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LOCAL PERCEPTION OF ILLNESS AND HEALING: RURAL HEALTH PRACTICES AND DEVELOPMENT IN BANGLADESHI VILLAGE

***Ishrat Jahan**

Department of Anthropology, University of Dhaka, Dhaka-1000, Bangladesh

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ABSTRACT

Like in many developing countries, in Bangladesh, health is regarded as 'an important index of human development' (Government of Bangladesh, 2013). To develop a global partnership for development the Government of the country puts enough weight on reducing child mortality, improving maternal health along with combating diseases with a commitment to ensure environmental sustainability (Noorani, 2008; Rahman, 2010). Health reforms, aided by national health policy and pro-poor health projects focus on immunization for children and contraception based family planning. Often such reforms do not take into account the role of indigenous medicine as informal health care arrangement in rural areas and prioritize modern medicine reflecting a western orientation towards understanding illness (Vaughan *et al.*, 2000). Particularly women's understanding of their health and illness and their indigenous knowledge of healing remain largely unnoticed or ignored. This article tends to understand the indigenous insights of traditional medical culture of Char Khankhanapur and Decree Charchandpur, two villages of southwestern Bangladesh and the consequence of modern medicine on local healing. I highlight people's indigenous perception of illness and healing and discuss about local health practices. It is important to understand local healing practices in rural Bangladesh to realise the impact of western oriented development in local lives. My aim is hence to see how local villagers understand illness and healing and how women work as healers using their herbal and religious knowledge to treat certain illness. This article critically investigates whether western medicine negatively affects local way of healing.

INTRODUCTION

Local perception of *oshukh* (illness)

People identify *oshukh* (illness) differentiating between *shorirer oshukh* (bodily ailment) and *moner oshukh* (mental illness). They perceive most illness as *bhagger lekha* (written in fate) and as *obhishap* (curse of God). If any one dies of chronic illness they believe that as an act of God, preferably as a form of natural punishment for a previously done misdeed rather than as a consequence of suffering from disease. Both men and women belonging to poor or rich households consider sexually transmitted diseases (STD) as *gopon oshukh* (secret disease) which is shameful to acknowledge publicly. They consider illness caused by unexplained reasons as *gayebi oshukh* (supernatural disease) which includes *jin-e-dhora* (evil spirit possession), *batash laga* (unknown disease brought by bad wind), *tabij kora/baan mara* (black magic/sorcery) and *bhut-e dhora* (possessed by ghost). According to them, some illnesses are gendered. For instance, women's diseases are seen as *meyeli oshukh* (feminine disease) which comprises of gynaecological problems such as menstrual irregularities and infertility. Some men and women consider menopause as an illness as it indicates a loss of womanhood and child bearing capacity. While western medicine understands infertility can be either with men or women, many poor men and women believe that infertility is merely a woman's illness and men do not have anything to do with the problem associated with childlessness. I found 20 cases at Char Khankhanapur and 15 cases at Decree Charchandpur where men took several wives if they had failed to become fathers. The hope remained that newly married women would bring offspring in their families. Poor men often do not consider women's ailments such as minor cuts and burns, fever, back pain and headache as *oshukh*. They call it *shorir kharap howa* (deterioration of health condition). Poor women also think the same. They believe that if they are *oshustho* (ill), they cannot work and look after their families. To treat minor ailments such as pain

****Corresponding author: Ishrat Jahan***
Department of Anthropology, University of Dhaka, Dhaka-1000, Bangladesh

and high temperature they prefer to depend on home remedies or herbal medicines. Only if the situation worsens and getting cured is beyond their capability, they notify to their husbands to seek allopathic treatment provided by informal drug sellers or government sponsored clinics and hospitals where low cost or free treatment is available. Both rich and poor, see bodily ailments such as fever, cough, skin rashes and stomach upset as naturally occurring illness believing human beings as prone to infectious diseases. They do not consider old age as illness. According to them, it as a normal process people reach as a stage of life cycle. Poor men and women are unaware of modern medical understandings associated with concepts such as heart problem and kidney dysfunction. They define tuberculosis as *Allaher shasti* (wrath of god) and a fatal illness which cannot be cured. Skin diseases such as eczema and acne, jaundice and eye infections are minor ailment from their point of view that can be easily cured by local medicines. They interpret leprosy in a similar way and term it as *gozob* (curse of God) and believe that if someone tries to treat leprosy, he or she will be cursed too due to direct contact with the infected one.

Elder men and women regard illness among children as a consequence of evil eye which they call *chokh laga* (bad sight). To shield from the effects of the evil eye mothers mark a black spot of kohl at either side of the forehead of their children. If someone praises a child's health and good attributes in front of his or her mother, the mother spits on the child believing that spitting can prevent her child from the harm of the evil eye. Many people believe enmity as a precondition of sorcery. They think that someone may suddenly become ill if he or she falls prey to black magic of the sorcerers appointed by their enemies. They however differentiate between evil forces caused by humans and those initiated by malevolent spirits or souls. Muslim men and women believe that ill conditions in human lives are brought by *saitan* (devil) as the most sinful spirit of the world and some bad souls called *jin* who dwell on earth as separate entities. Some Hindu men and women perceive illness or bad health to be caused by resentment of the goddesses whom they fail to satisfy by their worship and sometimes by *pretatta* (evil spirits). They believe that if someone ridicules or acts harshly towards an ill person, the illness transfers to him or her and cannot be remedied unless pardoned by the person ridiculed.

Poor and non-literate women often perceive psychological illness such as hysteria to be caused by ghosts and bad spirits. They classify psychic patients as *bhut-e dhora* or *jin- e dhora rogi* (patient possessed by ghosts or evil spirits). According to them, such patients' conditions cannot be related to madness as they possess unexplained force within them not common to human beings. Murdock (1980:19) explains similar illness in some traditional societies caused by 'some personalized supernatural entity- a soul, ghost, spirit or god'. Some poor men and women think that certain illnesses are not curable with modern medicines and require traditional therapies. Mostly, ailments in this category are caused by supernatural elements such as souls, spirits that need traditional healing. If children experience nightmares and cry at night parents take them to traditional healers. They believe that symptoms such as erratic social behaviour among individuals, memory loss, physical weakness, menstrual problems and sexually transmitted illnesses can get worse with modern medicine. Women healers classify illnesses into specific categories. For instance, they treat minor physical illnesses such as diarrhoea, abdomen cramps, skin diseases, eye infections and pain by preparing *bori* (tablets) with plant and flower extracts, *potti* (bandage made of dried leaves) and *puria* (syrup prepared from tree sap). Supernaturally caused and psychological illnesses such as fear, mental weaknesses, bad spirit attacks by *bhut* (malicious spirits) and child birth difficulties are cured by *fu deya* (reciting and blowing religious verses from the holy Quran or Veda in sick person's ears), *pani pora* (gusting sacred words to bless water) and preparing *tabij* (amulets by inserting written verses of holy scriptures into them). They do not go through spirit possession for curing the ill. Sometimes poor and some rich women ask women healers such as *pir* and *fakir* for infertility treatment believing that spiritual healing can enable them to become mothers. Nahar (2010) showed some cases where many rural and urban, middle class childless women perceive childlessness as illness caused by *obhishap* (curse of God), not to be cured by modern medicine.

Existing health care arrangements in rural areas

In confirmation of Claquin's (1981) findings that rural areas are not health care deserts, without any healing mechanisms, people at Char Khankhanapur and Decree Charchandpur have their own health management and belief systems, which are comprised of informal, as well as formal, health care providers. Often informal health care providers like village doctors, uncertified local pharmacists and drug sellers, *dai* (untrained, rural midwives) *kabiraj* (herbalist)*, pir (*spiritual healer*), fakir* and *huzur (*religious healer*)* do not have modern medical training and institutionalized certificates to dispense medicine, or to do medical treatment. Formal health care providers are medically trained officials and para-professionals, such as the physicians, nurses, community clinic health officers and paramedics (Wahed *et al*, 2012) who work in community clinics and local health centres.

Sick people turn, first, to locally accessible untrained health carers, but if their situation worsens, sometimes they turn to bio-medically qualified doctors at hospitals and clinics (Molla, 2007; Begum, 2012). Hasan (2012) showed that, sometimes, unavailability of trained health professionals in close proximity to their homes is a crucial factor when poor people have to make decisions about selecting health care options. While some rich men and women visit hospitals and clinics, most poor men and women choose traditional health care providers, as they are inexpensive (Claquin, 1981). Due to absence of women health carers in the formal health sector, and the tradition of *purdah* (seclusion), some rich women and many poor women tend to visit traditional female herbalists, instead, who treat illnesses and accidents with alternative medicines, such as *pora pani* (religiously blessed water), *tabij* (amulets) and *gasra* (herbal ointment). Particularly for child birth, they prefer to go to *dai* (midwives) instead of clinics.

Women in health care

Certain poor, elderly women work as professional healers for minor ailments through the use of herbal and spiritual remedies. Their age is significant in this context, as in old age they attain the menopausal state, and so can get involved in extra household affairs, being freed from reproductive

responsibilities. McClain (1989) suggested that postmenopausal status helps women enter the public domain, and to exert authority. Working as healers allows these women not only with the chance to secure an auspicious position in the society, but also provides them with a financial source. It also serves as a separate identity for women, that of traditional curer (McClain, 1989: 2). Healing is not always associated with witchcraft, as the case in some other Muslim societies such as Saudi Arabia (Doumato, 2000). Finerman (1989:25) found some mothers and grandmothers in Andean Indian communities diagnose illness of family members, and relieve it by home curing. I noticed that treatment by family members is regarded as the most appropriate first step towards curing a sick person. For example, in case of healing minor ailments such as coughs, women prepare ginger tea or mix honey with tea as remedy. To treat fever, women of the household put a wet cloth on the forehead of the ill person to minimise their rising body temperature. For curing heat strokes, they make a poultice with lentil paste and leave of local *pipul* (*Piper sylvanticum*) *tree*, and place it on their child's head to soothe the heating sensation. Werner *et al* (1993) noted that mothers appear to be the primary care givers and healers in the rural areas, when no doctors or other medical professionals are available.

He showed how mothers help prevent new born babies' stomach upsets, simply by breastfeeding and treating diarrhoea by feeding their young infants with rice water, or other forms of sweetened liquid, to maintain the balance of the water level within the babies' bodies. I found that during home curing of mothers offer emotional support and encouragement for children. Older women, usually grandmothers, work as *dai* (midwives). Among the Hindu of Char Khankhanapur *dai* belong to lower castes as midwifery is culturally constructed as polluting and a low profile job. Like the traditional *aji* (birth attendants) of Newar village in Nepal (Johnson, 2002), *dai* learn the skill of managing birth from their mother or mother–in-laws. They do not receive any formal training, from the government or non government organizations about child birth and hygiene. An expert *dai* is known as *bhalo dai* (good midwife) as she manages birth successfully, without any complications. According to Rozario (1998) *dai* are informed early, when families are expecting child birth, and are called upon when the time of child delivery is near. However, in poor households, elderly women firstly try to assist the child birth, and if situation worsens they call a *dai*.

While assisting in child delivery, the *dai* usually uses a thin bamboo slice, or blade, to cut the umbilical cord and tie it with cotton thread (Abdullah & Zeidenstein, 1982). They put hot heat pads made of cloth, and apply warm mustard oil to help heal new mother's birth wounds, which they identify as *kacha gha* (infection). As experts, they also suggest the types of food to eat, and how to avoid after child birth problems, and for quick recovery from birthing weaknesses. Hindu and Muslim *dai* believe that the entire process of child birth is polluting, and should take place at a separate location, other than the living area. They call it *atuur ghor* (delivery room aside house) where women stay for about five to seven days after giving birth. It is near this special room that the *dai* buries the placenta, immediately after a child is born. Rozario (1998) found that, locally child birth is perceived as a polluting phenomenon. *Bhut* (malevolent spirits) tend to roam the house ready to attack women giving birth, causing harm to mother and her newborn baby. Poor women and some rich women, who prefer home births, confirmed Rozario's findings of birthing' mothers being forbidden to come out of the delivery room, until the danger of spirit attack is considered to be over. To prevent *bhut* and its malicious activities, the *dai* sometimes asks the families with new born babies to obtain blessed water and amulets from the local spiritual healers. Although there are local family welfare centres (FWC) and community clinics, where poor women can avail themselves of pre natal and postpartum care, they still depend on *dai* for child delivery. Rozario & Samuel (2002) identified certain reasons behind this choice. One of the main reasons is that they perceive bio-medicalization of child birth as unfriendly, whereas with a *dai* they can have a humorous and cordial social relationship. Poor women often complain that doctors and nurses at hospitals and clinics behave arrogantly with them, and show hostility and negligence, and consider the local customs of *dai* led child birth, as superstitious and bad practice. Another reason is the observance of *purdah* of some poor, and rich Muslim women who do not want any male medical personnel to examine them during child birth (Rozario & Samuel, 2002). Molla (2007) found an instance where the decision of whether women should give birth at home or clinic, depends on the decision of their husbands.

He found some rural men who consider it as loss of *izzat* (prestige) if women of their families need male doctors' assistance, during what they consider is a private and wholly female event, such as child birth. Biomedicalization of birth has affected some poor and rich women. I can illustrate this with Halima's case, one of the poor women of Char Khankhanapur. Halima is married to Hamid, a poor rickshaw puller, and has had three daughters in the 10 years of her marriage. Hamid and his parents were desperately looking forward to having a son. During the sixth month of her fourth pregnancy, Halima went to the local community clinic for antenatal scan, to detect any birth anomalies of her unborn child. Her husband and in-laws eagerly wanted to know the sex of the child. When they came to know that she was going to give birth to a daughter again, they became very upset and angry with Halima as if it was her fault. Following the scan, Halima's in-laws and her husband started to torture her mentally, and were reluctant to give her sufficient food containing the necessary nutrients. This made Halima severely anaemic and under nourished. On 6th January, 2011 she gave birth to a malnourished daughter who died 15 days after her birth.

I found 10 similar cases at Decree Charchandpur, indicating how western medical system of antenatal scanning, leads to negligence of mothers if scan results do not show the desired sex, and increases the chances of maternal death and child mortality, due to lack of care, malnutrition and proper treatment. Some rich women, complaint that the doctors prefer to perform a caesarean operation as a mode of child delivery and demand much money from the mothers and their families. Such a procedure not only pushes households to undergo additional financial pressures, but also endanger women's health in terms of suffering from post operative illnesses such as pain and infections. *Dai* who have self respect and social dignity (Rozario, 2002:140), as experts in child birth, are also badly affected when child birth becomes increasingly

mechanized. To them, it is not only an economic loss, but also a social disappointment to experience the hammering down of their identity and power, as expert birth attendants. They consider that medically assisted birth is a cultural threat to child birth rituals, and see it as *faad* (trap) of modern medicine based health services. Most often women healers are called *nani* or *dadi* (grandmother), because of their old age and traditional healing expertise. By such terms poor men and women who depend on indigenous medicine for cures, maintain fictive kinship with them. Read (1966) showed how healers, in some traditional societies, create for themselves an atmosphere of trust and confidence, in the minds of their patients, by showing detailed interest to learn about their patients' problems. Women healers in Char Khankhanapur and Decree Charchandpur, also maintain the same delicacy of relationship with their patients, being indifferent to whether the women are poor or rich, and allow easy access for private consultation.

Women's knowledge of plants and expertise in indigenous healing

Poor women possess an extensive knowledge of their ecological environment, and employ their indigenous skills to make the maximum use of it (Sachs, 1996). They learn from childhood about the plants that grow in the fallow agricultural lands, home gardens and along village roads. As health managers of their family members, they depend on local plant species for the purpose of healing minor illnesses, which they believe can be cured better by home remedies, rather than modern biomedicine. It is in this way that poor women retain control over health care practices, and use their knowledge and experience of healing as 'a source of authority for them within the household' (Wayland, 2001: 174). Many poor women believe that modern medicine, available at local pharmacies, is detrimental to health, due to their life threatening effects. This is evident in the following statement of Jesmin Ara, woman of a poor farming household at Decree Charchandpur who had recently experienced some adverse effects of biomedical treatment:

'*Last year, before I could understand anything, I was pregnant for about 4 months. I had, already, two daughters, named Sonia, aged 6, and Rima, 5. Though I had a pressure from my husband to give birth to a son, I did not want to become pregnant again. My mother-in-law was old and ill, and my sister- in- laws did not live with us, so I had to do all the household chores and care for my children and animals. Once I discovered that I was pregnant again, I asked my husband to do something about getting rid of the unplanned pregnancy. Though he was not ready to listen to me, I managed to convince him, because none of us wanted our neighbours or relatives to know about the pregnancy, and the plan to abort the child, so my husband did not call the* dai *or go to any traditional healer. Instead, he brought some medicines from a local drug seller, but, after taking the medicines I began to bleed which continued for sixteen days at a stretch, and I was becoming weak and pale. Nothing could stop the bleeding, and when the situation worsened my husband took me to a* kabiraj. *The* kabiraj *examined me and gave me some plant shoots to chew until the bleeding stops. I started to take the roots after each meal for about a week, and which started to cure me. If I was taken it earlier, and hadn't taken the medicine from the local drug shop, I wouldn't have suffered.'*

Though Wayland (2001) found that biomedical practitioners undermine rural women's therapeutic knowledge, and refer them as 'incompetent' and 'uninformed', women healers claim that they have sufficient knowledge about healing, and that patients are cured after they take indigenous medicines. According to them, as they collect ingredients from nature, for preparing medicines, they do not have harmful with side effects. In their opinion by healing with the use of natural medicines, help people to recover more quickly, than with *bideshi oshudh* (modern medicines) sold by the local pharmacies.

Rahima, *kabiraj* of Char Khankhanapur aged 50, described that once a young girl came to her to obtain a cure for healing scars of acne, which she treated successfully, by applying coconut water and by telling the girl to apply a paste made of turmeric and lentils on her scars. If someone has, he/she is advised to make a paste of the leaves of local *kadam* (*Anthocephalus chinensis*), tree and put it in a poultice, and apply it on the affected place for three days. After three days he/she should wash the place thoroughly with warm water, and apply *chun* (a mixture of limestone), *holud* (turmeric) and *shorishar tel* (mustard oil) to heal the rashes. For treating eye infections, such as *sani pora* (eye disease with cataract) Rahima uses the young branches of a local shrub called *koi urhar*, which she sweeps twice around the infected eye during sun rise. According to her, local medicines should be applied at different times of the day, depending on the type of illness. For example, she applies *modhu* (honey) with *dalimer ful* (pomegranate flower) for curing *mukhe balai pora* (mouth ulcers) only in the afternoon.

Rahman *et al* (2011) showed that in the Patra community of north-eastern Bangladesh, older women possess a vast knowledge about the identification of medicinal plants and preparation of medicines. Younger women learn about the indigenous medicines from elderly women. I found that women healers identify certain plants as being medically useful for treating common ailments. For example, they use leaves of *bashok* (Adhatora *vasica Nees*) for treating ailments due to colds, asthma and piles; bark of *arjun* (Terminalia *arjuna*) to cure dysentery, diarrhoea and heart disease; fruits of *amloki* (Emblica *officinalis*, L) and *tetul* (Tamarindus *indica*, L.) to heal loss of appetite, vomiting, skin disease and digestive difficulties and use *neem* bark and leaves (Azadirachta *indica* A.Juss) to treat chicken pox, skin diseases, ulcer and diabetes.

Rozario (2002) found that the *dai* (midwives) have extensive knowledge of indigenous plants, which they use during child delivery. They tie roots of certain plants to the mother's thighs until she delivers, and then throws them away as soon as the child is born. She noted, also, that the *dai* scatters mustard seeds around the birthing hut, to prevent the attack of *bhut* (malicious spirits). I also noticed that the *dai* have a knowledge of plants significant to child birth. For instance, they believe that leaves of young pomegranate trees are useful in relieving labour pain, and tying sheets of young coconut leaves to mother's legs help minimizing the swelling of feet. Besides having of knowledge of traditional healing, poor women possess knowledge of indigenous herbal medicines, used for maintaining regular health. Idrisi *et al* (2010) found that women cook the bitter flowers of *Phlogacanthus pubinervius*, locally known as *titay*, with rice, in the Rangit

valley of South Sikkim, to regulate blood pressure and smooth body functions. Similarly, I found poor women making a paste of a local grass called *thankuni pata* (Centella *asiatica*) and *kali jeera* (black cumin seeds) and eating raw cloves to lower cholesterol. Often they take *lebu* (lemon) for preventing indigestion. They select roots and leaves of *kochu* (*Colacosia exculenta*) and *mankochu* (*Colacosia affinis Schott*) to obtain relief from constipation and mouth disease, and to prevent anaemia in pregnancy. For relieving the itching sensation of insect stings, they put onion on the affected area, and use *Tulsi* leaves (*Ocimum sanctum* L.) as an effective home remedy for coughs and stomach ache. To stop bleeding from minor cuts, they use marigold leaves (*Tagetes patula*) which are grown as ornamental plants. They, also, use *mehendi* (paste of henna leaves) for beautification, and prevention of hair loss and dandruff. Women healers differentiate their knowledge of indigenous healing, from that of male healers. For example, they say that while male curers provide medicines for sexually transmitted diseases, prostate gland infections, premature ejaculation and sexual problem such as erectile dysfunction, they, the women, prepare medicines for menstrual problems, ovarian infection and genital infections. They claim that they acquire their healing knowledge as part of *shongshar* (managing family) and say '*meyelok meyeloker oshuk bhalo bujhe, purush manush meye manusher koshto bujhe na* (women understand women's illness better, as men do not understand women's problems)'.

Tradition male healers

While Achterberg (1990) suggested that healing is a gender based profession, I found women curers as family carers, *dais*, herbalists and spiritual healers, whereas male healers as *palli chikitshak* (village doctors), *kabiraj* (herbal curers), *daktar* (local drug sellers), *ojha* (snake bite healers), *huzur* (religious guide), *pir* (magico-religious guide) and *fakir* (spiritual curers). Each type of healer cures illnesses according to his/her traditions and experience. Ahmed *et al* (2009) categorized traditional healers, as community health workers, village doctors and local drug sellers (untrained allopath), *kabiraj*, non secular faith healers, traditional birth attendants and homeopaths. Similarly, Patowary (2013) identified the presence of para professionals and community health workers, unqualified allopathic providers and local drug sellers, *kabiraj*, traditional birth attendants and homeopaths. Ghani (1990) found the existence of *Bede* as traditional healers in some villages and Gardner (1995) noticed presence of some *jhadu-kor* (magicians) in Sylhet. Though I did not find any *Bede* or *jhadu-kor*, I noticed some *pir* performing magical practices such as *hat chalan* (moving hand), *dim pora (magical egg)* and *ayna pora* (mirror reading) in response to villagers' requests.

Male healers are not trained professionally, and gather healing experiences through apprenticeships. Though the village doctors do claim that they receive training from government sponsored training programmes, in reality they do not attend such trainings. Some say that they have learnt about symptoms of illness and healing from their fathers, who were, also, village doctors. Wolffers (1988) found a similar type of informal medical practitioner in Srilanka, called *paramparika*, who take on curing as a *parampara* (tradition). H*uzur, pir* and *fakir* are most popular among the poor men and women, and some rich women, because of their charismatic healing power, through religious and magical spells exercised through the *jinn*. *Huzur* and *fakir* often have connection with *pir*, as they attend *orosh* (local religious festivals) (Kemp, 2002). *Huzur*, also known as *moulana*, are spiritual persons, dedicated to Allah (God) and who spend many hours in the *masjid* (mosque) for *namaj (prayer*). Mojibor *moulana*, aged 65, is a popular religious healer at Char Khankhanapur. He dispenses *tabij* (amulets)*, pani pora* (blessed water) and *tel pora* (blessed oil) based on *surah* (verses) from the holy Quran. He differentiates himself as being more important than the *pir* and *fakir*, by stating the following:

'I do not heal all types of illnesses or deal complex cases like enmity and disrupted social or matrimonial relationships, which s*ome* fakir *and* pir, *do in exchange for money. I prefer to cure the illnesses that the local people believe that I can cure, by applying Allah's* kalam *(religious prescription). Mostly, such illnesses include fear from evil people and spirit attacks, unexplained sickness that tend to repeat, despite having herbal or allopathic treatments, preventing* bod nozor *(evil eye) and applying* bondh *(protection) as a mode of protection from* Saitan*, the Devil, who is responsible for all evil on this earth.*

I need to take help of some good jinn *(spirit) to perform healing, along with reciting* surah *(verse from the holy Quran). For this I need to keep myself pure all the time, through prayers, and do not allow my soul to get contaminated by practising sorcery that requires application of black magic, which is aimed at harming people. I wake up very early in the morning around 3.30 am, and start praying the* tahajjud *(a prayer which is considered to be the most favourite and significant to Allah, when communicating with Him) and recite* surah jinn*, a particular* surah *that describes the* jinn*. However, I need to be very careful while reciting the* surah*, as during the process several* jinn *dwell around me. If, mistakenly, I recite wrong words, bad* jinn *can cause harm to me, even death.*

I prepare tabij *by writing relevant* surah *on blank white paper. Then I wrap it up and put it inside the cover of the* tabij*, and seal it with melted wax or candle. I ask people to tie this* tabij *to different parts of their body, generally, the arms for the adults and waist for children. I, also, prescribe* pani pora *(blessed water) and* tel pora *(blessed oil) by silently reciting certain* ayat *(lines from verses of the Quran) and blow it onto the water or oil brought by the people who come asking for cures. In doing all these, I charge a sum of small money as* hadiah *(remuneration) as a source of income, but, if someone is not capable of paying anything, I do not pressurize him or her, as I consider that is a* gunah *(sin).'*

Dependence on *pir* (magico-religious guide) is also popular. As part of faith healing, poor men and women become a *murid* (follower) of different *pir*. Many *murid* of Char Khankhanapur are followers of Manik Pir, who lives at Panchuria, a village near Char Khankhanapur, whereas *murid* of Decree Charchandpur follow the Hazrat Maulana Hashmatullah Faridpuri *pir*, who live in Atroshi, Faridpur. They call their *pir huzur* or *pir shaab* to show respect, as they consider it to be *beyadobi* (bad conduct), to call *pir* by their names. It is rare that *murid*, or even one *pir* go to other *pir* for healing, believing that by doing so one becomes a *beiman* (traitor) and loses the right to obtain benefit from the spiritual and religious

pir. Though the Atroshi *pir* claimed, that he does not take part in sorcery and works as a religious and spiritual guide, some of his assistants told me, that sometimes he does magical healing when his *murid* request him. They pinpointed that the *pir* often acts as shaman for healing *bann mara* (effects of black magic). I found some *pir* doing sorcery in exchange of money. As Hasnat Mollah, a local *pir* of Decree Charchandpur put it, '*If someone comes to me with a case of stealing, I start the process of* hat chalan *by casting spells on the hand of the accused. This will let his/her hands become disabled for the time being, and help me identify the thief*'. Gardner (1995) found a similar application of *jhadu* (magic), where through the use of mantras, *kabiraj* can see the face of the thief on a piece of paper, by immersing it in water. *Dim pora (magical egg)* and *ayena pora (mirror reading),* according to Hasnat Mollah, are also effective.

For example, he explained, '*in case of* dim pora*, I memorize some religious spells which I blow on an egg. If anyone has caused any loss or harm to others, once he/she eats the egg and starts vomiting, he/she starts to become weak and pale. At this point, the person admits his/her evil works and asks for forgiveness. If forgiven, the spell is withdrawn and he/she starts to heal*'. He further asserted, '*though I know it is not ethical to do this, I practice sorcery because of people's constant request for me to do so. It also brings a lot more money than what I get from other source of healing. For doing this I ask my clients to bring some specific materials, such as the roots of certain trees and use stuff, or body elements such as hair or nails of the person to be spelled on. Sometimes I also prepare special* tabij*, which has magical effects on the person on whom it is applied. This includes physical and mental illnesses such as* mukh baka howa *(deforming of facial structure),* pa kamrano *(leg cramps),* matha kharap howa *(madness),* fosholer khoti *(destruction of crops) and* batash laga *(bad air)*'.

Kabiraj (herbalists) heal less severe illnesses such as headaches, pain and fever by prescribing herbal medicines, *tabij* and *mantra* (spell) (Gardner, 1995), and *ojha* (snake bite healer) to cure snake bites. Although snake bite is not frequent, except in monsoon season (Rahman *et al*, 2010), it is not uncommon. Poor people believe that as *ojhas* know better about snakes, they have a specialized knowledge for healing snake bites. At this point, they make a difference between an *ojha* (snake bite healer) and a *shapure* (snake charmer) identifying *shapure* as an entertainer, and *ojha* as a healer.

Fig. 1. *Pallichikitshak* examining his patient at Decree Charchandpur

Ojha (snake bite healers) believe that not all snakes are venomous, but if a snake is poisonous and bites someone, immediate healing is required, by putting poultice made of leaves of a local shrub (*monsha gaach*) which was blessed by Manasa, the Hindu goddess of snakes. They believe that modern medicines do not have the power to heal snake bites. For instance, once a young boy at Decree Charchandpur died from snake bite after taking medicine from a local health complex. This made the *ojha* and some poor villagers believe that the death had been caused by *bideshi chikitsha* (modern treatment) that the boy received at the clinic, and the doctors' negligence of snake bite rituals.

A similar belief about modern medical facilities shapes poor people's reliance on *palli chikitshak* (village doctors) and *daktar* (local drug sellers). Some poor men and women say that doctors at hospitals and clinics do not have time to listen to patients' problems, and prescribe medicine without consultation. They believe that if they take such prescribed medicines, they will suffer from *nari pocha rog* (rotten intestines), a deadly illness which no one can heal. According to them, doctors are rude to the poor who struggle to pay for prescription charges. They think that *palli chikitshak* and *daktars* are more reliable than doctors and nurses, as they show interest in understanding their patients' illnesses, and are available for home visits and private consultation. They, also, identify the absence of *boro daktar* (specialist doctors) as a reason of such dependence. Banerjee *et al* (2004) also found that people's dependence on informal healers in Udaipur village in Rajasthan is due to the unavailability of medically trained doctors, at the hospitals. Although Ashraf *et al* (1982) highlighted the hazardous impact of untrained, allopathic medical practices of informal healers in the rural areas, I found poor men and women consider that *palli chikitshak* and *daktar* as the principal source of *bhalo chikitsha* (better treatment) for them.

Fig. 2. Local *daktar* at Char Khankhanapur *bazaar*

Biomedical treatment facilities

Some rich and many poor people's access to modern medicine is through *pallichikitshak* (village doctors) and *daktar* (local drug sellers), who manage their individual dispensaries at local *bazaar* (market). Ailing people visit their dispensaries either by themselves, or send someone to bring medicine on behalf of them, after their consultation. There are no trained doctors or nurses. Once a doctor tried to set up his clinic at Char Khankhanapur *bazaar* (market), but could not sustain it for long, because of the ongoing conflict with local *daktar*. He noticed that though there existed no local association of

traditional healers (Read, 1966), *pallichikitshak* and *daktar* were united as a self interest group, and resisted the access of trained medical professionals at local health market, thereby securing their own livelihoods. Welsch (1991) showed that among the Ningerum people of New Guinea, when indigenization of western medicine took place, people did not see traditional medicine and modern medicine as competitive, rather complementary. Wolffers (1988) also found that traditional healers dispensed biomedicine for healing in Colombo, but I found that most traditional healers consider modern medicine negatively. Rashid Mondol, a *kabiraj* of Char Khankhanapur illustrates this, as follows: '*These days poor men and women, sometimes ask me to suggest allopathic or homeopathic medicines, along with* tabij *or herbal preparations to cure their illnesses. Once I prescribed some modern medicine along with my* kabiraji *medicine, to a poor man suffering from severe fever. After three days his wife ran to me and informed that he was vomiting continuously, and having diarrhoea. I went to visit him and found that his health condition was deteriorating. I told him that it is nothing but the effect of modern medicine that worsened his health. I advised him to stop taking the medicine immediately and continue my medicine. Few days after this, he was cured'.*

Traditional healers such as *dai* (midwives) and *kabiraj* (herbalists) believe that incorporation of western medicine in rural health system seems have put additional stress on their livelihoods. Caldwell *et al* (1999) showed instances of community health officers raising awareness among poor women to visit local family welfare centres, and receive free modern medical facilities as part of Government's family planning projects for pregnancy planning or termination and child birth. However, I found such campaigns recently pulling some poor women towards health centres and clinics. As a consequence, *dai* and *kabiraj* get only a few poor women as their patients, so earn little money for themselves. For example, Santi Das, a Hindu *dai* of Char Khankhanapur blamed modern health clinics and family welfare centres as a major cause of her livelihood vulnerability. According to her, these days only very poor women and women from some conservative families ask her to assist at births. About 5 to 10 years ago she used to get good money from being a *dai*, but now she can hardly eke out a living from what she gets from child delivery. To maintain a minimum living now, she has to work as *aya* (maid) at local community clinic, which she does not prefer. She has lost her authority to deliver babies and no one evaluates her expertise as a *dai.*

Fig. 3. Modern health service at local community clinic at Char Khankhanapur

Ansar Ali, a *kabiraj* (herbalist) of Decree Charchandpur, also, considered modern medicine as a threat to his livelihood sustainability. As he put it, ' *due to media campaigns and health awareness programmes of Government and some NGOs now a few poor men are beginning to show interest in going to doctors to get advanced treatment, instead of coming to me for cures for their illness. Sometimes at hospitals and clinics doctors and nurses advice them not to see the local* kabiraj*, like me, or other untrained rural health professionals for healing. This is nothing but* pete lathi mara *(means of deteriorating livelihood) for us.'*

Some women and men herbalists see Government supported agricultural extension programmes as having negative effects on their healing practices. According to them, because of cash crop cultivation, rich farmers are acquiring more land for crop production, and so clear away many medicinal trees and shrubs for land preparation. Even in homesteads, now they consider it economically advantageous to grow vegetables and fruits, rather than medicinal plants. Such practices lead to depletion of many useful medicinal plants, and due to unavailability of medicinal herbs, many herbalists have stopped preparing medicines, their knowledge of indigenous healing is gradually becoming extinct. Islam (1980) showed a significant relationship between poor women's use of indigenous medicine and family planning. She noticed that in Tangail, rural women rely on folk medicine and natural processes for abstaining from sexual activity, as a traditional way of preventing pregnancy, rather than using western contraceptive methods. I found many poor women following similar patterns of indigenous contraception.

Though WHO (1999) considered western contraception family planning method as one of the factors for improving maternal health, and Schuler *et al* (1996) identified it as a means of reinforcing women's empowerment, but many poor women do not find modern contraceptive methods as improving their lives. Besides complaining about physical weakness, many poor women think that using biomedical contraception, such as sterilizing injections, have put them under emotional distress, and that it has caused disharmony and unhappiness in their family lives. For instance, Ameena, a poor, woman of Degree Charchandpur, aged 42, went to the local family welfare centre to have a sterilization injection, as it was provided for free to her. After having the injection, she started feeling unwell. When her in-laws and some neighbours, told her that due to her use of contraception, and she has lost her child bearing incapability, she suffered emotionally. Her husband, being motivated by his family members, also started to ignore her despite his primary consent of her sterilization. These consequences influenced Ameena to believe that western contraception is *oshubho* (evil), and had disempowered her and put her in a social distress.

Conclusion

While western perception of healing is based on either allopathic or homeopathic treatment (Koss-Chioino, 1992: 51), traditional understanding of illness and healing depend on people's relationship to their natural and supernatural world. Often such perceptions vary according to gender, age, class and status. For example while rich men and women consider mental illness as *oshukh* (illness) requiring biomedical treatment, poor men and women do not see it as any *oshukh*,

but instead, they differentiate between *shorirer oshukh* (bodily ailments) and *gayebi oshukh* (illness caused by unexplained non mundane elements). According to them, western medicines are not capable of healing epidemics or chronic diseases, as these are *obhishap* (curse) and *shasti* (punishment) from God. They believe that if anyone tries to cure such illness, he or she will be also cursed and suffer. Poor men, and sometimes women, themselves, consider women's illnesses as *shorir kharap howa* (deterioration of health condition) but not *oshukh* (illness). They depend on traditional healers such as *kabiraj* (herbalists), *huzur* (religious guide), *pir* (magico-religious guide) and *fakir* (spiritual healer) for healing minor ailments. Poor women sometimes heal their own illnesses, and those of their family members, with home remedies. Some elderly women are *kabiraj* (herbalists) and *dai* (birth attendants) exerting control over health care by securing a separate identity and livelihood. They pass their knowledge of healing on to their successive generations, by allowing young women to learn about indigenous healing.

Many poor women experience negative results from western medicine, and see biomedicine as unhelpful because of some unfriendly doctors and nurses at the local hospitals and clinics. Dependence on traditional healers is also defined by factors such as faith and respect for indigenous healing mechanisms, unavailability of trained medical practitioners, cultural beliefs and socio economic circumstances. While affluent and educated men and women take advantage of western medicine, at district and *upazilla* (sub-district) hospitals, most poor men and women rely on traditional healing. Incorporation of western medicine shows a direct conflict with the interests of local healers, resulting in the decline of their economic and social position in rural health market. Health care projects, such as providing free medication and family planning resources, at the Government and nongovernmental level, often do not acknowledge traditional healing knowledge of poor men and women. By imposing top-down, western idea based development; they are negatively affecting certain women such as *dai* (midwives) and traditional female *kabiraj* (herbalists), in terms of causing a loss of their healing knowledge and identity, as health experts. Similarly, agricultural extension projects of the Government, aiming at producing bumper food production, and profitable home gardening, are increasingly leading to the clearing of medicinal plants in rural areas, which many poor women see as a reason of extinction of indigenous healing knowledge.

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