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Health Seeking Behavior of Char People in Bangladesh: A Study in a Selected Area of Bogra District

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University of Rajshahi

PhD Dissertation

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Md. Nasir Uddin

A Dissertation Submitted to the Institute of Bangladesh Studies (IBS),University of Rajshahi, Rajshahi, Bangladesh for the Degree of
Doctor of Philosophy in Anthropology

Institute of Bangladesh Studies (IBS)
University of Rajshahi
Rajshahi 6205, Bangladesh
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Dedicated
To
My Beloved Parents, Wife & Son

DECLARATION

I do hereby declare that, except otherwise stated, this dissertation is completely my own work under the guidance and supervision of Dr. Md. Faizar Rahman, Professor, Department of Sociology, University of Rajshahi. This work has not been submitted in any form to any other University for any degree.

Md. Nasir Uddin
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Date: ……

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CERTIFICATE

This is to certify that the dissertation entitled **Health Seeking Behavior of *Char* People in Bangladesh: A Study in a Selected Area of Bogra District** is the own work of Mr. Md. Nasir Uddin, who has completed his dissertation under my direct guidance and supervision. Information included in this dissertation is original and was not submitted before for any other degree. I also certify that I have gone through the dissertation and found it satisfactory for submission to the Institute of Bangladesh Studies (IBS), University of Rajshahi for the degree of Doctor of Philosophy (PhD) in Anthropology.

Dr. Md. Faizar Rahman
Supervisor

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Md. Nasir Uddin

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LIST OF ACRONYMS

Acronym Full Meaning

CBR	Crude Birth Rate
CDR	Crude Death Rate
CDSP	Char Development and Settlement Project
CLP	Char Livelihood Program
EMT	Execution of Modern Transport
FGDs	Focus Group Discussions
GMSUS	Grameen Mohila O Shishu Unnayan Sangstha
GUK	Gram Unnayan Kendra
HBM	The Health Belief Model
IDUs	Injecting Drug Users
IGA	Income Generating Activities
ISPAN	The Irrigation Support Project for Asia and the Near East
LPP	Lack of Professional Physicians
MC	Mother's Club
MDG	Millennium Development Goals
MES	Meghna Estuary Study
MUAC	Mid-upper Arm Circumference
NCD	Non Communicable Diseases
NFA	No Frequent Assistance
NIA	No Instance Assistance
NSUP	Non Stand up Paddle
PIOP	Policies, Institutions, Organizations, and Processes
PRSP	Poverty Reduction Strategy Paper
RDP	Rural Development Programme
RTI	Reproductive Tract Infections
STD	Sexually Transmitted Diseases
SUP	Stand up Paddle
TMC	Tele Medicine Campaign
TMSS	Thengamara Mahila Sabuj Sangha
VGD	Vulnerable Group Development
VHWC	Village Health Watch Committee
VKC	Village Knowledge Centre
YVCHP	Youth Volunteer Community Health Provider
WHO	World Health Organization

ABSTRACT

Background: The *char* people are living under most at risk condition and have been fighting for sound health. Illness is vital cause of poverty and illiteracy. There is a

recognized relationship between health, poverty alleviation and sustainable development. Health is the indivisible ingredient of development. Development of health will increase income, ensure the monetary development and reduces poverty to a great extent.

Methods: The researcher administered participant observation, in-depth interview and FGD for data collection by using purposive sampling during November 2010 to June 2011.

Results: New born and children were affected mostly from communicable illness while the adolescents, adult and aged suffered from non-communicable illness. They were not aware about the stages of illness. Most of the respondents (58%) believed that their suffering was due to natural causes and 10 % of the local people believed that uncleanness and unhygienic practice may result the illness. On the other hand, as to the 20 % people "evil eye" was a most important etiology of above motioned illness and 12% respondents believed that the causes of their suffering were supernatural. People do not have equal access to all sectors of health care such as popular sector, the folk sector and the professional sector. The cyclical issues of an illness episode, culture of poverty, remoteness, lack of professional physician, cost of health care, lack of transport facilities, and lack of knowledge, superstition strongly influenced to take decisions for choosing sectors of health care. They were not capable to take decision in right time because it depends to a large extent on their accesses to livelihood assets in the households and community. The villagers used to prefer modern medical facilities which were inadequate in the village.

Conclusion: These findings clearly state that the *char* people are living under severe vulnerable condition in terms of health care seeking. To improve the health as well as livelihood status of the study people, the authority have to take short term as well as long term initiatives. The findings of the research will help Government and development agencies to take strategic decisions in terms of taking drastic steps especially in resource poor settings where modern facilities are still scarce.

Introduction

1.1 Preamble

According to the constitution of Bangladesh health is regarded as a basic need.[1] Health promotion programmes worldwide have long been premised on the idea that providing knowledge about causes of ill health and choices available, will go a long way towards promoting a change in individual behaviour, towards more beneficial health seeking behavior.[2] Sound health depends on health seeking behaviour and it is related with socioeconomic condition. It is a valuable wealth that supports people to be involved in producing works. Necessary and easy access to health services are essential to keep sound health. A healthy man is an asset of society, though sound health is an absolute phenomenon. The basic principle of health service is that *'equal access as to equal need for all*'. Access being defined as the ease with which health care is obtained or the freedom to use health care. However, the consistently inequitable nature of health system limits the access of quality health care to the poor who need the most. Health systems are usually ineffective in reaching the poor, generate less benefit for the poor than the rich, and impose regressive cost burdens on poor households. Negligence, abuse, and marginalization by health system are part of their everyday experience.[3] Much of the disadvantage in health arises from the socioeconomic condition in which the poor people live and make them vulnerable to differential treatment by the health system and society in addition to various financial, sociocultural and communication barriers.[4] Actually the

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[1] Ministry of Law, Justice and Parliamentary Affairs, "*The Constitution of the People's Republic of Bangladesh,Article 15 (A)*" (Dhaka: The People's Republic of Bangladesh, 2010).

[2] Sara Mackian, *A Review of Health Seeking Behavior: Problems and Prospects* (HSD/WP/05/03. Manchester: University of Manchester Health Systems Development Programme, 2003): 1.

[3] Sayd Masud Ahamed, *Exploring Health Seeking Behavior of Disadvantage Population in Rural Bangladesh (*Stockholm, Sweden: Division of International Health, Department of Public Health Science, Karolinska Institute, 2005): 1.

[4] SH Woolf, "Society's Choice: The Tradeoff between Efficacy and Equity, and the Lives at Stake,*" American Journal of Preventive Medicine* 27, no. 1(2004): 49.

poor people are neglected in the all spheres of development planning, especially health. Nowadays, the scholars of anthropology and sociology think that all present development models have failed in terms of sustainable development. Because, there is no scope to accumulate the native views in these development approaches and that's why these are not acceptable to local people. In this case, anthropologists consider the simple and disadvantaged people. They are very much attentive to draw a insight of traditional beliefs, rituals, and customs and so on. Both the material and non material culture are important for the anthropologists. In Bangladesh, anthropologists are studying on various aspects of rural culture but they have not found any opportunity to pay attention to health seeking behavior of *char* people as a severe problem.

Like all other sectors, the health sector has failed to ensure quality service to the people of Bangladesh. The health service of Bangladesh is not quite satisfactory, especially for *char* people. As to the article 15(A) of the constitution of Bangladesh[5], the Government has been taking the guarantee to ensure the basic needs of people, including health. Article 18 (A)[6] also claimed that, the basic duty of Govt. has to not only develop the health of people, but also the provision of nutrition. Universal primary health care has been the central principle of the public health policy of Bangladesh since the *Alma Ata* Declaration of 1978 and Millennium Development Goals (MDG). The health policy is articulated in the national health and population sector program (2011), which emphasizes a grassroots, decentralized approach to primary health care delivery.[7] But the Government has failed to ensure quality health services for all people within the targeted time. In these cases ethical problems as well as the participation of local people in the development planning process have an adverse impact. The conventional health service

[5] Ministry of Law, Justice and Parliamentry Affairs, "*The Constitution of the People's Republic of Bangladesh,Article 15 (A)*" (Dhaka: The People's Republic of Bangladesh, 2010).

[6] Ibid., "Article 18(A)."

[7] Ministry of Health and Family Planning Welfare, "*National Health Policy 2011*," (Dhaka: The People's Republic of Bangladesh, 2011), 5-10.

has an arbitrary attitude. The system is very much reluctant to consider the social, cultural, psychological and geographical issues that are associated with the human health and illness. On the other hand, there are no touches of the daily life system, beliefs, values, and customs of local people in the existing health service program those having the vital role to find out diseases, sickness and illness. The research has investigated the nature, types and state of the existing health care system of *char* people and their application. It has also tried to understand the constraints to health care seeking behavior of *char* people. The researcher believes that the Government and development agencies will take necessary steps based on the findings of the research.

1.2 Statement of the Problem

Char is a land located in an active river basin that is subject to erosion. *Char*, a tract of land surrounded by the water of an ocean, sea, lake, or stream; it usually means any accretion in a river course or estuary. *Char*s in Bangladesh can be considered a 'by-product' of the hydro-morphological dynamics of its rivers. The *char*s are extremely vulnerable to both erosion and flood hazards. During 1981 to 1993, a total of about 729,000 people were displaced by river bank erosion. More than half of the displacement was along the Jamuna. An assessment of 1992 dry season land sat image shows that the Jamuna contained a total of 56 large *char*s, each longer than 3.5 km. There were an additional number of 226 small *char*s, varying in length between 0.35 and 3.5 km. The total population in the *char*s during 1993 works out to be about 631,000. The majority of these people (65%) live in the Jamuna *char*s. The socio-economic condition of people living in *char*s varies widely between rivers and sometimes even between the upper, middle and lower reaches of the same river. The life of the *char* people is closely related to variations in the dynamics of river and *char* formation as well as the associated erosion and flood hazards.[8] Around 5-6 million people live in *char* areas and that the most

[8] Banglapedia (CD Edition), "*Inclusion of Char*," (Dhaka: Asiatic Society of Bangladesh, 2006).

affected and the most vulnerable people who are extreme poor, live in these *char* areas. Livelihood shocks and stress are high in the *char*s. Both wage employment and self employment are very low. Migration is a major option. Life is highly vulnerable mainly because of non-existent infrastructural facilities, poor sanitation, lack of primary health care, educational facilities, severe indebtedness and lack of social protection such as Vulnerable Group Development (VGD) and old-age allowance, oppression of ***jotdars*** (land grabbers) and their hooligans, exploitation by money lenders, violence against women including sexual oppression and religious fundamentalism. The incidence of poverty at the national level stands at around 43.8 percent, while in the *char* areas the rate is 86.4 percent. The *char* areas 61 percent people suffer from food insecurity occasionally while 31 percent face food scarcity round the year. The Poverty Reduction Strategy Paper (PRSP) acknowledges the problems in the *char*s and focuses on several issues, but unfortunately, in most cases *char* issues addressed in PRSP are neither sufficient nor focused.[9]

Although research on health seeking behavior of disadvantaged people is limited in Bangladesh, it is well admitted that compared to other areas *char* women, men have limited contacts with physicians and healthcare services in general.

It is hardly surprising to learn that for almost every condition common to both sexes, but the outcome for women tends to be poorer in the *char* Majhira. In terms of accessing health services, the people of this *char* are slower to notice signs of illness, and when they do, they are less likely to consult their doctors. It is wonder that most of the people admit that they wait too long before going to doctor for treatment at the severe stage in the area.

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[9] Atiur Rahman, "The Wretched of the Earth: A look into the Dimensions of Poverty in Island *Char*s of Northern Bangladesh" (a seminar paper presented to PKSF auditorium, PKSF Bhaban, Agargaon, Sher-E-Bangla Nagar, organized by the Institute of Microfinance (InM), Dhaka, May 29, 2008).

Introduction

The status of child health in general is not satisfactory, neonatal and maternal mortality remains unacceptably high in *char* Majhira, though Bangladesh has made remarkable progress in these sectors. Nearly half of pregnant women suffer from malnutrition and anaemia, and the proportion of deliveries assisted by skilled people is still low in the *char.* Malnutrition continues to be a serious problem for children , adolescents, especially for girls. Considerable progress has not yet been made in communicable disease control, and non communicable diseases (NCD) are showing a rising trend. Among communicable diseases, concerns are diarrhea, rickets, pneumonia, vaccine preventable diseases, endemic diseases such as *paralysis, asthma* and *emerging* diseases like avian influenza - fever. Unhealthy lifestyle and tobacco use are the contributing factors to the increased burden of NCDs where children, women and elderly population are usually the victims of it in the *char*. Ensuring safe drinking water is a major challenge in the area. Access to sanitation has increased steadily, but adoption of appropriate hygiene practices has been slow. Climate change is a great concern which causes above mentioned health hazards among the people of the *char*. Food safety, occupational health and safety, widespread uses of chemicals and pesticids in the crops land are also important issues for the vulnerability of these people.

In this *char* the main reasons for people being reactive, rather than proactive, in the maintenance and promotion of their own health are rooted in the following areas:[10]

- Lack of consciousness as to when they should be present for screening;
- Linked to this is the absence of a preventive health care ethos in the current delivery of general practice;
- People believe that, unlike by others, they are not socialized into the health, culture from an early age, and are therefore less likely to develop the confidence to seek preventive help which also deter them from seeking care services.

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[10] Rachel McEvoy and Noel Richardson, *Men's Health Forum in Ireland*, 2004. (Belfast, Ireland: MHFI Press), 59-61.

- Finally, they are less likely to interpret their symptoms as arising from physical symptoms, which may be a form of denial bound up in what they regularly referred to as the 'core cause'.

From the backdrop of the earlier discussion, it can easily understand that, the *char* people are living under most vulnerable situation in terms of sound health. Health is the inseparable part of development. Illness is the tremendious causes of poverty and illiteracy. There is an established relationship among health, poverty alleviation and sustainable development. Improvement of health will increase income, ensure economic development and reduces poverty. In this context, if we want to reduce poverty with a remarkable rate in the *char* area, we have to carry out the principles of national health policy by creating enough and balanced health service for the *char* people. So, the research **'Health Seeking Behavior of *char* People in Bangladesh: A Study in a Selected Area of Bogra District'** has worth done to investigate the answers of the following questions:

What are the types of illnesses the char people suffering from?

Who are the most vulnerable groups for Illness?

How are the people of this area expressing their views on various stages of illness?

Why and when are people exposing their sign of illness?

What are their beliefs and understanding regarding illness?

What are the curative systems available in the area?

What are the roles of health care providers?

Who is the first, second and third health care provider?

Why and when are people choosing these curative systems?

Who are the decision makers to take a particular option?

Which things do work as a key catalyst to make decisions regarding this?

When do people usually take decisions?

1.3 Rationale of the Study

The literature review provides a background and rationale for the study, and helps the researcher to understand the problem and its context. It helps to identify gaps and omissions in previous work or questions left unanswered, and provides a framework to locate the study. Considering these issues, the researcher has reviewed some relevant books, research papers and articles. Some of these are stated below:

Lincoln C. Chen et al., (1981)[11] have conducted a study on **'Sex Bias in the Family Allocation of Food and Health Care in Rural Bangladesh'**. This study examines the behavioral antecedents to the higher female than male mortality from shortly after birth through the childbearing ages in a rural area of Bangladesh. A framework is presented in which the intermediate variables through which sex-biased attitudes and practices might operate to affect health, nutrition, and mortality are postulated. The malnutrition rate was found to be substantially higher among female children than male children. In-depth dietary surveys showed that male consistently consumed more calories and proteins than female at all ages, even when nutrient requirements due to varying body weight, pregnancy, lactation, and activity levels were considered. Although child infection rates were similar between sexes, utilization of health care services at a free treatment unit showed marked male preferences. Implications for policy formulation and program implementation are discussed in the conclusion. The study had helped to investigate the state of health seeking behavior of this village.

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[11]Lincoln C. Chen et al.,"Sex Bias in the Family Allocation of Food and Health Care in Rural Bangladesh," *Population and Development Review* 7, no. 1 (1981): 55-70.

Introduction

M. Q. Zaman (1991)[12] in his article **'Social Structure and Process in *Char* Land Settlement in the Brahmaputra-Jamuna Floodplain'** offers a socio-economic and political analysis of accretion land *(char)* settlement in Bangladesh. Specifically, it discusses the rise, in the floodplain, of the system of relations between landlords and peasants known as *lathiyali,* which became an important politico-economic structure in land colonization during the zamindary period (1793-1950) in Bengal. It also provides a detailed account of the rivalry of powerful landlords in contemporary Bangladesh who exploit their dependent peasants as *lathiyals* to grab new *char* land. By demonstrating intercommunions between the rural landlords and political power at the state level, the article develops a critique of approaches which explain such local deployment of violence and power in terms of isolation, marginality and weak state systems. This article has led to investigate the health seeking behavior of *char* people by examining their power relation.

Abbas Bhuiya (2009)[13] in his book ***Health for the Rural Masses: Insights from Chokoria*** offers a significant insight into the situation of health system as it exists in a remote sub-district in Bangladesh. Consisting of eight chapters, the book highlights the findings on what constitutes the health systems, people's health-seeking behavior, role of formal and informal healthcare providers, size of the health market, and cost of healthcare. The book concludes with an examination of the implications of the findings given the reality in the ground and tried to make a case for paying attention to the informal practitioners of modern medicine. This work has facilitated to understand health seeking behavior of *char* people.

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[12]M. Q. Zaman, "Social Structure and Process in Char Land Settlement in the Brahmaputra-Jamuna Floodplain," *Man (*New Series*)* 26, no.4 (1991): 673-90.

[13]Abbas Bhuiya, *Health for the Rural Masses: Insights from Chakaria* (Dhaka: icddr,b, 2009): 1-130.

Syed Masud Ahamed (2005)[14] in his book ***Exploring Health Seeking Behavior of Disadvantage Population in Rural Bangladesh*** express the state of health seeking behavior of some selected disadvantage population like women, elderly and ethnic minorities in rural Bangladesh. The thesis is based on five studies from four different research projects conducting during 1995-2004 in Bangladesh. It offers an emerging cadre of 'para-professional' as main provider of formal allopathic care to the disadvantaged population was observed, in addition to the pre-dominance of self care. Household poverty was instrumental in shaping health seeking behavior. This work has supported to understand health seeking behavior of *char* people.

Pritti Biswas et al., (2006)[15] in their article,**'Dynamics of Health Care Seeking Behavior of Elderly People in Rural Bangladesh'** focuses on the coping strategies in cases of illness of elderly people and the contributing factors in determining the health seeking behavior of elderly persons. This article has enhanced the researcher's knowledge to conduct the study.

MacKian (2005)[16] in his paper **'A Review of Health Seeking Behavior: Problems and Prospects'** presents the theoretical explanation of health seeking behavior. In his discussion he tries to identify the process in which people can adopt with their local health system. He also seeks to answer the questions - how social, cultural, economic and geographical elements forced the people to choice health services. This article has helped the researcher to identify the process of health seeking behavior of *char* people.

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[14] Sayd Masud Ahamed, *Exploring Health Seeking Behavior of Disadvantage Population in Rural Bangladesh (*Stockholm, Sweden: Division of International Health, Department of Public Health Science, Karolinska Institute, 2005): 1-76.

[15] Pritti Biswas et al.,"Dynamics of Health Care Seeking Behavior of Elderly People in Rural Bangladesh," *International Journal of Ageing and Later Life* 1*,* no.1 (2006): 69-89.

[16] Sara Mackian, *A Review of Health Seeking Behavior: Problems and Prospects* (HSD/WP/05/03. Manchester: University of Manchester Health Systems Development Programme, 2003): 1-27.

Introduction

SM Ahmed et al., (2000)[17] stated in their article **'Gender, Socioeconomic development and health-seeking behavior in Bangladesh'**that in efforts to reduce gender and socioeconomic disparities in the health of population, the provision of medical services alone is clearly inadequate. While socioeconomic development is assumed important in rectifying gender and socioeconomic inequities in health care access, service use and ultimately, outcomes, empirical evidence of its impact is limited. Using cross-sectional data from the BRAC-ICDDR,B Joint Research Project in Matlab, Bangladesh, this paper examines the impact of membership in BRAC's integrated Rural Development Programme (RDP) on gender equity and health-seeking behavior. Differences in health care seeking are explored by comparing a sample of households who are BRAC members with a sample of BRAC-eligible non-members. Individuals from the BRAC member group report significantly less morbidity (15-day recall) than those from the non-member group, although no gender differences in the prevalence of self-reported morbidity are apparent in either group. Sick individuals from BRAC member households tend to seek care less frequently than non-members. When treatment is sought, BRAC members rely on a greater extent on home remedies, traditional care, and unqualified allopaths than non-member households. While reported treatment seeking from qualified allopaths is more prevalent in the BRAC group, non-members use the para-professional services of community health care workers almost twice as frequently. In both BRAC member and non-member groups, women suffering illness report seeking care significantly less often than men. The policy and programmatic implications of between group and gender differences in care seeking are discussed with reference to the literature. This work has helped the researcher to investigate the nature of health seeking behavior of *char* people.

[17] S Ahmed et al., "Gender, Socioeconomic Development and Health-Seeking Behavior in Bangladesh," *Social Science Medicine* 51, no.3 (2000): 361-71.

Ferdous Arfina Osman (2009)[18] attempted to identify in her article **'Public Health, Urban Governance and the Poor in Bangladesh: Policy and Practice'** that the weaknesses of urban governance that result in the poor having inadequate access to public and primary health services by reviewing the existing policies and institutional arrangements for the provision of services and by examining the extent to which they are put into practice in terms of ensuring access to these services for the urban poor. It draws on the findings of an empirical study conducted in four slums of the capital city of Bangladesh. This work has helped the researcher to investigate the policy and practice of health seeking behavior of poor people in Bangladesh.

S. M. Mostafa Kamal (2009)[19] discussed in his paper **'Contraceptive use and method choice in urban slum of Bangladesh'** about the factors affecting contraceptive use and method choice among women living in the urban slums in Bangladesh. It also aims to examine the source of modern method collection among them. This study has also helped the researcher to learn about the knowledge regarding contraceptives use of poor people in Bangladesh.

DR. M. Saeed Siddiqui et al., (2011)[20] discussed about the approach of people towards seeking medical advice with different options of healers, to observe thinking, feeling and various actions of people including level of self medication, and to know perception of people regarding various practices done by the healers in urban slum areas of Karachi in the article **'Health seeking behavior of the people; knowledge, attitudes and practices**

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[18] Ferdous Arfina Osman, "Public Health, Urban Governance and the Poor in Bangladesh: Policy and Practice," *Asia-Pacific Development Journal* 16, no.1 (2009): 27-58.

[19] S. M. Mostafa Kamal,"Contraceptive Use and Method Choice in Urban Slum of Bangladesh" (paper presented at the International Conference on Family Planning: Research and Best Practices, Kampala, Uganda, November 15-18, 2009).

[20] Dr. MS Siddiqui et al., "Health Seeking Behavior of the People; Knowledge, Attitudes and Practices (KAP) Study of the People of Urban Slum Areas of Karachi," *Professional Med J* 18, no.4 (2011): 626-631.

(KAP) study of the people of Urban Slum Areas of Karachi'. This study has also helped the researcher to learn about the health seeking behaviors poor people in Bangladesh.

Rasheed N et al., (2012)[21] attempted to assess the utilization of health services and client satisfaction for service provided by a Primary Health Care (PHC) at Delhi, India in their article **'Client satisfaction and perception about quality of health care at a primary health centre of Delhi, India'.** This study has also helped the researcher to conduct the study smoothly.

Iftekher Hossain and Mohammad Mainul Hoque (2005)[22] tries to identify the major factors determining the choice of delivery care in some urban slums of Dhaka city in their article **'Determinants of choices of delivery care in some urban slums of Dhaka city'** which helped the researcher to identify the determinants of choice of health care in the study area.

T-AB Mashego, PhD and K Peltzer, PhD (2005)[23] in their article **'Community perception of quality of (primary) health care services in a rural area of Limpopo Province, South Africa: a qualitative study'** said that the community satisfaction with free basic and preventive health care and social services provided but there is a need to look closely into the interpersonal dimension of the services provided, provision of medication with adequate explanation to patients on the medication given, and on structural aspects, there is need for the government to give support to the clinics to

[21] Rasheed N et al., "Client Satisfaction and Perception about Auality of Health Care at a Primary Health Centre of Delhi, India," *Indian Journal of Community Health* 24, no.3 (2012): 237-242.

[22] Iftekher Hossain and Mohammad Mainul Hoque, "Determinants of Choices of Delivery Care in Some Urban Slums of Dhaka city," *Pakistan Journal of Social Science* 3, no.3 (2005): 469-75.

[23] T-AB Mashego, PhD and K Peltzer, PhD, "Community Perception of Quality of (primary) Health Care Services in a Rural Area of Limpopo Province, South Africa: a qualitative study," *Curationis* 28, no. 2 (2005): 13-21.

provide adequate services. This study has also helped the researcher to understand the *char* people's perception on available health care options in the study area.

Nuzhat Choudhury and Syed M Ahmed (2011)[24] discussed in their article **'Maternal care practices among the ultra poor households in rural Bangladesh: a qualitative exploratory study'** that cultural beliefs and norms have a strong influence on maternal care practices among the ultra poor households, and override the beneficial economic effects from livelihood support intervention. Some of these practices, often compromised by various taboos and beliefs, may become harmful at times. Health behavior education in this livelihood support program can be carefully tailored to local cultural beliefs to achieve better maternal outcomes. This study has also helped the researcher to understand the *char* people's perception on available health care options in the study area.

Nuzhat Choudhury et al., (2012)[25] said that behavioral change messages are needed to increase the number of antenatal and postnatal care visits, improve birth preparedness, and encourage skilled attendance at delivery.Programs in the urban slum areas should also consider interventions to improve social support for key influential persons in the community, particularly landladies who serve as advisors and decision-makers in their article '**Beliefs and practices during pregnancy and childbirth in urban slums of Dhaka, Bangladesh'.** This article has helped the researcher to identify the knowledge and beliefs during pregnancy of the study people.

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[24] Nuzhat Choudhury and Syed M Ahmed, "Maternal Care Practices Among the Ultra Poor Households in Rural Bangladesh: A Qualitative Exploratory Study,"*BMC Pregnancy and Childbirth* 11, no. 15(2011): 1-8, accessed February12, 2011, http://www.biomedcentral.com/1471-2393/11/15/prepub.

[25] Nuzhat Choudhury et al., "Beliefs and Practices During Pregnancy and Childbirth in Urban Slums of Dhaka, Bangladesh," *BMC Public Health* 12, no.791 (2012): 1-6, accessed April 12, 2012, http://www.biomedcentral.com/1471-2458/12/791.

Neeraj M Srivastava1, Shally Awasthi and Girdhar G Agarwal (2009)[26] in their article **'Care-seeking behavior and out-of-pocket expenditure for sick newborns among urban poor in Lucknow, northern India: a prospective follow-up study'** assessed (1) distribution of neonatal illnesses and different health providers sought (2) distribution of out-of-pocket expenditures by type of illness and type of health provider sought (3) socio-economic distribution of neonatal illnesses, care-seeking behavior and out-of pocket expenditures. The work has helped the researcher to assess the neonatal health of the study area.

Cosmas Zyaambo, Seter Siziya and Knut Fylkesnes (2012)[27] in their article **'Health status and socio-economic factors associated with health facility utilization in rural and urban areas in Zambia'** examined associations of predisposing, enabling and need factors with health facility utilization in areas with high HIV prevalence and few people being aware of their HIV status. As to them the health care needs were the factors most strongly associated with health care seeking. After accounting for need differentials, health care seeking differed modestly by urban and rural residence, was somewhat skewed towards women, and increased substantially with socioeconomic position. This finding has also helped the researcher to understand the socio-economic factors associated with health facility in the study area.

Jane Chuma Vincent Okungu and Catherine Molyneux (2010)[28] in their article **'Barriers to prompt and effective malaria treatment among the poorest population**

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[26] Neeraj M Srivastava1, Shally Awasthi and Girdhar G Agarwal, "Care-Seeking Behavior and Out-of-Pocket Expenditure for Sick Newborns Among Urban Poor in Lucknow, Northern India: A Prospective Follow-up Study," *BMC Health Services Research* 2009, 9: 61, accessed July 2012, http://www.biomedcentral.com/1472-6963/9/61.

[27] Cosmas Zyaambo, Seter Siziya and Knut Fylkesnes,"Health Status and Socio-Economic Factors Associated with Health Facility Utilization in Rural and Urban Areas in Zambia," *BMC Health Services Research* 2012, 12: 389, accessed July 2012, http://www.biomedcentral.com/1472-6963/12/389.

[28] Jane Chuma Vincent Okungu and Catherine Molyneux, "Barriers to Prompt and Effective Malaria Treatment Among the Poorest Population in Kenya," *Malaria Journal* 2010, 9: 144, accessed 22 July, 2012, http://www.malariajournal.com/content/9/1/144.

in Kenya' said that multiple factors related to affordability, acceptability and availability interact to influence access to prompt and effective treatment. Regarding affordability, about 40 percent of individuals who self-treated using shop-bought drugs and 42 percent who visited a formal health facility reported not having enough money to pay for treatment, and having to adopt coping strategies including borrowing money and getting treatment on credit in order to access care. Other factors influencing affordability were seasonality of illness and income sources, transport costs, and unofficial payments. Regarding acceptability, the major interrelated factors identified were provider patient relationship, patient expectations, beliefs on illness causation, perceived effectiveness of treatment, and distrust in the quality of care and poor adherence to treatment regimes. Availability barriers identified were related to facility opening hours, organization of health care services, drug and staff shortages. This finding has helped the researcher to sketch out the barriers which played an important role to ensure equal access to the *char* people.

Sophie Coronini-Cronberg, Wongsa Laohasiriwong1 and Christian A Gericke (2007)[29] in their article **'Health care utilisation under the 30-Baht Scheme among the urban poor in Mitrapap slum, Khon Kaen, Thailand: a cross-sectional study'** discussed that in 2001, the Government of Thailand introduced a universal coverage scheme to the aim of ensuring equitable health care access for even the poorest citizens. For a flat user fee of 30 Baht per consultation, or for free for those falling into exemption categories, every scheme participant may access registered health services. The exemption categories include children under 12 years of age, senior citizens aged 60 years and over, the very poor, and volunteer health workers. The functioning of these exemption mechanisms and the effect of the scheme on health service utilization among

[29] Sophie Coronini-Cronberg, Wongsa Laohasiriwong1 and Christian A Gericke,"Health Care Utilisation Under the 30-Baht Scheme Smong the Urban Poor in Mitrapap Slum, Khon Kaen, Thailand: A Cross-Sectional Study", *International Journal for Equity in Health* 2007, 6: 11, accessed 11 July, 2012, http://www.equityhealthj.com/content/6/1/11.

the poor is controversial. As to them self-reported use of registered medical facilities in case of illness was stated to be predominantly due to the service being available through the scheme, with service quality not a chief consideration. Overall consumer satisfaction was high, especially among those not required to pay the 30 Baht user fee. This article has also helped the researcher to understand the Govt. initiatives in relation to the *char* people in Bangladesh.

Solome K Bakeera et al., (2009)[30] stated in their article **'Community perceptions and factors influencing utilization of health services in Uganda'** that healthcare utilization has particular relevance as a public health and development issue. Barriers to healthcare utilization exist for all the wealth categories along three different axes including: the health seeking process; health services delivery; and the ownership of livelihood assets. Income source, transport ownership, and health literacy were reported as centrally useful in overcoming some barriers to healthcare utilization for the 'least poor' and 'poor' wealth categories. The 'poorest' wealth category was keen to utilize free public health services. Conversely, there are perceptions that public health facilities were perceived to offer low quality care with chronic gaps such as shortage of essential supplies. In addition to individual material resources and the availability of free public healthcare services, social resources are perceived as important in overcoming utilization barriers. However, there are indications that having access to social resources may compensate for the lack of material resources in relation to use of health care services mainly for the least poor wealth category. This article has helped the researcher to grasp the real picture of *char* people in relation to perceptions and factors influencing utilization of health services in the study area.

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[30] Solome K Bakeera et al.,"Community Perceptions and Factors Influencing Utilization of Health Services in Uganda,"*International Journal for Equity in Health* 2009,8:25, accessed July 2011, http://www.equityhealthj.com/content/8/1/25.

Introduction

Marinka van der Hoeven, Annamarie Kruger and Minrie Greeff (2012)[31] said in their article '**Differences in health care seeking behavior between rural and urban communities in South Africa'** that inhabitants of urban communities rated their health significantly better than rural participants. Although most urban and rural participants consider their access to health care as sufficient, they still experienced difficulties in receiving the requested care. The difference in employment rate between urban and rural communities in this study indicated that participants of urban communities were more likely to be employed. Consequently, participants from rural communities had a significantly lower available weekly budget, not only for health care itself, but also for transport to the health care facility. Urban participants were more than 5 times more likely to prefer a medical doctor in private practice. This article has helped the researcher to sketch the social stratification of the study population in relation to health seeking behaviors.

J.T. Young (2004)[32] stated in his article **'Illness Behaviour: A Selective Review and Synthesis'** that singular and segmented approaches to illness behaviour have not clearly elucidated the complexity of the phenomenon. A more comprehensive and structured analysis of illness behaviour can be accomplished with mixed qualitative and hierarchical/structural quantitative techniques. Following a discussion of prior research in social psychology, demography, economics, social networks and geographic systems, he offers a template for future analysis of illness behaviour. This article has helped the researcher to accomplish the theoretical view of illness behavior in respect to the study.

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[31] Marinka van der Hoeven, Annamarie Kruger and Minrie Greeff, "Differences in Health Care Seeking Behavior Between Rural and Urban Communities in South Africa," *International Journal for Equity in Health* 2012 11: 31, accessed July 11, 2012, http://www.equityhealthj.com/content/11/1/31

[32] J.T. Young, "Illness Behaviour: A Selective Review and Synthesis," *Sociology of Health & Illness* 26, no. 1 (2004): 1–31.

Introduction

Lynn Clark Callister, RN, PhD (2003)[33] in his article **'Cultural Influences on Pain Perceptions and Behaviors'** discussed that the perception of pain and behaviors associated with pain are influenced by the socio-cultural context of the individual experiencing pain. His article provides an overview of the literature on these cultural influences. This article has helped the researcher to understand the illness behavior of the study people.

Arushi G. Saini, Bhavneet Bharti, and Suman Gautam (2012)[34] in their article **'Healthcare Behavior and Expenditure in an Urban Slum in Relation to Birth Experience and Newborn Care'** stated that newborn care practices and healthcare seeking are important determinants of neonatal morbidity and mortality in the resource-limited settings of the urban slums. They try to examine the current patterns of healthcare-seeking behavior and estimate out-of-pocket expenditure for delivery and common neonatal problems in the urban slums of Chandigarh. As to them 31.7% of the mothers delivered at home with 4.18±2.16 mean number of antenatal visits and 73.9% used prelacteals. Factors significantly predicting home deliveries were identified. About 44.7% of the neonates had problems after birth, with 40.3% requiring hospitalization. Choice of private healthcare providers governed the care seeking in the majority (61.4%). Out-of-pocket expenditure was significantly high for the private care providers in terms of the cost of delivery and the overall cost of neonatal illness though no gender-based differences were seen. This article has helped the researcher to understand the health care practice of *char* people in relation to new born.

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[33] Lynn Clark Callister, RN, PhD, "Cultural Influences on Pain Perceptions and Behaviors," *Home Health Care Management & Practice* 15, no. 3 (2003): 207-211.

[34] Arushi G. Saini, Bhavneet Bharti, and Suman Gautam, "Healthcare Behavior and Expenditure in an Urban Slum in Relation to Birth Experience and Newborn Care," *Journal of Tropical Pediatrics* 58, no.3 (2012): 214-19.

Introduction

Chiyoe Murata et al.,(2010)[35] in their article **'Barriers to Health Care among the Elderly in Japan'** stated that Japan is undergoing a set of health care reforms aimed at cutting rising health care costs and increasing the efficiency of health care delivery. This empirical study used a large-scale community survey on 15,302 elderly people 65 years and older (56.0% women) conducted in seven municipalities in 2006, to reveal clear-cut evidence of barriers to necessary care. The reasons for not getting health care is attributed to health care cost for the elderly with lower income, while higher income counterparts reported being busy or having a condition not serious enough to seek care. This work has led to the researcher to carry out the study smoothly.

Charles P Larson et al., (2006)[36] in their article **'Childhood Diarrhoea Management Practices In Bangladesh: Private Sector Dominance And Continued Inequities In Care'** stated that households seeking help from a health provider overwhelmingly utilize the private sector in Bangladesh. Gender inequities in the utilization of licensed providers and purchase of antibiotics, favouring males were identified. Findings suggest that higher income, urban households tend to practice greater gender discrimination. In order to better understand health dynamics in urban population, in particular slum-dwellers, there is a need to disaggregate survey data by household location. This work has led to the researcher to understand the health seeking behavior of *char* people.

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[35] Chiyoe Murata et al., "Barriers to Health Care among the Elderly in Japan," *International Journal of Environmental Research and Public Health* 7, (2010): 1330-1341, accessed July 11, 2012, http://www.mdpi.com/1660-4601/7/4/1330.

[36] Charles P Larson et al., "Childhood Diarrhoea Management Practices in Bangladesh: Private Sector Dominance and Continued Inequities in Care,"*International Journal of Epidemiology* 35, (2006): 1430–1439, accessed July 11, 2012, http://ije.oxfordjournals.org/content/35/6/1430.long.

Introduction

Rashed Al Mahmud Titumir and Jakir Hossain (2004)[37] stated in their article **'Barriers to Access to Public Services for the Urban Poor: An Enquiry into Dhaka Slmus'** that access to both kinds of services – universal form of services (i.e. services are to be made available to all citizens on a uniform basis regardless of income, status or power such as universal free primary education, the fire service, etc.) and those services where income, position or influence have the capacity to leverage particular individuals or groups– is affected by financial circumstances, creating different levels of access and situations in which the urban poor are disadvantageous from the outset. The interviewed population point out that access to public services by slum dwellers is driven by hierarchical framework of power. A change in the reverse direction, according to them, means a transformation of socio-spatial relations, a production of a new, emnacipatory space. This work has helped the researcher to understand the power relation regarding health seeking of *char* people.

Nizam U. Ahmed et al., (2006)[38] in their article '**Reaching the Unreachable: Barriers of the Poorest to Accessing NGO Healthcare Services in Bangladesh'** stated that the following four major categories of barriers emerged as roadblocks to accessing quality healthcare for the poor: (a) low income to be able to afford healthcare, (b) lack of awareness of the kind of healthcare services available, (c) deficiencies and inconsistencies in the quality of services, and (d) lack of close proximity to the healthcare facility. Those who were interviewed perceived their access problems to be: (a) a limited range of NGO's services available as they felt what are available failed to meet their demands; (b) a high service-charge for the healthcare services they sought; (c) higher

[37] Rashed Al Mahmud Titumir and Jakir Hossain,"Barriers to Access to Public Services for the Urban Poor: An Enquiry into Dhaka Slmus," *Journal of the Institute of Bangladesh Studies* 27, (2004): 27-46.

[38] Nizam U. Ahmed et al., "Reaching the Unreachable: Barriers of the Poorest to Accessing NGO Healthcare Services in Bangladesh," *J Health Populnutr* 24, no.4 (2006): 456-66.

prices of drugs at the facility compared to the market place; (d) a belief that the NGO's clinics are primarily to serve the rich people, (e) lack of experienced doctors at the centres; and (f) the perception that the facility and its services were more oriented to women and children, rather male. Others responded that they should be allowed to get treatment with credit and, if needed, payment should be waived for considering the level of poverty. While the results of the study revealed many perceptions of barriers to healthcare services among the poor, the feedback provided by the study indicates how important it is to learn from the poorest segment of society. This will assist healthcare providers and the healthcare system itself to become more sensitized to the needs and problems faced by this segment of the society and to make recommendations to remove barriers and improvement of access. Treatment with credit and waived payment for the poorest were also recommended as affordable alternative private healthcare services for the poor. This work has inspired the researcher to assess the available health care option in the study area.

MMH Khan, Oliver Grubner and Alexander Kramer (2012)[39] in their article **'Frequently Used Healthcare Services in Urban Slums of Dhaka And Adjacent Rural Areas and Their Determinants'** discussed that two frequently used healthcare sources utilized in 1 month preceding the baseline survey were pharmacies (slum, 42.6%; rural, 30.1%) and government hospitals/clinics (GVHC; slum, 13.5%; rural, 8.9%). According to the multilevel logistic regression analysis adjusted for age, sex and marital status, the likelihood of using pharmacies and GVHC were higher for those subjects who used non-hygienic toilets, who reported food deficiency at a family level, who expressed dissatisfaction about family income and who stated poor health status. Some more factors namely overweight, living in permanently structured house, smoking bidis and less

[39] MMH Khan, Oliver Grubner and Alexander Kramer, "Frequently Used Healthcare Services in Urban Slums of Dhaka and Adjacent Rural Areas and Their Determinants," *Journal of Public Health* (2012): 1-11, http://jpubhealth.oxfordjournals.org/content/early/2012/01/11/pubmed.fdr108.full.pdf.

frequency of watching TV were associated with higher likelihood of using GVHC. They also said that pharmacy was the most dominant healthcare service in both areas. As persons were running pharmacies often provide poor quality of healthcare services, they need continuous training and back-up supports to improve their quality of services and to strengthen the overall healthcare system in Bangladesh. This work has helped the researcher to understand the health market in the study area.

D. JUMA and R. MANONGI (2009)[40] in their article **'Users' Perceptions of Outpatient Quality of Care in Kilosa District Hospital in Central Tanzania'** said that use of users' perception in measuring quality of care has been shown to be useful in screening problems and in planning for improvement of quality of health care delivery. Traditionally, quality of care has been measured using professional standards, neglecting users' opinions which may leave psychosocial needs unattended. The objective of this descriptive cross-sectional study was to assess users' perceptions of quality of care given at outpatient department (OPD) at Kilosa District Hospital in Central Tanzania. Hospital based exit interviews were conducted to adult patients or caregivers of children attending the hospital. Focus Group Discussions were conducted among community members in selected villages within the hospital catchment area. Information on perceptions on care provider-patient interaction, cost of service, and availability of medicines, equipment and health personnel was sought from the participants. Overall OPD was perceived to have several shortcomings including verbal abuse of patients by care providers, lack of responsiveness to patients' needs, delays, inadequate examination, unreliable supply of medicines, lack of confidentiality and favouritism in health care provision. Cost of service was perceived to be reasonable provided medicines were available. In conclusion, provider-patient interactions, timely services, supply of medicines and favouritism were the major factors affecting quality of service at the hospital. Efforts should be made to

[40] D. JUMA and R. MANONGI, "'Users' Perceptions of Outpatient Quality of Care in Kilosa District Hospital in Central Tanzania," *Tanzania Journal of Health Research* 11, no.4 (2009): 196-204.

address the shortcomings so as to improve quality of care and users perceptions.This work has helped the researcher to understand the relation of supply as well as demand side in the study area respectively.

The above mentioned literature review is claiming that there is a huge gap of research on this issue in Bangladesh. On the other hand Bangladesh is committed to achieve the MDGs which includes among others, the pledge to have the proportion of people living on less than one US dollar a day by 2015 in line with the international commitment. Enhancing disadvantaged population ability to access quality health care at low cost has a potential poverty alleviating effect. It acts through mitigation of the income-erosion consequences of ill-health. For achieving the health related MDGs also improving health system ability to reach the poor effectively is essentials. To maximize this effect, health interventions need to be designed according to their needs and priorities. Knowledge and understanding about their current health seeking behavior including its differentials and determinants is required for this to happen.[41] There is a lack of disaggregated information in this respect for *char* people in Bangladesh. The socioeconomic condition of *char* area is so deplorable in which they are neglected from the quality health care facilities. To identify the existing constraints to health care access of *char* people as well as to explore the nature of health care activities within the society, the study has worth done. As there are no specific studies regarding this issue, the findings of the research will hopefully create a new arena of knowledge in which policy makers can take special initiatives for the development of this disadvantaged people.

[41]Sayd Masud Ahamed, *Exploring Health Seeking Behavior of Disadvantage Population in Rural Bangladesh(*Stockholm, Sweden:Division of International Health, Department of Public Health Science, Karolinska Institute, 2005): 19.

1.4 Theoretical and Conceptual Framework

A number of models have been used for understanding health-seeking behavior beyond knowledge, attitude and practice (KAP) surveys and ethnographic studies. The latter studies produce descriptive data on practices without providing explanation for these practices. The health-seeking behavior models provide relevant determinants for identifying problematic areas in order to intervene with specific health system strategies.[42] Some of the relevant ones are briefly described below:

1.4 .1. The Health Belief Model (HBM)

According to Sheeran and Abraham, action in the HBM is guided by i) beliefs about the impact of illness and its consequences (threat perception); ii) health motivation i.e., readiness to be concerned about health matters; iii) beliefs about the consequences of health practices (behavioural evaluation); iv) clues to action, which include internal and external factors; and v) conditions such as socio-demographic and psychological characteristics of the interviewed person. These factors are considered to be transformable through health education/health promotion campaigns, in contrast to structural or cultural factors like poverty, gender, religious norms etc.

1.4. 2. The "Four A's"

It has become popular among researchers to use different categories which group key factors for health-seeking behaviour. The best known is the grouping into the "Four A's":

- ***Availability:*** It refers to the geographic distribution of health facilities, pharmaceutical products etc.

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[42] Hausmann-Muela, S., Riberia, J.M. and Nyamongo, I, *Health-Seeking Behaviour and the Health System Response,*2003.(London:Health Economics and Financing Programme, London School of Hygiene and Tropical Medicine, DCPP Working Paper No. 14), 9-18.

- ***Accessibility:*** It includes transport, roads, etc.
- ***Affordability:*** It includes treatment costs for the individual, household or family. A distinction is made between direct, indirect and opportunity costs.
- ***Acceptability:*** It relates to cultural and social distance. This mainly refers to the characteristics of the health providers – health workers' behaviour, gender aspects (non acceptance of being treated by the opposite sex, in particular women who refuse to be seen by male nurses/doctors), excessive bureaucracy etc.

The 'model' of the "Four A's" has been widely used by medical geographers, anthropologists and epidemiologists who mainly emphasised distance (both social and geographical) and economic aspects as key factors for access to treatment (e.g. Good, 1987). The advantage of the "Four A's" is the easy identification of key potential 'barriers' for adequate treatment.

1.4.3. Pathways Model

In this model, paths taken from recognition of symptoms to use of different health services are followed and the role of extended groups of relatives and friends in illness negotiation and management ("significant others") is given importance. Most of the studies using pathways model to investigate the path until the first contact with a health facility. The strength of the pathways model is that it depicts health-seeking as a dynamic process.

1.4.4. The Health Care Utilization Model (Socio-Behavioural Model)

In the socio-behavioural model originally proposed by Andersen (1995), three categories of factors which influence health-seeking behaviour are grouped into a logical sequence:

- ***Predisposing factors:*** age, gender, religion, global health assessment, prior experiences with illness, formal education, general attitudes towards health services, knowledge about the illness etc.

- ***Enabling factors:*** availability of services, financial resources to purchase services, health insurance, social network support etc.
- ***Need factors:*** perception of severity, total number of sick days for a reported illness, total number of days

There have been further modification and extension of this model over the years to describe healthcare utilization and the following factors were gradually added to the original model:[43] health-service system factors (policy, resources, organization); consumer satisfaction; health status outcomes as influenced by external environment (physical, political, economic) and personal health practices (diet, exercise, self-care etc.). Finally, an emerging variant of the model emphasizes the dynamic and recursive nature of health service use and portrays the multiple influence on health service use and subsequently, on health status.

1.5 Conceptual Framework of the Study

Access to health care is a major health and development issue, but most of the above models centre on the individual characteristics and tends to 'blame the victim' for inadequate behavior. Most governments declare that their citizens should enjoy universal and equitable access to good quality care. However, even within the developed world, this goal is difficult to achieve, and there are no internationally recognized standards on how to define and measure "equitable access."

Evidently, huge disparities exist between the poor and the better off with respect to access to health care services and health status. Gaps in child mortality between rich and poor countries are wide, as well as between the wealthy and the poor within most countries. Poor children are not only more likely than their better off peers to be exposed

[43] R. M Andersen, "Revisiting the Behavioral Model and Access to Medical Care: Does it Matter?,"*Journal of Health and Social Behavior* 36, no.1 (1995): 1-10.

to health risks and have less resistance to disease, they also have less access to preventive and curative interventions. Even public subsidies for health frequently benefit rich people more than poor people. Clearly, more of the same is not enough: To improve equitable access, innovative and community-based approaches are needed to better align health care services with poor people's needs, expectations, and resources.

The present research has adopted a framework for analysis and action to explore and improve access to health care in *char* people, in Bangladesh, namely *The Health Access Livelihood Framework.* The framework links social science and public health research with broader development approaches to improve health system development. It was developed in the frame of the ACCESS Programme, which focuses on understanding and improving access to prompt and effective malaria treatment and care in rural Tanzania as an empirical case study.

Health-seeking studies provide a deeper understanding of why, when, and how individuals, social groups, and communities seek access to health care services and investigate interactions between lay persons and professionals.

In this perspective, social actors are the potential driving force for improving access to effective and affordable health care, but they are often constrained by social, political, cultural, and geographical and the economic factors on national and international levels. Health seeking behavior concentrate on factors influencing access to health care, and they commonly define it as utilization rates. They apply determinants' models and consider access as a general concept, summarizing a set of more specific dimensions, such as availability, affordability, accessibility, adequacy, and acceptability. Although they take into account demographic characteristics of health service users, their knowledge about the disease, and, more recently, wealth as measured by household assets, health services studies tend to pay more attention to both the supply & the demand side equally.

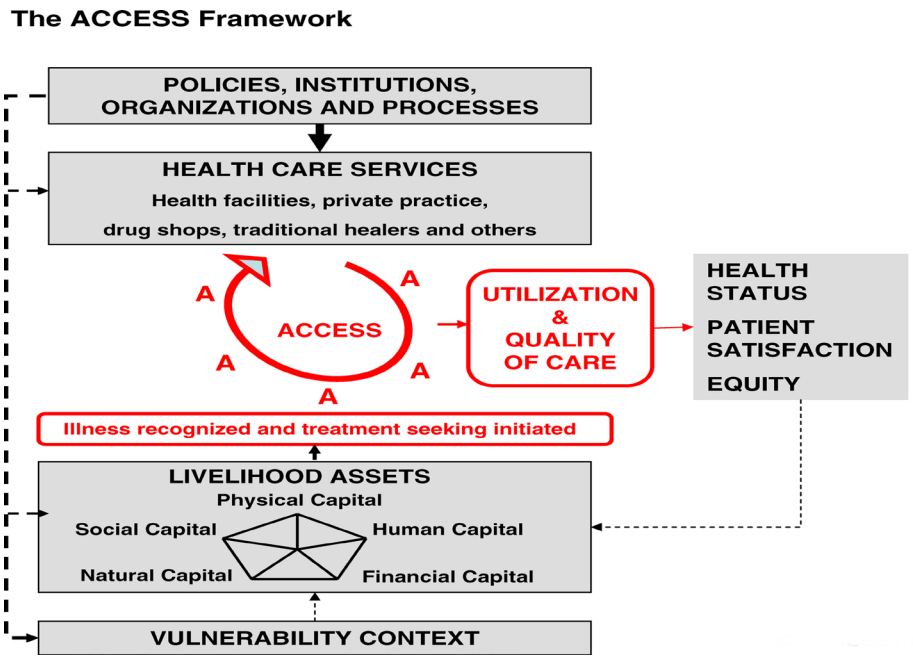

Figure 1.1: The Health Access Livelihood Framework

They search for policy interventions to reduce supply barriers and improve the delivery of services, including availability of health facilities, equipment, and qualified staff, staff skills, and protocols of diagnosis, treatment, and quality of care. Moreover, they are less oriented towards health seeking processes. Interventions on the demand side are commonly limited to Information, Education, and Communication (IEC) campaigns. Livelihood approaches—as the name implies—emphasize assets (including material and social resources) and activities needed to gain and sustain a living under conditions of economic hardship. Access is a key issue for sustainable livelihoods. In other words, not only possession, but mobilization of household and community assets is a critical factor influencing people's access to health care and other health-related services. Interventions target communities and social groups, emphasize solidarity and empowerment, and try to improve livelihood conditions.

The health access livelihood framework combines health service and health-seeking approaches and situates access to health care in the broader context of livelihood insecurity.

1.5.1 Five Dimensions of Access

Access becomes an issue once illness is recognized and treatment seeking is initiated. Five dimensions of access influence the course of the health-seeking process: Availability, Accessibility, Affordability, Adequacy, and Acceptability.

Problems of accessibility, including long distances to nearest dispensary or health center, scarce public transport, and lack of bicycles and other private means continued to be major access barriers. Issues related to affordability were also major obstacles: complaints about fees were frequent, and even if official fees were exempted (e.g., for children under five) or waived (e.g., for persons temporarily unable to pay), people often ended up paying for drugs, small charges, kerosene, and even ambulance transport. Poor people had to resort to short-term coping strategies like selling critical assets such as crops to pay for health care, especially in times of emergencies. Adequacy and acceptability in terms of people's judgment of quality of care also played an important role. What degree of access is reached along the five dimensions depends on the interplay between (a) the health care services and the broader policies, institutions, organizations, and processes (PIOP) that govern the services, and (b) the livelihood assets people can mobilize and combine in particular vulnerability contexts. Hence, access improves as health care services become better aligned with clients' needs and resources.

1.5.2 The Health Care Services and the PIOP

Sick persons and caregivers seek help not only in health facilities or private practice, but also in drug shops and pharmacies as well as from healers representing a wide array of medical traditions. Access to these health care service providers is governed by cultural

norms, policies, laws and regulations, which themselves are influenced by broader trends in society, global health policy, research, and development as a whole.

1.5.3 Livelihood Assets and the Vulnerability Context

Whether people actually recognize an illness and seek treatment in drug shops or through other health care services depends to a large extent on their access to livelihood assets of the household, the community, and the wider society. These livelihood assets comprise human capital (local knowledge, education, skills), social capital (social networks and affiliations), natural capital (land, water, and livestock), physical capital (infrastructure, equipment, and means of transport) and financial capital (cash and credit). The availability of these assets is influenced by forces over which people have little control, for instance economy, politics or technology, climatic variability or shocks like floods,river erosion, draughts, armed conflicts or epidemics. Such factors may be referred to as their vulnerability context.[44]

1.5.4 Perspectives to Health Problems

A useful place to begin gathering tools for assessing health seeking behavior is to distinguish between key viewpoints to health problems. There is close difference among the concept disease, illness and sickness.[45]

"**Disease** … is a pathological process, most often physical as in throat infection, or cancer of the bronchus, sometimes undetermined in origin, as in schizophrenia. The quality which identifies disease is some deviation from a biological norm. There is objectivity about disease which doctors are able to see, touch, measure, and smell. Diseases are valued as the central facts in the medical view.

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[44] B Obrist et al., "Access to Health Care in Contexts of Livelihood Insecurity: A Framework for Analysis and Action," *PLoS Med* 4, no.10:e308 (2007): 1584-88.

[45] Marshall Marinker,"Why Make People Patients?," *Journal of Medical Ethics* 1, no. 2 (1975): 81–84.

"Illness … is a feeling, an experience of unhealthy which is entirely personal, interior to the person of the patient. Often it accompanies disease, but the disease may be undeclared, as in the early stages of cancer or tuberculosis or diabetes. Sometimes illness exists where no disease can be found. Traditional medical education has made the deafening silence of illness-in-the-absence-of-disease unbearable to the clinician. The patient can offer the doctor nothing to satisfy his senses.

"**Sickness** … is the external and public mode of unhealthy. Sickness is a social role, a status, a negotiated position in the world, a bargain struck between the person henceforward called 'sick', and a society which is prepared to recognize and sustain him. The security of this role depends on a number of factors, not least the possession of that much treasured gift, the disease. Sickness based on illness alone is a most uncertain status. But even the possession of disease does not guarantee equity in sickness. Those with a chronic disease are much less secure than those with an acute one; those with a psychiatric disease than those with a surgical one …. .Best is an acute physical disease in a young man quickly determined by recovery or death—either will do, both are equally regarded." The above framework has helped the researcher to investigate the health seeking behavior of *char* people.

1.6 Operational Definitions

Health is nothing but the convenient state of the human body that supports people to perform their daily activity without any physiological, psychological and social difficulties.

Health Seeking Behavior refers to the sequence of remedial actions that individual undertakes to rectify perceived ill health. It is initiated with symptom definition, where upon a strategy for treatment action is devised.

***Char* People** are the most disadvantage as well as tormented people who are living in the *char* areas called *char* people. *Char*s are islands isolated from mainlands surrounded virtually nonexistent by water whole year or most part of it.

1.7 Objectives of the Study

The objective of the research was to understand the health seeking behavior of *char* people, that is to investigate how socio-economic, geographic and other factors contribute to the probability of utilizing health care and make it successful event, and analyze respondents' opinion towards different system of health care. To achieve the objective of the study, the researcher identified some specific objectives.

The specific objectives of this research, however, were

1. To know about the present illness of the people;
2. To explore the explanatory model about illness of the people;
3. To find out the *emic* (local) categorization of stages of illness;
4. To explore the multiple health care option that the *char* people frequently uses and their opinion on these options;
5. To explore the therapeutic decision making process of *char* people.

1.8 Methodology

1.8.1 Research Approach

The research was conducted by using the both *emic and etic* approaches. Because, an *emic* one is in essence, valid for only one language (or one culture) at a time… it is an attempt to discover and to describe the pattern of that particular language or culture. On

the other hand, the *etic* is deals with the outsider's view which is important for ensuring holistic nature of the research.[46]

1.8.2 Type of the Study

The research was qualitative in nature. It attempted to understand a given research problem or topic from the perspectives of local population it involves. On the other hand it always dealt with

- A clear statement of the problem;

- The identification of the socio-cultural and economic factors those are associated with the problems;

- A plan for data collection related to the problems;

- Building on existing data based on both negative and positive findings.[47]

1.8.3 Study Area

Char Majhira under Sariakandi Upazilla of Bogra district was selected as the study area. Because, this village is frequently affected by the natural disaster like river erosion, flood in every year and it is a remote village of this Uapzilla. The transport system of this village is so shocking. There is a lack of all modern medical facilities. The researcher was very much familiar with the socio-cultural milieu of the village which helped him a lot to grasp the actual picture of the village. That's' why, to understand the real vulnerability of this people the village was considered for the study.

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[46] N, Jardine, "Etics and Emics (Not to Mention Anemics and Emetics) in the History of the Sciences," *History of Science* 42, (2004): 261-278.

[47] A. Hardon et al., *Applied Health Research Manual: Anthropology of Health and Health Care (*Den Haag: CIP-Data, Konkinklijke Bibliotheck, 1995), 93.

1.8.4 Study Population

250 households of this village were considered as the study population. Household was the study unit. The head and aged people of the household were considered as the key respondents. As a head and aged member of the family, they have adequate knowledge as well as vast experience regarding these problems.

1.8.5 Sampling and Sample Size

250 households of this *char* were considered as the sample size for this research.

It is stated earlier that the data has been collected from the one village of Bangladesh. As the people possessed almost same traits in the area that's why simple random and purposive sampling techniques have been used for this research. Households of the villages have interviewed to find out the ill people. From the total 504 households, 250 have been selected as the study sample. 250 respondents have also used for scheduled in-depth interview, from 250 respondents, 40 have taken for 5 FGDs.

Table -1.1: Sample Distribution and Techniques

Category of Study	**Number of Sample**	**Sampling Techniques**	**Respondents**
Scheduled In-depth Interview	250	Random(simple)	Both male and female
FGD	5 (from the 250 respondents)	Purposively	Both male and female
Total Number of Sample	255		

1.8. 6 Types of Data

Both the qualitative and quantitative data were used for this study. The sources of the data of this study were

a) Primary Data:

The study was based basically on primary data, which have collected from primary source, i.e. from the village. In collecting primary data, participant observation, in-depth-interviews and FGDs were used during field work from November 2010 to June 2011 in this study.

b) Secondary Data:

This data were collected from various journals, articles, books, research papers, census reports, Govt. and non-governments organizations.

1.8.7 Data Collection Techniques

For collecting data, **Participant Observation** technique that involves systematically selecting, watching and recording behavior and characteristics of living being objects or phenomena was used for this research. Observation to understand human behavior may serve different purposes. It can give additional, more accurate information on behavior of people than interview. Observation can, therefore, check on information collected, especially on sensitive topics like their daily income, bad habits, personal behavior etc.

In-depth Interview is a data collection technique that involves oral questioning of respondents, for this research, in-depth-interview of people was selected. Because, in these interviews an interview schedule was used to ensure that all issues were discussed but at the same time, flexibility in timing and the order in which the questions were asked was allowed. Topics that are sensitive or controversial are only better handled through In-depth interview.

Table -1.2: In-depth Interviews Sample Distribution

Types of Households	Sex	Age	Number of People
Landless	Male	25-35	13
		36-45	28
		46-60	9
	Female	25-35	24
		36-45	23
		46-60	13
Small Peasant	Male	25-35	15
		36-45	19
		46-60	8
	Female	25-35	20
		36-45	18
		46-60	8
Medium Peasant	Male	25-35	7
		36-45	9
		46-60	4
	Female	25-35	11
		36-45	13
		46-60	5
Rich Peasant	Male	25-35	0
		36-45	1
		46-60	0
	Female	25-35	0
		36-45	1
		46-60	1
Total Male			**113**
Total Female			**137**
Total Respondents			**250**

In-depth-interviews were administered with a view to understand their knowledge, perceptions and practices regarding their illness and the factors affecting their choices to adopt a particular treatment options available to 250 households. To ensure balanced

representatives, participants were selected for the in-depth interviews based on the different households like landless, small peasant, medium peasant and rich peasant. The total numbers of male respondents were 113 and female 137. Total 50 male and 60 female were interviewed from 110 landless households where the respondents of small peasant's households were 42 male and 46 female, medium peasants' households were 20 male and 29 female and rich peasant households were respectively 1 male and 2 female. To meet the objectives of the study, aged people were considered as the participant of in-depth interviews.

FGDs were condcuted for this study to collect data. The main reason of this technique was to justify the data. Actually participants feel more comfortable or secure about expressing certain views when they are in a group. The distribution of FGDs sample are stated in the table no 1.3.

In order to get sufficient information from a particular group of people based on societal perspective within a short span of time, FGD was really fruitful. From 250 respondents, 40 have taken for 5 FGDs purposely. Each group formed by 8 participants. Among 5 FGDs 2 were conducted with female and 3 were with both female and male. The length of FGDs were 1-2 hours in an average.

In selecting participants for FGDs, issues like the nature of group composition (homogeneous/heterogenous), the degree of familiarity among participants (stranger/friends/relatives/colleagues) and the level of compatibility were considered to a great extent. Two moderators were used for every session of FGDs while one engaged in facilitation and another deployed for observing nonverbal communication taken place in the groups.

Table -1.3: FGDs Sample Distribution

Types of Households	Sex	Age	Number of People
Landless	Male	25-35	1
		36-45	2
		46-60	3
	Female	25-35	3
		36-45	2
		46-60	2
Small Peasant	Male	25-35	1
		36-45	2
		46-60	2
	Female	25-35	1
		36-45	3
		46-60	2
Medium Peasant	Male	25-35	1
		36-45	2
		46-60	2
	Female	25-35	1
		36-45	3
		46-60	2
Rich Peasant	Male	25-35	1
		36-45	1
		46-60	1
	Female	25-35	0
		36-45	1
		46-60	1
Total People			40

Though participatory approaches were the techniques of this research, the researcher also used some tools to gather data considering situation. These tools were: -

Field Diary were kept during the data collection period on which collected data, personal experiences, field situation and degree of relationship and observable phenomena were elaborately preserved.

The research regularly maintains **field notes** in a descriptive manner from the collected information. Field notes also played the role of mediator between the researcher and the supervisor of the study. Even supervisor valuable directions were preserved in this field note.

1.8.8 Tools of Data Collection

To avoid confusion in the use of terms, the table 1.3 points out the distinction between techniques and tools were applied in data collection for the study.

Table-1.4: Data Collection Techniques and Tools

Data Collection Techniques	Data Collection Tools
Participant Observation	Eyes and ears, pen and papers, watch. tape etc.
In-depth-interview	Interview schedule, checklist, questionnaire, tape recorder.
Focus Group Discussion	Discussion guide, tape recorder.

1.8.9 Validity and Reliability of Data

In the broadest sense, reliability and validity address issues about the quality of the data and appropriateness of the methods used in carrying out a research. The quality of the data and the appropriateness of the methods employed are particularly important in the social sciences because of the different philosophical and methodological approaches to

the study of human activity.[48] In order to corroborate data sources, the researcher's belief that the triangulation of the above techniques with its appropriate tools has increased the reliability of data. As the research was qualitative in nature, so, the above qualitative tecniques have ensured the validity of data.

1.8. 10 Techniques of Data Analysis and Interpretation

The study presented both the qualitative and quantitative data and information, which were gathered from households by using different techniques. At the time of data collection code and number were used for each household which were very helpful for data processing. Qualitative data have processed, analyzed and interpreted by using content analysis technique. The steps of content analysis were:[49]

1. **Defining the Unit of Analysis:** The unit (material) was confined to single words, to phrases to complex sentences. Only those facts were mentioned which are useful in solving the problem. The units were considered as the entity whose specified characteristics were determined and analyzed.

2. **Specifying Variables and Categories**: Once the unit was defined, the researcher conducted its analysis so as to create reproducible or objective data for scientific treatment and generalization beyond the specific set of symbolic material analyzed. For converting symbolic material into objective data it was necessary to specify the variables explicitly. There was a need for framing explicit rules specifying what features of the content were to be taken as an indication that fallen in one category rather than the other.

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[48] Dr. Virginia Cano, *Study Notes: Validity and Reliability in Qualitative Research*, (accessed May 05,2010), http://www.qmu.ac.uk/psych/rtrek/studynotes/web/sn5.htm

[49]Articles Gratuits.com, *Content Analysis as a Research Tool, (*accessed Nov.11, 2010), http://en.articlesgratuits.com/content-analysis-as-a-research-tool-id998.php.

3. **Frequency, Direction and Intensity:** Once the unit was defined and the variables along with their categories to be employed specified, the analysis was classified units in the material to be analyzed according to frequency, direction and intensity. Because, it dealt with the use of more than one technique to the investigation of the research question in order to enhance confidence in the ensuing findings.

4. **Consultation with Physician:**The researcher consulted with physicians of Sariakandi Upazila health complex to identify the medical name of illness based on the signs and symptoms described by the villagers.

On the other hand, quantitative data were processed, analyzed and interpreted through the used of SPSS. The analysis and interpretation of both data and information were also prepared through table, chart and diagram.

1.9 Ethical Issues

Research ethics deals primarily with the interaction between researchers and study people. The history and development of international research ethics guidance is strongly reflective of abuses and mistakes made in the course of biomedical research. This has led some qualitative researchers to conclude that their research is unlikely to benefit from such guidance or even that they are not at risk of perpetrating abuses or making mistakes of real consequence for the people they study. Conversely, biomedical and public health researchers who use qualitative approaches without having the benefit of formal training in the social sciences may attempt to rigidly enforce bioethics practices without considering whether they are appropriate for qualitative research. Between these two extremes lies a balanced approach founded on established principles for ethical research that are appropriately interpreted for and applied to the qualitative research context.

Agreed-upon standards for research ethics help ensure that as researchers we explicitly consider the needs and concerns of the people we study, that appropriate oversight for the

conduct of research takes place, and that a basis for trust is established between researchers and study participants. Whenever we conduct research on people, the well-being of research participants must be our top priority. The research question is always of secondary importance. This means that if a choice must be made between doing harm to a participant and doing harm to the research, it is the research that is sacrificed. Fortunately, choices of that magnitude rarely need to be made in qualitative research, but the principle must not be dismissed as irrelevant, or we can find ourselves making decisions that eventually bring us to the point where our work threatens to disrupt the lives of the people we are researching.[50]

The core principles of this research ethics were

Respect for person: The researcher was committed to ensuring the autonomy of research participants, and, where autonomy may be diminished, to protect people from exploitation of their vulnerability. The dignities of all research participants were respected. Adherence to this principle ensured that people would not be used simply as a means to achieve research objectives.

Beneficence: The researcher was committed to minimizing the risks associated with research, including psychological and social risks, and maximizing the benefits that accrue to research participants. Researchers must articulate specific ways which were achieved.

Justice: The researcher was committed to ensuring a fair distribution of the risks and benefits resulting from research. Those who take on the burdens of research participation shared the benefits of the knowledge gained. Or, to put it another way, the people who were expected to be benefited from the knowledge should be the one who was asked to participate.

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[50] Family Health International, *Qualitative Research Methods: A Data Collector's Field Guide* (USA: Research Triangle Park, North Carolina 27709, 2011), 9.

Respect for community: The researcher was committed to respect the values and interests of the community in research and wherever possible, to protect the community from harm." The researcher believes that this principle is, in fact, fundamental for research when community-wide knowledge, values, and relationships are critical to research success and may in turn be affected by the research process or its outcomes.

1.10 Feasibility of the Study

The researcher was confident enough to conduct an academic research about health seeking behavior of *char* people by having support from the feasible sources are cited below:

- The researcher has acquired knowledge on the subject of public health during the study period in the University. Some researches on health issues have carried out in different forms in Bangladesh which may provide knowledge to go well ahead.
- The researcher worked as `Field Investigator', 'Research Officer' and 'Project Coordinator' in various national and international organizations that has helped the researcher to conduct the study.
- Availability of literatures were not very uncommon in the library or relevant departments of Rajshahi University and other universities of Bangladesh, regional & zonal office of various national and international organization like USAID, Family Health International, Population Council, Plan Bangladesh, Practical Action, icddr,b, WHO,UNFPA have also provided some documents as literary support.
- After a year long course work including research methodology, language development skills in both Bengali & English etc. offered by IBS through expert faculties of IBS & various departments cemented the confidence of the researcher as scholarly supports.

- The above reasons were fruitful for kind guidance from the faculties of IBS with some required assistance followed by close supervision and monitoring by the supervisor of the research. Then the efforts have made the research possible and feasible.

1.11 Scope and Limitation of the Study

The research mostly focused with the health seeking behavior of *char* people of Bangladesh. There was an ample scope to investigate the problem within this village. It has not covered all the households of this village as well as adjacent urban area. The researcher observed that, the village is nothing but the social laboratory. There is an ample scope of future research. The researcher has only focused on the health seeking behavior of the villagers. The researcher feels that there are still some areas where other researchers can work in the area of daily life, economic system, political culture, religious culture, men's health, adolescent and reproductive health, hygiene practice etc that the researcher did not explore in the research.

1.12 Expected Result and Dissemination Policy

By conducting this research, the researcher has produced a dissertation. The fruit of the present research will help the development planners and policy makers to take the proper steps for this people and to improve their health care options. The research has informed us about the state of health seeking behavior of *char* people, which will be effective to establish them in a healthy environment and to create awareness regarding health and wellbeing. The dissertation is an authentic work and expected to be published later as a form of a book. By maintaining above mentioned procedures, the research findings will be communicated to the world.

1.13 Research Matrix

General Objectives			**Result**	
To understand the health seeking behavior of *char* people, that is to investigate how socioeconomic, geographic and other factors contribute to the probability of utilizing health care and make it successful event, and analyze respondents' opinion towards different system of health care.			Health seeking behavior was very much influenced by the socioeconomic, geographic and other factors.	
Specific objectives	**Verifiable /Indicators**	**Analysis**	**Data Source**	**Result**
To know about the present illness of the people	Various types of Illness	Qualitative and Quantitative	Field Study	They were affected by various Illness
To explore the perception about illness of the people	Knowledge , Attitude and Perception under laying behavior	Qualitative and Quantitative	Field Study	The perception level was so low
To find out the emic (Local) categorization of stages of illness	Various stages of Illness	Qualitative and Quantitative	Field Study	They were not aware about the stages of Illness
To explore the multiple health care option that the *char* people frequently uses and their opinion on these options	Opinion , Believes Popular Sector , Folk Sector Professional Sector	Qualitative and Quantitative	Field Study	They have not equal accessed to all sectors
To explore the therapeutic decision making process of *char* people	Decision Maker Socioeconomic Factors	Qualitative and Quantitative	Field Study	They were not capable to take decision in right time.

1.14 Structure of the Dissertation

The discussion of the study has been presented into 7 chapters.

The Chapter-1 of this dissertation has focusd on the research statement, justification through relevant literature review, theoretical and conceptual framework, and objectives of the research, methodology of the research, ethical issues, scope and limitation of the research with expected result.

The Chapter-2 has introdued the reader to conceptualize the context of the research by explaining geographical traits of *char*, c*har* population, poverty, health and environment, MDGs and health system in Bangladesh, perspective on ill health: health as a cultural phenomena and understanding health seeking behavior.

The Chapter-3 introduces the readers with the *char* people and their illness profile.

The Chapter-4 deals with the causes of illness, stages of various illness, perceived illness causation of the study people and metaphor of illness.

The Chapter-5 discusses the available sectors of health care in the study village with social and cultural aspects of health care pluralism: perception of *char* people.

The Chapter-6 represents the therapeutic decision making process of the villagers in respect to various illnesses.

The Chapter-7 explores the final discussion with possible recommendations based on findings of the study.

Contextualizing the Study

2.1 Introduction

The three major rivers of Bangladesh Jamuna, Padma and Meghna flow through north-west of Bangladesh depositing silt from the Himalayas. The delta of three rivers, the Brahmaputra, Ganges, and Meghna, has created the land of Bangladesh. The combined flow of these three rivers makes this the third greatest river system in the world.[1] In the dynamics of erosion and accretion in the rivers of Bangladesh, the sandbars emerging as islands within the river channel, or as attached land to the riverbanks, often create new opportunities to establish settlements and pursue agricultural activities on them. Once vegetated, such lands are commonly called *chars* in Bangladesh.

2.2 *Char* Population

The social and economic lives of *char* dwellers of which some 4.3 million people according to the inventory interview are in a large part determined by the ever-changing nature of the lands upon which they live. This study also demonstrated that *chars* were not all alike and the social structure of *char* people varies somewhat from people in the rest of Bangladesh. *Char* people therefore need to be understood within their own context. In 1992-93 there were some 4.29 million people lived in about 3300 mouzas covering 8,400 square kilometres in the main river *char* lands implying about 4.89 million in 2000. Additionally there were probably about 1.5 million people living in coastal *char*s and there were an unknown number living in or dependent on *char*s along other rivers, The island *char*s of the Jamuna and Meghna had relatively high population that in the 1980s increased faster than the overall population rate. An estimated 5 to 10

[1] Saidhur Rahman and Junior Devis, *A Survey of Rural Livelihood and Enterprise Development Opportunities in the Chars, Bangladesh,* 2005. (UK: Enterprise, Trade and Finance Group, Central Avenue, Chatham Maritime, Kent ME4 4TB), 3.

million people live on the *char*s and associated flood-prone areas between 4% and 8% of the Bangladeshi population.[2]

2.3 Size of *Char* Land

In 1993 the estimated total area covered by *char*s in Bangladesh was 1,722 square kilometres. During the period of 1989 to 1993, *char* areas increased in all rivers, except in the upper Meghna. The net increase in *char* area during this period amounted to 36000 hectare which is equivalent to about 25% of total *char* area during 1984. The inventory of main river *char* lands estimated total area at 8,444 square kilometers or almost 6% of Bangladesh (FAP 16/19 1993 a). In 1992-93, this comprised 33% unprotected main land and 67% *char* land. However, only 63% (5345 km2) was cultivated or vegetated in the dry seasons of 1992-93 based on analysis of satellites images, the remainder being water and sand.[3]

2.4 Land Holding

Lands on *char*s are used for purposes of settlement as well cultivation. The Irrigation Support Project for Asia and the Near East (ISPAN) study indicated that of the *char*s that are not eroded in the first four years of their emergence; over ninety percent are used for either cultivation or settlement by the end of these four years. After seven or eight years, both settlement and agricultural practices are commonly found in these *char*s. Reliable data on landholding size is difficult to obtain in the active *char*s where claims to land may be maintained although it is submerged where occupied land may be technically *khas* land, and where areas used change frequently between water and land and from grassland to crops. Moreover, some studies report operated land while other report total land holding and studies differ in the cut-off points adopted for different land holding

[2] Saidhur Rahman and Junior Devis, *A Survey of Rural Livelihood and Enterprise Development Opportunities in the Chars, Bangladesh,* 2005. (UK: Enterprise, Trade and Finance Group, Central Avenue, Chatham Maritime, Kent ME4 4TB), 3.

[3] Ibid., 3.

categories. The data from different sources indicate a generally much skewed distribution of land in the *char*s. According to a Government of Bangladesh national survey conducted in 1996, twenty nine per cent people have no land, 24 percent have land between 0.01-0.5 acres, 14 per cent have land 0.5-1 acres, 20 percent have land between 1-2.5 acres and 11 per cent have land between 2.5-7.5 acres and only 2 percent have land more than 7.5 acres. In the coastal *char*s a major difference is apparent between the project settled stable accreted *chars* of *Char* Development and Settlement Project (CDSP) and the non-project *char*s of Meghna Estuary Study (MES). In addition the MES locations were spilt evenly between three with 30% of households having over 1 hectare and where under12% had less than 1 hectare of land. Control over and access to the natural assets of the *char*s, and especially land, is critical to the livelihoods of *char* people. This access is a function of government laws, policies and rules and of local practice, social norms and social power. Within the *char* lands the dominant arrangement is private ownership of land. Land tenure in unprotected mainland that has a long unbroken history of ownership and use is not different from other mainland areas, except to the extent that proximity to an eroding bank-line makes it difficult to sell land. Often in the Jamuna, for example, these areas are resettled without involving government authorities and are managed by the local *matbars* (local leader) and *amins* (surveyors) with occasional disputes between equals settled through *salish* (local tribunals), but some benefits in areas gained going to the *matbars* who control surveying, maps and past records.[4]

2.5 Poverty, Health and Environment

Approximately 1.2 billion people in the world live in extreme poverty (less than one dollar per day). Poverty creates ill-health because it forces people to live in an unhygienic environment without decent shelter, clean water or adequate sanitation that make them

[4] Saidhur Rahman and Junior Devis, *A Survey of Rural Livelihood and Enterprise Development Opportunities in the Chars, Bangladesh,* 2005. (UK: Enterprise, Trade and Finance Group, Central Avenue, Chatham Maritime, Kent ME4 4TB), 4.

sick.[5] Poverty is considered as the 'biggest epidemic that the global public health community faces' currently.[6] Empirical data have shown that chronic poverty is more harmful for health than episodic poverty, long-term income is more important for health than current income, and income reductions appear to have greater effect on health than income increases.[7] On the other hand, environmental risk factors play a role in various major diseases and injuries around the world. Diarrhea, lower respiratory infections, various forms of unintentional injuries, and malaria are largely the result of environmental risk factors. These are precisely the diseases that most affect the poor in the poorest countries. As the world's climate changes, these existing health impacts are expected to worsen, particularly for the poor[8] and in *Char* communities in Bangladesh. The *char*s - some midstream islands and others attached to the mainland - are created from river sediment and are in a constant state of formation and erosion. Emerging *char*s create new areas for settlement and cultivation, an important resource in a land scarce country such as Bangladesh. However, a constant threat of riverbank erosion and flooding, combined with a lack of physical infrastructure, government services and employment opportunities in the *char*s, makes for a vulnerable, difficult and fragile way of life. *Char* dwellers are considered poorer than the mainland population and are increasingly becoming the targets of efforts to reduce poverty. Nevertheless there is still very little quantitative information on the health, nutrition and food security of these

[5] WHO, *Poverty and Health,* http://www.who.int/hdp/poverty/en/ (accessed Dec.15, 2011).

[6]Global Health Watch (GHW), *Introduction Global Health Watch,* http://www.ghwatch.org/sites/www.ghwatch.org/files/intro.pdf (accessed May 01, 2012).

[7] M. Benzeval, and K Judge, "Income and Health: The Time Dimension," *Social Science and Medicine* 52, (2001): 1371-1390.

[8] Rehydrate.org, *Poverty, Health & Environment,* http://diarrhoea/pdf/PovHealthEnvCRA.pdf (accessed Jan.25, 2012).

vulnerable people, partly because they are highly mobile and access to the *char*s is physically difficult.[9]

2.6 MDGs and Health Progress in Bangladesh

In September 2000, 189 countries attending the UN Millennium Summit, signed the UN Millennium Declaration, a manifesto to eradicate extreme poverty, hunger and disease among the one billion people in the world who subsist on barely anything (UN, 2000). The project sets a deadline of 2015 to achieve eight goals, called Millennium Development Goals (MDGs).[10] The MDGs are evident in the national planning framework. The revised National Poverty Reduction Strategy Paper has adopted a holistic approach to reduce poverty and improve other social indicators to achieve the MDGs, with special attention to the lagging regions.[11] Out of the 52 MDG targets, Bangladesh is on track on 19 of them; and 14 of them need attention.[12]

These eight goals are

1. Eradicate extreme poverty and hunger
2. Achieve universal primary education
3. Promote gender equality and empower women
4. Reduce child mortality

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[9] Helen Keller International, Nutritional Surveillance Project Bulletin No. 14, *"Life in the Chars in Bangladesh"*http://pdf.steerweb.org/FromKatalyst20pc/NSP20Bulletin%2014.pdf (accessed Jan.25, 2012).

[10] A. R. Bhuyan, *Millennium Development Goals (MDGs): A Review of Bangladesh's Achievements,*http://www.climatechange.gov.bd/sites/default/files/MDGs_A_ReviewBangladeshAchievement.pdf (accessed Feb.02, 2012).

[11] M. Didar Hossain, *Progress of Achieving Millennium Development Goals: Bangladesh Perspective,* http://bddevelopment.blogspot.com (accessed Feb.02, 2012).

[12] Dr. Md. Moniruzzaman, "Growth Trends of Major Development Indicators in Post Independent Bangladesh: An Economic Analysis," *Bangladesh Journal of Public Administration* 21, no.2 (2012): 20.

5. Improve maternal health
6. Combat HIV/AIDS, malaria, and other diseases
7. Ensure environmental sustainability
8. Develop a global partnership for development

Table -2.1: Health Related MDGs with Targets and Indicators[13]

Goals and targets		**Indicators to monitor progress**
Goal 1	**Eradicate extreme poverty and hunger**	
Target	Halve between 1990 and 2015, the proportion of people who suffer from hunger	Prevalence of underweight children under five years of age Proportion of population below minimum level of dietary energy consumption
Goal 4:	**Reduce child mortality**	
Target	Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate	Infant Mortality rate Under-five Mortality rate Proportion of 1 year-old children immunized against measles
Goal 5:	**Improve maternal health**	
Target	Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio	Maternal mortality ratio Proportion of births attended by skilled health personnel
Goal 6:	**Combat HIV/AIDS, malaria and other diseases**	
Target	Have halted by 2015 and begun to reverse the spread of HIV/AIDS	HIV prevalence among 15-24 year old pregnant women Condom use rate of the contraceptive prevalence rate Number of children orphaned by HIV/AIDS
Target	Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases	Prevalence and death rates associated with malaria Proportion of population in malaria risk areas using effective malaria prevention and treatment measures Prevalence and death rates associated with tuberculosis Proportion of tuberculosis cases detected and cured under directly observed treatment short course (DOTS)

Supported by UNDP and the UN system, the 2011 MDG Progress Report cites that overall improvement in poverty and hunger have been accompanied by rising regional and social disparities including persistent pockets of extreme poverty. The maternal

[13] UNDP, *MDG Progress Report-2012,*http://www.bd.undp.org/content/Bangladesh (accessed Feb.02, 2012).

mortality ratio of Bangladesh at 194 has shown a major turnaround. Performance on this goal which was lagging is a major achievement. The threat of climate change can also diminish the hard earned beneficial impacts of years of growth and development not just for the people in impoverished settlements along coastal belts and river banks, but for the entire nation. Achieving full and productive employment for all, including women and young people remain behind target. The labour force participation rate is low, it is about 51.7% and women's participation although improving, is much lower at 23%. It is highly unlikely that Bangladesh will be able to ensure employment for all by 2015. Yet another challenge that Bangladesh faces is addressing certain pockets of poverty that are lagging far behind with respect to the national averages and where the benefits of MDGs attainment need to be specifically reached. These areas include the urban slums, the hill tracts, coastal belts and other ecologically vulnerable areas.

Table -2.2: MDG Goal-1[14]

Goals, Targets and Indicators (revised)	Base year 1990/1991	Current Status (Source)	Target by 2015	Status of progress
Goal 1: Eradicate Extreme Poverty & Hunger: Goal will partially be met				
Target 1.A: Halve between 1990 and 2015, the proportion of people below poverty line				
1.1: Proportion of population below national upper poverty line (2122 kcal), %	56.6 (1992)	31.5 (HIES 2010)	29.0	On track
1.2: Poverty Gap Ratio, %	17.0 (1992)	6.5 (HIES 2010)	8.0	Goal met
1.3: Share of poorest quintile in national consumption, %	8.8 (2005)	8.85 (HIES 2010)	na	-
1.3a: Share of poorest quintile in national income, %	6.5 (1992)	5.22 (HIES 2010)	-	-
Target 1.B: Achieve full and productive employment and decent work for all, including women and young people.				
1.5: Employment to population ratio (15+), %	48.5	59.3 (LFS 2010)	for all	Need Attention
Target 1.C: Halve between 1990 and 2015, the proportion of people who suffer from hunger.				
1.8: Prevalence of underweight children under-five years of age (6-59 months), %	66.0	45 (BHFNSA 2009)	33.0	Need Attention
1.9: Proportion of population below minimum level of dietary energy consumption (2122 kcal), %	48.0	40 (HIES 2005)	24.0	Need Attention
1.9a: Proportion of population below minimum level of dietary energy consumption (1805 kcal), %	28.0	19.5 (HIES 2005)	14.0	Need Attention

[14] UNDP, *MDG Progress Report-2012,*http://www.bd.undp.org/content/Bangladesh (accessed Feb.02, 2012).

Table -2.3: MDG Goal-4[15]

Goals, Targets and Indicators (revised)	Base year 1990/1991	Current Status (Source)	Target by 2015	Status of progress
Goal 4: Reduce Child Mortality: Goal will be met				
Target 4.A: Reduce by two-third, between 1990 and 2015, the under-five mortality rate.				
4.1: Under-five Mortality Rate (per 1000 live births)	146	50 (SVRS 2009)	48	On track
4.2: Infant Mortality Rate (per 1000 live births)	92	39 (SVRS 2009)	31	On track
4.3: Proportion of 1 year-old children immunized against measles, %	54	85.3 (UESD 2010)	100	On track

Table -2.4: MDG Goal-5[16]

Goals, Targets and Indicators (revised)	Base year 1990/1991	Current Status (Source)	Target by 2015	Status of progress
Goal 5: Improve Maternal Health: Goal will be met				
Target 5.A: Reduce by three quarters, between 1990 and 2015, the Maternal Mortality Ratio.				
5.1: Maternal Mortality Ratio, (per 100,000 live births)	574	194 (BMMS 2010)	143	On track
5.2: Proportion of births attended by skilled health personnel, %	5.0	26.5 (BMMS 2010)	50	Need Attention
Target 5.B: Achieve by 2015, universal access to reproductive health.				
5.3: Contraceptive Prevalence Rate, %	39.7	61.7 (UESD 2010)	72	On track
5.4: Adolescent birth rate, (per 1000 women)	77	105 (BMMS 2010)	-	Need Attention
5.5a: Antenatal care coverage (at least one visit), %	27.5 (1993)	71.2 (BMMS 2010)	100	Need Attention
5.5b: Antenatal care coverage (at least four visits), %	5.5 (1993)	23.4 (BMMS 2010)	100	Need Attention
5.6: Unmet need for family planning, %	19.4 (1993)	17.1 (BDHS 2007)	7.6	Need Attention

[15]UNDP, *MDG Progress Report-2012,* (accessed Feb.02, 2012). http://www.bd.undp.org/content/Bangladesh

[16] Ibid.

Table -2.5: MDG Goal-6[17]

Goals, Targets and Indicators (revised)	Base year 1990/1991	Current Status (Source)	Target by 2015	Status of progress
Goal 6: Combat HIV/AIDS, malaria and other diseases				
Target 6.A: Have halted by 2015 and begun to reverse the spread of HIV/AIDS				
6.1: HIV prevalence among population, %	0.005	0.1 (MIS DGHS)	Halting	On track
6.2: Condom use rate at last high risk sex, %	6.3	44-67 (UNGASS 2010)	-	-
6.3: Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS , %	-	17.7 (NASP, 2009)	-	Low
Target 6.B: Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it				
6.5: Proportion of population with advanced HIV infection with access to antiretroviral drugs, %	-	47.7 (UNGASS 2009)	100	Need Attention
Target 6.C: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases				
6.6a: Prevalence of Malaria per 100,000 population	776.9 (2008)	512.6 (MIS DGHS 2010)	310.8	Need Attention
6.6b: Deaths of Malaria per 100,000 population	1.4 (2008)	0.32 (MIS DGHS 2010)	0.6	On track
6.7: Proportion of Children under-5 sleeping under insecticide treated bed nets (13 high risk malaria districts), %	81% (2008)	90% (MIS DGHS 2010)	90%	Goal met
6.8: Proportion of children under 5 with fever who are treated with appropriate anti malarial drugs	60% (2008)	80% (MIS DGHS 2009)	90%	On track
6.9a: Prevalence of TB per 100,000 population	639	79.4 (NTPS 2010)	320	Goal met
6.9b: Deaths of TB per 100,000 population	76	43 (MIS DGHS 2010)	38	On track
6.10a: Detection rate of TB under DOTS, %	21 (1994)	70.5 (MIS DGHS 2010)	70	Goal met
6.10b: Cure rate of TB under DOTS, %	73 (1994)	92 (MIS DGHS 2010)	>85	Goal met

The progress report of 2012 is shown in the tables no 2.2-2.5. Critiques argue that MDGs' emphasis on selected interventions to improve health of the population bypass the need for development of health systems infrastructure. Contextual factors for achieving these MDGs include good governance, economic growth, physical security and basic infrastructure, besides an equitable and functioning health system.

2.7 Health System in Bangladesh

In the words of Nobel laureate Amartya Sen, health, like education, is among the basic capabilities that gives value to human life. Better health translates into greater and more

[17]UNDP, *MDG Progress Report-2012,* (accessed Feb.02, 2012). http://www.bd.undp.org/content/Bangladesh.

equitably distributed wealth by building human and social capital and increasing productivity. However, it has been found that cost of healthcare itself can be a cause of poverty in low-income countries through loss of income, catastrophic health expenditures, and potentially irreversible crisis coping mechanisms that involve asset and savings depletion. The economic consequences of ill health for the poor households, especially the bottom 15-20% are also well documented in Bangladesh.

In the absence of any risk-pooling mechanisms and pre-payments, expenditure on health is mainly met by out-of-pocket payment by the households (>60%). This mode of payment for health-expenditure is the most regressive one and exposes people, especially poor and other disadvantaged people, to great financial risk and makes the health system inequitable.Thus improving the ability of the health system to reach the poor/disadvantaged population is essential to mitigate the income-erosion effect of ill-health and poverty alleviation in Bangladesh. To maximize this poverty-alleviation effect, health interventions need to be designed according to the needs and priorities of the poor and the disadvantaged. Such a health system with access irrespective of the ability or willingness to pay, and responsive to their needs and priorities is called a 'pro-poor' health system. Knowledge and understanding about existing health-seeking behaviour including its differentials and determinants are required for this to happen.

Recent studies on health-seeking behaviour of the poor and some selected disadvantaged population (e.g., the women, elderly, ethnic minorities, poor/ultra-poor) have found self-care as the predominant therapeutic activity (around 30-40%) undertaken by them for managing illness episodes. Self-care is regarded by WHO as 'a primary public health resource in the health care system. To use this resource to its full potential, its integration as an essential, informed and efficient component of the primary health care and as a cost-effective complement to the formal healthcare, is long overdue in Bangladesh.

Self-care is followed by treatment-seeking from unqualified providers (in around 20% of cases) in these studies. By far the single largest group among them is the 'unqualified allopaths' who are the sales people in drug retail outlets or drug vendors, with little or no

professional training in either dispensing of drugs or in diagnoses and treatment. Treatment-seeking from MBBS doctors varied from around 10 to 20% only in these studies of health-seeking behaviour. The studies also noted a decrease in the use of traditional practitioners (*faith healers,kabiraj/totka, and homeopathic*) over time in Bangladesh.

The interesting fact is that a cadre of semi-qualified para-professionals (medical assistants, mid-wives, village doctors, community health workers or CHWs) emerged as the main provider of formal allopathic care to the disadvantaged groups in more than 25% of illness episodes. CHWs trained in preventive and basic curative services by the government as well as the NGOs to work at grassroots level are the largest proportion among these para-professionals. This cadre of health workers has been increasing in size since the '90s with the expansion of the primary health care infrastructure (government and NGO) in the country. The medical assistants and midwives posted at the union level are a higher level cadre of para-professionals than the CHWs. The village doctors (palli chikitshaks) have received some semi-formal training from private institutions, including those trained through a short-lived government sponsored program that ended in 1982.

The overall health service consumption (from any source) in Bangladesh is low compared to other low income countries as well as level of need. Also, the number of qualified physicians and nurses in Bangladesh is quite low, compared to other low-income countries. Around 26% of professional posts in rural areas remain vacant and there are high rates of absenteeism (of about 40%), particularly among medical doctors in rural areas. In this context, the importance of para-professionals for healthcare in the rural areas of Bangladesh cannot be overemphasized.

Reducing poverty through specific targeting of the disadvantaged groups with a pro-poor health system in a country with large out-of-pocket payments for healthcare is possible,

and is urgently needed in Bangladesh. The above scenario should be kept in perspective while designing such a health care system for Bangladesh.[18]

2.8 Perspective on Ill Health: Health as a Cultural Phenomenon

All cultures have systems of health viewpoint to clarify what causes illness, how it can be cured or treated, and who should be concerned in the process. The degree to which patients perceive patient learning as having cultural relevance for them can have a reflective effect on their reception to information provided and their willingness to use it. Western industrialized societies such as the United States which see disease as a result of natural scientific phenomena, advocate medical treatments that combat microorganisms or use sophisticated technology to diagnose and treat disease. Other societies believe that illness is the result of supernatural phenomena and promote prayer or other spiritual interventions that counter the presumed disfavor of powerful forces. Cultural issues play a major role in patient compliance.

Asians/Pacific Islanders are a large ethnic group in the United States. There are several important cultural beliefs among Asians and Pacific Islanders that nurses should be aware of. The extended family has significant influence, and the oldest male in the family is often the decision maker and spokesperson. The interests and honor of the family are more important than those of individual family members. Older family members are respected and their authority is often unquestioned. Among Asian cultures, maintaining harmony is an important value; therefore, there is a strong emphasis on avoiding conflict and direct confrontation. Due to respect for authority, disagreement with the recommendations of health care professionals is avoided. However, lack of disagreement does not indicate that the patient and family agree with or will follow treatment recommendations. Among Chinese patients, because the behavior of the individual

[18] Sayd Masud Ahamed, *Exploring Health Seeking Behavior of Disadvantage Population in Rural Bangladesh (*Stockholm, Sweden: Division of International Health, Department of Public Health Science, Karolinska Institute, 2005): 12-14.

reflects on the family, mental illness or any behavior that indicates lack of self-control may produce shame and guilt. As a result, Chinese patients may be reluctant to discuss symptoms of mental illness or depression.

Some sub-population of culture, for example the Indian and the Pakistani, are reluctant to accept a diagnosis of severe emotional illness or mental retardation because it severely reduces the chances of other members of the family getting married. In Vietnamese culture, mystical beliefs explain physical and mental illness. Health is viewed as the result of a harmonious balance between the poles of hot and cold that govern bodily functions. Vietnamese do not readily accept Western mental health counseling and interventions, particularly when self-disclosure is expected. However, it is possible to accept assistance if trust has been gained.

Many African-Americans participate in a culture that centers on the importance of family and church. There are extended kinship bonds with grandparents, aunts, uncles, cousins, or individuals who are not biologically related but who play an important role in the family system. Usually, a key family member is consulted for important health-related decisions. The church is an important support system for many African-Americans.

It is seen that, each ethnic group brings its own perspectives and values to the health care system, and many health care beliefs and health practices differ from those of the traditional American health care culture. Unfortunately, the expectation of many health care professionals has been that patients will conform to mainstream values. Such expectations have frequently created barriers to care that have been compounded by differences in language and education between patients and providers from different backgrounds.

Cultural differences affect patients' attitudes about medical care and their ability to understand, manage, and cope with the course of an illness, the meaning of a diagnosis, and the consequences of medical treatment. Patients and their families bring culture specific ideas and values related to concepts of health and illness, reporting of symptoms, expectations for how health care will be delivered, and beliefs concerning medication and

treatments. In addition, culture specific values influence patient roles and expectations, how much information about illness and treatment is desired, how death and dying will be managed, bereavement patterns, gender and family roles, and processes for decision making. Cross-cultural variations also exist within cultures.[19] Strategies that any one can use in working with patients from different cultures as displayed in table 2.6.

Table -2.6: Strategies for Working with Patients in Cross-Cultural Settings[20]

- Learn about the cultural traditions of the patients you care for.
- Pay close attention to body language, lack of response, or expressions of anxiety that may signal that the patient or family is in conflict but perhaps hesitant to tell you.
- Ask the patient and family open-ended questions to gain more information about their assumptions and expectations.
- Remain nonjudgmental when given information that reflects values that differ from yours.
- Follow the advice given by patients about appropriate ways to facilitate communication within families and between families and other health care providers.

So, it can be said that, health attributions influence health belief and subsequent health behaviors. Health attributions are partly shaped by culture. In turn, cultural health attributions affect beliefs about disease, treatment, and health practices. Likewise, culture influences health and healing practices. Certain cultures have culture-bound syndromes about which medical practitioners should be trained. Other socio-cultural factors such as

[19]Euromed Info, *How Culture Influence Health Believes,* (accessed on Nov.25, 2011).*http://www.euromedinfo.eu/how-culture-influences-health-beliefs.html*

[20] L. Mc Laughlin & K Braun, "Asian and Pacific Islander Cultural Values: Considerations for Health Care Decision-Making," *Health and Social Work* 23 no. 2 (1998): 116-126.

immigration, acculturation, and social support play significant roles in health attributions and medical adherences. Culturally diverse patient populations require that medical educators learn new methods of cultural assessment and treatment in order to be effective. Medical educators also need teaching and learning approaches and philosophies that consider health attributions, beliefs, and practices of patients.[21]

2.9 Understanding Health Seeking Behavior

The worldwide Health promotion programmes have long been premised on the idea that providing knowledge about causes of ill health and choices available, will go a long way towards promoting a change in individual behaviour, towards more beneficial health seeking behaviour. However, there is growing recognition in both developed and developing countries that providing education and knowledge at the individual level is not sufficient in itself to promote a change in behaviour. An abundance of descriptive studies on health seeking behaviour, highlighting similar and unique factors, demonstrate the complexity of influences on an individual's behaviour at a given time and place. However, they focus almost exclusively on the individual as a purposive and decisive agent, and elsewhere there is a growing concern that factors promoting 'good' health seeking behaviours are not rooted solely in the individual, they also have a more dynamic, collective, interactive element. Academics have therefore started to explore the way in which the local dynamics of communities have an influence over the well-being of the inhabitants.

This reflects a growing interest across the social sciences in the contested concept of social capital. Attempts are now being made to develop this as yet it is under-utilised idea to incorporate knowledge about health seeking behaviour into health service delivery strategies in a way which is sensitive to the local dynamics of the community. This may be an extremely positive development. The whole area of knowledge around health seeking behaviour is rendered of little value if not incorporated into management and

[21] Lisa M Vaughn et al.,"Cultural Health Attributions, Beliefs, and Practices: Effects on Healthcare and Medical Education,*" The Open Medical Education Journal*, 2 (2009): 64-74.

system developments. The fact that health seeking behaviour is 'not even mentioned' in widely used medical textbooks perhaps reflects that many health seeking behaviour studies are presented in a manner which delivers no effective route forward. This results in an unfortunate loss for medical practice and health systems development programmes, as proper understanding of health seeking behaviour could reduce delay to diagnosis, improve treatment compliance and improve health promotion strategies in a variety of contexts.[22]

2.10 Discussion

Bangladesh, a 147,570 square kilometer area with a population of nearly 152.51 million[23] is a low-lying, tropical country composed of the flood plains and delta of three rivers, the Brahmaputra / Jamuna, the Ganges/ Padma and the Meghna. *Char*s are areas of new land formed through the continual process of erosion and deposition in the major rivers and coastal areas due to the monsoon rainfall and the silt carried by these rivers as they flow from the Himalayas to the Bay of Bengal. *Char* land areas irrespective of their geographic attachment to the mainland and distance from the growth centers are particularly vulnerable to floods, drought and river erosion. To identify the options and opportunities of the health provision of the *char* dwellers the study was conducted selecting a *char* of Bogra district. The above issues like *char* settlement patterns, MDGs, health system of Bangladesh, cultural construction of health and understanding health seeking behaviors act as a key catalyst to contextualize the conducted study easily.

[22] Sara Mackian, *A Review of Health Seeking Behavior: Problems and Prospects* (HSD/WP/05/03. Manchester: University of Manchester Health Systems Development Programme, 2003), 3.

[23] FAO, *Bangladesh At a Glance,* (accessed Feb.03,2012).http://www.fao.org/bangladesh/fao-in-bangladesh/bangladesh-at-a-glance/en/.

Char People and Illness

3.1 Introduction

The findings data presented in this chapter came from *Char* Majhira. The researcher started working in *Char* Majhira in 2010. This chapter describes the location of the area and selected health and socio-demographic characteristics of the study population based on both the primary and secondary data.

3.2 Geographical Location of *Char* Majhira

Char Majhira is one of the most vulnerable *char* of Sariakandi Upazila in Bogra district. Sariakandi Upazila came into existence as a thana on March 20, 1886. Long before that it, as a thana, had the name **Naukhila.**

Table 3.1: *Char* Majhira at a Glance[1]

Name of Upazilla	Sariakandi
Name of Union	Bohail
Name of village/*char*	Majhira
Total Area	1293 Acres
Total Household	504
Total Population	2057
Family Size	4.081
Literacy Rate	18.62

[1] Sariakandi Union Parishad, *Community Report 2011*(Dhaka: Local Government Engineering Department, Local Government Division, Ministry of Local Government, Rural Development & Cooperatives, The People's Republic of Bnagladesh,2012), 19.

Once a fateful land erosion caused the thana precincts and surroundings to disappear in river **Bangali**. Thereafter, the thana was moved to Sariakandi village and became known by the name of this village. The same village named **Sariakandi** as name of the Upazila has remained unchanged. The Upazila occupies an area of 408.50 sq.km. including 2.10 sq. km. forest area.

It is located between 24° 44" and 25° 04" north latitudes and 89°31" and 88°45" east longitudes. It is bounded on north by Sonatala Upazila and on east by Islampur and Madarganj Upazilas. On other flank, Sarishabari and Kazipur Upazilas boarder its south and Shibgaonj Upazila skirts its west.[2] It is under Bohail union of Sariakandi Upazila and bounded by Sughatta and Sonatola Upazilas on the north, Dhunat and Kazipur Upazilas on the south, Islampur, Madarganj and Sarishabari Upazilas on the east, Gabtali Upazila on the west.[3] Main rivers are Jamuna, Bangali and Sukhdaha. Main occupations are agriculture, agricultural laborer, wage laborer.

3.3 Socioeconomic Profile

Char Majhira consists of 3 *paras, Uttar (north)para, Moddhy (central) para and Dokkhin(South) Para*. The area of the *char* is 1293 acres. The *char* was identified in 1987. It has 504 households with population of 2057; male 51.63%, female 47.37%. Literacy rate among the *char* people was 18.62%. There were one secondary school (private), and one madrasa in the *char*. The arable lands were 745 acres, fallow 123 acres where single crop 65%, double crop 15%, and treble crop land 20%. The arable land under irrigation was 57%. There were 90% populations were Muslims and the rest were Hindus in the village. [4]

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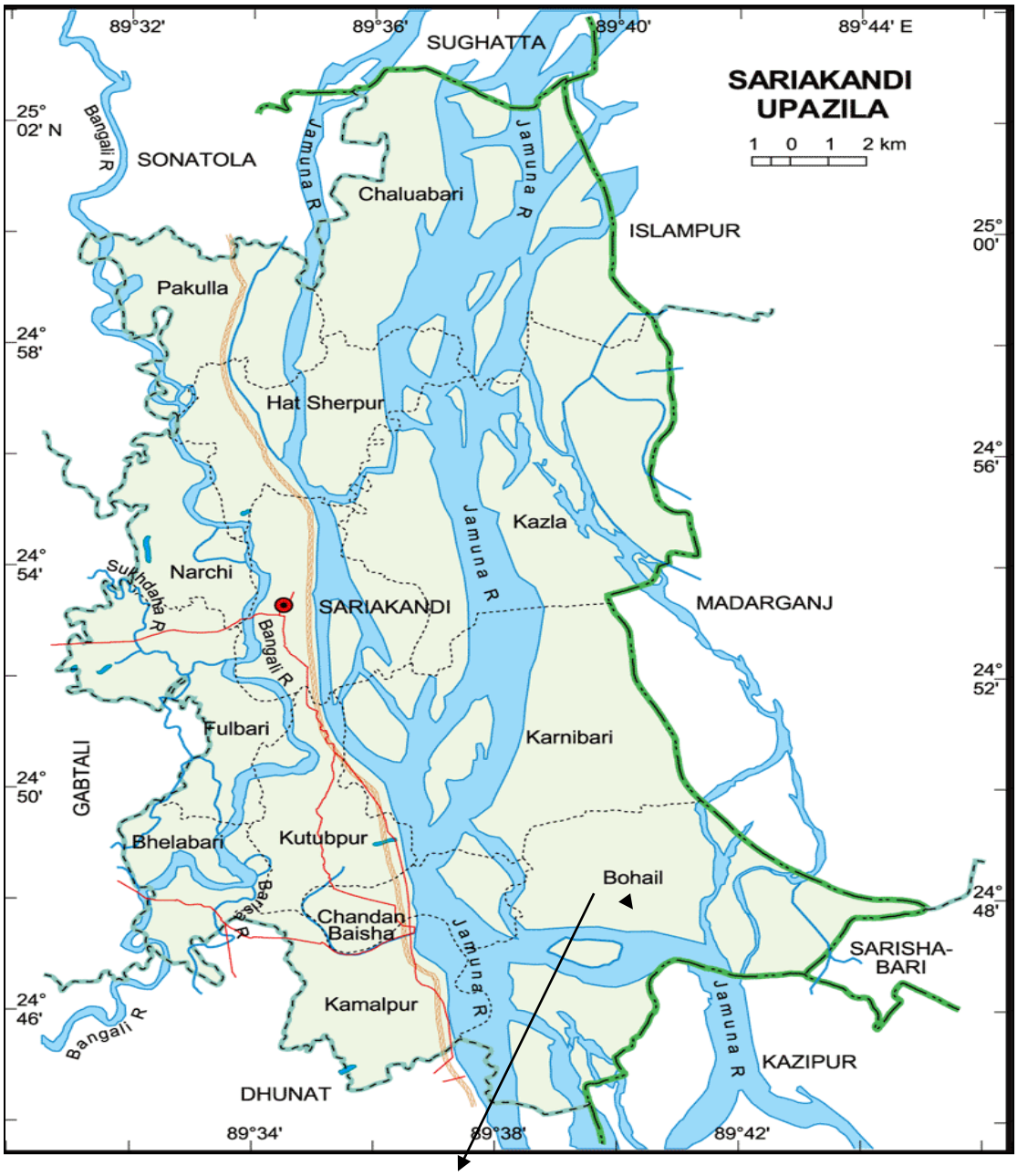
[2] Bangladesh Bureau of Statistics, *Bangladesh Population and Housing Census 2011, Community Report Zila*: *Bogra June 2012, Sariakandi Upazila* (Dhaka. Statistics and Informatics Division, Ministry of Planning, The People's Republic of Bnagladesh, 2012), 27.

[3] Ibid.,27.

[4] Sariakandi Union Parishad, *Community Report 2011*(Dhaka: Local Government Engineering Department, Local Government Division, Ministry of Local Government, Rural Development & Cooperatives, The People's Republic of Bnagladesh, 2012),19.

Map of the Study Area[5]



***Char* Majhira**

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[5] Local Government Engineering Department, Local Government Division, Ministry of Local Government, Rural Development & Cooperatives, The People's Republic of Bnagladesh, *Map Sariakandi Bogra*, http://www.lged.gov.bd/ViewMap2.aspx?DistrictID=51 (accessed Oct. 25, 2010).

Char People and Illness

Table 3.2: Classification of Households According to Land Ownerships[6]

Types of Households	Number of Households	%
Landless	110	44
Small peasant	88	35.2
Medium peasant	49	19.6
Rich peasant	3	1.2
Total	250	100

The 44% inhabitants who didn't occupy any cultivable land were landless, 35.2% were small peasant who have 0.01-1.00 acre cultivable land, 19.6% were medium who have 2.51 – 7.50 acre cultivable land and 1.2% was rich who has cultivable land 7.50 acre and/or above.

The value of first grade arable land was about Tk 8500 per 0.01 acres. The main crops were paddy, jute, wheat, potato, brinjal, patal, onion, garlic, arum, mustard and chilli. Extinct and nearly extinct crops Indigo (extinct); Til, (sesame), Tisi (linseed), Arhar, black gram, Kawan (Italian millet), yam, etc. Main fruits were Mango, jackfruit, guava, banana, papaya. There were 36 fishery families lived in the *char*s. The communication roads consist of mud roads 15 km and waterways 35 nautical miles from Upazila head quarters.[7]

Around one-fourth of the population aged six years and above in 2011 had never attended school. Of those who had been to school, 76% attended secular schools, and 24% attended religious schools. Among the males aged six years or above, 19 % were students, 57 % day laborers, 11% farmers, and the rest were unemployed. A small proportion of

[6] Primary data.

[7]Department of Agriculture Extension, Sariakandi Upazila, *Village Profile 2010, Sariakandi Upazila* (Dhaka: Ministry of Agriculture, The People's Republic of Bnagladesh, 2011), 61.

males were self-employed, mostly in small farmers. Among the females aged six years and above, 76 % were housewives, 12% students, rest were unemployed. Seven percent of the households in the area were female-headed, and 93% were male-headed. 97% of main earners were male. 8% of the households had a radio, 4% had a mobile phone at home. Materials used in building dwellings included corrugated tin, polythene, straw, leaves, and brick. Leaves were most normally used for structure of roofs (47%), followed by tin (14%), straw (36%), brick (1%), and polythene (2%). About 76% of the households had family members who were members of an NGO (Non-Governmental Organization). 46% of the households had at least one member selling daily labour to make their living. 87% of the households did not have any fixed place for defecation. Of those who had a fixed latrine, 22% had a ring slab or some kind of cemented latrine, and the remaining households had a fixed place without any protection against faucal contamination. River as a source of drinking water was almost universal with 99% of households reporting use of river water for drinking. Twenty three percent of the households were using latrine.

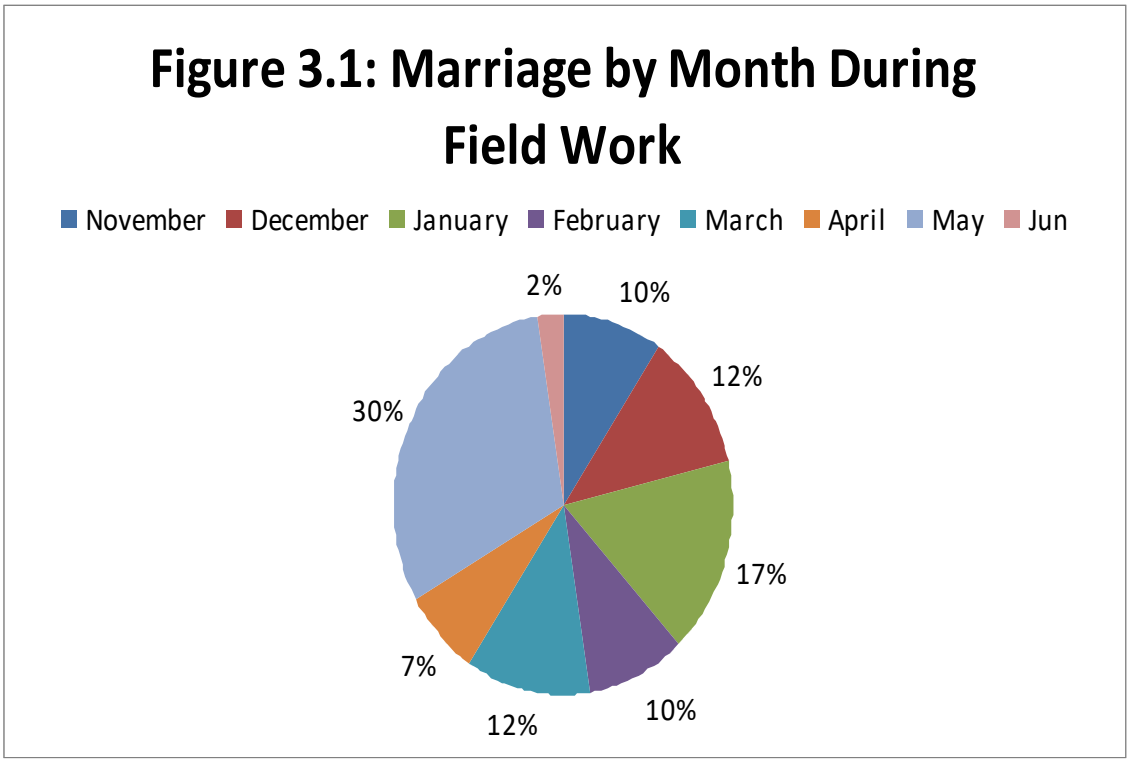
Traditional transports were boats, van, votvoti – a locally made motor vehicle. There were two manufactories rice mill at Majhira hats, the major NGO's were working in the *char*s like, World Vision, Thengamara Mahila Sabuj Sangha (TMSS), Gram Unnayan Kendra (GUK) and Grameen Mohila O Shishu Unnayan Sangstha (GMSUS).[8]

3.4 Marriage

In total, 42 marriages took place in the surveillance households in *Char* Majhira during 2011. The most of the marriages took place in May and the lowest in June 2011. The average age at marriage was 27 years for males and 16 years for females in 2011. The median ages at first marriage were 27 years for male and 16 years for female. Household socioeconomic statuses were positively associated with both the average and median ages at marriage. The legal age of females' marriage is 18 years and 21 years for male in

[8] Primary data.

Bangladesh. In 2011, 43.2% of women got married before 18 years age. The percentage of under-age female marriage was so high.[9]



3.5 Migration

The population of *Char* Majhira is mobile with nearly 54% of the population moving in and out of the area annually. In 2011, the rate of out-migration and in-migration was 55.0% and 12.5% respectively. The migration rates are claiming an increasing inclination with more out-migration than in-migration. There was hardly any sex differential in migration. A marked seasonality has been observed in both in and out-migration. Migration was highest during flood and river erosion for both sexes. The overall migration rate is somewhat higher than other rural areas.[10]

[9] Primary data.

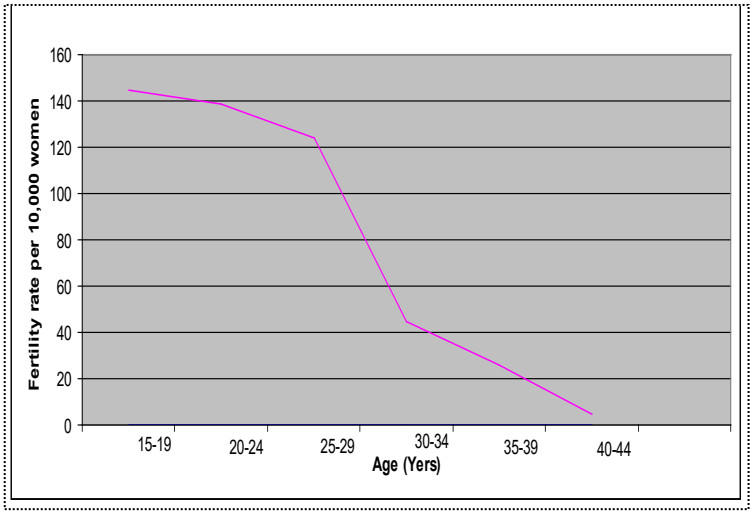
[10] Primary data.

International migration has not yet started to make its place in *Char* Majhira. During 2011, 49.9% of in-migrants were returnees from other places of the country and 2.5% out-migrants went out of *Char* Majhira.[11] 100% of the migrations were related to flood and river erosion.[12]

3.6 Citable Health Indicators of *Char* Majhira

(a) Fertility

Figure 3.2: Age –Specific Fertility Rate (2005-2009)



The fertility level in *Char* Majhira, though declining, has been somewhat higher than the national level 2.45. The crude birth rate (CBR) in 2009 was 26.6 per population, which was higher than the rate in 2006 (25.6 per 1,000 population).

Total fertility rates per woman showed a downward trend during 2005-2009, reaching a value of 3.5 in 2009. The age-specific fertility pattern has also been somewhat archetypal of Bangladesh.[13]

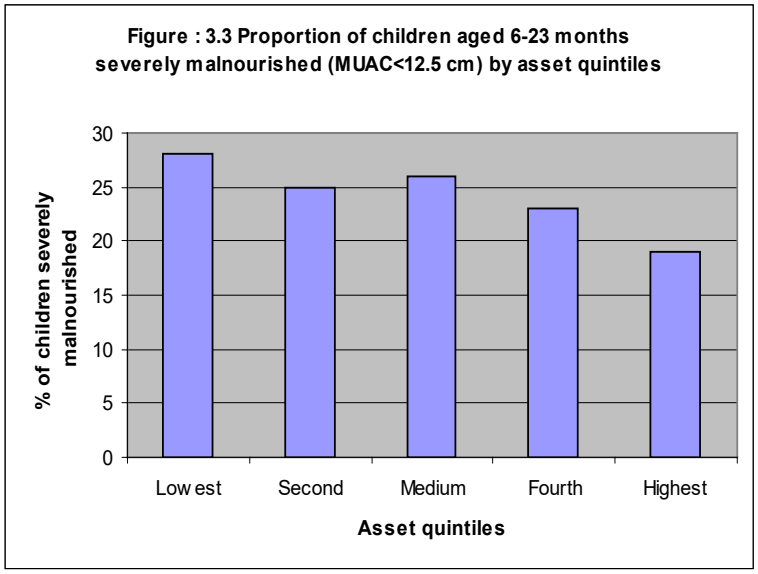
(b) Mortality

The crude death rate (CDR) in *Char* Majhira was 6.0 per 1,000 population in 2009. The infant mortality rate of 48.0 per 1,000 live births has declined sharply from 63.2 in 1999. The rate of mortality of children aged less than 5 years was 63.4 per 1,000 live births in 2009. 29% of all the deaths occurred before 5 years of age and 40% after the age of 60.

[11] Primary data.
[12] Primary data.
[13] Sariakandi Upazila Health Complex, *Health Bulletin 2010*, *Sariakandi Upazila* (Dhaka: Ministry of Health and Family Welfare, The People's Republic of Bnagladesh, 2011), 7.

Among the under-five deaths, 73% occurred during infancy.[14] Socioeconomic inequalities existed in under-five mortality with an inverse relationship between mortality and household asset scores. The children mortality rate from the lowest quintile was nearly double than that of children from the rich family. Gender-based inequality in childhood mortality was heightened.

(c) Child Nutrition



Data on nutritional status in *Char* Majhira have quite limited. Mid-upper arm circumference (MUAC) of children was collected in the area in 1994 and 1999. According to the World Health Organization (WHO), children with MUAC less than 12.5 cm are considered severely malnourished. The proportion of severely malnourished children has increased from 32.3% in 2007 to 35.0% in 2011.[15] Findings from the household in-depth interviews carried out in the *Char* Majhira by researcher in 2011 indicated that the proportion of severely malnourished children was markedly higher among girls than boys. Data also specified that a child's nutritional status in *Char* Majhira was inversely related to the child's household economic status. The proportion of malnourished children decreased with increasing economic status.

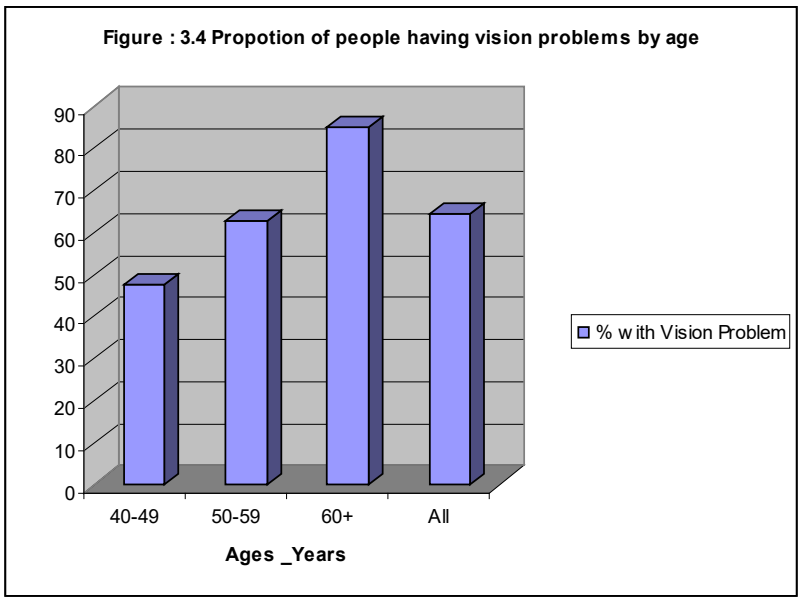
[14] World Vision Bangladesh, *Maternal and Child Health Care Project (2005-2009)*, Sariakandi ADP, 2010.

[15] Directorate General of Family Planning, *Annual Report 2010*, *Sariakandi Upazila* (Dhaka:Ministry of Health and Family Welfare, The People's Republic of Bnagladesh,2011), 37.

3.7 Salient Health Hazards of *Char* Majhira

(a)Vision Problems

The research findings of *Char* Majhira in 2011 showed that 65% of the people aged 40 years and above have vision problems, both short and long distance. These vision problems were identified by an ophthalmologist. The proportion of people having vision problems increased with age.[16]



(b) Rickets

There are many cases of nutritional rickets in *Char* Majhira. World Vision, an NGO, identified a high prevalence of leg deformities in this area after the flood of 1998. The oldest cases were 27 years age. Rickets can create severe malformation of legs, and many children become disabled when no treatment was given. It is uncommon to find rickets in such a sunny country like Bangladesh as not has the sun allows vitamin D production in the human body. The main cause of rickets in this region was not vitamin D deficiency, but dietary calcium deficiency. The prevalence of rickets deformities in the Bogra district was about 0.9% in 1999. Lack of calcium in vegetables, consumption of big fish instead of small fish (eaten with bones), and low consumption of milk were considered to be the main causes of rickets in *Char* Majhira.[17]

[16] Sariakandi Upazila Health Complex, *Health Bulletin* 2010*, Sariakandi Upazila* (Dhaka: Ministry of Health and Family Welfare, The People's Republic of Bnagladesh, 2011), 59.

[17] World Vision Bangladesh, *Maternal and Child Health Care Project (2005-2009),* Sariakandi ADP, 2010.

3.8 Leading Causes of Death in *Char* Majhira

In terms of causes of death, *Char* Majhira was similar to other rural areas, such as Sariakandi, which has somewhat comparable data. During household visits, causes of death were recorded as informed by the household members. The researcher classified the reported causes of death with medical synonym asthma, neoplasm, respiratory infections, senility, stroke, various conditions during neonatal period, accidents, cardiovascular illness other than stroke and diarrheal diseases, hepatitis and hypertension, and were the 10 leading causes of death in *Char* Majhira in 2007-2010.[18]

3.9 Most Common Illness in the Study Village

The illnesses mentioned in this chapter were reported symptoms or names of illnesses mentioned by the respondents themselves. The name of an illness mentioned was not validated by a physician. However, when labeling the Bengali terms or symptoms described by the participants by a medical name, a physician was consulted. The researcher will try to sketch-out a pen picture about the common illnesses of *Char* Majhira. These are stated by the following points.

3.9.1 Illness and Children

During the field work in *Char* Mahjira, The researcher observed the many childhood health problems. While visiting in the area, the researcher could easily identify according to his judgment that, some of the children were not well. Quite a few of them had swollen stomachs. Every now and then there was a child whose hair had curved red which is an emblematic sign of severe malnutrition. Many children had a gooey nose; they were coughing or had irritated eyes. Children also tended to have skin rush. But generally, children were not cleaner and better clothed that one would expect in a village environment where there was constant lack of pure water and sanitation.

[18] Sariakandi Upazila Health Complex, *Annual Report* 2010*, Sariakandi Upazila* (Dhaka: Ministry of Health and Family Welfare, The People's Republic of Bnagladesh, 2011), 57.

Char People and Illness

Table 3.3: Symptoms that, Mothers and Fathers Attached to Childhood Illness[19]

Symptoms that were Mentioned Over 20 Times	n	Symptoms that were Mentioned Over 10-50 Times	n	Symptoms that were Mentioned Less than 10 Times	n
Fever	135	Red eyes	36	Distended Stomach	2
Diarrhea	62	Respiratory changes	33	Discharge from Ears	3
Cough	47	Shivering	39	Child Rubs Ears	3
Discharge from eyes	6	Mouth/tongue sores	38	Blood in Urine	23
		Vomiting	33	Child is Unable to Play	80
		Swelling of the Child Body	43	Loose Sight	10
		Sunken/Swollen Eyes	9	Child Keeps Eyes Closed	15
		Blood in Stools	4	Headache	95
		No Appetites, Does Not Suck	3	Others	7
		Child Becomes Weak	3		
		Skin Color Changes	4		
		Nerves/Veins Show	5		

It becomes noticeable from the very beginning of the in-depth interviews and FGDs that there was a load of child health problems that hitch the mothers and fathers described in table 3.3. It was clear that, women were very eager to participate in the interviews and to discuss the theme. In the meetings there was an intense atmosphere because all of the participants wanted to say something about child health. The consciousness that, child health problems greatly bother mothers was reinforced by the result of the study.

During the in-depth interviews, mothers and fathers were asked whether they thought that their children were sick very often. Only 28 of them gave a negative statement saying that childhood illness does not pose a problem. The rest of them (222 mothers and fathers) said that, children fall ill frequently.

There was a great variety of child health problems that the mothers and fathers were concerned about. The number of different illnesses that were mentioned during the focus

[19] Primary data.

group meetings varied from 12 to 15 per gatherings. There was no difference between the aged and younger mothers and fathers regarding the illness mentioned or the number of illnesses that were named. In the in-depth interviews the issues of childhood health problems were introduced by asking about the illnesses children commonly suffer in a very normal way. Table 3.5 shows the common illnesses of children. At this point they usually only mentioned the illnesses by name, and did not explain anything more. A key issue in the study of this sort concern the translation between the terms that were used locally and those in English are based on bio-medical code.

In the focus group meetings, illnesses that the participants identified as problematic for their children's well being were discussed one by one. When it comes to the diagnostic criteria of the illnesses, the researcher asked the participants "how can you tell that a child has got this illness?" Usually one of the respondents mentioned one symptom, another added to it and may be a third one made the list complete. On a few occasions, participants decided that one of the symptoms initially associated with the illness, did not in fact refer to it. In this way, discussants sought a combination of symptoms that would gain common acceptance. As a result, the diagnostic criteria for any childhood illness consisted of several symptoms.

Furthermore, respondents pointed out on several occasions that it is often difficult to tell whether a child is really ill and what the nature of the illness is. During one focus group discussion, participants even turned to the researcher whom they knew to be a registered health assistant and asked him help in discussing the symptoms of the illness. One another occasion discussants also said that they believed that rich people know about different illnesses and have no need to ask for their knowledge. In the villages, there is too petite knowledge and they were not sure about different health problems, the participants said.

From the FGDs, the researcher concluded that, health and illness constitute a continuum, and the point at which one becomes the others is rather vague. During the in-depth interviews participants remarks on different symptoms which have been recorded. The response ravel a similar ambiguity related to diagnosing various childhood illnesses as

mother expressed in the FGDs. There was considerable variation in the symptoms that different respondents connected to the very same illnesses. Therefore, it was not sensible to draft details rules about how mothers and fathers diagnosed an illness. The diagnostic criteria was typically based on obvious and concentrate physical manifestation of illnesses. Table 3.3 shows the diversity of symptoms that 250 mothers and fathers attached to childhood illness and revealed the most often mothers and fathers mentioned fever, diarrhea, cough and discharge from the eyes.

3.9.2 Illness and Aged People

The qualitative data propose that, in universal participant used "aged" and "sick health" as undividable matters. When aged people's illnesses did not react to cure, they tend to clarify it by their "aged". As one male's participants said:

> *Their (health assistant of NGO/ medicine shops) remedial is very high-quality. He takes high-quality care of the patients and his tablets are good too. I like him a lot as I have said, tablets is not valuable in old age... (55 years old female respondents, a traditional health care provider- Kabiraj)*
>
> *He (health assistant of NGO/ medicine shops) does not forfeit as much as concentration to me as he used to ....does not finger the hurt areas with care either .....well, it is mature body and cannot get totally cured....(65 years old male respondents, FGD)*

Health- seeking behavior resting on the "realization" of health and ill health, and there is a well link between the usual health conditions of aged person and that of an older person have troubled with an ill situation . A number of villagers categorized exact health crises as aged illnesses such as stroke, paralysis, asthma, arthritis, memory loss, ear infection, lower back pain, and general weakness.

The alleged severity of old people's health problems were a different main aspect affecting health care seeking behavior, and the researchers sought to identify the doorstep at which an illness was regarded harsh enough to be treated. The data shows that unexpected spectacular

worsening of a "systematic" health problem was recognized as severe. For example, if any person who has persistently practiced a feeling of "weakness" unexpectedly falls and loses alertness, it was termed as a severe state. A 55 year old male respondent used "ass" for a symbolic differentiation. In his words:

> *...ass do take water but before that they will blend it to make the water unclean...that is our situation, we don't have a great deal of money, visiting health assistant means expense, so we halt and halt, until it is intolerable...I had abdomen torment, with diarrhoea, I suffered the first five days without any care, then it got bad... I went to the toilet about 20 times and then I determined to set out to the NGO clinic and ask for treatment... my stomach hurt became totally intolerable, so I had to set out finally….*

This type of experience appeared to be frequent across villagers, like :

> *... I have been suffering from back hurt... it happened about 3 months ago, a steady pain, I felt very ghastly; however, I did not accomplish anything and just suffered... it got shoddier and I had to go to the kabiraj first and medicine shops second ...(55 year old male respondent, FGD).*

When discussing resourcefully qualified medical physicians, commonly known as MBBS doctors, terms like, "too posh" were used. The overall propensity was to avoid going to fit doctors with proper medical training because they were costly and not consulted except the condition depreciates too much. Even if MBBS physicians were conferred, follow-up visits were rare due to economic limitation. The below case describes how a 56 year old man suffering from paralysis and how this was connected to his family and financial status.

> *Alamgir[20] suffered from paralysis for about a decade but cultured to live with it. It had not bothered him so much during the last year (the year before the interview), but he suffered from tiredness and lack of muscle. He tended to pay out the day lie downed and when he got up, his head revolved and he had a burning feeling in his body. He felt as if somebody was pushing him from back.*

[20] This is not his real name.

> *He accredited this to his arthritis.After suffering for about three months, he went to a kabiraj(herbalist) suggested by his neighbors. His elder son took him to numerous kabiraj, who treated him with blessed water and oil and one of them told him that he was suffering from the force of evil spirits (porir asor).The kabiraj asked for a payment of Tk. 8000 for a cure, but he did not have money, so he paid Tk. 100 for the first day's discussion fees. For all the kabiraj visits, he expended around Tk. 384 in total but at rest remained ill. At last, when he became too puny to even walk, his elder son took him to the sariakandi (local) Upazila hospital. His wife and his mother stayed with him, and he had to stay there seven days and six nights. The physician examined him by doing an ultra-sonogram and giving him a blood transfusion. One of his uncles donated a bag of blood and bought another bag for him. In seven days, they spend Tk. 14000 for the medicine bill, food, vehicle fare, and blood. He did not labor for a year due to paralysis, and he spent all his savings on livelihood and kabiraj fees. He had to trade part of his cultivable land worth Tk. 6000. He said he started to suffer ill yet again after returning house but was better during his time in the hospital, and the physicians and sisters were good.He could not walk simply, felt down in the dumps and anxious, and he only wondered why he did not get fit. (FGD)*

The active and intricate truth of health care seeking behavior was exemplified by two neighbors and friends, one of them a *kabiraj* (herbalist). Momena[21] was 47 years old and lived with seven other family members. Early June of 2010, she became ill. She had a fat sore spot on the back near her waist, and it tormented her for months. People in the community said she had a *fot* (locally known/used term for this health problem). She agreed but was hesitant about the cause, thinking perhaps it was due to destiny. After a sometimes, the spot became too hurting and required to be dealt with.

First, she went to her sister-in-law Mimi[22], who was a *kabiraj* in her community. Using a cutlass, the *kabiraj* cut the spot release and pressed out the bad blood, then put some plant

[21] This is not her real name.
[22] This is not her real name.

mixture on the spot. 7 days later, it compounded, and the *kabiraj* took her to consult a health assistant of NGOs'. The health assistant, who was well-known in the village, cleaned the tainted spot with warm water and tackled it with vaccination and medicine. He also adviced that she revisited every other day to dig up the injured dressed and cleaned. She continued to consult him for about three weeks and then when the hurt got improved, she stopped. The infection had not completely cleared up, but the hurt got improved and she started to put plant mixture on the spot again. After one month, she was well. In her words:

> *The kabiraj was fine, but it was my destiny that I did not find well. The health assistant of NGOs' was fine too, I was half-cured with his treatment, perhaps if I carried out it might have been cured faster, but I did not have much money to proceed with that treatment. It might have taken prolonged to cure, but with Allah's favor, I got healthy at last….*

Mimi (Momena's sister-in-law), on the other hand, was a 57 year old woman in Momena's community. One of her son worked in Dhaka, but she did not accept money from him. Mimi's husband was ill, so he could not work. She was known as a *kabiraj* in the village. She treated health difficulties irrespective of age and sex. She also treated such things as fever, arthritis, body pain, and toothache. She used varied plants and extra materials and also used *jhar-phuk* (spiritual healing) and *mantra* (incantation). During the interview, she was claiming to maintain confidentiality of the definite traits of the plants that she used to cure the patients in the village. From the last few days, Mimi began suffering from a kind of arthritis (*aguinya bat*). Her fingertips were inflamed and extremely painful, and some kind of illness was noticeable. She also criticized of body hurt. As Mimi had been suffering from high blood pressure for 10 years, she thought that the ground of the arthritis was related to her high blood pressure.

Even though Mimi was a *kabiraj* herself and made available treatment for a wide range of health difficulties to the patients of all ages, she did not attend to her own illness. She first went to homeopathic doctors whom she had known to well and had revisited for a similar problem before. She said that in spite of her not getting well the last time from his therapy, she liked to go there as she could get drugs on credit. She alleged that he was a high-quality

doctor for patients, and his therapy did not find a solution of her illness as she was aged. For the present illness, Mimi had to have a loan from relatives and community. She said with unhappiness

The money, I earned from my profession (herbal practice), all gone to doctors for my individual care.

From these two stories it can be easily said that evidently Mimi enjoyed a noteworthy point of faith and controlling from her patients; however, for her individual illnesses, she did not exercise her personal treatment, rather spent all of her incomes to forfeit for another types of care. In this case, health care seeking is identified more by individual association rather than therapeutic outcome. Even though Momena was conscious of her *kabiraj's* individual health care seeking exercise (i.e., not using her personal care), she always believed in Mimi's treatment. In spite of the harsh hurt and charge of curing her illness, she featured it all to her personal "ill-destiny" (*kopaler dosh*), not the scantiness of her neighbor.

3.9.3 Reproductive Health

Attention in human reproduction has broadened from a solely demographic matter to a wider concern in its connection with overall, human well-being .The researcher will discuss this issues under below points.

The exercise of diverse antenatal services was found to be consistently lower among *char* women compared to national rural average. Immunization for tetanus during pregnancy was much lower for both the Stand up Paddle (SUP) and the Non Stand up Paddle (NSUP) women, compared to the national rural average of 88%. Also, less than 18% of the *char* women received iron supplementation during their last pregnancy compared to the national rural average of 32.5%. The poorest women depended primarily on public health facilities for antenatal check-up. Nearly 44% of the *char* women never used safe delivery kits.

Women generally remained very active throughout their pregnancy. Up till the first labor pains, they carried heavy water jugs, husking grain with an equipment which is locally known as *dheki* and continued their arduous work as usual. This activity can be observed

both in rich and poor families and was in marked contrast to inactivity that would follow the birth. Most of the women of this village who went regularly to husk rice by *dheki,* and after the birth of their child, they sewed *katha* (quilts) to supplement their income. Most of the women did not follow a special diet during pregnancy. They believed that a mother should eat well so as to be healthy and strong but food was not adequate, a common occurrence, it was not during pregnancy but after wards that a special effort made to provide food of a better quality and in larger-quantity than usual. They did not substantially change the nature or the narrative value of a women's diet.

In case of illness during pregnancy, 'patent' medicine should be avoided, especially medicine for diarrhoea. It was believed that, this medicine works forcing the germ *(poka)* out of the body and the baby in the womb may well eat some of it thus causing an abortion. Diarrhoea during pregnancy can occur frequently as described by the study people. It will easily be understood from the story below.

> *Rafina[23], 16 years old, is awaiting her first baby. She is almost at period. For eleven days she has been in substantive labor with diarrhoea. Her husband was a man of letter and regularly adopted modern therapy but because his wife was expecting a baby and did not accept 'potent' drug, he called the folk healer's whose therapy credited to be aired. When the folk healer's came, he marked lines on the soil and pronouncing charm in a trial to assure Rafina was not attacked by an evil soul. In addition, by the similar ways and without examining her carefully, he stated that, labor ache have not in fact, oncoming. After this, he allotted drugs to treat the illness which was consisting of herbal design to drink with hot milk and amulet (tabij) to wear. After few days, though the uterine water bag broken but there was no delivery. Still, she has massive pain, but she was not sure whether it was as because of the labor of baby's birth or to internal difficulties. At last, the dai (birth attendant) was called just to rescue a child that has been dead for two or three days. Women of the community remarked that the folk healer's was simply a small one. The whole community believed that, the baby's death was as a result of the work of an evil soul*

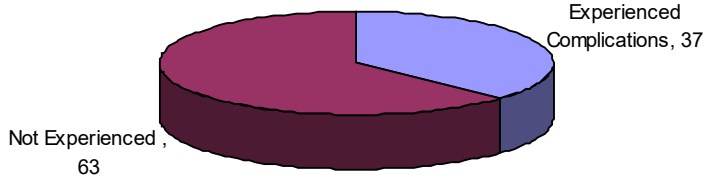
[23] This is not her real name.

i.e. the Jin. (FGD)

Actually a women who have had several pregnancies were giving informal advice to a newly pregnant younger women, telling her what symptoms to expect and the way of dealing with them in the study area.

Delivery related complication is one of the leading causes of maternal mortality in Bangladesh.[24] Figure 3.5[25]shows the incidence of delivery related complications, as reported by the women. It shows that, over one-third women reported to have experienced delivery –related complications some time during their most recent pregnancy.

Figure 3.5 : Pregnant mothers experiencing delivery related complications



The major delivery related complications as reported by the women included prolonged labor (51%), hemorrhage (8%), retained placenta (10%), eclampsia (7%) and laceration/ tear (3%).[26]

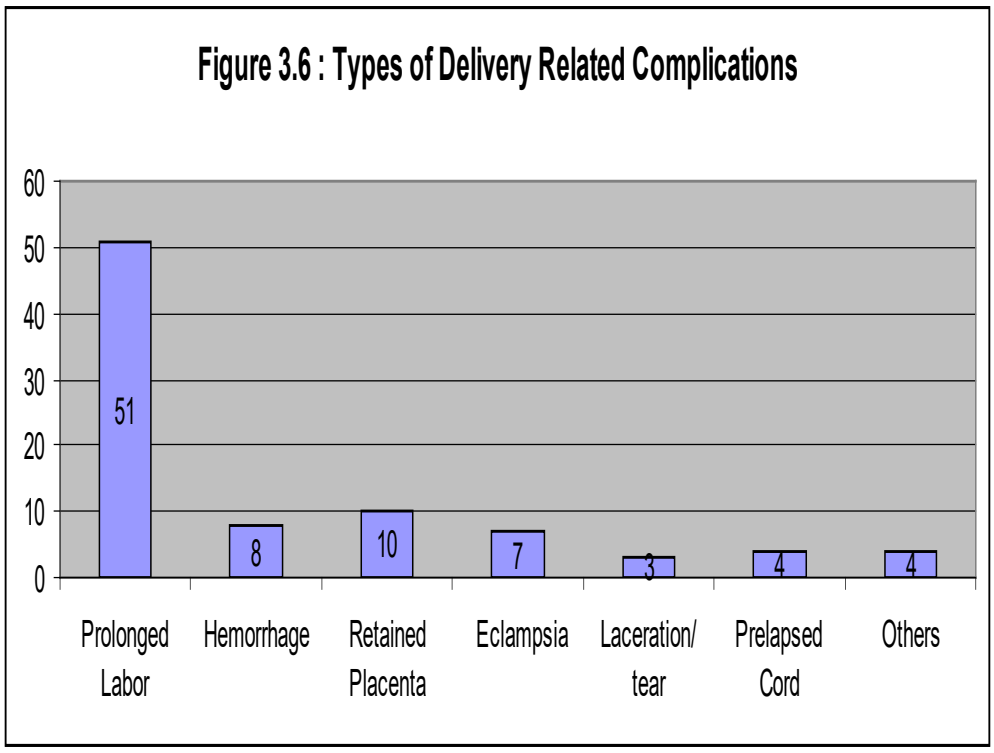
Because they were self –reported (by the women who experienced them during their most recent pregnancy) the incidence of delivery related complications might be high. Among those who said to have experienced delivery related complications, 51 % said "prolonged labor" which was undoubtedly very high. It was possible that women could not actually recall the duration of their labor during their most recent pregnancy. Therefore, over-

[24] S. Ahamed et al., *Abortion in Rural Bangladesh: Evidence from the MCH-FP Extension Project* (Dhaka : ICDDR'B, 1996), 1-25.

[25] Primary data.

[26] Primary data.

reporting may have occurred. Moreover, a normal labor may have been perceived by some women as "prolonged labor". This also could account for the increased incidence of delivery –related complication said by the participants.



One element of reproductive health that directly concern in human well being was reproductive tract infections (RTI). Table 3.4 is showing the RTI symptoms stated by the villagers. Women and men were vulnerable to a variety of RTIs in the village. RTIs as defined as infection of the reproductive tract caused by endogenous and/or exogenous organism. Endogenous infections are caused by an overgrowth of organism normally present in the reproductive tract. White discharge was the most common symptoms RTIs, followed by lower abdominal pain and itching genitalia. Both white and colorless discharges were recorded as 'white discharge'. The most common symptom was itching. Participants were also asked about the duration of their sufferings. Most participants said that, they had not continuously suffered, but they experienced intermittent periods of well beings. Taking into consideration of the continuity of the illness and the possibility of re-infection, the total

period, or duration of suffering, was calculated. The mean duration of the sufferings was 4.5 years for the female and 4 years for the male.

Table 3.4: RTI Symptoms of the Villagers[27]

Symptoms	# of Female (Based on 250 Households)	# of Male(Based on 250 Households)
White Discharge	67	19
Lower Abdominal	23	43
Blood Stained Discharge	17	15
Itching Genitalia	18	9
Ulcerous Genitalia	12	27
Total	137	113

Contraceptive prevalence rate among the *char* people at the time of study was about 34% among the SUP and nearly 39% among the NSUP eligible women compared to the national average of around 51%. The researcher found low levels of contraceptive prevalence among younger women compared to national figures for the matching up with age group, which would notably affect the fertility level among the *char* population. Most *char* women depended on traditional methods of contraception while only a few opted for modern methods. The most accepted method by far was the oral pill, followed by injectables and ligation. A large proportion of the *char* women were also sterilized, much higher among the SUP women.

[27] Primary data.

Char People and Illness

Table 3.5: Most Common Illness of Individuals from Different Age Groups[28]

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

[28] All the age ranges have identified by the villagers. FGDs and In-depth-Interviews have helped to identify the age range of the villagers. This is nothing but the absolute views of the villagers of *char* Majhira.

Table 3.5[29] shows that the representatives from the community identified malnutrition as severe illness for the younger age group, including newborns, children and adolescents. Convulsion was perceived to be the most severe illness for the new born. Pneumonia and diarrhea or loose motion was considered as severe illness for both the newborns and children. Asthma, according to the community people, was considered to be a severe illness for the comparatively older age group, i.e. adults and the aged. For the adults, stomach ulcer was mentioned as the most severe illness and for the aged, stroke/cardiovascular illness was identified as the most severe illness. Rickets was identified as the second most severe illness for the children in Majhira. Malnutrition was the most severe illness of the children and adolescents in the study village.

3.10 Discussion

From the above descriptions, it can be said that the study area located in an isolated flood prone area in the northern part of Bangladesh shares the demographic, socioeconomic, and health traits of an area which lags behind the rest of the country in terms of health and progress indicators. The scenario in terms of healthcare provision is comparable to the national scenario where the common health systems challenges facing the nation in general and the rural areas in particular are present. The area has some unique features such as malnutrition endemic, prevalence of rickets, vulnerability to flood and river erosion and other issues related to climate change. The area also has fairly lesser concentration of NGOs' compared to rest of the country.

[29] Primary data.

Emic Categorization of the Stages of Illness

4.1 Introduction

Linguist Kenneth L. Pike, in 1954, coined the terms *emic* and *etic* from phonemic and phonetic. Pike used *emic* to refer to the intrinsic cultural distinctions meaningful to the members of a cultural group and *etic* to refer to the extrinsic ideas and categories meaningful for researchers. For example, modern medical science defines "diseases" in precise, culture-free (*etic*) ways for any patient, whereas traditional people define "illnesses" differently based on their particular cultural contexts (*emically*). Western botanists categorize flora and fauna *etically*, based on the Linnaean taxonomy, whereas indigenous people categorize them *emically*, based on their particular folk-science worldview. Some cultures in Papua, New Guinea (PNG) classify bats with "birds" rather than "mammals" because they fly like most birds.[1] So, the researcher tries to discuss the common illness of *char* Majhira from both the native as well as outside point of view.

4.2 Illness and the Causes of Illness

E.J. Cassell[2] uses the word 'illness' to stand for 'what the patient feels when he goes to doctor and 'diseases' for what he has on the way home from the doctor's office. He concludes: disease, then, is something an organ has; illness is something a man has. Illness is the subjective response of an individual and of those around him, to his being unwell, particularly how he and they, interpret the origin and significance of this event, how it affects his behaviour and his relationship with other people and the various steps he takes to remedy the situation. Under this research, the researcher has seen that the *char* people are living with nature. Their pattern of life and household system help them to

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[1]Thomas N. Headland & Kenneth A. McElhanon, *Emic/Etic Distinction,* (accessed Feb.13, 2011), http://www.srmo.sagepub.com/view/ the-sage-encyclopedia-of-social-science-research-methods/n275.xml.

[2] F.E.Clements,"Primitive Concepts of Disease,"*University of California Publications in American Archaeology and Ethnology* 32, no. 2 (1932): 185-252.

attack various types of illness easily. The main cause of affecting the illness is stated as follows:

There are substantial variations in poverty in terms of place of residence. The incidence of poverty varies from one village to another. Extreme poverty was far more prevalent in this *char* along with the simultaneous existence of poverty pockets. It is clear from the comparative rates that the incidence of poverty is more than double in the *char* and that of extreme poverty is more than triple. The poverty gap intensity is the most severe in the northern region which is home of a good number of *chars*. An overwhelming majority of the people in the *char*s were extremely poor. Poverty line has been estimated for the *char*s using the household expenditure data followed by the method used in determining the government estimated upper and lower poverty lines. Bangladesh is moving quite well towards achieving the MDG-1 of poverty reduction and making the country free from hunger. Clearly, that will not be possible unless special attention is given to curb the extent of abject poverty among the *char* dwellers. Poverty gap share of total poverty and poverty severity was much higher in this *char* than that of rural-urban region. Accordingly, 44% inhabitants who didn't occupy any cultivable land were landless, 35.2% were small peasant who have 0.01-1.00 acre cultivable land, 19.6% were medium who have 2.51 – 7.50 acre cultivable land and 1.2% was rich who has cultivable land 7.50 acre and/or above in the study area. In this village, around one-forth of the population aged six years and above in 2011 had never attended school. Of those who had been to school, 76% attended secular schools, and 24% attended religious schools. Among the men aged six years or above, 19 % were students, 57 % day laborers, 11% farmers, and the rest were unemployed. A small proportion of men were self-employed, mostly in small farming. Among the women aged six years and above, 76 % were housewives, 12% students, rest are unemployed. About 76% of the households had family members who were members of an NGO (Non-Governmental Organization). Forty six percent households had at least one member selling daily wage to make their living and 87% of the households did not have any fixed place of defecation. Of those who had a fixed latrine, 22% had a ring slab or a cemented latrine and the remaining

households had a fixed place without any protection against faunal contamination. River as a source of drinking water was almost universal with 99% of households reporting use of river water for drinking and taking bath. Twenty three percent of the households were using latrines. These rates are extremely lower compared to the national rates. These percentages are alarming, especially when the researcher considers that from a national point of view. This harsh socio-economic condition i.e. culture of poverty, unhealthy lifestyle, tobacco use, lack of safe drinking water, widespread uses of chemicals in the crops, food insecurity, lack of knowledge, occupational health insecurity and constantly climate change led to the occurrence of various illnesses in *Char* Majhira.

4.3 Stages of Various Illnesses

The researcher observed the multiple stages of various illnesses, during the field work. These are stated below:

4.3.1 Newborn Illness

The newborns of *char* Majhira were affected the diseases like Convulsion, Pneumonia, Jaundice, Measles, Breathing Difficulty, Loose Motion, Fever, Skin Illness, Cold and Excessive Cry. The details of these are below:

4.3.1.1 Convulsion

According to the 89 % villagers neonatal seizures or neonatal convulsions are epileptic fits occurring from birth to the end of the neonatal period. The neonatal period is the most at risk of all periods of life for rising seizures, mostly in the first 1–2 days to the first week from birth. It may be short-lived actions lasting for a few days only. Neonatal (newborn) seizures are seizures in a kid who is less than 28 days old. Many different troubles can cause neonatal seizures. 11 % villagers said that most neonatal seizures are considered irritated seizures, rather than a factual epilepsy syndrome. A baby with neonatal seizures will not essentially go on to have epilepsy later in life, although his /her probabilities of developing epilepsy are a lot higher.

4.3.1.2 Causes of Convulsion

Eighty nine percent villagers said that neonatal seizures are habitually symptomatic, but a tiny number of neonatal seizures are idiopathic (unknown etiology) and seem to have an inherent origin. The causes are numerous. They may be the outcome of shabbiness on the part of parents; marrying at too premature or too advanced an age. Where the mother has been subject to a grand shock, or fright, or sturdy mental passion before the birth of her child, the kid will be very responsible to have convulsions soon after its birth. Prolonged and difficult labor may also cause convulsions in the child.

They may also be occasioned by anger, fright, or shame; by excessive mental emotion, tight bandaging a loud noise, sudden exposure to a bright light, impure, hot, or severe cold. Want of appropriate airing is a prolific cause of convulsions. During the 1st year of life they may be marked out to the Brest of the mother disagreeing with the infant. Cases are by no means atypical where passion, fright, or suffering on the part of the mother gives ascends to such a change in her milk as to turn out convulsions, if the baby is permitted to nurse, while the mother is under the control of these causes. As the child grows older, they may be instanced by concealing eruption, a bruise on the head, dentition, etc. They also recurrently set in, in relation with some serious illness, as tubercles on the brain, or inflammation and in fact with nearly all the serious illness to which a baby is subject.

According to most of the respondents, neonatal seizures may be caused by**:**

- Dearth of oxygen before or during birth because of troubles such as placental abruption (early aloofness of the placenta from the uterus)
- A tricky or delayed labour, or firmness of the umbilical cord contagion acquired before or after birth, such as viral encephalitis, syphilis, rubella (German measles) toxoplasmosis, or bacterial meningitis
- Stroke before or after birth
- Venous sinus thrombosis (a blood clot in the brain)

- Bleeding in the brain
- Ingrained brain abnormalities, either inherited or acquired in fetal improvement, such as tuberous sclerosis
- Blood sugar or electrolyte imbalances, plus hypocalcemia (low calcium), hyponatremia (low sodium), hypoglycemia (low blood sugar), or hypernatremia (high sodium)
- Metabolic difficulties, such as pyridoxine dependency, maple syrup urine illness, or phenylketonuria (PKU)
- The peril of seizures is higher if the child is early or of low birth weight

4.3.1.3 Signs and Symptoms of Convulsion

As to the respondents neonatal seizures transpire in kids who are less than 28 days old. Seizures in a baby are often squat and subtle; it can be intricated to notify whether a kid is actually having a seizure. Seizures in kids can include any or all of the following:

- Recurring facial movements, including eye movements, chewing, or sucking.
- Unusual pedalling movements of the legs
- Ogling
- Stop breathing
- Chewing movements
- Jitteriness
- Stretching
- Posturing sucking

4.3.1. 4 Prevention

The look of the child during the convulsion or spasm is often as dreadful as to unease the friends to such a degree that they are, utterly ailing for action. This is wrong, for we undoubtedly can do no good by giving mode to excitement, while if we handle our own

reckons, and are nifty and fixed in our treat merit, we may frequently be the means of saving the life of the child, said by the *char* dwellers.

The baby should instantly be placed in a balmy bath and left there 5 or 10 minutes, or until the sternness of the convulsion is broken. Then it should be taken away and covered with a balmy arid flannel. If the spasms still continue, or are only partly relieved, submerge the feet and leg sin water as balmy as it can be borne, at the same time pouring a flow of cold water on the head, from a distance of 2 or 3 feet. This course should be commonly repeated if necessary added the villagers.

The first question should be the reason of the convulsion. If the gums are swollen and red, and the assail obviously arises from dentition, with a spiky penknife they should be cut, applying the knife to the crest of the gum and curtailed, as late as the teeth are reached. If instanced by costiveness or an irritating body in the stomach or bowels, advanced at once to a *kobiraj*/ doctors. The 3 products most usually used by parents and other caretakers were lemon, honey, cod liver oil, and which were administered orally often in permutation in hopes of maddening stimulating or vomiting the baby to reclaim consciousness. Other materials occasionally, administered include got or cow milk, onion or garlic and rubbing alcohol. Articles such as sticks or spoons or fingers may be used in stabs to relax the jaws and avoid blockages. Flagellation may be used to revitalize the baby. Scarification or fumigation may also be done to contest chase or sorcery away wickedness spirits. A leg or hand may be plunged into hot water or blaze to revive the baby from a post convulsive coma. The applicability of these practices clarifies the lofty rate of mortality or morbidity following convulsions also said the villagers.

4.3.1.5 Pneumonia

Eighty nine percent villagers said that pneumonia is a illness of one or both lungs which is typically caused by germs *'poka'* (viruses, fungi, bacteria, or parasites). Detection of authentic basis of pneumonia in newborn babies is a multiplex venture. Newborn baby is highly susceptible to infection, which is most likely to go in an infant's body all the way

through the respiratory organ. Neonatal pneumonia could also come about before birth. Kids with maternal malnutrition or low birth weight fall victim to neonatal pneumonia.

4.3.1.6 Causes of Pneumonia

As to the most of the villagers various *poka* (virus/bacteria) of the air is constantly entering into the body when the baby breathes. They are mainly responsible for pneumonia.

4.3.1.7 Signs and Symptoms of Neonatal Pneumonia

Newborns and infants may not explain any symptom of the infection said the parents.

Table- 4.1: Signs and Symptoms of Pneumonia[3]

English Term	Local Term
Fever	*Jor*
Sneezing	*Hachi*
Cough	*Kashi*
Noisy breathing	*Ghor ghor shobdo kore*
Fever with shivering	*Kapuni diye jor*
Noisy cough	*Dom dom shobdo kore*
Running nose	*Nak diye pani pore*
Red skin rashes	*Lal lal gota*
Difficult breathing	*Shash tante or shash nite koshto hoi or nishash tante koshto*
Rapid breathing	*Ghono ghono shash tane*
Chest retractions	*Buk debe jai, buk venge jai*
Convulsion	*Khichuni*
Lethargic	*Netiye pore*
Common cold	*Thanda*
Asthma	*Hapani*
Heart disease	*Harter oshukh*
Cold to touch	*Hatpaa thanda*
Changing of body color (bluish or black)	*Gayerrong nil, kalo hoye jay*

Among symptoms of neonatal pneumonia are unstable body temperatures, grunting on exhaling, increased respiratory rates, fluid in the airways and increased mucus. Babies may tire and without energy & vomit, have a fever and cough, have difficulty breathing and eating or appear restless. Signs and symptoms of pneumonia as stated by parents are shown in the table 4.1.

[3] Primary data.

4.3.1.8 How Do We Know that a Newborn has Pneumonia

According to the most of the respondents the following indicator will help to understand that a newborn is affected by Pneumonia, these are

- is having intricacy breathing or is breathing strangely fast
- has a gray or bluish color to the lips or fingernails
- has a fever of high temperature

4.3.1.9 Prevention

The parents said that it is necessary to take baby's temperature at least once each morning and each evening, and call the *kabiraz*/doctor if it goes high. Then check your baby's fingernails and lips to make sure that they are pink and rosy, not gray, or bluish, which is a sign that the lungs are not getting enough air (oxygen). General treatment methods and set of treatment for pneumonia reported by the respondents are as follows:

Table: 4. 2- General Treatment Methods and Set of Treatment for Pneumonia Reported by the Respondents[4]

Kinds of Treatment	Local Procedure	Treatment Place
Religious Practice	Religious Inhiling, *Jhara Deya*	*Kabiraj/Maulovi/Huzur*
Indigenous Practice	Herbal syrup or remedies/ Massage of herbal medicine 1. *Telachuna* (Calcium Carbonate –*Chun* and Mustard oil heated on mango leaf) 2. Kerosene heated on mango leaf	At Home
	Lemon juice and extracts of *tulsi* leaf with lukewarm water	
	with or without condensed sugar (misri) at home	
Professional Practice	Antimicrobial suspension/ Globules or injectable, bronchodilator, cough depressant, and antihistamine suspension	Local Medicine Shops, NGO Clinic, Hospital

[4] Primary data.

4.3.1.10 Jaundice

According to the most of the villagers newborn jaundice refers to the yellow color of the skin and whites of the eyes.

4.3.1.11 Cases of Jaundice

Most of the parents identified the below causes of jaundice, i.e.

- Untimely babies, born before thirty eight weeks' gestation
- Kids who are not getting adequate breast milk, either because they are having a tough time feeding or because their parents' milk is not in yet
- Bruising at birth or other internal bleeding, infection, liver malfunction is also responsible for it.

4.3.1.12 Signs and Symptoms of Neonatal Jaundice

Most of parents claimed that the first sign of jaundice is a yellowing of a kids's skin and eyes. The yellowing may begin within 2 and 4 days of birth and begin in the face before spreading down across the body. If a finger calmly pressed on a kid's skin causes that area of skin to become yellow, it's likely a sign of jaundice.

4.3.1.13 Prevention

For the prevention of neonatal jaundice, the parents of the village used to practice the below things;

- Ensuring to provide enough fluids
- Ensuring essential breastfeeding
- Ensuring the light as well as ventilation in the room

4.3.1.14 Measles

Most of the parents reported that the measles skin complaint naturally has a reddish or red brown spotty appearance and first usually shows on the forehead, then ranges downward on the face, neck, and body, then down to the arms and feet.

4.3.1 .15 Signs and Symptoms of Measles

Most of the parents had identified the below sign and symptoms of newborn baby's measles, these are:

- Fever
- Runny nose
- Cough
- Sore, red, swollen eyes
- White, small, spots in the mouth
- Diarrhoea and/or vomiting

They also added that, when after three or four days these symptoms appear, we were noticeing red spots behind baby's ears and on his face and neck with huge temperature. The spots were spread over the body and increase a rough texture. During this time the babies becomes sick and tired and have pains and aches in his muscles.

4.3.1.16 Causes of Measles

Most of the villagers believed that the *"poka(germ)"*of air are the main responsible for the measles of the baby. Usually measles broaden through the air via sneezes coughs, and just merely breathing.

4.3.1 .17 Prevention

As to the parents, they were frequently practiced the following task for the remedies of newborn measles. Such as;

- Liquid like coconut or lemon juice are most useful to fight against newborn measles

- Barley water is used for relieve against dry, heavy coughs during measles
- Powdered licorice mixed with honey, turmeric powder mixed with honey or milk is helpful to reduce coughs and sore throats and boost immunity
- Barley bath is also soothing irritated skin and make the rash less itchy

4.3.1.18 Breathing Difficulty

Most of the parents said that breathing difficulties generally occur instantly after birth and for the time of the first hour of life. Unusually, a newborn baby may have no or extremely pitiable breathing because he has obtained little or no oxygen due to problem during labor, delivery, or right away after birth.

4.3.1.19 Causes of Breathing Difficulty

Most of the parents have identified the below causes of breathing difficulty, these are;

- Preterm birth
- The dark green substance forming the first feces of a newborn infant (Meconium Aspiration)

4.3.1.20 Signs and Symptoms of Breathing Difficulty

Most of the parents had identified the below signs and symptoms of newborn baby's breathing difficulty, these are;

- Blue color around the mouth and nose
- Flaring nostrils
- Grunting noises
- Nasal congestion
- Runny nose
- Itchy or watery eyes
- Chest congestion
- Coughing

- Whistling sound

4.3.1.21 Prevention

Most of the parents said that the following things were usually used to get rid of breathing difficulty of newborns in the village, these are;

- Keeping babies in warm
- Drinking teaspoon of fresh garlic juice,
- Drinking mixture of 1 cup of water, 1 teaspoon of fresh ginger and 1 teaspoon of fenugreek seeds, sweetened with honey

4.3.1.22 Loose Motion

Baby's bowel progress normally comes in different textures, ensigns and whiff based on what the baby is eating (breast milk, formula, or solid foods). Baby's stool is generally loose compared to an adult's. A slacker stool every once in a while is not uncommon said the parents.

4.3.1.23 Causes of Loose Motion

Most of the parents said that, loose motion of a baby can be caused by a number of things, ranging from a change in diet to an intestinal infection. Any of the following can cause loose motion in babies;

- Infection caused by a *'Poaka'* lives in the air (Virus, Bacteria, or Parasite). Babies can pick up the *'Poaka'(*bacteria /viruses) that cause loose motion through contact with polluted water or food, or by touching contaminated surfaces and then placing hands into mouths
- Drinking too much crop sap
- Poisoning

4.3.1.24 Signs and Symptoms of Loose Motion

As to the parents, these signs of loose motion in babies were usually found:

- Urinating less often than usual (fewer wet diapers/ katha)
- Tetchiness
- Dry mouth
- No tears when crying
- Unusual drowsiness or lethargy
- Sunken soft spot on the top of the baby's head
- Vomiting

4.3.1.25 Prevention

Most of the parents said that the following things are usually used to get rid of loose motion of newborns in the village, these are;

1. Prepared the juice of ¼ teaspoon of mustard seeds in a tablespoon of water. Hold it there for one hour. Now drink this water a normal oral tonic. Do again it for two to three times a day to get rid of loose motion.

2. Take out the juice from one full lemon. Add 1 teaspoon of salt and a tablespoon of sugar to it. Combine it well. Now drink this lemonade every hour till you feel that the toxins in the baby's intestines have been flushed out.

3. Eating the pomegranate seeds during loose motion may help in reducing the symptoms and stopping lose motion. Make sure that baby eats two fruits a day to reduce loose motions. The mother can also blend the pomegranate seeds in a mixer and extract its juice. Drink a glass of this juice at least three times a day to see effective results.

4. Take one to two teaspoons of dry fenugreek seeds and powder it in a food processor to reduce it into well powder. Now mix this powder in a glass of

water and take it every day in the morning on an empty stomach for two to three days to entirely get relief from loose motions of baby's.

4.3.1.26 Fever

Most of the parents reported that, fever is nothing but the increasing temperature of baby's day by day. It is nothing but the sign of illness. They said that newborn fever may find in a short time, long time (14 to 15 days) as well as without any sign and symptoms.

4.3.1.27 Causes of Fever

Most of the parents said that when babies attacked by the various *'poka'* (germ), then the temperature increased day by day. They also identified the few causes of fever, these are;

- Flu
- Reaction to vaccination
- Spending time outside on a hot day/becoming overheated from being dressed too warmly
- Colds
- Sore throat
- Croup
- Ear infection
- Pneumonia or bronchitis

4.3.1.28 Signs and Symptoms of Fever

Most of the parents have identified the below symptoms of infant fever, such as;

- Has a rash
- Vomiting
- Loose motion
- Trouble breathing,
- Not eating
- Sluggish

- Inactive
- Irritable
- Excessive crying
- Runny nose and cough.
- Poor sleeps
- Lack of interest in play
- Lethargy
- Convulsion

4.3.1.29 Prevention

To treat the newborn fever, the villagers have practiced the following things as a home remedy. These are;

- Dressing the baby in light, soft clothing
- Bathing the baby in lukewarm water
- Ensuring the baby is getting enough fluids
- Particular concentration must be paid to the disinfection and the storage of the water however secures its source. Drinking-water can be made secure by boiling it for one minute. Narrow-mouthed pots with wraps for storing water are obliging in reducing minor spread of fever

4.3.1.30 Skin Illness

Usually in the village the babies were accustomed to many sorts of skin states momentarily after the babies were born. Many of these stipulations last only a short time and will go away. The birthmarks that may not be noticeable at birth but will stay with the babies all through their lives stated the parents. The most common skin diseases of the newborn were found in the villages during the study period are skin peeling, greasy scalp rash, small white bumps, heat rash, newborn acne, rash of small red dots, dry skin, impetigo, eczema, sunburn, and birthmarks.

4.3.1.31 Causes of Skin illness

Most of the parents said that, when babies were attacked by the various *'poka' (germ),* then the babies were affected by the above skin Illness.

4.3.1.32 Signs and Symptoms of Skin Illness

Most of the parents identified the below sign & symptoms of skin illness of the village;

- Tiny red bumps
- A weepy, raw and red rash that looks ugly inside the skin creases
- Eczema erupts in dry, patchy areas on the skin
- Itchy and red bumps at the contact site
- Crying
- Fever

4.3.1.33 Prevention

Most of the parents said that, it is needed to follow the below practice to fight against skin disease of infants. These are;

- Resisting the urge to bathe the baby frequently
- Washing baby's clothing before it's worn
- Making sure baby wears only soft clothing

4.3.1.34 Excessive Crying

According to the parents of the village all infants sob as a form of communication. It is the simplest way they have to state a desire. Most crying is in reply to fear, discomfort separation or hunger, from parents. Such sobbing is usual and naturally stops when the needs are met—for example, when babies are hugged, fed. This sobbing tends to arise less often and for shorter times after babies are 3 months old. On the other hand too much crying passes on to crying that continues after caregiver have tried to meet routine needs or crying that continues for longer than common for a given baby.

4.3.1.35 Causes of Excessive Crying

The parents had identified the following causes of the excessive crying of the babies in the village. These are;

- Hungry
- Falling back to sleep after regular night awakenings
- Fatigue
- Fear
- Discomfort
- Difficulty in breathing
- Shiners or swelling over other parts or the head of the body
- Irregular movements or strolling of any part of the body
- Fever in an infant under 8 weeks old
- Acute irritability
- Too cold or too hot
- Needs sleep
- Tummy troubles (gas, colic, and more)
- Too cold or too hot
- Teething

4.3.1.36 Prevention

Most of the parents said that, we usually used the below practice to calm down the baby, such as;

- Rocking in an infant swing
- Being held, gently rock, or patted
- Listening to song
- Riding in a van/ boat
- Sucking on a sweetmeat
- Being fed
- Being swaddled

4.3.1.37 Cold

Most of the parents said that the frequent quaking cold wave to sweep the village affecting normal life and causing miseries to the babies in every year from December to March.

4.3.1.38 Signs and Symptoms of Cold

Most of the parents stated that if the baby has a common cold, you may notice some of the following;

- Cough with swollen lymph nodes, which are below the baby's armpits, on the back of his head and his neck
- Sore throat
- Reddened eyes
- Fever
- Runny, stuffy nose
- Loss of taste
- Irritability and restlessness
- Complexity sleeping
- Difficulty breathing

4.3.1.39 Causes of Cold

According to the parents, winter seasons as well as *"poka (germs)"* of air are main responsible for new born cold. Babies, can simply clutch a cold as they are constantly moving and exploring and then putting their hands in their mouths.

4.3.1.40 Prevention

The villagers used the below techniques to save their newborn from the cold. These were

- Keeping the baby away from people who are sick
- Washing the baby's toys, usually he puts in his mouth

- Keeping the baby in a comfortable as well as warm room
- Drinking the baby juice

4.3.2 Children Illness

Children of the village had been affected by the following illness as to the most of the villagers.

4.3.2.1 Malnutrition

The researcher observed that in *Char Majhira,* crop production, predominantly rice, was distinguished by the changeability in yield that was tied to climatic conditions. Frequent natural calamities such as floods and river erosion have affected rice production and the livelihoods of the village. Food security and access of the villagers to a diverse and balanced diet remains a challenge in the area. Villagers stated that, malnutrition is the state that occurs when the body does not get adequate nutrients. Levels of malnutrition are (wasting and underweight) not following a seasonal tendency, most of the time it remains same in the village.

4.3.2.2 Causes of Malnutrition

The villagers said that diarrhoea and acute respiratory infections are major causes of illness in children. Diarrhoeal disease has been frequently linked to increase the risk of malnutrition, underlined by states such as lack of clean water, poor sanitation and inadequate health services, lack of highly nutritious food like milk, meats, unemployment problem, etc. Moreover, the knowledge as well as perception levels of mother's regarding common and inexpensive food items (vegetables and fruits) are so low. This was the most important causes of child malnutrition in the village.

4.3.2.3 Signs and Symptoms of Malnutrition

The villagers have identified the below signs and symptoms of malnutrition's of children. These are;

- Dry eyes
- Enamel mottle
- Lethargic, apathetic behavior
- Weight loss/ skin or skeletal shape body
- Loose and wrinkled skin
- Fatigue and dizziness

4.3.2.4 Prevention

Malnutrition is the most important health problem in the village. No specific treatments were being practiced by the villagers during the study period. Because, most of the villagers live from hand to mouth.

4.3.2.5 Rickets

The villagers said that the ***'har baka' /*** rickets are nothing but the physical disorder of children in which their bone is gradually weakening. The villagers have identified this illness in the children usually in 5 to 18 months.

4.3.2.6 Signs and Symptoms of Rickets

The villagers have identified the below signs and symptoms of rickets, these are;

- Ache or warmed in the bones of children's arms, pelvis, legs, or spine
- Abnormalities in teeth or delayed tooth formation, an increased number of holes in enamel, abscesses, or defects in the structure of teeth
- Weakening growth and short figure
- Bone splinters
- Muscle pain
- Skeletal deformities, like an abnormally formed skull, legs that bow out, (bowlegs), bumps in ribcage, a bowed spine, pelvic deformities

4.3.2.7 Causes of Rickets

The causes of rickets in the village were identified by the villagers are;

- Water logging
- Wet environment
- Lack of food

4.3.2.8 Prevention

The villagers usually tried to adjust with the below circumstances to get rid of rickets of their children, these are;

- Basking the children in the sun
- Feeding fish, meat and green vegetables
- Consulting with the health assistant of NGO's clinic

4.3.2.9 Pneumonia

Like newborn, the villagers practiced the same thing for children pneumonia which has already stated in the newborn sections.

4.3.2.10 Diarrhea

Like newborn, the villagers practiced the same thing for children's Diarrhea which has already stated in the newborn's loose motion.

4.3.2.11 Measles

Like newborn, the villagers practiced the same thing for children, measles, which has already stated in the newborn's section.

4.3.2.12 Fever

Like newborn, the villagers practiced the same thing for child's fever which has already stated in the newborn's section.

4.3.2.13 Cold

Like newborn, the villagers practiced the same thing for children cold which has already stated in the newborn's section.

4.3.2.14 Fungal Infection

The villagers termed the illness as skin illness. As for the villagers fungi are germs like molds, yeasts and mushrooms, as parasites they live on humans and cause skin illness.

4.3.2.15 Causes of Fungal Infection

The villagers identified the below causes of fungal infections. These are

- The fungi attack the outer tier of skin on the scalp or body.
- Unclean skin, Warm, moist
- Touch of infected person, pet, or soil.
- Touch of hats, combs, clothing, or household items such as carpets.
- Unclean, sweaty feet

4.3.2.16 Signs and Symptoms of a Fungal Infection

The villagers identified the below signs and symptoms of fungal infections. These are

- Itchiness
- Mildly reddened borders
- Oval flaky or circular patches with raised
- An inflamed area, possibly oozing pus
- Raised tender boggy areas
- Short broken hairs

4.3.2.17 Prevention

The villagers identified the below practice to fight against fungal infections. These are

- Attempting not to let the child's skin get too hot or sweaty

- Wearing clean and soft cotton
- Keeping children groin area dry and clean
- Don't share towels, combs and hair brushes that could be carrying any fungi.
- Encouraging child to espouse excellent hygiene practices to halt fungal infections

4.3.2.18 Mouth Ulcer

Most of the villagers said that mouth ulcers are tender round or oval sores that form in the mouth, most often on the inside of the lips or cheeks. They're usually white, red, yellow or grey in color and are irritated (red and swollen) around the edge.

4.3.2.19 Signs and Symptoms of Mouth Ulcer

The villagers identified the below signs and symptoms of mouth ulcer, these are

- Swollen and red gums
- Fever
- A purple sore or red or cluster of sores on a lip
- Honey-colored crusting on the mouth
- Open, small, and painful sores that are white or yellowish with a red border on the inner lips
- A tiny, painless, fluid-filled sac that may be bluish in color on the inner lips, palate, gums, or beneath the tongue
- Velvety white patches on the tongue

4.3.2.20 Causes of Mouth Ulcer

The villagers recognized the below causes of mouth ulcer, these are;

- Winter season
- Eating foods – like peanuts, tomatoes and wheat flour

4.3.2.21 Prevention

As to the villagers, they were accustomed to the below habits to get rid of children mouth ulcer, these are;

- Drinking coconut water
- Drinking tulsi juice
- Using coconut oil in the infected area
- Using water and poppy seed mixture
- Dabbing a slight honey in the mouth ulcer or combine in a little turmeric to produce a paste that can be applied to the infected area

4.3.3 Adolescents Illness

Adolescents of the village were affected by the following illness as to most of the villagers.

4.3.3.1 Malnutrition

Like children, the villagers practiced the same thing for adolescent malnutrition, which has already stated in the children's section.

4.3.3.2 Gastric

As for the villagers gastric is normally used to depict pain or discomfort in the upper abdomen. It is common for adolescent as well as others in the village.

4.3.3.3 Causes of Gastric

The villagers recognized the below causes of gastric, these are;

- Anxiety lives and having irregular meals
- Eating very spicy food
- Disorder in digestion
- Smoking

4.3.3.4 Signs and Symptoms of Gastric

The villagers identified the below signs and symptoms of gastric of adolescents;

- Vomiting
- Invariable pain
- Indigestion
- Nausea
- Loss of taste
- Distension
- Heartburn

4.3.3.5 Prevention

The villagers said that, they were frequently used the below herbal to get rid of gastric, these are;

- Turmeric leaves with milk
- Guava leaves with boiled water
- ½ cup potato juice before 3 meals in every day
- Chewing ginger after 3 meals in a day
- Garlic and onion juice after 3 meals in a day

4.3.3.6 Typhoid

Typhoid is a keen disease associated with fever caused by the germs, as to the villagers.

4.3.3.7 Signs and Symptoms of Typhoid

The following signs and symptoms are most important to identify typhoid of adolescent sated by the villagers. These are

- Fever that increasing day by day, fever usually rises in the afternoon
- Headache and cough
- Abdominal pain
- Diarrhea
- Feeling weak, tired, or achy

- Constipation
- Stomach hurt and loss of taste
- Sore throat

4.3.3.8 Causes of Typhoid

The below causes were recognized by the villagers in relation to adolescent typhoid. Such as;

- River water
- Unhealthy environment
- Lack of sanitation
- Lack of education of parents

4.3.3.9 Prevention

Most of the parents had prevented adolescent typhoid in *Char* Majhira by maintaining the below things;

- Drinking tube well water
- Using soil/ash for hand washing
- Ensuring the adolescent is getting enough foods /fluids

4.3.3.10 Diarrhoea

Like newborn, the villagers practiced the same thing for adolescent diarrhea which has already stated in the newborn's loose motion.

4.3.3.11 Tonsil Infection

It is nothing but the irritation of the tonsils told by the parents.

4.3.3.13 Causes of Tonsil Infection

Most of the parents could not specifically identify the actual causes of tonsil taint, but they told that, *"poka (germs)"* of air may be the main catalysts of the illness.

4.3.3.14 Signs and Symptoms Tonsil Infection

When an adolescent affected by the tonsil infection, the following signs and symptoms were introduced by the parents in the village. These are;

- Throat tenderness
- Vomiting
- Abdominal pain
- Headache
- Redness of the tonsils
- Yellow coating on the tonsils
- Sore blisters or ulcer on the throat
- Loss of tone
- Loss of taste
- Ear sting
- Complexity breathing or swallowing through the mouth
- Fever
- Bad breath

4.3.3.15 Prevention

The villagers had identified the below habits for having a tonsil infection of adolescent in the village. i. e.

- Drinking balmy or very cold fluids relieve throat pain
- Getting enough rest
- Eating smooth foods
- Gargling with warm salt water

4.3.3.16 Skin Illness

Like children fungal infections, the villagers practiced the same thing for adolescent skin diseases, which has already stated in the children's section.

4.3.3.17 Fever

Like newborn/children, the villagers practiced the same thing for adolescent fever, which has already stated in the newborn's section.

4.3.3.18 Growing Pain

As to the villagers growing pains are factual, but really harmless brawny pain that can affect adolescent boys and girls.

4.3.3.19 Causes of Growing Pain

Though the causes of growing pain were unclear to the parents of the village, but they said that the below things may be responsible for it. It may be due to

- **Brawny Tiredness** – more bodily activity than common can be linked to more aching muscles for adolescent
- **Skimpy Stance** – standing, sitting or walking inelegantly puts greater than natural strain on the supporting muscles of the body
- **Poignant Upset** – pressure or unhappiness may trigger aches and pains

4.3.3.20 Prevention

The villagers used to this practice to get rid of growing pains, these are;

- Massaging the legs with oil of mustard seeds
- Enlarging the leg muscles
- Placing a warm cloth or heating pad on the sore leg
- Bounty of cuddles and hope that the pain will go away and that their legs will feel normal by morning
- Warmth treatment, such as warm baths and heat packs

4.3.3.21 Conjunctivitis

Conjunctivitis (*Pink eye*) is an irritation or illness of the transparent casing (conjunctiva) that lines the eyelid and part of the eyeball. Irritation causes the tiny blood craft in the conjunctiva to become more top which is what causes the red or pink cast to the whites of

the eyes, it is contagious, early diagnosis and handling is best to assist border its spread– said the villagers.

4.3.3.22 Signs and Symptoms of Conjunctivitis

The most general conjunctivitis signs and symptoms includes as to the villagers, which are;

- Redness in both or one eye
- Tearing
- Itchiness in both or one eye
- A coarse feeling in both or one eye
- Green /White discharge in both or one eyes that shapes a crust during the night
- Burning eyes
- Unclear vision

4.3.3.23 Causes of Conjunctivitis

The villagers believed that, *'alga batas/ poka'* (polluted air/germs) are main responsible for conjunctivitis.

4.3.3.24 Prevention

Villagers told that, practicing high-quality, cleanliness is the best approach to control the spread of conjunctivitis, these are

- Do not touching the eyes with your hands
- Washing hands carefully and frequently
- Changing clothes daily, and don't share them with others
- Changing the pillowcase
- Discarding eye cosmetics mainly mascara
- Don't use any persons else's eye cosmetics or individual eye-care items
- Staying always in a specific room
- Wearing optics during the outside movement

- Soaking a clean, lint-free cloth in temperate water and wring it out before applying it softly to closed eyelids

4.3.4 Adult Illness

The villagers said that, they had been frequently affected by the following illness during the adult age.

4.3.4.1 Ulcer

As to 97 % villagers it is nothing but the pain/ inflammation/ burning/ in the stomach. Others 3 % has not any idea about the ulcer.

4.3.4.2 Causes of Ulcer

The villagers identified the below causes of adult ulcer. These are;

- Smoking
- Spicy foods
- Being over 50 years age
- Family history

4.3.4.3 Signs and Symptoms of Ulcer

The villagers identified the below signs and symptoms of adult ulcer, such as;

- Starvation
- Start vomiting because of a full jam by scar tissue
- Lose taste and be incapable to eat a regular amount
- Dull, burning pain in the stomach
- Weight loss
- Not wanting to eat because of pain
- Bloating
- Burping
- Burning sensation in the chest
- Pain improves when you eat, drink
- Bloody vomit

4.3.4.4 Prevention

The villagers could understand that, it's not an easy task to prevent ulcer for the people like us who have to pass most of our time without sufficient as well as dietary food. But we are always trying to extricate of ulcer by doing the below things in our everyday life. These are;

- Trying to eat something when we felt hungry
- Trying to avoid smoking
- Trying to eat dietary foods like mango, guava, and green vegetables
- Drinking pure water
- Taking antacid or other medication as instructed by NGO's clinic/medicine shops

4.3.4.5 Asthma

All the villagers stated that, asthma is an unrelieved illness concerning the hard to breathe. These airways, or bronchial tubes, permit air to arrive in and out of the lungs. They were also added, if you have asthma your airways are forever inflamed. They become yet more distended and the muscles around the airways can make too tight when something triggers your symptoms. This makes it complex for air to move in and out of the lungs.

4.3.4.6 Signs and Symptoms of Asthma

The villagers recognized the below signs and symptoms of Asthma, such as;

- Coughing
- Wheezing
- Shortness of breath and/or chest tightness
- Feeling extremely tired or weedy when exercising
- Signs of a cold or allergies - headache, runny nose, sneezing, cough, nasal congestion and sore throat
- Trouble sleeping

4.3.4.7 Causes of Asthma

The villagers said that the below causes are responsible for asthma. Such as;

- Family history
- Irritants from indoor and outdoor air pollution
- Allergens for grain, grasses and flowers dust

4.3.4.8 Prevention

The villagers said that, they were forwarded the patient to the Upazila hospital for the prevention of adult asthma.

4.3.4.9 Diabetes

All the villagers marked that diabetes is nothing but excessive urination and thirst.

4.3.4.10 Causes of Diabetes

All the villagers have no idea about the causes of diabetes.

4.3.4.11 Signs and Symptoms of Diabetes

The villagers had identified the few signs and symptoms of diabetes in the village. These are

- Urination
- Huge thirst
- Tiredness
- Starvation
- Weight loss
- Blurry vision

4.3.4.12 Prevention

Villagers said that, they were forwarded the patient to the Upazila hospital for the prevention of it.

4.3.4.13 High Blood Pressure

All the villagers said that it is nothing but tension.

4.3.4.14 Causes of High Blood Pressure

Villagers identified few causes of high blood pressure, like;

- Lack of drinking water
- Working in high temperature in the field
- Lack of eating enough fruits and vegetables
- Family History
- Smoking

4.3.4.15 Signs and Symptoms of High Blood Pressure

The villagers identified few signs and symptoms of high blood pressure, these are

- Sweating
- Nervousness
- Difficulty sleeping or facial flushing.
- Vertigo
- Shortness of breath
- Blurry vision
- Heart attack

4.3.4.16 Prevention

Most of the villagers admitted that anyone can easily control high blood pressure by adopting below habits;

- Eating dietary foods
- Drinking pure water
- Avoiding smoking
- Taking a rest while worked in the open field
- Taking a bath regularly
- Managing tension

4.3.4.17 Arthritis

Most of the villagers said that, arthritis is the pain, swelling and stiffness in the joints of the body.

4.3.4.18 Signs and Symptoms of Arthritis

Villagers said that, they are accustomed to arthritis because of the following signs and symptoms;

- Numbness
- Foot difficulty
- Vision difficulty
- Morning awkwardness
- An abnormal small swelling or aggregation of cells in the body
- Fever
- Chills
- Fatigue/loss of energy
- Headaches
- Loss of appetite
- Muscle stiffness
- Tender urination
- Chest Pain
- Hopelessness

4.3.4.19 Causes of Arthritis

Villagers identified the below causes of arthritis, these are;

- A prior hurt
- Infections or an allergic reaction
- Abnormal metabolism
- Inheritance

4.3.4.20 Prevention

Eighty seven percent villagers have no idea about the prevention of arthritis. Only 3 % said that, dietary foods can prevent it. 10 % villagers said that they used flax seed oil, and the pest of ginger, alfalfa seeds, cinnamon and turmeric to get rid of arthritis.

4.3.4.21 Ear infection

Ear infection is the taint of the ear canal, the eardrum, or the middle ear, said the villagers. It may occur in the inner as well as outer ears.

4.3.4.22 Signs and Symptoms of Ear Infection

Signs and symptoms of ear infection consist of

- Ear pain
- Fever
- Nausea
- Hearing loss
- Effluent from the ear and ding in the ear
- Fullness in the ear
- Vomiting
- Vertigo
- Common cold
- Trouble sleeping as to the villagers.

4.3.4.23 Causes of Ear Infection

The villagers identified the below causes of ear infections, these are,

- Any unknown object in ear
- Water in the ear
- Use of sticks in the ear
- Eczema in the ear tube

- Allergies

4.3.4.24 Prevention

The villagers admitted that the following things are most important to fight against ear infection.

- Washing hands and body daily
- Avoiding pacifiers
- Keeping home free from any dust
- Staying away from who have cooled

4.3.4.25 Gastric

Like adolescent, the villagers practiced the same thing for adult gastric, which has already stated in the adolescent section.

4.3.4.26 Weakness

All the villagers said that weakness is an indication of a number of different illnesses. It is nothing but feeling weak, tired or bushed to do any normal work.

4.3.4.27 Causes of Weakness

The villagers identified the below causes of weakness. Such as;

- Hard Labor
- Starvation
- Lack of dietary
- Lack of pure drinking water
- Depression
- Fatigue
- Lack of sleep
- Overwork
- Stress
- Overall attacks of various illnesses

4.3.4.28 Signs and Symptoms of Weakness

The villagers said that, the signs and symptoms of weakness are;

- Tardy or leisurely movement
- Uncontrollable shaking (tremors)
- Muscle jerking
- Muscle pain
- Fever
- Changes in vision
- Talking complexity
- Diarrhea
- General ill feeling
- Thirst
- Missed menstrual periods
- Anxiety
- Lack of energy
- Sleep disturbances
- Sudden weakness or numbness on one side of the body
- Inability to stand

4.3.4.29 Prevention

All the villagers said that, "it is general health peril in the village." We are always trying to match with the environment, as we have to hand to mouth. We always try to arrange dietary foods for our family but we failed.

4.3.4.30 Headache

Villagers said that, headache is pain anywhere in the section of the head or neck. It can be a sign of a figure of the diverse conditions of the head and neck.

4.3.4.31Causes of Headache

The below causes were identified by the villagers for headache;

- Varies in sleep or need of sleep

- Pitiable attitude
- Skipped meals
- Pressure
- Dehydration
- Fever
- Ear Infection

4.3.4.32 Signs and Symptoms of Headache

The following signs and symptoms were identified by the villagers for headache, these are;

- Rigid neck
- Difficulty walking
- Difficulty seeing
- Difficulty speaking
- Coughing,
- Straining
- Feeling ill

4.3.4.33 Prevention

Most of the villagers told that, they had used the following practice to get rid of headache. There are;

- Sleeping
- Taking a rest
- Using basil oil
- Drinking a cool glass of water
- Drinking Mint Juice
- Using garlic paste

4.3.4.34 Fungal Infection

Like children, the villagers practiced the same thing for adult fungal infection, which has already stated in the children's section.

4.3.5 Aged Illness

Most of the villagers admitted that, the aged people of the village had frequently got the following illness.

4.3.5.1 Stroke

Eighty seven percent villagers were failed to define stroke. 3 % villagers said that it is blood related illness in which people may die at any time. The rest of the villagers have no idea about it.

4.3.5.2 Causes of Stroke

All the villagers have no idea about the causes of stroke.

4.3.5.3 Signs and Symptoms of Stroke

The villagers have recognized the below signs and symptoms of stroke, these are;

- Headache
- Walking difficulty
- Sweating
- Speaking difficulty
- Paralysis of the face, arms and legs
- Difficulty in vision
- Loss of balance

4.3.5.4 Prevention

As to the villagers, they had controlled stroke by applying the following strategies;

- Managing stress in life
- Stopping to take tobacco
- Increase the level of physical activity

- Maintaining a well-balanced diet

4.3.5.5 Paralysis

Seventy nine percent villagers stated that paralysis is the loss of muscle activity in any part of the body. Paralysis can be complete or incomplete. The rest of the villagers have no idea about it.

4.3.5.6 Causes of Paralysis

Stroke is the main causes of paralysis in the village, said the villagers of *Char* Majhira.

4.3.5.7 Signs and Symptoms of Paralysis

The villagers sketched out the following signs and symptoms of paralysis, these are;

- Loss of perception
- Awkwardness and numbness
- Cruel headache
- Complexity breathing
- Dribbling
- Difficulties in walking, speaking
- Changes in behavior
- Changes in vision/ hearing
- Sickness with or without vomiting

4.3.5.8 Prevention

Actually, we have not used specific prevention cult to defend paralysis, but we used garlic, ginger pest in the affected area, said the villagers. Like a stroke, we always tried to cope with the environment through the below habits, these are ;

- Managing stress in life
- Stopping to take tobacco
- Increase the level of physical activity

- Maintaining a well-balanced diet

4.3.5.9 Asthma

Like adult, the villagers practiced the same thing for aged asthma, which has already stated in the adult section.

4.3.5.10 Arthritis

Like adults, the villagers practiced the same thing for elderly arthritis, which has already stated in the adult section.

4.3.5.11 Memory Loss

Eighty seven percent villagers said that, memory loss is an abnormal position of humanity in which he or she doesn't recall his or her immediate course of action in daily life.

4.3.5.12 Causes of Memory Loss

The below causes are responsible for memory loss, told by the villagers, such as;

- Lack of dietary foods
- Stroke
- Head injury
- Depression
- Dehydration
- Anxiety
- Stress
- Aged

4.3.5.13 Signs and Symptoms of Memory Loss

The signs and symptoms of memory loss identified by the villagers are given below, such as;

- Confusion with time and place

- Complexity in speaking, walking
- Changes in mood and personality
- Problems in decision making
- Complexity in watching
- Attacks of various illnesses

4.3.5.14 Prevention

The villagers said that people who don't have communal contact with people and friends are at top risk for memory problems than people who have burly social ties. Social communication helps brain function in several ways: it frequently involves activities that defy the mind, and it helps ward off depression and stress. So, we tried to join a social gathering. Besides these we have applied the below thing in these cases;

- Maintaining a well-balanced diet
- Managing stress
- Taking a rest

4.3.5.15 Ear Infection

Like adults, the villagers practiced the same thing for elderly ear infection, which has already stated in the adult section.

4.3.5.16 Lower Back Pain

It's the common pain in the lower back portion of the body; said most of the villagers of *char* Majhira. Women were mainly suffered from lower back pain in the village.

4.3.5.17 Causes of Lower Back Pain

The villagers admitted that, the following causes are liable for lower back pain. These are;

- Menstruation
- Pregnancy

- Arthritis
- Sciatica
- Abnormal spine curvatures
- Inflammation of the joints

4.3.5.18 Signs and Symptoms of Lower Back Pain

The villagers admitted that, the following signs and symptoms are liable for lower back pain. These are;

- Difficulty in moving
- Pain has typically been on going
- Sleeping difficulty
- Anxiety
- Stress
- Aged
- Fever
- Weakness, numbness

4.3.5.19 Prevention

Self-care methods are frequently used by the villagers to get rid of lower back pain, these are

- Complete rest
- Applying cold water
- Massage
- Changing bed and sleeping on a firm surface

4.3.5.20 Toothache

Toothache is a pain in a tooth, simply said the villagers.

4.3.5.21 Causes of Toothache

As for the villagers, the below causes are responsible for toothache, such as;

- Decay of the tooth
- Fracturing tooth
- Infection
- Accidents
- Crooked teeth
- Wisdom tooth
- Ear infection
- Dental cavit

4.3.5.22 Signs and Symptoms of Toothache

Instant sensitivity to hot or cold foods is the most significant signs and symptoms of toothache, said the villagers. The others are;

- Injury or trauma to the area
- Pain with chomping
- Swelling around a tooth or swelling of the jaw
- Discharging or bleeding from around a tooth or gums

4.3.5.23 Prevention

The villagers said that garlic has long been applied as a native medicine for toothaches. Placing the clove of garlic in the mouth and chewed on it for several minutes in each day to ease pain as well as strengthening and revitalizing those pearly whites. Gargling salt water was another choice to relieve pain, particularly if gum illness was the root cause. Other impermanent remedies contain onions, lime/lemon juice for this illness.

4.3.5.24 Blurry Vision

Eighty nine percent villagers said that blurred vision is a significant pointer of eye illness. It affects one eye or both eyes and whether it happens often or seldom, if your vision is blurry, you are not capable to see very well details, and the need of sharpness may be frustrating. The others termed it as only the problems of eye.

4.3.5.25 Causes of Blurry Vision

The villagers identified the below causes of blurry vision of aged people of the village, these are;

- Cataracts
- Myopia
- Dry eyes
- Malnutrition
- Injury to the eye
- Family history
- Eye Strain
- Night Blindness
- Stroke
- Diabetics

4.3.5.26 Signs and Symptoms of Blurry Vision

The following signs and symptoms of blurry vision had been identified by the villagers, such as;

- Old age
- Headache
- Distance object seems shadowy
- Light sensitivity
- Dry eyes
- Itchy eyes
- Increasing tear production
- Poor night vision
- Red, bloodshot eyes
- Bleeding from eye
- Eye pain

4.3.5.27 Prevention

Villagers said that, we are trying to use optics to get rid of elderly blurry vision, but most of us have not capability to buy optics. We are trying to provide our aged people to eat spinach, milk, cabbage, broccoli, corn, peas and carrots in every day. We were also drunk the mixture of honey and liquorices for this problem.

4.3.5.28 Hearing Difficulty

Ninety five percent villagers said that it's the common health problem of elderly people in the village. It is the states in where people cannot understand anything due to the problem of hear.

4.3.5.29 Causes of Hearing Difficulty

The following causes of hearing difficulty were identified by the villagers, such as;

- Old age
- Headache
- Ear injury
- Foreign body in the ear
- Ear allergies
- Ear infection
- Malnutrition
- Huge sound

4.3.5.30 Signs and Symptoms of Hearing Difficulty

The following signs and symptoms of hearing difficulty were identified by the villagers, such as;

- Complexity understanding words, particularly adjacent to local noise or in a crowd of people
- Difficulty hearing consonants
- Recurrently asking others to talk more clearly, slowly and loudly
- Needing to turn up the volume of the radio

- Pulling out from conversations
- Escaping from social settings
- Muffling of speech and other sounds

4.3.5.31 Prevention

The villagers said that, usually we used the below plants to get rid of hearing difficulty of aging people. These are;

- Garlic
- Onion
- Olive
- Elder

4.4 Perceived Illness Causation

Inconsistency in treatment choice from different illnesses is largely dependent on the etiological perception of the local people. This research was conducted among the people of *Char* Majhira came to learn that the cause of their suffering was due to health awareness as well as a disadvantage living condition under they discussed this issue at length among themselves and developed a shared standard of perception with respect to above illness. Due to varied, personal, social, cultural and religious values they formed distinctive perceptions. The local knowledge formed this distinctive perception. The researcher with this point in mind tries to present it from various angles:[5]

a) The Individual World

Lay theories point out that locate the origin of ill-health within the individual world deal mainly with malfunction within the body, sometimes related to changes in diet or behavior. Here the responsibility for illness falls mainly on the patient himself.

Ten percent of the local people identified behavioral causes that ultimately results in above illness affecting; this was developed from their perception of unclearness and

[5] C.G Helman, *Culture, Health and Illness* (London:Butterworth-Heinemann Ltd,Oxford 0X28DP,1994):120-128.

personal hygiene standards and local health knowledge. Etiologically they perceived that unclearness and unhygienic practice may result in above illness.

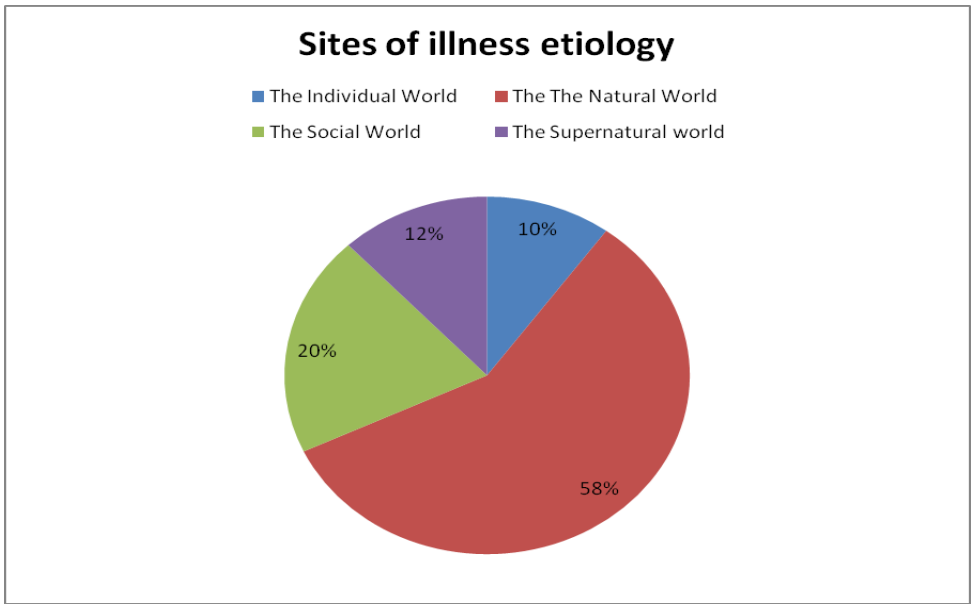


Figure 4.1: Sites of Illness Etiology[6]

b) The Natural World

This includes aspects of the natural environment, both living and inanimate, which were thought to cause ill-health. In this research, 58% respondents believed that their suffering was due to natural causes. Among 58 %, 18% respondents believed that stroke, ulcer, paralysis, asthma, arthritis, memory loss, blurry vision, gastric, conjunctivitis, weakness, hearing difficulty were a hereditary condition in some families.

The children of parents who had died of the illness were later observed and found that they were also suffered from the same condition. Twelve percent people believed that those people who were weak and with less resistance succumbed easily to the illness. Twenty six percent respondents reported that their food habits like 'starvation', 'drinking river water' may be the cause of the above illness.

[6] Primary data.

c) The Social World

Blaming other people for one's ill-health is a common feature of small-scale societies, where interpersonal conflicts are frequent.

As to the 20 % *char* Majhira people "*evil eye*" was a most important etiology of above motioned illness. It was also known as "*the narrow eye*" '*the bad eye'*, '*the wounding eye'* or simply as "*the look*". One respondent said that the evil eye as *'it relates to the fear of envy in the eye of the beholder, and [that] its influence is avoided or contracted by means of devices calculated to distract its attention, and by the practices of sympathetic magic, jealousy can kill via a look.'*

d) The Supernatural World

Here, illness had been ascribed to the direct actions of supernatural entities, such as gods, spirits or ancestral shades. Twelve percent respondents believed that the causes of their suffering were supernatural. Twelve respondents said that any *'Fokir'* (A man who possess superpower) had done the harm *"Kharap Korni"*. It was the symbolic representation of some supernatural power. They showed logic on behalf of their beliefs that the ulcer, arthritis, paralysis, skin illness did not affect the Muslims in the villages. Fifteen percent respondents believed that the *Kaviraj* has downed up the "*Kali*" (In the Hinduism *Kali* is an evil deity) by processing of *voron* (It was a processing by a deity or evil spirit deceive) they strongly believed that *kali* had visited the area, randomly whom *kali* touch, he must get ill even any person touches the *kalis* shade and see face to face each other he also must be ill. Another respondent said that the *'Kala Bau'* has come in the locality. This *Kala Bau* (Polluted air) was also the symbolic representation of some supernatural power.

4.5 Metaphors of Illness

The metaphors[7] of ill-health- particularly when they had such serious conditions of above mentioned illness- carry with them a range of symbolic association which can seriously affect-

- How the sufferers perceive their own condition.
- And how other people behave towards them.

Under this study, the researcher has found the following number of recurrent images or metaphors of the above illness:

Diabetes, Stroke, Paralysis, Asthma, Arthritis, Blurry vision, Conjunctivitis, Weakness, Skin Disease, Jaundice, Measles, Fungal Infections as an Invisible Contagion: In this image, illness like diabetes, stroke, paralysis, asthma, arthritis, blurred vision, conjunctivitis, weakness, skin disease, jaundice, measles, fungal infections were viewed as an unseen influence transmitted by virtually any contact with an infected person- whether this contact was with the finger/the body surface, body wastes and even with the air that they breathe as to the 48 % respondents.

This invisible influence can occur at speech, work, and home or wherever eat as to the villagers. Like medieval theories of illness, it this as it the sufferer were surrounded by an infected 'miasmal' or cloud of poisonous 'bad air', which causes illness to others nearby. Implicit in this image was the idea that the sexual lifestyles of sufferers from the illness might also be 'contagious' to those around them.

Diabetes, Stroke, Paralysis, Asthma, Arthritis, Blurry vision, Conjunctivitis, Weakness, Skin Disease, Jaundice, Measles, Fungal Infections as an Invisible

[7]C.G Helman, *Culture, Health and Illness* (London:Butterworth-Heinemann Ltd,Oxford 0X28DP,1994):177.

Contagion as Moral Punishment: In this image victims of the illness is usually divided into two groups, those who were innocent and those who were ‘guilty. These images of diabetes, stroke, paralysis, asthma, arthritis, blurry vision, conjunctivitis, weakness, skin disease, jaundice, measles, fungal infections as ‘judgment’ ‘divine’ punishment’ or ‘nemeses for a deviant lifestyle- like other forms of ‘victim-blaming as to the 52 % respondents .

4.6 Discussion

The villagers of *Char* Majhira have multiple experienced of illness in terms of newborn, children, adolescent, adult as well as aged people. Their perception and knowledge regarding illness, including definition, causes, sign, symptoms and prevention were so simple. It is indicating that, they are very much influenced by the surrounding environment. The livelihood patterns of the villagers have a great impact on their individual construction of illness.

The Sectors of Health Care

5.1 Introduction

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

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

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

5.2 Social and Cultural Aspects of Health Care Pluralism: Perception of the Study People

Anthropologists have pointed out that the health care system of any society cannot be studied in an isolation manner from other aspects of that society, especially its social, religious, political and economic organization. It is interwoven with these, and is based on the same assumptions, values and view of the world. Landy points out that a system of

health care has two interrelated aspects: a cultural aspect, which includes certain basic concepts, theories, normative practices and shared modes of perception; and a social aspect, including its organization into certain specific roles (such as patient and doctor) and the rules governing relationships between these roles in specialized settings (such as a hospital or a doctor's office). In most societies, one form of health care, such as scientific medicine in the West is elevated above the other forms, and both its cultural and social aspects are upheld by law. Besides this 'official' health care system which includes the medical and nursing professions – there are usually smaller, alternative systems, such as homeopathy, herbalism and spiritual healing in the UK, which might be termed health care sub-culture. Each has its own way of explaining and treating ill-health and the healers in each group are organized into professional associations, with rules of entry, codes of conduct and ways of relating to patients. Medical sub-cultures may be indigenous to the society, or they may be imported from elsewhere; in many cases, immigrants to a society often bring their traditional folk healers along with them, to deal with their ill health in a culturally familiar way. In the UK, examples of these are the Muslim hakims or Hindu vaids sometimes consulted by immigrants from the Indian sub-continent. In looking at health care pluralism, wherever it occurs, it is important to examine both the cultural and social aspects of the types of health care available to the individual patient.[1] In this text, the researcher has examined the pluralistic health care systems of the village, in order to illustrate, the range of therapeutic options available in the society.

5.3 The Popular Sector

This was the lay, non-professional, non-specialist domain of society, where ill health was first recognized and defined and health care activities were initiated. Most of the people informed that it includes all the therapeutic options that utilizes, without any payment and without seeking advice from either folk healers or medical practitioners. Among these options was self-treatment or self-medication advice or treatment given by a friend,

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

relative, neighbor, etc. Most of villagers said that, the main area of health care is our family. The key health care providers were women, usually mother sister or grandmothers. They said that, it usually includes a set of belief about the disease described in the chapter 3 and 4. These were usually a series of guidelines, which were specific to their cultural group, about correct behavior for preventing illness is oneself and in others. It includes beliefs about the 'healthy' way to eat, drink, sleep, cress, work, pray and generally conduct one's life. The researcher has observed that in this sector illness affected person has to maintain little food prohibition. There was a familiar belief in the village that the pregnant mother should consume slighter to keep the size of the baby minimum for easy delivery. In the village a distinguished outlawed was that newborn babies were not given colostrums as the faith that the fat material might upset the stomach. It is worth mentioning that almost all the mothers of landless, small peasant, medium peasant and rich peasant households were maintained few principles for illness of their babies for perpetuating their cultural beliefs, norms, values, customs and so on.

Table- 5.1: Food Prohibition for Mothers Whose Baby's were Illness Affected[2]

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

In the village, children, adolescent, adult and aged who were affected had experienced of food prohibition. The researcher has taken the following pen pictures of these cultural practices.

[2] Primary Data.

Table-5.2: Food Prohibition of Illness Affected Age Groups[3]

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

5.4 The Folk Sector

The study people were the innate religiosity on even fatalism which was observed among all sectors of the society. The one set of illness in the family would prompt a prayer or a special invocation to the family deity or the almighty for a benediction. This may involve a *Hujur* (religious leader), or a *Fokir* or any similar person who would also use their, '*Unconventional*' treatment method (s) which the householders would accept because their own presumed helplessness and their trust in the practitioner's ability to achieve the desired result. The therapists treating illness as caused by supernatural factors after religious leaders or priests whom supposedly in possession of supernatural healing power. They also used herbal related ingredients in their treatment. The practitioner's of the traditional system acquire their knowledge from other practitioner's. The following local methods were used to prevent illness in the studied society.

In the village, folk medicine was accumulated to both material and non-material elements. The material elements consisted of curative preparations from plants and

[3] Primary Data.

animal products (already described in the chapter 3 and 4). These were applied habitually in their raw forms and were used in treating illness like cold, fever, skin illness, loose motion, diarrhea, paralysis, arthritis, lower back pain etc. The non-material components were formed religious and spiritual items. The religious items were comprised by

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

Non-material elements, either independently or in permutation with material components was usually applied in the treatment of all types of illnesses but was specially used in the treatment of patients with physiological problems such as malnutrition, headache, paralysis, blurry vision, etc. Sometimes, their use widens to the treatments of illness like rickets, ulcer, asthma, memory loss and even convulsion as well as jaundice in newly born children.

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

The table 5.3 offers a list of important plants which were observed in the study area. These plants were favored by the villagers generally for two reasons as (1) their adaptability to the climatic conditions of the locality and (2) the varied utilize of many of them in different medicine preparation as the ‘basal’ component.

Table 5.3: List of the Major Medicinal and Spice Plants/ Animal Products Commonly Observed in the Study Area[4]

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

The village people have their personal terms and forms of treatment. For example, they have coined numerous home names to state different forms of diarrhea/ loose motion like *dudher haga, patla paikhana,* and breathing difficulty – *Dom Bandho,* Skin illness – *gha rog* etc. Someone's inconsistent behavior like hearing difficulty, blurry vision, memory loss was called *batash laga or alga batash*, and was featured to an intangible

[4] Primary data.

spirit or to a disembodied soul devoid of any hylic spirit. The villagers said that such spirits actually wanders through wind and enter the human body through its unlimited orifice. The researcher asked the villagers that how does *alga batash* responsible for illness? The rural people told stories to exemplify its working. They said *batash* does not always enter the body instantly. It comes through another person attached to a patient.

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

She was therefore separated and there is a taboo for man during such situations. Inferior status, opaque, *purda* system, and the customary feminine image was forced women to take the option to folk treatment. According to the village people, a healthy person is one who is sturdy, looks youthful, and shows energy in physical work. Slight illness, like headache, cold, fever, and stomach upsets do not bother them. An ill person does not go

to take any treatment unless the illness goes away from what were calculated minor illnesses. Their philosophies regarding illness generation were several fabulous perceptions, including improper food intake, influence of an evil eye or spirit, God's will, divine punishment for wrongdoing, etc already stated in the chapter 4.

It was generally believed in the village that one has to take the help of backdoor powers to treat illness. The backdoor hold comes from persons are believed to have occult power i.e. *fakir, pir, hujur (*folk healers*)* and others. General folk treatments were *telpada* (oil incantation), *panipada* (water incantation), *jhad phook* (oral incantation), and *tabij* (sacred amulet) in the village. Religious practitioners were invited to perform exorcism whenever a person is possessed by a *zin or bhut* (spirit).

The villagers were given *Bhoge* (offering a feast to diet) to the nearest *Dhorgabari/ Mosque* (*Dhargabari* is the place where live deity, ghosts, witches and ancestors) to please their diets/ almighty. They gave sacred food as milk, curds, banana, *batasha* (one kind of sweet), hen etc, and prayer to recover from illness under a big old banyan tree at Dhargabari. A priest/*hujur* patronize the *Mosque/Dhargabari,* he is also the representatives of almighty/deity as to the villagres. He takes the *Bhoge's* /foods and reaches the prayer to deity/Allah.

The rice processing customary therapeutic system contributed of jaundice, convulsion, stroke, ulcer bear testimony in the village. 5 % mothers were applied this process. They examined the patient to keep some rice's under the patient's pillow as he affects of jaundice, convulsion, stroke, and ulcer or not. If the patient really affected by jaundice, convulsion, stroke, ulcer the rice color would become reddish as like vegetable color. Then he treats the patients by traditional homestead forestry as plants, tree's roof etc.

Hindu people were believed that the evil deity *Kali* was visited the village and the above illness stated in the chapters 3 and 4 affected by the touching of *Kali*. So, they were taken the assistance of *fokir* to bring down the *Kali* to the village. A *fakir* came of rent to deceive *Kali*. He presented the *Kali* processing by *Bhoron* and received him. These beliefs and practices relating to illness which were the products of indigenous cultural development were not explicitly derived from the conceptual framework of modern medicine.

5.5 The Professional Sector

The people of the study village have badly suffered due to lack of proper treatment facilities. "*We are underprivileged of free health care services as there is no government clinic or medical centre here. We have to rely on kabiraj (herbal medicine practitioner) and medicine shops for treatment. Villagers go to the government hospitals in the mainland only when a patient's situation gets serious*," said all the villagers. "*We took an emergency patient to the government doctor's in the mainland a couple of days ago. We had to do the difficult job of carrying him, walking for over one and half hours on the sandy char. Still, we perceive fortunate as the ill man could be redeemed through care at the Upazila hospital*," they added. The people of the *char* have urged the government to set up clinics there to ensure healthcare services to them. The researcher has found that the professional facilities were comprised of both the government and non–government inside and outside the village. These are as follows:

5.5.1 Medicine Shops

In the village, there were three medicine shops from where medicine purchased by the villagers. 87 % people were turned to medicine shops for the primary health care for both the prescribed medicines and medicines without prescription. The medicine shops also provided medical advice to people for all health issues described in the chapters 3 and 4.

5.5.2 Satellite Clinic of NGO's

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

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

5.5.3 *Majhira* Community Clinic

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

5.5.4 Union Health and Family Welfare Center (UHFWC) and Upazila Health complex

These all were located outside of the village. People were seldom visited these services for first aid, medicines, minor testing and education. These categories all provide the same care but were monetarily differently supported. The Union Health and Family

Welfare Center (UHFWC) are funded by the government. The UHFWC and Upazila Health complex was the only healthcare service where Government doctor works a few times per months and all the other services work with paramedics.

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

5.6 Discussion

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

Therapeutic Decision Making Process

6.1 Introduction

Decision-making is nothing but the cognitive course resulting in the assortment of a belief or a process of act among a number of possible options. Each decision-making course constructs a final choice that may or may not term as rapid action. It is the lessons of selecting and choosing different options based on the assessments and preferences of the decision maker. In the village *Char* Majhira illnesses were not only a therapeutic matter, but also a communal subject that was of concern to family members. As the family structure regulates decision making within the household, it has important effects upon health care options. When the villagers recognized themselves as ill, they were acting a number of things. They were doing nothing. They were attempting to tackle the illness by themselves or with the family. They were talking to friends and relatives about what they should do. They were looked care from a number of different sources, including but not limited to physicians. Indeed, the study carried out in *Char* Majhira indicates that generally 90 to 92 % of all illness episodes were never seen by a physician. Many of these illness episodes were treated within the family during the study period. The major alternative to the physician was self/family care, traditional or folk healers in the village. The researcher has found the following practices in the village as a decision making process in relation to newborns, children, adolescents, adults and aged people.

6.2 Number of Illness People during the Study period

Among 250 households, 219 had at least an illness person during the study period and rest did not have any problems. The numbers of ill persons were 316 of which 297 received treatments from different options while the rest did not seek any options. As to

the table 6.1 among the ill persons 194 were females and 122 were males. The researcher has found that, among 316 sick persons adolescent people were in great number 123, among them males were 44 and females were 79, newborns were 27, among them males were 15 and females were 12, children were 49, among them males were 27 and females were 22, adult were 89, among them males were 26 and females were 63 and the elderly people were 28, among them males were10 and females were 18. Total numbers of ill persons of landless households were 153, among them males were 56 and females were 97. 97 people of small peasant households were affected illness described in chapters 3 and 4, where the number of medium peasant and rich peasant family were relatively less than others as 54 and 12 respectively. It is indicating that, the conditions of females were severe in the village and household's assets have a great impact on illness in this village.

Table: 6.1 Numbers of Households Based Illness Persons during the Study Period

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

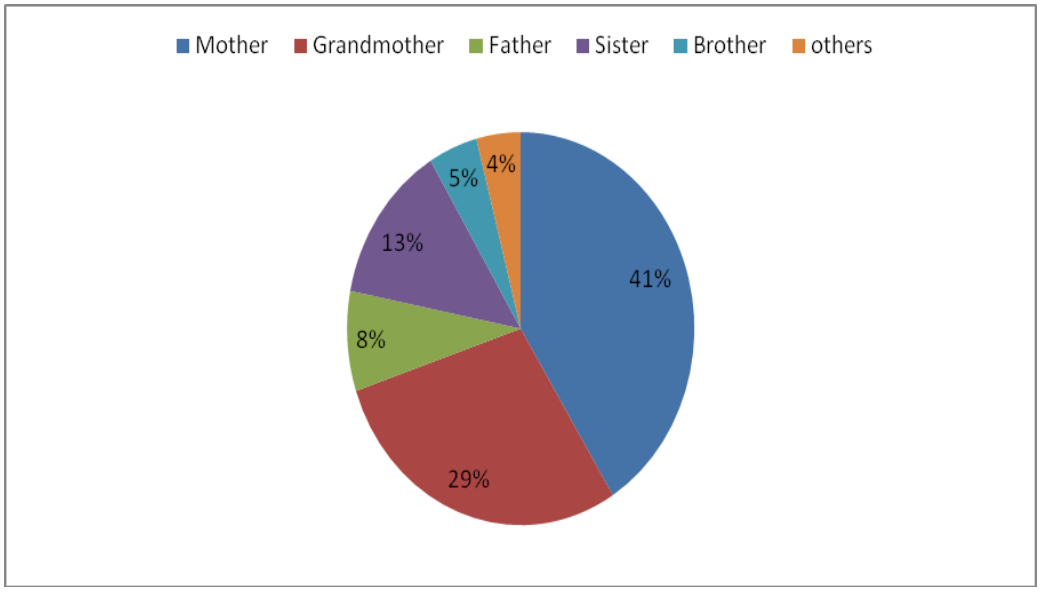
6.3 Decision Makers for Newborns, Children and Adolescents Illness

The villagers explained that it was usually the mother only or the parents together who first noticed that there is something wrong with the family members especially for newborn, children and adolescents. In some families other members, especially the grandmothers were also the ones to scrutinize first illness in the family members.

Therapeutic Decision Making Process

According to the native culture, older people are honored by all generations, particularly the younger, for their knowledge and expertise in life including how to construct decisions regarding the handling of illness. The Grandfather/Mother (*Dada/Dadi*) is the person who should be kept informed about all family related matters, including the health status of newborn, children and adolescents. The villagers said that the most important reason for contacting *Dada/Dadi* was to show them respect. They also attained in the decision making process in terms of helping, either sharing experience or others. Still, just about every two family said that they always contacted the *Dada/Dadi* when anyone was ill.

Figure-6.1: Person who was Very much Alert to the Illness of Newborn, Children and Adolescent[1]



Correspondingly, the majority of the parents said that they would begin treating the ailing members of the family with the medicines they themselves study were the most appropriate. Some of them discussed with other relatives, mainly uncle, brother, sister, father in law, mother in low and neighbors. The data on illness cases that mothers

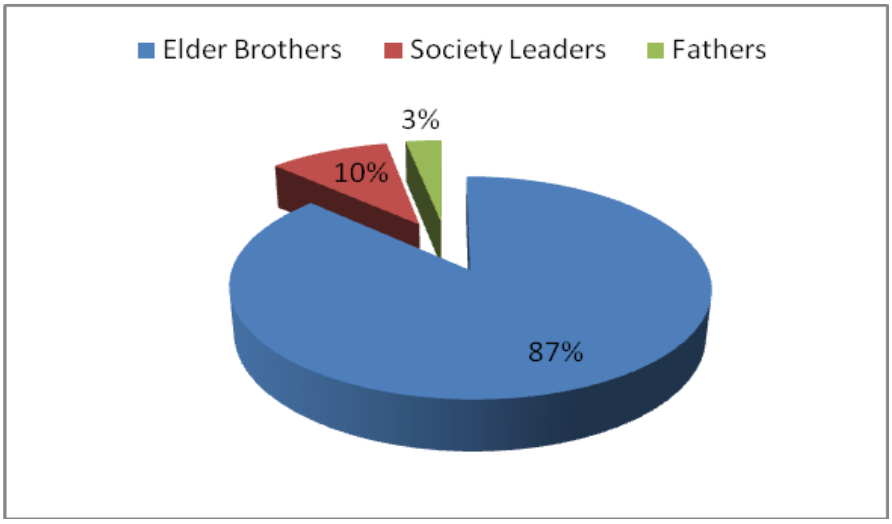
[1] Primary data.

considered to be more serious is shown in the figure 6.1. On the other hand, uncle, brother, sister, father in law, mother in law and neighbors are the relatives with whom the mother communicated. Discussion in this circumstance marks informal consultation rather than strict advice seeking. It also constitutes a verbal acknowledgement that the family member is ill.

6.4 Decision Makers for Adult Illness

In case of adult illness, the decision makers were varied based on the gender in the study village. For 26 adult male patients, 87% of the decisions were taken by patients elder brothers, 10 % by society leaders and the rest were taken by patient's fathers. The researcher observed that, wisdom and experience was the key determinants to select a decision maker among the villagers. On the other hand, consultation with the community leaders who possessed social dignity was another aspect of a decision maker in the village regarding adult illness.

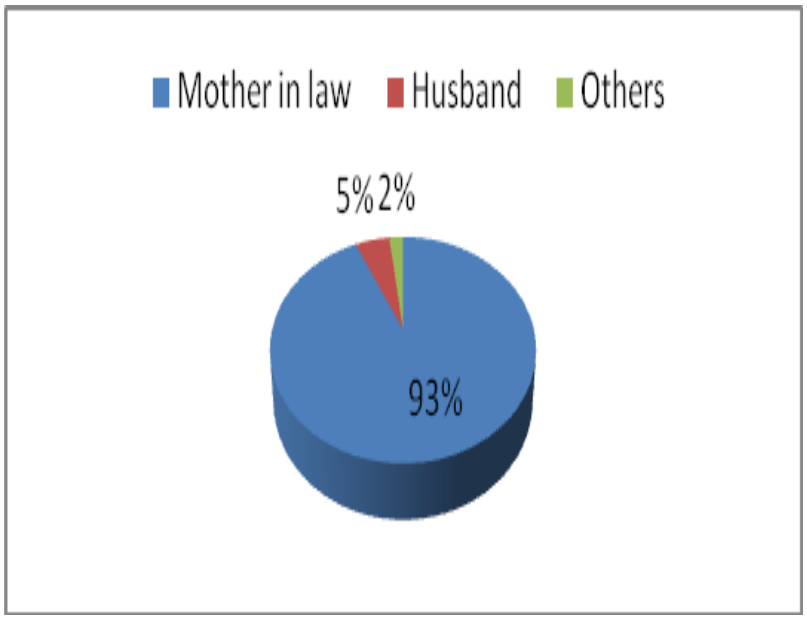
Figure -6.2: Decision Makers for Adult (Male) Illness[2]



[2] Primary data.

On the other hand, in case of adult 63 females, most of the decisions were taken by the mother in law as to the villagers. Husband has limited scope to take a decision in this case, because, most of the villagers believed that, they had specail knowledge on female illness.

Figure-6.3: Decision Makers for Adult (Female) Illness[3]

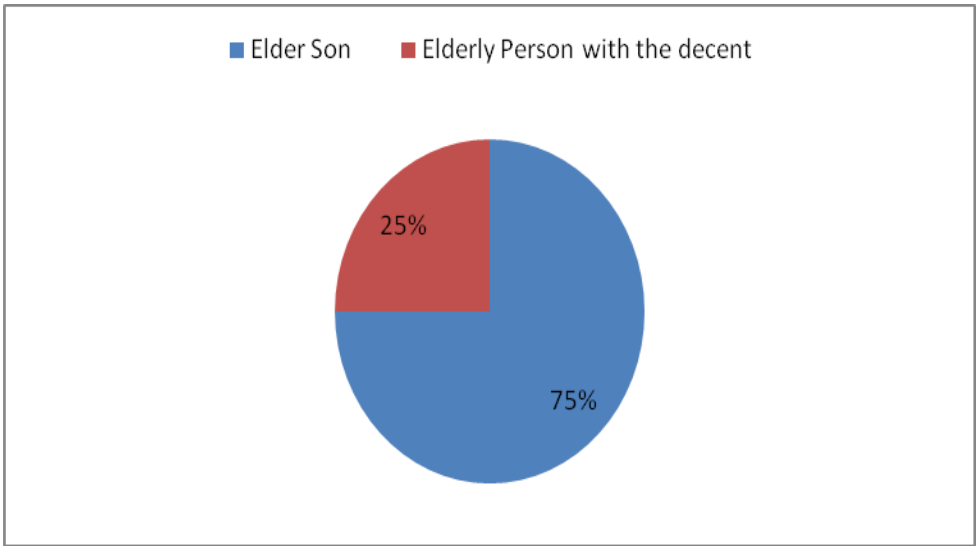


6.5 Decision Makers for Aged Illness

In the study village, most of the decisions regarding the elderly illness were taken by elder son. On the other hand, most aged people of the respective decent were playing an important role to take a decision in this regard who have distinctive knowledge regarding the illness.

[3] Primary data.

Figure -6.4: Decision Makers for Aged Illness[4]



6.6 Decision Making Phase

Time of taking decisions in relation to the illness of study people was not so simple. The researcher has observed that it depended on the cyclical issues of an illness episode.

6.6.1 Expressing as well as Dissemination of Illness Message to Family/ Community

It was the first step of taking decision for any illness, treatment of the study population as to the villagers. When the patient's were expressing their view to the family members as well as other people of the community, then they were treated as illness, persons in case of adolescent, adult as well as aged people. Defining oneself as being ill usually follows a number of subjective experiences, including[5] as to the villagers:

[4] Primary data.

[5] C.G Helman, *Culture, Health and Illness* (London: Butterworth-HeinemannLtd, Oxford 0X28DP, 1994): 109.

1. Perceived changes in the bodily appearance, such as loss of weight, changes in skin color or hair falling out.
2. Changes in regular bodily functions, such as urinary frequency, heavy menstrual periods, irregular heartbeats.
3. Unusual bodily emissions, such as blood in the urine, sputum or stools.
4. Changes in function of limbs, such as paralysis, clumsiness or tremor.

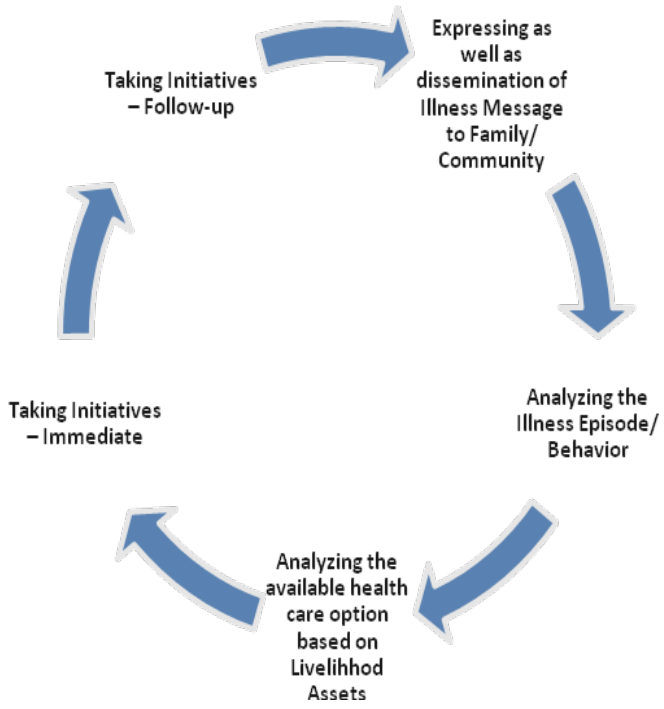


Figure-6.5: Cyclical Issues of an Illness Episode[6]

5. Changes in five major senses, such as deafness, blindness, lack of smell, numbness, or loss of taste sensation.

[6] Primary data.

6. Unpleasant physical symptoms, such as pain, headache, abdominal discomfort, fever of shivering.
7. Excessive or unusual states, such as anxiety, depressions, nightmare or exaggerated fears.
8. Behavioral changes in relation to others, such as marital or work disharmony.

6.6.2 Analyzing the Illness Episode/ Behavior

After expressing or defining the illness, it was the second steps to analyze the illness episode/behavior as to the villagers. The researcher observed that it was the notion about an episode of sickness and their treatments that were embodied by all those engaged in the therapeutic process. It was to examine the sorts of questions that the villagers were asked themselves, when they perceived themselves as being ill[7] and how they weave the answers to these questions into the story or narrative of their ill-health. These questions were as to the table no 6.2. at page no 157.

6.6.3 Analyzing the Available Health Care Option Based on Livelihood Assets

The researcher has observed that, based on the livelihood assets, the villagers were chosen available health care options stated in the chapter – 5 (the popular sector, the folk sector, the professional sector). We can discuss it to follow the below points.

- Physical capital
- Social capital
- Human capital
- Natural capital and
- Financial capital of the villagers

[7] C.G Helman, *Culture, Health and Illness* (London:Butterworth-HeinemannLtd,Oxford 0X28DP,1994):111-113.

6.6.3.1 Physical Capital

The physical capital of this village was relatively so poor compared to other areas of the country. The main crops were paddy, jute, wheat, potato, brinjal, patal, onion, garlic, arum, mustard and chilli. Extinct and nearly extinct crops Indigo (extinct); Til, (sesame), Tisi (linseed), Arhar, black gram, Kawan (Italian millet), yam, etc. Main fruits were Mango, jackfruit, guava, banana, papaya. There were 36 fishery families lived in the *char*s. The communication roads consist of mud roads 15 km and waterways 35 nautical Miles from Upazila headquarters. Materials used in building dwellings included corrugated tin, polythene, straw, leaves, and brick. The leaves were most normally used for structure of roofs (47%), followed by tin (14%), straw (36%), brick (1%), and polythene (2%). About 76% of the households had family members who were members of an NGO (Non-Governmental Organization). 46% of the households had at least one person selling manual labour to make their living. 87% of the households did not have any fixed place of defecation. Of those who had a fixed latrine, 22% had a ring, slab or a cemented latrine, and the remaining households had a fixed place without any protection against faucal contamination. River as a source of drinking water was almost universal with 99% of households reported use of river water for drinking. Twenty three percent of the households were using the latrine. Eight percent of the households had a radio, 4% had a mobile phone at home.

Physical capital has great impact on the issue of distance and thus physical access to health care services. From this village the Union Health and Family Welfare Center (UHFWC) and Upazila Health complex was at 15 km distance, located outside of the village, the 3 pharmacies was at 1.5 km distance and *kobiraj* was nearby at 1 km distance as to the villagers.

Table-6.2: Illness Episode Questions

Questions	Clarification
What has happened?	This includes organizing the symptoms and signs sated in the chapter 3 and 4 into a recognizable pattern, and giving it a name or identity.
Why has it happened?	This explains the aetiology or causes (stated in chapter -3) of the conditions.
Why has it happened to them?	This tries to relate the illness to aspects of the patients, such as behavior, diet, body-build, personality or heredity.
Why now?	This concerns the timing of the illness and its mode of onset, sudden or slow.
What would happen to them if nothing were done about it?	This considers its likely course, outcome, prognosis and dangers.
What are its likely effects on other people (family, friends, employers, and workmates) if nothing were done about it?	This includes loss of income or employment or a strain on the family as well as social relationships.
What should they do about it – or to whom should they turn for further help?	It includes strategies for treating the conditions, including self medication, consultation with friends or family or going to take therapeutic options available in the society.

In case of insignificant problems village people tend to go to the medicine shops first, and when the illness don't get cured and the trouble becomes bigger they decide to go to **Satellite Clinic of NGO's** of the *char* because there are more medicines, equipment and qualified doctors available in the clinic. They prefer the **Satellite Clinic of NGO's** and go by foot, van, votvoti or boat. They rarely visit the **Union Health and Family Welfare Center (UHFWC) and Upazila Health complex** because the services they got from **Satellite Clinic of NGO's** was practically the same as in and the distance was thus not worth the care supply. Villagers were reluctant to go to the union clinic as it was too far. When people have to go outer of the *char* for serious illness they depend on foot, van, votvoti or boat. The sand which always creates problems for the villagers need as the transports were so slow. One definite case that has been commonly emphasized was the fact that transport of pregnant women was extremely problematic.

6.6.3.2 Social Capital

Char Majhira consists of 3 *paras*, *Uttar* (north)*para*, *Moddhy* (central) *para* and *Dokkhin*(South) *para*. The 44% inhabitants who didn't occupy any cultivable land were landless, 35.2% were small peasant who have 0.01-1.00 acre cultivable land, 19.6% were medium who have 2.51 – 7.50 acre cultivable land and 1.2% was rich who has cultivable land 7.50 acre and/or above.

About 76% of the households had family members who were members of an NGO's (Non-Governmental Organization). 46% of the households had at least one member selling manual labour to make their living. There are one secondary school (private), and one madrasa in the *char*. Among the study people who had been to school, 76% attended secular schools, and 24% attended religious schools.

Gender biases as well as social stratification had adverse impact on the *char* life. The researcher noticed the difference in class. Most people were poor on the *char*, but as a member of the union, the counselor was evidently an especially respected man and richer than the common *char* dwellers. In an in-depth- interview with him, he said that he did not go to the **Satellite Clinic of NGO's** as well as **Union Health and Family Welfare Center (UHFWC) and Upazila Health complex** as they don't have any experienced and qualified doctors.

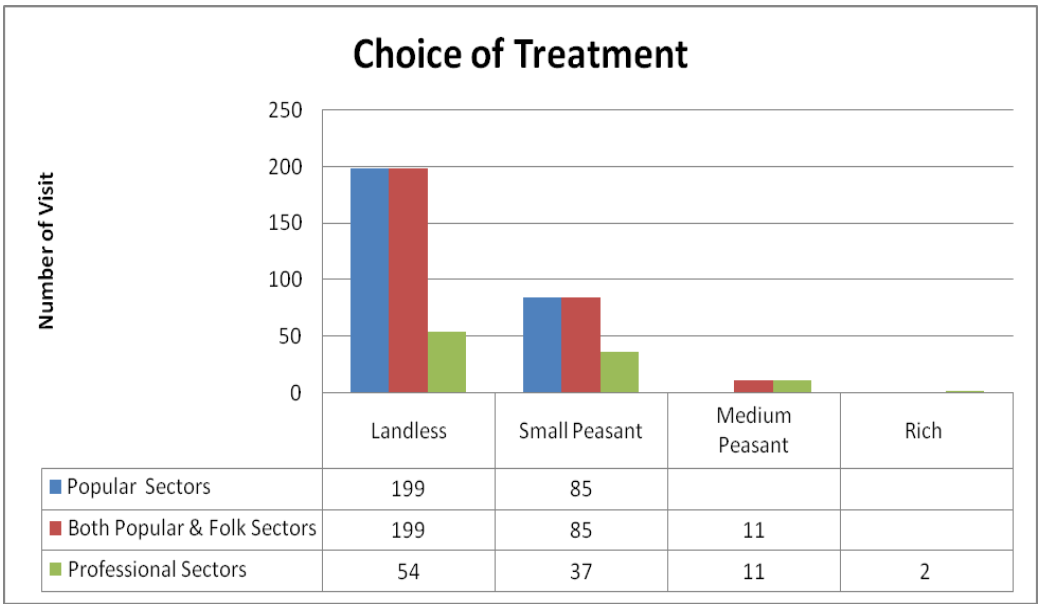
It is worth mentioning that his social status, connected with his economic situation. As to his affordability he went directly to the private hospitals outside the *char* in Bogra. The researcher could derive from the research that the increasing mobility on the *char* was exceptionally difficult.

Higher education is difficult for *char* dwellers to access and only 3 students who were graduated don't come back to the *char* and stay in the Bogra town.

Gender inequality on the *char* was so high. Seven percent of the households in the area were female-headed, and 93% were male-headed. 97% of main earners were male. In general, women almost never own land. It is always their husbands that own the land. Men mostly work in agriculture or fishing in the river. As to the respondent's female paramedics, visiting the *char,* but she were coming from outside the *char* as a part of **Satellite Clinic of NGO's.** On the *char* the researcher noticed among the women, 76 % were housewives, 12% students, the rest were unemployed.

In the use of health care the researcher noticed much dissimilarity. The researchers noticed one difference when talking about the *kobiraj.* Men clearly have a great deal of respect to the *kobiraj* and are very happy about his services, while women seem to be more serious and went less easily. Because, women were reluctant to consult with male *kobiraj.* The landless, small peasant, medium households were received treatment from popular as well as folk sectors. The figure 6.6 will show the choice of treatment of the villagers based on household assets.

Figure-6.6: Choice of Treatment[8]



If we look at the figure 6.6, we will find that, 199 landless illness people out of 297 were visited both the popular and folk sectors for their illness sated in the chapter 4. Among the 199 landless illness people 54 were gone to the professional sectors for treatment. 37 patients of small peasant households were gone to the professional sectors while 85 of the same households were consulted with both the popular as well as folk sectors for the treatment. 11 illness, persons from medium households were visited all sectors one after another respectively. But it is worth mentioning that, 2 persons from rich households were consulted only professional sectors outside the village.

6.6.3.3 Human Capital

Human capital represents the skills, knowledge, ability to labour and good health that together enable people to pursue different livelihood strategies and achieve their livelihood objectives. At a household level human capital is a factor of the amount and quality of labor available; this varies according to household size, skill levels, leadership

[8] Primary data.

potential, health status, etc.[9] In the study village, most of the people were living hand to mouth. They were not educated. They used to mainly depend on agricultural labor which was not technology based. It has great impact of their choice of treatment already stated in the figure 6.6 in this section.

6.6.3.4 Natural Capital

It is not supportable for the livelihood of these people. The area was highly prone to river erosion and floods. It has also the great impact of their choice of treatment already stated in the figure 6.6 in this section.

6.6.3.5 Financial Capital

As the researcher has already stated under the social capital issues that, The 44% inhabitants who didn't occupy any cultivable land were landless, 35.2% were small peasant who have 0.01-1.00 acre cultivable land, 19.6% were medium who have 2.51 – 7.50 acre cultivable land and 1.2% was rich who has cultivable land 7.50 acre and/or above. About 76% of the households had family members who were parts of an NGO's (Non-Governmental Organization). 46% of the households had at least one person selling daily labour to make their living. The vulnerable financial situations claimed that the cost of health services constitutes a serious threshold. Particularly treatment outside of the *char* was very costly. Services on the *char* tend to believe the financial capacity of the locals, because a landless villager needs medical assistance, usually he only needs to pay for the medicine. It is indicated that the available popular and folk health services regularly propose treatment free of charge. Mr. Golam Rasul[10] the health assistant, who works at health program of World Vision (NGO), claims that he also lets the landless villagers use his motorcycle charging the cost of fuel as well as fee 275 taka. However, in case of severe illness, villagers indisputably prefer expensive professional sectors outside the *char* like Bogra Sahhid Ziaur Rahman Medical College and Hospital and to the

[9] Dfid, 'Sustainable Livelihood Guidance Sheets,' (accessed October 11, 2012), http:// www.eldis.org/vfile/upload/1/docume nt/0901/section2.pdf.

[10] This is not his real mane.

char's own Satellite Clinic of NGO's. It comes into the view that no matter how the landless villagers were, they thought about it worth their while to spend such a huge cost when a life threatening illness hits their family. The landless need for selling advance in labor, to emergency crops to be able to pay for the sort of cure, others go into debt from NGOs. Five women of medium households even went as far as Bogra to get rid of sexually transmitted infection (STI). Their family has forced to sell their land in order to pay for the expenses about 8700 taka as to them. Because of the serious cost of proper medical care in hospitals outside the *char*, villagers tend to reschedule their visit to a qualified doctor. To save money, the villagers tried with the self-treatment first. They usually tend to wait three days or whole weeks until they go to a hospital in Bogra. If someone falls into the position, whether they goto hospital in Bogra or not, it was led him or her die in the meantime. So, the financial capitals represent a life-threatening margin for the disadvantage well as vulnerable people who are living in the village.

6.6.4 Taking Initiatives– Immediate as well as Follow Up

The researcher observed that, the villagers were taken immediate as well as follow-up initiatives by considering the above issues. It was an intrinsic cognitive as well as belief system which has great impact on the cyclical process of an illness episode in the village.

6.7 Utilization and Quality of Care

The researcher observed that the perception of a facility's worth is even more significant than its accessibility. That's why the researcher deeply examined the locals' first choice and satisfaction. It is transparent from the research that the quality of care is indeed an extremely significant deciding factor in the choices of health care.

There were two chief aspects that seem to characterize why people on the *char* choose a certain type of health care options. Such as

1. The explicit exercise and interest of the health care

Certain health care option specializes in specific problems. Based on the problem and the severity of the illness villagers were chosen the health care options for using. The popular sectors were used by the villagers for the illness stated in the table 6.3.

Table-6.3: List of Illness Treated in the Popular Sector[11]

Age Group	Illness
Children/Newborn	Diarrhea, Measles, Fungal Infection
Adolescent	Malnutrition, Diarrhea, Skin Diseases
Adult	Asthma, Diabetes, High Blood Pressure, Fungal Infection
Aged	Stroke, Paralysis, Asthma, Toothache, Blurry Vision

On the other hand, the villagers were going to the medicine shops for minor problems like headaches, fever and diarrhea, to the *kobiraj/ Fokir/ Hujur* (folk healers) for cold, fever, skin diseases, loose motion, diarrhea, paralysis, arthritis, lower back pain, etc, and they seldom leave the *char* and gone to Bogra to take medication from hospital for major problems that needs definite cost and qualified doctors.

The medicine shops of the village were close to get help. Villagers collected medicine straight from there. The villagers, and then more particularly the women, have generally great faith in the **Satellite Clinic of NGO's.** The villagers who have afforded to go to Bogra or **Union Health and Family Welfare Center (UHFWC) and Upazila Health complex** outside the *char* with a qualified doctor, they have definitely done so. In case of failure in this case they believed that "*Allah is always with them*".

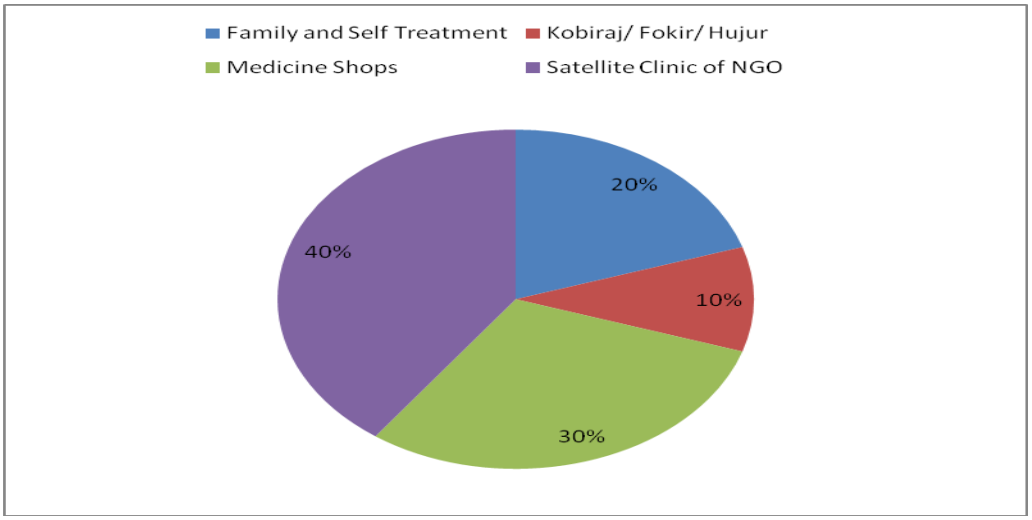
This is decisive from the research that they have an individual fondness for **Satellite Clinic of NGO's** with qualified doctors. If health care options offering the same services are available and closer to their home, the villagers tend to go there.

[11] Primary data.

2. **Patient satisfaction**

Another aspect was the extent of satisfaction of villagers about the different types of healthcare available in the village. The regular shortage of medicine as well as no qualified doctor represents deters villagers from making use of that type of health service. Normally villagers were happy when they got the help and efforts and they were dissatisfied about the particular health care when it didn't work. The researchers could clearly notify this fact from the **Satellite Clinic of NGO's** in the village. The villagers were satisfied with the services of this clinic when they received medicine as well as advice. But, as satellite clinics were held weekly in a particular location via boats/van with regular intervals (fortnightly or monthly depending on need and funding) with the frequent shortage of medicine, the villagers did not always receive the medicines they needed, which influenced their level of satisfaction to a great extent. The researcher asked the villagers to give marks on the respective health care options available in the village out of 10. They marked them as below.

Figure-6.7: Marked by Villagers to the Health Care Options in the Village Out of Ten[12]



[12] Primary data.

The villagers have given 4 marks to the Satellite Clinic of NGO's, 3 to the medicine shops, 2 to the family as well as self medication and 1 to the folk sectors like *kobiraj/ Fokir/ Hujur (*folk healers*)*.

6.8 Discussion

Explaining the practice of decision making based on above issues or categorization of statements of the villagers may not be sufficient, particularly because health care seeking affect by multifaceted interactions among many individual, household, community, and variables of the supply side. The researcher has analyzed the data through an iterative course that was always revising, and re-examining the themes.

The detail conversations and probing with the respondents pointed out that the cyclical process of an illness episode affect the final decision-making process on health seeking discussed in the above. Seeking treatment for illness is unconfirmed on illness and therefore, detection of the presence of illness is the first appreciation of the decision-making process. Sex, age, suffering, bodily weakness, and signs and symptoms of illness verify the health status of individuals, as well as indicating the extent of harshness of the illness.

When the patients and his family members become assured that the illness was becoming harsher the requirement for medical care was constructed. The necessity of medical care did not essentially decode into taking actual steps for seeking health care options. The gap between the requirement for care and medical care seeking were associated with the cost of obtaining health care services, recognized advantage of the care, affordability of the health care options, willingness to criticize anything to face the health care requirement amongst others. When health status appreciation, arises the villagers begin looking for information on availability of health care options. The ring of messages acquired from previous knowledge, knowledge of family members and friends, religious, social and cultural beliefs, customs and attitudes can be termed as indigenous knowledge. Based on this knowledge and other knowledge about therapeutic activities, family members as well as patients build and assess available health care options in the village. The substitutes are examined on the basis of assets, needs connected with the employment of the alternative supports and the resources the household had. This examination lets the villagers make a decision where to get the medical care services

from, when to ask for care, what to ingest, and what to use and not use. The decision-making process has described in figure 6.5.

The researcher has analyzed the strategy of the decision-making process of villagers. From the in-depth interviews with the respondents, it has been clear that the participants judged the decision-making process at every phase was as a mutual understanding process of family as well as community members. It is translucent, however, that the cyclical process of an illness episode defined at every phase express a allowable action of decision making founded on the cultural values, norms, customs, experiences, ideas, opinions priorities, and choices of patients, their families and community in the village.

Conclusion and the Way forward

7.1 Findings of the Study: At a Glance

The research was carried out to know about the health seeking behavior of *char* people in Bangladesh that is how socioeconomic, geographic and other factors contribute to the probability of utilizing health care and make it a successful event, and analyze respondents' opinion towards a different system of health care available within the society. It was conducted by using the both *emic and etic* approaches which were qualitative in nature and the research proposal was made based on the findings of field visit. Natural disaster prone *Char* Majhira under Sariakandi Upazilla of Bogra district was selected as the study area. 250 households of this village were considered as the study population. The household was the study unit. The head and aged people of the households were considered as key respondents. Primary data were collected from November 2010 to June 2011 by using simple random and purposive sampling method from 250 households through the triangulation of participant observation, in-depth-interviews and FGDs .

The previous chapters contribute a noteworthy approaching of the circumstances of the health system as it presents in *Char* Majhira. The information sketches what constitutes health systems, villager's health seeking behavior, the role of both the supply as well as demand side characters and cost of health care with the available health market.

The study area was chosen as this village is frequently affected by the natural disaster like river erosion, flood in every year and it was a remote village of this Upazilla. The transport system of this village is very shocking. There is a lack of all modern medical facilities located in the northern region of Bangladesh and logically fit with the rest of the rural as well as *char* areas in the country. The health access livelihood framework has played pragmatic role to identify the availability, accessibility, affordability, adequacy

and acceptability of health care facilities based on their present households assets in the study village. The conclusions derivatives from this study are relevant to improve the health of the *char* as well as rural people in the country.

The findings from the research plainly depicted the serious burden of illness prevailing in the village *Char* Majhira. It is highly prone to river erosion and floods. The total fertility rate in *Char* Majhira, during 2011 was 3.5. The infant and under-five mortality rates during 2011 were 48.0 and 63.4 respectively. Infectious and noninfectious diseases comprised the major causes of death. Life expectancy at birth was 67.2 years for males and 69.7 years for females in 2011. Average age at marriage for male and female during 2011 was 21 years and 16 years respectively. Ninety percent of the population was Muslims and the rest were Hindus. One-fourth of the population aged six years and above in 2011 had never attended school. 8% of the households had a radio, 4% had a mobile phone at home. About 76% of the households had family members who were members of an NGO'S (Non-Governmental Organization). 46% of the households had at least one member selling daily labour to make their living. 99% of households used river water for drinking. 87% of the households did not have any fixed place for defecation. The area was also characterized by the subsistence of socioeconomic inequities in various health indicators. The scenery of illnesses was a mixed bag of communicable and non-communicable illness. New born, children affected mostly from communicable diseases while the adolescents, adult and elderly suffered from non-communicable illness.

They identified the stages of illness as their views about the illness, causes of the illness, signs and symptoms of the illness and prevention i.e. home remedies of the illness. The villagers perceived the treatment provided by satellite clinic of NGO'S's and medicine shops another way for diverse conditions, the villagers preferring satellite clinic of NGO'S's for severe illness such as pneumonia among children, reproductive issues of women and medicine shops for all kinds of illness.

Conclusion and the Way forward

Harsh socio-economic condition and constantly climate change lead to the effecting of various illness in *Char* Majhira and developed a share standard of perception about various illnesses. Due to varied, personal, social, cultural and religious values they formed distinctive perceptions. 10 % of the local people identified behavioral causes that uncleanness and unhygienic practice may result the illness. 58% of respondents believed that their suffering was due to natural causes where 20 % peoples believed "evil eye" as a most important etiology of illness and 12 % respondents believed that the causes of their suffering were supernatural.

However, the fact that 199 landless ill person out of 297 visited both the popular and folk sectors for their illness stated in the chapter 4. Among the 199 landless illness people 54 were gone to the professional sectors for treatment. 37 patients of small peasant households were gone to the professional sectors while 85 of the same households were consulted with both the popular as well as folk sectors for the treatment. 11 ill persons from medium households were visited all sectors one after another respectively. But it is worth mentioning that, 2 persons from rich households were consulted only professional sectors outside the village. On the other hand the villagers have given 4 marks to the Satellite Clinic of NGO'S, 3 to the medicine shops, 2 to the family as well as self medication and 1 to the folk sectors like *Kobiraj/ Fokir/ Hujur (*folk healers*)* while they asked to give mark the respective health care options available in the village out of 10. This indicates that both the popular and folk sectors are a major player in the healthcare system in this village for the lacking of the availability of professional sectors like satellite clinic of NGO'S as well as others. The satellite clinic of an NGO'S having been very much a part of the village and is an inseparable part in the existing health care system. It founds in close vicinity to the villagers and is accessible for definite days in every week. It offers services with very low or without an advice fee.

This finding is also reliable for the situation in the rural area of the country as a whole. The cost of health care of the satellite clinic of an NGO'S was also considerably lower than health assistant and its availability has affected the villagers to a great extent. The

definite work hours and payment system of the satellite clinic made the villagers a rational choice.

The study tried to accumulate the concerns of health facilities prevailing on *char* lands. The researcher paid an attention to the villagers' individual opinions about their health demands and the essential aspects to have an easy access to health services and how to get over the existing constraints in the study area. While discussing in focus groups, which was the important process of checking conversation with the villagers, the researcher identified that health care was a big question in respect to the *char* lands. All the villagers said that there is *"No Frequent Assistance (NFA)"* and *"No Instance Assistance (NIA)"* on the *char*s.

The question of culture of poverty and remoteness was recurrently remarked as a key hindrance by the villagers. In order to improve health conditions on the *char*s, *Execution of Modern Transport (EMT)* needs to be considered immediately. The villagers pointed out frequently that due to the distance and the transport problems patients risk is increasing day by day. The counselor also pointed out that transport, especially in emergency cases such as during delivery, is highly imperative. So, a key attention needs to be attached here.

Another inner problem the villagers were keen to address, was the *Lack of Professional Physicians (LPP).* The focus group discussions claimed that professional practitioners are essentials in order to execute the medical necessity of the villagers. During the study period, the researcher did not find a single full time health assistant with proper qualification. On the other hand, two types of pharmaceutical training exist: one of 3 months and another of 1 year. All the medicine shop owners who were working as part of the professional workforce in the village didn't have any training. To become a pharmacist here, it is essential to carry out a training, to receive the appropriate certificates from the respective institutions and eventually achieve a license before they are able to launch a medicine shop.

7.2 Recommendations

From the previous discussion, it can be said that, to improve the health as well as livelihood status of the study people, both the short term and long term initiatives should be taken. The initiatives are as follows

7.2.1 Immediate Initiatives

1. The activities of satellite clinic of the NGO'Ss should be strengthened.
2. The satellite clinic of the NGO'S has to be opened for 6 days in a week.
3. To create awareness in the family as well as a community, the schooling children should be given primary health care training in which they can serve their family or community during the emerging crisis.
4. The Union Parishad (UP) should take responsibility to form Youth Volunteer Community Health Provider (YVCHP) to serve their community in respect to primary health care.
5. The UP should take responsibility to form Mother's Club (MC) in which they can discuss about their individual problem as well as work as a referral centre for severe cases.
6. The UP should take responsibility to train the shop keepers of medicine in which they can advise the villagers in the right path.
7. At least 3 emergency vehicles like votvoti, van and boat should remain in reserve in the respective areas of union councils in which the villagers can use it in crisis hours.
8. Community leaders or aged people of the village should form a mutual fund to face the emergency crisis as required to its member.
9. Trained Village Doctors or paramedics should be deployed from the Upazila Health Complex in the village immediately, who will stay in the area as a member of the village.
10. "Tele Medicine Campaign (TMC)" should open in the village by using the YVCHP, MC of the village.

11. "Village Health Watch Committee (VHWC)" should be formed by the villagers under the guidance of Upazila Health Complex in order to supportive supervision, monitoring as well as evaluating the activities TMC, YVCHP, MC and Village Doctors/Paramedics.

7.2.2 Long Term Initiatives

1. The community clinic should open as early as possible.
2. Seasons based means of transport like van, votvoti, boat should be increased by involving private entrepreneurships in the area under the guidance of District Commissioner.
3. "Income Generating Activities (IGA)" should be strengthened in the *char* area based on local knowledge.
4. "Village Knowledge Centre (VKC)" should be formed by the UP to collect, analyze, and accumulate indigenous knowledge regarding the illness of the villagers in order to spread among them through TMC, YVCHP, MC and VHWC.
5. The UP should take responsibility to install at least 2 (two) tube-well for every 20 families and 3 (three) sanitary latrine for every 5 families in the village.
6. The government should take initiatives to enhance the capacity of existing educational institutions to educate the people to a great extent.
7. Finally, the activities of non–governments organization which are running their programes in area like Thengamara Mahila Sabuj Sangha (TMSS), Gram Unnayan Kendra (GUK) and Grameen Mohila O Shishu Unnayan Sangstha (GMSUS) should be enhanced in the village through the proper guidance of the Char Livelihood Program (CLP).

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Appendix 1: Socio-Economic Information Checklist.

1. Name of the respondent
2. Age of the respondent
3. The sex of the respondent
4. Education of the respondent
5. Profession of the respondent
6. The religion of the respondent
7. Head of the family
8. Number of educational institutions
9. Types of educational institutions
10. Use of radio
11. Number of hats/bazaar
12. Number of mills
13. Use of mobile phone
14. Structure of households
15. Name of NGO working in the village
16. Number of family members who associated with NGO
17. Fixed place for defecation in the households
18. Source of drinking water
19. Name of the transports of the village
20. Peoples migration (in and out) annually
21. Time of migration
22. Place of migration
23. Causes of migration
24. Number of marriages during the field work
25. Age of marriage

Appendix 2: In-Depth Interviews/FGDs Checklist for Both Male and Female.

1. What are the most common illnesses of your village?
2. Please, say about 10 most common illnesses of your village.
3. What are the local terms of illness available in the village?
4. What are the types of illnesses of your family suffering from last 6 months?
5. Who are the most vulnerable groups for Illness?
6. What are the common and severe illnesses of newborn?
7. What are the common and severe illnesses of children?
8. Are the newborn fall ill frequently?
9. Are the children falling ill frequently?
10. How can you tell that a child/newborn has got this illness?
11. What are the most common and severe illnesses of adults?
12. Are the adult falling ill frequently?
13. What are the most common and severe illnesses of elderly?
14. Are the elderly falling ill frequently?
15. Who are the common health care providers of the village?
16. Who are the first, second and third health care provider?
17. What are the roles of health care providers?
18. What are the most common illnesses of women in the village?
19. What are the causes of illness – newborns/children/adolescent / adult and elderly?
20. How are peoples of this area expressing their views on various stages of illness?
21. What are the sign and symptoms of illness - newborns/children/adolescent / adult and elderly?
22. What are the prevention practice of newborns/children/adolescent / adult and elderly?

23. Why and when are people exposing their sign of illness?
24. What are their beliefs and understanding regarding illness?
25. How the sufferers perceive their own condition?
26. How other people behave towards them?
27. What are the curative systems available in the area?
28. What are the social and cultural aspects of health care, pluralism in the village? What are the perceptions of the villagers in this case?
29. What is a popular sector of health care?
30. Who are involved with the popular sectors?
31. Who are the main providers of popular sectors?
32. How many money is needed to take service from popular sectors?
33. Who is usually taking services from popular sectors?
34. What are the practices of popular sectors to take service for the illness of newborns/children/adolescent / adult and elderly?
35. What is a folk sector of health care?
36. Who is involved with the folk sectors?
37. Who are the main providers of folk sectors?
38. How much money is needed to take service from folk sectors?
39. Who are usually taking services from folk sectors?
40. What are the practices of folk sectors to take service for the illness of newborns/children/adolescent / adult and elderly?
41. What are the general folk treatments available in the village?
42. What are the components of folk medicine?
43. How material components folk medicine consists of?
44. How non-material components folk medicine consists of?
45. Which plants are usually used in the village for treatment of illness available in the village?
46. What is a professional sector of health care?
47. Who is involved with the professional sectors?

48. Who are the main providers of professional sectors?
49. How much money is needed to take service from professional sectors?
50. Who is usually taking services from professional sectors?
51. What are the practices of professional sectors to take service for the illness of newborns/children/adolescent / adult and elderly?
52. Why and when are people choosing these curative systems?
53. What is decision making process for Illness?
54. Who are the decision makers to take a particular option of health care?
55. How a decision is taken for any particular options?
56. What is the process of analyzing illness episode?
57. What is the first choice of the villagers to take the particular option?
58. Why they are or are not satisfied to take the particular option?
59. How will you mark the available health care option in the village?
60. Which things work as a key catalyst to make decisions regarding this?
61. When people usually take decisions to seek health care?

Appendix 3: FGD Checklist for Female.

1. What are the most common illnesses of your village?
2. Please, say about 10 most common illnesses of your village.
3. What are the local terms of illness available in the village?
4. What are the types of illnesses of your family suffering from last 6 months?
5. Who are the most vulnerable groups for Illness?
6. What are the common and severe illnesses of newborn?
7. What are the common and severe illnesses of children?
8. Are the newborn falls ill frequently?
9. Are the children falling ill frequently?
10. How can you tell that a child/newborn has got this illness?
11. What are the most common and severe illnesses of adults?
12. Are the adult fall ill frequently?
13. What are the most common and severe illnesses of elderly?
14. Are the elderly falling ill frequently?
15. Who are the common health care providers of the village?
16. Who are the first, second and third health care provider?
17. What are the roles of health care providers?
18. What are the most common and illnesses of women in the village?
19. What is menstrual regulation?
20. What is the cause of menstrual regulation?
21. What are the practices of women during the period/monthly cycle?
22. Are the antenatal, delivery and post natal services available in the village?
23. What are safe delivery kits? How many women (you) use it?
24. What are the households works you do during pregnancy?
25. What is the practice of diet during pregnancy?
26. What are your ideas about your health?
27. Who are responsible for taking a delivery case?

28. How many deliveries conducted by *dai* (birth attendant) in the last 6 months?
29. Which sectors usually used by you during pregnancy for any illness?
30. How many women (You) are suffering for delivery related complications?
31. Please, say the name of these complications
32. What are reproductive tract infections?
33. How many women (You) are suffering from reproductive tract infections?
34. Please, say about the duration of your sufferings.
35. What are the sign and symptoms of reproductive tract infections?
36. What are contraceptives?
37. How many contraceptive methods are available in the village?
38. Which contraceptive methods are useful for you?