Women’s Reproductive Illnesses and Health Seeking in a Bangladeshi Village

by

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Abstract

This dissertation explores women’s health seeking behaviors during reproductive complications in rural Bangladesh drawing on Bourdieu’s Theory of Practice. Based on a year of ethnographic fieldwork in a northern village of the country, where four types of health care services—biomedicine, homeopathy, kabiraji (ayurveda), and folk treatment—are available, it explores how women define illnesses and seek therapies for reproductive health. It shows that women’s health seeking and obtaining health services are influenced by their authoritative knowledge, cultural practices, therapy management groups, kin networks, household economics, education, and gender inequality.

In the case of reproductive complications, women first try to understand the nature and causes of the problem based on their cultural knowledge. They categorize illnesses into four categories—osukh, dushi, jadu, and gojob—with the help of their therapy management groups. The women with high economic, cultural, and social capital are more likely to categorize reproductive complications as cases of osukh and lean toward seeking biomedical treatment while the women with low economic, social, and cultural capital are more likely to categorize illnesses as cases of dushi or jadu and lean toward seeking folk healers.

When an illness is a case of dushi, jadu, or gojob, women prefer a folk healer for treatment. The women with high economic, cultural, and social capital prefer a folk healer of their same status while the women with low economic, cultural, and social capital prefer a healer who is “reliable” and “accessible”. When an illness is a case of osukh, women can seek biomedicine, homeopathy, or kabiraji for treatment. The women with low economic, social, and cultural capital first pursue cheaper options like kabiraji and homeopathy, and seek biomedicine when these options fail to cure the disease. On the contrary, the use of biomedicine by women with high economic, cultural, and social capital is influenced by their therapy management groups, household priorities, and the social capital of their households.

This dissertation contributes to the area of anthropology of women’s health that highlights women’s subjectivity, their gendered access to forms of symbolic capital, and the role of authoritative knowledge in health seeking.
Preface

Ethics approval was taken from the University of British Columbia Behavioural Research Ethics Board (BREB) for this research as it involved human subjects. The approval number is H06-03750.
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Glossary

_Allah_: God

_Apa_: It means elder sister and fictive kin who are like elder sisters

_Atmiya shajan_: Kin

_Bhodrolok_: High-status men; own a large parcel of land, have formal education and better lifestyle than other men of the village

_Bhodromohila_: Well-off women; Women of the _bhodrolok_ households

_Bhumihin_: Landless

_Borsha kal_: Rainy season

_Boshonto kal_: Spring

_Chasha_: Illiterate, uncouth, landless farmer

_Daktar_: The term to address biomedical physicians and homeopaths

_Dai_: Midwife

_Dhani_: Rich farmers, own a vast amount of land and hire labor

_Doa_: Blessings

_Durbolata_: Weakness

_Dushi_: Illnesses that occur due to unnatural causes such as bad winds or attack of _jinns_

_Ghor_: Household

_Gola ghor_: A big storeroom to keep agricultural products

_Gorib_: Poor, landless farmers

_Gojob_: Punishment from God; illnesses which occur as an outcome of sin

_Gorur gari_: Ox-cart

_Grishsha kal_: Summer
Haram: Prohibited

Jadu: Black magic; people also apply the term to refer to illnesses that occur as a result of black magic.

Jinns: invisible creatures, which are neither humans nor angels, mentioned in the Quran.

Kabiraj: It refers to ayurvedic practitioners and folk healers

Kharap batash: Bad wind, when a jinn occupies a certain space, people believe that the air of that area becomes harmful and identify it as kharap batash.

Khalamma: A term to address a maternal aunt; People also use the term to address the senior women of the neighborhood

Khoda: God

Krishok: Farmer

Lokkhon: Symptoms

Ma: Mother

Mashik: Menstrual blood

Mathkormi: Fieldworker

Milad: A kind of prayer

Moddhobitta: Middle farmers who work their own land and sometimes work as sharecroppers on rich farmers’ lands

Monga: A seasonal food crisis, which usually occurs between September and November

Mantras: Spells

Moulana: People who graduate from religious schools, called madrasahs, and lead prayers at mosques

Osukh: Illnesses that occur due to normal reasons

Pani pora: Sanctified water

Palki: Palanquin

Pitha: Traditional cake
Pir(s): A spiritual person who is believed to have supernatural power

Purbo purush: Lineage

Purdah: Modesty, a physical separateness of women from outsiders particularly from men

Samaj: A territorially defined social group

Shakti: Force

Sebika: Health worker

Shit kal: Winter

Tabij: Amulet

Tawba: A promise made to Allah in front of a moulana not to do a prohibited work again

Tel pora: Sanctified oil

Thana: A small administrative unit with a police station; Bangladesh is divided into 507 thanas.

Union: The smallest administrative unit comprised of several villages; Bangladesh is divided into 6888 unions.

Vitemati: The site of a hut
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Dedication

To the women who are bereft of health care across the world
1. Introduction

Her name was Hasina\(^1\). She was only 21 years old, and was a landless day laborer like her husband. She died two days after delivering a dead baby. I heard the story of this mother from a nurse of RDRS (Rangpur Dinajpur Rural Services), one of the NGOs working in Rupsha\(^2\). When I asked about the cause of her death, the nurse replied, “This morning I visited the house and saw the dead body. She was so skinny that she looked like a skeleton. How could a woman with such a poor health survive?”\(^3\) A dai (traditional midwife) named Parveen who also attended this woman elaborated:

Actually, the baby died in the womb. I heard it from the women who were there. The whole night she had pain and could not deliver, but they did not take her immediately to the hospital. I feel very angry with these people. Every time whenever we visited these people, we suggested they take women to a hospital whenever women faced difficulty in delivering, but they did not listen. (After some silence, she again started to talk about the death) They took her to Dimla Thana Hospital next day where doctors recommended they take her to Rangpur Medical College Hospital for a C-section. I heard that BRAC (Bangladesh Rural Advancement Committee), another NGO working in the village, would pay a part of the hospital costs.

When I asked Parveen whether the woman died in the hospital, she replied,

No, after the surgery, she came back to the village two days ago. The problem began just after one day. She had convulsion and vomited many times (gorgor korchilo). After hearing about her situation, some sebikas (health workers) of BRAC took her to Dimla Thana Hospital and she died there.

This was Hasina’s third pregnancy; she became pregnant thrice in three years. Her first two pregnancies ended with miscarriages. She did not go to any health center for a

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\(^1\) This is not a real name. Pseudonyms have been used throughout the dissertation to protect the privacy of the respondents.

\(^2\) This is the pseudonym used throughout the dissertation for the village where this research was conducted.

\(^3\) All conversations reported in this thesis were conducted in Bengali and translated by me, except when specifically noted.
check-up. Another dai named Julekha who visited her during those days noted that she was not interested in a prenatal check-up. I asked Julekha the reason for Hasina’s unwillingness to come for a prenatal check-up. She replied, “They are illiterate people. They do not know the importance of such check-ups.” Later she explained that Hasina had household responsibilities and used to work as a day laborer. Moreover, Julekha added, her mother-in-law discouraged her from visiting the health center. However, after experiencing two miscarriages, Hasina visited the RDRS health center once during her subsequent third pregnancy. Dai Julekha recalled, “I brought her to this center after spending a lot of time with her. On many occasions, I tried to convince her for check-ups and finally, I persuaded her to come for once, and that was it. She did not come anymore. If she kept coming, I believe, this would not happen.” Similar to other women of the village, Hasina and her mother-in-law considered pregnancy as a natural process and interpreted miscarriages as an outcome of a sin or attacks of malevolent forces.

Like Hasina, every year 12,000 women die from pregnancy or childbirth related complications in Bangladesh (UNICEF 2009). The government and NGOs claim to be concerned to eliminate maternal mortality with the help of international organizations such as the WHO, UNICEF, and UNFPA. In the last two decades, the government and NGOs have developed infrastructures for prenatal check-ups and safe deliveries in the rural areas. They separately train traditional dais to ensure the presence of “skilled” persons during childbirth. Many women like Hasina in rural Bangladesh do not receive prenatal or antenatal care although such services are available in the villages. Her death and refusal to receive prenatal check-ups left many unresolved questions for me. I began to ask why do poor women like Hasina refuse to get prenatal care despite the persuasion of dais? What measures do they take
during pregnancy related crises? Do they receive help from any medically trained professionals such as dais, nurses, and doctors? How do they make decisions during such crises? What factors contribute in making such decisions? What do wealthy women do during their pregnancy related crises? What are the various health-seeking behaviors of women in this area? Do these have any relation to maternal deaths?

My ultimate goal for investigating these questions was to understand women’s health seeking behaviors and processes during the time of pregnancy and childbirth in rural Bangladesh. Few events in life are more uncertain for a woman than pregnancy and childbirth. It is important to know how women deal with this uncertainty in a country where the maternal death rate is 3.74 per 1,000 live births. I conducted this research in a medically pluralist setting where biomedical healthcare services exist alongside folk medical practices and alternative healthcare systems such as homeopathy and kabiraji (ayurveda). Research in a pluralistic setting helps researchers to pinpoint what leads people to choose a particular healthcare option. My research suggests that women’s health seeking behaviors in rural Bangladesh are shaped by multiple factors, such as their cultural knowledge of illnesses, cultural practices, kin networks, household economics, education, and gender inequality.

1.1 Health and disease in Bangladesh

In order to contextualize my research, it is necessary to have a brief overview of health and disease in Bangladesh. Bangladesh is a least developed country (LDC) in South Asia with 142.31 million people living in a land area of 147,570 square kilometers; the density of population is 964 people per square kilometer (Bangladesh Population Census
Around 90 percent people are Muslim, mostly Sunni Muslim, while the rest include Hindus, Christians, and Bhuddists.

Figure 1.1  Map of Bangladesh

The Bangladesh Population Census 2011 reports that the male-female ratio of the population is almost equal with 71.25 million males and 71.04 million females. It is estimated that 37.4 million people live in urban areas while 109.2 million people live in rural areas (BBS 2009).

Life expectancy at birth is 65.7 years for men and 58.3 years for women. The World Bank estimates that 40 percent of people live below the poverty line (World Bank 2005). Although there was no study to confirm it, maternal mortality may have contributed to the low life expectancy of women in Bangladesh.

The common diseases the rural people suffer from include: respiratory diseases (e.g., tuberculosis, pneumonia and asthma), mental illnesses (e.g., depression, schizophrenia, anxiety disorder, and dementia), vector-borne diseases (e.g., malaria, dengue, and kala-azar), sexually transmitted diseases (e.g., gonorrhea and syphilis), diarrheal diseases (e.g., cholera and diarrhea), genetic diseases (e.g., diabetes and thalassemia), infectious diseases (e.g., leprosy and measles), and deficiency related diseases (e.g., anemia, goiter, and night blindness). The rates of death from these diseases differ between men and women (See Table 1.1).
Table 1.1  Gender variance in terms of disease and deaths in rural areas

<table>
<thead>
<tr>
<th>Disease</th>
<th>Death rate of women (Per 1,000)</th>
<th>Death rate of Men (Per 1,000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malaria, typhoid, influenza, dengu and other fevers</td>
<td>41.1</td>
<td>48.4</td>
</tr>
<tr>
<td>Asthma and other respiratory diseases</td>
<td>83.8</td>
<td>143.8</td>
</tr>
<tr>
<td>Blood pressure and heart disease</td>
<td>61.7</td>
<td>114.3</td>
</tr>
<tr>
<td>Diphtheria and meningitis</td>
<td>0.6</td>
<td>1.7</td>
</tr>
<tr>
<td>Tumor and cancer</td>
<td>1.3</td>
<td>55.7</td>
</tr>
<tr>
<td>Malnutrition</td>
<td>16.6</td>
<td>11.0</td>
</tr>
<tr>
<td>Rheumatism</td>
<td>12.8</td>
<td>9.1</td>
</tr>
</tbody>
</table>

Source: According to the BBS (2009: 392)

Table 1.1 shows that two diseases—malnutrition and rheumatism—cause more women to die than men. However, both conditions pale in their impact when compared to the mortality and morbidity of women. “Maternal mortality refers to those deaths which are caused by complications due to pregnancy or childbirths. These complications may be experienced during pregnancy or delivery itself, or may occur up to 42 days following childbirth” (Policy Project 2002). Maternal mortality rate is higher in the rural areas (3.74 per 1,000 live births) than in the urban areas (2.07 per 1,000 live births) (BBS 2009). However, it is difficult to calculate the exact number of maternal deaths because it is estimated that 85 percent of the births are delivered at home and deaths at homebirth are rarely registered (WHO 2010). The maternal mortality ratio in the country was 340 per 100,000 live births in 2008 (UNICEF 2011). The common pregnancy related complications causing maternal
deaths include ectopic gestation, eclampsia, post-partum haemorrhage, anemia, and obstructed labor (Chowdhury et al. 2004). Post-partum hemorrhage is responsible for 26 percent of maternity complications, abortion 21 percent, eclampsia 16 percent, puerperal sepsis 11 percent, obstructed labor 8 percent, and other obstetric causes 18 percent of maternal deaths in Bangladesh (Pendzich 1998). Of these deaths, 25 percent die before childbirth, 50 percent die within 24 hours of childbirth, 20 percent die after seven days of childbirth, and five percent die within two to six weeks of childbirth (Khanom 2006). This large number of deaths and the impact of such deaths on the families have made maternal mortality a major healthcare and social problem in Bangladesh (Dey 1998).

Women also suffer more than men do from nutritional deficiency-related diseases that may contribute to their poor maternal health. Forty three percent of girls suffer from anemia caused by iron deficiency (Barkat and Majit 2003). In the rural areas of Bangladesh, 47 percent of pregnant women, 33 percent of non-pregnant women, 35 percent of lactating women and 29 percent of non-lactating women suffer from anemia or iron deficiency (BBS 2009). Most expecting and lactating mothers suffer from other deficiencies as well. For example, 85 percent of them suffer from low hemoglobin, 45 percent from protein deficiency, 42 percent from vitamin A deficiency, and 40 percent from clinical goiter (Jorgensen 1983). Anemia and other deficiencies also affect women’s reproductive health in various ways. According to Jorgensen,

With each pregnancy, a woman’s general status of health is worsened, for example, by anemia. The loss of blood and calories at childbirth are never compensated, but there is also a strain on muscles and other tissues in the lower abdomen. It is not surprising; consequently, that rupture of the uterus is one of the most frequent causes of death in relation to pregnancy in Bangladesh. … As a consequence of the women’s chronically bad nutritional status and their anemia, their power of resistance to infections is low. There is frequent bleeding both before and after birth (Rochat, p. 162). The bad nutritional situation of women also leads to an underdevelopment of
their bones, which is important particularly at childbirth, since the pelvis might be very narrow. The most frequent cause of pregnancy-related mortality in Bangladesh is obstructed labor, whether because of the narrowness of the pelvis or for other reasons. [Jorgensen 1983:58-59]

Gender disparity that begins at the earliest stage of life, immediately after the birth, at home is a key factor affecting women’s health. For example, in many cases, parents celebrate the birth of a son by sacrificing animals and offering a big feast to relatives and friends, but the birth of a daughter simply goes unnoticed because the society treats her as an economic burden (Nazneen 1995). As in India where home is a place of “masculine dominion” (Das 2008), a son in Bangladesh is considered the future breadwinner not only for his wife and children, but also for his parents during their old age. He is often served better food and provided with a better education than a daughter is provided. In a typical family, male children grow up as future breadwinners while female children grow up as dependents of the male members. Women have limited control over household resources since male members such as husbands, fathers, or brothers control the resources (Rozario 2001). A woman’s status is defined by the status of her father (before marriage) or her husband (after marriage). It is observed, “One in every two women will have her health care decided by her husband. Often, her mother-in-law will be a key decision maker” (UNICEF 2011).

Mother’s poor health contributes to a high neonatal mortality rate. The neonatal mortality rate in Bangladesh is 37 per 1,000 live births, while the post-neonatal mortality rate is 15 per 1,000 live births (WHO 2011). Fifty-two children out of every 1,000 born in Bangladesh die before their first birthdays; 37 of such deaths occur within the first months of life, while the rest occur after the first months of life but before reaching the age of one year.
It is estimated that around 120,000 newborns die every year in Bangladesh (UNICEF 2011). The majority of women in Bangladesh suffer from reproductive complications during the course of their lifetimes; the nature of their conditions and treatment varies considerably. Although the rate of maternal mortality is higher in the rural areas, the rural women have lower access to skilled assistance during deliveries (WHO 2011). A national survey conducted in 2007 showed that around 60 percent of women who had at least one live birth used antenatal care services (WHO 2011). Out of them, around 51 percent received the services from medically trained personnel that may include physicians, nurses, paramedics, and dais. Of them, around 16 percent visited the care provider once, around 24 percent visited two-three times, and the rest visited four times or more. These statistics do not give any idea about the use of antenatal services in terms of geographical location.

According to the same survey, out of the total reported births in the country, 85% took place at home while the rest took place at a health facility; only 18 percent of the births were attended by skilled birth attendants. Out of the total births reported, 79 percent took place in the rural areas; only 13 percent of the births that occurred in the rural areas were attended by skilled birth attendants.

According to the same survey, the number of women to receive postnatal care was also low, around 30 percent. Out of them, 17 percent received care from a qualified doctor, four percent from a nurse, midwife, paramedic, or female welfare visitor, and nine percent from non-medically trained providers such as traditional birth attendants (WHO 2011). Most of them received the care within four hours of the childbirth. Around 40 percent of the urban mothers received the care while around 26 percent of the rural mothers did that.

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4 These statistics do not give any idea about the use of antenatal services in terms of geographical location.
1.2 Reproductive health and health seeking

A review of the published literature on reproductive health reveals that research has taken place in six major areas. The areas include: 1) the significance of the availability of healthcare services and the role of women’s socio-economic status in using them during reproductive complications, 2) cultural interpretations of the female body, 3) infertility and the role of reproductive technologies, 4) etiological explanation of illness, 5) the influence of knowledge and actors in childbirth, and 6) cultural interpretations of childbirth practices.

Many studies of health seeking in non-western contexts have explored reasons why women do not use biomedical healthcare services during reproductive complications. They have identified numerous factors including the role of the accessibility of healthcare services, women’s autonomy as well as economic status and education, and costs as important factors in this regard. For example, in Namibia, women cannot use maternal services because such services are not equally available in all areas of the country (Zere et al. 2010). Women underutilized maternal healthcare services in Southern Tanzania as they were not aware of these services and the services were yet to expand in every area (Mpembeni et al. 2007). In southern Indian provinces like Andhra Pradesh, Karnataka, and Tamil Nadu, women’s use of maternal services was limited by their places of residence, as the healthcare services were not equally available across the states (Navaneetham and Dharmalingam 2000). Women in Kathmandu, Nepal, high-caste Hindu women could not use biomedical services because they did not have any decision-making power (Brunson 2010). The unavailability of prenatal and postnatal care and the lack of trained personnel to assist during pregnancies have been significant influences on women in seeking maternal services during reproductive complications in Bangladesh (Chen 1983, Jorgensen 1983, Aziz 1989, White 1992, Nazneen...
1995, Pendzich 1998, Chowdhury et al. 2004, and Dey 1998). The reproductive biomedical healthcare services are limited in the rural areas as the Bangladeshi healthcare services are skewed toward urban areas. The recent spur in the growth of the private health care system in the country has exacerbated the disparity between the care provided by the private and public sectors.

Alongside differential distribution of healthcare services, women’s socio-economic status plays important roles in health seeking. For example, in Peru, educated women utilize maternal health services more than their uneducated counterparts do (Elo 1992). High-status women in Nepal, who had formal education, employment, and power to make intra-household decisions, had a better possibility to use maternal health services than low-status women had (Matsumara and Gubhaju 2001). In Karnataka, India, women’s educational level, economic status, and religion were significant factors in their utilizing maternal healthcare services (Bhatia and Cleland 1995). Women with education and high economic status were more likely to use healthcare services. In Varanasi, India, autonomous women, who had control over finances, decision-making power and freedom of movement, were more likely to use maternal healthcare services during reproductive complications (Bloom et al. 2001). Women who had close ties with natal kin were more autonomous. Autonomy was also a significant factor in utilizing the maternal health services by slum women in Mumbai, India, as autonomous women were more likely to use maternal health services (Matthew et al. 2006).

Costs and inaccessibility to healthcare services hinder people’s use of these services in rural Mexico (Young and Garro 1981). Young and Garro emphasize, “Accessibility … is the principle factor facilitating or constraining decisions to seek a physician’s treatment”
Rural women in Bangladesh underutilized the existing biomedical health services (Akhter 1994, Rozario 1993, Afsana and Rashid 2000). The costs of healthcare services and purdah, a socio-cultural practice, hinder women’s access to cosmopolitan healthcare services. The practice of purdah implies that a woman will rarely go outside the household. Whenever she goes out, she will wear a veil and will not expose herself to unknown males. This practice varies depending on the economic status of the households. Usually in the rural areas, the women of the rich and high status households maintain purdah since it is a symbol of the family’s high status (Bertocci 1995, Zaman 1996).

Microeconomic factors are also important in health seeking. Nichter has focused on the influence of such factors in health seeking and therapy management. He writes, “Therapy management invites analyses of transactions that are at once influenced by cultural values, social roles and institutions, power relations, and economic circumstances that influence the ways in which illness is responded to in context over time.” (2002:82)

Sometimes, broader cultural and ideological assumptions also play an important role in individual’s use of healthcare services. For example, in Ghana, religious leaders played an important role in utilizing maternal health services for fertility and contraception by women (Gyimah et al. 2006). They influenced women’s decision-making related to the use of maternal health services. Muslim women were less likely to use these services than Christian women were because the former women were less educated and more obedient to their religious mentors.

It is also necessary to have an idea about the cultural conceptions of the female body to understand women’s health seeking because such cultural notions influence women’s decisions about treatment during pregnancy, childbirth, and reproductive complications. In
cultures where biomedicine is dominant, the female body is treated like a machine (Thompson 2002). A mechanical understanding of the body implies that different parts of the body become dysfunctional from time to time like a machine and require medical interventions (Martin 2001 [1987]). On the other hand, in South Asian cultures like those in India and Bangladesh, the female body is frequently linked with the ideas of purity and pollution. In northern India the womb is considered both as “a dirty pit and a space of life” (Pinto 2008:80). On the one hand, childbirth is a period of pollution and on the other it is a joyful event. People do not perform any religious ritual in a birthing room since they consider it as a “polluted” place for worshipping any god or goddess. Since pregnancy and childbirth involve pollution, women are a target of attack by malevolent spirits during such times. Women should perform various rituals and observe taboos to keep their bodies “pure” (Rozario and Samuel 2002, van Hollen 2002, Jeffery and Jeffery 1993, Pinto 2008). It is believed that a woman’s body becomes “hot” during pregnancies and “cold” during post-partum periods (Rozario and Samuel 2002). In these traditions, this notion suggests that women should follow different diets before and after childbirth (van Hollen 2002). It is implied that women are vulnerable for physiological reasons and they bear the responsibility of protecting themselves. If anything goes wrong, women can seek treatment from the healers who are able to remove malevolent spirits from a possessed body. Although the notions of purity and pollution are strongly associated with the Hindu caste system, in this region of Bangladesh these are somewhat different and reflect the influences of Islamic beliefs and practices (as elaborated in Chapter 2).

In such a context of pollution and vulnerability, gender differentiation also influences the management of the post-partum body. For example, in northern Indian villages placentas
of baby boys are buried at home but those of baby girls are thrown into a body of water (Pinto 2008). It is believed that a son maintains the patrilineal kinship line and “he will remain in his natal home….His placenta (ideally) grounds him there…” (Pinto 2008: 85-86). On the other hand, a girl is “flowing water” who moves to another house after marriage (Pinto 2008: 87).

Both women and men can be affected by infertility, but women are blamed for childlessness in patrilineal societies (Gerrits 2002). The experience of facing stigma for being infertile differs based on class as well. In the Indian context, age and social class are “important mediators of women’s experiences of the stigma of infertility” (Riessman 2002:166). Women can seek any treatment for infertility including new reproductive technologies such as in vitro fertilization (IVF) and donor insemination. Accessibility to these treatments is dependent on their household income and religious notions about adultery and reproductive technologies and the importance of children to family life (Inhorn 2002). In some societies, such as Egypt, a woman commits adultery when she uses another male’s sperm other than her husband’s for conception (Inhorn 2003). The acceptance of IVF is associated with the notion of halal (permitted) and haram (prohibited). For the Sunni Muslims, artificial insemination with husband’s semen is halal or religiously permitted while donor insemination is haram or religiously prohibited, as it is believed that donor insemination obstructs the maintenance of the purity of a family genealogy. Only the elites can use new reproductive technologies as these involve huge costs. However, in Israel, these technologies are available to the people of all classes and the culture is more open to accepting these technologies since the Israeli state encourages citizens to have children (Kahn 2002). The rabbinic interpretation of adultery, which is an extramarital sexual union
between two Jews but not between a Jew and a non-Jew, allows using non-Jewish donors for fertilization without sacrificing “Jewishness”.

Infertile couples in India, where IVF is socially stigmatized, prefer these technologies to the adoption of a child as these technologies allow the child to have some biological connections with at least one of the parents. These technologies allow the wife to bear and “deliver” the child, ensuring the child’s biological connections with his parents. The biological connections between a child and parents are necessary to maintain the family lineage; in the case of an adoption, there is no such connection. Moreover, the visible signs of biological connections—child bearing and delivery—are important to offset the stigma of infertility. The couples also try to hide the information about their use of IVF for children from relatives and friends (Bharadwaj 2003). However, reproductive technologies are yet to be widely available in Bangladeshi society where motherhood is one of the most desired stages of a woman’s life.

Women’s therapy seeking during reproductive complications depends on their etiological explanations and illness beliefs. Sargent’s research on the Bariba women of Benin shows that women largely derive the decisions regarding the utilization of alternative medical services from the sharing of assumptions about the diagnosis and treatment of the sickness or disorder (Sargent 1982). Bariba women would prefer traditional midwives when they faced complications during deliveries since they and traditional midwives shared similar etiological explanations, diagnoses, and beliefs related to pregnancy and had similar expectations. Women’s fewer visits to nurse midwives, she contends, are the result of differences between their own and nurse midwives’ explanations of the etiologies of complications and related treatment processes.
Rural people in Mexico rely on four criteria in making a treatment decision (Young and Garro 1981). These are seriousness of illness, availability of homemade medicine, effectiveness of a specific treatment, and costs. Usually people begin with the lowest-cost alternative. Young and Garro (1981) argue that costs along with seriousness of illness dominated the decision-making process among Mexican villagers. In urban Ecuador, people would seek folk healers for treating the illnesses that they thought occurred due to supernatural causes (Kroeger 1983). In rural India (Kapur 1979) and Taiwan (Kleinman and Sung 1979), people sought folk healers for mental illnesses.

In seeking therapies, people maintain a sequence. Young and Garro observe that “even though people would prefer first to choose the highest likelihood of cure, economic limitations constrain their choices in favor of lowest estimated cost, approximating a cost-ordered sequence” (1981:168). The idea of sequential therapy seeking has been further elaborated by Rumanucci-Ross (1977) who argued that people chose therapy or therapies sequentially in a plural setting, creating a hierarchy of resort. Sometimes people began their treatment with “modern” medicine, such as biomedicine, and sequentially moved toward the earlier modes of treatment, creating an “acculturative hierarchy of resort”. In some cases, people began their treatment with the earlier modes of treatment and gradually moved toward the “modern” medicine, creating a “counter-acculturative hierarchy of resort”. People chose therapies sequentially according to the perceived success of the treatment. They moved from one therapy to the next when the first therapy failed to cure the illness. In his research in a Cameroonian village, Ryan (1998) showed that lay people used a limited number of treatment sequences and avoided the repetition of a treatment sequence.
Central to understanding women’s decision-making is the issue of the kinds of assistance that women may receive before, during and after childbirth. Women need assistance from other people during childbirth. Who will help and what kind of birthing will be chosen depend on how a society perceives childbirth. For example, childbirth is considered a “medical procedure” in the U.S., a “stressful but normal part of family life” in the Yucatan, a “natural process” in Holland and “an intensely personal, fulfilling achievement” in Sweden (Jordan 1978:34). These differential understandings of childbirth are expressed through the differential prenatal care provided in these cultures. In the Yucatan, a pregnant woman receives instructions for wellbeing from other people such as experienced family members, neighbors, or friends during childbirth (Jordan 1978). There is no “single authoritative expert” in this regard. On the other hand, formal instructions by professionals are more common in the developed world (Jordan 1978:42). For example, prenatal care was considered a “doctor’s business” in the U.S. who would decide the diet and restrict the activities of pregnant women (Jordan 1978).

A team of people including the female parent, a midwife, an assistant to the midwife, and other “non-specialist” attendants (e.g. husband, sisters, and friends) usually attend a woman during labor and delivery in Sweden and Holland. All these participants work as a therapy management team and their interactions with the birthing woman are friendly (Jordan 1978). The midwife makes the decision in case of the use of medication for the birthing woman. Midwives do not see parturient women as patients but as persons who are quite capable of delivering babies on their own. The job of a midwife during childbirth is to watch parturient women and do some technical tasks such as cutting the umbilical cord (Jordan 1978).
The status of the birth attendant is an important consideration in understanding the choices that women make. In the Indian context, midwives called dai are “low status menials, and necessary for removing defilement, with no special delivery techniques” (Jeffery and Jeffery 1993:24). Dais are considered the cleaners of “birth pollution”, not skilled persons (Rozario and Samuel 2002), and are not involved in any prenatal or postnatal care. They do not have any control over the birth process; they just follow the instructions of other senior female attendants such as mother-in-law in a delivery process (Jeffery and Jeffery 1993, Rozario and Samuel 2002). In Bangladesh, dais receive the same treatment as in India, as usually women from the low status groups work as dais (McConville 1989); I will elaborate this in Chapter 3. In the literature on dais in South Asia there is a debate about whether or not to consider a dai as a midwife. Pinto (2008), in response to Jeffery and Jeffery’s (1993: 17) opposition to consider a dai “as a midwife in the contemporary western sense”, argues that the developmentalist and interventionalist imagery has constructed the image of a dai as a midwife. She is in favor of considering these post-partum workers “as a separate category of practitioner whose work is necessary to bring a baby into the world and manage its vulnerability through both body and trash work” (Pinto 2008:71). Women’s kin networks influence their use of birth attendants during uncomplicated pregnancy and childbirth in Bangladesh (Edmonds et al. 2012).

A theme that runs through the literature of birthing is the control of knowledge about birthing, assumptions about authoritative knowledge, and the control that is exerted over women during childbirth. It is often argued that medical interventions undermine women’s autonomy and knowledge. In hospital birth, women are dependent on physicians and do not receive any credit as all the responsibility and credit go to physicians. In contrast, in home
birth, women and their family members carry out the responsibilities related to childbirth and get the credit for it (Jordan 1978). O’Neil and Kaufert (1995) in their research among Inuit women argue that medical interventions in childbirth threaten the cultural notion of womanhood, which implies that women should take care of childbirth. In hospital birth, this responsibility goes to physicians, which the Inuit see as a devaluation of women. Moreover, they believe that their family identity and unity are in jeopardy when children are born in hospitals outside their community. Van Hollen argues that homebirths were safer than hospital births in Tamil Nadu, India, as the latter involved excessive doses of pitocin and “physical violence on the part of delivery room staff” (2003: 87).

The critics of hospital birth draw inspiration from Foucault’s *The Birth of the Clinic* where he argues that medical knowledge is a mechanism of power that works through the relationship of physicians and patients (Foucault 1975). Foucault has identified power relations in every sector of the society such as family, hospital, and school. In this book, Foucault explains the existence of power in the clinical context and refers to this as biopower. Medical knowledge provides medical professionals an authoritative position to define illness and treatment. This authority is exercised and maintained through a mechanism of surveillance. Foucault claims that the clinic or hospital is a place where medical professionals monitor and discipline the human body. This monitoring helps to establish the control of medical knowledge over the human body. This Foucauldian idea of power has been used to understand how a particular medical system becomes dominant.

In a society, multiple knowledge systems about birthing exist but the participants do not value all of them equally (Jordan 1978). One knowledge system receives more legitimacy or value than the others receive and becomes authoritative. The legitimization of a particular
knowledge system occurs through a consensus among the participants. This legitimization has its consequences as the establishment of a dominant way of knowing or authoritative knowledge either “devalues” or “dismis ses” other knowledge systems. The authoritative knowledge perpetuates its position continuously through production and reproduction as the participants of the domain continuously accept, produce, and reproduce it (Jordan 1993).

In the birthing process, technical knowledge “counts” or becomes authoritative among the participants of the process in the U.S. (Jordan 1993). In a hospital birth in the U.S. context, only “experts” such as physicians and nurses attend during labor and delivery. Historically, “non-specialists” such as a spouse, relatives, or friends were not allowed to attend, which has changed over the past 30 years. Every birth, whether it is normal or complicated, goes through some sort of medical procedures (Jordan 1978). Obstetricians possess authoritative knowledge compared to midwives in the Japanese context (Fiedler 1996). Their authoritative knowledge derives from their access to and control over technologies. The use of technologies such as fetal scanning (e.g., ultrasound technology) in Greece helps the people in charge of these technologies to exercise authority (Georges 1996).

The idea of authoritative knowledge explained by Jordan has received critical reviews from Sargent and Bascope (1996). In their study, they accepted and rejected some of Jordan’s ideas. They argue that in a low technology birth system technological expertise does not give a person authority in the birth process. Instead, social status and experience are more important for people, involved with the birth process, to exercise authority. In contrast, in the case of a high technology birth system, women’s knowledge is devalued compared to the knowledge of physicians and medical personnel. Physicians and nurses are the decision-making authorities and this authority is legitimimized through their access to and control over
the technology. Especially, in the case of surgical birth, doctors and nurses hold the decision-making authority. In some cases, lack of interactions or “negative interactions” between patients and medical personnel (i.e., doctors and nurses) help construct the authority of the medical personnel (Sargent and Bascope 1996). Sargent and Bascope re-examine the concept of authority and conclude that authority does not rest on the low technology—high technology distinction, but on the patterns of the distribution of culturally valued knowledge about birthing. This thesis explores the differential valuation of authoritative knowledge about birthing, access to this knowledge and the practical ability to apply the knowledge in a timely and effective manner during pregnancy and delivery, particularly when complications arise.

Most western studies on childbirth have focused on developing a critique of the medicalization of the birthing process by raising the question of control. They make us aware that childbirth does not need to be a medicalized process. Childbirth related research hardly explored which women chose hospital birth, which women chose home birth, and why they did so. In this regard, Janzen (1978) focused on the distribution of knowledge and the social dynamics of therapy and the role of therapy management groups. A therapy management group may include close kin, extended kin, healthcare specialists, and even the whole clan. Among the BaKongo in Lower Zaire, where he conducted his research, a patient’s kin would decide their therapy management and health seeking. The members of a therapy management group shared and consulted information, provided support, and made decisions about seeking a particular therapy. The authoritative knowledge described by Sargent and Bascope (1996) was found among these therapy management groups. Consensus among the members of the therapy management group is important in a therapy seeking process. Kin members, with
their experience and authoritative knowledge help to arrive at a culturally acceptable etiological explanation and an “appropriate” therapy.

In order to have a comprehensive understanding of women’s health seeking during reproductive illnesses, we need to look into the availability and accessibility of healthcare services and socio-economic factors, such as purdah, gender disparity and costs, and to be aware of the cultural understandings of the female body, infertility and childbirth, and disease etiology, and the role of therapy management groups that may influence healthcare decision-making. In my research, I have taken a comprehensive approach to understand women’s health seeking behaviors. The high maternal mortality in Bangladesh invites critical research into maternal care and childbirth with specific attention to the relationship between the care provided by medicalized care and home birth to assess women’s health seeking processes. The Bangladeshi research on reproductive health has concentrated on identifying the obstacles to seeking biomedical services such as the lack of the availability of biomedical healthcare services in rural areas and the cultural constraints (e.g., purdah), but hardly explored how women, particularly rural women, managed their illnesses and sought therapies during their illnesses. Women certainly have their own interpretations and knowledge about illnesses that guide their therapy management and health seeking processes.

In this research, I have examined how women define reproductive complications based on their cultural knowledge, when they seek healthcare services for this, what factors influence their decisions, and how they weigh the treatment options against each other. This research helps to explain the complexities of women’s health seeking and provides a foundation for the development of an appropriate maternal health policy. The UN adopted the elimination of maternal mortality in poor countries like Bangladesh as a new millennium
development goal. This research will help the Bangladeshi government and international organizations working in Bangladesh to have an understanding of the concerns of women, the target population of maternal mortality related projects

1.3 Theoretical framework

This thesis uses Bourdieu’s Theory of Practice as its theoretical framework. Pierre Bourdieu, one of the most influential French social thinkers of the 20th century, developed his thoughts on human agency and social structure based on his fieldwork experiences among the Kabyles and urban poor in Algeria as well as his observation in French society. Bourdieu (1977) expressed dissatisfaction about both phenomenological and structural approaches to knowledge because of their inability to understand social reality in its entirety. He wanted to develop a theory of practice, which would collapse the dichotomy of structure and agency. In his effort three concepts—habitus, field, and capital—are important. He depicts the relationship between these concepts through an equation which says: \((\text{habitus} \times \text{capital}) + \text{field} = \text{practice}\) (1984:101). This equation shows practice as the result of relations between the sphere created by interactions between habitus and capital, and the field. *Habitus* refers to “systems of durable and transposable dispositions” which create the principles of generating and structuring of individual and collective practices in society (Bourdieu 1977:72). He goes on to say that:

The habitus, the durably installed generative principle of regulated improvisations, produces practices which tend to reproduce the regularities immanent in the objective conditions of the production of their generative principle, while adjusting to the demands inscribed as objective potentialities in the situation, as defined by the cognitive and motivating structures making up the habitus. [Bourdieu 1977:78]
For Bourdieu, individual practices generated by one’s *habitus* are dependent on social structures, *economic bases*, which determine them in the last instance (Bourdieu 1977). He observes a dialectical relationship between individual practices and social structures that constantly produce and reproduce each other through the mediation of the *habitus*. Bourdieu suggests that the understanding of this dialectical relationship requires analyses of both structures and the structuring principles. An individual or group engages in this interaction within their social *fields*. For Bourdieu, field is an apparently autonomous socially instituted domain or space that has a history of development (Bourdieu 1996). It is also a space of struggle for *stakes* that operates like a game with its own rules, norms, and participants. Many fields such as bureaucratic field, journalistic field, academic field, intellectual field, medical field, and healthcare field exist in a society. Social fields are interrelated and differ in terms of the degree of autonomy. People take positions and generate strategies to interact in their particular fields based on their *habitus* and the *capital* they have in their control. According to Bourdieu (1986), people can utilize three types of *capital*—economic, cultural and social. Economic capital refers to something that is “immediately and directly convertible into money and may be institutionalized in the form of property rights (i.e., material wealth)” (Bourdieu 1986: 243). Cultural capital may be institutionalized in the form of educational qualifications (i.e., creative and intellectual skills). It can exist in three forms—in the *embodied state* (i.e., the dispositions of the mind and body), in the *objectified state* (i.e., in the form of cultural goods such as pictures, books and instruments), and in the *institutionalized state* (i.e., that is in the form of recognized qualifications such as academic degrees). Social capital is “made up of social
obligations ("connections")” and “may be institutionalized in the form of a title of nobility” (i.e., existing or potential resources an individual can dispose because of their social connections or networking) (Bourdieu 1984:243). The quantity of social capital possessed by an agent depends on the size of the network of connections he can mobilize and the individual possession of economic, social, and cultural capital by the individual members of the network. Cultural capital and social capital are convertible into economic capital on certain conditions, while all the forms of capital can turn into symbolic capital if they possess symbolic efficacy. A person’s position in a field is dependent on the kinds and strengths of capital possessed by them (Samuelsen and Steffen 2004). Capital is unequally distributed in a field.

Bourdieu’s Theory of Practice attempts to combine political economy (as he talks about structural factors such as social class, rules, norms, and institutions) and phenomenology (as he sees people as agent who possess variable amount of capital and interact with the structures). Drawing on Bourdieu, I combine a critical political economy with a phenomenological approach to explore structural, cultural, and individual initiatives in health seeking. A political economy approach, known as a critical approach to medical anthropology, is a neo-Marxist paradigm, which began to develop in medical anthropology in the 1970s. This perspective takes a historical approach to study health and illness and sees these as social products shaped by political and economic forces. Hans Baer, Merrill Singer, and Ida Susser in their seminal book Medical Anthropology and the World System nicely define this approach. They write that political economy “views health issues within the context of encompassing political and economic forces that pattern human relationships, shape social behaviors, condition collective experiences, re-order local ecologies, and situate
cultural meanings, including forces of institutional, national and global scale” (Baer et al. 2003:3-4). This descriptive definition of political economy lays out the overall assumptions involved in this approach.

From this perspective, any social system like healthcare develops over the years through interactions between various social forces. In a capitalist society, the healthcare system works according to the logic of capital that is—the maximization of profit. A capitalist society is a class society where disease (the loss of social, psychological, and physical well-being) is a consequence of social inequality (Navarro 1993). The ruling class or the capitalist class, which controls the mode of production, controls the healthcare system, and such systems serve the interests of wealthy people. For example, in advanced capitalist countries like the U.S., big corporations control medical services. Poor people suffer more from diseases compared to rich people as poverty, malnutrition, and lack of access to healthcare make poor people sick (Farmer 1999, Baer 1989).

Initially a political economy analysis in medical anthropology was concerned with the role of capital and class in dealing with health issues. Recent works have also taken the issue of race and gender into analyses, as evidence suggests that women and people of color are more vulnerable among working class people (Farmer 1999, Briggs and Briggs 2003). The women of the same class can have different health and illness experiences because of their age, race, and the place of living. In general, disease and illness disproportionately affect the poor, racial minorities, marginalized people, and women (Farmer 1999).

The political economy approach to medical anthropology suggests looking into how a healthcare system develops in a capitalist society, how this system benefits wealthy people and deprives vulnerable people including working class people, women and ethnic
minorities. It suggests analyzing how this inequality in terms of healthcare affects disease and illness. However, it does not provide any tools to see how individuals deal with the healthcare systems as it generalizes that a sufferer’s experience is a “social product” (Baer et al. 2003) and is shaped by “structural violence” (Farmer 1999), and implies that analyses of social and political factors are adequate to understand a sufferer’s experience. The political economy approach helps us to explain the development of the healthcare system, and make us aware of social inequality and the role of class and gender, but does not help to explain women’s individual experiences in healthcare. We need a phenomenological approach to understand women’s individual experiences.

For a phenomenological approach to medical anthropology, which emerged from the phenomenology of Husserl, Heidegger, and Merleau-Ponty, the idea of the primacy of experience is important because it examines illnesses as a subjective experience and asks how individuals experience and communicate health and illness. It explores sufferers’ experiences and their meanings. For instance, to understand the meanings of sufferings, Kleinman (1992) talks about a sufferer’s “local moral world” within which their sufferings make sense. Medical anthropologists working within this approach take the body as an important site of research to get first hand experiences of health and illness. To them “body” is the site of experience, expression, struggle, and meaning as it expresses both individual experiences and social actions. In their framing of the body as an entry point in the study of health and illness, Schepers-Hughes and Lock (1987) speak of three forms: the individual body, social body, and body politic. The individual body is the phenomenological body with its experiences and existence. Each individual body along with its experiences is distinct from others. The social body is a social symbol, which is created through social interactions,
and represents society’s signature. It expresses cultural meanings and social identities. The body politic refers to the regulation and surveillance of the body. Social institutions such as clinics, hospitals, prisons and schools, and social norms control or regulate the body (Foucault 1975).

A phenomenological study of health and illness requires considering all these aspects of the body (Scheper-Hughes and Lock 1987). Illness is not an isolated event rather it is a “form of communication—the language of the organs—through which nature, society and culture speak simultaneously” (1987:31). Individual emotions or feelings bear the traces of the three aspects of the body; emotion is where the mind and body intersect (Scheper-Hughes and Lock 1987, Csordas 1990). Therefore, an understanding of emotions or feelings is important for a phenomenology of disease and illness. One frequently used method of collecting individual experiences of illness is recording individual narratives. A narrative is an account constructed by individuals both consciously and unconsciously (Mattingly and Garro 1994). Illness narratives include the constructions of people’s past, present, and future understanding of a disease. Social and cultural contexts shape narratives. Mattingly’s idea of “therapeutic emplotment” seems useful here as an example of the process of narrative construction (Mattingly 1994). Therapeutic emplotment refers to a particular process of narrative construction where interactions between medical personnel (i.e., doctors or healers) and patients in clinical settings spontaneously produce narratives. Clinical plots give meanings to therapeutic actions (Mattingly 1994).

An illness narrative embodies the explanatory models and shared cultural models of the illness. Different explanatory models exist in a health situation. Patients, physicians, and family members all have their own models. The explanatory models of non-professionals
such as patients and their relatives are non-technical, personal, and cultural. The non-technical explanations involve many aspects of a culture such as the cultural models of gender roles, family roles and the professional hierarchy of the society (Price 1987).

A phenomenological analysis helps us to understand individual experiences, while a political economy analysis helps us to understand the role of structural factors in health seeking. Although these approaches to medical anthropology belong to very different poles, they need to be combined to have a comprehensive understanding of people’s health seeking behavior. Pierre Bourdieu’s Theory of Practice provides a way out for us as it collapses structure and agency (Csordas 1990).

In this dissertation, I explore what forms of capital rural women in Bangladesh possess and how they use their capital to carry out their health seeking practices in the healthcare field.

1.4 My field research

This study is based on a year of fieldwork from December 2006 to November 2007 in Rupsha, a village located in Nilphamari, a northern district of the country. The Bangladeshi government defines a village as an ensemble of several paras, however; the people defined a para, which consisted of several close neighborhoods with shared boundaries, as a village. I followed people’s definition of the village as I tried to see it through their eyes. I have chosen to call the village, where I worked, “Rupsha”, a pseudonym, to protect the privacy of the villagers as this study discusses many personal health issues. From this village, it takes around seven hours by bus to reach Dhaka, the capital of Bangladesh. The total population of the village is about 2,367 with approximately 1,229 males and 1,138 females.
I chose this village for fieldwork due to my familiarity with the northern part of the country. As I was born and raised in one of the nearest district towns, Rangpur, I was familiar with the cultural practices and local dialect of the Bengali language spoken by the villagers, which helped me build rapport with them. Access to the village community posed the fewest problems for me as my familiarity with the local dialect identified me as one of their own. However, initially many people assumed that I was an employee of one of the NGOs that, since the 1990s, employed many educated workers in the area. Another reason to choose the village was to observe health seeking in a region that was afflicted with poverty and experienced an annual seasonal food crisis called *monga*, which results from a lack of sustainable crops and income generating activities such as agricultural work for landless labourers. Prior connections and experiences with people of the area helped me to see whether poverty had any relation with health seeking.\(^5\) Finally, this village has a plural medical system involving biomedicine and various forms of indigenous medicines. The existence of multiple healing systems in a social setting opens an opportunity to understand people’s choices of a treatment for an illness.

During my fieldwork, I interviewed a variety of women and health practitioners to know their opinions about illness and health seeking. At the beginning of the research, I used a “big-net” approach, discussed by Fetterman (1998) which suggests mingling with everyone in the field, who is accessible, in order to have an overall idea about the village. I tried to have a clear idea about the village by collecting information about the demographic compositions and physical structures of the households, occupation and education of the household members, landholding patterns, sanitation, availability of drinking water, access to

\(^5\) I did my undergraduate research fieldwork in a nearby village, exploring social stratification.
the media and telecommunication, availability of electricity, and household priorities in spending money (which I explore in the next chapter). Two research assistants went door-to-door to collect these data based on a questionnaire prepared by me. These data helped me better understand the villagers and their socio-economic conditions. Alongside the research assistants, I also visited many households with the help of my local host, who is a family planning health worker, a sebika (female health workers employed by NGOs) and a dai. Since they are native to the village and dealt with health issues, I was able to learn about the household settings, the availability of different healthcare services in the village and health practices of the village women. They also introduced me to local dais (traditional birth attendants), sevikas, kabirajes (ayurvedic practitioners), and folk healers. My visits to the households helped me build rapport with women. After collecting the above mentioned information about the households, I selected some women and health practitioners to more extensively inform me about women’s healthcare practices. After selecting them, I consulted with my key informants—the family planning health worker, the sebika and the dai—to finalize my interviewee list. I crosschecked the information of one informant with another when I felt it was necessary.

I selected the interviewees at the end of my second month of stay in the village. I selected them based on purposive sampling and their availability. I interviewed 21 women who were all married, and will use pseudonyms to introduce them in the dissertation in order to protect their privacy. All the interviews were conducted in the local dialect, which I subsequently transcribed and translated into English for using in this dissertation. I also used some Bengali terms and dialects in the dissertation when translation failed to capture the

6 It is also a requirement of the UBC Behavioral Research Ethics Board to use pseudonyms for the interviewees to protect their privacy.
meaning of the term. I included women belonging to rich and poor households, women from different age groups, and women with different educational levels in light of my data on the demographic and occupational composition of the households. The purpose of selecting women from different categories was to see how their experiences varied, as, drawing on Lila Abu-Lughod, Allen (2002) has warned us about the danger of homogenizing women. Of the interviewee women, 14 are aged between 20 and 40 years and seven are aged between 50 and 70 years. Of these 14 women, four—Monwara, Ritun, Haifa, and Shima—are aged between 20 and 40 years and belong to the dhoni (landholding) households of the village. While Ritun and Shima’s family rely on agriculture, Monwara and Haifa’s family engage in business alongside agriculture. They have different educational qualifications. Both Ritun and Shima have a SSC (Secondary School Certificate) degree, Monwara has a HSC (Higher Secondary School Certificate) degree, and Haifa has a Master of Arts (MA) degree. Ritun and Shima do not work outside home. They look after their children, prepare family meals, and supervise the work of the female domestic workers. Ritun has four children while Shima has one. Monwara teaches at a primary school while Haifa teaches at a college. Both Monwara and Haifa has two children each.

In addition to these educated and economically stable women, I interviewed nine women who belonged to the bhumihin (landless) households. They are Banu, Nurjahan, Aleya, Roshna, Romicha, Momena, Acia, Kabita, and Forina. They are 20-40 years old. They have no formal education and work as day laborers at the landholding households. Banu has three children, Nurjahan has four, Aleya has five, Roshna has three, Romicha has one, Acia has one, Kabita has two, Momena has one, and Forina has four children. I also interviewed
Rehana, who had an elementary school degree and belonged to a *moddhobitta* (middle farmer) household. She is 20 years old and has a child.

In addition to these 14 young women, I interviewed seven elderly women named Khadija, Hajera, Akima, Halima, Abia, Maleka, and Nura. Khadija is 65 years old and belongs to a household, which owns a large parcel of agricultural land. She completed grade 10, and has five children. Maleka, 55 years old, also belongs to a landholding household, has three children, and has elementary school education. Hajera (50 years old), Abia (50 years old), and Nura (70 years old) belong to the *bhumihin* (landless) households and have no education. They all have children; Hajera has four, Abia has five, and Nura has two. Two elderly women, Akima (50 years old) and Halima (45 years old), belong to the *moddhobitta* (middle farmer) households. Among them, Halima does not have any children, while Akima has four.

To know about women’s experience of illnesses and health seeking, I asked them unstructured questions about etiology of illnesses or complications, symptoms, and management. I talked to them in a way that they could bring whatever issues they thought relevant to the topic. I sat more than once with 12 interviewees but was able to conduct only one session with nine interviewees due to their unavailability for additional sessions. In most cases, I talked with them at their households or work places based on their preferences. In addition to these interviewees, many health related concerns and issues came up during informal gatherings with women. Usually the women of neighbouring households gossip and socialize together in the late afternoon when they pass their leisure time. Sometimes I joined them with my seven-month-old son. My son and their children created good starting points for our conversations. We used to ask each other about the wellbeing of our children.
Consequently, different issues related to health would come up, giving me opportunities to hear their concerns and opinions. These gatherings would have women of different ages expressing their opinions. Women would contradict or complement each other.

Women’s narratives gave me information about the criteria and decision-making processes they followed to choose a particular therapy (e.g. costs, availability, severity, etiology, and accessibility), the number of therapies they sought during complications, the first resort and the last resort, and the constraints (e.g. economic, cultural, and infrastructural such as distance and unavailability) they faced in seeking therapies.

I also interviewed the healthcare providers working in the village. I interviewed a biomedical physician, a homeopath who had a degree from a homeopathy college, another homeopath who did not have any homeopathy degree but treated patients combining homeopathic knowledge with magical knowledge, four folk healers, a kabiraj (ayurvedic practitioners), and two trained dais (traditional birth attendants). I attended and observed healthcare delivery systems of a physician, a homeopath, and two folk healers to learn how they deal with women to cure reproductive illnesses. I had informal discussions with a family welfare worker and a “pharmacist” who does not have any medical knowledge but sells medicine at a village store and sometimes recommends medicine to patients when they come with “normal” problems such as flu, cold, and weakness. I also had informal discussions with two other physicians who worked at Rangpur Medical College Hospital, located in downtown Rangpur, where many women from Rupsha visit as patients in case of reproductive complications. The healthcare providers told me about their roles in care delivery, how they perceived the issues related to women’s health, the costs of various
therapeutic systems, treatment procedures, constraints in delivering healthcare services, women’s use of healthcare services, and causes of maternal mortality.

I also talked with the head of the village administration and government and NGO officials working in the village to collect documents about the healthcare facilities and services. I collected survey reports, posters, leaflets, and guidebooks from three NGOs—BRAC, RDRS and Jonogoner Dorbar—which have health programs running in the village. I collected yearly health reports from Dimla Thana Hospital, the main hospital visited by the villagers, and information on landholding from the village land office. The NGOs BRAC and RDRS have special programs on maternal health. I talked with some officials of these organizations, visited their health centers, and observed how they do counseling and provide prenatal check-ups. I also attended several EPI (immunization program) sessions organized by the government family planning association. These health centers and sessions gave me opportunities to learn about the biomedical health service delivery system in the village (I discuss the health services in detail in Chapter 3).

I obtained oral consent from the interviewees for participation in this research although written consent was required by the University of British Columbia Behavioural Research Ethics Board (BREB). Before conducting this research, I had to take approval from the BREB as my research included human subjects. I had to let the Board know in their prescribed forms when I would conduct the study, what kind of data collection methods I would use, how I would involve the research subjects, how I would take their consent, would they face any risk or gain any benefits from this research, and how I would protect their privacy. After getting its approval, I went to the field for data collection.
When I did my fieldwork in Bangladesh throughout the year of 2007, the country went through political turmoil. At the time, a “non-partisan” caretaker government backed by the army ruled the country and arrested the major politicians, including two former prime ministers, and many businessmen on charges of corruption. The Bangladeshi constitution had a provision that an elected government would hand over power to a non-partisan cabinet at the end of its tenure and the non-partisan cabinet would conduct the next parliamentary election within three months of its tenure and hand over power to the newly elected cabinet. At the end of 2006, when an election was due, the outgoing government and the main opposition parties could not agree on the formation of the non-partisan cabinet for the election. The outgoing government entrusted the president of the country to create the new cabinet to hold the election. The president himself decided to act as the head of the new cabinet and handpicked the cabinet members. The main opposition party rejected this new cabinet arguing that this cabinet would not be able to conduct a fair election, as the president was a member of the outgoing government. It demanded the president create a new cabinet with “non-partisan” people to hold the election. Protests and strikes paralyzed the country. During this political crisis, the army forced the president to dissolve his new cabinet, and created a cabinet with “non-partisan” people. This “non-partisan” cabinet, backed by the army, ruled the country for two years with a plea to reform the political and electoral processes and institutions of the country. When I was in the field, many politicians including two former prime ministers, several former ministers, and some businessmen were in jail on charges of corruption. The caretaker government conducted assessments and evaluations of the activities of different government and non-government organizations to identify “corrupt” officials and practices to “eliminate” corruption. In this political climate, people were afraid
to give anything in writing. The research participants became suspicious about my goal when I asked for written consent. Consequently, I had to be satisfied with oral consent and, and in some cases, was forced to refrain from using a tape-recorder during interviews.

My objective in this dissertation is to explore the different facets that contribute to women’s care seeking when they encounter complications in childbirth. To understand their practices, I will describe the health situation in the region in which I conducted the study, examine the health systems that provide modes of explanation and care in the region and examine the particular circumstances in which women make these decisions. My goal is to provide a glimpse of the complex cultural, social, and economic milieu in which women and their family members make what are often life and death decisions.

1.5 Chapter outline

In Chapter 2, I will present the social and cultural milieu that shapes women’s lives. I will discuss household structures, patterns of livelihood, and social organization of the village, which guide women’s day-to-day life and influence their therapy seeking.

Chapter 3 examines the health systems, such as folk, ayurveda, homeopathy, and biomedicine, available in the village. Emphasis is on costs, structures, and availability of treatment services. This chapter also focuses on how biomedicine has been promoted as the dominant healthcare option.

I will examine how women identify the causes of illness and categorize illnesses in Chapter 4 by exploring women’s narratives. In addition, I will explore the cultural practices involved with different categories of illnesses and assess whether etiology and cultural practices have any relation to women’s health seeking behaviors.
In Chapter 5, I explore women’s reproductive complications and health seeking processes. I focus on material and cultural factors that influence women’s health seeking processes during pregnancy and childbirth related complications. I explore how women’s experiences differ based on their economic, cultural, and social capital.

Chapter 6, the conclusion shows how women’s ability to mobilize economic, social and cultural capital influences their healthcare practices. It also talks about the limitation of the dissertation and issues for future research.
2. Rupsha: People and Their Capital

Villages in Bangladesh are quiet places with fewer inhabitants and less noise. Vast agricultural fields, absence of industries, and movements of fewer vehicles on the streets distinguish a village from a town. When people compare a village with an urban area, they identify the village as a traditional place where strong kin ties exist, while an urban center, by contrast, is a “modern” place. The village people who are critical of urban life describe it by saying that “they (urban people) are busy people with less time to gossip.” Some would say, “We feel breathing problems when we go to an urban center. It is so crowded.”

Like many other Bangladeshi villages, Rupsha is a village where agriculture is the predominant economic activity, generating capital for the villagers to carry out other activities like health seeking. As I already mentioned in the introduction, relying on Bourdieu, I see capital in its three forms—economic, social, and cultural—as his concept of capital incorporates both economic and cultural realms. In a society, people are diverse in terms of control of these forms of capital, and the women of Rupsha do not produce any exception to this. In Rupsha, the available forms of economic capital include land-ownership, jobs, and business, cultural capital include education, and social capital include networks and family honor. People’s health seeking and ability to generate, possess, and dispense capital are connected with geographical location, transportation facilities, and climate.

This chapter discusses the geographical location of the village, its climate, its economics, and the diversity of the villagers in terms of their control of economic, cultural, and social capital to facilitate our understanding of women’s health seeking behaviors, which are discussed in chapter 4 and 5.
2.1 Geographical location of the village

About 350 kilometers away from Dhaka, Rupsha is located in the northern part of the country and is a part of Dimla, a thana\(^1\), which includes 10 unions\(^2\) and 53 villages. Dimla, now a part of Nilphamari District, was a part of Rangpur District until 1984 when the government divided Rangpur District to create four new districts—Nilphamari, Lalmonirhat, Kurigram, and Gaibandha—to further decentralize the administration.

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\(^1\) Bangladesh is divided into 507 administrative divisions called thanas with each having a police station.

\(^2\) A union is the smallest administrative unit comprising several villages and is smaller than a thana. Bangladesh is divided into 6,888 unions.
One of the biggest rivers of Bangladesh, the Jamuna, separates the northern part of the country from Dhaka. A bridge, called Jamuna Bridge, which was constructed on the river in 1998, connected the northern part with Dhaka and reduced the daylong journey from Nilphamari Town to Dhaka to eight hours. These days many people from the northern districts like Rangpur, Nilphamari, Lalmonirhat, Kurigram and Gaibandha frequently go to Dhaka for shopping, study, jobs and medical treatment. Mobility towards Dhaka city is a sign of “development” of one’s socio-economic condition, which people frequently mention.
during their conversation, since the “best” civic facilities (e.g., schools, hospitals, and job opportunities) are concentrated in this city.

Two nearest district towns to the village are Rangpur Town and Nilphamari Town. Rangpur Town, the center of Rangpur District and a key administrative and economic hub in the northern part of the country, is also a key place for the people who live in the neighboring towns and villages including Rupsha. Rangpur Medical College Hospital, one of the large district hospitals of the country, is located in the town. Beside this public hospital, the town has a good number of private clinics and hospitals. Nilphamari Town, the center of Nilphamari District, which is only a 40 minutes bus ride away from the village, also has shopping malls and other services but is much smaller than Rangpur Town. Its public hospital is also smaller than Rangpur Medical College Hospital in terms of number of beds, physicians, and technical facilities. Frequent bus services between Rangpur and Dhaka and the availability of better civic facilities in Rangpur Town makes it a more attractive place for the villagers than other neighboring towns including Nilphamari Town.

The construction of a dam on the river Tista in 1980 to increase agricultural production, by controlling floods and increasing irrigation facilities, allowed the construction of roads by connecting the village with neighboring towns and villages. Before the construction of this road, it was a day-long journey involving multiple modes of transport such as boats, bullock carts, buses, and trains from the village to Nilphamari Town and then to Rangpur Town. Rahmat, an elderly man of the village, recalled his experience of traveling to the nearest towns in the following way:

Earlier it would take a day to go to Rangpur Town. We used to start our journey very early in the morning by an ox-cart, which would take 8/10 hours to reach Nilphamari Town. Then, we would get on a train, which would take another 6/7 hours to reach Rangpur Town.
Travel difficulties reduced with the introduction of direct bus services between the village and the towns. Now the villagers can easily go to the neighboring towns for anything, including visiting a doctor, within a short time. These days, students in large numbers from the village go to the towns for higher education, many people go for work, and many businesspersons go for purchasing goods. Halima, a 50-year-old landless woman of the village, appreciated this change as she said, “In the past we didn’t have any option during *monga* (a period of acute food shortage) but to stay in the village and collect *mar* (gravy created when rice is boiled) from wealthy people’s houses to satisfy hunger. Travelling to the towns was very difficult. Now our *purush* (men) can easily go there and get work during *monga.*”

After the construction of the connecting routes, interaction between the village and the nearby towns increased dramatically, facilitating the flows of various prepared food (e.g. cookies, noodles and cakes), consumer goods (such as electronics, appliances and cosmetics), and medicines to local bazaars from the towns. The availability of prepared food has greatly influenced the villagers’ food habits. Momena recalled, “Earlier we used to prepare rice flour to make different varieties of *pithas* (traditional cakes) to entertain guests. Now the younger generation of women does not learn this skill. They do not make *pithas* since they have noodles to treat guests.”

Some villagers, particularly rich farmers, now have televisions and refrigerators at homes as the dam facilitated the expansion of rural electrification. The number of pharmacies went up because it became easy to get supplies of medicine to the village. Hashim, the owner of the oldest pharmacy at a local bazaar, said, “my pharmacy was the only one till the early 1990s as people did not find interest in this business due to poor transportation services. Now
we have four pharmacies in the village.” These local pharmacies not only sell medicine, but also house the physicians who provide their services on a pay-per basis. Housing a physician increases the medicine sales of a pharmacy because the physician prescribes the medicine, which the pharmacy has in stock. Bus services between the village and the towns have paved the way for physicians from the towns to come to the village to provide services.

2.2 Demographics, transportation, and mobility

The total land mass of Dimla is 80,740 acres including farmlands (see Table 2.1). According to a survey conducted in 2001 by the thana administration, the total population of this thana was 218,100 with 111,060 males and 107,040 females. The people of this thana practice mainly two religions: Islam and Hinduism (see Table 2.2). Two age groups—5-14 years and 15-49 years—dominate the population (see Table 2.3). The people of this thana are involved with a variety of occupations such as farming, fishery and small businesses, with farming as the dominant occupation (see Table 2.4). Some people are involved with more than one profession at a time. For example, some wealthy people own both lands and businesses. Landless farmers change occupations depending on the seasons. A number of them pull rickshaw vans (a three-wheeler with a square wooden platform at the back to carry goods and people) during lean seasons. The thana administrative office classified the families of the area into three categories based on income, without mentioning the level of income. In Rupsha, typically a male day laborer gets Tk 80 per day (82 Taka = $1 U.S.), while a female laborer gets Tk 40.
### Table 2.1  Land distribution in Dimla

<table>
<thead>
<tr>
<th>Distribution of land</th>
<th>Quantity in acre</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agricultural land</td>
<td>57,505</td>
</tr>
<tr>
<td>Forest</td>
<td>2,631</td>
</tr>
<tr>
<td>Water and low land</td>
<td>13,625</td>
</tr>
<tr>
<td>Roads and other infrastructure</td>
<td>2,900</td>
</tr>
<tr>
<td>Cattle rearing</td>
<td>1,503</td>
</tr>
<tr>
<td>Land not suitable for agriculture</td>
<td>13,375</td>
</tr>
</tbody>
</table>

Source: Dimla Thana Office Profile 2005.

### Table 2.2  Distribution of people in Dimla based on religion

<table>
<thead>
<tr>
<th>Religious groups</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Muslims</td>
<td>186,500</td>
</tr>
<tr>
<td>Hindus</td>
<td>31,000</td>
</tr>
<tr>
<td>Buddhists</td>
<td>50</td>
</tr>
<tr>
<td>Christians</td>
<td>250</td>
</tr>
<tr>
<td>Others</td>
<td>270</td>
</tr>
<tr>
<td>Total</td>
<td>218,100</td>
</tr>
</tbody>
</table>

Source: Dimla Thana Office Profile 2005

### Table 2.3  Distribution of people in Dimla based on age

<table>
<thead>
<tr>
<th>Age</th>
<th>Boys / Males</th>
<th>Girls / Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-11 months</td>
<td>3,551</td>
<td>3,413</td>
</tr>
<tr>
<td>12-23 months</td>
<td>3,545</td>
<td>3,524</td>
</tr>
<tr>
<td>2-4 years</td>
<td>10,766</td>
<td>10,994</td>
</tr>
<tr>
<td>5-14 years</td>
<td>33,911</td>
<td>31,288</td>
</tr>
<tr>
<td>15-49 years</td>
<td>73,757</td>
<td>68,338</td>
</tr>
<tr>
<td>50+ years</td>
<td>11,130</td>
<td>12,170</td>
</tr>
<tr>
<td>Total</td>
<td>136,660</td>
<td>129,727</td>
</tr>
</tbody>
</table>

Source: The Dimla Thana Health Complex Report 2006
Table 2.4 Occupation of people in Dimla

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Number of families</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agriculture</td>
<td>22,900</td>
</tr>
<tr>
<td>Fishery</td>
<td>310</td>
</tr>
<tr>
<td>Weaving</td>
<td>05</td>
</tr>
<tr>
<td>Pottery</td>
<td>130</td>
</tr>
<tr>
<td>Business</td>
<td>18,185</td>
</tr>
<tr>
<td>Others</td>
<td>1500</td>
</tr>
</tbody>
</table>

Source: Dimla Thana Office Profile 2005

Table 2.5 Distribution of people in Dimla based on income

<table>
<thead>
<tr>
<th>Classification of families</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rich</td>
<td>4,805</td>
</tr>
<tr>
<td>Poor</td>
<td>18,950</td>
</tr>
<tr>
<td>Middle</td>
<td>24,785</td>
</tr>
</tbody>
</table>

Source: Dimla Thana Office Profile 2005

Rupsha is connected with Dimla thana headquarters by a wide road (partially made of concrete), and it takes 10 minutes by a bus and 25 minutes by a rickshaw-van to reach there from the village. The villagers usually avail rickshaw vans to go to the thana headquarters for treatment, administrative work, education, and shopping. When they cannot meet their needs at the thana headquarters, people go to the nearest district towns.

The advent of an all-weather road has changed the nature of transportation in the village. The villagers would walk or ride bicycles to go to different parts of the village, but rickshaw vans became a popular transport after the construction of the road. A man operates a rickshaw van by pedaling it like a bicycle and can carry up to six people. During harvesting seasons, people use this transport to carry agricultural goods as well. A traditional transport called palki has almost disappeared. A palki (palanquin) looks like a square wooden box, with handles on four sides, where two people can comfortably sit. Four people carry it on
their shoulders by the handles to transport people from one place to another. Usually the women of wealthy households or a newly married woman would use this transport. This transport began to disappear in the late 1960s due to its labor costs. Another popular transport, gorur gari (ox-cart), began to disappear in the late 1980s. Rickshaw vans and buses have gradually replaced gorur gari. If someone visits the village these days, they will notice the presence of a good number of rickshaw vans and bicycles—two principal transports of the villagers—on the streets. Village bazaars are the places where one can hire a rickshaw van.

The bazaars are located at three parts of the village where the villagers buy their daily necessities. The tea stalls at the bazaars are places for men where they socialize with other men. Men also gather at the marketplace called, hat, where farmers from neighboring villages sell their products twice a week—Tuesdays and Saturdays. The farmers use baunkas made of bamboo splits to carry goods to the hat. Usually a man carries a baunka on his shoulders with around 50 kilograms of goods hanging from each side of the baunka. Traditionally the bazaars and hat are men’s places, and women are rarely visible in such places. While having tea there, men discuss village conflict, politics, and business.

Elderly men usually socialize with other elderly men of their neighborhoods in open spaces close to their houses, while women usually socialize with other women in their backyards. They talk about domestic matters and issues related to health, marriage, and children. Usually men and women do not gather to gossip or socialize. They follow a social rule of avoidance, which defines the mingling of men and women as an indecent act. Jorgensen observes, “Outside the home everyday contacts between men and women are very limited. Although most women do not adhere strictly to the demands of purdah (physical
separateness from men), men and women work separately and do not sit together. That men and women should touch is unthinkable.” (1983:31).

However, family members can sit and talk together during their leisure times, following some rules of avoidance. For example, a daughter-in-law maintains a distance with her father-in-law, mother-in-law, and elder brother-in-laws. Similarly, a son-in-law maintains a distance with his mother-in-law, father-in-law, and elder sister-in-laws. These rules of avoidance factor in during a woman’s illness. For example, a newly married woman who lives with her in-laws hesitates to share health concerns with the in-laws, including the mother-in-law. Although the mother-in-law has the key responsibility for the health of her daughter-in-laws, a daughter-in-law rarely shares her health concerns with her mother-in-law because in most cases the relation between a mother-in-law and daughter-in-law is a relation of domination where the mother-in-law dominates. However, in case of childbirth, when a mother-in-law realizes that her daughter-in-law is expecting, she voluntarily advises her about what to do and what to avoid. A newly married woman is shy to disclose the news of her conception to the mother-in-law and other elderly people in the household. She shares such things with the younger sister-in-laws, while the elderly family members learn of it by either overhearing the discussions of the younger members or seeing the symptoms. However, the situation of a daughter is different from that of a daughter-in-law since the former has an informal relationship with the elderly people of the household. For example, a daughter does not need to cover her head when she sees or talks to a senior, but a daughter-in-law is expected to do so. Both a daughter and a daughter-in-law are expected to maintain a distance from unknown males. A woman has to think twice before going to a health practitioner’s place alone because of the social rules of avoidance.
However, many such traditional practices have begun to change due to the introduction of micro-credit and expansion of education among females. The landless women who are the target population of micro-credit programs negotiate with the male officials operating these programs when they need to borrow money. They attend meetings and meet them from time to time when pay their loans. Many educated women who work at local schools, colleges and NGOs, also interact with their male colleagues and officials.

2.3 Village climate

This village is a floodplain like most areas of Bangladesh with the Tista as the main river. The villagers experience six seasons—*Grishwa kal* (summer), *Borsha kal* (rainy season), *Sheet kal* (winter), *Shorot kal* (autumn), *Hemonto kal* (late autumn) and *Boshonto kal* (spring)—which present variable opportunities and challenges. *Shorot kal, Hemonto kal* and *Boshonto kal* are short lived and have minor impacts compared to *Grishwa kal, Borsha kal* and *Sheet kal*.

*Grishwa kal* which is hot and humid begins in the month of *Boishakh* (usually the corresponding English month is April) and continues until the end of the month of *Joistha* (usually the corresponding English month is May). The Bengali New Year is celebrated on the first day of *Boishakh*. On this day, businessmen treat their clients with sweets and begin a new financial year by closing the accounts of the previous year. Women prepare and serve *chirotar rosh* (a traditional sour and bitter drink prepared by squeezing *chirota* leaves) to their household members, as it is believed that people need to drink something sour and bitter at the beginning of a hot season to protect their bodies from seasonal diseases like fevers,
skin rash, and stomach upset. Well-off families celebrate the day with lavish meals including *pulao* rice (rice cooked with ghee and spices), chicken, fish, beef, sweets, and fruits.

Day temperatures vary from 30 to 40 degrees centigrade. The village experiences less rainfall during this period, and the hot and rainless summer sometimes results in drought, which the villagers called *khora*. The village and the other areas of the pre-1984 Rangpur District are counted as medium drought-prone areas of the country. High drought-prone areas like Rajshahi District and some parts of Dinajpur District and Bogra District are also in the northern part of the country. A long lasting drought affects the farmers and the economics of the village as less rainfall and a low capacity of the soil to hold moisture during this time hamper the growth of plants. Many ponds and some parts of the Tista dry up affecting fisheries and livestock. Elahi and Ara (2008) claim that people in the northern part of the country face a shortage of drinking water during drought. However, Rupsha never faced an acute shortage of drinking water during drought.

Drought requires women to do some extra work. For example, they have to collect water from the nearby deep tube-wells to clean utensils, which they can do at the adjacent ponds when there is no drought. Women also have to water their homestead gardens regularly and spray water on the courtyard to protect the houses from dust. Farmers arrange prayers for rain and the urge for rain found expressions in popular children’s rhymes, such as:

*Aye brishti jhepe* (Oh rain, come in full swing)

*Dhan dibo mepe* (I will give you sufficient paddy)

A popular song which people love to sing during drought is: *Allah megh de, pani de, chaya dere tui* (Allah give us cloud, rain and cold) … .
This rainless *Grishwa kal* sometimes spreads diseases like *zol bosonto* (chicken pox) and *patla paikhana* (diarrhea), making women worry about their children’s health. When *zol bosonto* breaks out in their neighborhood, women collect herbal medicine from *kabirajes* (ayurvedic practitioners) as a preventive measure. However, people feel comfortable when *kalboishakhi*, a late afternoon storm with strong wind and thundershower, appears. People believe that when *kalboishakhi* appears diseases like *zol bosonto* disappear. They believe that there is a mutual relationship between human body and nature, which cannot do absolute harm to each other. The nature takes away something, while gives back something at the same time. For example, *kalboishakhi* destroys many houses and trees but removes diseases like *zol bosonto*.

*Grishwa kal* is also the season when people can eat a variety of fruits such as mangoes, jackfruits, black berries, guavas, and litchis, and share fruits with neighbors. When *kalboishakhi* hits the village, many fruits, especially mangoes, fall from the trees. Women and children collect the fruits, particularly green mangoes, from under the trees in the neighborhood. Women and children enjoy green mango salad and send green mangoes as gifts to neighbors, friends, and relatives.

*Grishwa kal* disappears when *Borsha kal* begins in the month of *Ashar* (usually the corresponding English month is June). The village experiences tropical monsoon-type weather during *Borsha kal*, which continues throughout the months of Ashar and *Sravon* (usually the corresponding English month is July). A relatively cooler monsoon begins in early *Ashar* when day temperatures vary from 20 to 30 degrees centigrade. This monsoon rain is a result of the hot summer, which creates a low pressure in the surface in western India and a high pressure in the Indian Ocean. Cold wind from the high-pressure zone flows
to the low-pressure zone, creating rainfalls in Bangladesh as well as in India (Sanderson and Ahmed 1978). *Borsha kal* relieves people from heat and facilitates crop production by supplying the necessary water to the soil. During this time, both men and women harvest jute for fiber, one of the main crops produced in this village. Men work in the fields and cut the crop after it matures, while women move the stalks to a high land. Women also remain busy in moving cattle from the fields into their sheds because of frequent rain. The women of poor households face difficulty in finding sheds to cook, as they usually do not have kitchens.

Monsoon rains sometimes causes floods in different parts of Bangladesh including in Rupsha. Floods destroy crops and damage houses, roads, and affect poultry as well as cattle. However, the frequencies and nature of these disasters vary from year to year. Floods do not affect a place every year to the same degree. In addition to floods, riverbank erosion occurs, affecting people during *Borsha kal*. Such breeches of the banks occur fast and furiously, destroying crops as well as houses. People who live close to the Tista are most seriously affected by this disaster as they lose their homes and have to move to other parts of the district. *Patla paikhana* and *zor* (fever) are two common health hazards during *Borsha kal*.

Gradually rains begin to cease in the month of *Vadro* (usually the corresponding English month is August) when *Shorot kal* begins. Two Bengali months—*Vadro* and *Ashwin* (usually the corresponding English month is September)—make *Shorot kal*. During this season, the sky shines by shedding the gloom of the rainy season. After the monsoon rains of *Borsha kal*, the trees now turn green and fresh, and the blue sky and green nature make *Shorot kal* the most pleasant season. The paddy fields begin to ripen and the ponds and canals have fish in plenty. Men catch fish from nearby ponds and canals, which women prepare and cook.
However, at the end of Shorot kal, monga would begin and continue until the first half of Hemonto kal. People would refer to monga as mora kartik or the time of hunger and death as it turns ominous during the month of Kartik (usually the corresponding English month is October) (Muhammad 2008). During monga, many poor households would eat a meal a day for continuously up to three days a week, while the poorest households would eat a meal a day continuously for up to a week. Every member of such a household would have to work to earn their livelihood and would not have any food to share. Both men and women would have limited opportunities to work to earn a living. For the landless agricultural workers, this would be a time of unemployment and little or no income. During monga, due to the unavailability of agricultural work, wage laborers earn lower than regular wages when they can find work, and the amount is fixed through negotiations between the employer and the employee.

Monga forces many poor people to migrate to the urban areas to sell labor. Ali, a day laborer of the village, moved to Rangpur Town during every previous monga to work at a factory or a brickfield or to pull a rickshaw. He said, “The only job available in the village during monga was domestic work which could be performed by young laborers or women and girls. People hire women and children with low wages for these kinds of jobs. The only option for many of us was to move to towns for work to earn money.” Ali preferred to return to the village during harvesting times. He said, “During a harvesting time we (he and his wife) can earn better by staying at the village. I prefer to come back to the village this time to earn money and spend time with my family.” Like Ali, many people would move to towns or cities for survival although they would dislike the city environment. For example, Nurjahan,
a single mother, who moved to Bogra Town (another nearby town) during the last *monga* to work at a factory, came back. She said:

> I went to Bogra to earn money, but my life turned into hell. Life is so hard there that one has to work hard for a small payment. With the small amount of money, which I earned there, it was very hard to pay house rent, buy food, and meet other expenditure. Moreover, I was always anxious for my other three kids who were working at other people’s houses in the village. Now I am back forever and will do whatever work I can find in the village during *monga*.

Those who are not dependant on agriculture would also suffer indirectly from *monga*.

Rahmat, a 20-year-old rickshaw van puller, narrated his experience to me in the following way:

> Our income declines during *monga*. We can earn better during harvesting seasons as we carry goods from the fields to the homes and to the bazaars. During *monga*, there would be no agricultural goods to carry, and people would spend less for their transport, causing us to suffer.

> Poor people would follow different strategies to cope with *monga*. Borrowing rice and money from rich farmers would be a common practice. For instance, Akkas said that during the last *monga* he took five kilograms of rice as a loan from Jabbar, a rich farmer of the village, on condition that he would return seven kilograms in the following harvesting time. Women and children would work at rich farmers’ houses only for daily meals. Many people would sell whatever they possessed of value such as trees, furniture, cattle, and poultry to survive. However, *monga* would affect rich farmers less since they would have educated members in the household who did non-agricultural work, such as teaching at local educational institutions, to have salaries. Some of them also owned businesses alongside lands. *Monga* would end by the end of *Hemonto kal*, which comprises the months of *Kartik* and *Agrohaiyon* (usually the corresponding English month is November), when a harvesting season begins. The NGO officials working in the village claimed that *monga*’s effect has

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been compromised and the dependency of landless laborers on rich farmers during *monga* has decreased due to micro-credit programs. Now many landless laborers do non-agricultural activities during *monga* with the small loans they receive from the NGOs.

Traditionally *Hemonto kal* has been called the harvesting season when men would collect paddies from the fields and women would separate them from the straw for husking. *Hemonto kal* is considered a good time for wedding since people can have money by selling agricultural products, and the weather is temperate.

After *Hemonto kal*, *Sheet kal* begins in late *Agrohaiyon* and continues through the months of *Poush* (usually the corresponding English month is December) and *Magh* (usually the corresponding English month is January). It is dry and cold with day temperatures varying from five to 20 degrees centigrade. The northern part of the country experiences the coldest winter compared to the other parts. *Sheet kal* is a time when the villagers produce and consume a wide variety of vegetables such as *sak* (green leafy vegetables), tomatoes, cauliflowers, cabbages, carrots, pumpkins, and different types of beans and lentils. Women make different kinds of *pithas* with rice flour and sugar and send them as gifts to kin members and neighbors.

*Sheet kal* is also a good time to organize marriage ceremonies as people can have money after selling vegetables and the weather is cold. Jorgensen notes, “Sexual activity is high in winter, during December, January, and February. One explanation of this might be that people cuddle up together to keep warm. During the hot period, the husband often sleeps on the verandah” (1983:35). However, *Sheet kal* causes some health problems. Many men and women suffer from fevers and other cold-like respiratory diseases, while many children suffer from pneumonia.
The last two months of the Bengali calendar—*Falgun* (usually the corresponding English month is February) and *Choitra* (usually the corresponding English month is March)—make *Bosonto kal*. With the beginning of *Falgun*, the temperature begins to rise as *Bosonto kal* arrives, and this season continues until late *Choitra* and is marked by the blossoming of different kinds of fragrant flowers.

**2.4 Occupations and economics**

If one visits the village during a harvesting season, as I did when I started my fieldwork, they will see men and women drying up paddies. Mostly women were doing the work, while at some places men were working alongside them. Women used the courtyards and some parts of the concrete built road (where a few vehicles ply) for drying up the paddies. As far as my eyes could see, I saw farmlands and the village looked like a sum of hundreds of farming plots separated by tiny borderlines. The village was divided into clusters of households connected by narrow muddy roads. Every household was surrounded by different types of trees such as bamboo, coconut, betel nut, mango, and jackfruit, with bamboo and betel nut as the most common. Many villagers used bamboo to make their huts and ate betel nuts for enjoyment.

Farming is the main occupation in Rupsha, with a small number of people involved in non-agricultural work such as small business and service jobs at the local schools, colleges, and NGOs. Some families do weaving and make potteries and bamboo products for the local bazaars, while a few people work as blacksmiths. Non-agricultural jobs begin to develop significantly in the early 1980s when some NGOs began to work in the village. NGOs such as BRAC, RDRS, Jonogoner Dorber, and Grameen Bank operate in the village, and all of
them, except Jonogoner Dorber, provide microcredit to the *bhumihin krishok* (landless farmers) so that they can pursue income-generating activities. With the availability of microcredit, many *bhumihin krishoks* have begun to rely on non-agricultural occupation such as pulling rickshaw vans and running small businesses. Many women from the *moddhobitta* (middle farmer) and *bhumihin* households have received training from the NGOs as *dais* to help during childbirth. Many young men and women of the village have found jobs at these NGOs as fieldworkers.

Farmlands work as the principal form of economic capital of the villagers as it generates money from crop sales to generate other forms of capital. Mostly people acquire lands through inheritance. Men inherit more of the family property than women do. Although the Bangladeshi legal system is based on the British common law tradition, inheritance is decided by a person’s religion. The Muslim Personal Law determines the inheritance for Muslims while the Hindu personal laws determine the inheritance for Hindus and Bhuddists (The Law Commission, Bangladesh 2005). According to the Muslim Personal Law, sons inherit an equal share of their father’s property after his death while a daughter inherits half of a son’s share. If a person leaves behind just a daughter, she will receive a half of his property. When there is more than one daughter, the daughters together will inherit two-thirds of the property. The wife receives one-eighth of the deceased husband’s property if he leaves behind children, while the husband receives one-fourth of the deceased wife’s property. If there are no children, the wife inherits a quarter of the deceased husband’s property. In case of the property in the name of a deceased mother, every child has an equal share of the property. On the other hand, according to the Hindu personal laws, only the unmarried daughters and daughters with sons can inherit their father’s property. The right is
limited in the form of life interest, that is, on her death the property goes back to the next heir of the person from whom she inherited the property. Widows inheriting property from husbands also have limited rights (i.e. life interest). Irrespective of religion, most Bangladeshi women tend not to claim their share of the parental property to maintain good relations with their brothers. Hartmann and Boyce argue that in rural Bangladesh a “woman turns to her brothers for refuge. She not only visits them for a holiday; if her husband divorces her or dies leaving her without land or children to care for her, she relies on her brothers for economic support” (1983:92). Claiming inheritance by a woman can jeopardize her relations with her brothers. Men who do not have lands use labor power as their principal form of capital. However, landless people can buy lands if they can generate enough money through working other people’s lands.

Landed people receive more agricultural products to have surpluses and invest the surpluses to buy more lands or to start businesses. Their life is more secured than other people’s are since they can sell or use their surpluses during a crisis. Land-ownership also helps generate other forms of capital such as cultural capital (i.e., family honor and social status) and social capital (i.e. connections with the people of power). The members of the land-holding households can gain cultural capital (i.e. education) and social capital (i.e. connections with the people of power) using the income generated by their economic capital.

Based on land ownership, the villagers are divided into different groups—dhoni krishok (rich farmers), moddhobitta krishok (middle farmers) and bhumihin krishok (landless farmers). Based on my survey, a dhoni krishok owns 06-50 bighas of lands and hires labor to work the lands. A dhoni krishok is able to influence the power structure in many ways. First, during an election, as a patron he can influence his clients (landless laborers and
sharecroppers who are dependent on his lands for survival) to vote for a particular candidate. Second, he can also finance the election campaign of his chosen candidate. Third, he himself can run for offices as he has enough money to bear the costs of elections. Finally, a *dhoni krishok* can sit on the governing bodies of the local schools, colleges, mosques and soccer and other sports clubs by donating money. As a governing body member, he can influence the decision-making processes in these organizations. He also has good relations with the officials of NGOs working in the village. All these networks work as his social capital. The *dhoni krishok* comprise only about 12 percent of the village households, while the *moddhobitta krishok* make up about 36 percent (See Table 2.6).

A *moddhobitta krishok* possesses 01-05 *bighas* of lands and cultivates his lands with the assistance of his family members. In addition, he sometimes works as a sharecropper on rich farmers’ lands when his production fails to meet the household demand. The women of these households (*moddhobitta*) usually do their own household work. Some of them hold jobs at the local NGOs as *sebika* (female health workers), *mathkormi* (fieldworkers), and *dai* (midwives). A few of them have their own crafts such as sewing and handicrafts. The children of the *moddhobitta krishoks* go to the local schools and colleges, but cannot afford to go to the towns for higher education.

<table>
<thead>
<tr>
<th>Amount of Land in Bighas</th>
<th>Number of Households</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>01-05</td>
<td>213</td>
<td>36.16</td>
</tr>
<tr>
<td>06-10</td>
<td>38</td>
<td>6.45</td>
</tr>
<tr>
<td>11+</td>
<td>37</td>
<td>6.28</td>
</tr>
<tr>
<td>Total</td>
<td>288</td>
<td>48.89</td>
</tr>
</tbody>
</table>

Source: Field data 2007
The *bhumihin krishok*, who make up about 51 percent of the village households, refer to those people who work as wage laborers on other people’s lands. Some of them own their *vitemati* (the site for a hut), while many lack even that (see Table 2.7). Those who do not have their own *vitemati* build their huts on rich farmers’ lands. Usually the *dhoni krishok* households of the village allow their poor clients to build shelters on their lands, and the clients work as laborers for them in return. Both men and women of the *bhumihin* households work as day laborers. Men work on *dhoni krishoks’* lands, look after their cattle, and do other outside work, while women do household work and post-harvesting work at the *dhoni krishok* households and sometimes in the fields. The children of the *bhumihin krishok* go to the local primary schools, but cannot even dream to pursue higher education.

**Table 2.7  Land distribution among gorib and bhumihin krishok in Rupsha**

<table>
<thead>
<tr>
<th>Amount of Land in <em>shotangsha</em> (33 shotangsha make a bigha)</th>
<th>Number of Households</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Landless</td>
<td>73</td>
<td>12.39</td>
</tr>
<tr>
<td>01-15</td>
<td>121</td>
<td>20.54</td>
</tr>
<tr>
<td>16-30</td>
<td>107</td>
<td>18.17</td>
</tr>
<tr>
<td>Total</td>
<td>301</td>
<td>51.10</td>
</tr>
</tbody>
</table>

Source: Field data 2007

I have categorized people into the above groups to explain the socio-economic structure of the village, but these are not static. Some people overlap the groups. The continuous fragmentation of land due to the rule of inheritance and the fluctuation in
agricultural production due to natural disasters make the economic condition of a household variable and vulnerable to change in rural Bangladesh (Bertocci 1970).

The people of Rupsha who are involved with farming produce different varieties of rice such as Aman, Aus, Boro and Irri during different seasons as rice is the staple food. In addition to rice, they produce wheat, tobacco, corn and a variety of vegetables such as potatoes, onions, cucumbers, and tomatoes. Both men and women work in the fields with clear divisions of labor. In terms of rice cultivation, men’s responsibilities include land preparation, sowing, weeding, irrigation, and threshing, while women’s responsibilities include seed testing, storing and germination, and boiling, drying, and husking rice. However, in recent years women cannot do some of the work they would traditionally do due to the improvement of the transportation system and the introduction of “modern” technologies to agriculture. In the 1960s, a new type of agriculture called modern agriculture, which used tools like tractors, rice mills, deep tube wells and water pumps for irrigation, chemical fertilizers, pesticides, and the high yielding varieties (HYV) of rice, was introduced in Bangladesh because of the green revolution. In the past women had the primary responsibility for seed conservation, germination and testing by using their traditional knowledge. In case of rice cultivation, women’s knowledge and labor were essential to assess how well the seeds will germinate, how much rice can be realized by processing paddies, how much rice and seeds will be stored, how much rice will be kept for home consumption, how much rice will be kept for sale, and how the by-products will be used (Abdullah and Zeidenstein 1982). Rahmatan, a 75-year-old landless woman, recalled:

Earlier we did everything. We conserved the seeds. We did all the work after our men collected paddies from the fields. We would collect cow dung for the soil. Now seeds are available at the local bazaars. Chemical fertilizers are used instead of cow dung to nourish the soil. No work is left for us.
The village women would cooperate with each other by sharing their agricultural knowledge. Because of their important roles in farming, the women had greater influence in the households.

After the introduction of “modern” agriculture, women not only lost their role as seed conservators, but also became redundant in post-harvesting work. The introduction of technology in post-harvesting work has reduced the opportunities for the women of the *bhumihin* households to work as wage laborers by mechanizing the tasks they have traditionally done. For example, the introduction of rice mills in the village made the women laborers, who were formerly involved with the winnowing, threshing and husking of rice, redundant, eliminating the main source of rural women’s employment. Similar things happened in the villages across the country (Abdullah and Zeidenstein 1982). During my fieldwork, I observed that women, who were in the 50s and who used to husk rice before the emergence of the rice mills, saw the change as an economic loss and a loss of social networks for women. Hajera said,

*Dhan vana* (husking of rice) was solely our (women’s) job. It was our fixed job. At the beginning of harvesting, *jomiwalara* (a colloquial term to refer the landowners) used to book us for the job. They do not call us these days. We have to search jobs at their houses and compete with men for that. Now they bargain with us and say that men provide better labor than we do.

The farmers use a combination of “traditional” and “modern” techniques. They still depend on some “traditional” tools such as *kodal* (spade) and *langol* (indigenous country plough) to prepare the soil. They gave up using organic fertilizers and gradually became dependent on chemical fertilizers, decreasing the work of the *bhumihin* women who used to collect cow dung to prepare the soil.
Since farming makes the heart of the village economy, the villagers’ joy, happiness and sadness in everyday life centers on crop cycles. The villagers pass busy days during planting and harvesting times. Harvesting is a time of happiness when food and work are available. Keeping the crop cycles in mind, people make schedules for doing the social activities, such as kin visits, marriage, and health seeking, which require a free time or a significant amount of money or a travel outside the village. People usually prefer the post-harvesting times to do such activities as they usually have some extra money at hand from selling the harvest and can have free time.

2.5 Social hierarchy

Rupsha is hierarchical with various status groups primarily based on economic capital, that is, lands. The people of the households with high economic capital have high cultural and social capital. Mukherjee (1971) identified many occupational groups and status groups in rural Bangladesh creating social hierarchies. In his occupational hierarchy, the top category included those people who worked for the government on high-ranking positions, zamindars, jotdar (big landowners and rentiers), and rich farmers. The second category included ryot (self-cultivating farmers), artisans, small traders, and non-cultivating landowners. The bottom of the hierarchy consisted ryot-borgader (owner cultivator cum sharecropper), borgader (sharecropper), agricultural laborers, and beggars. The top category of people enjoyed a high standard of living, while the bottom category of people had a low standard of life.

He identified different status groups among the Muslims and the Hindus. He observed that the Hindus were divided into two categories—caste Hindus and scheduled
caste—based on the idea of pollution and purity. The caste Hindus were divided into upper caste and middle caste. The Muslims were divided into two groups based on their socio-economic conditions such as *somvranto* (aristocratic) Muslims and *kulu* Muslims. The aristocratic Muslims were wealthy and enjoyed the superior status, while the *kulu* Muslims were poor and inferior. He argues that the upper caste Hindus and the aristocratic Muslims would possess similar economic conditions.

However, Karim (1956) identified multiple status groups among the Muslims on the basis of occupation and land ownership such as *Chowdhury* (feudal chief), *Khundakar* (priestly group), *Bhuiyan* (rich farmer), farmers who owned and cultivated land, landless laborers, and *Gulam* (domestic aid). He argues that these groups do not socialize with each other; marriage rule is one of the means, which keep them separate. For example, marriages between the members of *Chowdhury lineage* and *Khundakar lineage* were common, marriages between the members of *Chowdhury lineage* and *Bhuiyan lineage* were rare, and marriages between the members of *Chowdhury lineage* and *Ghulam lineage* would be something impossible to happen.

Similar to Mukherjee, Chowdhury (1978) identified status groups among the Muslims and the Hindus. The Muslims were stratified into high status Muslims and low status Muslims based on land ownership, education, and life-style. He observed a correlation between landholding and social status as the high status Muslims owned land and the low status Muslims worked mainly as sharecroppers and landless laborers (Chowdhury 1978:86). He divided the Hindus into upper caste, lower caste and scheduled caste based on the rituals of pollution and purity.
The Hindu caste system is based on an idea of purity and pollution (Dumont 1980). Brahmins are at the top of the Hindu caste system, while Shudras are at the bottom. The middle castes include Boniks and Kayesthas. The caste system categorizes people according to their occupation. Brahmins as the educated priestly class lead religious rituals, look after religious places like temples, and survive on people’s voluntary contributions. Usually a zamindar would patronize the Brahmins who lived in his jurisdiction. Boniks are the people who run businesses, while Shudras do menial work. This image of caste has been portrayed in the west as a key feature of Indian society. However, Dirks (1992, 2001) claims that the British colonial rulers constructed this image of caste as the main feature of Indian Hindu society to characterize it as inhuman. On this basis they justified their invasion of India as freeing people from the curse of the caste system.

Although the Muslims are not stratified based on purity and pollution, there is a strong influence of the Hindu notion of purity and pollution on the lives of the Bengali Muslims (Blanchet 1984, Rozario 2001, Jorgensen 1983). The notion of purity and pollution rooted in the Hindu Brahminical tradition influenced the Muslims because many Muslims in the area, which is now Bangladesh, were Hindus before the spread of Islam. Moreover, Islam as a religion also subscribes to a notion of pollution-purity. Blanchet elaborates this nicely. She writes:

In both (Islam and Hinduism), ritual purification is a prerequisite to religious activities. Elaborate rules on how the body should be cleansed of all its impurities before approaching God are laid down in the book of Manu and the Quran. Parturient or menstruating women cannot participate in religious activities for they are considered to be in a state of pollution. They must wait for a prescribed number of days before ritually bathing to regain purity. Men also can be in a state of impurity and temporarily marginalized, as elements of bodily functions such as semen or excrement are equally pollutant. [Blanchet 1984:28]
However, there is a degree of difference between the Hindus and the Muslims in terms of dealing with purity and pollution. In Hinduism, purity and pollution refers to a static condition which a person inherits and maintains lifelong (Blanchet 1984). The higher caste Hindus are pure, while the lower caste Hindus are impure because the latter do menial work. The lower caste Hindus have to do menial work not only for living but also for fulfilling their religious obligations. The lower caste occupational groups such as napit (barber), dai, and dhupa (washer man) live in a permanent state of impurity, while impurity affects their higher caste clients only temporarily. According to the Manu, the Hindu sacred book on law (1984), a Brahmin is polluted when he touches a menstruating woman, an outcaste, a parturient woman, or a corpse, or when a menstruating woman stares at him when he eats food. He must bath to be pure again. The high caste Bengali Hindus would do the rituals of purification after dealing with the low caste Hindus and the Muslims.

By contrast, Blanchet (1984) observes that the rules of purity and pollution are situational for the Muslims. For example, a Muslim man is not polluted when he touches a menstruating woman, a Hindu or a corpse, but he is polluted when he touches menstrual blood or human or animal feces. However, both Bengali Muslims and Hindus shared some common notions of pollution and purity in many areas of social life such as women and children’s health. “The dangers to [a] woman’s life and [a] newborn baby’s life are seen to derive from pollution and from the potential attack of the bhut. Thus, miscarriage, menstrual complications, extended labor pain, postnatal diarrhea, infants’ diarrhea and tetanus are explained by evil spirits,” observes Rozario (1998:154-55).

The Muslims and the Hindus follow different rituals and taboos for avoiding pollution and for purification. For example, childbirth is a polluting event in Bangladesh (Rozario
1998), and serious sicknesses may occur if any dirt or blood, released during childbirth, contaminates the places where the family members cook or wash their foodstuff. The Hindus use cow dung to purify their houses, but the Muslims hate this practice as they consider cow dung impure (Rozario 1998). Both the Muslims and the Hindus cut the nails and shave the hairs of newborn babies to remove pollution (Blanchet 1984). The villagers of Rupsha, who are Muslims, also consider childbirth as a polluting event and perform the rituals of purification. There are some similarities among the women in these communities, all of whom perform some common practices and rituals such as avoiding prayers in a birthing place unless the polluting period is over. It is believed that ferestas (angels) do not enter such places due to pollution. Every woman considers menstrual pollution as less harmful than that of childbirth. They bathe every morning from the first day of the menstrual period to stay “pure” and have a ritual bath after the end of the period. However, women also differ to some degree in performing other rituals and taboos. For example, after childbirth, the dhoni women stay away from cooking for 40 days since this period is a polluting period. Other members of their extended family cook for her. They also avoid going outside except for urgent work. On the other hand, the bhumihin women cannot avoid cooking due to the unavailability of help. They minimize the danger of pollution by bathing before they cook meals.

Thus, the women of Rupsha interpret and use the term “purity” in two ways. One is to stay “pure” from polluted substance such as menstrual blood and dirt that attracts malevolent spirits. On the other hand, sometimes they use the term as a synonym for “modesty” and “chastity” that brings honor to a woman and her household. To achieve this purity, women need to avoid adultery, maintain a distance from adult males, wear proper clothing, and avoid visiting public places. While the women of all categories try to maintain chastity and distance
as best they can, the *bhumihin* women, due to the nature of their work, cannot avoid public places.

Chowdhury observes that in Bangladesh it is not enough to classify people based on caste and status, and suggests ranking people in terms of power—the ability to influence people and the power structure to act. From this perspective, he divided rural people into two groups—one group who held power and the other group who lacked power. The sources of power for an individual included land-ownership, membership in the elected bodies of the village administration, such as *union parishads*, academic qualification, membership in the political parties, connections with political leaders and parliament members, and connections with high-ranking government officials and law enforcement agencies. To use Bourdieu’s terminology, rural people gain and exercise power based on their economic, cultural, and social capital.

Although, the Muslims are usually stratified into status groups and the Hindus into castes, the rural people, irrespective of their religions, can be classified into various groups based on land-ownership. Drawing on Marx, Chowdhury (1978) argues that land-ownership is the principal unit of social stratification in rural Bangladesh since it is the only means of production. Based on land-ownership, he categorized rural people into three different classes: landowners, tenants or sharecroppers, and landless laborers. However, Chowdhury warns us that these classes do not correspond to the classes Marx mentioned, when he says:

If we follow Marx strictly in defining class, we cannot call them three different classes. Because it is very doubtful, whether class-consciousness exists among the members of all these three different classes [Sic]. Moreover, we are concerned with only agrarian classes and not industrial classes. Again, following Marx, we can call them three different classes for they occupy different positions and perform different functions in the organization of production and the classes are based on the ownership and non-ownership of the means of production. [Chowdhury 1978:17]
In Rupsha, land-ownership determines a person’s status since land is people’s principal form of economic capital. A *dhoni krisok* possesses a high status, while a *bhumihin krisok* possesses a low status. Due to their high status, the *dhoni krisok* are called *bhodrolok* (High-status men). The concept of *bhodrolok* originated during British colonial rule, which continued in this area from 1757 to 1947. The *Permanent Settlement Act of 1793* created a new *zamindari* system where *zamindars* would own lands and pay a yearly tax to the colonial administration. Before this act, the *zamindars* had only revenue collection rights but not the ownership of the lands they had in their control (Hartmann and Boyce 1983). If a *zamindar* failed to pay his taxes, his estate would be auctioned off for arrears. As the colonial administration set the tax assessment high, many *zamindars*, who were primarily Muslims, failed to pay their taxes and lost their estates to Hindu merchants (Hartmann and Boyce 1983). The new *zamindars*, who were mostly upper caste Hindus, were known as *bhodrolok* because of their high economic capital (e.g. lands), social capital (i.e. connections with the colonial administration and other *bhodroloks*) and cultural capital (i.e., education and knowledge of English language).

Alongside the *zamindars*, the other higher caste Bengali Hindus such as the *Brahmins*, who collaborated with the colonial administration, also enjoyed the status of *bhodrolok*. The *bhodrolok* of Bengal would value western education and knowledge. Most would send their children to learn English to ensure white color jobs for them in the colonial institutions in the future (Kumar 1998). The *bhodroloks* of Bengal were superior in social status for their economic capital (i.e., lands), social capital (i.e., connections with the colonial administration), and cultural capital (i.e., education) to the other people of the society. It was
implied that those who were not *bhodrolok* were *ovodro*. The *bhodroloks* would not do any menial work, while the *ovodroloks* would do that.

The concept of *bhodrolok* became familiar in Dimla after the settlement act. The first *zamindar* of this area was from Babu Harram’s family who came to this area from Orissa, India, in 1755 as a revenue collector of the *nowab* who ruled the area before British occupation. After the permanent settlement act, Babu Harram became the *zamindar* of Mahigonj, a nearby *thana*. After his death in 1790, his son Ram Jibon Roy succeeded him. After the death of Ram Jibon Roy in 1807, his son Joy Ram became the *zamindar* and moved his residential and administrative center to Dimla from Mahiganj. As a collaborator of the British colonial administration, this *zamindar* family contributed to the implementation of many British policies including the expansion of a British-styled education system in the area. It established the first high school in Dimla and constructed a road connecting the nearby villages with the school, making it possible for many *dhoni krishoks* to send their children to the school to become *bhodroloks*. Although the colonial rule ended around 60 years ago and the *zamindari* system was abolished, the concept of *bhodrolok* remains in this area and in overall Bengali society.

The *bhodroloks* of Rupsha also have high economic capital (i.e., lands), high cultural capital (i.e., education), and high social capital (i.e., influence on the local power structure). Abstention from menial work is a way for the *bhodroloks* to express their higher status. They own lands and hire labor to work them. Some *bhodroloks* own businesses in addition to lands, and their educated children work at the local schools, colleges and government and non-government organizations in various capacities, generating economic, cultural and social capital. The *bhodroloks* can ensure that their offspring gain high cultural capital (i.e.,
education), social capital (i.e., connections with influential people), and economic capital (i.e., jobs). The children of the bhodrolok households attend the local schools and colleges for high school education and move to cities or towns for higher education.

The women of these households (who are known as bhodromohilas) hire female domestic workers to do household tasks such as cleaning, childcare, and raising poultry and cattle. The female domestic workers are also required to do post-harvesting work (such as boiling and drying paddies and making them ready for taking to the rice mills) during a harvesting season. The bhodromohilas prepare meals for their families and supervise the work of the female domestic workers. Many young bhodromohilas who have high cultural capital (i.e., education) hold jobs as teachers at the local schools and colleges and as secretaries at the local NGOs.

Most bhodromohilas maintain purdah, which means the physical separateness of women from outsiders particularly from men, and “modesty”, which refers to “proper” mannerism and a dress code for women. Maintaining purdah is important to maintain the purity of women (that I discussed early), which is necessary for maintaining family honor, a form of cultural capital for a household. The dhoni households spend money (by appointing domestic aids to do the outside work) so that their women can maintain purdah. Adultery by a woman or an emotional involvement of an unmarried girl with a boy or a man is a shameful act for her family. Family honor, as a form of cultural capital, is important to maintain as well as gain social capital such as establishing relationships with other bhodroloks through marriage. It could also be used to gain another form of social capital (i.e., influence on the village power structure) by winning elections, as people would like to elect people from honorable families on the union parishads as their representatives.
The high status of the bhodrolok households of Rupsha is also symbolically represented through the physical structure and decoration of the houses. Most bhodrolok houses are made of bricks, as it is a recent trend among the bhodrolok to have brick-built houses to show their higher social status. This trend began after the construction of the road, which connected the village with the neighboring towns where “modern” buildings have been built with bricks, as the road reduced the time and cost of carrying construction materials to the village from the towns. Some bhodrolok houses were made of wood and tin. A typical bhodrolok house has several large bedrooms and separate spaces for cooking, dining and bathing, and a big storeroom known as gola ghor to store agricultural products. A big gola ghor marks land-ownership and the high social status of the household. In recent years, rural electrification has helped the bhodrolok households to furnish themselves with ‘modern’ electronics such as light bulbs, fans, televisions, and appliances like refrigerators. The male members of these households ride motor bikes, while the female members hire rickshaw-vans to go to distant places. In recent years, most dhoni household members, including women, have access to cell-phones, increasing and strengthening their networking with distant kin and friends.

### Table 2.8  
Physical structure of houses in Rupsha

<table>
<thead>
<tr>
<th>House building materials</th>
<th>Number of houses</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bricks</td>
<td>36</td>
<td>6.11</td>
</tr>
<tr>
<td>Bricks + Tin</td>
<td>2</td>
<td>0.34</td>
</tr>
<tr>
<td>Tin + Wood</td>
<td>1</td>
<td>0.17</td>
</tr>
<tr>
<td>Tin</td>
<td>386</td>
<td>65.53</td>
</tr>
<tr>
<td>Tin + bamboo</td>
<td>95</td>
<td>16.13</td>
</tr>
<tr>
<td>Straw</td>
<td>63</td>
<td>10.70</td>
</tr>
<tr>
<td>Clay</td>
<td>6</td>
<td>1.02</td>
</tr>
<tr>
<td>Total</td>
<td>589</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Field data 2007
The *moddhobitta krishok* households have a lower status compared to the *dhoni krishok* households because a *moddhobitta krishok* owns less economic capital (i.e., lands), less cultural capital (i.e. education and family honor) and less social capital (i.e. influence on the power structure). Most *moddhobitta krishok* houses are made of bamboo and tin, as they cannot afford bricks, while some are made of tin. Most *moddhobitta krishok* households have power supply, but cannot afford other utilities such as televisions, refrigerators, and motor bikes like their *dhoni* neighbors. Some have access to cell-phones. The women of these houses do their own household work and many work at *dhoni*-farmer households when necessary.

The *bhumihin krishok* have the lowest status in the village as they possess the least economic capital (i.e., lands), cultural capital (i.e. education and family honor), and social capital (i.e. influence on the local administration). Most *bhumihin krishok* houses, which are made of mud, straw, or bamboo, are called huts. A typical hut has a single room and a tiny space for cooking. It is rare to have any furniture or ‘modern’ facilities such as power supply, electronics, and appliances in a hut. A few *bhumihin* households have cell-phones, which they may have bought with their small loans, and use them to earn some extra money in addition to working as day laborers. The *bhumihin krishok* are sometimes called *chasha* by the *bhodroloks*. The literal meaning of *chasha* is agricultural laborer, but the connotative meaning of the term refers to someone who is illiterate and uncouth.
2.6 Family, kinship, and social groups

_Ghor_ (household), _atmiya-shajans_ (kin), and _samaj_ (a territorially defined social group) as forms of social capital have important influence on a villager’s life. A _ghor_, composed of the members of a nuclear family or, in some instances, the members of an extended family, is the primary social unit in the village. Usually the members of a _ghor_ share workload, contribute money for food, and invest their savings together.

<table>
<thead>
<tr>
<th>Number of People per Household</th>
<th>Number of Households</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>00-02</td>
<td>98</td>
<td>16.64</td>
</tr>
<tr>
<td>03-05</td>
<td>403</td>
<td>68.42</td>
</tr>
<tr>
<td>06+</td>
<td>88</td>
<td>14.94</td>
</tr>
<tr>
<td>Total</td>
<td>589</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Field data 2007

The number of members of a _dhoni krishok_ household is higher than that of a poor household. In an Indian context, Wadley (2002) argues that, an extended family structure is more common in land-owning households than in landless households. An extended family is a source of power as it helps people maintaining economic capital (i.e. lands), social capital (i.e. kin networks) and cultural capital (i.e. family honor). In Rupsha the _dhoni_ households would have three (patrilineal) generations—grandparents, parents and married sons—living jointly in a household. Usually the household head and his married sons would jointly look after the lands and share the income. For example, in Khadija’s extended family her three married sons would collectively look after the family lands, which was about 60 _bighas_. Her extended family lasted until two years after the death of her husband. When I was at the end
of my fieldwork, her extended family split up. While talking to her, Khadija said, “If their
father was alive, they would not be able do this. As the mother, I could not be tough.” Like
many villagers, Khadija believed that bagol howa (splitting an extended family) is a shame.
To her, it was tough but honorable to maintain an extended family because outsiders would
appreciate the cooperation and sacrifices of the members of the family.

During a marriage, membership in an extended family would add an extra quality to a
girl’s resume as it is assumed that the daughters of such families know the value of
cooperation. An extended family would split up after the death of the household head or
because of the presence of people with strong opinions and choices who would not like to
compromise. The person, usually a married son, who initiates the separation, is called
sharthopor (selfish). Other factors, which contribute to split an extended family, include
conflicts between the daughter-in-laws. Khadija said that conflicts between her daughter-in-
laws destroyed her extended family. She elaborated, “They (daughter-in-laws) quarreled
almost every other day. Each of them would claim that she did all the household work and
the others did nothing. Finally, I decided that separation was better than quarrel.” Khadija
was upset when she made the final decision. However, she consoled herself that her sons did
not leave the bari (homestead). They just built their individual households. Many elderly
women including Khadija prefer an extended family because such a family has someone to
look after elderly people during illnesses.

On the other hand, a few bhumiin krishok households had the extended family
structure. At a typical bhumiin household, husband, wife, and their unmarried children
would live together. Some bhumiin households had a senior parent or parents living with
nuclear families as members. Married sons would make their own separate households after
their marriages. The *bhumihin* households hardly held any idea of common property. Jansen (1986) notes that the poor households of rural Bangladesh split-up and change structures during different periods of the year in response to the scarcity of resources. Many *bhumihin* households in Rupsha would split during *monga*. The *bhumihin krishok* would adopt different strategies to cope with *monga*, which included reducing the number, quality, and quantity of meals, borrowing money from others, and splitting households. Due to the lack of common land-ownership or other material resources, the *bhumihin* households would split frequently and create neolocal residences.

When *monga* ends, at the beginning of the harvesting time of *Aman* rice, the members of a split household rejoin to share income and food. Banu said that her family splits during *monga*. She has a five-member family including her husband, two children, and her widowed mother-in-law. During harvesting seasons, she and her husband feed the family by working as day laborers, but during *monga*, her mother-in-law also has to work as a day laborer. Sometimes her sister-in-laws (her husband’s younger sisters) who are well off and live outside the village would take her mother-in-law to their houses. However, she would not stay there for long because staying at a son-in-law’s house for a long time is considered a shame. Usually, a woman would visit her son-in-law’s house during childbirth or in case of sickness of her daughter to provide assistance.

Although marriage is monogamous by law, the village had a few polygynous couples (Table 2.10 shows the marital statistics of the village). Both village endogamy and exogamy were in practice. Serial monogamy was more common among the *bhumihin krishok*. Economic capital (i.e. lands) and cultural capital (i.e., social status) of the households play important roles in selecting mates. Usually the *dhoni* or *bhodrolok* households would prefer a
bride or bridegroom from the households with a similar status. Although it is legally a punishable offence to pay dowry and NGOs are campaigning against dowry as a part of their social development policy, few marriages take place without the bride’s family paying a dowry.

Marriage is considered a way to strengthen the position of the family within the community. Although marriages within similar status groups are preferred, it is not uncommon for dhoni men to have mates from the moddhobitta households. However, marriages between the people of dhoni and bhumi hin households were rare. Such marriages would be damaging for the dhoni households. If a dhoni man would marry a woman from a bhumi hin household, his relatives would cut ties with him and would maintain relationship on condition that he and his wife would not maintain any relation with his wife’s family.

### Table 2.10 Marital statistics of Rupsha

<table>
<thead>
<tr>
<th>Marital status</th>
<th>Number of Individuals</th>
<th>Percentage</th>
<th>No. of Households</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td>1140</td>
<td>48.16</td>
<td>589</td>
</tr>
<tr>
<td>Unmarried</td>
<td>1191</td>
<td>50.32</td>
<td></td>
</tr>
<tr>
<td>Widow</td>
<td>36</td>
<td>1.52</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>2367</td>
<td>100</td>
<td>589</td>
</tr>
</tbody>
</table>

Source: Field data 2007

Divorce is considered a matter of shame. Divorce would take place for any of the two reasons: childlessness and the failure of the bride’s family to pay the dowry. In any of the cases, a bhumi hin household prefers a divorce and re-marriage because a bhumi hin man lacks ability to provide supports for two wives. On the other hand, in case of childlessness a dhoni man prefers to marry again without divorcing his infertile wife.
The villagers follow patrilocal and neolocal residence patterns. Patrilocal residence pattern is prevalent among the *dhoni* and *moddhobitta krishok* where a woman usually moves into her father-in-law’s house after marriage. On the other hand, neolocal residence is prevalent among the *bhumihin krishok* where a woman might initially move into her father-in-law’s house, but eventually moves into her own house built adjacent to her in-laws’ houses. Irrespective of the pattern of residence, patrilineal kin prefer to live at a close distance. It is quite common for the houses of brothers or close patrilineal kin sharing a courtyard, creating a *bari* (homestead).

In a household, whether *dhoni* or *bhumihin*, men decide how the household expenditure will be met and women manage the kitchen and childcare. Beside household members, social capital—the networks of *atmiya-shajans* (kin)—plays important roles in people’s lives especially during the time of joy (i.e., marriage) and sorrow (i.e., financial crises, sickness, and death). Patrilineal kin are important to recognize *purbo purush* (lineage), while both patrilineal and matrilineal kin play almost equally important roles during ceremonies and crises. In case of a marriage, vital *atmiya-shajans* need to be present to demonstrate family unity, and the absence of such people would portray the family as *ekghora* (unsocial). *Atmiya-shajans* help in shopping, cooking, cleaning, and looking after the guests, and negotiating the *den-mohor* (bride price) and dowry. During a crisis, *atmiya-shajans* would lend money without interest. Like marriage, death is another event when the *atmiya-shajans* of the deceased play important roles by helping arrange funeral services and providing food to the deceased’s family. Usually after the death of a family member, a family does not cook for three days to show respect to the dead and mourn. During these days, *atmiya-shajans* and neighbors prepare food for the family.
In addition to family and atmiya-shajans, samaj is important in a villagers’ life. Aziz (1979) defines the samaj as a territorially defined social group. Everyone who lives within the boundary of a samaj becomes its member. A samaj provides the basic frame of reference for social activities for its members. It has the authority to punish any member who deviates from the established group norms. Refraining people from anti-social and anti-religious activities is an important function of a samaj. From area to area, the pattern of samaj varies from highly cohesive to loosely informal forms. Usually a samaj has many sub-samajes. People, whether rich or poor, pay heed to the samaj to maintain group values and norms, but interact and maintain social relationships with the members of their own sub-samaj. Sub-samajes develop based on religion (such as Muslim samaj and Hindu samaj) or social status. Religion based sub-samajes define religious norms and taboos and perform religious rituals and celebrate festivals together.

The samaj of Rupsha, which is divided into multiple sub-samajes based on the social statuses of the members, define the social boundaries of interactions for its members, set the norms and values, and punish those who deviate from the norms. For example, the members of the bhodrolok sub-samaj reside in the same territorial boundary and maintain ties between themselves by occasionally visiting each other’s homes and exchanging food. Similarly, the members of the sub-samajes of the moddhobitta krishok and the bhumihiin krishok interact among themselves. Muhammad Rafiq, a 55-year-old man of the village, said that people would feel obligated to help the people whom they considered members of their sub-samaj. However, during marriages, deaths and religious ceremonies, the members of the samaj get together to share joy or sorrow, but do not dine together as dining spaces are status specific.
The *bhodroloks* would have dining tables and chairs to have food and their dining space would separated by curtains from the other groups who would dine on a mat.

### 2.7 Conclusion

This chapter has given a comprehensive picture of the village life by exploring its geographical location, climate, demographics, social hierarchy and economics. The villagers, depending on their social statuses, possess different forms of capital such as economic capital (i.e., lands, businesses, and jobs), cultural capital (i.e., education, family honor, and social prestige), and social capital (i.e. influence on the local power structure and kin networks) to use them in case of a need.
3. Health, Medicine, and Healers

The health field of Rupsha has four treatment systems—biomedicine, ayurveda, homeopathy, and folk medicine—operating at the same time. Each healthcare system has its distinct approach, models, and nature of care giving. Biomedicine and homeopathy expanded in the area, which is now Bangladesh, during the British colonial rule. Biomedicine is the privileged system in the country’s health field as the public health system is based on this medical system, and it expanded from the urban areas to the rural areas over the years. It is necessary to understand the nature of the healthcare systems to know what strategies women use to act in the health field. Taking a historical approach, this chapter explains the healthcare systems operating in the health field of Rupsha. The first section of the chapter discusses the evolution of healthcare systems in Bangladesh, and the second section deals with the healthcare systems functioning in the village.

3.1 Evolution of the healthcare systems in Bangladesh

Biomedicine, a western medical system that came to the Indian subcontinent during the age of European colonization, ayurveda, unani, and homeopathy are practiced side by side in Bangladesh. Ayurveda is an ancient healing system of the Indian subcontinent, including in Bangladesh, while the others came from abroad at different times during foreign occupation.

Ayurveda survived challenges from foreign medical systems like unani and biomedicine to remain in practice. One of the main features of this indigenous medical
system is that its healing emphasizes the holistic soundness of health. It not only focuses on curing a disease but also on promoting longevity and soundness of the human body (Basham 1976). Ayurveda perceives the human body as a composition of three main elements—dosas, dhatus, and malas. Dosa involves three components—vata (wind), pitta (gall) and kapha (mucus). Dhatu refers to seven elements: plasma, blood, muscle, fat, bone, bone marrow, and reproductive tissues. Malas means waste materials such as urine and sweat. According to ayurvedic philosophy, sound health means the balance of dosas, dhatus, and malas, while their imbalance results in a disease (Murthy 1987, Obeyesekere 1976, Thakar 1992). This notion of disease suggests that an ayurvedic physician tries to find out the causes of disease in a body part for cure and emphasizes maintaining the soundness of the whole body (Singh 1992).

Ayurveda’s concept of the holistic soundness of the body emanates from its etiological explanations of illnesses. The classical texts of ayurveda documented it as a scientific healing system, which was an improvement on the ancient Indian magico-religious framework of explaining disease (Lock and Nichter 2002). According to the first major text on ayurveda, Caraka Samhita (which appeared in the first century of the Christian era), ayurveda developed by incorporating a rational and humoral approach that recommended healing by drugs and diet into the earlier approach to healing (i.e., religious and magical). The second major text on ayurveda, Susruta Samhita (appeared in the fourth century of the Christian era), documented the use of surgical procedures in ayurvedic treatment. According to the third major text on ayurveda Vagbhata Samhita (appeared in the eighth century), ayurveda was a secular and rational healing system (Dunn 1976, Langford 2002). Ayurveda “reflected a transition in therapeutics from association with religion and magic to a more
rational and scientific method of treatment” (Bala 1991:25). Ayurveda explained diseases as caused by natural forces (Basham 1976), not by a god, goddess or evil forces, and propagated that humans could maintain good health if they had the necessary knowledge.

However, some medical practices, such as corpse dissection, were taboo in Ayurveda for a long time. Zimmer (1948) claims that ancient ayurvedic physicians did not have any clear idea about the functions of brain, lungs, and heart. They used to believe that human heart, not the brain, controls human consciousness. However, nobody is certain whether classical ayurveda used dissection and surgery for treatment. Basham (1976) argues that, corpse dissection was not unknown to ayurvedic physicians, known as vaid or kabiraj.

The teaching and learning methods of the ancient ayurvedic tradition were different from the present day ayurvedic practices. There were no formal institutions to train students in ayurveda during the ancient time; a student would go to a kabiraj, who would be the guru, to learn the medicine (Basham 1976). A guru would provide his students with both theoretical and practical training necessary for practicing ayurveda (Basham 1976, Mishra 1992). It was believed that this teaching, which included moral lessons and rituals, would establish a sacred relationship between a guru and a student (Basham 1976). An initiation ceremony, when the guru would lead his students to circumambulate a fire three times and recite mantras, was an important part of this training. This initiation ceremony would also accompany lessons on moral issues such as honesty, chastity, and modesty. The student would learn the methods of dealing with patients and other people as a physician. The guru would instruct his students to keep the knowledge of medicine secret (Basham 1976), and outsiders were not allowed to hear or participate in the teaching sessions.
Ayurveda reached its classical form during the Gupta Empire, which ruled India during the early centuries of the Christian era (Basham 1976). Zimmer (1948) notes that ayurveda was accessible only to aristocrats. A Chinese traveler to India noted the existence of hospitals during this period as he spotted a hospital in Patna, funded by the rich people of this city, where patients received treatment and care from physicians (Basham 1976). Most ayurvedic physicians used to treat patients and prepare medicines primarily at their homes.

Ayurveda faced challenges from unani in the 12th century when the Mughal rulers of India brought the unani medical system to India and from biomedicine in the 18th century when the British colonial administration introduced this medical system to the Indians. The people who fought for the revival of ayurveda claimed, “The introduction of Yunani (unani) medicine to India caused Ayurveda to decline. … the development of cosmopolitan medical institutions in India caused the further deterioration of Ayurvedic knowledge and practice” (Leslie 1976:357). The impact of biomedicine was deadlier than that of unani. Kumar (1998) observes that the rapid expansion of biomedicine helped reduce the acceptability of both ayurvedic practitioners and unani practitioners (haakeem). He writes:

The ignorant vaids and Hakeems were losing their practice and influence was evident from the fact that more and more patients were flocking to the government hospitals and dispensaries. The people were increasingly getting convinced that the method of allopathic treatment was superior to their own and that it could cure disease in a manner never seen before. [Kumar 1998:68]

However, at the beginning of the British rule, the colonial administration did not show any ‘negative’ attitudes toward the healing systems, which existed in India (Harrison 1994). British doctors took suggestions and advice from the vaids/ kabirajes and Hakeems because the latter had better knowledge about health problems, weather, and indigenous medicinal plants (Harrison 1994). However, this positive attitude began to decline when the colonial
administration started using its science and knowledge to justify its rule. Citing David Arnold and Mark Harrison, Forbes notes that “western medicine became a tool of empire: keeping white masters and colonial subjects healthy, facilitating social control, and creating knowledge that fed a discourse justifying imperialism” (2005:103). The colonial administration began to identify local healing systems and practices as ‘irrational’, ‘unscientific’ and promoted its science and knowledge as superior (Arnold 1985).

Relevant colonial documents show that the British subjugated indigenous medical systems in the Indian subcontinent in a planned way (Brass 1972). The expansion of the biomedical system subjugated the other healthcare systems in terms of infrastructure and government support but could not eliminate them (Bala 1991). It was not possible to subjugate the practicing healing systems in India, especially ayurveda, because of a popular revivalist movement organized by the kabirajes to save their profession. Leslie (1976) argues that this movement emerged as a response to a declining status of ayurveda caused by the expansion of unani and biomedicine. The revivalist movement gained momentum in 1907 in the British India with the establishment of a professional organization called ‘All India Ayurvedic Mahasammelan’, which involved the kabirajes throughout India (Brass 1972). With political backing from the Indian National Congress in 1920, it demanded government support for ayurvedic education and treatment. Because of this movement, many ayurvedic institutions were established during British rule throughout the undivided India, including Bangladesh (Brass 1972).

Unani, a Greco-Persian medical system, began to spread in India during the Mughal period in the 12th century. Mughal rulers, who came from the Persian region, brought their own physicians who introduced unani medicine in India (Jeffery 1988). The unani medical
system was originated in ancient Greece and was later modified and enriched in Arabia and Persia (Bala 1991). Like ayurveda, unani is also a humoral medical system. It believes that the human body is a composition of four fluids—dam (blood), balgham (phlegm), safra (yellow bile) and sauda (black bile)—and a healthy body means a proper balance of these elements (Ghani 2005). The balance of these body fluids creates a power of “self-preservation or adjustment” in the body which is called quwwat-e-mudabbira (medicatrix naturae). When this power weakens or the balance is disrupted people feel sick (Ghani 2005). In terms of healing a disease, unani also suggests the restoration of soundness of the whole body like ayurveda. Ghani notes that different types of “medicine are used in this method of treatment to help the body to regain this power to an optimum level, thereby restoring humoral balance and helping to cure the disease” (2005:1). However, it was difficult to practice unani in India because Indian weather would not allow producing many unani herbs. Hakeems read ayurvedic texts to learn about the medicinal plants available in India and felt that a good treatment system could emerge by combining unani and ayurveda (Basham 1976). In the 16th century, the Mughal administration took initiatives to combine unani and ayurveda to produce a composite medical system (Leslie 1976, Leslie 1974). Basham observes, “The practitioners of the two systems seemed to have collaborated, because each had much to learn from the other” (1976: 40). In many respects, kabirajes adopted the methods of hakeems to interpret illness. For example, the classical ayurveda did not have any practice of pulse examination but unani had. Learning from unani, the kabirajes would have pulse examinations in treating patients (Sharma 1992) and use mercury and opium in medicine (Leslie 1976). Ayurveda and unani are the two healthcare systems, which
had been in practice across the Indian subcontinent, including Bangladesh, for centuries before the arrival of homeopathy and biomedicine.

Homeopathy, a German medical system, came to the Indian subcontinent during British colonial rule when John Martin Honigberger, a direct disciple of Hahnemann (the founder of the science of homeopathy) introduced the medicine in Lahore in 1838 where he worked for 15 years. During his stay, he treated many people, popularizing the medicine across the sub-continent. He treated many cholera patients successfully and was known as the “Cholera Doctor” (Kumar 1998). Although it did not get any institutional or financial support from the colonial administration, homeopathy spread to the every part of the sub-continent by the late 19th century (Kumar 1998). Homeopathy practitioners, known as homeopaths, set up several homeopathy institutions in the colonial Bengal to teach the medicine as well as continue treating people with the help of some zamindars (Kumar 1998). A homeopathy school was established in Dacca, now Dhaka, in 1882. Homeopathy employs a naturalistic etiology and uses drugs in diluted forms to cure disease. From the homeopathic perspective,

Ill health, therefore, is a condition of the whole person, though its symptoms may be localized in the body and appear or disappear according to particular sequences or patterns. Moreover, each person has their own characteristic disease profile and ‘constitution’. There are certain types of constitutions, configurations of propensities, habits and tastes which correspond to particular remedies, thus in classical homeopathy, prescribing must relate to the individual profile of the particular patient rather than to a named disease or syndrome of symptoms. [Cant and Sharma 1996:581]

Biomedicine is the other widely practiced European medical system in Bangladesh. It follows a naturalistic etiological explanation, but operates on a mind/body dualism, diagnosing a disease in either the body or mind. Critics argue that biomedicine diverts people’s “attention from the social origin of illness” to its biological or physiological origin (Baer 1989:1106).
The Portuguese merchants who came to the subcontinent for business purposes introduced biomedicine in this region, while the British colonial administration established it as the ‘superior’ healthcare system (Kumar 1998). The colonial administration initially established biomedical facilities to treat soldiers and bureaucrats, but eventually had to open them up for others to protect trade and commerce interests from the diseases, which broke out like epidemics during the colonial period (Bala 1991). Drawing on historical data Doyal (1979) argues that many infectious diseases such as smallpox, leprosy, and measles spread in Africa, America, and Asia during colonial rule. The neglect of the subsistence economy and imposition of taxes by colonial administrators, and insufficient wages from the cash economy helped increase poverty and reduce the quality of the diet of people in the colonies increasing malnutrition and susceptibility to infectious diseases. The subcontinent also faced this consequence as malaria, plague, smallpox and many venereal diseases spread in the region during the colonial rule.

Initially the British doctors would treat the patients, but their number was not enough to fulfill the duty when the number of military stations increased significantly. To meet the growing need, the colonial administration looked for low-cost local helpers (Kumar 1998). A military medical department was established in 1812 to train native doctors who would be recognized as counterparts to the British doctors (Kumar 1998). Medical education started in native languages, such as Bengali, by translating the English texts and had some courses on indigenous medicine. However, some colonial officials opposed this initiative by raising questions about the effectiveness of a medical education through translation. They suggested teaching the medical sciences in English to impart “error free” medical education and dropping courses on indigenous medicine (Kumar 1998). Consequently, the medical
institutions that taught biomedicine and indigenous medicine simultaneously were abolished by 1835. The colonial administration made biomedicine the only acknowledged system of study, and showed tendencies to subdue the indigenous healing system, labeling them as ‘quackery’ (Forbes 2005). Biomedicine became institutionalized in the area, which is now Bangladesh, through colonial initiatives.

The colonial healthcare system based on biomedicine was an urban biased structure from the very beginning as health facilities were built primarily at the urban centers to provide healthcare to the British officials, soldiers, and local elites who collaborated with the regime. Although healthcare of common people was not a concern at the beginning, by the early 20th century, the colonial administration began initiatives to improve the health of common people in both rural and urban areas to ensure a healthy workforce to run trade and commerce (Osman 2004). It tried to decentralize the healthcare system to spread health resources to semi-urban and rural areas. It gradually expanded some health services such as vaccination and sanitation programs in rural areas. The health department formed a health survey and development committee in 1943 with Sir Joseph Bhore as chair which released its report, known as the Bhore Report, in 1946 (Osman 2004). The Bhore Report recommended a radical reform of the health system of the Indian subcontinent with the government taking responsibility to provide health services to everyone. Some of the key objectives of the report were as follows:

- that no individual should fail to secure adequate medical care because of inability to pay for it;
- the health programme must from the very beginning, lay special emphasis on preventive work with consequential development of environmental hygiene;
- the health service should be placed as close to the people as possible in order to ensure the maximum benefit to the communities to be served;
• it was thought essential to secure the active cooperation of the people in the development of health programme, and active support of the people was to be sought through establishment of a health committee in every village;
• the doctor-the leader of the health team should be a ‘socio-physician’, who should combine remedial and preventive measures to confer the maximum benefit on the community, and future doctors should be trained to equip themselves for such duties. [Osman 2004:73]

This Report emphasized the expansion of healthcare facilities across the subcontinent so that all people could have easy access to healthcare. However, British rule ended before implementing the recommendations of this report, leaving the healthcare as a curative, urban based and elite-centered system (Osman 2004). After the end of British rule in 1947, the subcontinent produced two independent countries—India and Pakistan (the area which is now Bangladesh joined Pakistan as East Pakistan). In the newly created Pakistan, the healthcare system continued to work as an urban-based system with hospitals located in the major cities. The Pakistani government did not pay attention to the Bhore Report until malaria and small pox spread like epidemic in the early 1960s. An alarming spread of such infectious diseases compelled the government to initiate some of the steps recommended by the Bhore Report such as expanding healthcare facilities on people’s doorstep. By 1970, healthcare facilities were expanded, building health centers in rural areas; health centers were built at 140 thanas of East Pakistan (Osman 2004).

East Pakistan became separated from Pakistan after a nine-month war in 1971 to become Bangladesh. The Bangladeshi government continued many health policies of the Pakistani regime for quite some time. Bangladesh’s initiatives and plans related to healthcare have been codified in its national development plans called the five-year plans. The first five-year plan (1973-78) emphasized expanding healthcare services at the thanas. The plan emphasized eradicating communicable diseases, reducing morbidity and expanding training
facilities for healthcare professionals. However, a major change in the health policy occurred since 1978 after the signing of the Alma Ata Declaration, which was adopted at a World Health Organization conference at Almaty (formerly Alma-Ata) in Kazakhstan. In this Declaration, the signatory states committed to provide primary healthcare to all.

After signing this Declaration, the Bangladeshi government began to take action to spread primary healthcare at the grass-roots level (Osman 2004). The healthcare system shifted focus toward preventive and rehabilitative services, from curative services, and community participation in healthcare by decentralizing services (Osman 2004).

The main slogan of the second five-year plan (1980-85) was to provide healthcare to all by 2000. For that, the plan emphasized primary care, proposed to expand healthcare at every thana, and establish health centers at the unions. Similar to the second five-year plan, the third five-year plan (1985-90) also focused on primary care and the expansion of health infrastructure at thanas and unions. The fourth five-year plan (1990-95) continued the same strategies with a promise to ensure healthcare for all by 2000. Another goal of this plan was to have an integrated primary healthcare delivery service by collapsing mother and child-health department and family and welfare department. The fifth five-year plan (1997-2002) emphasized expanding health infrastructure at the villages.

The health policies of Bangladesh formulated over the years reveal that the state is committed to making healthcare services available to all its citizens—urban as well as rural and males as well as females. Universal healthcare is a constitutional obligation of the government as the constitution states that:

It shall be a fundamental responsibility of the state to attain, through planned economic growth, a constant increase of productive forces and a steady improvement in the material and cultural standard of living of the people, with a view to securing to
its citizens- a) the provision of the basic necessities of life, including food, clothing, shelter, education and medical care. [Planning Commission 1998:446]

Although constitutionally the state is committed to secure healthcare for all, in reality it is far away from doing that. People do not have equal access to healthcare. Osman (2004) claims that individuals afford healthcare services based on their ability to pay. Ahmed et al (2006) argues that although the government affirms the rights of all citizens to healthcare in official rhetoric every now and then, the public healthcare system is beyond the reach of many people as it is crippled by ineffective healthcare delivery modes (Ahmed et al. 2006). Osman identifies the Bangladeshi healthcare system as entrepreneurial as it is neither fully controlled by the government nor by the market. “[I]n such a system, government healthcare programs are relatively weak and limited to some particular sections of the population. Access to healthcare is considered as the individual’s responsibility.” (Osman 2004:65).

3.2 Dispensation of healthcare services

In Bangladesh, both public (i.e. state owned and operated) and private sectors provide healthcare services, with the private sector playing the dominant role (see Osman 2004, Siddiqui and Khandaker 2007). Osman (2004) notes that the private sector, consisting kabirajes, hakeems, homeopaths and biomedical practitioners, provides 75 percent of the total healthcare services. Siddiqui and Khandaker claim that “in Bangladesh, 13% of treatment seekers use government services, 27% use private/NGO services, and 60% [use] unqualified services; the folk sector (consisting practitioners who do not have any academic degrees on healthcare) provides 60% of the private sector healthcare services” (2007:221).
Private biomedical hospitals and clinics started to flourish in the country from 1977 when the then military government encouraged the private sector to help fulfill the healthcare needs of people alongside the public sector. Between 1975 and 1981, the state-owned banks granted low interest loans to private entrepreneurs to set up private hospitals and clinics. The private sector in healthcare got a further boost when the Medical Practice, Private Clinics and Laboratory Ordinance of 1982 legalized private healthcare services and stated the rules and regulations for establishing private clinics and hospitals (Planning Commission 1985, Rahman 2007). The successive governments continued supporting private sector growth in healthcare. Alongside the private sector, NGOs got involved in providing healthcare services. Most biomedical private clinics and hospitals are located at the urban centers. The physicians of the public hospitals serve at the private clinics and hospitals to earn some extra money (Osman 2004, Gruen et al. 2002, Andaleeb 2000).

The public health system is based on biomedicine and employs only biomedical practitioners. State support for alternative healthcare service delivery is limited to institutional development. This discrimination against alternative healthcare practitioners compelled them to provide their services through individual initiatives. To provide public health services, both government and non-government organizations train and employ different categories of biomedical practitioners such as physicians, nurses, and dais (traditional midwives). To become a biomedical physician, one has to complete a five-year degree program called MBBS (Bachelor of Medicine and Bachelor of Surgery) from a medical college, after finishing high school education, while to become a nurse one has to do a three-year diploma program from a nursing college. A woman can become a dai after completing a short training course on maternal health offered by the Department of Public
Health and NGOs. These biomedical practitioners possess different qualifications and statuses in the society.

In the biomedical occupational hierarchy, physicians enjoy the highest status as they possess ‘superior’ knowledge, which Jordan (1978) would call authoritative knowledge, while the dais enjoy the lowest status. The medical education, the cultural capital of a physician, which they master at a medical college, is considered superior and scientific, as it is British-styled. This education facilitates one getting a decent job in public health and being treated as a bhodrolok in the society. On the other hand, in Bangladesh, nursing is considered an ‘inferior’ profession and as a result, people, especially women, from poor socio-economic backgrounds take nursing as a profession. Dais are considered ‘inferior’ to nurses in terms of economic capital (i.e., monthly wages) and cultural capital (i.e., skills and education). While nurses receive monthly salaries for their employment, most dais are on call for maternity services. A dai receives whatever the family of a birthing woman voluntarily pays to her.

The public healthcare delivery system of a district is top-down with the services branching out from the district headquarters to the communities. The healthcare services get gradually better and bigger from the community level to the district headquarters, creating an urban-rural disparity in the public health structure. The following chart shows the public health tier of a district:

**Community level → Ward level → Village level → Thana level → District level**

The public health department has a trained person in every community to disseminate health information and motivate the community members to maintain health and hygiene. It has a male health assistant and a female family welfare assistant assigned at every ward (several wards make a village). They periodically visit the households of the ward and set up
makeshift clinics at different locations, decided in consultation with the target people, to
provide some healthcare services. They provide immunization services, have thermometers
to measure body temperatures, and have blood pressure machines to measure blood pressure.
They also have a limited supply of oral saline, to provide primary care for diarrhea treatment,
cold medication, and painkillers, which they distribute free.

Every union has a health center, called the village health center, staffed by a
physician holding an MBBS degree, a health assistant (usually a paramedic), and a
pharmacist, provides some outpatient services. It provides treatment for minor illnesses and
has programs to motivate people to adopt family planning methods. They refer patients with
complicated illnesses and needing surgeries to the hospital of the thana.

Every thana has a public hospital, popularly known as thana hospital, operated by the
public health department and staffed by nine physicians and a number of nurses and other
medical attendants, to provide both inpatient and outpatient services. Each of the physicians
holds an MBBS degree and some of them have 3 to 6 months specialized trainings on
medicine, surgery or gynecology, but none of them is a specialist doctor (Osman 2004).
Complicated patients, who require care from specialist doctors, are referred to the district
hospital, a public hospital located in the district headquarters.

The district hospital provides inpatient and outpatient services with general as well as
specialist physicians. The common specialist doctors in a district hospital include the
specialists on medicine, surgery, and gynecology. A district hospital is larger than a thana
hospital in terms of the number of physicians, surgical units and equipments and the number
of beds. It provides preventive, curative, outpatient and inpatient care. When the doctors at a
district hospital face extremely complicated cases, they refer those patients to specialized
hospitals in Dhaka city. Rural people need to go to the district headquarters or Dhaka city to see a specialist doctor and for surgeries.

3.3 Health, medicine, and healers in the village

All the medical systems except unani are available in Rupsha. Since biomedicine forms the public health system of the village, I will discuss it first and then move to the other systems—homeopathy, ayurveda (kabiraji) and folk. A government funded health center provides biomedical healthcare to the villagers. The center has positions for a biomedical physician, a pharmacist, and a medical assistant to provide only outpatient services. The biomedical physician appointed at the village health center possesses an MBBS degree from one of the country’s public medical colleges. The medical assistant to this doctor, popularly known as “compounder”, hailed from the village and had a high school degree and a short training on primary healthcare. He belonged to a moddhobitta krishok household of the village. In the absence of the physician at the health center, he would voluntarily suggest medicine for patients with minor illnesses. The compounder explained his job to me the following way:

Look, sometimes the physician is absent from work. Usually physicians do not prefer to work in the village health centers. Our village clinic does not have any physician for the last three months but everyday 30 to 35 people visit the clinic. I suggest medicine and pain killers for treating minor illnesses such as cough, fevers, and diarrhea. However, I refer serious cases to the thana hospital.

For example, he refers women with reproductive complications to the thana hospital, which has female nurses. He further notes that usually poor people who lack abilities to go to the thana or district hospital come to the village health center for treatment. The center is equipped to provide treatment for minor illnesses such as fevers and diarrhea. However, the
absence of a doctor in the village health clinic makes it a failing apparatus of the public health system. Women can have pregnancy tests and measure blood pressure and weight there, but the clinic does not have facilities to conduct routine check-ups necessary during a pregnancy, deliver babies, and conduct a surgery. Obstetric technologies that are common in Western biomedical settings, such as fetal monitors and ultrasound are not available in the village health clinic. The patients needing surgery are sent to the Dimla Thana Health Complex, the *thana* hospital, which is about three kilometers away from the village.

Although the village health center did not employ a pharmacist, the village had several ‘pharmacists’ who sold medicine at the local drug stores without any degree in pharmaceutical medicine. Some of them have high school education, while a few of them have bachelor degrees in humanities. Most of them own their stores and belong to the prosperous *bhodrolok* households of the village. Sometimes they suggest medicine, painkillers, and vitamins for treating cough, fevers, weakness, and headache. Raju, owner of a drug store, explained:

> Many men and women come to us and ask for medicine as they do not find a doctor at the village health center most of time of the year. I suggest medicines for them in cases of minor illness. For example, I give them *paracetamol tablets* for fevers, *piriton syrup* for cough, and oral saline for diarrhea. Many women want medicine for their *durbolata rug* (weakness). In such cases, I provide them vitamin and iron pills. I do not suggest any antibiotic medicine. I tell them to go to a hospital if I see them in a critical condition.

Alongside the public and private hospitals and clinics, NGOs like RDRS and BRAC have health services in the village to treat patients with tuberculosis, conduct prenatal check-ups for pregnant women and train *dais* for childbirth. Another NGO, *Jonogoner Dorbar*, provides support and counsel for sanitation. The *sebikas* (female health workers) and *dais* employed by RDRS and BRAC visit pregnant women at their houses to provide prenatal
services and for counseling. While the *dais* of RDRS encourage pregnant women to visit its health center for counsel and check-up, BRAC sends its *sevikas* to homes for prenatal check-ups. Both of these organizations encourage women to call trained *dais* during childbirth so that they can benefit from “trained professionals” during childbirth. Dalia, a 35-year-old *dai* working with BRAC, said:

> We visit each household every month and enlist pregnant women. We record information regarding their present and past pregnancies. We give them necessary information related to nutrition and health. For example, I suggest them to eat extra food, take rest, and take iron and vitamin pills regularly. We measure their weight, body temperatures, and blood pressure every month. We also measure the weight of the new born. We motivate women to have TT (Tetanus Toxoid) shots, immunization and a have regular check-up. We advise them to call a trained *dai* during a normal delivery and go to the hospital when complications arise.

Dalia distributes leaflets that explain what to do when complications arise. She showed me a leaflet, which she was distributing during one of our meetings. This leaflet discussed the risks of a pregnancy and the ways to deal with them.

To explain their roles in the RDRS programs, Nazma, a senior *dai* and an employee of RDRS says,

> I travel across the villages to register pregnant women. When I find a pregnant woman, I try to convince her and her family to register with our program and visit our center for prenatal check-ups. I have to go to a pregnant woman’s house several times to persuade her to enroll in our program.

The *dais* employed by BRAC and RDRS distribute leaflets, iron and vitamin pills and check pregnant women’s blood pressure while they visit pregnant women.

In addition to making health services available, BRAC provides microcredit to their long-term clients to avail certain health services such as a c-section delivery. A document of RDRS shows that they offer different kinds of maternal services (See Table 3.1) across
Dimla. Both NGOs claim that so far they have made a large number of women in the village aware of the need of medical interventions during pregnancy and childbirth.

Table 3.1   Services provided by RDRS in Dimla in April 2007

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of registered pregnant women</td>
<td>387</td>
</tr>
<tr>
<td>Mothers attended the clinic</td>
<td>1190</td>
</tr>
<tr>
<td>Total number of deliveries</td>
<td>384</td>
</tr>
<tr>
<td>Deliveries conducted by the trained dais</td>
<td>294</td>
</tr>
<tr>
<td>Delivery conducted by doctors/nurses/family welfare attendants</td>
<td>28</td>
</tr>
<tr>
<td>Number of safe deliveries</td>
<td>322</td>
</tr>
<tr>
<td>Number of medical kits used</td>
<td>305</td>
</tr>
<tr>
<td>Received antenatal care at least four times</td>
<td>230</td>
</tr>
<tr>
<td>Number of still births</td>
<td>16</td>
</tr>
<tr>
<td>Perinatal deaths</td>
<td>19</td>
</tr>
<tr>
<td>Total number of maternal deaths</td>
<td>01</td>
</tr>
<tr>
<td>Abortion</td>
<td>17</td>
</tr>
<tr>
<td>Complicated cases referred to hospitals</td>
<td>27</td>
</tr>
<tr>
<td>Mothers immunized</td>
<td>374</td>
</tr>
</tbody>
</table>

Source: Data collected from an official, who sought anonymity saying that they had no authority to provide any such information, during my fieldwork in 2007.

The village has a number of dais trained by the public health department and the NGOs. The training programs provided biomedical knowledge to retrain traditional dais and the new recruits. Tohsina, a 30-year-old dai, who completed a training program during my fieldwork, explained her feelings this way:

The training was very systematic. I learned many things. I learned how to take care of a pregnant woman and a newborn baby. They taught us the importance of a prenatal check-up, TT injections, and blood tests. I learned that a pregnant woman has to eat good foods, take enough rest, keep away from pulling heavy things, and take iron and vitamin rich food regularly. The training also taught us about the important aspects of a delivery—how to determine a true or false pain, how to deliver a baby, how to cut the cord, how to clean the newborn and how to avoid infection.
Tohsina claimed that the traditional *dais* who did not receive such a training lack ‘scientific knowledge’ and she was ‘superior’ to them in terms of skills. *Dais* provide biomedical care to pregnant women by counseling women during their pregnancies and attending childbirths. A few of the village *dais* have elementary school degrees, while most of them did not go to a school. Only a handful of *dais* are on the payroll of the NGOs to receive meager salaries. Most *dais* belonged to the *moddhobitta* and *bhumihin krishok* households of the village and lived on agricultural work.

Alongside the *dais*, the village has several family planning health workers employed by the family and welfare division of the government. Their main job is to provide immunization and encourage village men and women for adopting family planning methods. However, many village women consult the female family planning workers when they face any difficulty during a pregnancy or a delivery.

When the village health services fail to provide health care to people, people go to the Dimla *thana* hospital which provides both in-patient and outpatient services. The *thana* hospital is equipped to conduct minor surgeries, such as forceps deliveries, but do not have facilities for a caesarean section. It has 12 physicians with MBBS degrees, but no specialist doctors. People have to go to the Rangpur district hospital, Rangpur Medical college Hospital, or any private hospital located in Rangpur Town to see a specialist doctor. Private clinics and hospitals do not require referrals to see specialist physicians.

Alongside the physicians, the *thana* hospital has five female nurses. Usually nurses attend childbirths at this hospital, but when any complications arise, they call a doctor or refer the patient to the district hospital. People take treatment from this hospital for different types of diseases. One record shows that the *thana* hospital treated around 8,000 patients in
2000 and the number of patients grew significantly from 2002 (See Table 3.2). Alongside this public hospital, a private clinic provides services in Dimla on a pay-per basis.

**Table 3.2 Patients’ visit to Dimla Thana Health Complex between 2000 and 2006**

<table>
<thead>
<tr>
<th>Year</th>
<th>People’s visit to the thana health complex (THC)</th>
<th>Number of people taken in-patient services</th>
<th>Number of people taken out-patient and emergency services</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>7,963</td>
<td>3,466</td>
<td>2,562</td>
</tr>
<tr>
<td>2001</td>
<td>7,067</td>
<td>3,555</td>
<td>4,607</td>
</tr>
<tr>
<td>2002</td>
<td>10,729</td>
<td>4,029</td>
<td>3,338</td>
</tr>
<tr>
<td>2003</td>
<td>10,085</td>
<td>5,100</td>
<td>3,338</td>
</tr>
<tr>
<td>2004</td>
<td>10,583</td>
<td>5,153</td>
<td>3,459</td>
</tr>
<tr>
<td>2005</td>
<td>10,876</td>
<td>5,432</td>
<td>3,687</td>
</tr>
<tr>
<td>2006</td>
<td>14,378</td>
<td>5,219</td>
<td>3,500</td>
</tr>
</tbody>
</table>

*Source: According to the Thana Health Complex record, 2007*

The nearest district hospital to the village, Rangpur Medical College Hospital, located in downtown Rangpur, is 75 kilometers away and takes a two and half hours bus ride.

Compared to the thana hospital, this hospital has a larger capacity to provide in-patient and outpatient services including specialist doctor services in gynecology, surgery, and medicine. Surgical and pathological facilities in this hospital are better equipped to deal with different types of specimens in large numbers than in the thana hospital. Usually the village people who require surgeries and to see specialist doctors go to Rangpur Medical College Hospital. A woman who needs a caesarean section visits this hospital or a private hospital in the town based on their need and ability to pay as the city has a number of private hospitals.

Homeopathy is a popular healthcare system in the village and the homeopaths of this village are self-employed. The village has two homeopaths and they are different from each
other based on their training. Claquin (1981) categorized the homeopathic practitioners in Bangladesh into two groups based on their training. One group has institutional training and the other has no such training. The practitioners who have no formal training in homeopathy learned the medicine either assisting ‘trained’ people or are self-taught. Although Claquin’s work is useful to categorize the practitioners, she did not explain how this categorization manifests when they treat patients. During my fieldwork, I noticed that these two categories of homeopaths also differ in terms of the ways they treat patients.

One homeopath of the village, Mahtab, completed a four-year diploma course on homeopathy at a homeopathy college. He has an office at a local bazaar where he treats patients. On the other hand, another homeopath, Nurul, does not have any formal education in homeopathy. He learned the treatment from his father and uses both homeopathic and folk methods to treat patients. In addition to homeopathy, he uses tabij (amulet), pani pora (sanctified water) and tel pora (sanctified oil). Mahtab and Nurul criticize each other’s approach and knowledge. According to Mahtab, institutional training and ‘scientific knowledge’ made him the better homeopath of the village. He claims,

Those homeopaths that do not have any formal degrees are dangerous for patients. They are ‘unscientific’. By the name of treatment, they actually cheat people. In many cases, they identify illnesses as dushi (attacks of jinns or bad wind) which is completely an unscientific approach.

On the other hand, to Nurul, treatment is a holistic thing, which he thinks, cannot be learned only from an institution. He explains,

There are different ways you may get sick. Some reasons are normal, some are not. If you get sick because of the attack of bad jinns, normal homeopathic medicine will not work. You will need a different kind of treatment. I treat all kinds of illnesses which is a matter of broad knowledge and experience. My father was a knowledgeable man who taught me all the necessary things. Treating patients is our family tradition. My father learned it from my grandfather.
Although the homeopaths follow different approaches to treatment, they take similar fees from their patients most of whom are women and children. To explain this, Mahtab says, “The villagers have a wrong notion that homeopathy does not work if someone has a nesha (smoking habit). Since the majority of the men of this village have this habit, they do not come to us.”

Beside biomedicine and homeopathy, ayurveda (kabiraji) is another treatment system available in the village. Like homeopathy, ayurveda is also not a part of the village public health system. The village has two kabirajes who treat patients with herbal medicine and learned ayurveda from their relatives without going to any ayurvedic college. The Ayurvedic Practitioners’ Association of the country would not recognize them as ayurvedic physicians as they did not have formal education in ayurveda. The kabirajes claimed that they prepared medicine from different plants and herbs by using ayurvedic formulas. In their treatment, they follow the classical concept of humoral therapy as they classify diseases as ‘hot’ or ‘cold’ and provide therapies accordingly. For example, one of the kabirajes explained to me “diarrhea is a hot disease. If someone takes any hot liquid like tea and warm milk during diarrhea, it will exacerbate. To cure a hot disease like this, one needs to drink cold liquid such as green coconut water and take medicine which can reduce hotness.” Although, pregnancy is also considered a hot condition, kabiraji does not have any services for women during pregnancy or childbirth. According to the kabiraj, this is a domain of women, and dais are the people to deal with such issues. Sometimes the kabirajes provide suggestions to pregnant women, which they believe many senior or experienced women of the village also can impart. For example, one kabiraj said that during the post-partum period a woman should avoid some foods to maintain body balance. This period is a transitional period when women
may suffer from heartburn and other problems, which usually occur due to the increase of *vata* or gas like things in the body. Avoiding certain foods and spices such as ginger, hot chili, garlic, and ghee, which are some essential elements of Bangladeshi cuisine, can help keep the balance of *vata* in the body and keep a post-partum woman free from the sufferings. However, *kabiraji* has treatment for the post-partum women who do not produce enough breast milk. Many women collect medicine from the *kabirajes* to solve this problem. The medicine the *kabirajes* produce from herbs, roots and leaves at their homes are believed not to have any ‘side effects’, but cure diseases and enhance the strength of the female body. However, unlike the classical ayurvedic practitioners, the *kabirajes* use stethoscope and pulse examination to diagnose a disease.

Finally, 10 folk healers, all of whom are male, treat people in the village, using herbal as well as magical knowledge. The villagers identify these folk healers as *kabiraj* as well although their modes of treatment are different from the *kabirajes* who treat people using ayurveda. The villagers use the term ‘*kabiraj*’ to address all those practitioners who are not ‘daktar’ (biomedical physicians) or homeopaths.

The folk healers of this village learned their trades from their relatives, or from a guru or are self-taught. In addition to herbal medicine, they use *tabij, pani pora,* and *tel pora* to treat patients. The folk healers of the village can be divided into two groups, considering their socio-economic background. The most of the folk healers did not have any formal education and belonged to the *bhumihin* group of the village. Healing was their part-time jobs alongside agricultural work. However, two folk healers were literate and belonged to the *moddhobitta* group. One of them was the *moulana* (a Muslim religious expert who leads prayers at a mosque) of a local mosque. A man can be *moulana* by pursuing Islamic religious
education. A moulana’s main job is to perform religious events and to give religious education to people, primarily children. Although moulanas are not professional healers, they provide amulet and blessed water or oil if people request them to do so. The moulana, I interviewed, had formal education in Islamic religion and used to lead prayers at a local mosque. He would provide pani pora, tel pora, and tabij if someone “suffered” from the attack of bad winds or jins. He uses Quranic verses to prepare tabij, pani pora, and tel pora. His knowledge of Islam is considered the source of his ability to treat jinns. The other literate folk healer, who is a teacher at a local college, also belonged to a moddhobitta krishok household. Although his formal education was not in religion, he said he learned healing by reading the Quran and other Islamic books. Similar to the moulana, he treats people when they “suffer” from the attack of bad winds and jinns. He also uses Quranic verses to prepare tabij, pani pora, and tel pora to treat patients.

The folk healers of this village follow a personalistic etiological explanation, which sees a disease as an outcome of the attack of external forces or agents. They categorize illnesses into four groups such as dushi, jadu, gojob, and osukh (these categories are elaborated in the next chapter). Among these, osukh occurs because of natural causes while dushi, jadu, and gojob occur due to unnatural causes. No folk healer of the village treats all these categories of illnesses. During our conversation, many folk healers said that daktars (biomedical and homeopathic physicians) should treat osukh, but they cannot treat dushis. The folk healers treat dushis and apply different strategies to treat patients. Many of them adopted some practices from biomedicine to make their treatment more “efficient” and “reliable”. For example, many folk healers of the village use stethoscopes to examine
patients. During my fieldwork, I talked with two folk healers, Mannan kabiraj and Shafiqul kabiraj, to know their experiences in dealing with patients.

Mannan, a teacher at a local college, serves as a folk healer. He does not have specific charges for his kabiraji services, and accepts whatever people voluntarily pay for his services. Mannan said he learned healing by reading the Quran and other religious books. He said, “You will find a complete lifestyle in the Quran. It provides solutions to all problems of human life. However, you need to know how to get it. You have to do sadhona (research) for that”. Usually Mannan treats dushi and jadu but does not treat any osukh. Whenever a patient comes to him, he first tries to check whether it is a case of osukh or not with his “religious” knowledge. He believes that he gained a special power to distinguish illnesses by studying some Islamic holy books including the Quran. He explained:

When someone visits me with pet betha (a pain in the stomach), I try to check whether the case is osukh or not. I ask the person to stand in front of me for some time. If the hairs of my hands rise, I categorize the case as a dushi or jadu. However, if the hairs of my hands remain as usual, I categorize the case as osukh. In such cases, I suggest them to see a physician.

If a case is not osukh, Mannan tries to know whether it is a case of dushi or jadu. He said, “To distinguish a case of jadu from that of dushi, I burn a black tabij (amulet) at the nose of the patient. If I see that the tabij turns into brown color, I assume it as a case of dushi. On the other hand, if it turns into green color, I assume it as a case of jadu.”

To treat both dushi and jadu he provides tabij, pani pora, and tel pora, which he prepares with using different Quranic verses. Alongside these, to treat dushi, he claims that he sometimes communicates with the jinn that attacked the patient. He claimed to me that he knew how to force a jinn to talk before the patient so that the patient can understand the reasons of attack. To bring a jinn to talk, he creates a protikriti (symbol) of a human or an
animal with a paper so that the jinn can embed this. Mannan told me that jinns are invisible, and usually people cannot see them and hear their voices. However, when he creates the protikriti and the jinn embeds it, the patient can hear its voice. When he interrogates the jinn, the patient can hear the responses to the interrogation. After hearing the reasons of the attack from the embedded jinn, he asks it to leave the patient. He provides the patient some chini pora (blessed sugar) to eat and some pani pora to drink to force the jinn to leave their body. According to Mannan, some jins are good and they leave the patients as soon as the patients eat some chini pora and drink some pani pora. However, some jinns are so bad (khochchor) that they do not leave the body with such solutions and need a harsh treatment. Mannan claimed that he applies a different method to remove the bad jinns. He said:

It is a simple work for me. I prepare a tabij. I know the appropriate Quranic verses to write on it to destroy the jinn. I hold it at the nose of the patient and after some time burn it. When I burn it, the patient starts jumping around and faint. It indicates the removal of the jinn from the body. When the patient wakes up, they are a completely normal person.

Like Mannan, Shafiqul also treats dushi and jadu but employs a different method of treatment. He is illiterate and learned healing from a guru. Healing is his part-time work alongside farming. When a patient comes to see him, he listens to their problems and closes his eyes to identify the problem. An extraordinary power, which he claimed to have received from his guru, helps him identify whether it is a case of dushi or jadu. After identifying the illness as a case of dushi or jadu, he performs some rituals to cure that. During one of our meetings, a young girl along with her mother came to see him. The girl was facing challenges to get married. After hearing the girl, Shafiqul told that someone applied jadu to her and it was necessary to destroy the bondh (barriers) created by the jadu for the girl to get married. He drew a circle by keeping the girl standing at the center and put a banana leaf underneath
her feet. Then he poured water on her feet and recited some *mantras* (spells). After finishing this ritual, he asked the girl to leave the circle. He cut the banana leaf into several pieces, tied the pieces with straws, and gave them to the girl to throw them into a village pond. By this, he claimed he destroyed the *jadu* and finished the first part of the treatment.

After this part, he went into a trance to “know” why the *jadu* was applied. He sat on a small *choki* (a square wooden stool), putting his hands on his knees and recited *mantras* by swinging his body in a circular motion. He told me that he did not feel normal during the trance as he felt the existence of an invisible extraordinary force in his body. I observed that he spoke in an unusual voice during his trance. He claimed that his voice changed because the extraordinary force spoke through him. The extraordinary force narrated why the *jadu* was applied, and gave a description of the person who applied it. The force also recited *mantras* to some water and sugar to cure the girl from the *jadu*. When he finished all these rituals, he said that the force left his body and he fainted. When he woke up, he talked the way he normally does.

### 3.4 Costs involved in different healthcare systems

Of the village healthcare systems, biomedicine is the most expensive option with homeopathy as the distant second. A homeopathic physician of the village, Mahtab, nicely explained the difference between biomedicine and homeopathy in terms of costs. He said:

Biomedical treatment is more expensive than ours is. For example, a biomedical doctor’s fee is Tk 50. Moreover, a patient has to pay the costs of medicine. If the doctor recommends an antibiotic medicine, the patient has to take it for five to seven days, which may cost Tk 40-50 per day. It is hard for many people to afford biomedicine. On the other hand, a person may cure a disease with homeopathy by spending a total of Tk 50, which would be enough for paying the doctor’s fee and for medicine for a week.
If a person needs to go to the *thana* hospital or the district hospital for cure, he or she has to think about the costs of transportation, medicine, and bribing the attending nurses and other staff. Although the doctors of the *thana* hospital are required to offer free consultation, patients have to bribe them to receive services. Acia told me “nothing is free at the *thana* hospital. People have to pay for medicine, and sometimes have to pay some cash to the *dakter* (doctors) and nurses.”

A district hospital like Rangpur Medical College Hospital charges fees for outpatient consultation and inpatient admission. However, these charges are waived for the extreme poor. The district hospital also charges for other services such as ambulance services, x-ray imaging, ECG, radiotherapy, and shared and single rooms (See Table 3.3). Patients also have to buy their medicine.

**Table 3.3  Costs of services at a district hospital**

<table>
<thead>
<tr>
<th>Services</th>
<th>Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>An outpatient admission ticket</td>
<td>Tk 6</td>
</tr>
<tr>
<td>An inpatient admission ticket</td>
<td>Tk 12</td>
</tr>
<tr>
<td>Ambulance services</td>
<td>Tk 8/km</td>
</tr>
<tr>
<td>An x-ray imaging</td>
<td>Tk 100</td>
</tr>
<tr>
<td>An ECG</td>
<td>Tk 86</td>
</tr>
<tr>
<td>A single room</td>
<td>Tk 200 – 400</td>
</tr>
<tr>
<td>A surgery</td>
<td>Tk 550 – 1,000</td>
</tr>
</tbody>
</table>

Source: Field data 2007

In addition to these official costs, there is an unofficial cost—bribes, popularly known as *bokhshish*. The low-level employees, such as *ayahs*, ward boys, cleaners, and other support staff who assist patients in registering and obtaining services, ask for *bokhshish* for their assistance. In many cases, the payment of *bokhshish* determines the quality of services. In addition to paying for transportation, hospital charges, and *bokhshish*, a patient has to pay
the costs of meals of herself and of a companion. During a hospital stay, the companion plays a crucial role, buying medicine for the patient from the outside of the hospital and notifying doctors and nurses about the condition of the patient. Although it is their responsibility to look after every patient, the attending doctors and nurses frequently fail to do this since they are overwhelmed with a large number of patients. However, some also slack on their duties. Sometimes the companion has to comfort the patient with a hand fan during the hot summer when power fails frequently.

Homeopathy is cheaper than biomedicine. Homeopath Nurul told me that he was flexible in charging patients. He said, “When a patient does not have the ability to pay for my services and medicines, I accept whatever amount they can pay.” He went on to say that “for example, that lady (pointing to a woman who was leaving his office) came to me for her and her son’s treatment. My total charge was Tk 99, which included my consultation fees (Tk 30 per-patient) and the costs of medicine for the woman (which was Tk 20) and her son (which was Tk 19). However, she had only Tk 80 to pay me. I was fine with that.”

Compared to biomedicine and homeopathy, kabiraji is cheaper. The ayurvedic kabirajes charge a patient around Tk 25 to 30 per visit, including the cost of medicine, which is usually homemade. The folk healers do not have any fixed fees and take whatever the patients voluntarily pay them. For example, the moulana usually does not take any money for healing people.

3.5 Biomedicine as symbolic capital

We have discussed above how the colonial administration established biomedicine as the leading healthcare system in the subcontinent and how the postcolonial Bangladesh has
continued to promote this medical system by using it as the public health system across the country, including Rupsha, through state initiatives. Recently NGOs have joined hands with the government to provide biomedical services.

Biomedicine’s privileged status in the village reminds us of Ronald Frankenberg and Hans Baer’s argument about the dominant position of biomedicine in the U.S. Using Gramsci’s idea of hegemony, they argue that the healthcare arena is a site of struggle where various systems of healing compete with each other to achieve the hegemonic status, and various classes compete with each other to control the healthcare system (Frankenberg 1988, Baer 1989). Using the U.S. health field as an example, Baer (1989) argues that biomedicine became hegemonic in this country with the development of industrial capitalism in late 19th century. According to him, the 19th century America had a plural medical system including different Euro-American ethno medicine, African-American medicine, American-Indian medicine, homeopathy, bone setting, osteopathy, and chiropractic. Allopathic medicine, now popularly known as biomedicine, existed at that time but was not dominant. It became the dominant healing system when various corporations became involved with the business of medicine with the help of the state. Biomedicine could maintain its superior status due to its education system, technological superiority, people’s faith in its effectiveness in healing acute conditions, and state help (Morsy 1988, Brass 1972, Baer 1989, Alubo 1987).

In Rupsha, the other health practitioners acknowledge biomedical physicians’ ‘superior’ knowledge and refer the patients with complicated illnesses to them. However, they justify their importance by saying that their medicines are natural and have “no” side effects. Many folk healers claimed that they have a holistic approach, which is able to treat
both osukh and dushi, while biomedicine can only treat osukh. They told me that people visited them to treat dushi, which biomedical physicians cannot heal.

In Rupsha, biomedicine is a status symbol for the people who belong to the high status group of the village. The bhodroloks prefer biomedicine to show their desire for ‘modern’ medicine and scientific knowledge. They have economic capital (i.e. money to pay for) and cultural capital (i.e., knowledge about the availability and efficacy of biomedicine) to get biomedical services, and in turn, their avail of biomedical services contributes to maintaining their cultural capital (i.e. social status in the village). They do not rely on the village health center. Instead, they go to the district hospital or private hospitals in Rangpur Town or Dhaka City, while the majority of the village people pursue the local options first.

However, the villagers are not happy with the performance of the health center. During my fieldwork, Banu would say the following about the health center:

The doctor is absent from work for the most of the time of the year. If one can see the doctor, they will just get a referral to go to the thana hospital or the district hospital. He does not offer any treatment except checking blood pressure and weight. People working at the center are very rude.

The alternative healing systems exist in Rupsha because of both the unavailability of biomedical treatment and for their distinct functions in the healthcare field, which reminds us the functional model of explaining the co-existence of multiple healthcare systems in a society (Kroeger 1983, Lock 1980, Gould 1965). The functional model provides an idea why multiple treatment systems exist in a social setting, but does not explain why and how people choose a particular treatment system.
4. Illness Etiology and Therapy Seeking

Every person has their own explanation or model to define and categorize illnesses. These individual models are cultural that people develop them over a period by living in a culture, but these models are not always shared models (Garro 2000). A cultural model of illness helps an individual develop etiological explanations and choose a ‘right’ therapy or a healthcare option. Kleinman (1978) calls them explanatory models as such a model includes explanation of any or all five issues related to an illness such as etiology, symptoms, pathophysiology, course of sickness and treatment. “Explanatory models are tied to specific systems of knowledge and values centered in the different social sectors and subsectors of the healthcare system. Thus, they are historical and socio-political products” (Kleinman 1978:88). Kleinman argues that the explanatory models of professionals are different from that of common people, and the former defines a health crisis as a disease while the latter define it as an illness. He elaborates the idea of disease in the following way:

Disease is most commonly associated with the Explanatory Models of professional practitioners (modern or indigenous), where it relates to special theories of disease causation and nosology that are stated in an abstract, highly technical, usually impersonal idiom (e.g. the disease models of biomedicine, or Chinese or Ayurvedic medicine). [Kleinman 1978:88]

On the other hand, “illness is principally associated with the Explanatory Models of the popular culture arena of healthcare where sickness is most frequently articulated in a highly personal, non-technical, concrete idiom concerned with the life problems that result from sickness” (Kleinman 1978:88). Disease and illness are “different ways of explaining sickness, different social constructions of reality” (Kleinman 1978:88).
People’s etiological explanations of illnesses influence their therapy seeking. For example, villagers in rural Ghana classifies illnesses into three main types—illnesses caused by natural agents, illnesses caused by supernatural agents, and illnesses whose causes include both natural and supernatural agents (Fosu 1981). People prefer traditional healing for the illnesses caused by supernatural forces and allopathic medicine for the illnesses caused by natural agents. In Lower Zaire, BaKongo people categorize illnesses into two types: one is “illness of God” or illnesses caused by natural factors or causes beyond human intensions but not divine and the other is ‘illness of man’ or illnesses caused by human actions (Janzen 1978). “Generally, mild conditions which respond readily to therapy when no particular disturbance exists in the immediate social relationships of the sufferer are thought to be diseases or misfortunes of God” (Janzen 1978:8). The reasons for man-made illnesses include incestuous marriage, witchcraft, lack of marriage payment, lack of father’s blessings during a marriage, and clan conflict. They seek therapies such as ritual purification, forgiveness ceremonies, resolution of clan conflicts, and correcting an “inappropriate” marriage to treat the man-made illnesses based on their causes. To treat illnesses, caused by natural causes, such as mild cough, fever, malaria, or accidental wound, they seek allopathic medicine. When people fail to receive expected outcome from a therapy, they consult kin members or other traditional healers. Kin members help them to arrive at a culturally acceptable etiology and an appropriate therapy. Similar to Janzen, Sargent argues, “Decisions regarding the utilization of alternative medical services are largely derived from the diagnosis of the sickness or disorder” (1982:157). For example, if a complication is believed to be caused by witchcrafts, women prefer traditional or indigenous midwives since indigenous midwives know how to treat it. In treating such cases, biomedicine is the last resort. These
studies emphasize that people visit different practitioners based on etiological explanations or diagnoses of illnesses. People believe that different practitioners cure different illnesses and have their own domains of treatment.

In contrast to Janzen and Sargent, Young and Garro (1981) argue that people choose healthcare options based on the likelihood of cure, the costs associated with each alternative, the severity of illness, and the availability of resources for treatment within the household. Young and Garro observe that “even though people would prefer first to choose [the] highest likelihood of cure, economic limitations constrain their choices in favor of [the] lowest estimated cost, approximating a cost-ordered sequence” (1981:168). People cannot afford “modern” medical treatment due to their inability to bear the costs to access these services (Young and Garro 1981).

In this chapter, I show that the women of Rupsha have their own explanations about illnesses and their explanations influence their choices of medical systems or practitioners to some extent. The women categorize illnesses into four categories—*osukh*, *dushi*, *jadu* and *gojob*. Women’s categorization of illnesses varies based on their cultural capital (i.e. education); educated women differ from their uneducated counterparts in explaining illnesses. Women’s etiological explanations of illnesses play a significant role in their healthcare practices such as health seeking, which is similar to the findings of Janzen and Sargent discussed above. Irrespective of their social status, women visit folk healers for treating *dushi*, *jadu* and *gojob*, while to treat *osukh* they can go to a biomedical practitioner, a homeopath, or an ayurvedic practitioner. In choosing a folk healer women vary according to their social statuses.
4.1 Illness categories and selection of health practitioners

During my fieldwork, I have observed how women’s categorization of illnesses into the four categories influences their health seeking. To treat dushi, jadu, and gojob women consults folk healers because women believe that folk healers have “specific” knowledge to treat such illnesses. It is their cultural models, which enable them to categorize illnesses into dushi, jadu, and gojob and lead them to the practice of seeking a folk healer to treat such conditions.

4.1.1 Osukh

Popularly, people explain osukh by saying “sukh nai” (no happiness). Osukh is not merely the physiological discomfort rather it is a total discomfort of mind and body. This definition of osukh is a reflection of indigenous medical system of rural Bangladesh (i.e. ayurveda) which does not apply a mind-body dualism in diagnosing a disease. As Schepker-Hughes and Lock (1987) rightly note, the western medical system based on Cartesian mind-body dualism is not universal. Many non-western medical systems do not possess such dualistic ideas, and examine human sickness in relation to the whole body or the natural world.

In Rupsha, the villagers believe that anyone—young, old, male, or female—can suffer from osukh. There are some real reasons behind osukh and the sufferings created by osukh are explained based on a naturalistic explanation, which defines “illness in impersonal, systematic terms. Disease is thought to stem, not from the machinations of an angry being, but rather from such natural forces or conditions as cold, heat, winds, dampness, and above all, by an upset in the balance of the basic body elements” (Foster 1998:112).
The women of Rupsha, irrespective of their age, education, and social status, adhere to this explanation of osukh. When they refer to osukh, they explain it as an imbalance between the mind and body, between the climate and the body or between the body and the work, and the range of osukh is vast including fevers, jaundice (a symptom of hepatitis which villagers identify as a disease), and diarrhea. They think that osukh such as fevers, jaundice, diarrhea, and indigestion occur due to normal reasons such as cold, heat, and food. They visit a homeopath, a biomedical physician or a kabiraj to treat osukh. These practitioners treat illnesses based on their cultural capital which includes formal and informal education in their respective fields. Hajera, a 50-year-old bhumihin woman explained to me what causes an osukh. She said, “Suppose, it is raining and I work the field in the rain and get a fever the next day, I will consider it as a normal osukh.” Kabita, a 35-year-old woman, suffered from a fever for five days during my fieldwork as she worked in the rain and caught cold. When she explained her sickness, she said, “So much work to do everyday! How can I stay well? Do I have time to take care of myself?” She continued by saying that “that day it was raining, I worked in the rain, had panta (a dish prepared, to have for the breakfast, by preserving the leftover rice of the night’s dinner in water) with chili and salt. I was feeling cold in the morning, but did not have anything warm for breakfast. I only had panta to eat.”

For her sickness, Kabita pointed out how external factors such as rain, day temperatures, food intake, and workload created an imbalance in her body. Both rainy reason and panta are considered cold. If one eats panta on a rainy day, they may catch cold. Since cold can cause a fever, Kabita knew that she should have eaten something hot, but due to her inability to arrange a hot food, she ate panta. On the other hand, stomach upset, measles, and small pox are “hot” osukh when people prefer cold foods and drink. A dhoni educated
woman Hamida (35 years old and has a HSC degree), who is a mother of two school-going children, defined the *osukh* of her children this way: “Every time during the school final examinations my both children get sick. Both of them are meritorious students and they study so much that they get sick.” Similar to Kabita, Hamida pointed out the relationship between increased workload and sickness.

I observed that when people suffer from fevers, cold, or cough they prefer hot water, hot food like honey, and hot herbs like ginger since it is believed that these are hot elements and contribute to maintaining a normal body temperature during such illnesses. Sometimes, people rub the feet and the chest with mustard oil for comfort. People believe that mustard oil can remove cold by increasing body temperature. On the other hand, people use cold foods to deal with hot *osukh*. The water of a green coconut is one of the “cold” drinks that can reduce the hotness of the body. The villagers might have got the idea of hot and cold disease and hot and cold food from ayurveda, which has been practiced in this region for centuries (In chapter 3 we have discussed ayurveda in detail).

I observed that the villagers do not prefer medicine to cure some hot diseases such as measles and small pox, but they take medicine to cure a severe cold, fever, or pain. Hajera and Nura explained to me that if one took medicine to cure a hot disease, they would encounter the recurrence of the disease after some days because medicine cannot remove the germs of a hot disease. The germs of a “hot” *osukh* caused by “hot” substances remain inside the human body unless they are allowed time to come out as skin rashes and blisters. It is better to let them be fully exposed and the *osukh* will cure after some days without medicine. This idea suggests that alongside the humoral theory, the villagers also follow a germ theory.
of disease causation that is practiced by homeopaths and biomedical practitioners. The use of this germ theory implies that the villagers see osukh occur because of natural causes.

4.1.2 Dushi

*Dushi* is a kind of sickness, which creates discomfort in both mind and body. However, it is believed that this type of sicknesses do not derive from an imbalance between the body and external factors or due to an imbalance within the body, but occurs because of unnatural reasons such as by the acts of bad winds or invisible spirits such as jinns. *Dushi* is defined based on a personalistic etiological explanation which, unlike a naturalistic explanation, defines illnesses as outcomes of “the active, purposeful intervention of an agent, who may be human (a witch or sorcerer), nonhuman (a ghost, an ancestor, or an evil spirit), or supernatural (a deity or other very powerful being)” (Foster 1998:112). *Dushi* differs from osukh in the sense that the illnesses created by the former do not occur due to any understandable reason but occur due to the attack of evil spirits or bad winds. *Osukh* may occur equally to men, women and children, but *dushi* mainly occur to women and children since they are not “strong” like men. In Rupsha, women are more vulnerable to *dushi* when they are polluted.

The village women identify *dushi* in many ways such as by looking at the symptoms (whether they are strange or normal), considering their etiologies (whether they are sudden or without any understandable reason) and examining the place of origin based on their experiential knowledge. Sometimes they refer to a *dushi* by its supposed causes as well. Like other villagers, they believe that when a jinn occupies a certain space, the air of that space becomes harmful, and identify the air as “*kharap batash*”. It is said that Allah (God) created both humans and jinns, and humans are visible beings while jinns are invisible. Jinns are said
to have some extraordinary qualities compared to humans such as the ability to travel thousands of miles within a second, to move through the sky and the waters, and possess a human body. Nura, a 70-year-old woman of the village, told me that, “like good humans, many jinns are good who pray five times a day and do good things, while some jinns are bad and do evil things”. According to Mannan kabiraj, bad jinns can attack people for many reasons. Sometimes they attack just because they like the person and want to get hold of them, and sometimes they attack to do harm.

The village women as well as folk healers believe that many complaints such as sudden pain, mental illnesses, sudden weaknesses, and complications during childbirth may happen due to attacks of bad jinns and categorize these illnesses as the cases of dushi. To identify the cases of dushi women take suggestions from elderly women who have knowledge and experiences of dealing with such illnesses. Hajera explained dushi to me by saying that:

One can understand a dushi by looking at the lokkhon (symptoms). Few days ago, a one-year-old baby of that house (pointing to a neighboring house) suddenly started crying and continued for two days without any reason. It was screaming with no pain and fever. After two days, we realized that it was a case of dushi. We were right. The kabiraj (folk healer) came and gave tel pora, and the baby stopped crying and became normal.

(After some silence) Now look at another example. If a pregnant woman feels pain during her ninth month, we assume that she will deliver and this pain is normal. However, if she feels a pain when she is in her fourth or fifth month, it is not normal and it is a case of dushi. Similarly, if a woman gets hurt and has miscarriage afterwards, we assume it as a normal miscarriage, but if a miscarriage happens without any reason, it is definitely a case of dushi.

Hajera is not alone in diagnosing such conditions as dushi. Many women, like her, believe that any illness, which is sudden and occurs without any apparent reason is dushi. Haifa, a local college teacher and dhoni woman, narrated her experience of dushi to me. She said:
I remember, one night, my son started crying. Everything, I mean his tummy and body temperature, was normal. Even he had his regular quantity of milk at the night. I was scared and it was difficult to visit a doctor at the time. My mother-in-law gave him some *pani pora*, prepared by the *moulana*, which she always keeps at home to deal with emergencies. After having the *pani pora*, he continued crying for some time, but gradually calmed down and slept at the time of *fozor* prayer (in the early morning).

Haifa elaborated that infants and babies get scared because they can see malevolent forces and crying is their way to express that. This fear induced cry is also termed as *dushi* by Haifa and other village women and is believed that *pani pora* removes babies’ fear. Haifa became convinced at the existence of *dushi* since the following morning the baby behaved normally. The *pani pora* that was prepared by blowing Quranic spells into the water is believed to have the ability to remove human fear caused by *dushi*. To identify and treat *dushi*, the *dhoni* women, such as Haifa, and the *bhumihin* women, such as Hajera, use their experiential knowledge (cultural capital) which they learned from seniors and from everyday experiences. However, Shamsher, a biomedical physician of the *thana* hospital, whose biomedical education provided his cultural capital, said that this was a misdiagnosis of an infant’s condition (i.e., sudden crying), which might have been caused by intestinal gas. He explained, “An infant may cry continuously for many reasons such as the entrapment of gas in the intestine. But most women of this village interpret this continuous crying as an attack of a malevolent force.”

If a person moves into a new place and gets sick, people become suspicious about the place and begin to ponder whether it is occupied by a bad wind or a bad *jinn*. During my fieldwork, I met Nurjahan, a 35-year-old woman, who believed she was suffering from *dushi*. My conversation with her helped me understand the experiences of *dushi* in detail. Among her four children, the eldest is 12 while the youngest is six years old. Her eldest son is a
rickshaw-van driver and the other children work as domestic workers at the dhoni households. In 2006, Nurjahan went to a neighboring town to work as a day laborer, and came back to the village after eight months. Nevertheless, after some days of her return, she fell sick and could not return to the town. When I asked her what happened to her, she whispered to me that she was suffering from dushi. Like Nurjahan, I observed, the village women always whisper when they talk about dushi because they believe that if the invisible forces hear their conversation, they may cause further harm to them. Another reason for whispering is that women do not want to spread this news. They believe that the body becomes vulnerable when it suffers from dushi, and if any of their enemies hears this news, they may cause further harm by applying jadu.

To know more about Nurjahan’s experiences, I kept hanging out with her. In a fine morning, she and I gathered at a field where her second son was doing post-harvesting work with other day laborers. Nurjahan was upset and told me, “When I see people working I feel bad. I want to work; my hands want to work. I do not like to pass lazy times without doing anything. But I have a bad luck that I cannot work.” When Nurjahan became sick, she stopped working outside home and relied on her eldest son for food. She went on to say, “I feel a headache most of the time. Sometimes I feel dizzy and my eyes lose vision. When I try to work, my hands shake.” Nurjahan did not show these symptoms when she was in the town where she used to work every day from dawn to dusk. These symptoms began to surface after she arrived at the village. Nurjahan told me that her house was empty for eight months as she was away. She thought some bad jinns occupied it during that time and attacked her when she came back.
As the villagers believe that an empty house is a place for bad jinns, they usually arrange a milad (a kind of prayer followed by distribution of foods) to purify the house when they move into a new house or a house which remained empty for a long time. It is believed that bad jinns leave the house when the prayer is performed. However, sometimes the prayer fails to remove the occupying jinns and that is what is believed to have happened to Nurjahan, as she got sick in spite of performing the prayer. She arranged a milad in her house when she returned to the village, but it could not remove the bad jinns. Some bad jinns require punishment that some folk healers can give to them, she added. She told me that she realized the existence of dushi in her body when she felt the lokkhon (symptoms). Sometimes she felt sudden and severe pain. She elaborated to me, “These days they (jinns) disturb me a lot. Sometimes they beat me. They beat me on my gits (bone-joints) and I feel severe pain afterwards.” Nurjahan thought that this sudden and severe pain was unusual.

It was not her first encounter with dushi. Her two children, she said, also died from it. Alongside describing her own sickness, she also told me about the death of her two children. Her first child died when it was three months old. During that time, Nurjahan visited her father’s house and she thought that an evil spirit attacked her baby somewhere during the journey. When she reached her father’s house, all of a sudden, the baby started screaming (kadte kadte shik lagchilo). Her father immediately called a folk healer, but the folk healer failed to do anything. After three days, she came back to her father-in-law’s house and consulted another folk healer there. However, he also failed to cure the baby and the baby died. Nurjahan told me that, “the both kabirajes (folk healers) understood that the baby would not survive since dushi already destroyed it but they did not tell us in advance because they did not want to make us upset. After the death of the baby, the kabiraj (folk healer)
whom I consulted last told me the reason of its death.” Nurjahan accepted the explanation of the *kabiraj* (folk healer) because she believed in his magical knowledge which seemed special to her and helped her to confirm her speculation about the attack of *dushi*. According to Nurjahan, her third child also suffered from *dushi* and died immediately after its birth. She believes that *dushi* attacked her when she was pregnant. She explained:

> When I was pregnant, I used to feel an unusual thing that someone threw stones to the roof of my house at midnights. It happened several times. One midnight I felt something like a human was jogging on the roof. After the death of my newborn, I realized that those were *jinns*. The illness symptoms of my baby indicated that they were caused by *jinns*. Before its death, its face color turned from red to dark to blue, which was unusual. After the death of the baby, I moved my hut from the site.

During my conversation with Nurjahan, she said this time, when the symptoms first appeared, she consulted her two neighbors who were senior to her but friendly. They suspected she suffered from a case of *dushi* by looking at the etiologies and symptoms. Following their suggestions, she visited a folk healer to confirm and cure the illness. The folk healer also confirmed her as a case of *dushi* by examining the etiologies and symptoms. Both the healer and the neighbors suspected that she became sick following the attack of a bad *jinn*, which occupied her house in her absence. For Nurjahan, her neighbors’ network was the main source of social capital to consult about decision-making during such crises.

People in general including women believe that there are bad *jinns* in the village but not sure exactly where they live. They believe that *jinns* can reside on the trees, peoples’ homes, or even in the water bodies. Human beings cannot see them but can feel their existence when they come under attack. However, the villagers say that sometimes the acts of *jinns* signal their existence at a place. When a big branch of a tree falls down suddenly (without any storm), people believe *jinns* felled the branch. When people suspect the
existence of jinns at a place, they try to avoid the place. Hajera explained this the following way:

Look at the village. There are hundreds of trees and plants. Jinns can reside anywhere. Some places of this village are good and some are not as they are occupied by jinns. I do not know all the places where they are living, but know some of the places. If one passes by one of those places at a wrong time, they will be attacked by jinns.

People also believe that evil forces such as bad jinns prefer places like bamboo groves to live. Hajera suggested me that “when you pass by a bamboo grove, be careful and do not forget to tie up your hair in a bun. A woman, who passes by a bamboo grove without tying up her hair in a bun, can easily be attacked by these forces.” The villagers believe that these forces prefer certain times of the day for their movements such as the mid-day, when the sun is at its zenith, or the time of sunset. A dhoni and educated woman of the village, Shima, explained to me that:

It is not wise to go out of the house by snuggling babies during the time of sunset, the time of Maghreb’s azan (a Muslim call for prayer during the sunset) because jinns prefer this time for their movements. I observed that whenever I went outside the house with my baby during the sunset my baby caught some sort of illness.

Both men and women believe that most bad jinns attack a woman when she passes through some vulnerable stages of her life such as during menstruation, a pregnancy, and a post-delivery period. The village women consider menstruation as a time of pollution, and believe that evil forces can attack them if they are not careful during this time. Blanchet observed similar practices in another Bangladeshi village. She notes, “Haez (menstrual blood) and nefaz (puerperal blood) are the greatest of all pollution (onek lomba napak). The blood of birth like that of menstruation is harmful (doshito) and disgusting (ghrinito). It is repulsive to Allah who will not accept the prayers or the fast of a woman in that state.”
(1984:33). The women of Rupsha neither perform daily prayers nor fast during the month of Ramadan if they menstruate as prayers and fasting are sacred rituals which must not be performed during menstruation. Women do not touch sacred books, such as the Quran, and avoid entering sacred places like mosques and shrines while they menstruate.

I observed that the elderly women of a family teach the girls how to stay clean and cope with this stage of life. Menstruation is considered a “hot” condition, and women prefer to eat “cold” foods such as rice and vegetables during this time. There are some food taboos for girls. For example, they do not take sour fruits during menstruation since it is believed that sour fruits can increase the outflow of blood. Women and girls also avoid eating meat and fish during the first two days of menstruation because meat and fish are considered “hot”, which could create bad smell to attract malevolent forces. Roshna provided me with an explanation for avoiding meat and fish during menstruation. She said, “Both meat and fish are hot foods which take lots of ginger and garlic to cook as curries. Nobody likes to eat meat or fish curries if they are cooked without the right amount of ginger and garlic. Ginger and garlic make meat and fish hotter.” Roshna believes that if a menstruating woman eats these hot foods during a menstrual time, she will feel discomfort because of hotness, which will come out of the body as gas.

Women try to stay “clean” during menstruation. Usually during this time, women take a bath every morning to stay clean by removing “pollution” before they start their household work. They believe that if they do household work, such as cooking, without bathing, food will be polluted to cause diseases affecting family members, especially children. If their mother does not take a bath every morning during menstruation and cooks
food, children get sick. Women also have to wash and keep menstrual pads in a secret place so that bad winds cannot touch them. Blanchet observes that:

… the soiled rags of menstrual blood are highly polluted but are also believed to contain some life matter. When too old to be used, these rags must not be thrown away carelessly. Should a bird (stands for an old woman in popular mythology) seize them, it might cause the girl to become sterile. The same might happen if a dog or a jackal dragged them away. … the soiled rags should never be burned for “Muslims do not burn life”. They should be buried but only after being washed carefully. The earth where the rice grows, where the ancestors are buried, cannot “digest” polluted things. [Blanchet 1984:38]

Forina claimed that her elder daughter, who was 14 years old and was working as a domestic worker at a house in the *thana* headquarters, got sick by washing polluted clothes. She complained that the lady of the house would give her daughter to clean her clothes polluted by menstrual blood and as a result, her daughter became sick. She said, “When I heard from my daughter about this I did not take time to move her away from that house because I sent my daughter to that house for her betterment, not to make her sick.”

Menstruation is a period of isolation for girls and women. As I noted early, they are not allowed to perform any religious rites or rituals during this time, and sexual intercourse is also prohibited. Jorgensen explains this by saying that:

The days of a woman’s menstruation are included among the non-religious taboo days, since it is considered as a great sin within Islam to have intercourse with a woman when she menstruates. If intercourse takes place all the same, the man believes that his life will be shortened in punishment and the woman believes that she will contract some illness in her private parts. [Jorgensen 1983:35]

The people of Rupsha also subscribe to this notion, and believe that sexual intercourse during menstruation can make a woman sick. The sickness can occur at any time as a punishment from Allah for breaking the taboo. During a conversation about this issue, Julekha narrated
the case of one of her sisters who was once forced to have sex by her husband during menstruation. She said,

Without any reason, my sister started to lose weight. All the time she was having a *mathaghora rog* (headache caused by weakness). It was unusual for her. We did not find any reason. One day, my mother took her to a *kabiraj* (folk healer) who identified her as a case of *dushi* and gave an amulet. However, it did not work and she kept losing weight and weakening. One day my sister told me about the intercourse and I understood the reason of her getting sick. After the end of this harvesting season, we will take her to another *kabiraj* (folk healer) and tell him the fact. Let us see, what is waiting for her.

Like menstruation, pregnancy is also a vulnerable stage of a woman’s life when a woman may be attacked by *jinns* or bad winds. It is believed that evil forces can attack a pregnant woman in many ways. They can cause miscarriage or complications during delivery. Hajera said, “Evil forces do not need to reside at a particular place as they have the capacity to reside anywhere. But certain places are favorable for them. One of such favorite places is a bamboo grove.” If a pregnant woman goes near a bamboo grove during the midday or sunset, evil forces may attack her, because evil forces such as bad *jinns* travel from one place to another during these times and attack if they find anyone vulnerable. Like bamboo groves, the women should also avoid the graveyards and some areas around the village ponds to stay safe from the attacks of bad *jinns*.

Another polluting period is childbirth when evil forces can attack women. Rozario (1998) notes that “the woman giving birth wears an old sari since the clothes she wears will be polluted and will normally be given away to a beggar or the *dai*. It is for reasons of pollution, too, that the birth usually takes place on the mud floor with a bare minimum of bedding for the women to lie on, even in houses where she would normally sleep on a bed” (1998:150). In Rupsha, women prefer to deliver babies on the floor of their houses as child
delivery is a polluting event, and bury the materials, which cannot be washed for re-use, used for a delivery under the soil after the end of the delivery. The bhumihin and many moddhobitta households spread washable mats made of bamboo strips or coconut leaves on the floor for delivering babies. Some households, which cannot afford mats, use beds made of straws and burlap bags. Some moddhobitta households and the dhoni households spread worn bed linens on the mats. After the end of a delivery process, these bed linens are given away to the dai. The newborn baby gets its head shaven and fingernails cut within the seven days of its birth, as the hair and nails are considered pollutants. The hair and nails are buried under the soil. It is believed that the evil forces may attack a newborn baby if its head is not shaven and nails are not cut.

However, the evil forces not only attack women when they are in a polluting period (e.g. menstruation, childbirth), but also during other times. The likelihood of attacks is higher during the polluting periods. Nura explained, “When a woman is not at a napak (polluting) stage, she can protect her body by praying or reciting doa. But during the polluting stages her body becomes a target of attack and she cannot pray.” From their everyday life experiences, they form a habitus to deal with dushi. People believe that women primarily suffer from dushi because evil forces can easily attack them. However, evil forces “fear” men as they are “strong”, not women as they are “weak”.

The bhumihin women and bhodromohila differ from each other in identifying dushi. One bhodromohila, Nilufar, said, “Yes, there are some cases of dushis and sometimes people may be attacked by jinns. But the likelihood of attack by these forces does not mean that every illness is a case of dushi. Look at uneducated women. They identify every illness as as case of dushi or jadu. They cannot judge correctly.” A similar concern was expressed by
another bhodromohila of the village, Halida, who worked as a union health worker, said (pointing to a poor woman):

Look, this woman sometimes feels weak, as she cannot afford good food because of poverty. She comes to me from time to time and I give her vitamin capsules. Whenever she had the vitamins, she said she felt good. However, if you ask her what happened to her, she would reply that she suffered from dushi.

Although men are not as vulnerable as women are to dushi, sometimes the evil spirits can also attack them especially when they are polluted. It is believed that a man becomes polluted after a sexual intercourse and needs a bath for purification. Similar to women, children are vulnerable to evil spirits since they are not “strong”. The degree of harm due to pollution varies in terms of gender. For example, if a woman does not purify in time, her pollution may bring harm not only to herself but also to the family. However, a man’s pollution is not considered a threat to the health and wellbeing of his family.

It is believed that one can avoid dushi by not visiting the places where bad winds or jinns live and avoiding the times when these forces move. However, one can go around the places of evil forces and move at any time without the risk of an attack if they recite verses from the Quran. Shima said, “If one needs to go out during the times when the jinns travel, they should recite verses from the Quran to avoid attacks.” To treat the cases of dushi, women usually prefer a folk healer. Hajera told me, “To treat dushi one has to go to a kabiraj (folk healer) because daktari (biomedical treatment or homeopathy) will not work in such cases. One has to use the appropriate knowledge to deal with such a condition.” Similar to Hajera, Nurjahan also told me “if someone suffers from a dushi and they do daktari to heal that, kabiraji (folk healing) will not work. So, it is better to go to the right place from the very beginning.” The folk healers treat such problems with pani pora, tel pora, and tabij.
Mofiz *kabiraj*, who claimed to possess both herbal and magical knowledge, told me that “*daktars’* (biomedical physicians and homeopaths) job is to treat *osukh*; they cannot treat *dushi* because they lack knowledge about controlling the evil spirits which cause *dushi*. We know what to do in the cases of *dushi* and how to heal them.” *Nurjahan* was under the treatment of a folk healer who gave her a *tabij* and some *tel pora* to cure her *dushi*. She said, “the *kabiraj* (folk healer) did not take any fees for his services but took some money for meeting the costs of the materials used for treatment”.

Women usually choose a folk healer who lives in the same village so that they can get treatment without affecting their daily work and consult their relatives, friends, and neighbors to know about his qualification for deciding to seek his treatment. For example, to choose her healer, *Nurjahan* consulted her close friends although she also knew some healers from her previous experiences. Like *Nurjahan*, many women believe that it is not a good idea to go to an “unknown” healer, and one should be certain about the “reliability” and “skill” of the healer before taking his services and medicine to avoid fraud and deception. The village women are concerned about potential harm, and prefer a “reliable” healer from the village who do not share patients’ privacy with others.

During my stay in the village, I met a folk healer who recently moved in to Rupsha from another village and built his hut close to *Nurjahan’s* hut. However, *Nurjahan* did not consult him and as a reason she said, “Still I don’t know enough about him as he is new to this village. None of my friends and well-wishers yet visited him. I cannot see such an unknown person to deal with my health problem.” *Nazma*, a 50-year-old *bhumihin* woman, said, “A *kabiraj* (folk healer) can cure problems but can also create problems”. Like her,
Many women of the village think that many folk healers take money from evil people and do whatever they instruct them to do in return.

Mofiz *kabiraj* also agreed with the assessment that many folk healers are involved with corrupt practices, but added that they also did useful things. He tried to convince me that he was honest. He said, now, he was dealing with a problem of a man of a neighboring village whose wife left him. Mofiz said, “This man loves his wife but his wife does not want to stay with him since he is unable to fulfil her sexual needs. He offered me a good amount of money to bring back his wife by applying a *jadu*. I said I will do it if I can solve your physiological problem.”

The educated *dhoni* women of the village also believe that folk healers can do harm to people and for that they emphasize the education and socio-economic background of a healer in selecting them. They believe that an educated healer knows the specific Quranic spells to cure patients and is aware of the punishments of Allah for doing harm to people. For example, Khadija, a 70-year-old *dhoni* woman, consults the *moulana* when she faces any *dushi*. When I asked her about folk treatment, she replied, “*kabiraji* (folk treatment) is unscientific and obsolete, and some *kabirajes* (folk healers) are fraud. They do not know treatment, but use tricks to earn money. We see a doctor when we feel sick.” To face the attacks by *jinns*, she prefers taking preventive measures. She said, “If one regularly reads the Quran, prays five times a day and remembers Allah, evil spirits such as bad *jinns* cannot attack them. When someone fails to do so, they need a *tabij* to protect their body from those forces.” For a *tabij*, Khadija prefers to consult the *moulana*. She described her perspective to me the following way:

One of my granddaughters is a medical student. She fainted when she dissected a human body for the first time. She did not face any problem immediately since her
teachers took care of her. However, for the next couple of months she had fevers for several times, which seemed unusual to me. I guessed she was frightened when she dissected the dead body and as a result, she got the fever. It happens to humans. If a person is frightened, they may get sick. A bad wind or spirit may live close to a dead body and may attack the person who handles the dead body. Sometimes the sickness caused by this is not cured easily. For this, one may need a *tabij* containing Quranic spells. Such a *tabij* keeps the body sacred and prevents the attacks of bad *jinns*. Therefore, I consulted the *moulana* who knows the appropriate Quranic spells for this, and he gave a *tabij* for my granddaughter.

She distinguishes the *tabij* provided by a *moulana* and other folk healers by saying that

“some *kabirajes* (folk healers) may use Quranic spells to make a *tabij*, but many of them use magic, instead, which is completely *haram* (prohibited) in Islam. It is difficult to know which *kabirajes* use magic, which do not. Therefore, it is better not to see them. On the other hand, *moulanas* always use Quranic spells to prepare a *tabij*.” Her reliance on *moulana* is rooted in her religious beliefs. Similar to people in rural North India (Jeffery et al. 2008), the people of Rupsha popularly distinguish between religious education and mainstream secular education. The mainstream education system is called worldly or *parthib* while religious education based on the reading and understanding of the Quran and other religious books is divine.

Beside the *moulana*, many educated *dhoni* women also visit *pirs* (Muslim saints), when they suffer from *dushi* or complicated illnesses. Shamima, a 48-year-old woman and the wife of a biomedical physician, had two surgeries in renowned private hospitals under the care of biomedical physicians. Every time when she got sick, she visited a Muslim shrine first and then saw a physician. When the physician recommended a surgery, she consulted her *pir* to get *doa* (blessings) and take permission for the surgery. Like her, many women believe that biomedicine has limitations and involves risks and cannot guarantee a hundred percent successful surgery all the time. Any misfortune may happen during a surgery. Her *pir’s doa* gave Shamima mental courage to have the surgeries. Many women believe that
Allah listen to pirs since they are spiritual people. The people of the village have to travel distant places to see a pir or to visit a shrine since there is no pir or shrine in the village.

When folk treatment fails to treat an illness, it is considered “too late to cure”. In some cases, the folk healers recommend biomedical or homeopathy treatment to patients as a follow-up to their treatment to cure the cases of dushi. It is believed that if evil forces attack and stay in a human body for a long time, biomedical treatment or homeopathy may be necessary after folk treatment. A patient needs folk treatment to remove dushi from the body and needs biomedical or homeopathy treatment to cure the damage that dushi did to the body.

During my fieldwork, Farina, a 45-year-old woman who lives her life as an agricultural laborer, had a chronic pain in her legs. Sometimes the pain would get severe. She and her close kin members identified it as a case of dushi. Whenever the pain recurs, Farina goes to a folk healer for treatment. The folk healer gives her some pani pora or tel pora to remove dushi and a tabij to protect her from further attacks. After every healing session, Farina visits a local pharmacy or a homeopath to get medicine to cure her pain. She told me that “first, it is necessary to remove dushi. If one does not remove dushi, daktari medicine will not work.”

Although every time the folk healer provided her with a tabij to save her from further attacks, the pain made a comeback after some days. Farina explained the reason of the recurrence of the pain in the following way:

It is difficult to keep the tabij sacred. If one fails to keep a tabij sacred, it loses its usefulness. To keep the tabij sacred, it is necessary to keep the body clean from all kinds of sua (pollution). For example, if one touches mashik (menstrual blood), she has to take a shower immediately. If she fails to do so, her body is polluted. Similarly, if a woman touches anyone after having sex, the person is polluted. It is necessary to have a bath immediately after having sex (said in a low voice since women consider sex as a private thing). However, many women do not do this and pollute others.
The village women believe that any delay to treat *dushi* further complicates the condition, making it difficult to cure. Hajera explained to me “if one can identify a *dushi* early, the *kabiraj* (folk healer) can cure it fast. However, if it is late, *kabiraji* (folk treatment) may not work. For example, if a pregnant woman suffers from a *dushi* and is late to see a *kabiraj* (folk healer) for treatment, the *kabiraj* (folk healer) may be able to cure the woman from *dushi*, but may fail to save the baby.”

4.1.3 Jadu

Alongside *dushi*, the villagers categorize another kind of complications, which are caused by *jadu* (black magic). The nature of illnesses due to *jadu* is in many ways similar to those of *dushi*, but the illnesses caused by *jadu* occur because of human action while the illnesses caused by *dushi* occur due to non-human agents. Many complications such as sudden pain, childlessness, and complicated childbirth may occur due to *dushi* or *jadu*. The symptoms of *dushi* and *jadu* are similar. However, the area of sufferings from *jadu* is vast compared to *dushi*. *Dushi* can only cause illnesses, but *jadu* can cause illnesses as well as economic loss, marriage complications, and infertility. While women and children are the victims of *dushi*, men and women may equally suffer from *jadu*. Children are rarely a victim of *jadu*. It is believed that children are *fereshta* (angels) and possess special blessings from Allah (God) to protect them from *jadu*. A layperson cannot identify whether a sickness is because of *dushi* or *jadu* but a folk healer can do this.

Although both men and women can suffer from *jadu*, the nature of illnesses and problems caused by *jadu* differ based on gender. The most common illnesses that women suffer because of *jadu* include infertility, complications during childbirth, and abortion. Women may face problems to get partners for marriage, have difficulties in married life, or
suffer from *durbolata* (weakness) as a result of *jadu*. Men usually suffer from illnesses such as madness because of *jadu*, but can also be harmed economically as *jadu* can damage one’s economic fortune.

A man or woman may be targeted for *jadu* for many reasons. In most cases, it happens out of jealousy. In the case of men, a man can be jealous to see the economic progress of another man and apply *jadu* to spoil the progress. In the case of women, a woman may feel jealous to see the happiness of another woman and apply *jadu* to make her childless since an infertile or childless woman is a socially stigmatized. Sometimes people use *jadu* to punish their enemies. It is a common belief in the village that women are the principle sufferers of *jadu*. Afsar Ali, a 50-year-old man who pulls a rickshaw-van, explained it to me this way: “Women are the worst sufferer of *jadu*. Men also suffer from it, but not like women. Mostly women initiate *jadu* to harm their enemies who are in most cases women as jealousy is predominantly a feminine vice.” A *jadu* can be applied to a person in many ways such as mixing magical spells with their food or drink and placing magical substance in their house by *jinns*. The folk healers, who are believed to have connections with bad *jinns*, can instruct them to carry the magical substance and apply *jadu* to a person.

I heard many cases of *jadu* during my stay in the village. Nurjahan told me that her husband disappeared from the village about four years ago, and she thought that someone applied *jadu* to him to make him mad and disappear. She tried a lot to find him but failed. I heard the stories of two families who were rich and possessed good amount of lands, but lost everything gradually because of *jadu*. Rahima, a woman who belonged to one of those households, said, “My husband was a successful man. Whenever he started a business venture, he gained out of it, which many people were jealous of. We do not know what went
wrong during the last few years. He lost his business and started to sell family lands.”

Nahida, a 55-year-old woman of the other dhoni household said,

My husband had a good job in Dhaka and we had 16 bighas of lands. We had a tension free life. However, all of a sudden, my husband decided to quit his job and came back to the village permanently. We all forbid him to do that but he did not listen to us. He stuck to his decision. He came back to the village, started a business, and lost all the money he had. Whenever he needed money, he sold lands. Now we have nothing-valuable left.

Both Rahima and Nahida believed that their economic conditions deteriorated due to the actions of jadu, which was applied by some unknown enemies.

During my fieldwork, I heard Rukhsana, a 20-year-old girl, was suffering from jadu. I talked to her mother Akima and came to know their experiences in dealing with the problem since usually parents disapprove their unmarried daughters to discuss such problems with others. Therefore, I had to talk to Akima to know about this. Akima, a 50-year-old woman and a mother of two sons and two daughters, elaborated the idea of jadu to me as she was dealing with a jadu problem of her youngest daughter Rukhsana. Akima’s family owns vitemati and some agricultural lands. Since their own lands is not sufficient to maintain their livelihood, Akima’s husband and sons work as sharecroppers on dhoni krishoks’ lands. Akima and her husband live with the family of their eldest son, who is married, and Rukhsana. Akima thought that someone applied jadu to Rukhsana so that she could not get married. She told me: “It is a terrible experience for parents. I spend sleepless nights. I am afraid if she cannot get married at this age, what will happen to her. None will marry her after some days.” Like Akima, many village women believe that it is difficult to arrange late marriages (marriage after the age of 20) for girls.

When Rukhsana completed her high school education at the age of 17, Akima and her husband began to look for a suitable bridegroom for her without any success. Akima
explained the failure to me by saying that: “Many families proposed to have Rukhsana as a bride but none of the proposals worked out (Such proposals are usually made via intermediaries). We could not have sit together to discuss the issue with any of the proposing families. We were willing to meet and talk, and they were willing to do so. But every time, I do not know for some reason, the other side lost interest in the marriage after a certain period of time.” Akima went on to say that, “it would be reasonable if the bridegroom side had any disagreement with us and cancelled the discussion afterwards, but in my daughter’s case, it was not like that. Even I was not allowed enough time to invite the party for discussion or meeting my daughter. Every time the interest faded before any progress was made.” To describe her daughter’s mental condition, she said, “These days I cannot bear looking at her face as she always looks upset. She was a cheerful girl, but she is getting pale day by day.” Akima thought her daughter’s case mysterious and consulted a local folk healer, whom she knew for a long time, to deal with the issue.

The folk healer confirmed Rukhsana as a case of _jadu_. Akima told me “I also suspected that she was suffering from a _jadu_ which is now confirmed by the _kabiraj_ (folk healer). The _kabiraj_ (folk healer) also gave me an idea about the enemy.” When I asked her how the folk healer identified the enemy, Akima replied “_kabirajes_ (folk healers) usually do not mention the name of the enemy as it is unethical for them, but they will give you some hints.” In Rukhsana’s case, the folk healer gave Akima hints about the location of the enemy’s house and a possible reason of the application of _jadu_. According to Akima, they had an enmity with a family over a piece of land, and she suspects that they applied _jadu_ to her daughter to take revenge. The folk healer recited a _mantra_ to remove the _jadu_ out of Rukhsana’s body and treated her with _pani pora_ and _tel pora_. Akima was hopeful and told
me that, “let us see what happens. A kabiraj (folk healer) is treating her. I am praying to Allah to give us good news about her marriage soon.” Akima with her experiential knowledge understood the problem of her daughter as a case of jadu which was later confirmed by the kabiraj (folk healer). She was confident about the special knowledge of the kabiraj and believed that his treatment would help her to overcome the crisis.

Although there are some suspected cases of jadu, the villagers believe that it is a great sin to apply jadu to someone. Nura, a 70-year-old woman told me that, “those who apply jadu to people, will be deprived of Allah’s blessings. They will never go to beheshto (heavens) after their deaths.”

**4.1.4 Gojob**

Unlike dushi and jadu, gojob does not refer to a sudden illness, which is caused by unusual forces. Gojob refers to an illness, which seems like a “normal osukh”, but is caused by the anger of Allah (God). This may affect an individual, a family, a particular group, or the whole village. When several members of a family suffer from a chronic or acute illness, or a good number of villagers suffer from an epidemic, it is assumed that they do so because of Allah’s disappointment and such illnesses are the expressions of His anger. Sufferings caused by the anger of Allah are called gojob although sometimes the village people use the term ‘gojob’ to refer to a misfortune also. If any illness or misfortune is identified as a gojob, people perform some rituals to get rid of it. The rituals include prayers and tawba (a promise made to Allah in front of a moulana not to do the things that anger Allah).

The villagers believe that people may face a gojob because of a sin. If a man or a woman does any immoral act or breaks the incest taboo and gets sick afterwards, it is
considered as a case of gojob. In the case of women, immoral activities include adultery, eloping for marriage, pre-marital relationships, abortion, and disobedience to the husband. Women’s behaviors are very important to maintain family honor as well as the well-being of the community. If a woman loses her honor due to any wrongdoing, she can bring harm not only to herself but also to her family and community. In the case of men, the sins that can bring gojob include disobedience to seniors, and beating or killing others. Men also have a responsibility to maintain the family honor. If a man kills someone or steals something from someone’s house, he shames the family. A man can commit a great sin by disobeying his parents, as it is believed that a man will go to a heaven after his death if he takes care of his parents. Parents’ dissatisfaction may invite a gojob for him. In most cases, it is believed that women experience the result of a gojob as illnesses and men experience it as economic losses.

During my fieldwork, Aleya, a 36-year-old woman and a mother of four daughters and a son, told me about her experience of gojob. She and her husband work as day laborers at other people’s houses. They own neither any vitemati nor any agricultural lands. They built their hut on a dhoni krishok’s land. After having three daughters, Aleya wanted to adopt a birth control method—tubectomy—to avoid any further pregnancy. However, her mother-in-law forbid her by saying that “don’t you need a son? Who will take care of you during your old age?” Aleya got pregnant again and had a son this time. After having the son and the daughters, Aleya started taking birth control pills to avoid any further pregnancy. However, she got pregnant again and tried to have an abortion to spoil this. She said,

I took bori (birth control pills) for a long time not to get pregnant again but it did not work. When I got pregnant this time, I tried to have an abortion because we had a hard time to manage food for our existing kids. Therefore, I bought some homeopathy medicine worth of 20 taka to spoil the pregnancy and took that. Believe me; it did not
work. After this attempt, one of our big cows that were healthy suddenly died. We did not find any reason for its death. Everyone said, “Since you wanted an abortion, now see, what Allah gave you—a gojob”. If I was yet to realize his wish and continued trying for an abortion, the gojob would affect my body. I thought about it and did a tawba that I would never try to have an abortion.

Aleya believes that her tawba and her decision to carry out the pregnancy saved her from getting ill and from an unknown danger that might come. Like Aleya, many village women consider abortion as a sin. If anyone aborts her pregnancy, she will get sick or have a misfortune because of gojob. There is a popular saying in the village that “if Allah creates a mouth, he will provide the food too”. During our conversation, Aleya told me “actually, I forgot that I didn’t need to think about arranging food for my kids, there is an uporwala (Allah) who is kind and provides food for his creatures”. Aleya believes that Allah was kind to give her a warning by killing her cow instead of causing a bigger loss. She realized the warning and will not make the same mistake in the future.

Gojob may also cause infertility and other kinds of reproductive complications to women. If a woman disobeys the seniors or break any social norms, she may suffer from reproductive complications because of gojob. In the case of Halima (a woman of the moddhobitta group who does not have any children), relatives suspect that she could not produce any children because of a gojob. She had the gojob because she did not perform her responsibilities as a daughter-in-law, and on top of that, she quarreled with her father-in-law, which the villagers consider as a heinous act.

4.2 Conclusion

In this chapter, we tried to see how women explain illnesses and how their explanations lead to their health care practices. Our discussion above shows that the women
of Rupsha categorize illnesses as *osukh, dushi, jadu,* and *gojob,* and these categorization influences their therapy seeking. A woman does this categorization based on her cultural models and sometimes with the help of her social capital—family members, relatives, and neighbors and her categorization of an illness directs her to choose a healthcare option or practitioner.

The village women are aware that biomedical physicians, homeopaths, and ayurvedic practitioners (*kabirajes*) can treat only one category of illness that is *osukh,* but for treating the other types of illnesses they need to go to a folk healer. Out of their religious convictions, Muslim women, regardless of their status, believe that evil spirits like bad *jinns* exist and may cause harm to humans, causing *dushi.* However, there is a difference between educated *dhoni* and uneducated *bhumihin* women when they explain *dushi.* The educated has a different explanatory model because education enables them to explain illness differently. The educated *dhoni* women believe that evil spirits exist, but it is not logical to believe that they are responsible for all kinds of illnesses. They differ from the uneducated *bhumihin* women by saying that their educational backgrounds made them aware of many “false notions” and “prejudices” related to health and illness helped develop social networks to know the availability of biomedical treatment for various illnesses. They are able to assess *dushi* and *osukh* more logically. They claim that poor women consider all kinds of misfortunes as the cases of *dushi or jadu* at the first sight that is “illogical”. Thus, women share the same cultural model to explain the existence of *jinns* but differ about the degree of their influence. The level of education makes the difference between them, and the more educated lean toward biomedical treatment.
Although they prefer to see a folk healer to deal with *dushi*, women’s criteria to choose a healer vary according to their social status. The *dhoni*-educated women choose the healers who are spiritual or have formal religious education. Since most folk healers of the village are from the *bhumi hin* group and do not have any formal education, they have little acceptability to the *dhoni* and educated women. Many of the healers work as day laborers at the *dhoni* households since healing is their part-time job. I observed that to cure *dushi* or *jadu* many *bhodromohilas* consulted the *moulana* because his religious education made him more credible to the educated and *dhoni* women. Many educated *dhoni* women also visit *pirs* when they suffer from *dushi* or complicated illnesses.

Women regardless of their social status respect *pirs* as they believe that *pirs* “possess” spiritual power. However, the poor of the village cannot visit a *pir* or a shrine frequently as the village has no *pirs*. Moreover, a woman’s religious tradition influences whether she will visit a *pir* for healing or not. Two Islamic religious traditions are prevalent in rural Bangladesh—Wahabism and Sufism. The women following the Wahabi tradition respect *pirs* as spiritual persons, but do not believe that they possess any special power. To them, all human beings are equal to Allah and no one has any special power from Him. On the other hand, the women following the Sufi tradition believe that *pirs* are “special” people who possess “special power” from Allah, and their *doa* can solve many problems and cure many illnesses.

In Rupsha, women’s cultural models suggest them that if they suffer from *osukh* they have to see a biomedical physician, a homeopath, or a *kabiraj* for cure, but in the cases of the other types of illnesses they have to seek a folk healer. This observation presents a functional explanation of why different healthcare systems exist, but does not answer which women
pursue a biomedical physician, which women pursue a homeopath, and which women pursue a \textit{kabiraj}, and what influences this decision-making. In the next chapter, I explore these questions in relations to reproductive complications.
5. Women’s Reproductive Health and Therapy Seeking

In a fine winter morning, I was walking after breakfast, passing by the house of Nura, found she was talking with Hajera, while comforting in the morning sun. Both of them were senior by the definition of the village women although Hajera was 50 years old and junior to Nura by 20 years. Women whose children are married are treated as seniors in the village. Nura and Hajera smiled and asked me to join them, which I appreciated. After having sometime talking about their well-being, I asked Hajera about her daughter who was at the second trimester of pregnancy and visiting her for a month. Hajera told me that her daughter went to the RDRS health centre for a prenatal check-up under the influence of the shebika who lived close to her house. Nura did not like this. Both Nura and Hajera expressed disappointment about external interventions during pregnancies.

Nura, who has no formal education, belongs to a bhumihin household and a mother of four children told me, “Allah blessed us with pregnancies and we delivered. We did not have any problem. But women now have so many problems with pregnancies.” She went on to say, “When we gave birth, the male of the house (husband) did not have a clue. Now women go to doctors and cut their stomachs to deliver [meant a c-section delivery]. Some women cannot do any work during pregnancies. We did everything during pregnancies.” To Nura, expressing pains and difficulties to the husband and other male members during pregnancies is shameful. The cultural notion of a “perfect” woman suggests that she will be able to manage her own pregnancy related risks. Since pregnancy is believed to be a domain of women, failure to manage the domain without male interventions brings shame. Agreeing
with Nura, Hajera, who also has no formal education and belongs to a *hhumihin* household, said:

Look at me; I gave birth to five children. I did not realize anything. For example, each time the pain started at night and by the early morning, I delivered. By 10 o’clock in the morning, I finished all the cleaning. We did everything with pregnancies such as we cooked, husked rice, and collected drinking water from the *kua* (a deep water well). Now we are hearing so many things from doctors: do not work, do not carry heavy things, and so many other types of restrictions. During our time, we did our work and did not have any problem.

Another elderly woman, Maleka (55 years old), who delivered her five children at home, also objected to medical interventions during pregnancy and childbirth a few days ago when I met her at her residence. Unlike Nura and Hajera, she had an elementary school degree and belonged to the *dhoni* group. She explained her experiences the following way:

During our pregnancies, we had everything normal. I did not hear about any health screening for pregnancies. Whenever my pain started, I called my mother (who lived close to my house), mother-in-law, or sister-in-law to help me. My all deliveries took place at night and every time I performed my regular responsibilities such as cooking and looking after the seniors.

Elderly women’s objection to medical interventions during pregnancy and childbirth gave me a clue about a generational conflict over using biomedical services during pregnancies. Further investigation into this matter revealed that the generational conflict was an important factor in the village in terms of health seeking during pregnancy and childbirth.

In Rupsha, reproductive issues such as pregnancy, infertility, and childbirth are the subjects of women’s domain. The older generations of women are against seeking biomedical services during pregnancy and childbirth. They argue that pregnancy and childbirth are the exclusive domains of the women and women can manage them by their cultural knowledge, which they have learned over the generations. When a woman gets pregnant, she can receive valuable information from elderly and senior women. Knowledge passes from the senior to
the junior and from the mother to the daughter. Senior women who gave birth to children without any difficulty work as valuable guides. From their experiences and knowledge, elderly women advise younger women on how to work, what to eat, which foods to avoid and which rituals to follow during a pregnancy. The need for the involvement of male members and choosing a healer would arise only when something went wrong. In the case of a normal pregnancy, the birth takes place at home. When there is a complication during a pregnancy, other people including male members and healers get involved. Women also involve male members and healers in the cases of childlessness.

In the previous reproductive health research, as I already mentioned in the introduction to this dissertation, issues such as authoritative knowledge, role of the therapy management group, and women’s non-use of biomedical health services during pregnancy and childbirth related complications have received emphasis. In many western societies, such as in the U.S., childbirth predominantly takes place in hospital and during hospital births, the knowledge of women is ignored and medical practitioners exercise authority (Jordan 1978). I show in this chapter that the elderly women in this Bangladeshi village are unwilling to allow medical practitioners to intervene during pregnancy and childbirth as they think pregnancy and childbirth as their domain. On the other hand, the younger generations of women who are aged between 20 and 30 years, are willing to seek biomedical services.

Like many other non-western societies, such as Egypt (Inhorn 2003) and India (Bharadwaj 2003), infertility or childlessness is stigmatized in Rupsha. Usually women endure the most of the stigma and it is their responsibility to seek cure. Like in Lower Zaire (Janzen 1978), groups involving household members, neighbors, and kin members manage therapies for women during reproductive illnesses, which can be called therapy management
groups, in Rupsha. This chapter also shows that along with the therapy management groups, the possession of economic, cultural, and social capital by a household is important in health seeking. Women first try to understand whether the complication is caused by *osukh, dushi, jadu, or gojob*. When it is not a case of *osukh*, women prefer a folk healer. When it is a case of *osukh*, women seek biomedical practitioners or homeopaths depending on their economic, social, and cultural capital. For the women with low economic capital, cost is a factor in accessing biomedical care. The women with high economic capital can afford biomedical services but their use of such services is influenced by the role of the mother-in-law and the cultural and social capital of the household.

In summary, in this chapter, I explore how women deal with their reproductive issues and what factors influence their decision-making. More specifically, I show how women seek therapies during complicated pregnancies, childlessness or infertility and childbirth. For this, I rely on women’s narratives. I present their stories by grouping them according to the nature of the complications. The *dhoni* woman Haifa had a complicated pregnancy, the *bhumihin* woman Banu had both diabetes and complications during pregnancy, and the *bhumihin* woman Acia had an obstructed labor and as a result, she delivered at Dimla Thana Hospital. The *dhoni* woman Monwara had a complicated pregnancy followed by childlessness for 10 years, while the *bhumihin* woman Momena had a second marriage and suffered from a stigma of infertility. Roshnara delivered at home without any complications. The purpose of presenting these narratives is to show in detail what women consider in making decisions on reproductive issues.
5.1 Complicated pregnancies

When they face any problem during pregnancies, women try to understand the nature of the illness with the help of their household members and in some cases with the help of kin members who work as a therapy management group. The explanatory models of the individual members of the therapy management group may vary. Their explanatory models ask them to define whether it is a case of osukh or dushi and assess the seriousness of the illness. When it is osukh, people want to see a biomedical physician. In cases of the dhoni women, the authority or control of the mother-in-law and household responsibilities are key factors in choosing a health service. In cases of the bhumihin women, economic capital is the dominant factor. For people, in general, social capital plays an important role in choosing a health service. The following narratives discuss health seeking by various women during pregnancy related complications.

5.1.1 Story of Haifa

Haifa is a 32-year-old woman who belongs to a dhoni household and teaches at a local college named Janata College where her husband also teaches. She has an MA degree from a college. She is a mother of two sons. Haifa’s household owns businesses alongside agricultural land. She experienced a perinatal death as her first baby died immediately after birth. She had to go through a cesarean section for all her later deliveries because of gestational diabetes.

While talking about her first pregnancy, she told me “after conceiving, I used to feel pain and weakness. I talked to my elder sister who lives in Dhaka. She suggested that I go to a gynecologist at least for once for a check-up. They (in-laws) were not interested to allow
me to go to a doctor for prenatal check-ups.” After listening to her sister’s advice, Haifa decided to go to Rangpur Town to consult a physician. However, it was not easy for her. As a daughter-in-law, she had to get permission from her father-in-law and mother-in-law since she lived with them in an extended family. Her mother-in-law was not supportive of such check-ups. Her mother-in-law told her “I gave birth to my five children at home without visiting any doctor and without having any problem.” To her mother-in-law, visiting a doctor without any serious illness means wasting money. Although Haifa has income, she cannot spend her earnings freely as she has to rely on her father-in-law. She said, “Every month I and my husband give the major portions of our salaries to my father-in-law since he is the head of the household.” It is typical in rural Bangladesh that the household head manages family costs by collecting contributions from the earning members of the household.

To convince her mother-in-law, Haifa contacted her elder sister-in-law who lives in a city and has a good influence on her parents. Her elder sister-in-law requested her parents to allow Haifa to go to Rangpur Town for a prenatal check-up. Finally, she could go to see a gynecologist in the town when she was in the fifth month of her pregnancy. The physician recommended that she have blood and urine tests. She said, “After the tests, the doctor told me that I had diabetes and suggested to see her from time to time. I saw her again when I was in the seventh month of pregnancy and that time she suggested that I move to a hospital or clinic prior to my due date. I was ready to do so, but I could not. As a result, I couldn’t save my baby.”

Haifa’s mother-in-law got sick when Haifa was supposed to move to a hospital in Rangpur Town. When Haifa’s labor pain began, her mother-in-law was also feeling a severe pain in her stomach. Some relatives, who live close to their house, came to help them. Her
father-in-law discussed with two senior female relatives about Haifa’s situation and her mother-in-law’s condition and decided to wait and see if their condition improved. Her father-in-law decided that Haifa would be taken to a hospital in Rangpur Town if she failed to deliver at home. They waited for a home delivery and waited until for the pain of her mother-in-law to decrease. Haifa said, “Everyone waited to see if her (mother-in-law’s) pain was relieved. If her pain was reduced, she would stay home and I would go to the hospital.”

After having her mother-in-law in pain for 12 hours, her father-in-law, husband, and other relatives came to a consensus that if her mother-in-law’s pain did not decrease by the night, and if Haifa could not deliver normally, they would take both Haifa and her mother-in-law to a hospital. Haifa said, “They made such a decision because if they would take me and my mother-in-law separately to the town, it would cause double transportation costs.” Haifa’s and her mother-in-law’s conditions were too severe to take them on a bus. It was necessary to hire a microbus. Haifa’s father-in-law decided to take them to a private hospital in Rangpur Town because the accompanying family members would be able to stay at the house of the younger sister of Haifa’s mother-in-law who lived there.

Finally, when they reached the clinic, her mother-in-law had to undergo surgery as doctors found an appendicitis causing the pain, while Haifa had to go through a cesarean section to deliver her child. Her child did not survive. Nevertheless, Haifa had to take blame for the death since her baby did not survive in spite of paying a lot of money to the hospital. Although the baby died because of her late arrival to the hospital, in-laws and neighbors taunted her for going to the hospital.

Six months after the death of her first child, Haifa attempted to see a doctor for her diabetes and to discuss a future pregnancy. Again, she faced difficulties to get permission
from her mother-in-law and father-in-law. Her mother-in-law told her “the last time, you visited a doctor and spent money, but could not get the result”. This time Haifa engaged her elder sister to manage the permission for her. Her elder sister contacted one of Haifa’s aunt-in-laws (a sister of Haifa’s father-in-law who had influence on Haifa’s in-laws because of her education) who was a doctor living in Dhaka. Haifa’s elder sister explained Haifa’s condition to the aunt-in-law and the aunt-in-law agreed to counsel Haifa’s husband and father-in-law to allow Haifa for regular prenatal check-ups so that she could have a successful childbirth. Under the influence of her aunt-in-law, Haifa’s father-in-law and mother-in-law allowed her to go to Rangpur Town regularly to see a gynecologist. Haifa conceived twice and gave birth to two sons.

In both cases, she visited a private clinic. Haifa’s brother, who owns a big farm in the same village, paid for the costs. Haifa said, “Private health clinics are better places than the public hospitals. They are calm and quiet, and services are much better. Doctors and nurses are available all the time. However, they are expensive. To have a delivery at a private clinic you have to pay around Tk 25,000.” Haifa went to a private health clinic in Nilphamari Town where one of her elder sisters lives. In both cases, she went to her sister’s house in advance and stayed there until her labor pain began and then moved to the clinic. She came back home one month after the birth of each child. She said, “Since I had to go through a cesarean section every time, my sister did not allow me to come to my household immediately. If I would come back immediately, I would have problems getting rest because of household work.”

When asked about her choice of the medical system, Haifa said, “I did not consult a kabiraj when I felt discomfort. As an educated woman, I know that biomedical treatment is
very useful. I thought my diabetes and reproductive complications were cases of *osukh*, not *dushi.*” She added, “*Kabiraji* (folk treatment) is unscientific and even harmful”. However, she did not rely solely on biomedicine. She said, “Although I visited a doctor, I took *panipora* from a local *moulna* and prayed regularly. It is almighty Allah whose blessings are essential for everything.”

If we try to extract meaning out of Haifa’s narrative to understand her health seeking process, we see two types of decision making were involved—one in diagnosing the health problem and the other is in seeking a healer. These decisions had to be made on three occasions. The first occasion was during her first pregnancy when she felt pain and weakness. In diagnosing her illness, her cultural and social capital played the dominant role. Her education (i.e., cultural capital) and social capital (her network with her elder sister who lived in Dhaka city) helped diagnose her illness as a case of *osukh* and helped her seek biomedical treatment. Haifa’s family valued her elder sister as a conscious woman since she lived in a city and was well aware of the risks of childbirth. Haifa’s sister was a housewife who took care of her two school-going children, but had a friends’ network from where she would get information on health, education and other everyday issues. During her childbirths, she visited a doctor for check-ups. However, she had normal homebirths with the assistance of a female doctor whom she hired for the services. Since she received the “benefits” of prenatal check-ups, she advised Haifa to visit a gynecologist. In this way, she fulfilled one of the moral responsibilities of elder siblings in Bengali culture to guide the younger siblings.

However, her habitus as a part of the household made it difficult for Haifa to go out of the village to seek biomedical treatment. Her mother-in-law restricted her movement as she was living in an extended family. Her household responsibilities and the *purdah*, what
she and other women of the *dhoni* and *moddhobitta* households practice, taught her to obey elderly people like mother-in-laws and father-in-laws. In an extended family, it is expected that a daughter-in-law will seek permission from the elderly members of the household before going outside the home since it is a shameful act for females like daughter-in-laws to do so without permission. A woman’s primary job is to manage her household chores. Those who can perform it properly, receive appreciation from relatives and neighbors. Doing outside work does not necessarily enhance women’s status in the rural areas. Rozario (2001) also observed this in her research in another Bangladeshi village. According to her,

In a society where a family’s and a community’s honor is defined by women’s purity, women’s increased mobility outside the households is a problem for their families, since it is seen as compromising their purity. Thus, middle and upper class women are generally excluded from participating in such employment. Until recently, only the poorest of the poor would go out of the households in search of paid work, and there is little evidence of any increase in status resulting from their labor outside the household. [Rozario 2001: xviii]

In Rupsha, women irrespective of their socio-economic status are visible in different outside jobs in recent years. The women of the *bhumihin* households do menial work for their survival. There is no question of enhancing or decreasing social status for them. In selecting outside work, they consider the amount of wage and workload. On the other hand, the *dhoni* women hold different opinions about outside work. Some elderly women do not prefer outside work because they think that only those women whose husbands are unable to manage the family expenditure will earn money. One senior woman Aklima said, “It is a shame for those who are solvent but send their women outside home for earning money.” However, some elderly women have a different view. Bina, an elderly woman, said, “The days have changed. Women are earning and helping their families, which was not possible when we were young.” Since the time is changing, women can do outside work to contribute
to their families. Almost every elderly woman appreciates women’s education since they believe that an educated mother can contribute to the education of their children. Compared to the elderly women, younger women are more positive about outside work since they consider it as a reflection of their educational background. However, they have preferred certain kinds of job. For example, teaching at a school or college is the most preferred job by the women since it does not require visiting unknown places and facing unknown persons.

As I mentioned earlier, doing a job outside home does not necessarily enhance a woman’s status or decision-making capability. In Haifa’s case, she needed permission from her father-in-law, who was on the governing body of the college, to do the job. Haifa said, “He would not allow me to do other types of work”. Since he was on the governing body, he allowed Haifa to join the college, as she would not face any difficulty or harassed by anyone at her workplace. To allow a daughter-in-law to work at an unknown place or organization is a matter of concern and may bring shame for the family. Rozario (2001) notes a similar observation on women’s participation in outside work in the rural areas. She notes that respectable women fear sexual harassment by male colleagues at work places. She further notes that for most rural women “… once their education has been completed they generally return to an enclosed life within the household little different in substance from that of their mothers and grandmothers before them” (2001: xvii). As we have discussed above, Haifa, in spite of having higher education and a decent job, could not take the course of action, which she thought, was necessary to seek appropriate care. She had to engage her sister-in-law to convince her mother-in-law and father-in-law to go for prenatal check-ups.

On the second occasion, during the time of going to the clinic for childbirth, a therapy management group, including her father-in-law, mother-in-law and some elderly female
relatives, made the decision. Her time of moving in to the clinic coincided with an unusual event—the illness of her mother-in-law. The therapy management group had to make two decisions. As I already said in the previous chapter, the cultural models of illness influences people’s diagnosis of illness and seeking therapies for it. In Haifa’s case, the doctor told her that she would have to move to a hospital beforehand for her childbirth. The job of the therapy management group was to decide when and how to take her. The therapy management group decided to wait and see whether Haifa could deliver at home without any doctor. In Rupsha, people see pregnancy and childbirth as a natural and regular phenomenon, which does not require any physician or hospital. The therapy-seeking group was concerned about minimizing costs by taking Haifa and her mother-in-law together in a microbus. In the case of her mother-in-law, the therapy management group had to diagnose the illness first and then decide which therapy to seek. In this case, they diagnosed the illness as a case of osukh and decided to take her to a hospital if her condition would get worse. They waited to understand the severity of her illness, and decided to seek biomedical care.

In choosing biomedical care, in both cases, Haifa’s father-in-law preferred a private hospital. In Bangladesh, private hospitals are more caring than public hospitals as they provide their services on a pay-per basis. Wealthy people go to the private hospitals for better care. In Rupsha, visiting a private hospital by a family for treatment expresses its awareness about “modern” healthcare options and signifies the family status. People with good economic capital (i.e., the people of the dhoni and moddobitta households) try to avail of a private clinic, in spite of high costs. In choosing which private hospital to go, Haifa’s father-in-law relied on his social capital. He chose a city hospital near the house of one of his kin members so that he could get some support from them, which was a usual move in a kin-
based society like Bangladesh. In such cases, the relatives do not hesitate to arrange accommodation and food for the people who accompany the patients. This is a process of bonding and re-bonding which strengthens a person’s social capital.

On the third occasion, Haifa also had to rely on her social capital to get permission from her mother-in-law and father-in-law to go for prenatal check-ups and consequently for availing of hospital facilities for childbirth. She used her aunt-in-law to convince her mother-in-law and father-in-law, as educated people who have jobs and live in cities are considered more knowledgeable than rural people since the former have access to a “modern” lifestyle, “modern” knowledge, and the mass media. This time Haifa went to a private clinic near her sister’s house. On this occasion, she not only went for biomedical treatment, but also went to a folk healer—a moulana. Her religious beliefs and his credibility and social status guided her in pursuing the moulana.

Siblings and parents are always supportive during pregnancies. Her sister took care of Haifa, while her brother paid up the medical bills. A birthing woman can also manage post-delivery cleaning with the support of her paternal family members, as she does not have to hesitate to ask for help. On the other hand, the in-laws’ house which became her own house after marriage, is a place of responsibility where women are expected to perform some duties even after a childbirth and clean the things which became polluted during the childbirth on their own. It is a shame for a daughter-in-law to show inability to do the “essential” tasks—bathing and bathing the baby every morning, washing the materials used for child delivery, cleaning the bedroom daily, and lighting up “agor bati” (tiny sticks wrapped with fragrant substance) every evening to purify the air of the house—during the first 40 days of the childbirth.
5.1.2 Story of Banu

Banu is 26 years old and works as a day laborer like her husband as she belongs to a *bhumi hin* household. During the lean seasons, Banu earns some money by sewing clothes. Banu is proud to tell about her sewing career since she is one of the lucky women who can pursue this profession. She received a yearlong training on handicrafts and sewing from the local handicrafts society run by the social welfare ministry of the government. Describing her training experience, Banu told me “it was a yearlong program. They did not take any money from us. Moreover, we received 28 kilograms of rice per month.” Banu said that she got the opportunity to do this training because she completed grade six of school education during her childhood. The program enrolled those women who had elementary education—grade five graduates.

After finishing the training, Banu became a member of Grameen Bank, the renowned Bangladeshi non-government bank that provides credit to rural poor women without any collateral (Grameen Bank 2011). Banu heard about the bank from her neighbors who are also members of this bank. This bank prefers women from poor, landless, and assetless families for credit and provides guidelines on how to use the credit for income generating activities. It is assumed that women’s earning capability will raise their status in the household and will lead them to take part in family decision-making along with their male counterparts.

Banu took a loan of Tk 4,000 from the bank to buy her sewing machine. However, she was dissatisfied with her earnings because she had to compete with a good number of women of the village who survived on this work. Some of them who are older than she is and already made a reputation in this work get most orders from the villagers. Moreover, many villagers do not pay for the work on time, which she thinks, is the risky part of this work. Due to such risks, Banu works as an agricultural laborer during post-harvesting periods. Like
other poor women of the village, she gets a lower wage than a male worker does. Banu works full-time during the post-harvesting times to earn three meals a day for the family and save some money to survive during *monga*. Banu and her husband have to arrange meals for their five-member family, including her mother-in-law and her two young children. The wages Banu and her husband earned were spent primarily to buy foodstuffs for the family members, which included two kilograms of rice per day, sugar, oil, and vegetables. During the lean seasons, her husband worked as a domestic worker at a *dhoni* household and had his daily meals there. Banu, her children and her mother-in-law survived with the little money they saved during the post-harvesting season and with the little income, which Banu had from her sewing work.

Banu’s husband had to take the responsibility of bearing the marriage expenditures of his two younger sisters. He sold two *shotoks* of land, which he owned alongside his *vitemati*, to arrange the marriage ceremonies of his sisters. In Bangladeshi culture, in the absence of the father, the eldest brother looks after the well-being of younger siblings—a moral and social obligation for elder brothers. Since Banu’s father-in-law was not alive, her husband had to bear the marriage expenditures of his sisters.

Banu was struggling with diabetes when she conceived for the third time. During my stay in the village, I saw her suffering from the disease, which was exacerbated by the pregnancy. When I left the field, she was in her sixth month of pregnancy. When asked about her diabetes, Banu said, “Diabetes is an *osukh*. I got it from my mother who died a diabetic.” Banu already had two children—a girl and a boy—when she conceived for the third time. Her eldest child (daughter) was five years old and her son was four years old. Banu said, “I
became a diabetic two years after the birth of my son.” She recalled the time when she first suspected her diabetes. Banu said:

As my mother suffered from diabetes, I know the symptoms of this disease and its impact on health. I began urinating more frequently than usual. The soil (like most poor women Banu did not have a toilet), where I used to urinate, would turn white. One day, while I was visiting my relatives at Syedpur (a neighboring town to the village), I felt the symptoms. Most of my maternal relatives live there where I spent many years of my childhood with them. Since I grew up there, everyone there loves me and treats me with sweets whenever I visit them. This time, when I visited them, I ate many sweets and had frequent urination. Many of the relatives who saw my mother and her sufferings suspected that I also got diabetes. After some days I came back home and one day I saw some blisters adjacent to my genital.

To treat blisters and diabetes, first she visited the village health center. She said in a frustrated voice “most time of the year you will never see a doctor there. You will only find the assistant who cannot treat disease.” The assistant gave her a medicine, but it did not heal her. Then, he suggested she take a urine test. The test confirmed her diabetes. The health center cannot treat diabetes, so, the assistant referred her to a physician at Nilphamari District Hospital. Banu went there and spent Tk 300 for the physician’s fee, Tk 280 to buy a guidebook that suggested proper diet and practices for a diabetic and Tk 100 for bus fair. The physician advised her to see him once a month, but Banu said she could not afford to do that. Banu spent a large portion of her Grameen Bank loan, Tk 6,000, to pay for her initial treatment instead of buying the rickshaw van she wanted to buy. She said,

I am struggling to pay back the loan. I cannot think about visiting the doctor again. Daktari (biomedicine) is not for us. The first time when I visited a doctor two years ago to treat diabetes, I had to spend TK 800. I needed to see a doctor regularly to check my diabetes, but where should I get money to pay for the costs?

Due to costs, Banu gave up visiting the physician. She started going to a homeopath in the village. She said, “Both of them (biomedicine and homeopathy) are costly. If you go to a
hospital, you need to spend a large sum of money at a stroke. But if you see a Homeopath, you need to spend money day-by-day.”

After confirming her diabetes, Banu and her husband decided not to have any more children. Banu began taking birth control pills, but she said they betrayed her. She got pregnant for the third time. Banu now needs to deal with a pregnancy as a diabetic. She is aware of the availability of prenatal check-up programs in the village since the dais and sebikas appointed by BRAC and RDRS visited her house and told her about the programs. But Banu does not go to their health centers because of costs. She told me, “I don’t have the ability to afford the services. The income my husband and I have is spent to bear the costs of food and the homeopathy medicine for diabetes. If I want to visit an NGO health center, I need to pay Tk 15 as an entry fee and pay for a van (for transportation). They (dais and sebikas) always suggest us to go to their centers, but do not say how we will arrange money for that.”

If we review Banu’s narrative, we see that Banu had to make decisions for health seeking on two occasions—first, to treat her diabetes and second, for prenatal check-ups. Banu diagnosed her illness as a case of osukh not as a case of dushi. She saw the experience and treatment of her mother who suffered from the disease. By watching her mother, she came to know about the symptoms and treatment procedures. Banu tried to avail herself of biomedical treatment but failed because of costs. She opted for a less expensive treatment—homeopathy. Banu also knows that she needs to have prenatal check-ups during pregnancy, but could not avail herself of them due to costs. After meeting family costs, Banu barely has money for her treatment. Unlike Haifa, Banu did not face any problem obtaining permission from her mother-in-law since she did not live in an extended family. Purdah was not a
barrier for her since the women of her status group work in the fields and other places outside home to earn their living.

5.1.3 Story of Acia

Acia is a 20-year-old woman and a mother of a three-month-old daughter. Like Banu, Acia also belongs to a bhumihin household of the village. She and her husband work as day laborers. Acia’s hut is close to her parents’ house. Her father-in-law and mother-in-law passed away and other in-laws live in different parts of the village. When we talked, she was at her mother’s house. During our conversation, Acia’s mother Abia was with her. She added many points of information and concerns alongside her daughter’s. Acia is the eldest daughter of her mother. Like many other rural women, Acia moved to her parents’ house during her childbirth. Women usually move to their parents’ houses during childbirth for various reasons. One reason is to get assistance from their mothers and other relatives when it is unavailable at their husbands’ houses. In many cases, husbands send their wives to their parents’ houses to avoid paying for the costs of childbirth. Both things happened in Acia’s case. Acia had an obstructed labor.

When Acia’s labor pain started in the evening, she came to her mother’s house and informed her about her condition. After observing her, Abia confirmed that Acia was in labor. Abia waited the whole night and the first half of the next day for a normal delivery, but it did not happen. When Acia could not deliver by noon, Abia thought that an evil spirit attacked Acia. Abia said, “Sometimes these kinds of somoshya (complication) happen due to dushi.” Abia sent her husband to a local kabiraj (folk healer) and collected some pani pora and tel pora from him. Abia said, “Sometimes pani pora and tel pora help to remove dushi from the body and make the childbirth easy.” Following the recommendation of the kabiraj
(folk healer), Acia drank the *pani pora*, and her mother Abia rubbed the *tel pora* into her stomach for several times. But nothing worked.

Abia’s sister-in-law and three other female neighbors who live close to her hut came to see Acia. After consulting with them and observing Acia’s symptoms repeatedly, Abia became sanguine that it was not a case of *dushi*. Abia and her neighbors waited several more hours to have a normal delivery at home, but Acia failed to do that and screamed continuously because of pain. Abia, her sister-in-law and the elderly neighbors consulted about the next step. As I already mentioned, women play major roles in childbirth in rural areas, as it has been a domain of experienced women. Experienced and senior women consult each other to identify the complication and necessary treatment. In Acia’s case, they had a split opinion. Some suggested calling a *dai* and the others suggested taking Acia to Dimla Thana Hospital. Abia was not in favor of calling a *dai*. Abia said,

I did not call that stupid Parvin (the available experienced *dai* of the village). My sister-in-law called her when my niece delivered her baby but regretted later. She was bleeding a lot, but the *dai* could not do anything. She even delayed my niece’s travel to the hospital. This time I did not call her.

Like many other women of the village, Abia had low confidence in *dais*. The households, which have better economic capital, call *dais* to clean the polluting substances. On the other hand, the *moddhobitta* and *bumihin* households may call a *dai* when complications arise since in recent years NGOs have been campaigning to take assistance from a trained *dai* for a safe delivery. Most women are upset that the *dais* cannot solve all the delivery related problems without referring women to go to the hospital. When a *dai* fails to deliver a baby, the family has to take the birthing woman to the hospital for delivery. In such cases, the family has to pay the *dai* and for the hospital costs. To avoid paying for these two
services, Abia decided to take Acia directly to the thana hospital where Acia would eventually give birth to her baby. Abia said, “I took my daughter to the hospital directly. It is better to pay at the hospital than paying the dai. It is wise to pay at one place.” She said, “I gave birth to my five children. I know when to do what.” She did not consider going to the village health center. Abia said, “The health center does not have any services to offer. The people there can only check blood pressure, and if you ask for something more, they will say: go to the thana hospital or Nilphamari or Rangpur district hospital.”

At the hospital, Abia had to pay Tk 1,000 to a nurse for forceps delivery. Moreover, she had to pay for medicine and saline. Abia and her husband were worried about the costs since they lived hand to mouth and barely had any savings. Similar to Banu, Abia and her husband managed the costs by borrowing money. Abia said, “Fortunately we had some money at home and we could save the baby as I took a loan of Tk 5,000 from RDRS for income generating activities”. She spent a large portion of this loan for Acia—for marriage and now for her childbirth. During Acia’s marriage Abia paid Tk 2,000 as dowry and some new garments as gift to the bridegroom. Although the villagers are Muslim, they follow the Islamic rule related to bride price symbolically. Each marriage occurs with a commitment on bride price but usually the bridegroom does not pay the price unless he divorces his wife. However, dowry, although officially illegal, is a key cost of a marriage. The bride’s side is expected to pay the committed amount before or on the day of marriage. Muslims in rural Bangladesh borrowed the practice of dowry from Hindus in the late 1940s (Mukherjee 1971). Hindus take dowries for marrying their sons and pay dowries for marrying their daughters. Hartmann and Betsy argue, “… with the spread of education [among Muslims]—largely restricted to boys—parents of the sons began to demand a dowry as a return on their
investment” (1983:83-84). In Rupsha, a partial payment or failure to pay the dowry causes violence to women and sometimes results in divorce. To avoid the harassment of their daughter, Abia and her husband paid the dowry on the day of marriage.

After paying the dowry and for other marriage expenditures, they had some money left. Abia and her family attempted to increase the amount to initiate an income generating activity such as raising cattle or poultry by saving a taka per day. But just at the end of the first year, they had to spend the money for Acia’s delivery. Abia said,

First, I thought her case would be like mine. I delivered all of my babies at home. My mother-in-law, other relatives, and neighbors helped me. By the blessings of Allah, I did not have any problem. For example, my last child was born at night, and in the following morning, I cleaned my house, dirty clothes and did my regular tasks. We are poor people. We have to work everyday to earn our living. With our two persons’ income (her and her husband’s), we have to feed the family and repay the loan on monthly installments. I have to pay Tk 135 per installment. I earn Tk 40 per day while one kilogram of rice costs Tk 20. If I buy a kilogram of potato, it will cost another Tk 10. No money is left to repay the loan, if we try to have balanced meals. Then, what do we do? We save money by having less food and sometimes by starving.

In Acia’s case, Acia had to make decisions on two occasions—first, to diagnose the problem and then to seek a healer. Acia had a problem with the delivery of her child. She needed to decide first what was wrong with her child delivery and what she should do to solve it, but she had no authority to make these decisions on her own. Initially, her mother and later a therapy management group involving her mother and relatives made the decisions. Based on her experiential knowledge on pregnancy and childbirth, Acia’s mother thought that she would have an obstructed labor because of the attack of evil spirit and got remedies from a folk healer for that. When folk treatment failed, her mother, in consultation with some relatives and neighbors (her social capital), decided that her case was not dushi, but osukh. The therapy management group had a split opinion whether Acia would take help from a dai
or go to the *thana* hospital. The group lacked confidence in the efficiency of the *dai* in handling complicated pregnancies, and decided to take her to the *thana* hospital although they were worried about the costs. Acia’s parents had Acia deliver at the *thana* hospital by using the money they borrowed from an NGO for another purpose. Acia’s marriage and hospital delivery have created a huge financial burden for her parents.

Acia’s case also reveals a conflict between women and the trained *dais*. When *dais* suggest women that they should go for prenatal check-ups women react since routine check-ups during pregnancy are a new practice for rural women. This new practice contradicts with women’s belief that pregnancy is a natural process, which does not require any supervision unless something goes wrong. One *dai* Karima narrated her experience to me by saying that “every time when I suggest such check-ups, they (village women) reply they also delivered their babies earlier and they didn’t need to see any *daktar* (physicians). So, why do I badger them now to have prenatal check-ups?”

A conflict also occurs when the *dais* undermine women’s knowledge. Training provided to the *dais* by the NGOs began with an assumption that the village women are ignorant of their health issues. They lacked knowledge about the risks of pregnancy and childbirth, and local knowledge and practices related to pregnancy and childbirth were harmful for both women and their babies. The training emphasized continuous monitoring of pregnant women by the trained *dais*. The *dais* would also educate rural women about the notion of health and hygiene and the risks of pregnancy, and motivate them to use prenatal care services.

I attended a health session for pregnant women organized by RDRS during my fieldwork. The session gave me an idea how trained *dais* and nurses undermine women’s
knowledge when they deal with the reproductive health of women. A nurse and couple of dais conducted the session where 20 pregnant women from different villages participated. In this session, the nurse checked women’s weight, blood pressure, fetal heartbeats, fetal positions, and doled out iron and vitamin capsules. The following is a part of that session which shows how nurses and dais criticize local practices.

Session:

Nurse (to the pregnant women): Are you following all the rules to maintain good health? Eat extra food and regularly have the iron and calcium tablets that I gave you. Today a mother died (during delivery). She was not strong enough. She came to this center only once. If she visited us regularly and followed our instructions, she would not have this misfortune. We advise you on how to maintain good health, but you people do not want to come to our center.

First dai (supporting the nurse’s comment): I try hard to make them aware of the risks of a pregnancy, but they are so illiterate that they do not get it. They ask, “Why do we need to see a daktar (doctors) these days? We did not need a doctor before.”

Nurse (to women, after the dai ended): Do not say this kind of things anymore. Sometimes your mother-in-laws may forbid you to visit our center, they may tell you that “we did not see any doctor, but we successfully gave birth to children”. Do not pay heed to this kind of rubbish argument. Do check-ups regularly, eat extra food and take rest.

One woman (pointing to the other women): Yes, you are right, sister (nurse)—they do not want to come although you people are trying hard to convince them to come. Look at me; I visited a doctor alone when I was pregnant. Today, I pushed her (pointing to her sister-in-law) to come here.

This narrative shows how the dais and nurses condescend the older generation of women, such as mother-in-laws, who oppose health screening for pregnant women. The comments of the dai and nurse also hinted that they possessed a “superior” knowledge and had an obligation to educate “illiterate” women. But women cannot get the necessary treatment at the NGO health centers if they have any complications because the centers limit their roles to providing services like routine check-ups and counseling.
However, women do not hesitate to challenge the knowledge and authority of a *dai* since the *dais* belong to the lowest strata of the village. The *dai* Tohsina expressed her frustration to me when she discussed her experiences in dealing with poor women. She told me, “It is difficult to handle the village women. They don’t listen to us.” The poor economic condition of the *dais* also forces them to demand money from their clients, which sometimes create tension and conflicts between the parties. NGOs pay poor salaries to their appointed *dais*, the persons who perform the principal job of providing care to pregnant women and attending childbirth. Their education (a short training on maternal health) helps the *dais* to earn some extra money, but does not change their economic status as the most of them belong to the *bhumihin* households. Moreover, the education they received is in an area that deals with the impurity of childbirth. They only have connections to the local offices of the NGOs as social capital, and have limited or no ties to those in the village or the region who are influential.

### 5.2 Infertility

The villagers define infertility as a condition that can be caused by *osukh, jadu, or gojob*. People may differ with each other in diagnosing individual cases. For example, in some cases a woman’s explanation of the causes of her infertility differs from the explanations of her kin members. But this disagreement does not stop a woman from seeking advice from her kin members for healing. The women of the *dhoni* households usually choose biomedical treatment. In some cases, they may seek folk treatment at the same time but prefer a folk healer who belongs to a similar status group. Women’s cultural capital and social capital influence their decision-making. Usually, the women of the *bhumihin*
households prefer folk treatment for infertility. Their low economic capital and cultural capital influence their decision-making. Folk treatment is cheaper and more available than biomedicine in treating infertility. In selecting a folk healer, prior knowledge about the healer is important for the women of every status group because of a fear of sexual harassment. Usually women are blamed for childlessness; an infertile woman is stigmatized in the society. I met two women—Monwara and Momena—who lived through the stigma of childlessness for some years.

5.2.1 Story of Monwara

Monwara is 37 years old and belongs to a dhoni household of the village. She has a high school degree and teaches at a Primary School. Her husband is a businessman who owns a sizeable amount of agricultural land. Monwara told me about her experience of childlessness and her initiatives to conceive during the first 10 years of her married life. Monwara could not give birth to a baby after having 10 years of married life while, in Bangladeshi culture, children are expected after the first year of a marriage. Giving birth to a baby ensures the stability of the marriage. Monwara gave birth to her son after 10 years. During my fieldwork, her son was five years old and she had a seven-year-old adopted daughter.

Monwara said, “The first year of my marriage went well. I conceived but could not deliver a baby as I had a miscarriage.” She visited a private health clinic when she had this problem. She elaborated that:

I do not know what happened. When I was in the third month of my pregnancy, all of a sudden I saw blood in my private part. I talked to one of my relatives who was a gynecologist and lived in Dhaka. She suggested I check in a hospital immediately and I did that. My husband hired a microbus and took me to a private health clinic. The doctor conducted a D&C (Dilatation and Curettage) to clear my system. I am happy
for the support I received from my husband during all the difficult periods of my married life.

After recovering from the miscarriage, Monwara had to wait for nine years to get pregnant again. Recalling her childless years, Monwara said, “Those were difficult times. I stopped going to my neighbors’ houses. Whenever I met anyone, I had to hear some harsh words.” Infertile women are so stigmatized that they have to hear humiliating words even from neighbors and relatives. Monwara went on to say that, “some of our relatives encouraged my husband to get married again. As he is a man of strong personality, he did not listen to them. He supported me and waited for the years.”

Monwara visited several gynecologists at different hospitals to treat her problem. Monwara said, “I even went to Dhaka and consulted two gynecologists there. I had another D&C and a surgical operation to remove fat from my ovary but failed to conceive.” Since Monwara’s husband had good economic capital, she was able to see gynecologists to “solve” her problem. Monwara got permission from her in-laws to visit the gynecologists since her infertile condition was a “shame” for the household. “Those were helpless times,” Monwara added. After visiting a good number of gynecologists and failing to conceive, she stopped doing anything. Monwara said, “I just started devoting myself to Allah as only He could give me a baby.”

By this time, one day, when Monwara’s husband went to a neighboring village to look after his construction work, he heard a pathetic story of a poor family. He heard that after the birth of their third baby, the husband started begging on a village street with his newborn since he did not have a single poisa (penny) to feed his wife and the other children. Monwara’s husband felt pity after hearing this and went to the man begging on the street. He
gave the man some money and showed interest to adopt the newborn baby. The poor father
took some time to think and finally agreed. However, he wanted more money so that he
could do something to raise his family. Monwara’s husband gave the additional amount of
money and adopted the baby.

Both Monwara and her husband were happy to get a baby, but got a mixed welcome
from the relatives. Some relatives appreciated the initiative since showing kindness to a poor
baby is a great virtue in Islam. Many villagers believe that “it is a good deed to adopt a baby
from a poor family and raise it like one’s own.” Nura told me, “Allah blesses the person who
shows kindness to an orphan or poor. If anyone adopts an orphan or a poor baby, they have to
raise it like their biological child. If they fail to do so, they will get punishment from Him
(Allah).” Due to this moral underpinning, many relatives of Monwara appreciated her and
her husband. However, some relatives were critical and raised concern that an adopted baby
did not have lineage to the family. They suggested Monwara and her husband keep trying to
give birth to a baby alongside this adoption. Monwara said, they suggested, “Monwara, raise
this innocent baby like yours. If you do so, Allah may bless you with a baby.” Monwara
added, “They were right. We loved this baby so much that Allah blessed us with a son later
on.” Monwara conceived after 10 years. When Monwara conceived, her relatives and
neighbors reminded her that she should not ignore the adopted child when she will have her
biological child. After conceiving, Monwara visited a gynecologist from time to time. She
said,

You know; I conceived for the second time after 10 years of my married life. After
conception, I regularly went to a private clinic in Rangpur Town for prenatal check-
ups. But at the final stage, the position of the baby was not good. My doctor advised I
move to the clinic in advance. I did not take any risk. I checked in the clinic in
advance and I had to go through a cesarean section. My son was born.
Monwara had her childbirth at a private health clinic in Rangpur Town because she had a relative’s house nearby it where she could stay before her admission to the clinic. She elaborated that:

A private health clinic is an expensive place. Not everyone can stay there for a long time. There is also a concern about the accommodation of the person who accompanies the patient. Moreover, it is hard to eat the foods served at the clinic. They are so dull. Therefore, I chose to go to a clinic in Rangpur Town where one of my sister-in-laws lives so that I could get some support from her.

Monwara’s narrative reveals that her cultural and social capital influenced her diagnosis of her situation. During her first pregnancy, she had a miscarriage and sought biomedical treatment with the suggestion of a kin member who was a gynecologist. Monwara identified her problem as a case of \textit{osukh} and consulted biomedical physicians. During her second pregnancy, she religiously pursued biomedical treatment. In both cases, she could afford biomedical treatment because her husband had good economic capital. In addition to seeking biomedical treatment, Monwara would regularly pray to Allah for a child. Like Monwara, Momena also lived through pain for not giving birth to a child after her second marriage.

5.2.2 Story of Momena

Momena, a 40-year-old woman, got married to Afas (a 50-year-old rickshaw van driver) six years ago. Momena works as a day laborer and belongs to a \textit{bhumihin} household. For both Momena and Afas, it was their second marriage. Her first husband divorced Momena, while Afas’s first wife died of diabetes. Both Momena and Afas have a child each from their first marriages. But they do not have any children from their marriage. At the beginning of our conversation, Momena said, “to cement a marriage one needs to give birth
to a child and no marriage sustains without children”. Momena and Afas both wanted to have a child from their marriage, but failed.

Momena discussed this issue with one of her neighbors. After their discussion, Momena suspected that she could not conceive because of either dushi or jadu. Her neighbor recommended she see a specific folk healer. Since Momena had a child from her first marriage, she was confirmed that her childlessness was not a result of osukh. After consultation with her husband, she visited the folk healer recommended by the neighbor. The folk healer identified her problem as a case of jadu and gave her some pani pora and a tabij to destroy the jadu. Momena said, “I took pani pora for two weeks and used the tabij for several months. Six/seven months elapsed but nothing happened. This treatment failed to solve my problem. I became frustrated.”

Momena shared her problem with few other neighbors who were close to her. After hearing her problem, again a neighbor suggested she visit another folk healer who had a good reputation in curing dushi and jadu. But this healer lived at a distant place from the village. Momena hid her desire to visit the folk healer from her husband because her husband would not allow her to visit an unknown healer who lived at a distant place. One day when Afas went to the thana headquarters, Momena visited the folk healer by accompanying a neighbor. After hearing Momena’s problem, the folk healer told her the “secret reason” of her childlessness. Momena said:

The kabiraj (folk healer) told me that medicine would not work because your man (husband) had a defect. The kabiraj (folk healer) whom I visited earlier could not identify this. But this kabiraj could do. He told me that my husband had a surgical operation and as a result, he lost his power to procreate. He told me that my husband would always deny this.
After hearing the reason from the folk healer, Momena remained frustrated for some days and stopped doing any further treatment. Momena said, “I trusted the kabiraj because he could tell a lot of things about me and my husband without knowing us”. Although her husband denied that, he had a surgery, Momena believed in the folk healer’s explanation. She told me that:

*Purush* (men) will never acknowledge their faults. It is their character. My husband never visited any kabiraj or healer. Even he was not interested about my treatment. I thought it many times why he was so reluctant. Now I know the reason. Since he knows his fault, he is silent.

Momena’s story reveals that Momena along with her therapy management group recognized her childlessness as a *dushi* or *gojob*. Her social capital helped her to find out a solution to her problem. Momena took an active role in treating her problem.

The cases of Monwara and Momena show that infertility in rural Bangladesh is primarily a woman’s problem; men can never be infertile. When a couple cannot produce a child, the female partner has to seek treatment for that. An infertile woman is stigmatized and humiliated for not being able to produce children. Kin and social networks play an important role in seeking treatment for infertility as well.

### 5.3 Home birth

When there are no complications related to a pregnancy, the villagers prefer home birth. In the case of a home birth, a woman can do all of her regular work, carry out other responsibilities and get help from her mother or other relatives or even from neighbors during labor and childbirth. However, sometimes, solitary deliveries take place in the *bhumihin* households during the harvesting seasons. On the other hand, assisted deliveries are common
in the dhoni and moddhobitta households because their female members do not work outside home. In the case of an assisted delivery, experienced women are the key actors in delivering babies. The top category of experienced women includes the woman’s mother and mother-in-law. When they are not available, other experienced women of the household play the key role. In the case of the unavailability of experienced members at the household, the experienced females of the neighboring households play the key role. The birthing woman has little say in the birth process. Maleka, who gave birth to her five children at home, told her experience of the birth of her last child. She said,

During the birth of my last child, no one (senior females), including my mother, was at home. They went to attend the marriage ceremony of one of our relatives at Domar (a neighboring thana). At night, when pain started, I was perplexed. I sent Julekha (a young domestic worker) to chachi’s (a senior female of the neighborhood) house. She came and helped me.

Forina, a 45-year-old woman, who delivered her five children at home, told me that,

Listen (laughing), I did not need any daktar (doctors), any kabiraj, or any medicine; I needed nothing. Even I delivered one of my daughters alone. (After some silence, she elaborated) I was alone at home. I felt pain and delivered. When everything was done, she (pointing to her sister) came back home and cut the cord.

(She narrated another experience). Do you know what happened when I delivered this child (pointing to her fourth child)? It was at night. My mother was at home. I went outside for a bowel movement. All of a sudden, do you know what happened? Oh khoda (Allah), there was no bowel movement. I delivered. I was calling ma, ma, ma (mother). Ma came, and was scared to see me. She held me and asked, “What happened to you? Did anything bite you?” Then, I replied you do not need to hold me, hold the baby. (Laughing) This way I delivered the child.

When Forina was sharing her stories, another woman Roshna (30), was willing to tell her own stories. She described her experience:

Do you know what happened when I delivered this girl (pointing to her second daughter)? Her father told me to cook rice, as he was hungry. I just poured some rice into the water and felt the pain. I delivered before the rice boiled. During the birth of this girl (pointing to her third daughter), it was at night when I felt the pain. I finished
my cooking and everyone finished their dinner. I requested my husband to go out of the room. He guessed and went out and called the *khalamma* (a term to address a maternal aunt. People also use this term to address a senior woman of the neighborhood.) When I saw *khalamma*, I told her not to worry and go home. I did not have any problem. When I was telling her to go, I was giving birth to the baby.

Roshna’s courage and efficiency in handling her child deliveries were her credentials to advise younger women during their pregnancies. When her younger sister-in-law Ramicha (24 years old) became pregnant, it was Roshna’s duty to advise her. Both Roshna and Ramicha lived in the same household. Ramicha had complications during her childbirth and eventually had to deliver in the *thana* hospital. One day, when I was hearing child delivery experiences of Roshna and Ramicha, Ramicha was silent because she failed to demonstrate her ability to solve her own problem and created monetary burden for the family by delivering in the hospital. On the other hand, her successful child deliveries at home enhanced Roshna’s status at the household.

The women of the *dhoni* households sometimes seek external help during childbirth. Usually they hire *dais* to clean the “polluted” things. Ritun, a *dhoni* woman told me “during all my childbirths a *dai* helped me. She helped me bathe, cleaned my bed, my house, and all the dirty clothes.” A *dai* is appointed to help with delivery of the child and to do the “cleaning” if a woman cannot do these on her own. As remuneration, the *dai* receives saris, soap, and food or money. On the other hand, the women of the *moddhobitta* and *bhumihin* households usually take care of the post-delivery cleaning on their own. Seeking help from other people, especially in-laws, to clean the “polluted” things is a matter of shame and sometimes results in humiliation and raises questions about a woman’s ability to take care of her own problems. For this reason, many women also prefer to move in to their natal homes during the time of childbirth.
The stories of Forina and Roshna suggest that unproblematic home deliveries give women a special status in the household. These demonstrate her ability and courage, which everyone acknowledges and appreciates. Women feel proud to remember and narrate the stories of their natural child deliveries, and love to share these stories with other women. A woman’s ability and courage during child deliveries helps to raise her voice in the decision-making process. The in-laws value her experience, courage, and knowledge. She gets the right to look after the younger women of the household during labor and childbirth. In Roshna’s case, her mother-in-law and father-in-law gave her the responsibility to handle and make decisions for other younger women of the family during pregnancies. Roshna said,

My mother-in-law grew older. When my sister-in-law was pregnant, I had to look after her. During her childbirth, I was with her the whole night. She is a very weak personality. I told her to push but she was screaming and screaming. I had pani pora and tel pora from a kabiraj (folk healer) and gave her the pani pora to drink and rubbed the oil into her stomach but could not make her deliver. She could not deliver, as she was not strong like me. When her condition remained unchanged, I consulted with the apa (a family welfare officer) and with the bhabi (a woman of a neighboring house) about what to do. After that, I told the purush (male members of the household) that we had to take her to a hospital.

However, in recent days, women’s attitudes toward care seeking during pregnancies have begun to change. The women of the younger generation who are in their 20s prefer biomedical care throughout a pregnancy. Rehana, who was 20 years old and pregnant during my fieldwork, attended two prenatal sessions arranged by RDRS. She belonged to a moddhobitta household. Her husband was a farmer who cultivated his own land and worked as a sharecropper on a rich farmer’s lands. Rehana attended the sessions since she heard from her elder sister-in-law and a local dai about the “benefits” of prenatal check-ups. She said, “I am doing fine. Still I do not have any problem. But I visited them so that I do not face any problem during my final stage.” The nurse of the center suggested she take iron and vitamin
capsules everyday, which she found useful. However, she does not follow all the suggestions made to her. Rehana told me, “They told us to take rest and not to do any hard work. Is it possible? Look, all women of this village do household work even until the time of delivery. Are they not having children?” She went on to say that, “they suggest us do regular tests. Why should I go for a test when I am doing fine?” Rehana followed those suggestions which she thought beneficial for her and ignored those which she thought was unnecessary.

The women of the younger generations justify their acceptance of the biomedical procedures related to pregnancy by saying that the women of earlier generations were stronger than they were and did not need medical care for pregnancies. Gulshan, a 33-year-old woman said, “People of the older generations could work harder than us. They worked hard and got less sick.” Pointing to Rahmatan (a 70-year-old woman) she said, “She is very old, but still I think, she will be able to husk one maund (1 maund = 35 kilograms) of rice without any rest. Many people of this village still prefer her as a domestic worker.” The quality of meals played an important role in making the earlier generations stronger, Rahmatan explained to me. She said, “The foods we ate during our childhood, the women of the later generations cannot have them these days. We ate chira (traditional rice cereal) with pure doi (yogurt) for breakfasts. Does anyone eat that now?” Rahmatan also told me that because of “modernization” many new foods became parts of the daily meals, replacing some “traditional” foods. She said, “During our youth, we husked our own rice for consumption. It was so tasty. Now I don’t find any taste in the rice husked in the mills.” Nura, another elderly woman, added, “Now women do not have to do anything. They wait for the mills to husk their rice. I see many women buy masalas (spices) from shops. Oh khoda (God)! We prepared those ourselves. If one buys everything from shops, what she will do.”
The older generations of women including Nura and Hajera think that biomedical interventions and routine check-ups undermine women’s ability to handle pregnancies. Both Nura and Hajera think that a woman can demonstrate her abilities and *shakti* (power) by handling a pregnancy and childbirth alone. van Hollen (2003) found a similar notion in South India where it is believed that a woman generates *shakti* by going through the sufferings and pains of childbirth. The cultural meaning of “*shakti*” is associated with the power of Hindu goddess *Ma Kali*. It is believed that without the *shakti* of goddess, male gods are impotent. *Shakti* is believed to be the “activating principle of life” (van Hollen 2003:58). This cultural belief encourages South Indian women to tolerate labor pains and sufferings to demonstrate their *shakti*—the power of activating life. Similar to South Indian women, the older generations of women in Rupsha think that when external interventions, such as health check-ups during childbirth, take place it marks women as vulnerable to the male members of the house. They are in favor of childbirth without any involvement of the male members and external people.

5.4 Conclusion

In the above, we discussed women’s health seeking for reproductive complications by drawing on the narratives of women from different status groups, age groups, and educational levels. Etiological explanations and economic, cultural, and social capital influence women’s decision making related to health seeking and obtaining care. The younger women hardly have any freedom to take actions during pregnancy related illnesses. In cases of home births and pregnancy related illnesses, the elderly women of the household make decisions related to obtaining care.
The above narratives also show that women first try to categorize whether the illness is a case of *dushi* or *osukh*. We have seen that Haifa as a woman with high cultural and economic capital categorized her complication as a case of *osukh* and preferred biomedical treatment. Banu, a woman with low cultural and economic capital, also knew that her diabetes was an *osukh* from her experience and wanted to continue seeing a doctor for “better” treatment but she could not afford for costs. She opted for a cheaper option that was homeopathy. In the case of Acia, her mother first thought her childbirth was delayed because of *dushi*, and to verify her diagnosis, she went to a folk healer and collected some *tel pora* and *pani pora*. When these things failed to solve Acia’s delivery problems, her mother realized that it was not a case of *dushi* but *osukh*. Then her mother decided to take Acia to the thana hospital.

In the cases of *osukh*, everyone whether *dhoni* or *bhumi hin* prefers biomedicine. The women having cultural capital are aware of the biomedical services from newspapers, the electronic media and through their social capital (i.e., connections with relatives and friends living in cities). The women having low cultural and economic capital are also aware of the importance of biomedical treatment because of the NGOs, which run motivational campaigns to encourage women to avail of their services. But their use of the biomedical services varies based on the economic capital of their households. For the women of the *bhumi hin* households, costs is the number one hurdle to seeking biomedicine.

But in the case of the *dhoni* women, in addition to costs, the influence of the mother-in-law, household priorities, patriarchy, and generational conflict become important in considering treatment by biomedical practitioners. In Haifa’s case, the family gave equal importance to her mother-in-law’s sickness and her labor pain so that costs could be
minimized by transporting both of them together. Although Haifa is an educated and working woman, she has not right to spend her income and decide about obtaining health services. Since Haifa lives in an extended family, the elderly family members are in charge. In her case, the patriarch—her father-in-law—decided how the family money would be spent and when and how she would go to the hospital for her childbirth.

In the case of her second childbirth, Haifa faced opposition from the older generations of women like her mother-in-law. The older generations of women are less interested in allowing medical interventions into a birthing process since they find it unnecessary, which costs money and hampers household work. They forbid the younger generations of women to seek biomedical care during pregnancies because they consider childbirth as a normal process, which does not require medical interventions. They operate without a biomedical model of childbirth. However, Haifa managed to move in to a private health clinic to deliver her second baby. Her brother volunteered to pay the costs to save his sister from humiliation. Usually the natal family of a woman is expected to bear the costs of a hospital birth. The parental family’s economic contribution enhances a woman’s status at her in-laws’ house.

The women consulted in general are dissatisfied with the care provided at the village health center, and they have to pursue other alternatives according to their level of income when they get sick. They have to go to the *thana* or district hospital depending on the illness. But travelling alone outside the village is not culturally acceptable for a *bhodromohila*. It tarnishes her reputation and demonstrates that she does not maintain *purdah*. A family loses honor when its female members do not maintain *purdah*. The *dhoni* households control the movement of women to maintain family honor. However, for the *bhumihin* women *purdah* is hardly any barrier to their movements. They are, instead, concerned with costs.
To travel a long distance for healthcare, say for going to the district hospital, costs a household a lot of money. First, a family has to pay the bus fare for the patient and their companions. A patient has to have a companion to look after them during the journey and during the stay at the hospital. Buses are the cheapest options for the poor to go to the district towns, but they are crowded since they regularly carry twice as many people as their capacities. A long journey in such a crowded bus requires a patient to take someone with them so that the person can look after them if anything goes wrong. After reaching the hospital, the patient has to face some challenges such as a long wait time to see a doctor.

Although a patient requires someone to accompany her to the hospital and stay with her, it is not always possible for the *bhumihin* households to find someone for that because everyone has to work for their living. If a working woman, who relies on an hourly wage, takes off from work for a day, she along with her family may have to starve for the day. Only during the harvesting seasons, poor men and women can earn three daily meals and some extra money at the cost of hard work. If a harvest worker goes outside the village, they will lose the daily meals and income. During these periods, the *bhumihin* people prefer to work as much as they can and see a healer close to their houses in the case of illness. On the other hand, during *monga*, poor people have a hard time to get work and earn enough for food and treatment.

To bear the costs of biomedical treatment, a *bhumihin* household encounters considerable difficulty and may adopt many strategies. Spending the loans, given by NGOs to women intended for income generation, but re-allocated for healthcare is a common practice. A *bhumihin* household can hardly have any savings as it has to spend its total income to bear the costs of daily meals. Sometimes the costs of biomedical treatment
encourage the *bhumihin* people to pursue the other available options in the village when they suffer from *osukh*. Many prefer homeopathy treatment.

The older generations of women regardless of their status groups oppose biomedical care during pregnancy and childbirth. They would say that Allah blessed them and they did not need to see any doctor during pregnancies. They even justified the higher rate of maternal death by saying that if Allah wanted a woman’s death that way there was no way to protect her. For example, Nura said, “Everyone’s life is at the hands of Allah. If a mother dies during a delivery, she will directly go to a heaven because such a death is *shorgio* (divine).”

However, the younger generations of women are aware of the benefits of visiting biomedical physicians and hospitals during pregnancy related problems. They try their best to afford biomedical services.
6. Women’s Health Seeking Practices: Interplays of Symbolic Capital and Habitus

I undertook this research to understand the resources that women in rural Bangladesh have and the strategies they use when they encounter reproductive complications. Among my research questions were: how do women define and categorize illnesses? what sources of healthcare do they seek? what factors influence their decision-making? how do these factors relate to reproductive complications and maternal deaths? and finally, do women differ in terms of social status, age, and education in making decisions related to health seeking?

To address these questions, I have drawn upon Bourdieu’s Theory of Practice to frame my analysis of the social and cultural contexts of women’s experiences with reproductive health decisions. I have based my analyses on his theoretical concepts of symbolic capital and habitus. This approach has enabled me to incorporate both political economic factors (e.g., poverty, social inequality, and gender inequality) and phenomenological aspects of individuals’ experiences related to health seeking. Analyses based only on one of these aspects are deficient.

In this research, I have examined the options available to individuals, especially to women, in obtaining healthcare services and how structural factors and individual healthcare practices are interrelated. My research suggests that women in Rupsha differ in their access to economic, social and cultural capital. These differences in capital have profound effects on women’s health seeking practices. The residents of Rupsha recognize three different social categories of people, which can be expressed in terms of the forms of symbolic capital that
they have access to. Rupsha is unequal in terms of people’s control over economic, cultural and social capital. Based on the ownership of economic capital (i.e. lands), the people of Rupsha are divided into three categories—bhumiin, moddhobitta, and dhoni. Among the members of bhumiin households, labor power and wages are their primary economic resources. Almost every member of a bhumiin household, both men and women, work for the more prosperous dhoni households to make their living. Men usually work as agricultural laborers on the fields while women look after children and do domestic work in their own and in dhoni households. The need for laborers fluctuates during the agricultural cycle, creating uncertainty for many bhumiin. During the harvesting seasons, workers are in demand because of the abundance of work, and consequently their income is better than during other times of the year. On the other hand, during a lean period, such as monga, they hardly have any work and rely on whatever savings they have accumulated. In addition to agricultural labor, a few of the bhumiin households own rickshaw-vans. The men of these households pull rickshaw-vans to transport people and goods within and around the village to supplement their agricultural work. Some bhumiin women also generate income through activities such as raising poultry and cattle and growing vegetables in homestead gardens. They do these activities during “leisure” times with the help of their young children. A few bhumiin women have their own crafts such as tailoring clothes and making potteries. Recently, bhumiin women have been able to borrow money from the NGOs that run micro-credit programs in the village to facilitate income-generating activities.

The primary form of cultural capital bhumiin people have is experiential knowledge about life and living, as they did not have opportunities to attend academic institutions where they or their children could acquire another key cultural capital: education. Primary school
education is free of costs in the country but children from the *bhumihin* households cannot stay at classrooms, as they have to contribute to their household income by helping their parents at work or by working at *dhoni* households. Young girls in particular are less engaged in institutional education since they spend more time in household activities such as cooking, raising poultry and cattle, and working as domestic workers at *dhoni* households. A few *bhumihin* men who practice folk healing have magical knowledge as their cultural capital while some *bhumihin* women who work as *dai* have either experiential knowledge or biomedical knowledge about childbirth as cultural capital.

*Bhumihin* households’ limited economic and cultural capital also restricts the nature of their social capital. The social capital that *bhumihin* are able to develop consists of their connections with kin and their neighbors, who belong to the same social group, their employers, and the service workers of the NGOs working in the village. Their social networks are composed primarily of local family and kinsmen, and neighbors. Since they hardly have enough economic capital to maintain their livelihood, they cannot regularly perform the rituals and practices that generate and regenerate kin ties—such as kin visits, gift exchange, and offering feasts. They are also outside the mechanisms of delivering formal education that open up avenues for participants to expand their social networks beyond kin members.

The poor households are seen as lacking family honor by others. Every member of the family has responsibility to maintain that honor. Women have to maintain family honor by practicing *purdah*. As the *bhumihin* households do not command the same honor in the community as the *dhoni* households do, the practice of *purdah* is different for the women of the *bhumihin* households. For example, a woman of a *bhumihin* household is free to visit the
known places in the village alone, but to go outside the village or visit an unknown place for anything, such as treatment, she needs someone to accompany her. They are more visible in the village since the *bhumi hin* women have to earn their own livelihood.

More specifically, the social resources *bhumi hin* women have are their relations with the women of neighboring households, employers (i.e., *dhoni* women) and fellow workers who belong to *bhumi hin* households. A woman’s relationship with her employer is one of conflict and cooperation where the both parties try to extract maximum benefits from each other. The employer expects more work at the cost of the least wage while the employee wants to extract the maximum wage in a given circumstance. A woman’s network with her fellow workers is a relationship of both unity and rivalry. As I have described in Chapter 2, women have to compete with their fellow labourers for work, especially during the period of *monga*. A *bhumi hin* woman’s social networks are restricted by her need to observe *purdah* in order to maintain her family’s honor.

The *moddhobitta*, who are the middle category people, in contrast, have more varied forms of symbolic capital at their disposal. Economically they derive capital from both their labor power and their control of land. Each *moddhobitta* household owns a small amount of land, which they cultivate. In addition, many *moddhobitta* frequently work as sharecroppers in the lands owned by *dhoni* households. Few *moddhobitta* men work as *kabiraj* alongside working their own lands. The male members of a *moddhobitta* household, including boys, work in the fields, and the women and girls of these households work in their own households. Some women make and sell their crafts, including pottery, and provide services such as tailoring clothes. Some also raise poultry and few of the women are employed as *se bikas* with the NGOs.
The *moddhobitta* vary considerably among themselves in terms of their cultural capital (i.e. education). Some *moddhobitta* men have some primary and even secondary education, while others lack formal education, but have locally valued expertise. The *moddhobitta* men who work as *kabiraj* have ayurvedic knowledge as their cultural capital. Those *moddhobitta* women who work as *sebika* have some biomedical knowledge about pregnancy and childbirth. Most *moddhobitta* women have experiential knowledge about pregnancy and childbirth as their cultural capital.

Like the *bhumihin*, the *moddhobitta* people have social networks as social capital. The social networks that the *moddhobitta* people have include their kin networks and their relationship with other small landholders in the area and with the *dhoni* households where they work as sharecroppers. The *moddhobitta* households that locate at the upper end of the *moddhobitta* category have kin networks outside the village and networks based on their school ties or trade connections. The *moddhobitta* households command more honor than the *bhumihin* households do because of their landownership. The *moddhobitta* women are supposed to maintain the family honor by practicing *purdah*.

The *dhoni* households have the most diverse and extensive forms of capital of all of the people in Rupsha. Lands are their principal form of economic capital. Each household owns a sizeable amount of cultivable land and they employ *bhumihin* people to work their lands. Most *dhoni* households maintain their living by selling agricultural products. They also receive rent from the *moddhobitta* who are sharecroppers on their lands. Some *dhoni* households also own businesses which supplement their agricultural activities. Additionally, some *dhoni* households have members who are employed in white color positions in government and non-government organizations outside the village.
Most dhoni women work at home to prepare their family meals and supervise domestic workers. A few dhoni women have jobs and as a result, have direct access to economic capital though they do not have the freedom to spend this capital. Like other villages of the country, Rupsha has a male dominated society where women have to obey men. Men control family resources including land and income from rents, and the sale of produce.

The members of the dhoni households have education as their principal cultural capital. Most men and many women in the dhoni households have a certain level of education and ensure that their children get education. However, some elderly men and women have experiential knowledge as their cultural capital. The dhoni households have family honor and social networks as social capital. The social networks of a dhoni household are manifold. They connect it to a wide variety of social networks based on kin ties and other associations. Their economic resources enable them to maintain and extend ties through kin, extended kin, and friends by hosting rituals and feasts. Education and commercial or business connections also contribute to the social capital of the members of a dhoni household. Education allows people to gather rational knowledge and gain membership in different social and administrative bodies such as the local government while the business activities, which are part of their economic capital, land-ownership, and job allow people to develop, maintain, and strengthen their networks of social relations and social capital. The social networks of a dhoni woman like those of the male members of the household include her personal connections with her relatives and friends and the social networks of the members of the extended family. The dhoni women who have jobs have social networks through their colleagues. However, a dhoni woman’s social network and hence her resources are
constrained by the need to maintain her family honor by practicing *purdah*. Consequently, women’s social networks and capital are dependent on that of the male members of the household when attempting to access social ties beyond the household, extended kin, and former schoolmates. In recent times, due to access to cell phones *dhoni* men and women contact their kins and friends more frequently than before, which strengthens their social capital. This also has some influences on women’s health because women receive health information from relatives who live in cities and towns where biomedical information and services are more readily available.

Regardless of their socioeconomic category, all women have available to them knowledge of childbirth through either their own experience or through assisting other women with their children’s births. Elderly women have developed authoritative knowledge about reproductive complications from their experiences in dealing with such illnesses over the years. They use this authority in defining illness and suggesting appropriate therapies. Relying on their knowledge, which may be experiential for uneducated women and both experiential and academic for educated ones, women first try to identify whether an illness is a case of *dushi, jadu, gojob,* or *osukh.* Despite their shared knowledge about these different diagnostic categories, women of different socio-economic groups present different explanations about illnesses and take different actions to heal an illness. In the process, women from each group make use of different forms of economic, cultural and social capital.

I have documented that the women of Rupsha categorize illness into four categories: *osukh, dushi, jadu,* and *gojob,* which I have discussed in Chapter 4. This is a classification system shared by women regardless of their socioeconomic and educational status. *Osukh* occurs due to explicit causes. For example, if a woman has a miscarriage because of any
tangible reason, people would characterize this incident as a case of *osukh*. *Dushi, jadu,* and *gojob* are caused by various unnatural reasons. *Dushi* is caused by *jinns* or evil spirits, *jadu* is caused by human actions, and *gojob* is a punishment from Allah (God). The variation within a Bangladeshi community in attributing an etiology is consistent with the findings in other studies. Studies such as Sargent’s (1982), Young and Garro’s (1981, 1982) identified variations in people’s interpretations of the causation of illness within communities, but did not explore how various socio-economic factors influenced such interpretations. Illness categorization recognized by women in Rupsha supports Janzen’s (1978) contention that communities have their own ways to categorize illness. Janzen found that the BaKongo people categorized illness into two categories—illness of God (i.e., illness caused by natural factors) and illness of man (i.e., illness caused by human beings).

Women, regardless of their socioeconomic category, have access to some forms of cultural capital. First, as women, they have a gendered cultural capital derived from their authoritative knowledge about childbirth, gained either as mothers or through attending other women during and after childbirth. This knowledge however varies depending on their status and the extent to which they become involved in caring for other women during childbirth and the pollution that accompanies birth. The *dhoni* women assist close kin during childbirth but do not deal with the pollution, while the *bhumihin* assist with women who are both close and more distant during childbirth and in cleaning pollution. Similarly, women of all groups have knowledge of the concepts of *dushi, jadu,* or *gojob* as potential causes of illness, employ these concepts differently according to the other forms of knowledge of health systems and access to various kinds of care. In the practice of dealing with childbirth
complications, women from each of the three categories have somewhat different resources and employ them differently, creating patterns of habitus that reflect their resources.

In defining illness, the *bhumihin* women and the *moddhobitta* women are more likely to define pregnancy and childbirth related complications as the cases of *dushi* or *jadu*. Unlike the women of the *bhumihin* and *moddhobitta* households, the women of the *dhoni* households are guided more by biomedical concepts and knowledge obtained through schooling or public health programs than those who have not had formal instruction. The women of the *dhoni* households mostly categorize pregnancy and childbirth related complications as cases of *osukh*. Like other women, they also believe that invisible forces such as *jinns* exist but do not think that every illness is a result of the actions of such forces. They claim that their cultural capital (i.e., education) makes them able to distinguish between the cases of *dushi* and *osukh* more systematically than the women of the other types of households.

Differences in social capital are evidenced in the ways in which women of each of the three groups constitute their therapy management groups. A *bhumihin* woman’s therapy management group typically includes people of their own social networks such as the female members of their neighboring households who lack formal education. The experiential knowledge of seniors and neighbors help them identify the nature of illness and determine therapies. However, the composition of the therapy management group changes based on the seriousness of an illness. When the complication is minor, household members and next-door neighbors form the therapy management group. During some serious complications, folk healers and local *dais* are drawn into the therapy management group.

The therapy management groups at the more wealthy *dhoni* households are constituted initially by family members, as it is the case in both *bhumihin* and *moddhobitta*
households. The social capital of *moddhobitta* women produces a similar pattern of care seeking and progressive inclusion of people in the therapy management group in case of a severe complication. The people who are drawn into the therapy management group include kin members living in the village and *dais* or the female public health workers of the village.

The composition of the therapy management groups for *dhoni* women also vary as the condition increases in severity. When the complication is minor, the women of the household such as mother-in-law and sister-in-laws make the group. However, when the complication becomes more severe the elderly women relatives living in the neighboring households and within the village join the group. The network of relations drawn into the therapy group can expand to include the local representatives of the public health department, such as female family planning workers, and biomedical doctors. The *dhoni* women are more likely to use biomedical care, which may be expensive, but the men who control the economic resources of the family play the key role in deciding whether a patient would go outside the village for care.

Thus, similar to Janzen (1978), I find that a woman’s therapy management group varies from episode to episode. I have also shown that its formation varies based on household patterns and socioeconomic backgrounds of people. The members of a therapy management group consult each other in categorizing an illness. Sometimes the members of the group differ with each other in explaining the illness, causing delayed decisions. Adams et al. (2002) in their research in Mali have also shown that therapy management groups do not necessarily contribute toward positive decisions. All the members of a therapy management group provide suggestions, but experienced, educated, or knowledgeable women play the key role in making decisions during reproductive problems.
The practices of healthcare seeking are similar for all groups when an illness is a case of *dushi, jadu, or gojob*. In such cases, everyone prefers a folk healer. The women of different socio-economic groups follow different criteria in choosing folk healers. Most women choose those folk healers who belong to the same status group or possess the desired qualities. The *bumihin* and *moddhobitta* women choose those healers who live close to their households, possess “spiritual” or “special” knowledge, and are easily approachable. The *dhoni* women consider formal training as a criterion in choosing a folk healer. They prefer to go to a *moulana* who is well versed in Islam to treat the illnesses of *dushi, jadu, or gojob*. They are critical of the other folk healers and do not want to consult them for pregnancy related complications as they think the other folk healers are illiterate and frauds.

The women of the *bumihin* households in Rupsha first consult a folk healer in seeking therapies for any pregnancy related complication to make sure that it did not occur due to *dushi* or *jadu*. When the folk healer fails to treat the illness, they become certain that the illness is a case of *osukh* and pursue other options. When a complication is a case of *osukh*, women obtain any of the three options: biomedicine, homeopathy, or *kabiraji*. The particular path of care seeking reflects the forms of economic, cultural and social capital that they can expend in care seeking.

The *bumihin* and *moddhobitta* women seek homeopathy or *kabiraji* services available in the village as their first resort to treat the cases of *osukh* because such treatment involves low costs. Treatment in the village also requires little expenditure of social capital. Seeking biomedical treatments, the last option, places demands on both social and economic resources, and is only sought when other options fail to treat the illness.
In seeking biomedical treatment, both *bhumi*hin and *moddhobitta* women first try to get help from the biomedical services available in the village. The village health center is the key public health facility in the village that fails to provide the minimal services it is designed to provide to the villagers because of the limitations of the assigned doctor who does not attend the center regularly. *Dais* are the most available source of help although they can provide limited services during complications because they are trained to help normal childbirth at home. Sometimes there are also cultural conflicts between *dais* and women. Based on their acquired cultural capital (i.e. scientific knowledge about childbirth), *dais* as the agents of “modernity” preach the need for “modern” medical care during pregnancy and criticize women, who rely on more traditional beliefs and practices, for their “ignorance” of pregnancy and childbirth related illnesses. In return, the women also do not hesitate to question *dais’* knowledge and authority since the *dais* are mostly from the *bhumi*hin households and command less respect due to their poor position in the cultural hierarchy and even in the realm of “modern medicine”. They gained limited cultural capital through their training that is not enough to deal with all types of pregnancy related complications. When the biomedical options, that are available in the village, fail to serve their need, the *bhumi*hin and *moddhobitta* women go to the Thana Health Complex for treatment.

Biomedical treatment in hospitals drains economic and social capital for *bhumi*hin women and their households. When a *bhumi*hin woman wants to visit the *thana* hospital for treatment, she needs to take off from her work for the day which is difficult during a harvesting season. If the illness is serious, she can get an unpaid holiday. Losing daily wages by a *bhumi*hin woman may lead herself and her family to starve for the day. There is also a risk of losing the work since the employer’s need for domestic workers is high during this
time and replacements are available. Nobody could ascertain that someone lost her work for going outside the village for treatment, but everyone thinks twice before taking off from work as it is challenging to find a companion to go to the thana hospital.

Although poor people are supposed to get discount on hospital services such as consultation with doctors, charges for hospital beds, and laboratory tests, they have to bribe hospital staff to get these services and bear other costs such as for buying medicine and other necessary items like saline, bandage, and cotton. Bhumihin women may take advantage of their social ties to the NGOs that have provided them with loans for income-generating activities. Instead of using the money for small business as intended, some have used it to pay for treatment in emergencies. Lack of economic capital or poverty frequently contribute to delayed decision making for the bhumihin women who need to seek biomedical care outside the village.

Going to the hospital for medical care also places a strain on a household’s social capital and the economic costs of maintaining social ties. A pregnant woman needs someone to accompany her to the hospital to maintain purdah, because it is disgraceful for a family if its women members go outside the village alone. Taking a companion requires that the household bears the economic burden of transportation and meals for at least two people in addition to paying for official and unofficial costs of receiving care at the hospital. The problem is compounded by the difficulty of finding a travel companion if medical care is needed during the harvesting seasons. The bhumihin women also have few social networks outside the village to help them with food and lodging at or near the hospital.

The moddhobitta women, like the bhumihin women, also cannot go to the thana hospital affecting their agricultural work during a harvesting season as they are the principal
workers in her own households. The *moddhobitta* women like their *bhumihin* counterparts have a say in making decisions related to the household’s economic capital which are necessary in obtaining healthcare services. They also face similar limitations in their social networks. *Purdah* limits their development and use of their own social capital and imposes burden in requiring a woman to find a companion when seeking medical attention at the hospital.

In contrast, women of the *dhoni* households have more economic and social resources at their disposal, creating a very different healthcare seeking habitus. They are more likely to understand biomedical treatments and feel comfortable in biomedical hospitals than the *moddhobitta* and *bhumihin* women who have had less education and less experience outside the village. It is possible for the *dhoni* women to go to a private health clinic or hospital in any of the nearby towns or in the capital city to treat reproductive complications. Private hospitals, which operate on a pay-per consultation basis, have qualified doctors and nurses available for treatment. They take biomedical therapy as their principal resort to treat *osukh* and may pursue folk healing at the same time. Interestingly, it is not seen as culturally appropriate for the *dhoni* households to seek biomedical services in the village. It would undermine their cultural capital as “modern” by suggesting that they are not aware of the more complex and “modern” treatment services available in towns and cities, and it might also suggest that they do not have enough money for treatment. In Rupsha, only the poor seek biomedical treatment in the village.

The *dhoni* women expect to go to a city hospital to see a doctor, when they face difficulty during childbirth, and to deliver their babies. Their households have economic capital to afford hospital costs. But they face different types of problems to go to a town to
have treatment. A dhoni woman cannot decide on her own when to seek biomedical care because she does not have the decision-making power to use her or her household’s economic resources. In the dhoni households that have extended family structure the family head who is in most cases the father-in-law makes the decisions related to spending the economic capital of the family members. The women of the dhoni households usually do not bypass elderly people like the mother-in-law and father-in-law to use healthcare services. Like other women, the dhoni women also need companions to go outside the village. If no one is available, it is hard for women to get treatment.

The more extensive social capital of a dhoni household may be expended and even enhanced by a woman’s travel to a hospital for care. The household head, the patriarch, chooses a private hospital close to a kin member’s house so that the patient and the accompanying people can get some support such as food and space for rest and staying nights. This is done with a view to minimizing costs, and at the same time the visit, if managed carefully, may help strengthen kin bonds and increase social capital.

In some cases, the social capital (i.e. kin networks) of the dhoni households poses an obstacle to the dhoni women in seeking biomedical treatment. A dhoni woman has more expansive kin and family responsibilities than a moddhobitta or bhumihin woman has. They are expected to perform their kin and family responsibilities first and then go to a doctor since such a sacrifice makes them honorable in the household and helps them not being labeled as “sharthopor” (self-centered), an undesirable cultural label. Sometimes pregnant women suppress their complications since their travel to a town would affect their family responsibilities. They delay antenatal check-ups and hospital visits to take care of sick family members. Particularly it is crucial how their therapy management groups evaluate the illness.
If they identify the problem as serious, they will facilitate the women’s travel outside the village. For example, Haifa, an educated dhoni woman, who was a college teacher, had to delay her visit to the hospital during her labor due to the sickness of her mother-in-law and the suggestion of her therapy management group. However, in most cases, their social capital works as an important asset in obtaining treatment at a hospital outside the village.

The dhoni women’s decision-making related to treatment in Rupsha has similarities with Nichter’s findings. Nichter (2002) has argued that household economics, kin relations, and generational conflict play important roles in therapy management. In his study in India and the Philippines, Nichter shows that the members of a poor household set their household priorities and allocate resources accordingly. Household economics, kin relations, and generational conflict interplay in making a family’s priority list. In Rupsha, I found social capital (i.e. kin networks and family honor) and household economics, which, drawing on Bourdieu, I have defined as economic capital of the household, to play crucial roles in women’s health seeking behavior. Especially for the dhoni women, control over economic capital and social capital are important while the availability of dispensable economic capital is more important for the bhumihin and moddhobitta women in obtaining biomedical services. None of the households in Rupsha routinely sets aside money for health seeking. Rather people arrange money for this purpose whenever it becomes necessary.

The resources and strategies I have described here for the three categories of women must be understood against the background of ongoing cultural, social, and economic change, which is seen in the tensions between women of different generations. Regardless of their socio-economic background, women in Rupsha consider the periods of pregnancy and childbirth as times of pollution when mothers and babies are susceptible to attacks by evil
spirits. Women try to avoid pollution and follow some cultural restrictions to prevent the attacks. In terms of childbirth, every woman prefers home delivery if there is no complication related to the pregnancy so that she can show courage and strength by managing the birthing process herself. Women learn to manage childbirth from seniors and through practices. To the elderly women, solitary delivery demonstrates a woman’s power and capacity. The elderly women who have experiential knowledge as their only cultural capital, irrespective of their socioeconomic background, consider pregnancy as a natural process that a woman can manage without the interventions of outsiders like physicians or nurses. They do not consider pregnancy and childbirth related complications as serious concerns. In most cases, they oppose any biomedical intervention such as routine check-ups by medical practitioners during pregnancy and childbirth. They claim that they managed their pregnancies and childbirths without seeing a doctor, and ask why women need to see doctors these days. They claim that the deterioration of food habits and avoidance of physical work during pregnancy cause complications. They argue that biomedical interventions make women dependent on doctors, ignore their capacity to handle their own problems, and devalue their knowledge. However, government and NGO campaigns have confronted this notion in recent years, highlighting the utility of regular biomedical care during pregnancy and childbirth.

This conflict between the elderly women and the agents of “modern” medical services seems a conflict between women’s authoritative knowledge, gained through experience, and biomedical knowledge introduced through schooling and the work of government and NGOs. The change agents of “modernity” such as dais, nurses, and public health workers criticize elderly women for their “ignorance” of reproductive health issues and offer biomedicine as the panacea. The women of the elderly generations face the change agents arguing that
pregnancy and childbirth are natural processes and the domain of women that women can handle with their cultural knowledge. The older generations of women are afraid that if biomedical practitioners decide the well-being of women during pregnancy and childbirth they will lose an important area of their “expertise” and “importance” in everyday life. These women have seen that improvements in transportation and modernization of agriculture have eliminated many significant household work women used to do, reducing their importance in the households.

However, the high maternal mortality in the country demands that women remain alert to avoid complications during pregnancies and childbirth and to go through certain medical procedures for this. The maternal mortality rate is on the decline; however, if it has to come down to a negligible level, I concur with Rozario “there is a real risk of mythologizing and romanticizing the process of ‘natural childbirth’ and of projecting this image onto a Third World context where it is not always appropriate” (1998:144).

Now the younger generations of women, who are in their 20s, irrespective of their socio-economic backgrounds, want prenatal check-ups to make sure that they do not face any problems during childbirth. Many women of younger generations treat pregnancy as a serious condition that involves risks, and they think that the lack of regular check-ups during pregnancy and childbirth may cause harm. For example, a dhoni woman, Haifa, had gone for prenatal check-ups ignoring admonition from her mother-in-law, while a bhumihin woman, Banu, had prenatal check-up once and could not afford to continue having it throughout the pregnancy. The younger women of the dhoni households have learned the benefits of biomedical services through their access to cultural capital (i.e. education) and social capital (i.e., kin and other social networks), while the younger women of the bhumihin households
became aware of this through their social capital (i.e., connections with the NGOs). The NGOs that work in the village play important roles in educating the women of the *bhumihin* households about the importance of biomedical treatment. However, the use of the services by the younger generations of women is determined by their ability to mobilize economic, cultural and social capital.

Women are inclined to rely on their traditional cultural knowledge in categorizing illness, to practice *purdah*, and to perform the rituals of purity and pollution. In light of these habits, women have limited room to maneuver in the healthcare field. They do not challenge the cultural knowledge of illness and the practices of *purdah* and purity and pollution. By not challenging these practices, women produce and reproduce healthcare practices that form a habitus consistent with the expectations of older women. However, women acquire new patterns of healthcare practice and create a new habitus related to healthcare under the influence of changing cultural and social capital. Women’s understanding of the etiologies of illnesses and the healthcare seeking strategies that follow from these understandings are influenced by their available economic, cultural and social capital. In particular, new practices, such as seeking prenatal check-ups by the younger generations of women, have developed under the influence of changing cultural capital (i.e. health education campaigns by government organizations and NGOs). Women are born into households with established patterns of practices—but the increasing changes in the practices of individual women result in a constantly emerging, transformed habitus of care seeking and healthcare.

In this dissertation, I have applied Bourdieu’s Theory of Practice and explored how women’s economic, cultural, and social capital influence their decision-making and health seeking practices. I have also documented other complex issues related to women’s health
seeking such as gender differentiation in access to forms of capital which are not addressed by Bourdieu’s Theory of Practice. Gender differentiation, as Pinto (2008) observed in India, is an important issue of women’s life in rural Bangladesh. Any health seeking study without exploring gender differentiation is deficient. I have documented how women’s lack of control over economic capital influence her health seeking process, how women face the stigma of infertility, and how women are referred to as “vulnerable”, “jealous” and “carrier of pollution” to illustrate their subordinate status.

By examining women’s health seeking practices from multiple perspectives, I have contributed to the anthropology of women’s health by listening and analyzing women’s narratives. This research has provided detailed ethnographic data on women’s understandings of health and illness, has examined how gender differences shape access to capital for healthcare, and has explored the means and strategies women utilize in health seeking. I have demonstrated that women are active subjects who have authoritative knowledge about reproductive health, and have also shown that differential access to economic, cultural and social capital by women of different socioeconomic categories, when combined with gender inequality within these categories, have health-demoting effects on women. I have argued that explaining women’s health seeking and obtaining health services during reproductive complications require combining the analyses of the structural factors, such as poverty and gender inequality, that constrain the choices available to women needing healthcare for childbirth complications.
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