidi* and cigarettes are widely available in almost every shop of the village, which is perceived to be another precipitating factor for smoking. We noticed that a cigarette was available every fifty metres, either in a shop or a tea stall. During the FGD with the smokers, we discovered that tobacco-manufacturing companies were rewarding shopkeepers in cash for remarkable cigarette sales. Every other day a van from a cigarette manufacturing company comes to the village to re-supply cigarettes. Tobacco manufacturing companies may argue for the right to sell products for smokers, but they should also consider the rights of the smokers' wives, children and parents who are the victims of secondary smoking. Cigarette manufacturing companies may pay high taxes to the government or support the national economy by providing livelihoods to some people, and therefore, it may be difficult for the government to take some serious steps in order to ban cigarette production or control smoking and its life threatening affects.

Society plays a vital role both in promoting smoking practices, as well as, in quitting The smoking habits of adult men are somewhat socially accepted, but smoking for women is not. Young people smoking cigarettes in front of the elders is still regarded as a disrespectful act. Smoking is one of the problems in this village and everybody knows it, but we felt that this community was not restricting this habit to a bare minimum. Teenagers are not facing any problems while developing a smoking habit. Even though they are initially starting it as a hobby or out of curiosity, it becomes an addiction with time. We feel that society does not like smokers but it is not taking any steps against them either. The smokers told us that the non-smokers had achieved better social position in the society, and this was understandable. Society neglected the young smokers. It gradually becomes a vicious circle, makes the smokers too frustrated to lead a healthy life.

Sexual and reproductive health

Women and white discharge

Manjula Singh & Rumana Jesmin Khan

This chapter will describe explanations of and treatment seeking for white discharge among women in the village. Initially we contacted twenty women for the free listing of illness. Age between nineteen to ninety years, and they came from nine households in a particular cluster of the village called *Nagpara*. Four of them were selected for in-depth interviews and six for an informal group discussion. These women were either those who had experienced or heard about *dhatu bhanga,* or those who were currently suffering from it. The socio-economic profile of the women was similar to that of the other women in this particular *para*: five of them were Hindu, three economically well off and two were not that well off; five of them were Muslim, three economically well off and two not that well off, all of them married with one to four children. Among the women there was a graduate student, a teacher and rest of them were homemakers without an income of their own. Only one woman was illiterate and childless.

Data were collected for one week using a daily activity schedule, free listing, in-depth interviews, and informal group discussion with the women. We also interviewed a woman health provider usually consulted by the woman for treatment. Informal group discussions with married women were conducted to obtain general views, opinions and treatment seeking practices with regard to white discharge. The groups also served to validate trends and patterns emerging from in-depth interviews.

Local terms used for white discharge

A detailed list of women's common illnesses, the locally used terms and associated signs and symptoms were elicited from the women through free listing. Headache (*matha betha*), white discharge or leucorrhoea, low blood pressure (*low presar*), gastric problems (*gastik*), and fever (*jor*) were listed as the illnesses most frequently experienced by women in *Nagpara*. Headache and low blood pressure were perceived as the most prevalent illnesses affecting their lives, as well as, the symptom of 'white discharge'. Almost all the women perceived 'white discharge' as the most severe illness saying that "if one has *shada srab* (white discharge) one becomes weak and vulnerable to other illnesses and can even die".

The women used six different terms for 'white discharge': *kosha, dhatu, dhatu bhanga, shada srab, rajo rog* and *shugar*. They had heard these terms from their family members, neighbours or traditional healers.

Perceived causation

Women's perceptions of white discharge are derived from their perceptions of the reproductive process. These are deeply embedded in the unfavourable gender norms related to their everyday

reality of life. While some women recognised *kosha*, marriage, and heavy workload as the root causes of white discharge, others attributed white discharge to external factors like hot weather, intake of hot food, use of steel utensils and intake of vegetables grown with fertilisers.

Women perceived *kosha* as one of the direct causes of white discharge. They used the term *dhatu bhanga* and *kosha* interchangeably. According to them *kosha* means drying of the body and its symptoms include scanty and red urine, pain and burning sensation during urination. An old woman aged around ninety said, "If people do not obey or respect the elderly, they are cursed by God and can get kosha which leads to *dhatu bhanga*."

Women believed marriage and household responsibilities made them weak which in turn led to increased white discharge. Almost all women shared that their problem of discharge started after marriage and increased every time they had sex with their husband. They mentioned that if they perform sex while having the discharge problem, they become weak and the flow of discharge increases. They are, however, unable to refuse their husbands for fear of upsetting them.

They saw menstruation as another factor that led to increased white discharge. Most of the women shared having experienced severe discharge during their periods (menstruation) that continued up to ten to fifteen days. One of the women said, "The proportion of white discharge is more than that of blood flow during my periods" (Twenty-year-old married woman). Sister Abha, one of the popular health service providers from whom women sought treatment, stated menstrual regulation as the cause of discharge among women. Most of the women said that they did not take their meals regularly and some thought there might be a link between white discharge and their poor or irregular diet. While pregnancy came up as another factor leading to white discharge among women, the oldest among the women said that, "having white discharge during pregnancy is normal because at that time women have certain changes in her body" (Ninety-year-old woman)

Many of these women attributed their illness to external factors like hot and humid weather. This they believed made them tired and weak, which eventually increased white discharge.

We noted that some of the women were unable or unwilling to ascribe an underlying cause for their illness. They perceived it as a natural phenomenon inside a woman's body. One said, "*Allah* knows everything" (Thirty-eight-year-old married woman). Another woman said, "How can I know the cause? Am I a doctor?" (Forty-two-year-old woman).

Perceived signs and symptoms

Most women related symptoms of white discharge to their overall family and village situation. They said they felt severely weak because of white discharge. However, their symptoms were not only related to the body. Almost everybody talked about the political situation of their area and went on to explain how they had headaches and tension due to police harassment. Cases had been lodged against their husbands in the wake of a recent mob killing of a man in their area.

One woman, married for about six years, had been suffering from white discharge for a long time. She attributed her illness to her husband's apathy. She said, "I have a feeling that I will die soon

because I have constant headache and breathing difficulty. Nobody understands that I am sick. My husband says that I do not have any problem. Nothing seems to be alright. I do not even feel like taking care of my child. I think the source of all my problems is *dhatu*."

Weakness was perceived as the most common symptoms of white discharge. Several women repeatedly said that white discharge was the main cause of their weakness and all of them said that it was because something was going out from the body. They had headaches, giddiness, backaches, nausea, a burning sensation all over their body, as well as, mental tension. Almost all those women suffering from white discharge complained of pain during intercourse. One woman who had been married for six years and had a child said, "I do not feel like doing it but my husband insists on having intercourse. It is very painful and difficult as I have *dhatu bhanga*. I also feel weak for the next two or three days".

Many of these women said that this illness made them vulnerable to other diseases as all the nutrition and strength left their body because of it. They explained that when someone has this disease the protection power of the body is lost, and then she is prone to be affected by common diseases like *jor*, *jondis* or *gastik* or she may get major problems like *jorayute gha*[86] or cancer.

According to them, their discharge is like menstrual bleeding. Sometimes their clothes get wet. Discharge also spills over to the floor when they move around. Usually the discharge is whitish, lime like, mucous like or watery. At times, it is be thick like a thread and one has to pull it out by hand. Most women said it was odourless. However, some said that it had a smell but could not describe what it was like.

Most women associated white discharge with 'hot' symptoms like burning of hands and feet, burning sensation in the whole body, dizziness and joint pains. They were unable to stand up or work for a long period under the sun, they complained of backaches and itching in the genital area. They considered white discharge a serious illness.

We tried to find out how they distinguished 'abnormal' discharge from 'normal' one. Several women responded that they could differentiate it when their flow of white discharge persisted for almost twenty-four hours or when they needed more than the usual amount of water to clean themselves. One of them said, "To me it is a problem when I need more water than usual to clean myself after urination, also when it persists twenty-four hours a day and thirty days a month" (Twenty -year-old woman). A nineteen-year-old woman said that it was a problem for her when the discharge hampered her routine work. Many of them said that it was 'abnormal' when the petticoat got wet. For some, itching in the genital area was another indicator of abnormal discharge.

86 *Jorayute gha* means ulcers inside the uterus; may also refer to ulcers inside the vagina although *jorayu commonly* refers to the uterus.

Perceived consequences

These women perceived white discharge as a general state of being unwell that includes not only physical but also mental, socio-cultural and sexual elements. Almost all women suffering from white discharge feared that if *dhatu bhanga* persisted they would be vulnerable to other diseases and die soon.

Weakness, ulcers in the genital area, breathlessness, inability to walk or perform routine work, e.g., taking care of the child etc. are some of the other physical consequences of white discharge as expressed and perceived by the women. Fading of their beauty and charm, weight loss and growing old at an early age were some of the other reported consequences of *dhatu bhanga*. Most women complained of being upset, depressed and anxious. They said they were embarrassed to talk about their illness because it involved a very private part of the body. They had shared their problem only with their husbands or mothers-in-law. One said that she had not spoken about her problem to nobody in the family, not even to her husband or mother. One said her mother too had *dhatu bhanga* but she did not let any of the family members know until the final stage of her life when it was too late to seek treatment. She said, "Maybe my mother did not tell us out of shame and fear of being stigmatised by her relatives and neighbours."

Almost all women indicated that their illness added to their family's financial burden, which often restrained them from seeking treatment.

Health seeking

In most cases, the family members' understanding of the problem shaped the women's own understanding of their illness. One of them said that when she first told her husband about her illness he replied, "You are feeling like this because you do not take adequate rest, you do not take food regularly and you also do not drink plenty of water" (Thirty-five-year-old woman). Another woman said, "My brother, who is a traditional healer, told me that I had *kosha* that eventually led to *dhatu bhanga*. I listened to his advice and drank a lot of water." (Twenty-year-old woman). Most women said that they sought treatment only when they were bedridden and unable to carry out their routine work: "I was bedridden for eight days because it was severe. I could not work. My mother-in-law did all the household work at that time. That is when my mother-in-law took me to a homeopathic doctor for treatment" (Thirty-five-year-old woman). It seems only family support extended by husbands and mothers-in-law could encourage them to seek treatment. One woman, however, complained that her husband did not support her. She felt it had aggravated her problem: "My husband says that I do not have any illness and that I am just looking for an excuse to avoid having sex with him. He neglects me and does not give me money for treatment. I do not think I will recover" (Twenty-year-old woman).

Most women preferred treatment from private providers or from a pharmacy, usually in addition to home remedies. None of them, however, preferred traditional healers either because of the personal experience of disliking the bitter taste of the medicine given by the *fakir* or because of lack of confidence by family members, especially male members, in the traditional healers. All of them

believed that traditional healers can cure only few diseases like jaundice or infertility but curing white discharge is beyond their capacity.

None of the women had gone through a physical check-up for white discharge. The prescription they got was based on verbal description of the signs and symptoms shared by the woman herself or the family member accompanying her to the health provider. Sometimes women did not want to talk about white discharge to a male pharmacist, because they were embarrassed or they just assumed that the pharmacist would not understand their private words for the illness. This led to inappropriate advice and inadequate help for women patients and resulted in poor quality health care. This also had implications for the decision not to seek treatment next time from the same service provider.

Pathways of seeking treatment

Interviews revealed that once a woman had decided to seek treatment, her first resort was home remedy, the second a visit to a pharmacy, followed by visit to a clinic or homeopathic doctor. Except for one, none of the women reported completing their treatment due to various reasons including cost, ineffective treatment, as well as, certain socio-cultural factors as described in the next paragraph.

In-depth interviews and informal discussions with women revealed that a number of socio-cultural and economic factors shaped their decision to seek treatment for white discharge. Some of the prominent factors are the culture of silence, women's lack of autonomy, competing priorities, as well as, accessibility and affordability issues concerning treatment. A culture of silence was evident among women who felt embarrassed and hesitant to share their problem involving the genital area with anyone in their family. The issue is further complicated when the medical practitioner is male. One of these women said, “I feel shy to talk about my problem with a male doctor. A woman doctor is better” (Bokul, nineteen -year-old woman). They showed their reluctance to describe their problem and seek treatment from a male provider. One woman, however, said she would prefer going to the male provider's father, as his father was married and elderly. In almost all cases, the husband talked to the male doctor about his wife's illness. Only in one case, the mother-in-law spoke to the health provider. Women's lack of autonomy also played an important role in health seeking. All three women during the in-depth interviews shared that they were dependent on their husbands for money and decision-making.

The decision to approach a particular provider was largely influenced by the opinions of family members, mainly the husband and mother-in-law. The women needed their husband's permission to visit the health facility and the husbands accompanied them most of the time. If a husband did not consider their health complaints worthy of financial expenditure the problem became aggravated. One of the women said, “I avoid treatment when my husband neglects me. My husband takes all the decisions, as he is the one who gives me money. I expect him to take care of me, but he is too busy. These days when I am not well, I just lie down and expect my husband to understand. There is no point telling him again and again, you see?” (Twenty-year-old woman). Another significant barrier to seeking health care for white discharge was competing priorities of women's time, particularly when the health facility is far off. Childcare, food preparation, household chores and other necessities were perceived to be more urgent than seeking health care in their busy schedule. A twenty-year-old

woman said, “I also have to take care of the child and have lots of household responsibilities. I avoid going to the doctor until it becomes unbearable. I am reluctant to take my child to the doctor's clinic… I want an older person to accompany me to the clinic, not my child.”

Costs of conveyance, doctor's services and medicines were also barriers to effective health care. One woman, whose husband was currently unemployed, said, 'We can not afford to pay the doctor five hundred taka (about seven USD) every time.' Another woman added, “When my husband was not working my treatment was hampered. It was quite difficult for us to continue. Sometimes my father-in-law and husband shared the cost of my treatment.”

Finally, many women said they found it difficult to go to the clinic as it was far off and even if the rickshaw was available, travelling alone was not socially acceptable. They themselves were also reluctant to travel alone, as it gave men an opportunity to harass them.

Discussion

'White discharge' or 'leucorrhoea' is a common illness that makes women weak and susceptible to other diseases. This finding agrees with a growing literature on 'white discharge' among women in South Asia including India, Pakistan and Bangladesh (Trollope-Kumar 2001; Bhatti and Fikree 2002; Ross et al. 2002). Among respondents in an ethnographic study of health seeking behaviour among women with reproductive tract infections (RTI) in Karachi, Pakistan, vaginal discharge was a common complaint. Women reported that discharge interfered with their physical health causing 'weakness' as well as with religious obligations, work, social activities, and sex (Bhatti and Fikree 2002).

Our study showed that women suffering from white discharge experienced a wide range of symptoms from lower abdominal pain and headache to weakness and burning sensations in the body. Stress-filled days with little time for rest or relaxation may have contributed to their explanations of the physical consequences of white discharge. Women also tended to worry about their families' socio-economic condition, their husbands' income, their relationship with their husband and in-laws, childcare and the recent political and criminal activities in the community. These findings corroborate with those of Nichter (1981), Chaturvedi et al. (1993) and Trollope-Kumar (1999). They suggested that the complaint of vaginal discharge may be a way of 'speaking through the body' about a variety of psychosocial concerns. Nichter's (1981) study suggests that, “for people in structurally powerless situations the body may be the only available way of expressing dissent”.

A qualitative study in rural Maharastra mentioned white discharge as the most important problem for women and described women who thought this was caused by weakness. Probing of the term weakness elicited the following symptoms: reduced sexual satisfaction, loss of energy, giddiness, lethargy, generalised aches, loss of appetite, gloomy mood, and loss of desire to speak to anybody. These complaints are identical to the diagnostic symptoms of depression and anxiety (Patel & Oomman 1999).

From a biomedical perspective, the symptoms of vaginal discharge are most often associated with reproductive tract infections. In a study conducted by Trollope-Kumar (1995) in the Garhwal region

of India, it was observed that women who complained of *safed paani* (leucorrhoea) often complained of vague somatic symptoms that included burning hands and feet, dizziness, backache and weakness. However, the majority of women complaining of vaginal discharge had little clinical evidence of infection. In a study conducted in rural Bangladesh by Hawkes et al. (1999) it was observed that among women complaining of vaginal discharge only thirty-two percent had reproductive tract infections and the rate of sexually transmitted disease was only 1.1%.

The WHO guideline on syndromic management of RTIs advocates the treatment of complaints of abnormal vaginal discharge as equivalent to a definitive RTI (Patel & Oomman 1999). This approach is based on the assumption that self-reported symptoms are likely to represent biomedical diseases, an assumption which is problematic in the cultural context of South Asia (Trollope-Kumar 2001). In an evaluation of the syndromic approach to management of STIs it was found that the poor specificity of this approach led to significant over-treatment of women presumed to suffer from STIs. Antibiotic over-use is expensive, causes harmful side effects and promotes antibiotic resistance (Hawkes et al.1999).

Our findings with regard to the women's health seeking behaviour for white discharge showed that husbands were the key decision makers, which had a direct bearing on the women's interpretation of illness and health seeking behaviour. Most women do not have the decision-making power, physical mobility or access to material resources to seek treatment. This, along with other socio-cultural factors such as household responsibility, shame and stigma, played an important role in shaping women's illness experiences. The study also revealed that women seek treatment only when their health problem caused great physical discomfort or when it affected their work performance. This finding confirms what has been said in the literature regarding gender and reproductive health, which highlights the importance of women's work, childbearing roles, and lack of access to resources, as well as, their socialisation, and the norms related to shame and sexuality which directly and indirectly influence their physical, mental and social well-being (Ramasubban 1995; Koenig et al. 2002).

Findings also show that women preferred treatment from private providers or pharmacies, often in addition to a home remedy. They did not mention the nearest Government Health Care Centre in Samair village as a possible choice. None of the women preferred traditional healers either due to personal preference or due to lack of faith in the healer. This finding is contrary to the research conducted by Zaman et al. (2004) which found the *kabiraj* to be the first choice for treating *meho* (another local term for white discharge).

The data from this study indicate that there are a significant number of women who are forced into having sex with their partners even when they have acute pain. Almost all women seemed to succumb to painful sexual intercourse, as they preferred dealing with discomfort to coping with a husband's bad temper. The cultural expectations of women living in countries like India and Bangladesh include obligations to fulfil the desire of their husbands in the institution of marriage and women internalise the societal values linked to the woman's subordinate position as well as acceptance of physical violence.

Conclusion

This study shows that diverse and interrelated demographic, socio-cultural and economic factors shape a woman's perception of white discharge. These include the meanings, causes, signs and symptoms, as well as, the consequences and decision-making with regard to treatment seeking behaviour, as reflected in our study. An understanding of the explanatory model of common illnesses becomes imperative to promote collaborative and improved clinical outcomes, increase patient's satisfaction, promote better doctor-patient communication and improve health-seeking behaviour. Developing effective reproductive health care is a complex concern and it must be dealt with in a comprehensive way. From our interaction with the women of this village, we assume that some of them may not have confirmed RTIs and there is a strong possibility that some of the physical complaints represent underlying psychological and social stresses and conflicts. That is why it is important for health practitioners and community health workers to be aware of a cultural explanatory model of white discharge, in addition to the treatment of infection. We hope this small study will facilitate realistic approaches and strategies in health education and promotion, and enable the development of appropriate health services based on, and tailored towards, the need of service users.

Sexual and reproductive health

Unwanted pregnancy

Shampa Maria D'Costa & Sharon Low

This chapter will explore the perceptions and practices related to unwanted pregnancies. Initially a *body mapping exercise* was done in a focus group to stimulate discussion. Respondents were invited to draw the outline of a female body, to identify the reproductive system and define key terms related to pregnancy. There were in total two focus groups with four to six women in each group. The age range were from nineteen to twenty and twenty-four to thirty years. The major issues explored were causes of unwanted pregnancy; perceived factors influencing the termination or continuation of the pregnancy; attitudes and norms related to unwanted pregnancy; and decision-making processes in selecting the route of termination.

In-depth interviews with an experienced *dai*[87], and a woman who had a spontaneous abortion during her fifth month of pregnancy, were carried out. These interviews presented with personal attitudes, behaviour, experiences and perceived understanding of the circumstances surrounding unwanted pregnancy and induced abortion. Keeping in mind the sensitive nature of the topic, all sessions were conducted in settings that offered as much privacy as possible.

The women

Three of our respondents did not receive any formal education, two attended primary education and five women had secondary education. Eight of them were Muslims, one Hindu and one Christian. One woman works as a *dai* and the other women earn modest incomes working at home, for example through agriculture, poultry raising or handicrafts, and one is a student. Nine women were married and one unmarried. Two women were married early at the age of ten, six women between fifteen to nineteen years and one was married when she was twenty years old. Five women shared their experiences of *unwanted pregnancies* and described their dilemma. Only one of them actually proceeded to terminate the pregnancy.

Perceptions of unwanted pregnancy

This section will examine how the notion of unwanted pregnancy is conceptualised at the community-level through description of the perceived causes of unwanted pregnancy, factors influencing termination or continuation of unwanted pregnancies, as well as, the personalistic perspectives surrounding these circumstances.

Causes of unwanted pregnancy

> Those husbands who are living outside the country, do you know what is happening to their spouses? This is a basic instinct. How long can you control that [sex]? At some point, the women begin to start an affair with another guy and any accident can happen. (In-depth interviewee, thirty years old)

87 *Dai* is the traditional birth attendant (TBA).

Most focus group respondents mentioned that the main cause of unwanted pregnancy was negligence in taking contraceptive pills. Two disagreed and mentioned that it was more because of the ignorance about the fertility period and having unprotected sex right after delivery as well as in old age. The two in-depth interviews revealed more or less the other reasons, such as, unprotected sex in premarital and extramarital affairs.

Motives leading to continuation of pregnancy

The typical woman would want to keep her baby even if it was an unwanted pregnancy. Here we present the case study of a woman who decided to continue with the unexpected pregnancy.

Case 1 (Typical)

Age: Thirty years

Education level: Sixth grade

Cause of unwanted pregnancy: Forgot to take contraceptive pills (unexpected)

Number of children at the time of the recent pregnancy: One

Factors influencing family to keep pregnancy:

Fear of pain (during MR) and support of husband. The woman said, "I am a pill user and I missed taking pills for few days. After some days, I started to feel dizziness and vomiting. I was not okay. I discussed with my husband about my physical condition. After few days, we found that I was pregnant. We discussed about continuing this pregnancy because I developed a negative attitude regarding MR. I was so scared about what I had seen earlier! My feeling was that I could not go through the same pain like one of those women I saw in the clinic. I shared my feelings with my husband. He understood my scary feelings and supported my decision to continue the pregnancy. Both of us decided to have the child. We are happy that we made the right decision."

The most commonly cited motive for women to keep an unwanted pregnancy is the support of their husband. Although several respondents that women do have a say in such matters, it is clear that the husband's support is crucial.

In addition, previous experience or knowledge of induced abortion also plays a role in influencing the decision of whether to continue or terminate the unwanted pregnancy. According to most women, death, blood and pain are associated with all forms of abortions, irrespective of where and who performs the abortion, be it at a *kabiraj*'s place or an MR in a hospital. Thus, the general perception towards induced abortion is negative. Most, if not all the women rely on some form of contraceptives.

Motives leading to terminating pregnancy

The decision to terminate an unwanted pregnancy is not a usual case in the village. Here however we present the case study of a woman who decided to continue with the pregnancy to provide a contrasting picture. We heard the following from the discussion we had with the other women who told us about the tragic fate of this woman, who decided to terminate her pregnancy.

Case 2 (Contrast)

Age: Twenty-four years

Education level: No formal education

Cause of unwanted pregnancy: Poverty, forgot to take contraceptive pill (unexpected)

Number of children at time of pregnancy: Two

Factors influencing family to terminate pregnancy: Poverty, lack of spousal support

The women mentioned that the couple was not doing well financially. She and her husband decided to keep the family small. She started taking contraceptive pills from the village clinic. However, due to an overwhelming workload, she forgot to take the pills for a few days. Before she realised it, she was already three months pregnant. She was horrified and kept it to herself for many days. Finally, she decided to discuss the matter with her husband. He was furious and refused to be responsible for the child. He also refused to discuss any other option and pressed her to have the baby aborted. The woman was devastated and eventually consulted the *kabiraj* because she was familiar with him. He assured her that everything would be okay. He gave her a tree root and advised her to insert it into her uterus and keep it there for one full day. She would bleed but after that, everything would be "cleared". She was happy and followed his direction. The following day, she did her work as usual but she started to feel sick. She did not dare tell her husband and instead silently bore with her pain. After several days, it was too painful and she started to bleed. A solid mass, believed to be the foetus, came out with the blood. A few days later, she died.

The key motive cited for the termination of unwanted pregnancy here was financial and a desperate attempt to keep the family size small. A mistimed pregnancy, due to short birth spacing and consequent physical and economic constraints to take care of all these children was also mentioned as a motive. Another factor of mistimed pregnancy mentioned in one of the focus group was pregnancy after all other children were already grown up. A forty-five -year-old woman said in the focus group:

> Suddenly I found I was pregnant. This is a big problem for me. Both of my son and daughter are married. I have a grandson. I became confused.

Pregnancy because of pre and/or extra marital relationships was highlighted in both in-depth interviews. A small number of women during the FGD mentioned that the woman's health condition was also a factor for considering termination. One respondent who had an induced abortion during the fifth month of her pregnancy underwent termination because her husband had abandoned her and she had no support.

Ethical viewpoints

The traditional birth attendant considered abortion to be a sin and had a strong view against the decision to terminate an unwanted pregnancy:

> If you do not want to keep the child, you should still go through the pregnancy and if you have problem with the child, then give the child to me. I will raise him/her… but do not kill the child…Allah will never forgive you. It is a very big sin. For committing this big sin, you may not get pregnant again (*Dai* Rabeya, thirty years old)

The women in focus group discussion and during in-depth interviews expressed strong ethical views on unwanted pregnancy. They saw Allah or spirits as their judge, and considered the religious (and

folk) beliefs to be the standards of value, specially the religious principles, as supreme ethical standards. They felt that Allah would never forgive women for terminating a pregnancy by MR or induced abortions. For those who experienced MR or abortion, they felt that it was a practical issue but they lived with a sense of guilt for a long time. One woman said:

> After going through the abortion, I felt very bad. It was twenty years ago, but I still have nightmares about it. I would never want to do such a thing but I had no choice. My husband left me and my mother was worried that if I had a child then, no one would marry me again. What else could I do? I try to convince myself that I have a valid reason for doing so, but I still feel terrible mentally. After the abortion, I was down for a long time. (Thirty-year-old woman in an in-depth interview)

In one focus group discussion the women said that it was common knowledge that pregnant women should never enter the bushes on Saturday, or Tuesday; neither should she cut *hilsa*[88] fish. This kind of behaviours infuriated the evil spirits. In these cases, women were considered directly responsible for their own actions if they experienced spontaneous abortion as a consequence of such irresponsible behaviour.

Spousal and family involvement in decision making

Most women mentioned that the decision to terminate or continue a pregnancy was usually a joint decision between husband and wife, or a girlfriend and her boyfriend. They emphasised that men were not always the dominant decision-makers in such situations. It is obvious that in some families men command more authority in any decision-making processe. Women in one focus group and both in-depth interviewees mentioned that mothers, sisters-in-law, aunts and close friends played important roles as well. In the case of pre and extra-marital pregnancies however, decisions had to be made alone.

Abortion methods and/or providers

Popular, folk and formal methods were mentioned in varying degrees. The following figure depicts all methods mentioned by the women.

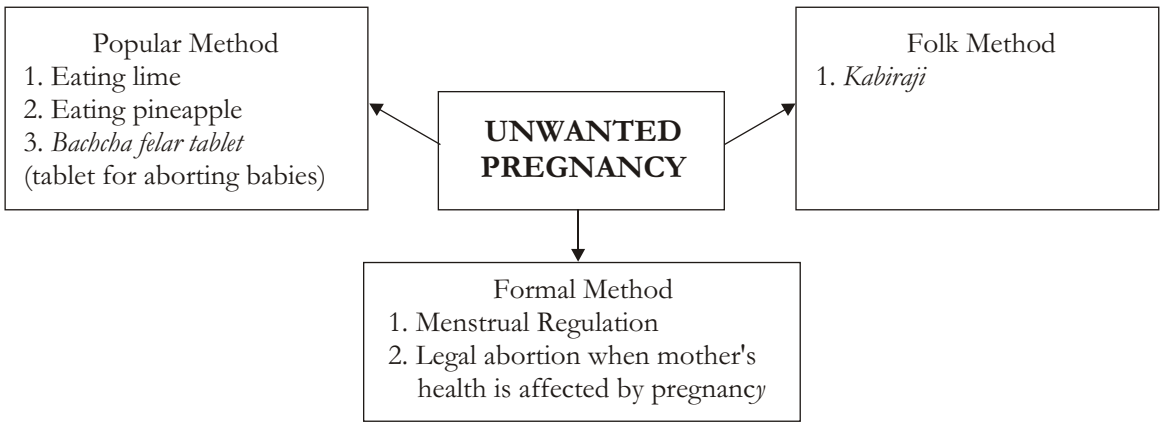

Fig.1: Abortion methods mentioned by the village women

88 *Hilsa* is the national fish of Bangladesh, popular among Bengalis.

Popular methods

Many women believe that eating excessive limes or pineapples would induce abortion. They heard about such methods from their families and friends. One focus group respondent mentioned that she tried eating three pineapples but was not successful in her attempt to abort. In one focus group, respondents seemed to be familiar with the white, *bachcha felar tablets,* which they could purchase from village clinics for seventy taka (about one USD). However, in both cases mentioned, these methods were not successful.

Folk methods

Most stories narrated in the focus groups involved women who seek termination of unwanted pregnancies through the *kabiraj*. Those who used this method usually had to seek emergency treatment in a clinic or even died. Two women mentioned that they tried to induce abortion by inserting a tree root into the uterus, and subsequently they had to be treated in the clinic. Smearing smashed herbs and taking medicine made from papaya were also mentioned as methods used by the *kabiraj*.

Formal methods

MR or *Wash* is socially and legally accepted. However, we noted during data collection that women rarely made any distinction between the two terms. Villagers from Savar usually go to *Ma- o- Shishu*c[89] linic in Mirpur for MR.

Dai Rabeya mentioned that university students learnt about MR or 'wash' through their friends or public education. Thus, those who are confronted with unwanted pregnancy would seek this service. According to her, a high percentage of MR patients in the hospitals and clinics in Savar are university students. Although, a husband's signature is supposed to be mandatory for this process, it was iterated throughout the interviewees that money could usually solve these 'problems' without any hassle.

The focus group mentioned incidents where those who sought MR after unsuccessful treatment by a *kabiraj* would usually experience complications, e.g., they would have to undergo a painful and bloody process and/or suffer side effects. One woman described a case where the woman was referred to Dhaka by a hospital in Savar for better treatment as she had previously had a caesarean section. There was a young woman who gave us many detailed stories during the FGD. Here we present her case as deviant.

Case 3 (Deviant)

Age: Nineteen years
Education level: SSC[90]
Status: Unmarried
In the village, the average age for women to be married is around fourteen to fifteen (although the legal age is eighteen). During our data collection phase, we found a young mature woman, nineteen years old, well informed about contraceptives and various induced abortion methods. To our surprise, she was still single and was now preparing for the SSC examination. She participated in one of the FGDs and spoke openly on reproductive health topics. She was able to articulate the methods, attitudes and norms in the village much clearer than the married women in the group were. She became our key informant. However, when we tried to conduct an in-depth interview with her, she closed up and showed extreme discomfort. We terminated the interview accordingly.

89 *Ma o Shishu*= Mother and Child

90 SSC is the Secondary School Certificate Examination (equivalent to standard X).

Reasons to select a specific method and/or provider

Three main reasons were cited for the choice of method of abortion. Common knowledge came out on the top.

Common knowledge

The TBA said,

> Probably they (unmarried women) have some sort of discussion with their friends in the school or area and they have good and clear knowledge about what they need to do in this sort of situation.

One respondent in a focus group discussion mentioned that women generally opted for the provider based on either their common knowledge (availability and acceptability of the service provider) or word-of-mouth within their family or community (accessibility).

Previous experience

Most women have heard stories of women seeking induced abortion in various forms. A few of them knew someone who was in such a situation and one of them had the experience of induced abortion herself. All this information could affect the community's attitude and perception, thus influencing their decision-making processes.

Confidentiality

The traditional birth attendant spoke again about the issue of keeping these matters private:

> For married women, those who have extra-marital sex, they will take this decision alone and get this service from the *kabiraj*… they go to the *kabiraj* first because they think if they go to there they can keep the matter secret. If they go to the hospital, other people might see them and get to know about it. Therefore, they prefer to go to the *kabiraj* and have some herbs instead. (Thirty-year-old *dai* Rabeya)

Dai Rabeya also mentioned that in case of extra-marital unwanted pregnancy, women usually chose self-induced methods, like eating lime, pineapples, taking *bachcha felar* tablets or went to the *kabiraj* because confidentiality was the main factor in choosing the method or the provider. There would be little privacy if they went for MR, they also wished to avoid any association with a particular clinic that performed MR.

Order of treatment-seeking

Women in general seemed to seek termination of an unwanted pregnancy in a certain order of preference. First, they would try *safe* methods like using limes, pineapples or purchasing white pills. When self-help failed, they would seek out a *kabiraj*. Their second choice would be the methods prescribed by the *kabiraj* and finally MR. MR was seldom the first option in a rural setting. Overall, it is done only after unsuccessful attempts or when women required treatment for the complications of an unsafe abortion.

Discussion

In this chapter, we attempted to explore two issues. First, the causes and motives surrounding unwanted pregnancy and abortion and second, factors that influence the decision-making processes resulting in the termination of an unwanted pregnancy.

We know from previous studies that economic status, husband or family support, previous experience or evaluation of service provider, completed family size, spacing between children, pre- or extra-marital relationships and health of mother are the principal causes of unwanted pregnancy (Caldwell et al. 1999; Islam 2005). There are also ethical views of strong personal culpability situated within a general context of belief and religion. Our findings support these studies because here we also see that husbands and family members play a significant role in the decision to continue or terminate a pregnancy and are usually pivotal in the selection of a provider. Most women mentioned common knowledge (regarding availability, accessibility and acceptability of service providers), previous experience or prior knowledge as well as the assurance of confidentiality as the main reasons to select a service provider.

In Bangladesh, abortion is illegal. However, the government has made family planning methods and MR available to curb the consequences of unwanted pregnancies. In contrast, in Rajasthan, India, a research conducted by the Population Council (2004) showed that after more than thirty years following the legalisation of abortion, the legal right to abortion was yet to become a reality for the majority of women. Drawing parallels from this study, we can assume that it could be the same in Bangladesh. Legalisation of abortion may not lead to social acceptance and may not adequately address the issue of unsafe abortion.

The overriding causes for unwanted pregnancies are the social and cultural factors influencing the accessibility of formal services for women, quality of formal services and the knowledge and awareness of safe treatments and services.

Implication for policy and practices

> Whatever a country's legal position on abortion, all women suffering from abortion-related complications have a right to treatment and high quality post-abortion care, including family planning counselling and services, offered with compassion and confidentiality (WHO 1999).

The question that remains to be answered is how women can be saved from the potential danger of unsafe abortion. It is known that most induced abortions are a result of unwanted pregnancies. We feel that there are three key messages that emerge from our study. First, that consistent and correct use of contraception methods can avert many unwanted pregnancies and, in turn, save lives. WHO SEARO (2003) reports, women may not be using the family planning methods despite their availability in Bangladesh. This could happen because of financial constraints; lack of access to information and services; personal and religious beliefs; inadequate knowledge about the risks of pregnancy following unprotected sexual relations; concerns about the perceived adverse effects on health and future fertility; women's limited decision making ability with regard to sexual relations and contraceptive use, incest or rape. It is therefore very important to popularise family planning methods and ensure their maximum use and effectiveness at community and national levels.

Secondly, even when contraception is available, some women will experience unwanted pregnancies and some will seek to terminate the pregnancy. Thus, the prevention of unwanted pregnancies alone may not be enough, and a complementary health care service, facilities for safe abortion, e.g. provision of MR and follow-up services, training of health providers, post-abortion counselling and confidentiality, need to be accessible to women (Bhuiya et al. 2001). Availability, accessibility and affordability of quality care would greatly avert the fear and misconception of formal service providers among women and influence the selection process for a safer abortion option.

Finally, it is evident that a number of women turn to informal service providers due to lack of support from husbands or due to their perceived need to maintain confidentiality, e.g. pre- or extra-marital relationships, social acceptance issues etc. Currently, MR services require the husband's consent. We believe that this further complicates the issue, often just not implemented. Thus, policy makers might wish to review the spousal consent requirement while planning meaningful access to medical service. This would be an important consideration for women in selecting a formal service provider.

Reflections

When we first selected this topic, the most common response from our course mates and course instructors was that it was an important but sensitive subject and that we had to conduct the study very carefully. There was a lot of apprehension about receiving enough data, as we were unsure about the community's response to this subject. However, we went to the field with an open mind, wanting to learn and understand an issue close to the hearts of many women. We were pleasantly surprised, rewarded with many personal stories, as well as saddened by the misfortune of some women who lost their lives.

Sexual and reproductive health

Menopause: Entry into old age

Najia Rafiq Paracha & Nusrat Homaira

This chapter describes the menopausal experiences of women in the village of Kakabo. Data were collected from seven menopausal women aged forty-five to seventy years old through observations and in-depth interviews; and about thirty women, both menopausal and non-menopausal, through several informal discussions. Two key informants were interviewed, a *dhoroni*[91] and a local *daktar* (originally from the word 'doctor'; in this case however the *daktar* is a medicine vendor) who were consulted frequently for treatment of the physical problems of menopause. Most of the respondents were Muslims. None of them received formal education. Three women among the seven in-depth interviewees were married and the other four were widows. We prepared a free list of the signs and symptoms of menopause experienced by these women and ranked in the ascending order of frequency.

Onset of menopause

Women in general related the initiation of menopause with aging. Through informal discussions, we noted that the women believed that menstruation usually stopped after the age of forty and by the age of sixty, all women had gone through the experience of menopause.

While talking about the subject, the women usually referred to menopause as *mashik bondho hoiche* (menstruation has stopped) or *mashik bondho hoa* (cessation of menstruation), which are the two commonly used Bengali terms for menopause in the area. These were more like processes than specific terms. We realised that no specific local term existed for menopause in this area.

The main cause of menopause was to mark the commencement of old age as pointed out by most women. One woman remarked, *"Boyoshe vati porle mashik bondho hoia jai"* (With aging menstruation stops). They also believed that menstruation was God's gift and God took it away when they aged.

Attitude towards menopause

The women considered the onset of menopause as something normally happening to them in old age. To them it is not very significant when a woman's menstruation stops. They believed that, "with aging menstruation stops and there is pain in the body because blood gets trapped inside". A seventy -year-old woman said,

> *Ekhon shorire shokti nai tai durbolota beshi, joan kale shokti chilo tai durbolota kom chilo* (I am old and do not have strength so the weakness is more, when I was young I had more strength and weakness was less.).

91 *Dhoroni* is *dai*, a traditional birth attendant.

One sixty-three -year-old woman stated, "*mashik bondho hoia geche rog bimari dhoira loiche*" (With cessation of menstruation, my body has become prone to other illnesses).

The TBA had a similar explanation. She believed, after menopause 'bad blood' gets trapped inside the lower abdomen as a big clot and the body swells up and comes out in the form of pain in different parts of the body. She explained, *"Joan kale eto khani betha eto tuku lage, boyosh poira gele eto tuku betha etokhani lage"* (When we get old, little pain causes great suffering, when we were young even a great pain caused little suffering). A sixty -year-old woman explained her idea about menopause with a beautiful comment:

> *Jibon ta gacher lahan, joan kale gach ta lok lok kore, phool chilo oikhan theke phol hoiche ekhon gachta shukhay geche tai phool o geche, ar phool na thakle phol o thakena* (Life is like a tree that has flowers, and when the tree was young it bore fruits. Now the tree is old. The flowers are gone, and so are the fruits).

She referred to menstruation as the 'flower' of the tree and to children as its 'fruits'.

For some women, the cessation of menstruation was actually a relief because now they could say their prayers without any restrictions. A fifty -year-old woman said,

> I feel relieved that my menstruation has stopped now. Previously, I could not fast and take a prayer when I bled but now I can recite *Qur'an* whenever I feel like, take my prayers, fast and move around freely. I am happy that my *menses* stopped before my sons got married because when I had my *menses* I used to bleed so much, it would be a shame if my daughters-in-law saw that.

One woman said that she wished she still had her menstruation so that she could reproduce more, as her children had died and she desired children. She said,

> My daughters died three years ago, one from cancer and another from delivery complications. I wish I still had my menstruation so that I could have children again. There is no way I can have a child now. I only have the pain of losing two daughters.

Manifestations/symptoms of menopause

> I started to have heavy bleeding a year before my menstruation finally stopped… The passage of blood was too much. I passed thick round clots. All the older people said that I would go into menopause now. I even went to a doctor (Zia *daktar*). He also said that my menstruation would stop. (A fifty -year-old woman)

The women claimed that the first sign of menopause they experienced was irregular menstruation. In some cases, this was in the form of decreased blood flow while in most cases the irregular pattern was in the form of heavy bleeding, sometimes even twice a month. A fifty-five-year-old woman said, **"**Before my menstruation stopped, I was having irregular cycles. I had menstruation twice in one month. Then all of a sudden, it stopped. I developed weakness, backache, body ache, palpitation (*poraner bhitor osthir lage*), and a burning sensation in the head. I also lost appetite when the symptoms aggravated."

Most women pointed out that once the menstruation stopped, it was followed by various physical pains such as body ache, weakness, palpitation, pain in the lower abdomen, waist, both limbs and burning sensation in the head (hot flushes).

Table 2: Ranking of the free listed manifestations/ symptoms of menopause

1.	Weakness
2.	Body ache
3.	Waist pain
4.	Pain in the joints
5.	Loss of vision
6.	Restlessness
7.	Burning in the head (hot flushes)
8.	Palpitation
9.	Lower abdominal pain

Table 2 shows the order of the most common physical problems women suffered. Palpitation was the second least common symptom. Most women responded in the following manner:

> Before menstruation stopped, my blood flow decreased. Then it stopped suddenly. After the cessation of my menstruation I had pain in my hands and in my legs (*hat pa kalay loy*), pain in the waist, burning in the head and in my hands and legs. (A seventy -year-old woman)

> The changes occur in the lower abdomen and menopause occurs because the vagina is blocked and the bad blood cannot come out. I have pain in the legs, hands, and in the waist because of the 'poison', as they have no outlet anymore to clear out. I also have restlessness in the centre of the chest because of the poison. (A fifty-five-year-old woman)

The women in the village consider that all symptoms are due to changes in the lower abdomen because that is where the baby sac (uterus) is. Blood is trapped there, which in turn causes heaviness in the lower abdomen and pain in the waist. They believe that there is no outlet for the 'bad blood' when menstruation stops. The poison moves inside the body and causes the physical pain. They received this kind of knowledge from their elders, mainly mothers and grandmothers.

Three women said that menopause was due to old age and, therefore, it was natural that it also diminished their eyesight. A sixty-five-year-old woman said, "*Boyosh hoiche mashik geche chokher dooti o geche"* (As I have grown old, I have also lost eyesight). A forty-four -year-old woman said, "After my menstruation has stopped I am losing eye sight (*Chokher dooti noshto hoe jaiteche*). If I still had my menses, my body would clear out and I would feel good but now it is accumulated inside me."

Women in general found the cessation of menstruation a relief. A seventy-year-old woman confirmed, "I did not have any emotional problem and rather felt good because there was no problem of conceiving anymore and sex was free of tension."

Sex and menopause

This topic was discussed to explore sexual problems like loss of libido and painful coitus known to be experienced by women after menopause. Two of the women had stopped having sex, because their husbands were sick and the doctor advised the couples not to have sexual intercourse. Generally, the women complained of pain during sexual intercourse, and lack of desire and sexual pleasure. A fifty-five-year-old woman mentioned, "My sex desire decreased with cessation of menstruation. I feel it but I never let my husband feel it". Another fifty-year-old woman said,

> I feel pain in the lower abdomen during sex after my menstruation stopped, my sex drive has also decreased but my husband is different and does not have any problem with that.

In response to this statement, the TBA said, *"Tor lagbo betha tor swamir kichu hoibona"* (Sex may become painful but only you will feel it. Your husband will not know).

Interestingly, most women pointed out that they did not let their husbands realise their lack of sexual desire. Some said that even if they did, their husbands would not mind that. The attitude of husbands as portrayed by the wives appeared to be cooperative and understanding. We felt that these statements needed to be explored further but we decided not to discuss this any more so as not to offend the women. A fifty-year-old woman stated,

> When menstruation stops if a woman has a husband and she is unable to enjoy sex because of pain and decreased sex urge it is a great problem. She will suffer, but who can express such inner distress *(oi jala boro jala ontorer bhithorta ki dekhano jai?)?* If sex is good then there is no problem. For me sex became painful and for the last few years I have no sex urge but my husband is different, he has no problem with that.

One woman (forty-seven-year old), however, expressed the view that sex was better after menopause as it did not have any mental tension such as getting pregnant. She said, "Sex is better after menopause; no worries about bleeding or conceiving."

Health seeking

The health seeking of menopausal women revealed that they considered the different physical problems during menopause to be part of the normal process of aging and there was no permanent treatment for these problems. A sixty-two -year-old woman put it like this:

> When my menstruation stopped, I went to Zia *daktar* in the Akrain *bazaar*, for the bodily pains. He gave me some red capsules and vitamin syrup which helped me for a while but I had to come back the next month. I also went to *fakirs* who gave me enchanted water, enchanted oil and I put cold water and oil on my head to relieve the symptoms.

According to a sixty-three-year-old woman, it was for physical pain that she took vitamins but did not feel the need to take any other medicine, as this was only "part of aging".

For temporary relief the women relied on the medicine vendor (Zia *daktar*) in the nearby Akrain

bazaar and on the local traditional healers (*fakir*, *kabiraj* and TBA). A fifty-year-old woman said,

> I never took any medication because we do not need any medicine, but when the pain did not go away I went to the *dhoroni*, and she gave me oil massage (*jharaichi*) but I never went to a doctor because they cannot solve these problems.

In another case, a sixty-year-old woman supported the previous statement by saying: "We only go to doctors for temporary relief but we know it is not going to go away as it is just part of old age". Interestingly, three women thought that worrying about menopause or going to the doctor for menopausal symptoms was a new idea and mainly for people of the new generation. A seventy-year-old woman pointed out: "I never needed any medicine for my problems. We are people from an older generation (*ager kailer manush*). We do not need medication. Nowadays people need medication. All our children were born at home without any medicine."

The economic aspect of their health-seeking behaviour did not clearly come out in the interviews. Maybe this was because the women did not feel the need of extensive treatment for their physical problems. However, the following remark came up in one in-depth interview. A fifty-year-old woman, who had hardly any money to support her family said,

> If I had money, I would go to a better doctor where I could have some saline and cure my weakness. I also think that if I had money, I could eat good fish and milk and that would help me get over my problems.

Role of health care providers

Both health care providers (TBA and medicine vendor) said that when menstruation stopped the women came to them with complaints of pains in joints, waist and lower abdomen. The treatment they provided varied. The medicine vendor treated the women based on biomedical principles and the TBA relied more on traditional healing methods. *Daktar* Zia said, "If a woman complains of sudden cessation of menstruation and if she has a husband, then I send her for pregnancy test first to confirm that she is not pregnant, and I treat her only after that." If the woman is not pregnant, and complains of bodily pains and weakness after cessation of menstruation, then he treats her with vitamins, calcium tablets and other medicines of the paracetamol group. Furthermore, Zia mentioned, "Usually these medicines work in such condition but if they do not, I refer them to a lady doctor in Savar". Zia *daktar* also pointed out that the number of menopausal women who visited him for treatment had increased in the last two years, as women were now more aware of the problems they faced, especially after the use of contraceptive methods had increased.

The TBA mentioned that women also came with the complaint of painful sex to her and that Zia *daktar* had no knowledge about the topic. She felt that being a man, he did not have deeper insight into the women's personal problems. She said,

> When women come to me with such problems, I tell them to bring *Bilati mod*[92] in which I dip my fingers and put it around their vagina and also soak a cotton ball in alcohol and press it against the vagina. The alcohol has to come from abroad and women buy them from Dhaka. The alcohol takes away the pain, poison and

92 *Bilati mod* is foreign liquor.

> infection from the vagina. I learned this technique from Rob Banu who is a master of my master (*Amar Ostader Ostad*). Then I advise them to use hot oil before having sex and use hot water mixed with dettol (antiseptic liquid, a common household item) when they have such pain. This way the problem goes away. When someone's menstruation stops her baby sac also comes down. This treatment also heals that type of condition. For their bodily pain, I give them massage with hot oil and tell them to use hot water.

Socio-cultural construction of menopausal symptoms

The women of the village experience positive and negative changes linked to menopause and old age. Menopause to them is a time for better sex without the tension of pregnancy and menstruation. They enjoy greater freedom and happiness, which is also a common finding of research among Australian and Filipino women (Berger & Wenzel 2000). Among the negative changes, the women, referred to menopause as a time of diminished health, without the monthly flow of blood they felt their body became weaker and were prone to illnesses. Similarly, Lock (1998) in her research on menopause in Japan found that for hundreds of years the end of menstruation has been considered as an event that leaves 'stale blood' in the body which cause many non-specific symptoms in some women that often last for a few years.

The most prominent physical symptoms mentioned by the women in this village were weakness, loss of vision, backache, joint pain, restlessness and hot flushes.

Unlike their western counterparts, the women of this village do not seem to experience societal pressure to remain 'forever young'. They have little medical information about menopause or modern treatments, which helped them to tolerate menopausal symptoms as part of aging. For them, the only available treatment for menopause is vitamin and calcium tablets from the nearby pharmacy. The women believed that these aging aggravated physical problems and that there is no remedy.

The influence of religious beliefs in shaping their perceptions should not be underestimated. They considered cessation of menstruation as 'God's act' over which they had no control. They felt that it was better to accept it because according to them, some issues were beyond explanation. A sixty-five -year-old woman said, "*Andharer jinish amader bujhar kono upai nai*" (It is in the dark and there is no way we can understand this).

Most women experienced loss of libido and painful sex after menopause though sex was supposed to be tension-free. For their problems with 'sex' they mostly turned to the *dhoroni*, who treated these women with alcohol and hot water. This sort of treatment does have some justification as alcohol and hot water have anti-inflammatory and analgesic property respectively. *Dhoroni* also advised them to apply oil in the vagina before sex that would act as a lubricant.

Someone mentioned that if there was a loss of sexual urge after menopause and if one had a husband, the situation could be traumatizing. Sex is the key to a successful married life. Women, therefore, did not let their husbands know about their difficulties with sex and continued to comply with their husbands' desire. This raises several questions about sex, sexual desire and gender that we cannot address within the scope of this chapter. For women of this village menopause seems to be just a part of aging, it is not considered a major crisis. Most women seem to pass through it without any major difficulty.

Traditional healing

Shared world of patients and healers: *Batash Laga*

Mizanur Rashid Shuvra & Nabeel Ashraf Ali

The purpose of this chapter is to describe and discuss how healers (*fakirs*), patients and people in the community perceive an illness, which they call *batash laga*. We will present our findings in the form of an explanatory model, which is how the *fakirs* and clients respond to this affliction. As we proceed, we will talk about the relevant factors that shape their responses. The main finding of our exploration is that patients and healers hold very similar views on *batash laga*. We conducted two ethnographic interviews with two well-known male traditional healers, known as *fakirs,* in the community, as well as, participant observation with a popular female *fakir*. The observation was followed by a discussion with the healer. Free listing exercises with all *fakirs* and body mapping with two male *fakirs* were done. A focus group discussion was undertaken with a group of eight women, which included both affected and non-affected (in terms of *batash laga*) individuals. We also conducted two informal discussions with two patients, one who recovered and another one who did not, along with their family members. Later, we modelled these discussions into two case studies.

What is *Batash Laga*?

Literally, *batash laga* means, "to be touched by air." However, unlike the ordinary air this *batash* can cause illnesses[93] resulting in several different signs and symptoms, including death. In what follows, we provide the emic perspectives of both the traditional healers (*fakirs*) and their clients regarding this *batash* or air.

Batash is perceived as a part of nature with additional malevolent properties. It is practically indistinguishable to the naked eye and can only be felt. There are no definite morphological features of this *batash*. According to both the *fakirs* and their patients, it resides with the natural wind and travels with it. As one traditional healer said, "It is mixed with the wind that moves the leaves of the trees and roams around with it."

A woman participating in a focus group discussion described it as follows:

> It is like, you feel this wind…whoever is touched by *batash* may suddenly have a bellyache or start to have convulssions. This is a different kind of *batash*.

According to the respondents, there are several types of *batash*. Both the provider and client perspectives on various types of *batash* are a reflection of perceived severity, signs and symptoms that result from being touched by *batash*. Broadly speaking, both providers and clients classify *batash* in

93 *Batash Laga* is perceived and spoken of as both illness and a cause of an illness interchangeably.

two major categories: *Alga batash* (minor) and *garo batash* (major). *Alga batash* is called *alga* because the affect of it is minor compared to that of *garo batash*. The process of healing is also considerably shorter (three days at the most).

Garo batash on the other hand has a greater impact. It is believed to cause paralysis (*ordhango batash*), burning blisters (*agun jola batash*), and even sudden death (*thapra batash*)[94]. A woman participating in an FGD observed:

> We recognise that it is only a slight *batash* when I get a slight headache. Then I go to a *fakir* and tell her about what has happened and how I feel. Then she does a bit of *jhara* and it is healed. Say, if it touched me in the morning, I can be healed by afternoon (*shokale lagle bikaler moddhe vala hoy*). However, if it touches you with full force (*pura chote lagle*), it will bring me down… then it can take two to three months to heal (*beshi batashe dui tin mash lage vala hoite*).

When *alga batash* affects an adults it causes headaches on one side of head and nausea, but when it affects a breastfeeding mother (*mayer buke dudh barle*), then the breastfeeding children are also affected and the children develop diarrhoea, fever, respiratory difficulty (*hapra tane*), convulsion (*khichuni*), depression of skull bone (*chandi daiba jai ga*) etc. On the other hand, the types of *garo batash* are based on the signs and symptoms of that particular *batash*. A person affected by *ordhango batash* starts to feel a tingling sensation in one side of the body and then, eventually, that side literally falls asleep (*ghumay pore*). When the *agun jola batash* affects someone, it creates blisters as if the person literally was burned, while the *thapra batash* feels like a slap and it knocks one unconscious:

> People suddenly fall over unconscious, as if they have been slapped really hard. If attacked by *thapra batash*, people can die if they are not brought to a *fakir* quickly. (Traditional healer)

Why me, why now, and how?

Practically speaking, *batash laga* can affect anyone regardless of age, sex, or religion. However, there is a common belief among providers and clients that women who are young, pregnant or currently breastfeeding babies are more vulnerable as they are 'tastier':

> *Batash* in fact would not have been as bad as it was, only if I was not breastfeeding then. (Woman participating in an FGD)

> When you want to eat a fish, do you not select the ones that have eggs in it? ...
> This is why…it affects pregnant women more. (Woman participating in an FGD)

Illness may also be the result of someone else's failure to comply with the norms of social life. A young girl who was brought to a *fakir* was diagnosed with *batash laga* and her affliction was stated as a result of the fact that her aunt was still unmarried.

Both clients and providers agree on the activity of *batash* in relation to a particular time and place. The times are usually early morning, noon, after sunset, and in the dead of night (*bara rait*). Talking

94 The list is by no means exhaustive. There are several local variations of *garo batash* i.e. *bakurali batash* (whirlwind), *oshukhi batash* (sudden illness causing *batash*)

about the time when his wife got affected the husband said:

> About three years ago, four days before the *Ramadan*, she went over to her cousin's house after dark to watch television. She stayed there for some time and then returned home around ten in the night.

Batash can affect people even when they are asleep. It is believed to be more active in certain places, for example dark bathrooms, a juncture of three roads, and is often associated with behaviour that are socially unacceptable, for example urinating while facing the east at sunrise or going outside the house during the hours mentioned above (specially for pregnant women). It is not that *batash* will affect everyone who goes to certain places or does certain activities, it will affect only when all the circumstances, time, place, and person come together. Talking about *bakurali batash* a woman said:

> If it gets you in the right time, then either your tummy will swell up, or you will have diarrhoea or asthma; you may vomit. If you are pregnant, you may have a miscarriage, you may become paralysed, you may die from bleeding through your nose and mouth.

Batash enters through the pores of the hair follicles and pollutes the blood. It travels through the veins of the body, their tributaries and deactivates the normal function of the particular parts of the body it reaches. *Ordhango batash* specifically works in this way and affects the muscles of the limbs, causing them to literally fall asleep. According to the providers, it cuts off nutrition necessary for the limbs to function. It also affects the tendons (*shada rag*) and makes them weak. In case of *thapra batash*, a sudden force of wind can create extra pressure and cause them to rupture. This is why there is bleeding from nose and mouth in some cases.

What to do with *batash laga*?

Types of illness traditional healers treat [95]

Here we provide a list of illnesses *fakirs* treat. Among the acute illnesses, there are, *Peter moddhay chakka*: sudden feeling that there is knot in the stomach or stomach cramps; *Batash laga*: A more general & widespread term literally meaning 'touched by air' gives rise to a number of acute complaints; *Upri bhap*: Being under the influence of *bhut* ; *Adh matha:* A sudden onset of one sided head ache; and, *Khun bhanga:* excessive menstrual bleeding. Among the longstanding or chronic problems are, infertility leading to infidelity, unhappy marriages etc., and, *Dhatu bhanga,* a complaint by men described as generalised weakness and impotence.

Categorisation

> We brought him over to the *fakir* since we thought it was a job for the *fakir*. If we thought it was a doctor's job, then we would have taken him to the doctor. (Middle-aged woman in an FGD)

This, in essence, is at the heart of why people go to the *fakirs* for some of the illnesses and why they go to the doctors for other complaints. In case of *batash laga*, people do not think twice about where to go. As soon as the decision regarding the nature of affliction is assessed, the decision regarding

95 This list is not exhaustive.

what kind of provider to visit is also made. According to them, some diseases are in the domain of the *fakirs* and others are in the domain of the biomedically trained doctors. The providers' perspectives on this are similar:

> I treat patients who cannot get relief from the doctors. You see, there are illnesses that the doctors are good for and then there are diseases that only the *fakirs* can treat. (Male *fakir*)

In fact, the *fakir* perspective regarding biomedical treatment of *batash laga* is stronger than the opinion of people in the community:

> If anybody takes biomedical care, especially if someone gets an injection, then none of what I do will work. An injection traps the *batash* within the body and does not let it come out. No amount of exorcism can work then. (Male *fakir*)

People's beliefs in this regard are rooted in the social relations and cultural traditions. Even when *fakiree* (matters related to *fakirs*) treatments do not work, they do not resort to biomedical care. In fact, the opposite is true; people may try out biomedical care without being sure of the nature of the affliction, and then return to the fold of *fakiree* healing.

> Since the time of affliction, three *Ramadan*s have passed by. We have tried many *fakirs* and spent a lot of money on treatments, but she did not get better. However, we still did not visit a doctor. Our relatives and neighbours told us that the doctors would give injections and make things worse. (Husband of patient)

There are self-claimed specialists among the healers; self-claimed because these specialisations are not strictly followed by the specialists themselves. For instance, the female *fakir* in our study is a specialist on children, and women with marital problems, while the other *fakirs* treat the adults. However, there are times when she will also treat adults with problems like *thapra* or other kinds of *batash*, if an adult patient comes to her.

Care seeking and care giving

As soon as people have identified obvious symptoms of *batash laga* according to their knowledge and by labelling the relatives and neighbours, they resort to the *fakirs* for treatment. However, actual care seeking may be delayed because of other extraneous factors.

> Her family and neighbours identified her illness as *batash laga* when she and her companion talked about the cold wind in the field. (Husband of patient)

Care at home is given by the one who is available most of the time. Even a seriously ill person may be left to the mercy of the caregiver alone.

> Her oldest daughter has already been married off and the son is quite young. Therefore, it is the younger daughter who takes care of her, since she is unable to do much of anything on her own. (Husband of patient)

Changes in perception

With time and modernisation in the Kakabo village, the perception of *batash laga* with regard to its existence and prevalence is changing:

> Now there is 'current' (electricity) so there is nothing; in earlier days when there was no 'current,' there were a lot of things lurking in the dark…. these things do not stay in the light too much. (Woman participating in an FGD)

However, healers had a different explanation for the rarity of patients in Kakabo village. According to them, people show up at their places for treatment and, more often than not, these people are from all over the place, not necessarily from this area. However, we also found one young man who did not even believe in the concept of *batash laga* at all.

Knowledge of the villagers

Interviews, informal discussions, and the FGD made it amply clear that the people of the community are well aware of *batash laga*. People could identify various forms of *batash laga* (*bakurali, agun jola, thapra, ordhango, alga,* etc.), as well as other supernatural afflictions that occur due to *jinn*, *pori* or *bhut*. They could also explain how these affected people and when. People are particular about what kind of *batash* has affected them, which eventually determines the treatment procedure they adopt.

When asked about who created *batash* and how, people unanimously mentioned Allah. This is also the case with the healers. What may seem to the researchers as something shrouded in mystery, for the people it is simple. They attributed the origin of *batash* to the will of Allah or Bhogoban and they are not bothered to find out more about it, or alternatively, they do not think that there is anything more to it:

> Everything is Allah's will. He is the lord of all things. He is the one who created *batash*. If he wants, he can save you from it as well. (Woman from the village)

Villagers know about the types of *batash laga* and how they affect particular individuals are common knowledge. The explanations provided are strikingly similar to that of the healers. However, healers seem to know much more about how one kind of *batash* is different from another kind and how they may be treated.

While talking about *ordhango batash* in specific, village women could graphically express how it affects the body:

> [This *batash*] stops the normal blood flow in affected parts of the body. [When and] if the blood flow is hampered in the muscles, the muscles automatically dry up. (Woman from the village)

Identification

Villagers have their way of identifying illnesses, though they cannot articulate them, and thereby, confidently resort to the *fakirs*. This trust on the *fakiree* domain and the belief that certain illnesses are outside the domain of biomedicine stimulates them to seek the *fakir's* help.

> We bring them to the *fakir* because it is the 'job of a *fakir*' (*ey ta fakirer kam*) but if we think that it is the job of a doctor then we will take the patient to the doctor…
> If it is because of *batash* then there are certain recognisable signs, if there is something else causing the illness then we can understand that as well. (Woman participating in an FGD)

Traditional healing

According to the healers, people come to them simply because they benefited from their treatments. They do not even have to advertise their expertise; relying fully on mouth-to-mouth seems adequate to them. Besides, they know that there are illnesses that belong to the domain of the *fakirs* and there are illnesses that belong to the domain of doctors. Some of the healers mentioned yearly *orosh* (yearly congregation, akin to a pilgrimage) as one of the reasons why people come to them.

The clients' primary reason for going to a healer is directly related to the categorisation of their illnesses. There are *fakiree rog* (illnesses that *fakirs* treat) and there are *daktari rog* (illnesses that doctors treat). Therefore, they visit the *fakirs* when they perceive themselves to be afflicted by a *fakiree rog*, *batash laga* being one of them. During the FGD, women put it as simply as the following:

> We women [identify]… that *batash* has touched us, so we [should] go to the *fakir*'s house and do the *jhar fuk* (incantation) and are healed. We do not need to go the doctors [for that].

However, there are dissatisfied clients as well. One patient's husband mentioned,

> None of the *fakir*'s treatments worked. We only ended up spending a lot of money with no results.

However, despite the obvious disillusionment, they did not visit any other kind of health care provider, since the illness was categorised as a *fakiree rog*, only a *fakir* could be of help.

Popularity

All the *fakirs* that we met were well respected in the community. Just about everyone in the village knows where they live and what they are expert in doing. Their popularity extends beyond the Kakabo village, people from distant villages come to them. In fact, we saw people coming over from Dhaka to see one of the *fakirs*. The traditional healers interviewed for research have been known to the community through generations of practice. These healing practices are passed on from one generation of healers to the next.

Medical pluralism

There is very little evidence to suggest that there is medical pluralism in terms of care seeking in *batash laga*. However, people can simultaneously seek various forms of treatment depending on the specific signs and symptoms. Some symptoms (e.g., headaches - especially partial headaches, nausea, etc. after being touched by air) are considered *fakiree* and some symptoms are considered *daktari* (e.g., coughing blood). Both of these can accompany an illness episode of *batash laga*. According to a patient:

> A *fakir's* job is to treat *fakiree* illnesses and a doctor's job is to treat *daktari* illnesses… both of them work…this is how I have been cured.

Traditional healers on the other hand are suspicious of combining biomedical treatments with their treatments. This happens specifically in case of injections. All the *fakirs* interviewed unequivocally mentioned that they could not treat a *batash laga* patient if s/he had been injected.

Orosh and mela

All the *fakirs* arrange yearly congregations of people including those who have been cured and those who have faith in traditional healing. These congregations are connected to the cultural aspects of the society at large. Devotional songs with accompanying music create the ambiance for the occasions and they tend to run through the night. People gather in large numbers to enjoy the events that take place and pay their respect to the healers.

> I do *orosh* on the twentieth of *Baishakh*[96]. We invite everyone, even the police. There is entertainment with songs…people who were treated earlier, come and they bring chickens, roosters, etc. as their *manti*. We prepare *shinni*[97], *khichuri*[98], and feed them… (Traditional healer)

Who treats and how does s/he treat?

Becoming a *fakir*

Fakirs inherit their skills and knowledge primarily through dreams and apprenticeship to another *fakir*. The ones we interviewed for the study mentioned receiving instructions through dreams. They also mentioned that a lot of the knowledge was passed on to them from their fathers, who had been *fakirs* themselves. These *fakirs* have inherited the skills of the trade from their parents. They are not all equally willing and encouraging about passing it on to their children in turn. Earning a livelihood to sustain their families is what has made them push for a different profession.

> Times are really bad now… our parents ate much better than us, we ate better than our children … our children are not getting any of that… the times are bad. Now they are working as *muchi* (cobbler) in the village and go over to Dhaka to sell the products. (Traditional healer)

Source of inspiration

> However, at the end of the day it is God (*Allah* or *Bhagoban*[99]) who can do or not do something…it does not matter whether the person is a Hindu or a Muslim the Lord answers to everybody's call. (Traditional healer)

96 *Baishakh* is the first month of the summer season in Bengal.

97 *Shinni* is the sweatmeat or food made of rice or wheat flour, distributed among people mainly during *Orosh,* or other Islamic festivities and ceremonies.

98 *Khichuri* is a local cuisine prepared by boiling rice and lentils together.

99 *Bhagoban* or *Bhagwan* is the supreme deity (According to some traditions of Hinduism).

> … In a sense I am nothing, I am just a medium, healer is the only one (*ami to kisu na, aami ekta usila, sharoner malik ekjoni*). (Traditional healer)

In a way this source of inspiration from the healers plays a role in repeatedly reminding clients, and eventually establishing the fact, that *fakirs*' healing processes are consistent with the clients' religious beliefs and also the informal admiration of the clients for the healers' relationship with God. Activities taking place in the house of a *fakir* regarding the treatment process reveal this clearly (to a client from Mirpur, Dhaka). First she explained that it was all *Domer Madar* (locally known as the spirit of the grand son of Hazrat Ali), the source of all her powers and insights. She made it clear to them that she cannot and does not do anything on her own. If there is Allah's mercy upon the girls, and if the *Domer Madar* guides her, only then they will be cured of their ailment, not otherwise.

Rapport building

Fakirs usually treat their patients as 'guests' and their overall approach toward them is very informal. It does not matter whether the patient is new or old. This informal dealing tends to put the patients at ease for a short time, which enables them to talk about their problems freely. *Fakirs* also take the extra step in explaining the whole situation to the clients as well as their parents and/or guardians, which makes it easier for them to understand. If a *boithok* or 'sitting' is necessary, they also describe the process of it, so that clients know what to expect. In terms of providing the treatments, they are extra cautious in explaining how they should take the medicine, wear the amulets, take the enchanted items, and the dietary guidelines they should follow.

Boithok

Boithok literally means a formal sitting. In the context of traditional healing, this formal sitting is where the spirit with whom the healer communicates is invoked. In the case of one of the *fakirs*, it is referred to as *Domer Madar* (also known as the giver of breath). An object found in dreams usually represents the spirit, and it is different for each *fakir*.

Boithoks are not always necessary. They occur when the healer cannot be certain and/or needs guidance in terms of figuring out what medicine to provide that the *boithok* is arranged or the spirit invoked. Arranging a *boithok* requires preparation. *Dhup*[100], candles, and incense are lit; empty floor space is prepared for people to sit on; rose water is sprinkled on the people who have gathered for the event, etc. Altogether this creates a solemn atmosphere, congenial for the invocation to begin.

The arrangement could be more elaborate, depending on the needs of the specific patient and also whether the patients are willing to spend more money. Depending on these contingencies, a *boithok* session may include devotional songs and music, where a lot of people are invited. A big feast may also follow such a session.

Things begin with chanting, which is similar to standard prayers of the Muslims. Things vary depending on whether the *fakir* is a Muslim or a Hindu. Muslim healers utter verses from the *Qur'an*, while the Hindus utter verses from the Vedas or some other Hindu scripture. At the end of the initial session, everyone is asked to join in the prayer. After the prayers, a second chanting session begins. It is believed that the invocation works better if there are more people joining in the chanting. This

100 A kind of incense that is burned during a *boithok* or sitting.

session can last indefinitely, since it goes on till the spirit is invoked and starts to speak through one of the persons present in the session usually the healer her/himself. They are recognised as the best mediums. This is when the solutions to the problems and guidance to recover from the illness are usually discussed.

At this point, the *fakir* reaches out to the afflicted individual/s and puts her/his hand on their heads and the process of *jhara* or exorcism begins. At the end of an exorcising session, the *fakir* does something to the afflicted person, i.e. ties her/his hair in a knot never to be undone. Afterward he or she provides the other kinds of treatment.

Treatments

Treatment is based on shared features between client and provider. The provider has several means of holistic treatment, i.e., building rapport with the clients, relaxing them and the family members, consultation, informal and formal diagnosis (*boithok).* They also prescribe herbal medicine and explain the aetiology of the illness from a shared socio-cultural perspective. Their counselling involved the family members in the discussions, instructing scheduled treatments, preparation of the medication and its distribution, means for protection from specific illness and also alternate treatment in case of non compliance to treatment. Patients are sometimes asked to come for follow up visits. However, healers do not reveal the names of specific herbs to people.

Treatment principles strictly relate to the perceived pathophysiology of the illness. For instance, *ordhango batash* is treated by tying the limbs with strings and ropes and then literally pulling down the circulating polluted blood that causes the paralysis and expelling it out of the body. It follows the same principle as the treatment for snakebites. This is another form of *jhara*. However, the clients do not know much regarding the mechanism of how the healing of *ordhango batash* works. They only know that it works!

The ingredients of the medicines enhance people's trust in the medication. A medicine derived directly from nature makes it seem more trustworthy. This is a belief shared by both the providers and the clients.

Referral

A sense of altruism is prevalent among the *fakirs* in terms of their role in the community. They make it clear that they do not practise in order to make money, but only for the wellbeing of the people. A similar point was raised when we talked about one healer succeeding in curing a patient, while another failing. According to them, no one can tell in whose hands a patient will be cured, since everything depends on the will of Allah. They apparently expressed no antagonism against other healers because they felt it was the wellbeing of the people that really mattered. In fact, there is an informal referral system among the *fakirs*. This system is more like suggesting that one should visit this or the other *fakir*, when her/his treatment fails. People in the community also talk about the healers with a certain sense of respect and admiration. Like the healers themselves, the people believe that the healers have dedicated their lives for the betterment of other people.

Payment

Payment for the services that the traditional healers render varies from one healer to the other. Some have fixed charges and some do not. Those who do not have fixed charges leave the payment up to

the discretion of clients. However, all the traditional healers interviewed for the present study mentioned that there are expenses involved if and when a *boithok* is necessary. However, they claim their healing procedure is far more cost-effective for the clients than the expenses incurred in biomedical procedures:

> …when there is a problem with their menstruation (*jokhon tago khun vange*), they spend over two thousand taka, but still they are not healed properly. Instead, I give a bit of ordinary enchanted water and a little herbal (*gachonto*) medicines, and in three days, there is hardly any blood. People get benefits. That is why the come to me. (Traditional healer)

In case of one of the providers, payment for *boithok* is fifty-one taka. This fee needs to be paid before the *boithok* begins. However, elaborate *boithoks* require more money, since that may involve a big feast, music, etc. Clients, on the other hand, do not seem to make comparative judgements on between the payment plans of these procedures (*fakiree* and *daktaree*). To them, both procedures require money.

How to protect?

There are measures by which a certain level of protection can be achieved against *batash laga*. These measures are culturally prescribed and socially enforced. Both the clients and the providers share a common belief regarding these matters. However, these measures can never be fool proof. If God shows His mercy, only then it can be ensured. Certain measures harnessed from nature and then they are combined with the healer's verses and mantras. Thus, they become effective:

> Yes, there are amulets, made of seven metals. There are also some *gachonto* (herbal) medicines that I can put inside an amulet and do a little incantation… if one wears it as s/he should, then s/he can be safe. (Traditional healer)

Discussion and conclusion

There are striking similarities between the worldviews of the providers and clients, when it comes to *batash laga*. Both the providers and the clients believe that *batash* is a malevolent agent with certain personality characteristics (Foster 1998 cited by Hardon et al. 2001: 13-14), for which exorcising is necessary. However, despite this fact it cannot be considered completely personalised, since it is not understood in terms of *purposeful* intervention of the agent, though there is an agent. Our findings in this regard contradict the definition of *alga batash* as provided in the *Banglapedia* (Faroqi 2005):

> Someone's erratic behaviour is called *batash laga* or *alga batash,* and is attributed to an intangible spirit, or sometimes, to a disembodied soul devoid of any corporeal spirit. Such a spirit apparently wanders through wind and penetrates the human body through its unlimited apertures. How does *alga batash* cause disease? The rural people will tell various stories to illustrate its working. *Batash* does not always penetrate the body directly. It may come through another person linked to a patient.

In our study, we found that people hardly mentioned there was a *purposeful* agent as *batash*. Rather it is believed to be more naturalistic, because it moves and touches individuals as inert air does. Both parties classify the types of *batash laga* based on the perceived severity and kinds of signs and symptoms resulting from being touched by *batash*.

The pathophysiology of *batash laga,* as revealed by the body mapping exercises, reflect the healers' shared knowledge of the body and the malevolent activities of *batash* which strongly supports the symptoms for the respected illness, indicating the healer's logical diagnosis and perhaps the treatment as well. Clients also describe the pathopysiological processes, specifically for *ordhango batash*, in a similar fashion.

The cardinal theme that guides people in terms of considering a *fakir* as the appropriate person to treat *batash laga* is linked with their knowledge of the affliction, their perceived expertise of the provider, and the concepts they shared with the *fakirs* regarding the meaning of the signs and symptoms. Traditional healers are the best options for a patient suffering from *batash laga*. The local culture enriches the people through the lessons learnt from the deleterious effects of delay in care seeking from a traditional healer or a *fakir***.** Pluralistic health care seeking behavioural pattern in terms of *batash laga* depend on the perceived expertise of the care providers and the specific signs and symptoms associated with the illness. A case of *batash laga* may very well have signs and symptoms that are associated with both *fakiree* as well as *daktaree* expertise.

However, there is a conflict between the mystic entity of *batash* and the process of modernisation in the community. Nevertheless, the simple fact that electronic lights drive away the darkness usually associate with the presence and the invisible malevolent actions of *batash* does not necessarily obliterate their beliefs about the existence and concept of *batash* itself.

The holistic features of the traditional healing procedures provide meanings to the clients' illness experiences. Besides providing some meaning to an unexplainable phenomenon, this peculiar therapeutic approach becomes a major step in the therapeutic process of the individual's illness episode. In addition, the *gachonto* ingredients from natural resources and the shared nature of human beings to believe in God establish the trust for the healing process and solidify the healer-patient relationship. This trust that binds the provider to the client is in fact a stated covenant that lies in the heart of medicine in all its forms (Cassel 1996). Healers make no bones about the fact they do not do anything, they say God does everything.

The socio-economic condition of the *fakirs* needs a special mention here. Apparently, these healers are in no way different from the villagers in the community. Most of them till the soil to grow food to live on; all of them live in a *bari*[101] that is just like any other *bari* in the village; even their appearances are like that of any other person in the village. In a word, they are only villagers, belonging to the same community and sharing the same cultural values and social responsibilities. Except for their skills in healing, they are at one with the rest. This helps to alleviate any possible tension that may arise in the hierarchy of clientprovider relationship, a problematic and widespread phenomenon in the biomedical tradition. The physical setting of the consultation speaks of the same truth. When villagers visit these *fakirs*, they do not feel intimidated by the setting of their house and quickly become comfortable.

We need to mention that although the concept of *batash laga* is quite prominent among the villagers, it is difficult to find *batash laga* patients, at least the *ordhango* or *thapra batash* kind. People repeatedly mentioned, "this woman has been suffering for a long time…", but she turned out to be someone we already talked to. People often say they do not know anyone with *batash laga* right now or mention

101 *Bari* refers to the homestead.

that not many cases of *batash laga* are found these days. We even found people who do not believe in *batash* as such. It seems, more and more people are talking about *batash laga* in terms of paralysis.

The common stock of knowledge regarding types, signs and symptoms, and persons to visit in case of *batash laga* is the crux of the synergism between the clients and the providers. *Orosh* and/or *melas* also provide a concrete cultural context of the synergism between the client and provider relationship. The altruistic motif of the *fakirs* is yet another aspect where the synergism is most evident. Perceived benefits, and not the payment, are why clients visit the *fakirs*.

In conclusion, traditional healing is a inter-generational practice. The teachings are passed on to a son or a daughter from their parents, or from one teacher (*guru*) to his or her apprentice (*shishsho*). However, the struggle to earn a livelihood is adversely affecting the prospects of becoming a traditional healer. It would not be an exaggeration if we were to say that traditional healing is facing a sort of 'death' in the face of a market economy and eventual modernisation. In the wake of this modernisation, we must not forget that these traditions are intimately connected to the greater cultural and social norms. In other words, in the name of modernisation, we may very well be witnessing the 'death' of certain elements of culture and society, as we knew them to be.

Explanatory models of both the providers and the clients indicate that there is a plethora of factors behind the apparent synergism in this kind of client-provider relationship. One of them is the similarity in the worldviews of both parties. We believe any programmatic intervention to improve the health status of the people must take these issues seriously into account.

Traditional healing

Perceptions of traditional healers towards biomedicine

Abebual Zerihun & Faria Shabnam

In this chapter, we explore perceptions of traditional healers towards traditional medicine and biomedicine. This exploration also raises issues related to possible collaboration with the two types of medicine in providing health care in the village. We involved villagers in drawing a social map to the locations of eleven local traditional healers. Later, we purposively selected one female and three male traditional healers to represent members from both genders. Three were Muslims and one was Hindu. We conducted in-depth interviews and employed several PRA tools, e.g., to collect data regarding lists of diseases, local names of diseases, various signs and symptoms of those diseases. We also explored the healing practices and the interaction between traditional healers and their patients.

The first process of our fieldwork began with locating the residences of traditional healers using a social map drawn by villagers themselves. Only four traditional healers were available and gave their consent to be interviewed.

Terms and definitions

The purpose of defining certain conditions and terms listed below is twofold. One is to understand the local meanings of traditional medicine. The second, and most important thing, is that it helps to explore the perceptions of traditional healers towards biomedicine through understanding the key words in their definition.

Definition of biomedicine

The majority of our respondents defined biomedicine by comparing their practices with medical practices provided in different health centres:

> Doctors' practices are called allopathic and homeopathic. Homeopathic action is delayed but works much better whereas allopathic means instant action. Traditional medicine is neither homeopathic nor allopathic. It is not instant or delayed. It is in the middle. It is called *Kabiraji*. (*Kabiraj* Babul Chandra, forty-seven-year-old male Hindu traditional healer)

The traditional healers described biomedicine comparing different diagnoses:

> Doctors need scanning, blood sample, bandages, and x-rays, but we just diagnose it by seeing and checking the pulse…all medicine they are currently using are

> produced from herbal…it is taken from what we have used for years and years. We use original and natural herbs and it cannot expire like their medicine. (*Fakir* Abdul Karim, sixty -year-old male Muslim traditional healer)

Table 3: A brief description of four traditional healers in Kakabo

Name: *Pir*/*Fakir* Abdul Karim (male) **Age:** Sixty years **Education:** Sixth grade **Family Background:** Married with two daughters and two sons. He is from a very well known family in the community **Source of income:** Cultivation, selling produces, and house rental (he has a house in Dhaka) **Twenty years of experience as a healer** All his children are educated or in school Claims to have visited India, Greece, Kuwait, and Italy	**Name:** *Fakir* Minara Begum (female) **Age:** About ninety years **Education:** No formal or informal education **Family background:** She has a daughter and six sons, nineteen grandchildren, and seven great grandchildren **Source of income:** Cultivation, offerings **Seventy years of experience as a healer** She received her healing lessons through her dreams one night from a supernatural power. She claims to have visited India, Chittagong, and Barisal
Name: *Kabiraj* Babul Chandra (male) **Age**: Forty-seven years **Education**: HSC completed **Profession**: Primary school teacher **Family Background:** Married with three daughters and a son **Source of income**: Cultivation and teaching salary **Twenty-two years of experience as a healer** All his children are in school. He inherited the healing tradition from his father	**Name**: *Kabiraj* Khalek Mia (male) **Age**: Fifty-eight years **Education**: No formal or informal education **Family Background:** Married with three daughters and four sons. His sister in-law and her four children live with him **Source of income**: Cultivation **Fifteen years of experience as a healer** Gained knowledge by training from outsiders (*Guru)*

Definition of traditional medicine

We asked the traditional healers how the villagers usually addressed them and wanted to know their local terms for traditional medicine. We found that there was no single specific name used to indicate traditional medicine:

> People call me *fakir shaheb* and *pir shaheb*, because I use the power of God in my healing practice. The power has two forms, the *Shariyat* and *Marefat*. *Shariat* is that you can see and *Marefat* is a spirit that you cannot see.' (*Fakir* Abdul Karim)

> For those who are only herbalists and apply spiritual healing from the holy books only occasionally, people call them *Kabiraj*. Those who only use herbal and receive money for their service, they are called *Hakim*, and there are those who are bonesetters. They are the *Bede*. You will not find them here because they live and spend their life on the boat. (*Kabiraj* Khalek Mia, fifty-eight-year-old male traditional healer)

Three kinds of perceptions

We free listed the perceptions of the traditional healers towards biomedicine and we then categorised the perceptions into three major classes. There is an overlap of different perceptions expressed by certain individual healers. It is to convey the difference in the nature of healing practices that we present their perceptions in these broad categories:

Separate entities

One category of perceptions we repeatedly came across were notions that traditional healing was a separate entity from any kind of biomedical practice. Ninety-year-old Minara explained with pride in her voice:

> Doctors do not use a spirit but most diseases are caused by evil spirits. They should be treated with the spirit and according to what the spirit tells us to do. The herbals are also depending on spirits…(hmm)… we have different ways of doing it, and it is completely different. They cannot be mixed and compared. It is like this (she raised her two fingers side by side to indicate that these two systems ran parallel). No one is better. We are different.

Complementary systems

The other popular perceptions regarded recognition of the benefits of biomedicine in certain conditions to ensure better health. These conditions are usually cited based on the different kinds of diseases or injuries:

> With the rise of doctors and health centres, we lost people's respect. If there were no doctors, people would give us more value and respect…but you see we need both, if we do not have one of them - people will die. For example, we need a doctor for an operation…but for the first and the faster action in the community, *kabiraj* is very much needed. (Fifty-eight-year-old Khalek Mia)

Abdul Karim, one of the well-respected *fakirs* in Kakabo village holds a similar view:

> If the bone is broken, the doctor is important because he does *'abosh'* (local term for anaesthesia), our local herbal is not as effective as *'abosh'*. When we treat the patient, he has a lot of pain and we believe that it hurts his heart.

Competitive and threatening adversaries

The same respondents also shared their experiences and fears of biomedicine. They express the sense of being taken over by biomedicine. Most of the respondents share their experiences with sadness and a sense of being at war:

> Nowadays doctors are stealing all our methods of treatment. For example, in the case of snake bite, previously doctors were not able to cure the patients but now they can, because they took it from us…Now it is a scientific time and people become dependent on books and *fakirs* are threatened (Khalek Mia).

The other form of threat is the fear of extinction because there are fewer people who want to learn and convey the knowledge of traditional medicine to the next generation. They blame science and think that biomedicine is a major contributor to their demise. Looking far to the river next to where we sit, Babul Chandra, a teacher and traditional healer said:

> I cannot hand over my knowledge because nobody wants to learn. None of my children wants to learn this. Since it needs life commitment it has to be voluntary, as you know - it is a voluntary work and there is no income. With advancement of health centres and education, currently people are more interested in business, and due to that, our practice of traditional medicine is decreasing. As a result, they always want to dominate us.

In conclusion, although all these categories of perceptions look different and may seem to be in conflict with each other, these perceptions exist in harmony within a single individual healer. Their views are not entirely independent of the others. The reality is that a single person often holds more than one kind of perception.

Differences between bio-medicine and traditional medicine

The traditional healers mention various differences between biomedicine and traditional medicine, as presented below in a tabulated format:

Table 4: The difference between biomedicine and traditional medicine as identified by the traditional healers

Biomedicine	**Traditional medicine**
The healers	
Biomedical healers perform the treatment for the sake of money	Traditional healers perform the treatment for the health of the people. Not for money.
Doctors misbehave a lot	Traditional healers do not misbehave
Doctors do not believe in *Kabirajñ* treatment	A *Kabiraj* believes in a doctor's treatment
Doctors want to dominate the *kabiraj*. Usually they mock the traditional healer.	A *Kabiraj* does not do the same.
Doctors never refer a patient to the traditional healer	Sometimes traditional healers refer a patient to the doctor and sometimes they do not
Treatment	
Doctors give tablets, capsules or syrup	*Kabiraj* gives herbals and exorcises the patient with *ayats*[102] or *mantras*[103] (uttering excerpts from holy books)
Biomedicine is useful in case of operation	Traditional healing does not include operation
Biomedicine needs scanning, blood sample, X ray, bandage	Traditional healers diagnose the disease by observing the symptoms and feeling the pulse
Characteristics of medicine	
Biomedicine has an expiration date. After this date if anyone takes the drug it might be harmful.	Traditional healers use herbs, which are original, natural and can be used forever.
Components of tablets and capsules are not known to the traditional healer.	According to traditional healer traditional medicines are pure.
Medicine is important because it can reduce pain, *anaesthesia,* for example for setting bones.	Traditional healing doesn't include this. By treating displaced limbs through traditional medicine the patient may feel pain.

102 *Ayat* are collection of *ayah*, verses from the holy *Qur'an*

103 *Mantra(s)* is a verse or hymn from the holy texts believed to have healing effects on the afflicted (in Hinduism and Buddhism).

Biomedicine	Traditional medicine
Affordability and accessibility	
Doctors' treatment is quite expensive. Poor people cannot afford it.	Traditional treatment is free of cost. It is the main way of treatment.
For the remote rural areas doctors are out of reach.	*Kabiraj* gives instant treatment in rural places.
Diseases that are treated/ not treated	
Doctors cannot treat paralysis *(Atonker batash, lular batash, ordhanger batash).*	*Kabiraj* can treat paralysis more successfully if it is in the first stage.
Doctors prescribe hot compression in piles *(kata baushi, rokto baushi)* or do operation which is not successful all the time.	Traditional healers can treat piles more successfully with a few herbs.
Doctors cannot treat *batash laga* (evil air) because they have no spiritual power.	Traditional healers can treat this and most of the children's diseases due to evil air.

Factors that shape these perceptions

We just described the three categories of perceptions towards biomedicine with supporting quotes from the traditional healers. Now we shall try to explore the factors that shape these perceptions.

Values and principles

One of the most common issues that came to our mind was the values and principles held by the traditional healers that are directly opposed to the values propagated by biomedical practice. One of the best descriptive examples was cited when a respondent expressed his perception towards taking money from clients. It is considered evil and against God's will:

> We serve God's people not for the sake of collecting money. If even by mistake we take money it is a curse, the treatment will not be effective, so for that reason I never and will never accept money. Sometimes when people give me cloths I accept, otherwise I never accept money. However, we see that doctors are taking a lot of money, and that is the reason why God's people are suffering and dying. (Abdul Karim)

This traditional healer has been directly affected by this perception. He has travelled to other areas to find a master who could teach him about healing and he tried a lot to learn from his father. He told us that his father was a *Kabiraj* too. Although he asked his father to teach him, his father refused. When we asked him what his reason for refusal was, Abdul Karim said after a long pause:

> My father was a *kabiraj* but he never wanted to teach any of the family members. He never liked his work as *kabiraj* and I must say that he was a hidden *kabiraj*. He used to have his own book. He never allowed me to read it. My father thought that by being a *kabiraj* a person could destroy many people. He can misuse it, like he thought he might receive money and he was always afraid about it and wanted to avoid it. Therefore, think that he wanted to avoid the wrong a *kabiraj* could fall prey to.

We can clearly see how traditional healers' values conflict with practices of biomedicine. This conflict could have a direct implication in shaping healers' attitudes towards biomedicine.

Types of healing practices and sources of knowledge

We found that there was no consensus regarding the perceptions towards biomedicine and different types of healing practices. Traditional healing practice was labelled as herbalist, spiritual, or both. We have found that complete spiritualist and spiritual-herbalist have strong opposing views about sharing experiences with or learning from the biomedical health practitioners. We also found that the healers who believed that knowledge came from supernatural sources or inheritance had strong and uncompromising views towards biomedicine (medical practitioners, drugs, health centres and hospital aid machines). However, healers who have gained their knowledge through training from outsiders hold, different views. For instance, *Pir* Abdul Karim remarked:

> How can I learn from or teach a doctor? I use spirits, and the doctors do not believe in it and have no respect for my knowledge; I do not have to learn anything from them. We are opposites.

Kabiraj Khalek Mia, who got his knowledge through training from an outsider, seemed more supportive; he told us that there was nothing wrong with biomedicine and that he was willing to take any lesson from a doctor and also teach one if the occasion arose. Therefore, the source of their knowledge of healing may be one factor that can shape traditional healers' perceptions towards doctors and medical practice.

Self-esteem

One of our respondents, Abdul Karim, who treats on an average almost five hundred patients per month (twelve patients per day for twenty-two days of the month, he does not work on Sundays and Thursdays), says that he feels honoured and respected in his community. People love him like God. He confesses that his status in the community affects his level of commitment to them and he wants to maintain his reputation. He thinks that doctors are unaffordable and always run after money. He does not want to be like them.

Personal experience and exposure

We found that the healers who have a strong antagonistic view towards biomedicine have a wide range of healing experience and exposure to successful healers of the country and the outside world, which may have helped them to maintain their views and perceptions. *Pir* Abdul Karim told us that they held training events among themselves. He said,

> There are a number of powerful *kabiraj* in Bangladesh, India and in other countries. I have attended many spiritual and healing events in Chittagong, Barishal (Southern part of Bangladesh). I also travelled to India and Kuwait. We go there and gather knowledge. The holy men teach us something new and we share our knowledge with each other so that we can improve our practice.

Failure of biomedicine in some diseases

All four respondents agree that there are diseases that biomedicine cannot treat. They tell us that biomedicine cannot treat diseases like *paralysis* at the primary stage, or conditions in which the uterus comes out through the vagina (uterine prolapse). Abdul Karim says,

> For example, if there is *'lular batash'* at the primary stage or *'gorvonali ber howa'* (uterine prolapse) doctors can perform operations. An operation is not good and usually fails if any injection is given (*'shui' futalei mone koren shesh*). When the patients come to us, we treat them very well with immediate success... Usually patients visit me after they have visited the doctors and they tell me that the doctors could not solve it. The second is '*baushi*' (something comes out through the anus). Doctors usually give it a hot press or do operation but this is not successful either. With some herbal medicine we can cure it, instantly and that result is forever. The condition never returns. Sometimes when children do not have appetite for breast milk, a doctor does not know how to treat this. But we do.

The perception of failure on the part of biomedicine and the importance in filling the gaps between biomedicine and traditional medicine may have shaped the traditional healers' ideas regarding biomedicine as an entity that is yet to stand on its own two legs.

Relationship between traditional healers, biomedicine and biomedical practitioners

We did not have a clue at the early stage of our research that there was such a great imbalance in patient referral behaviour among the doctors and traditional healers. This could be the chief reason why there is this attitude of stubbornness and competitiveness among the healers towards biomedicine. With a high voice, the ninety -year-old Minara Begum told us:

> Doctors do not want to mention the name *kabiraj*, do not want to acknowledge our work. When I find a patient that I cannot treat, I send him to the hospital. Doctors never do that, at least not officially. I know some patients who come and tell me that the doctors cannot treat them and that they tell them to try other ways. What does that mean? The doctor is indirectly telling them to visit us…but they do not want us to know because they do not believe in our practice. They do not believe in *jhaar phuk*. We mention their name, but they do not.

Behaviour of health practitioners

The traditional healers repeatedly mention that the health practitioners frequently misbehave with the patients. The healers think that such behaviour is evil and against God. They tell us that healers should have a healthy and affectionate relationship with their patients. We had a chance to observe the level of interaction between a traditional healer and his patient. It was very intimate and the patient was obviously at ease with the healer. *Kabiraj* Chandra describes the situation as follows:

> Usually delivery happens easily and it is simple. In case of doctors however, for the sake of money they complicate a normal delivery and put the normal woman in the operation room. They have some contract with some pharmacy so that when you want to buy some medicine they tell you to go only to one place. It may be far away or expensive but they do all this for the sake of commission. This is inhuman and dangerous.

Minara Begum told us that more than half of all diseases can be cured by just touching the patient gently and showing that you care, rather than barking like most people experience in hospitals.

Use of biomedicine by traditional healers

To elicit the perceptions towards biomedicine, we discussed the use of biomedicine by traditional healers themselves or their family members. Almost all traditional healers go or send their family members to the nearby health centre. The major explanation offered by the healers is that the

treatment they provide cannot work for them or their close family members. Each said that their source of knowledge (supernatural power, God, the book, 'holy books', *Guru*) clearly taught them not to use their own treatment on themselves. Babul Chandra said:

> Yes, there were few times when I have sent my family to doctors, because it is clear that I cannot treat my family members. Personal knowledge does not work for my wife or children. The spirit does not work for my family.

Discussion

Traditional medicine is one of the practical aspects of traditional knowledge and it is part of the traditional religious and belief systems. Any change to that will not only disrupt the indigenous healing system but, also, the traditional life-style in which healing is embedded

For centuries, traditional healers have been functioning in some part of the world. They are still reagarded as cultural authorities, mediators of social conflict and violence, and key interpreters of local culture. The failure of traditional healers to transform knowledge to the next generation, technological transformation in the biomedical field, shortage of natural herbs, and gradual decrease of patients coming to traditional healers due to an increase in drug dependency are the major indicators of a socio-cultural transformational threat to the traditional healers. A field research done in Cambodia showed the status of traditional healers as key forerunners and bearers of cultural systems for healing and that the culture was now threatened by post-conflict transition (CERI 2004).

Health policy makers, in recognition of the contrasting frameworks of western science and indigenous knowledge systems, are calling for culturally relevant frameworks and processes for knowledge generation and knowledge transfer. Such a situation can create a group of people or even 'cartel's with motives of cooperation to preserve the traditional culture (Vogel 1996).

We mentioned at the beginning of this chapter that an in-depth exploration of traditional healers' perceptions towards biomedicine would help to identify areas of collaboration between the two. Discussions and expert debates are still going on regarding collaboration. This paper offers three areas of discussion based on perceptions of traditional healers. The first one is related to the fact that some healers are completely antagonistic and have a strong belief that biomedicine practice is a completely different practice that goes against their values and beliefs. Some healers would agree with the differences and conflicting nature of biomedicine but, also, believe in the importance of collaboration during selective conditions. The third group of healers perceived that they were threatened by neglect of concerned bodies and social transformation. This group of traditional healers usually feels helpless and sad with the current situation. However, under the same category there are also some who view that they are in competition with doctors, which has filled them with stubbornness and resistance against any ideas of collaboration. They believe that they are deprived of appropriate recognition.

These factors need to be kept in mind before we discuss the option of collaboration between traditional and biomedical health care. We would like to emphasis that current programme interventions towards collaboration of traditional healers and biomedicine lacks important elements from the traditional healers' perspective. Thus, a close exploration of every dimension and cause of perception in terms of attitude, knowledge, and values is required. Furthermore, ethnographic research exploring the lives and knowledge of traditional healers should be conducted. Last but not the least intervention programmes targeting the documentation of cultural transformation and indigenous knowledge should be encouraged with a view to enhance the cultural competency of the public health system in Bangladesh.

Health information

Who knows what from where: Sources of health information

Iffat Sharmin Chowdhury & Sarah Mcleod Wilbur

In this chapter, we shall describe the sources as well as barriers to health information for adult men and women in the village of Kakabo. We interviewed three men and two women in-depth. We also conducted two FGDs broken into separate groups for both genders, five respondents in the men's group and six in the women's group. Observation of the locality and the local people also revealed their way of life, interactions with each other, intentions, body language, gestures, behaviour and small incidences in their daily lives. The respondents described their perceptions of the meanings of the words "health" and "disease." They identified their sources of health information through the process of freelisting. In addition, they identified the barriers they encountered in obtaining health information, as well as, their preference for sources of health information in the future. We took photographs in several parts of the village and scanned through three newspapers the villagers commonly read. Specific health information provided outdoors in the village, on the walls and in the newspapers were collected separately in different times.

The women overall were younger, ranging in age from an estimated age of eighteen to twenty years up to approximately thirty-three years. While some older women were contacted only younger women actively participated in the FGDs and in-depth interviews. This may reflect a higher level of literacy (although one of the women in the group admitted that she had never attended school at all) than is generally reflective of women as a whole in the village. The other women participating in the study reported formal education ranging from class six to HSC. The men ranged in age from approximately thirty to sixty-eight years. They reported some degree of formal education extending from fifth graders to a graduate who is a teacher in the village school.

Health and disease

Before attempting to identify the sources of health knowledge that respondents used, we felt it was incumbent to learn their definitions of "health" and "disease." Almost all of their responses indicated a close relationship between "cleanliness" and "nutrition" as the fundamental aspects of "health." However, it is notable that the women also included mental well-being in their definitions. Some even mentioned *Chinta Rog* the local term used to describe a depressive illness as a threat to health. "Health is a beautiful mind, absence of disease and cleanliness of my house," said a twenty-nine-year-old woman with secondary schooling in the FGD. Men, however, focused only on cleanliness and nutrition. "Nutritious food…fruits and vegetables…cleanliness…these are healthy," said a thirty-five -year-old small trader who sells aluminium utensils.

With respect to disease, once again women included mental issues, whereas men focused on physical symptoms, described disease as "a hazard to health and no comfort to the body." Women, however, talked about disharmony and imbalance. "When your mind is not in peace, that is when you are diseased," said an eighteen -year-old unmarried girl.

Sources of health information

Three major sources were identified as sources of health information by the respondents. In most cases, the sources were parents, relatives, friends and neighbours. Interestingly, many people in our study group seemed to play a dual role, they seek health information from others and vice versa. The next most frequently identified sources of health knowledge are the health professionals, a large group comprised not only of doctors and other clinicians, but also of *Swastho Shebikas*[104] or other community health workers with some rudimentary health training, as well as, other outsiders, such as, church missionaries who periodically visit the community. The third most frequently identified source of health knowledge is the Media: newspapers, television, posters, radio and plays staged within the community.

Family, friends and neighbours

Thanda Jor (common cold or flu) is listed by almost every single adult in our study, as one of the most frequent illnesses to affect people in the community and knowledge of how to prevent it comes from parents as naturally as mother's milk: "Do not play with water; you will catch a cold!" (Advice frequently imparted to children).

Other regular illnesses that occur in the village were mentioned as *gastik* (indigestion and peptic ulcer diseases), diarrhoea (although that is less common now, they say), *gola betha* (sore throat) and *jondis* (equivalent to jaundice, and various kinds of hepatitis). Knowledge of how to handle each of these illnesses has become common in the community, handed down through generations.

The respondents mentioned that the stock of common knowledge had grown in recent years as well. Immunisation campaigns had proven particularly effective, and this had bolstered the community's faith in them. The respondents feel that immunisation campaigns are no longer considered a source of knowledge. It is common knowledge.

Ali, a devout Muslim and a shopkeeper at the far end of the village views himself as a fount of health knowledge as well. Not only does he sell various medications (antacids for gastric symptoms, for example) but he also takes it upon him to be a community activist whenever he hears of an immunisation programme coming to the area. "I am a busy man," Ali said, "But whenever there are immunisation programmes in the community I make sure I go and tell people. Even though I'm busy, I take time to tell them."

Health professionals

All but one of the respondents spoke of relying on health care professionals from the evidence-based bio-medical community as a source of health knowledge. The exception, the poorest member of our study group, informed us that her grandmother-in-law was a spiritual healer. Given that her grandmother-in-law was listening to her interview, Feroza declined to volunteer information on whether she had more faith in her grandmother-in-law's knowledge than that of advocates of evidence-based medicine, whether she would even consider the subject, or whether economic factors made pursuing such options prohibitive. However, she did inform us that prior to her marriage she learned about immunisations from a *Swastho Shebika*. "Both of my sons got their full immunisations," she said proudly. Other women echoed her, noting that the community health volunteers who made house-to-house visits were effective and meaningful sources of health information.

Men, too, said that they went to doctors, hospitals or clinics for knowledge as well as treatment. Ali gave the specific example of his wife's recent pregnancy as a time when he sought both knowledge

104 BRAC Community Health Volunteers are known as *Swastho Shebika*.

and treatment from clinics and a hospital in Dhaka. The women seem more likely to access doctors and clinics in the company of their husbands. They are also more likely to benefit from home visits by community health workers and volunteers. Both men and women are apt to specify "*gynae doctors*," (gynaecologist & obstetricians or doctors with some training in gynaecology & obstetrics) as a health information source for women.

Nahid, a not-yet-married woman, age somewhere between eighteen to twenty years, has taken advantage of yet another source of medical knowledge in the community. Missionaries from Grace Christian Church in the village have provided a number of health programmes for the community, which Nahid says are well attended. She herself has attended their programmes on sanitary latrines, personal hygiene and environmental cleanliness. She said, "I got advice from the church for not going to a *kabiraj*. They said I should go to a 'proper doctor.'"

Mass media

Men overwhelmingly identified mass media as a major mode of obtaining health information, citing newspapers, posters and roadway signs as important sources of health knowledge. Despite the limited levels of formal education, many of the male study respondents reported that literacy did not appear to be a barrier to using these sources. Indeed, during the course of the FGD with the men, two men in the community were observed reading Bengali language newspapers while loitering near the shop.

The most popular newspapers in the community are reported to be *The Daily Ittefaq*, *The Daily Inquilab* and *The Daily Janakantha*, all of which have weekly medical advice columns written by many of the country's recognised physicians, yet published in simplified language so as to reach a wide audience. Some columns also address specific queries submitted by readers, which physicians answer. A quick review of column topics for the month of February showed that they included maternal and child health care, treatment of peptic ulcers, prevention and treatment of the common cold and bleeding piles.

Women, on the other hand, considered posters and newspapers "completely useless." Literacy is not the barrier. Time and mobility are. However, the women do have some access to health knowledge from the media. Both men and women reported either radio or television as health knowledge sources they use. Almost all agreed that most houses in the village had televisions, but many implied that they had little time to watch television programmes. This kind of self-reporting may understate the role of television as a source of health information. Despite saying that their schedules were too busy to watch T.V. or that the timing of health programming conflicted with the children's study or their work, all respondents except Ali and Feroza expressed good knowledge of health programmes on television, even going so far as to identify two programmes by name: *Swastho Bidhi* (Health Guidelines) and *Shukhi Poribar* (Happy Family).

One father claimed that television was helping to improve the level of health knowledge in his family. He credited the UNICEF cartoon *Meena*[105] for educating him through his children. "I have a television but I do not watch it much," said Ahmed. "But my son and daughter do. They watch *Meena*. Because of that, I do not have to teach them anything about health. They are the ones who are teaching me sometimes. Like how I need to wash my hands with soap or ash after using the bathroom."

105 The Meena Communication Initiative was developed by UNICEF as a mass communication project aimed at changing perceptions and behaviour that hamper the survival, protection and development of girls in South Asia. Gender, child rights and educational messages are communicated using the medium of popular entertainment. The main character is a young girl called Meena whose life experience exposes the discrimination against girls and women and offers positive insights from which families and communities can learn. (UNICEF 2007)

Value and use of sources

"Health is wealth. Perhaps it is even more important." said Salam, the teacher. Ahmed said, "If you have money and you lose it, there are hopes to gain it again. But if you lose your health you do not get it back." More pragmatically, Feroza said, "I try to implement many things to prevent disease because we are poor and disease is a burden." With a daily expenditure of forty to fifty hard-earned taka (less than one USD), a medical crisis could send her family into financial, as well as, emotional ruin.

Yet despite the value all respondents placed on health knowledge, and their insistence that they implemented it when they received it, their perceived level of practice does not seem to always live up to our critical *etic* eyes. For example, while conducting an FGD with the women, a toddler stepped onto a plate of fruit the woman had set out to put the snacks on. She quickly called for a bucket of water and re-washed the fruit, but without using soap. Despite her own association of "cleanliness" with "health" her perception of what comprised "clean" with respect to food involved nothing more than a brisk rubbing in water.

Ali has observed this too. "If only people would read the *Hadith* and try to follow its advice. The *Hadith* clearly states, "Do not lie. Do not cheat people. Keep clean and your body will be fit and fine," he said. He also added, "Less expensive clothes that are clean are better than expensive clothes that are dirty."

Preferences for sources

In an ideal world, the men and women of this village would be able to rely on their local health centre as an accessible facility and source of health knowledge. In reality, however, they universally decry it, complaining about a lack of service and lack of knowledge. "It is half a kilometre away," said Salam, gesticulating for emphasis. "It is useless. No information. No medications. No help!" "If there's a good health centre there's no need for going house-to-house," Ahmed added. "Everyone would go to the health centre at whatever time the centre said, in order to get health information."

We observed that the health centre was only open on one of our four trips to the village; at that time, no one was available to speak with us regarding its practices in health information distribution. The posters observed on the walls inside the centre pertained only to population policies and human trafficking and little to do with health.

However, with flagging hope that the centre can be relied upon at any future point, the respondents outlined other means by which they would prefer to receive health information. Men and women readily agreed that house-to-house visits worked best, but that community health volunteers and workers should come from both genders, because due to cultural prohibitions women workers would not always be able to interact with the men that much. "The best way is to go by ten to fifteen houses or at least a whole neighbourhood," Salam said, recognizing that a visit to every household in the village would take even more time and effort. The men's FGD group, as a whole, emphasised the necessity of having female community health workers, so that the women could "completely confide in the volunteer health informant." Moreover, all FGD respondents expressed an enthusiastic willingness to become volunteer community health informants, if "someone" with good health information could just educate them.

The third most widely expressed source (this was only expressed by the male respondents in the study) was a programme of "papering and postering." Ali was quick to elaborate that such posters

should be in pictures rather than words in order to reach a wider, half literate audience. Salam made an impassioned plea for more education in general, seeing it as a panacea for many of Bangladesh's woes. "Education is [the] backbone of [the] nation," he said in English.

Barriers to seeking health information

As noted earlier, the adults in this village obtain health knowledge from a variety of sources, not all of which are effective for all people in the community, especially when gender becomes an issue. Men appear unable or unwilling to educate themselves about specific medical problems of women. At the same time, restrictions on mobility prevent most women from seeing the nutritional posters on display even less than a kilometre away from their homes.

However, gender is not the sole issue that restricts access to health knowledge. All respondents in both the FGDs and in-depth interviews identified illiteracy, poverty and inadequate communication (including the poor condition of the roads and transportation options) as major factors that inhibited their ability to access health knowledge. Despite the presence of a health care centre half a kilometre from their neighbourhood, the community universally condemned it for its inadequacy as both a source of health information as well as a treatment facility. "Let it be pain in the head, let it be pain in the stomach, let it be diarrhoea or itching, they're giving us all the same thing," respondent after respondent said of the health centre that purports to serve their community: "Paracetamol, antacid, and antihistamine."

Feroza looks beyond the issue of an inadequate health care facility and bemoans the overall lack of development in the area. "If there were more urbanisation and a hospital I'd try to get employment," she said. "A job would widen my world and I'd learn so much more about so many things, including health. I want BRAC to set up a hospital or at least a garment factory. A hospital would be best, but at least a factory would be a chance for employment. And if I were employed there I would have a chance to meet more people and learn more about health."

Discussion

The men and women in this village obviously depend on a multi-pronged approach to obtain health knowledge. This underscores the need to use multi-faceted tactics in disseminating health knowledge whenever embarking on a public health programme. A public health programme that relies exclusively on one source would miss a significant segment of the population. Sensitivity to gender issues stemming from culture and religion is essential as well. Failure to do so not only risks alienating the community, but also would disenfranchise women who are unable to participate. Poverty and illiteracy also play roles regarding access to health information, as well as, community health needs, and should be kept in mind so that information campaigns are informative, understandable and pertinent.

The tendency of members of the study population to associate the terms "cleanliness" and "nutrition" with "health," suggests that this village can be an excellent springboard for public health programmes in these fields. A plethora of literature on this subject is available, for great strides have been made with respect to this field; however, issues of malnutrition and poor hygiene still flourish. From 1991 to 2000, for instance, Bangladesh saw overall reductions in the percentage of children who were malnourished, thanks to an increased food supply and reduction in poverty, yet sixty percent of the children of poor families are still malnourished (Halder & Urey 2003). The authors make particular note of the devastating effects of malnutrition early in life, and also observe that malnutrition is an issue with wealthy, as well as, poor families in Bangladesh (*ibid*), which suggests that a lack of awareness, and not just poverty alone, may contribute to the problem.

Fifteen years ago, a study by Karim and Chowdhury (1992) as to the efficacy of certain BRAC programmes looked closely at actual health practices. With respect to hygiene it is noted that hand-washing with soap following defecation was substantially higher in the programme area compared to a control group, seventy-three percent and thirteen percent respectively (*ibid*). Contrast this with an adult male in this study who claimed that he was unaware of the importance of this practice until his children educated him after learning about proper handwashing from a television programme. The fact that basic hand-washing skills still need improvement brings to light incomplete success in raising awareness of hygienic practices among the poor in Bangladesh.

The BRAC study also noted that one of the programme goals was to generate a greater demand for health facilities (*ibid*). In this village, the men and women expressed a significant demand for services, along with a great deal of frustration at the lack thereof. With respect to the inadequacies of the local health facility, as expressed by the people residing in this village, one may conclude that at least in some parts of Bangladesh, awareness activities such as those evaluated in the study, have borne fruit. Now that the demand exists, however, more efforts must be made to ensure that the services are in place to meet it.

The recognition that medical crises are expensive and difficult to treat due to issues of transportation, obtaining medicine, etc., is an exceptionally strong motivator for these people to make use of a great deal of the health information which comes their way. Further research has also indicated to what degree children are becoming sources of health information for their communities. With public campaigns to promote education, including government stipends to families who educate their girls, one can speculate that the level of literacy and presumably health knowledge will only increase in coming generations. Moreover, the influence of the UNICEF cartoon *Meena* mentioned above may further enhance the role of health educator that children may be assuming.

Finally, people from this village visibly express a hunger for more health knowledge, indicating that they feel their present resources to be insufficient. They are ready, indeed, eager, to build upon the foundation of health knowledge they have already received, recognizing that such knowledge can help them lead healthier, happier, more productive lives. Granted the divide between knowledge and practice must be addressed as well. Factors such as perceived practice (Salma's washing of fruit without soap) as well as barriers to implementation (such as the inability to buy soap) bear further investigation, particularly since they were beyond the scope of this study. Still, the zeal with which the people in this study expressed their desire to know more and to share that knowledge with others indicates that the villagers would be receptive to future information-driven public health programmes.

Reflections

Perhaps the most difficult moment during our research occurred when, during our in-depth interview with Shahana an older female relative approached us. “You take and take and take from us and what do you give?” she asked. “Here.” She pointed to a small child at her feet, looking directly at Sarah (a US citizen). “Why do not you take our children to America?” The enormous burden of the community's poverty came crashing down on both of us in that moment. That moment perhaps made us realise more vividly than ever why we need to continue with this kind of work.

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Appendix 1

Note: We provide here a selected list of social science publications on health and health care in Bangladesh. This is only a selection and by no means an exhaustive one.

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Appendix 2: List of acronyms

ARI	Acute Respiratory Infection
ARROW	Asian-Pacific Resource & Research Centre for Women
BA	Bachelor of Arts
BAPSA	Bangladesh Association for Prevention of Septic Abortion
BRAC	Bangladesh Rural Advancement Committee
CAD	Chronic Airway Disease
CERI	Centre d'études et de recherches internationale (Centre of International Studies and Research)
CRP	Centre for Rehabilitation of the Paralysed
EM	Explanatory Model
FGD	Focus Group Discussion
HSC	Higher Secondary School Certificate Examination
ICDDR,B	International Centre for Diarrhoeal Disease Research
JPGSPH	James P Grant School of Public Health
LMP	Last Menstrual Period
MBBS	Bachelor of Medicine and Bachelor of Surgery
MPH	Master of Public Health
MR	Menstrual Regulation
NIPSOM	National Institute of Preventive and Social Medicine
NGO	Non-Governmental Organisation
PRA	Participatory Rapid Appraisal
RED	Research and Evaluation Division
RTI	Reproductive Tract Infection
SSC	Secondary School Certificate Examination
SSS	Society for Social Service
TBA	Traditional Birth Attendant
UIS	UNESCO Institute for Statistics
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations International Children's Fund
USD	United States Dollar
WHO	World Health Organization
WHO BAN	World Health Organization Bangladesh
WHO SEARO	World Health Organization Regional Office for South East Asia

Appendix 3: Glossary of local terms

adha pagla	half-wit
alga batash	malevolent air (*batash*) with minor effects
Allah	the almighty God (in Islam)
asar/upri bhab	possession/influence by evil spirits
atonker batash/lular batash/ordhanger batash	evil air (*batash*) of terror believed to cause paralysis or disability
baat	arthritis like illness
bachcha felar tablet	tablets for abortion
bangla mod	local brew
batash laga	touched by malevolent air (*batash*)
baushi/baush	piles (haemorrhoids)
bazaar	marketplace
bhagoban/ bhagwan	the supreme being (in some traditions of Hinduism)
bhai	brother (literally), addressed to a man of the same age group or someone a little older. For much older males in the community, the usual term is *chacha*
bhut	ghosts/malevolent spirits (believed to pick on humans because they have unfinished business in this world)
bhut dhora/kalay dhora	afflicted by the evil spirits
bidi	locally made cigarette (without filters, made of leaves)
bilati mod	foreign liquor
bishakto batash/ shaapa batash	poisonous air (*batash*)
boithok	formal sitting
brain out/brain nashto	crazy head
chinta rog	worry (*chinta*) illness (*rog*)
dai/dhoroni	traditional birth attendant (TBA)
daktar	doctor (refers both to the formal medical doctors and informal village doctors)
daktaree	practice of medicine (by formal and informal doctors)
dhatu	whitish fluid discharged per vagina or penis
dhatu bhanga	white discharge
dhup	special kind of incense
dhoom pagal	someone considered to be completely deranged and insane; the most severe kind of mentally ill person
dupatta	traditional long scarf like clothing, usually worn by adolescents and young women with *shelwar* (trousers) and *kameez* (long tunic)
Durga puja	the biggest festival of Bengali Hindus worshipping goddess *Durga*, celebrated once a year in autumn
Eid	the biggest religious festival celebrated by Muslims, celebrated twice a year
fakir/fakir sahib	local healer (usually from Islamic healing traditions)
fakiree	practice of indigenous healing (usually from Islamic healing traditions)
gachonto oshudh	herbal (*gachonto*) medicine (*oshudh*)
ganja	popular addictive substance (known in the west as marijuana/hashish/pot); scientific name, *cannabis indica*

garo batash	malevolent air (*batash*) with major effects
gastik	gastritis like illness
gayebi mal	objects (*mal*) thought to have supernatural origin
guru	a master (revered teacher/spiritual guide)
Hadith/Hadis	recorded words and deeds of Prophet Muhammad who is considered the last and the greatest prophet in Islam
jala pora	burning sensation
jhara/jhar fuk/jhaar phuk	exorcising evil spirit by brushing the victim's body with a broomstick, and uttering incantations, charms (blowing air over water or oil)
jinn	spirits made of fire (both good and evil) mentioned in the *Qur'an*
jondis	jaundice like sickness
jor	fever
kabiraj	traditional healer (usually from the *ayurvedic* tradition)
kabiraji	practice of local healing (usually from the *ayurvedic* tradition)
kata baushi/rakto baushi	bleeding piles
kheali bhab	absentmindedness
khichuni	convulsions
khora/langra/lula/nula/pongu	disabled (derogatory term for someone who does not have a limb or has trouble walking properly)
khun bhanga	passage of blood (*khun*)
kosha	drying of the body due to lack of water (usually associated with constipation and other symptoms, e.g., white discharge)
low presser	low blood pressure
madrasa	Islamic religious schools
manta/manti	pledge made by people in certain holy places to sacrifice something in return to the blessings they receive for problems of living or health conditions
Marefot/marefat	esoteric practices in Islam in the quest of divine knowledge
mashik	monthly (literal meaning); commonly used term for menstruation
mazar	final resting place of a *pir* (Muslim holy man) where devotees gather to pay their respects
meho	white discharge (sometimes it means seminal fluid)
mela	village fair
menses	menstruation
mental	mental
mirgi rog	Epilepsy like sickness
mirgi maachh	*mirgi* or *mrigel* fish (most people do not like to eat this type of fish)
moner ashukh	sickness of the mind
motkila	tree with medicinal properties (twigs used as toothbrush)
neem	tree with medicinal properties (sticks used as toothbrush)
nesha	addiction
nesha paani	addiction of all kinds (dry or liquid)
nesha tablets	commonly abused sedative tablets
orosh/ urs	yearly congregation held at the tomb or *mazar* of Muslim saints
paan jarda	betel leaf (*paan*) with processed tobacco (*jarda*)
paglami	madness like phenomenon

pagal	mad man
pak	pure
para	cluster of households in a hamlet or village
pir/pir saheb	holy man with followers, belonging to various sects of Islam
poka	insect
pori	fairy like ephemeral creature, feminine spirits often considered to be evil
pratibandhi	disabled
Qur'an	holy book of Muslims (a compilation of revelations from *Allah*)
Ramadan	holy month of fasting; mandatory for Muslims
rog	illness/sickness/disease
safed paani/shada srab/shada rog	leucorrhoea (white discharge)
saree	traditional long piece of cloth worn by women in Bangladesh
shalwar kamij/shelwar kameej	two piece suit with trouser like pyjamas and a long tunic with accessory *dupatta* (usually worn by young women in Bangladesh)
shariyat/sharia	body of Islamic law that deals with aspects of day-to-day life
shishsho	disciple/apprentice
taari	locally made liquor from *taal* (a blackish-brown round shaped fruit) extracts
tagod	strength (literal meaning); it has various connotations as suggested by the text
taka	Bangladeshi currency
uthan	front yard (courtyard)

Appendix 4: Tables and figure

4.1. Tables

4.2 Figure

Appendix 5: Maps

5.1. Savar sub-district in Bangladesh within the global map.

5.2. Birulia union in the map of Savar sub-district.

5.3. Kakabo village in the map of Birulia union.

5.4. James P Grant School of Public Health, Master of Public Health (JPG SPH MPH) campus near Kakabo.

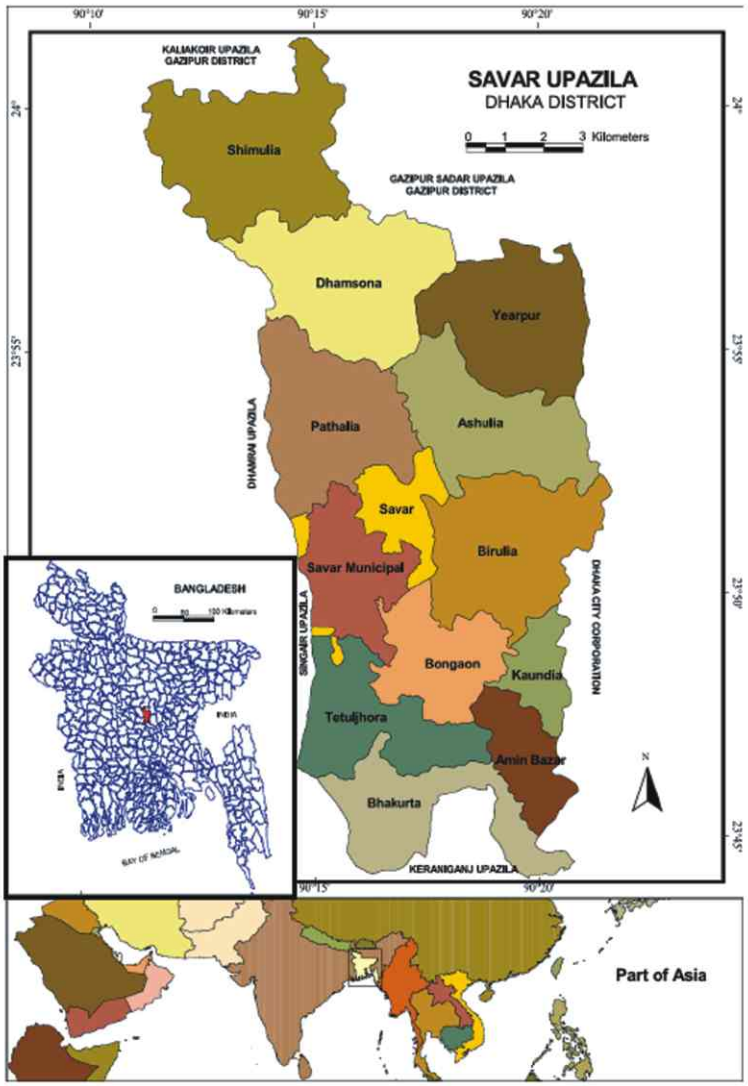

Fig: 5.1

Figure shows the administrative distribution of Savar upazila (sub-district)within Asia and the world. Savar is near the capital Dhaka, approximately at the centre of Bangladesh.

Reference : Islam, Z. I. & M. A. Islam. 2006. *Achieving the millennium development goal of universal primary education in Bangladesh: How much GIS can offer?d/g/al* Electronic document, accessible from http://www.lse.acuk/collections/BSPS/pdfs/2006_Islam_GIS.pdf

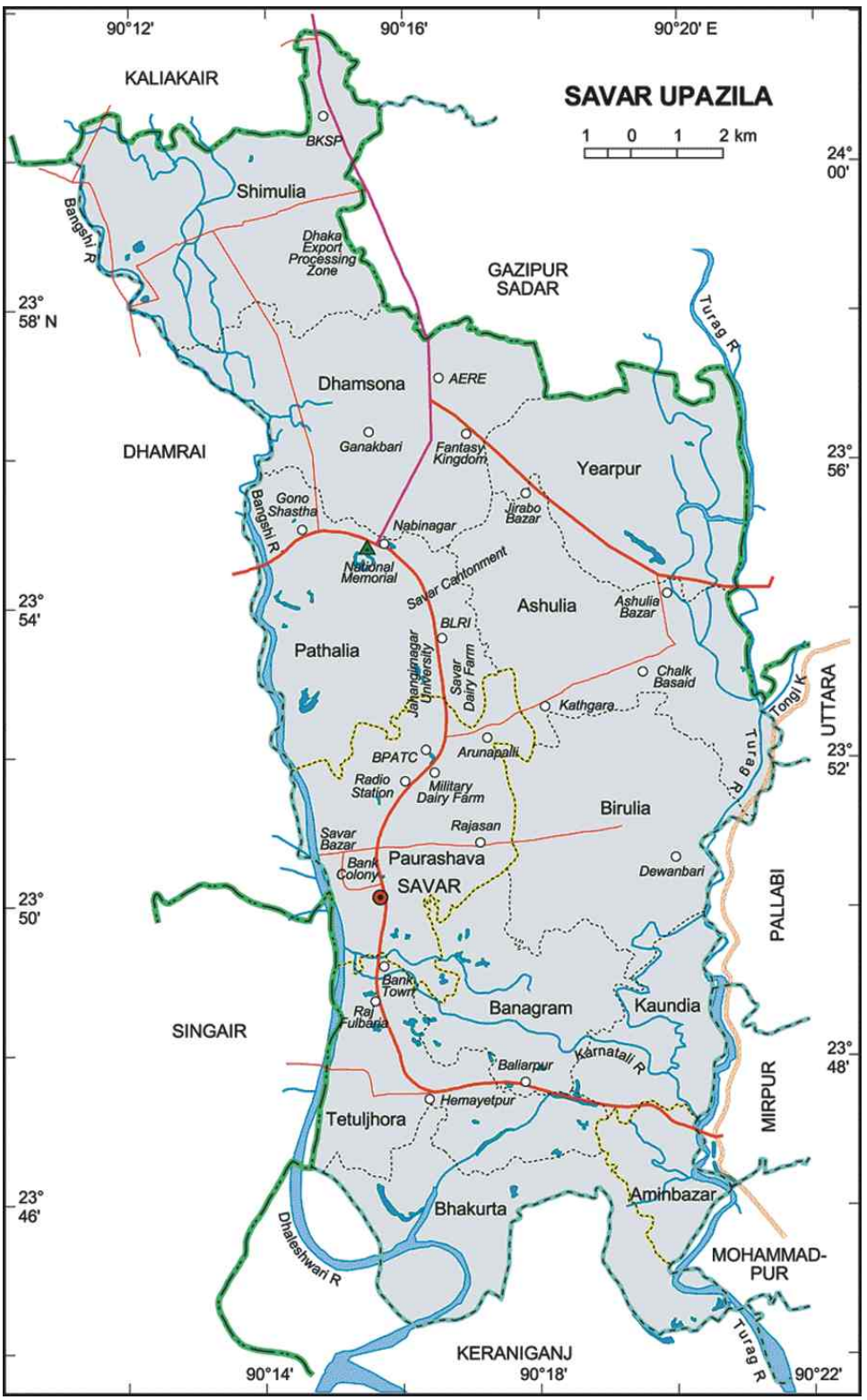

Fig:5.2

Geography of Savar upazila showing the major roads and rivers in and around the upazila.

Reference : Banglapedia.2006. *Savar Upazila.* Electric document, accessible from http://banglapedia.org/HT/S_0148.HTM

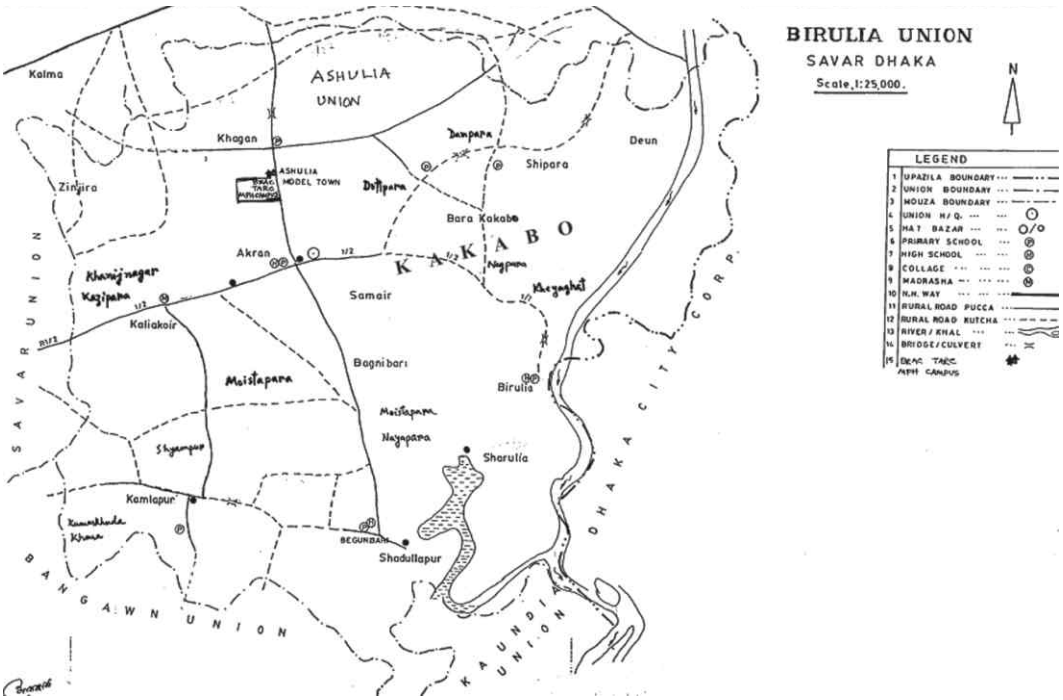

Fig: 5.3

Birulia union, one of the largest administrative units within the Savar upazila contains an important site for the MPH programme,i.e., Kakabo village.*Courtesy :* Savar Upazila Parishad.

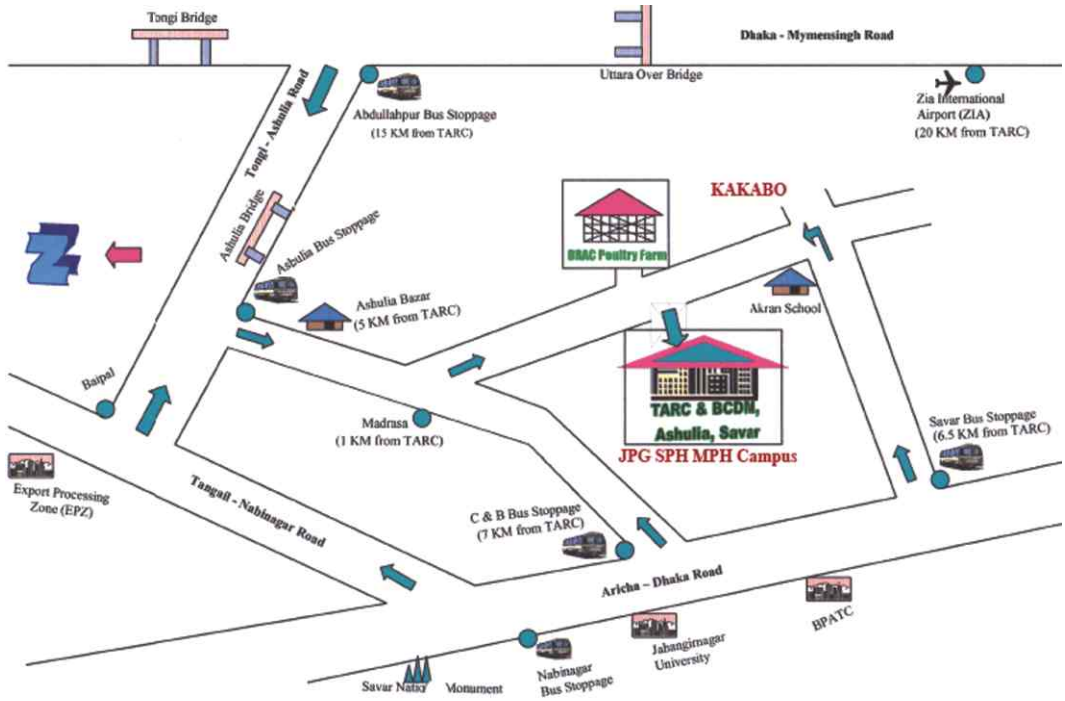

Fig: 5.4

Schematic diagram showing the location of BRAC TARC in Savar, the campus for the School of Public Health. Also seen are the roads that crisscross the area and pathways connecting the campus to the field site in Kakabo. *Courtesy :* BRAC TARC, Savar.

Appendix 6: Photographs of Kakabo

Fig: 6.1

Using *Neem* stick to brush teeth is a common practice in Kakabo. Villagers enjoy an early morning walk while brushing teeth.

Fig: 6.2

MPH students building rapport with the villagers of Kakabo. They visit the villagers and interact with them for academic purpose.

Fig: 6.3

Village men frequently use barber shops to have a hair cut. Women cannot access this facility. One often sees idle villagers spending time in these premises.

Fig: 6. 4

Growing with the green is common for a young boy in Kakabo. A gourd grows green and healthy in the kitchen garden of this boy's home.

Fig: 6.5

Growing flowers is one of the many diverse income generation activities in Kakabo. A man is seen spraying insecticide in a rose garden.

Fig: 6.6

In such local shops, *sherbets* are made from herbs. These are popular drinks believed to provide relief in different abdominal problems.

Fig: 6.7

Young girls usually take care of the livestock. A young girl is seen bathing a sheep with water from a ditch.

Fig: 6.8

Molasses from date juice is not just a delicacy in the rural areas of Bangladesh but also a means of income. A man is seen boiling date juice to prepare molasses in an early winter morning in Kakabo.

Fig: 6.9

Kakabo village grows rice, the staple food of Bangladesh. The green fields often extend from one end of the village to the other.

Fig: 6.10

People come to sell their vegetable products in the local market on specific weekdays called *haat*. A *haat* is also a place for popular games. This photo shows two youngsters playing carom.

Fig: 6.11

A water buffalo cart is the most common means of transport for goods across the village. Such a buffalo cart is seen carrying loads of bamboo.

Fig: 6.12

A traditional latrine made of corrugated tin. This type of latrine is slowly being replaced by sanitary latrines.

Fig: 6.13

A very common scene in the villages where a man is seen plucking fruits from the tree.

Fig: 6.14

Small canals are made to run water to the crop fields for irrigation. Often a 'footpath' like space is left beside for people to walk or rest.

Fig: 6.15

It is not unusual to find such impoverished houses in Kakabo village. This house is made of mud and bamboo stick with a corrugated tin shed.

Fig: 6.16

A cowshed without a wall or fence is perhaps the best one would find in the village for the cattle.

Fig: 6.17

Animals and men both find the village to be their sanctuary. Hardly any household would object to trespassing by harmless animals or children.

Fig: 6.18

A Nepali student is seen riding the bicycle on his way to Kakabo. MPH students learn to endure the sun and ride their bikes to Kakabo village to interview people. This is one of the major tasks of the MPH students during their stay in Savar.

Fig: 6.19

Two sisters standing beside a pile of dried leaves and twigs, often times the playground for the children in the village.

Fig: 6.20

Unused slabs lying around the ground, evidence of a past attempt to build a sanitary latrine which ended up being incomplete or simply unused, perhaps due to poverty.

Fig: 6.21

A verdant papaya tree raising its proud head with abundant fruits.

Fig: 6.22

The predominant feature of Bangladeshi villages is their greenery and Kakabo is no exception. A vast green paddy field in Kakabo covers the horizon.

Fig: 6.23

Many villagers enjoy electricity. Here is a house with electric meter stuck on the wall proving thehousehold subscription to the power supply.

Fig: 6.24

MPH students were given bikes to visit the rural area and households for academic purpose. A student from Bolivia is seen riding a bike on his way to Kakabo on a sunny afternoon.

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