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Introduction

Sjaak van der Geest & Nasima Selim

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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