Shutika a reproductive illness in Bangladesh: Cultural interpretation and coping mechanism of the rural women

Thesis submitted

by

Amina Mahbub

Supervisor: Dr. Anita Hardon

Amsterdam Masters In Medical Anthropology

Medical Anthropology Unit

Faculty of social science

University of Amsterdam.

November, 1998

Table of contents

Acknowledgments

I am grateful to my supervisor Dr. Anita Hardon for her guidance in my work on the theme and methodology of my interest.

It was impossible for me to carry out my study and field work without the financial support of BRAC. I would like to thank Mr. F. H. Abed and Dr. Salehuddin Ahmed respectively the Founder and Executive Director and the Deputy Executive Director I of BRAC for their kindness. My utmost gratitude to Dr. Mushtaque Chowdhury, Director Research BRAC, whose enormous support helped me to join the course.

My gratitude to Mr. Bert Schijf for his assistance in developing the survey questionnaire. Special thanks to Dr. Ria Reis, AMMA program manager and Ms. Trudy Kanis-scholts AMMA secretary for their several kinds of supports during my study in AMMA course.

Thanks to my colleagues Dr. S.M. Ahmed, Samir Ranjan Nath, Dr. Kaoser Afsana, Dr. Hasema-E-Nasreen, Dr. Rukhsana Gazi, Rita Das Roy, Samiha Huda and Masud Rana in Research and Evaluation Division, BRAC for their time to time assistance in structuring my idea during field work and data analysis. I would like to appreciate the cooperation of the personnel of the RED field office in Matlab, particularly Anisa for her excellent assistance at field work. Special thanks to Abdur Razzaque, Bodrul and Babul for their patient attention in data entry and typing some parts of the thesis. My appreciation also to my friends Preeti Kirbat, Mala Ramanathan and Kees Van Eijsden whose kind company always cheered me up during my study in Amsterdam.

I am indebted to my parents and youngest sister Ajanta for taking care of my son during my absence. Without their contribution perhaps it was not possible for me to carry out my courses and field work so smoothly. I acknowledge the silent moral support of my husband Tipu as well.

It would be really injustice if I do not mention about my son Shourjo here, who stayed at home for a year without his mother. But never complained rather tried to inspire me with his little words. Still, I could see deep pain in his eyes during my short stay for the field work that expressed again and again "Maa I am missing you too much!"

Finally my gratitude to Jahanara of Char Nilokhi village who worked so hard in assisting data collection. I would like to give special thanks to the women in the village who participated the research and spent their valuable time with me.

Summary

My present study was conducted to explore the cultural interpretation of *shutika* and coping mechanisms of rural women in Bangladesh who experienced the illness. Maternal morbidity is widely prevalent in Bangladesh and along with other illnesses s*hutika* as a health problem related to childbirth has been identified by the rural women in Bangladesh (Mahbub and Ahmed 1997). Indeed it is a folk illness and there is no biomedical equivalent of it. In Bangladesh the medical doctors refer the illness as postpartum diarrhoea. Yet the rural women have their own idea about the illness and they seek their health care accordingly. Until recently no study has been done specifically on *shutika.* Since many women in Bangladesh suffer from *shutika* and it affects their reproductive health in the long run, to gain insight in their *shutika*-related notions, practices and coping strategies is important. Such inquire will assist in promoting maternal care strategies of both Government and Non Government Organization (GO-NGO) in Bangladesh.

The general objectives of the study were : i. to assess the prevalence of *shutika* illness among the women in the study area; ii. To explore the cultural interpretation of *shutika* illness; iii. to understand coping mechanism of the rural women during s*hutika* illness and iv. to sensitize the policy makers in BRAC about the prevalence, notion and cause of *shutika.*

It was an exploratory and descriptive study and the study design was a combination of qualitative and quantitative. Different data connection techniques were used in the study to collect information on different variables and themes. The techniques were: survey, in-depth interview, key informant interview and illness narrative for case studies. Besides two group discussions were also conducted to cross check the validity of data. The study population was pregnant and lactating women in the study area, because they were the population at risk. The survey was conducted on them. For in-depth interview twelve women were selected through quota sampling technique from two categories: pregnant and lactating women. In this regard socioeconomic class and BRAC village organization membership were considered as well. The key informants were selected purposively from the aged women and the traditional healers in the village. Six cases of *shutika* were selected purposively from survey and they were followed up for one month.

During the survey (June-July 1998) of the study overall 33.3% among the pregnant women and 48.5% among the lactating mother were suffering from *shutika.* The survey result indicated that irrespective of age, socioeconomic classes, parity and gravidity the women in the study area were suffering from *shutika.* Nonetheless it is obvious that the young illiterate women were the most sufferer in this regard.

The study revealed that the women in the village defined *shutika* as an illness related to pregnancy and delivery. They systematically divided it into two categories: *gorvo shutika and shukna shutika.* In their opinion *gorvo shutika* was related to pregnancy where as *shukna shutika* happened after childbirth. The village women also made an outright

distinction between diarrhoea and *shutika*. They usually labeled the illness through judging the sign and symptoms in the combination of women's condition (pregnant or lactating). The most reported causes of *shutika* were: weakness and disobey of food taboos. In this regard a discourse was explicit between young and aged women in the village.

The social and family attitude had an inevitable affect on the illness situation. It acted as an influencing factor at every stage from illness identification to treatment seeking behaviour. It was clear from the women's description that as soon as the illness condition aggravate they encountered various reaction in their in-laws' house. In this context they compel to develop their own way of copping with the situation.

Since cultural interpretation of *shutika* was different from the biomedical explanation the women were unwilling to visit a medical doctor for their illness. They usually preferred traditional treatment for the illness. Nonetheless, in the study they were found to use allopathic medicine for vertigo and weakness which were the symptoms of *shutika*. Yet it was noted that the illness as a whole required traditional remedies to get completely cure. Faith on expected efficacy of the traditional medicine was very apparent in terms of evaluating the treatment of *shutika*.

Finally, the explanatory models of *shutika* illness clearly revealed the sociocultural aspects of the society. In fact the description of the illness situation allow us to analyze the social origins of the illness which is derive from the gender relation as a form of sufferings.

In conclusion I would like to place following recommendation for the policy makers of BRAC on the basis of my findings:

BRAC could develop certain health education messages regarding *shutika* in a cultural sensitive way as a part of its Essential Health Program (EHC). The health education messages can incorporate the inter genrational aspect of the problem as well. Since the *shasthya sebikas* (health assistant in the community) live inside the community and they are quite popular among the village women; BRAC can imparted the message through them. BRAC can also provide the *shasthya sebikas* new knowledge on the early treatment of *shutika* as a syndromic condition.

Chapter One

Introduction

Every year millions of women in developing countries experience life threatening, high risk, chronic or other serious health problems related to pregnancy or childbirth (Akhter 1996:xi). It has been estimated that majority of the world's maternal death occur in developing countries (Goodburn et al. 1994:2). Awareness of huge differentials in maternal deaths between developing and developed countries and the realization that the majority of these death are preventable, are the main reasons behind the fact that the 1993 World Development Report has recognized maternal health as being one of the highest priority areas for next decade (WB 1993).

The extent of maternal health problem is often expressed in terms of number of morbid events to every death. But maternal morbidity, those are not directly connected to death are also important to be paid attention, because these have a long-term impact on reproductive health. Models using serious morbidity or 'near miss' events as a more frequent proxy for maternal death (Stones 1991) have been criticized. As the risk factors leading to a serious morbidity which results in death may well be different from those leading to a morbidity, which does not result in death (Goodburn et al. 1994:2).

In Bangladesh the magnitude of reproductive health problem of women is reflected through high maternal mortality ratio of nearly 5 per 1000 live births (Akhter et al. 1996:xi). A survey on the prevalence of maternal morbidity in Bangladesh shows that more than 50% of the women had prenatal or postpartum morbidity, and about 33% had intrapurtam or chronic morbidity. About 80% of the women had one or more morbidity (BIRPERHT 1994). Information regarding maternal morbidity is also found in a BRAC study done in rural areas in Manikgang. The study indicates that maternal morbidity is widely prevalent and it is believed that vesicovaginal fistula (VVF), chronic pelvic infection, prolapse and secondary infertility are very common morbidity (Goodburn et al. 1994). Among the common morbidities related to childbirth *shutika* was identified by the

women in the rural area of Bangladesh as one of the health problem (Mahbub and Ahmed 1997, Gazi et al. 1995).

Shutika is a folk illness[1] and there is no biomedical equivalent of it. In Bangladesh the medical doctors refer the illness as postpartum diarrhoea. In their opinion malnutrition, improper calorie intake during pregnancy and nursing period, frequent pregnancy are responsible for the illness. However, the rural women have a different notion about the illness and they seek their health care accordingly. The term '*shutika*' has emerge from the word '*shuta*' which means thread in Bengali. The explanation behind the term is – if you once get the illness you will gradually become thinner like thread. This illness is very fearful for the women because in case once anybody get this illness she has to suffer for the rest of the life[2]. According to the local version the women usually get this illness within eighteen months after delivery. Although some women reported that it also happens to the pregnant women but that is not serious. The woman who is suffering from the illness generally experiences pain in limbs, anorexia, fatigue, abdominal pain, feverish and vertigo and she becomes weak and thinner than before (Mahbub and Ahmed 1997:19). In another study it is also identified as a common problem after childbirth that includes severe weakness, loss of appetite, lower abdominal pain, fever and diarrhoea. According to that study, this type of problem following childbirth can be clarified as being due to a combination of severe malnutrition and postpartum infection (Gazi 1995:39).

Literature related to maternal morbidity in Bangladesh describes that after child birth due to certain factors women experience general weakness, pain in the abdomen and anemia, but until recently no research has been done specifically on *shutika*. Since many women in Bangladesh suffer from *shutika* and it is seen to affect their reproductive health in the long run, it is necessary to gain insight in their *shutika*-related notions, practices and coping strategies. Such inquire will assist in promoting maternal care strategies of both Government and Non Government Organization (GO-NGO) in Bangladesh. With this

[1] See conceptual framework for the definition of folk illness.
[2] Information collected by personal communication with both rural and urban women in Bangladesh.

concern I planned to conduct my present study on *shutika*, a reproductive health problem in Bangladesh. Primarily the study was conducted as a part of Amsterdam Masters in Medical Anthropology (AMMA) courses. But Since the cost for fieldwork was provided by BRAC (an NGO in Bangladesh), the research findings was also disseminated to the policy maker of BRAC for the utilization in their program.

The problem

In 1996 I conducted a study on women's perspective about their illnesses in a rural area of Bangladesh, I found that many women had been suffering from a number of reproductive morbidity from a long period. The women considered these disorders as not that much severe as these did not cause death. Yet, these caused prolonged suffering and affected their daily activities in the household. Since certain social stigma related to these problems and due to avoid uncertainty of their marriage the women did not usually seek clinical treatment in this regard. They had developed their own way of coping with these types of morbidities.

In that study the rural women classified the obstetrical illnesses into two categories: illness before childbirth and illness after childbirth. The illnesses after childbirth were more important to the village women because to them these caused prolong suffering. The illnesses they identified in this category were postpartum hemorrhage, dysentery and tenderness in back, prolapse, rotten uterus and *shutika*. Among all of these illnesses many of the village women had been suffering from *shutika* from a long period. Although there is no accurate statistical figure has been documented about the gravity of the illness but a maternal morbidity study in Bangladesh showed that 60% of the women in the rural area reported about feeling of fatigue during the sixth week after their child birth (Goodburn et al. 1994) and according to the village women that is one of the symptom of shutika (Mahbub and Ahmed 1997:19). In my previous study the rural women were found to prefer traditional treatment for the illness as they think there was no treatment of *shutika* in modern medicine. I conducted my present study to explore the cultural interpretation

of *shutika* and the coping mechanisms of rural women in Bangladesh who experienced the illness.

Objectives of the study

I conducted my study with the following broad objectives:

- To assess the prevalence of *shutika* illness among the women in the study area.
- To explore the cultural interpretation of *shutika* illness.
- To understand coping mechanism of the rural women during *shutika* illness.
- To sensitize the policy makers in BRAC about the prevalence, notion and cause of *shutika*.

My specific objectives in the study were as follows:

1. To identify the related demographic factors like age, education, class, parity and gravidity of the women in relation to shutika.
2. To understand the variance in magnitude of the illness by age, education, class, parity and gravidity.
3. To explore women's notions of susceptibility.
4. To know the recognizable pattern of the illness.
5. To identify perceived causes of the illness.
6. To understand the progression of the illness.
7. To seek out women's behavior, dietary practices in relation to the illness.
8. To investigate the choice of treatment and the reasons behind it.
9. To elicit the social attitudes (neighbours, friend) towards the illness.
10. To understand the family situation (mother-in-law, husband's attitude, women's negotiation power) of the women.

Conceptual framework

When many people in a culture or community agree about a pattern of symptoms and signs and its origin, significance and treatment it is considered as folk illness with a recurring identity. Folk illness is more loosely determined than medically defined 'disease' and is greatly influenced by the sociocultural context in which it appears (Helman 1995:113). Rubel defined folk illness as "syndromes from which members of a particular group claim to suffer for which their culture provides an etiology, a diagnosis, preventive measures and regimens of healing" (Rubel A. J. 1977). Folk illness is also considered to be culture bound syndrome as it is only recognized within a culture and not between cultures (Susan et al. 1994:19).

Culture bound syndromes are unique disorders as they are recognized mainly by members of a particular culture and treated in a culturally specific way. In defining a culture bound folk illness Rubel puts it, 'symptoms regularly cohere in any specific population, and members of that population respond to such manifestation in similarly patterned ways' (Rubel cited in Helman 1995:113).

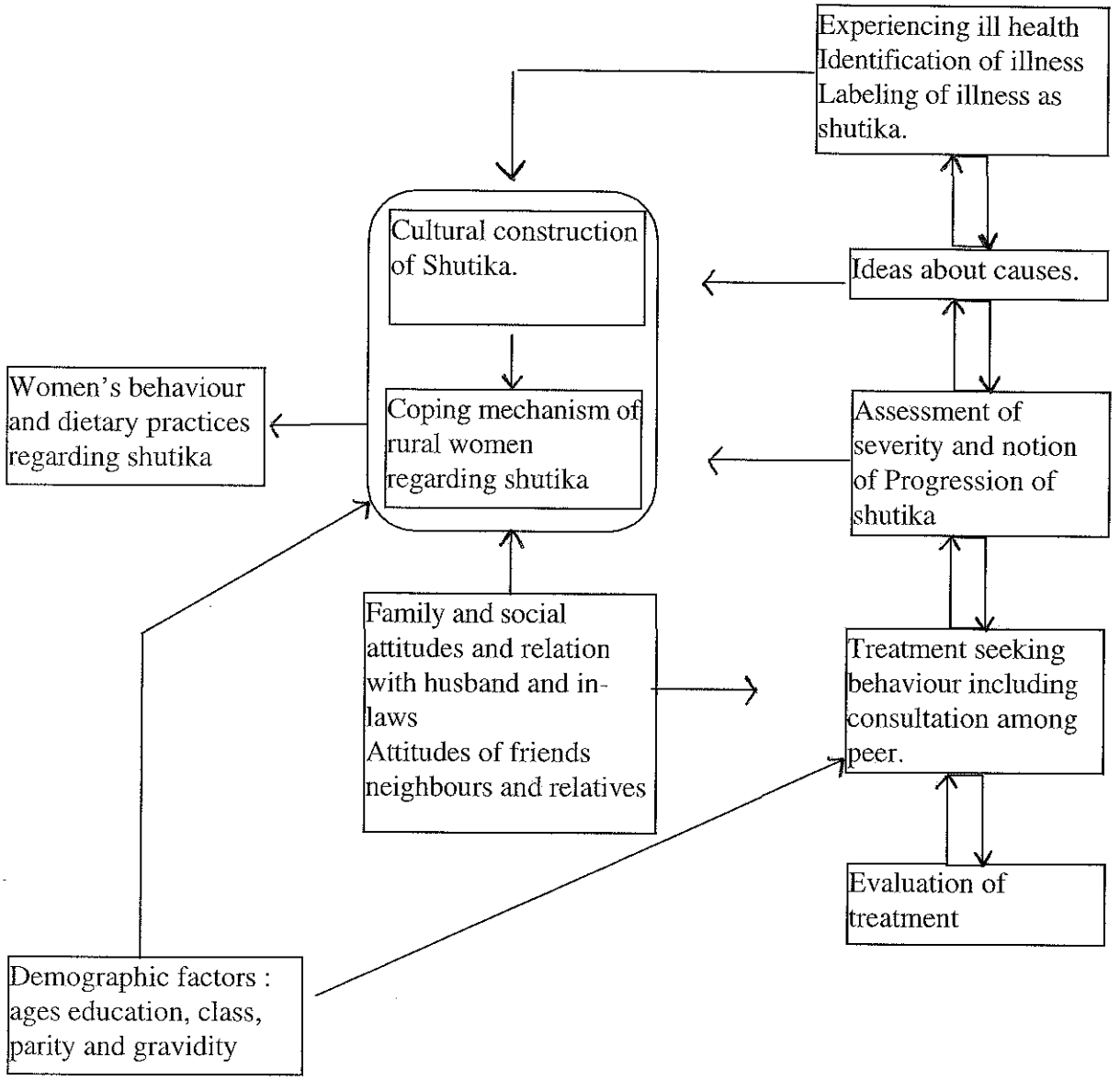
As a part of a culture folk illness is beyond specific signs or physical discomfort, with a range of a symbolic meaning, which incorporates social, economical, moral and psychological aspects of the sufferer. Kleinman's Explanatory Model (EM) is a useful way of looking into the process in which illness is patterned, interpreted and treated. Kleinman defined EM as "the notion about an episode of sickness and its treatment that are employed by all of those engaged in the clinical process". In particular EM contains explanations of any or all of five issues: etiology, onset of symptoms, pathophysiology, course of sickness or severity and treatment. EMs are the reflection of particular episode of illness and having influenced by both personality and cultural factors (Kleinman 1980).

Through EMs the health care system of a society can be understood. According to Kleinman health, illness and health care aspects of societies are articulated as cultural

system. As he clarified health care systems are like other cultural system; for example kinship and religious system are built in out of meanings, values, behavioural norms, etc. Health care system articulates illness as cultural idioms linking beliefs about disease causation, the experience of symptoms, specific patterns of illness behaviour, decision concerning treatment alternatives, actual therapeutic practices, and evaluation of therapeutic outcomes. As they are part of a cultural system, illness and health care need to be understood in relation to each other. Health beliefs and behaviour, illness beliefs and behaviour and health care are governed by the same set of socially sanctioned rules (Kleinman 1978:86). Cultural construction of illness is socially learned and sanctioned experience (Kleinman 1978:87). The EMs of a folk illness denotes specific systems of knowledge and values of a society as the illness exists in the specific society from generation to generation.

The prime concern of my present study was to conceptualize the problem in terms of insider's view; the study tried to adopt the 'ethnosciences' methodologies, which has been expressed as 'emic' approach (Pelto and Pelto 1978). Cultural conception of illness was considered as a key factor in the study and illness episode was the proper context for examining the cultural conception and coping mechanism regarding *shutika*, the folk illness. Kleinman's concept of EMs helped to map out and interpret the ideas. Accordingly, the problem in my study incorporated some interrelated factors. In the following diagram I made an effort to explain the interrelated factors of the problem. In the study along with individual experience, I considered the related social institution as well, because they are systematically interconnected (Kleinman 1980). Moreover, I also took into account the socioeconomic demographic factors of the women in examining the correlation with *shutika.*

Conceptual framework



Chapter Two (prima fin. overrided)

Women's health situation in Bangladesh: Attitudes, belief and practices

In this chapter to contextualize the issue of the study I ~~shall try~~ to provide an overview of women's health situation in Bangladesh. In Bangladesh women's health issues are traditionally neglected and inadequate importance is given by all concern. In general, women's health is utterly miserable and particularly pregnant and nursing mothers are deplorable by virtually any standard. A majority of the women experience significant morbidity associated with pregnancy and delivery (Goodburn et al. 1994). Rural Bangladeshi women are generally considered as chronically malnourished and their main weight is lower than that of female population (Huffman et al. 1985, Ford et al. 1988). Recent researches have shown that women's health behaviour is largely governed by the sociocultural context and their own perception of illness (Islam 1980, Jorgensen 1983, Blanchet 1988, Goodburn et. al. 1994, Mahbub and Ahmed 1997).

Sociocultural, demographic and economic aspects are profoundly interrelated in many ways with the overall health situation of women in Bangladesh. Besides specific customs, food taboos and other health practices contribute to their health situation. To understand the reasons of women's poor nutrition and health, it is important to know the social set up in which a rural woman begins her life and how she grows into an adult and mature woman. Over eighty-five per cent of Bangladeshi women are born in rural household where poverty affects every aspect of their life (Islam 1980:7, Akhter 1990:1). Gender differences in health, or the lack of health, overwhelmingly reflect the low sociocultural status of women in Bangladesh (Aziz and Maloney 1985). Several studies show that women's deprivation starts from the very early childhood (Akhter 1985:4). Female children are disadvantaged within the family in terms of food allocation and health care to her male counterpart. In a pilot study in Matlab, it was found that mothers favoured their sons not only in terms of household food intake, but also for food intake outside home (Das Roy 1995). Another study in same area revealed that with regard to attendance at hospitals for diarrhoea disease was 66% more frequent for male children than for female

children. The condition of female children was far more serious when they were taken to the hospital (Chen et al. 1981). However, the young female child grows older the social expectation increases. The value of self-sacrifice and patience and growing up eating less than what she wants are emphasized in household (Akhter, 1985:5).

Most women in rural Bangladesh have no control over the age at which they get married. Moreover, they have no control over the timing of their first pregnancy (Aziz 1994:277). Majority of the women in Bangladesh is married by the age of sixteen. According to the social norms following marriage a wife will go with her husband to live under her husband and in-laws' control. The husband will protect her honour and prestige and provide food, clothing and shelter. In return a wife has to earn her husband's satisfaction by obeying him, obtaining his permission before going anywhere, and remaining ever ready to fulfill his needs including his sexual urges (Aziz 1994:277, 278). Due to the subordinate position in the house of her in-laws a woman can not take part in any decision, but as she grows older she gradually takes part in decision making in the family. In the existing cultural setting although women are responsible for all domestic work but they are considered to be unproductive member and thus viewed as a liability (Akhter 1985:7). Most often they are entrusted with the key to the moneybox but are not allowed to spend money without her husband's concern (Blanchet 1988:3).

In a rural household the role of a woman is usually care giver in the family. She hardly pays any attention to her own body and illness. Since the husband is the breadwinner in the family, his health is the priority to her (Mahbub and Das Roy 1997). With all these concerns, women's perception about their own illness has been developed. A study showed that the rural women only considered themselves ill when they could no longer work and were bed ridden (Mahbub and Ahmed 1997:7).

In Bangladesh attitudes and practices regarding pregnancy and childbirth are other contributing factors to poor health condition of the women. When a rural woman becomes pregnant her in-laws mostly expressed interest in hopes of the child' s sex, not in

practical help with her work or better food. The rural women usually carry out the same amount of work when they are pregnant as when they are not. A pregnant woman also eats less than the actual requirement. There is also a belief that if she eats less her child will be small and it is easier to deliver the child. Prevalent notion of food affects their nutritional status during pregnancy. The low standards of malnourishment affect the pregnant women or women who have just given birth a child. Virtually most of all pregnant women are anemic and eighty percent of pregnant and lactating women suffer from iodine deficiency (Jorgensen 1983: 37, 40, 94).

During childbirth women in Bangladesh run great risk of complications because of their low age, small bodies, many previous childbirth, generally poor state of nutrition and lack of qualified help. Childbirth usually takes place with the help of an untrained mid wife, other village women or family members in the household (Jorgensen 1983:96). Rural mothers in Bangladesh perceive the problem related to childbirth as a normal condition for womanhood (Gazi 1995:40). For example, in a study the women did not identify the postpartum hemorrhage as a problem but considered as process of purification after childbirth (Blanchet 1984).

Ideally in rural Bangladesh the seclusion (*choti*) after childbirth ranges from seven to forty days, but often it is not seen in practice. A study on postpartum practices in rural Bangladesh revealed that in many times, a newly delivered mother resume her work as early as two days after delivery and deprived from minimum physical rest after child birth. Besides, the mothers believe that the *choti* (seclusion period) is meant for the babies' health, not for the mother. Thus in case of still birth or death of a baby the length of *choti* is short. The study also shows that in rural areas after delivery, along with different food taboos intake of normal amount of rice is forbidden. Rather it is preferable for the newly delivered mothers to have one meal a day, consisting of smaller amount of rice. Sometimes after childbirth fluid restriction for the mother is also practiced (Gazi 1995:37, 38). However, some researches have indicated that the dietary taboos during pregnancy and postpartum period are harmful and resulted in low serum levels for folic acid, carotene

and iron (Chen cited in Jorgensen 1983). Hence, practices and attitudes related to childbirth have a major impact on maternal health.

Limited or non-use of contraception until attainment of socially desired family size leads to short birth intervals and also a strain on maternal resources (Koeing et al. 1987). In Bangladesh if a woman survive to age forty nine in a marital union she will on average experience almost seven pregnancies (Ross et al. 1994:1). Yet birth spacing is not uncommon now a days but most prevailing solutions in birth regulation are sterilization and induced abortion. Unsafe abortion is a major cause of mortality and morbidity among rural women. But most of the time women do not aware of the connection between many child birth and abortion and a weak body. Most of the rural women have no knowledge about her own body and conception (Jorgensen 1983: 94).

Additionally, the observance of the value of 'purdah' affects women severely. It secludes them from being mobile and having access to education, information and health care facilities (Akhter 1986:7). Usually a woman in rural area always expected to need a male escort to go out side her village. Sociocultural restrictions on mobility of women outside their homes and disregard for their complaints contribute to a general lack of attention to their health status and limited care provision in case of disease (Fauveau and Chakraborty 1994).

On the basis of the entire situation 'culture of silence' (Dixon-Mueller 1991, Khattab 1992) regarding their health has developed. It has a reflection on utilization of health services. Most of the time the women in the rural area have to cope themselves with their illnesses and sociocultural factors influence their dependency on traditional medicine (Islam 1980:5). Although Bangladesh Government provides village services to women and children through family welfare assistants and health assistants. But the services are often bad and not easily accessible due to distance and time management. There are many NGOs with health related programs are also providing both community and clinic based MCH services in Bangladesh. With all these efforts service utilization is very limited yet,

especially in case of reproductive morbidity. Due to cultural values the rural women often are not allowed to expose to a male doctors for physical examination (Gazi et al. 1995:5).

Therapeutic choices of the women in the village largely depend on some particular criteria. Availability of the medical services, economic condition and efficacy of the treatment is notable in this regard (Mahbub and Ahmed 1997:29). In considering these factors women confide in indigenous medicine. With the onset of illness the rural women usually try with home remedies to get relief, if fail in most cases they consult to a traditional healer.

The traditional healers in a village usually practice in the midst of their community. Physically and socially they are most accessible (Blanchet 1988:23). They are not unfamiliar with the women and they share the same worldview about the illnesses. As health problems related to reproductive organs and child birth are often matter of embarrassment to the village women, they are not very frank to discuss the problems with the others of her surroundings. Besides as a rural woman is considered as a liability in her in-laws' house and they are invariably not very willing to spend money for her treatment. These situations result in the fact that rural women take resort to the traditional healers in the village. To them they can go and consult easily during their leisure time and even in the middle of their work. As mostly the treatment is almost free or the payment is often in kind (rice, vegetables, sweet, etc.) which is easily payable for the rural women. Because they can freely exchange the other products of the household such as vegetables, rice, eggs without their husband's concern.

The traditional healers in Bangladesh usually provide herbal medicine, amulet and sanctified water and oil for the treatment. Sometimes they exorcise with uttering charms to treat some special illnesses (Blanchet 1988:23). They are both male and female in gender. But the female healers are relatively close to the women.

Chapter Three

Methodology

The study reported in this dissertation was undertaken for three months. The study was exploratory and descriptive by nature. As the study attempted to achieve insight into the problem by investigating women's view and interpretation about the problem and how they seek solution. Besides, the study tried to provide a clear picture of the situation by describing some cases regarding *shutika*. The study was designed in a combination of quantitative and qualitative methodology, because it made an effort to approach the problem both in general and in-depth.

Prior to explore cultural interpretation in order to obtain a holistic impression of the situation the study also concentrated on the biomedical explanation of *shutika* as a disease. However, the following sections in this chapter describe variables and data collection techniques, study population and sampling, field operation, data processing and analysis and ethical considerations. Finally, the limitation of the research is also discussed in this part.

Variables and data collection techniques

Data was collected during end of May to mid of July 1998 and different data collection techniques were used in the study to collect information on different variables and themes. Specific objectives of the study led to the variables and themes to look at in the study. Different data collection techniques were survey, in-depth interview, key informant interview and illness narrative for case studies. Table 1 shows an overview of data collection techniques, variables and themes and the number of respondents.

These different data collection techniques were complementary to each other. Triangulation of different techniques and sources was done to maximize the validity and reliability of data and to reduce the chance of bias. At the end of data collection two group

discussions were conducted to cross check the validity of data. While data collection was carried out, the context or the setting was always be taken in to consideration.

Survey questionnaire, interview schedule, ethnographic questions for in-depth interview were used as data collection tools. Different checklists were followed for key informant interview and narrative of illness episode. Some secondary sources such as finding of different researches of the BRAC-ICDDR, B Matlab research project and other study reports on maternal morbidity in Bangladesh were also reviewed in the study.

Study population and Sampling

The study population was all pregnant and lactating women[3] in the study village, because they are the population at risk for *shutika*[4]. I identified them with the assistance of the village women. The village women through social mapping exercise identified twelve pregnant women and thirty-three lactating women. I included all of the forty five women for the survey.

For in-depth interview in the study twelve women were selected through quota sampling technique. Pregnant and lactating categories were considered here (six women from each group). In selecting the women in each category I also took into account representation from different classes and BRAC VO (Village Organization) membership. I assumed that the notion and coping mechanism regarding *shutika* may differ from class to class. In a previous study in the study area on socioeconomic issues and well-being (Mahbub and Das Roy, 1997) the villagers according to their own definition already identified different classes of the village. In that study the villagers categorized themselves into four socioeconomic categories. These are : rich, middle, poor and the poorest of the poor. The categories were used in the present study. The idea behind considering BRAC VO

[3] In rural areas of Bangladesh usually the mothers continue the lactating period up to four years of the children. Here for the purpose of the study I have considered the lactating period up to 24 months.
[4] The population at risk is the group of people, healthy or sick, who would be counted as cases if they had the disease being studied (Coggon et al. 1997).

membership was: since BRAC provides loan and initiates income generating activities for the VO members it may have an effect on the status of the women in the family. BRAC also gives health education to the VO members, which may influence the explanatory model of the BRAC women.

Traditional healers such as midwives, *kabiraj* (traditional healers), etc. of the area were regarded as the key informants. According to the requirement of the study women disregarding age could be the key informants; but she should be knowledgeable, spontaneous and should have many stories to tell. They were selected purposively. Besides, for obtaining biomedical explanation I interviewed three medical doctors in rural and urban areas as key informants.

For case studies six women were included who were suffering from the illness during study and I followed them up for one month. They were also taken purposively from the survey.

Table 1. An overview of data collection techniques, themes/variables/topics and number of respondents.

Data collection techniques	No. of respondent	Themes/variables/topics
Survey	45	Age, education, class, gravidity, parity, symptoms of illness, treatment choice, consultation network.
In-depth interview	12	Susceptibility, recognizable pattern, severity, health behaviour and dietary practices, cause, network for consultation, choice of treatment and reasons, social attitudes, family situation.
Key informant interview	9	Biomedical explanation of *shutika*, Women's behaviour, attitudes and practices, social and family attitudes towards the women who suffer from shutika, treatment seeking behaviour.
Case study	6	*Shutika* episode.

Field operation

Since I used some data of Matlab research project as secondary sources in the study and the study was done in a village under the project, consent of the principal investigator of Matlab research project was my primary consideration. After taking his permission I started my data collection in the study area. During the field work I appointed a research assistance who lived in the study village to help me in data collection. The survey and in-depth interview were divided into both of us. The follow up of the illness episode was done by the research assistance under my supervision.

At the beginning of my field work I required two days to visit the households in the village and clarified the village women about the purpose of my study. I also called upon a meeting with the elite of the village to describe my activities of data collection and the prospect of the study. Afterwards, I conducted a small pretest and I evaluated the following aspect of the study:

- Availability of the study population like theirs working schedule, their acceptability of the questions and their willingness to answer the questions.
- The questionnaire for survey was also pretested and necessary revision was taken place. The main considerations were: sequence of the questions, use of word and accurate translation.

Subsequent to pretest I took two days for the training of my research assistant before the data collection took place. The data collection was carried out with in a specific time frame. Table 2 presents the time frame of the data collection.

The field note was finalized almost every day in the field and the data compilation was also tried to complete in the field as far as possible. Finally, after primary analysis I initiated two group discussions to impart the study findings to the village women and also to provide them necessary health education regarding *shutika*.

Table 2. Time frame of data collection.

Activities	Days
Document review:	5days
Survey:	6 interview per day 45: 6 = 7.5 days
12 in-depth interview	2 interviews per day. 12 : 2 = 6 days for interview[5]
Key informant interview	It went on till the end of data collection.
Case studies	1 month including follow up. It started after survey.

Data processing and analysis

The qualitative data was processed and analyzed manually. The computer software program SPSS was used to analyze the quantitative data ~~in the study methods~~. Data processing included coding of the collected data, compile data under different variables, comparison of the facts and relation between variables.

Ethical consideration and beyond

Anthropological researchers have some primary ethical obligations to the people with whom they work (American Anthropologist Association 1997: 2). As the issue of the study was very sensitive to the women, some ethical consideration will be taken into account during the study.

[5] Sometimes two to three visit were required to complete an in-depth interview. In those respect, the interviews were tried to complete side by side to other activities such as key informant interview, follow up of case studies, etc. or any other free time.

I explained the purpose of the study to the respondents from the very beginning and without their consent I did not note down or recorded any information. I also assured them that all of the information regarding illness and other sensitive issues would be kept confidential. I also tried to convince their mothers-in-law as they often became very suspicious about my interview with their daughters-in-law. Yet few of them were not interested in allowing their daughters-in-law to attend the interviews. In this regard mostly the women used to come to my place in their leisure time as they were very eager to talk about their problems.

The survey was conducted during the busy harvesting season. Due to heavy work load it was difficult for the women to spare much time in answering the questions. Although I adjusted my work schedule with their activities and often squeezed it into their daily routine; but still now and then the interview appeared as a disturbance in the household works.

During interviewing the traditional healers as well as the women in the village I showed respect to their values, beliefs and attitudes. The traditional healers in the village did not welcome me in talking to them and also were not zealous to attend the interview initially. As they were anxious about their position and they feared to be replaced by modern medicine. They were also doubtful that through the interview my intention was to learn their treatment procedure. Ultimately, I was able to satisfy them with my reasoning and make them involve with the interviews.

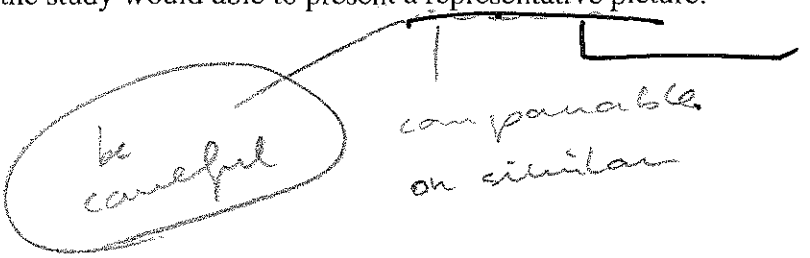
In conclusion, as a justification of applied research I conducted two group discussions with two groups of women (aged and young) to communicate the finding of my study. In that discussions I also conveyed the health messages (as I learnt from the medical doctors) to the women regarding *shutika* from biomedical point of view. I considered it as my moral responsibility to let them know about the causality and the treatment of the illness, so that they became aware about their condition. Although in those discussions I did not disobey their beliefs and values.

Limitation

The limitations of the study are in the following:

Since the study themes were translated into English from Bengali and sometimes it was not possible to translate keeping all the cultural connotations, so there was a chance of loosing the exact meaning. I tried to overcome the limitation by writing particular quotation and terminology in Bengali along with English translation.

The study involved a selected rural area in Bangladesh. The result of the study should not be generalized for the wholé country. But still, my impression suggests that, in spite of the limitation the study would able to present a representative picture.



Chapter Four

Shutika : A biomedical explanation

"*Shutika*! what is that?" replied a doctor, while she was asked if she could clarify *shutika* illness from biomedical point of view. '*Shutika*' as a terminology is not seemed very familiar to the doctors in Bangladesh, where as many women mostly in rural area are found to suffer from this illness. Before exploring the cultural interpretation of *shutika* I attempt to investigate the biomedical explanation of it as a disease in order to gain a through knowledge. However, by reviewing the obstetrical literature I did not obtain any exact definition of *shutika* illness as a disease. Finally, I decided to interview three doctors who mainly dealt with gynecological and obstetrical diseases in rural and urban area in Bangladesh. In the following I describe the nature and causal factors of *shutika* as a disease from their point of view.

According to the doctors there is no established definition of *shutika*, but in considering the sign and symptoms it seems to be a syndrome[6] which happens to nursing mothers, probably due to chronic malnutrition. Indeed one of the doctors identifies it as a combination of chronic malnutrition and reproductive tract infection during postpartum period and sometimes diarrhoeal diseases also occurs additionally in this condition as well. Therefore, the disorder is also called postpartum diarrhoea.

In denoting the causal factors they state that in Bangladesh, by reason of certain social factors most of the mothers are suffering from malnutrition from their adolescent age. Parallel to that due to prevailing beliefs and practices they are also deprived from appropriate diet from the early pregnancy state to nursing period. Hence, the condition becomes chronic. In doctors' opinion, the combination of strong superstition, socioeconomic condition of the women and unhygienic practices after childbirth is mainly responsible for *shutika*.

[6] Group of symptoms.

Regarding childbirth and postpartum practices they mention in rural areas of Bangladesh generally the birth processes attend by the untrained traditional birth attendant and the birth practices are unhygienic. Eventually, the probability of getting reproductive tract infection is higher among the women. Additionally perineal tear and certain practices of postpartum period as for example reuse of old rags for postpartum discharge increases the chance of infection. All of these factors exasperate the possibility of occurring *shutika.*

The doctors point out that due to hyper emisis gravidarum[7] the women experience loss of appetite and severe weakness and in due course it contribute in the process of chronic malnutrition. They also add that total number of gravidity may have a connection with the disorder, as it is a strain on maternal health. Yet the loss can be recovered through adequate diet and care so the doctors consider it as a secondary cause. Moreover, they clarify, the women in Bangladesh do not pay much attention to their other diseases unless those become much severe. So apparently, chronic malnutrition in association with other diseases deteriorates the condition after childbirth.

As the consequences of all above situations the women finally suffer from severe weakness, vertigo, anorexia, chronic dysentery, white discharge, feeling of fatigue, sunken eyes and blurring of vision. According to the doctors most presumably, this condition is familiar as *shutika* among the women.

As preventative measures they mention avoid food restrictions; adequate nutritious food should be taken throughout the pregnancy and lactation period. Besides, they need to maintain proper hygiene in times of food intake, as for example washing hand before having meal. That will reduce the chance of getting several diarrhoeal diseases. During lactation period mothers need adequate fluids. They elaborate the point as if a mother suffering from dysentery in addition to breast-feeding, lack of adequate fluid her situation will be worsen. But inadequate fluid intake is common among the mothers in rural area.

[7] In this condition excessive vomiting happens to the women during pregnancy.

Hygienic measures should be undertaken in preparation of postpartum discharge as well for the prevention reproductive tract infection.

In respect to treatment, as they state that in addition to continue proper nutritious diet, adequate fluid the reproductive tract infections should be diagnosed and treated separately. The reasons for different diarrhoeal diseases required to be identified for accurate treatment also.

Chapter Five

Char Nilokhi: Description of the study village

I carried out my research in a village called Char Nilokhi. I selected the village purposively for my study as I did my two previous studies in that village and I was more or less familiar with the community. The village Char Nilokhi is situated in Matlab Thana of Chandpur district. It is a typical small village and consists of 123 households with a population of 749. All the villagers are Muslim. Other small villages called Uddomdi, Char Pathalia, Char Mukundi and Nilokhi and also low land and Dhonagoda River surround the village (See annex 1). The village is only about 2 km south west from Matlab Sador and during dry season (October to May) the village is accessible by foot and partly by bicycle using two roads and crossing a couple of bamboo and wooden bridges; but in rainy season it can only be reached by boat.

It is basically a low lying area and the homestead land and the roads are raised artificially and deep trenches and ponds have been excavated beside them. These raised homestead land look like islands during the rainy season, starting from Baishak-Joistho to Ashwin-Kartik[8]. The local people then move by boat or by foot across the inundated land in knee-deep water. In some places, temporary bamboo or banana plant bridges have been made. The rainy season is a slow period of agricultural season; when only jute and Aman[9] remain in the field. As a result, work availability in the village in this season is less, but the villagers usually involve in fishing and ferrying boat during this season.

The soils of Char Nilokhi are mostly sandy and loam and are replenished every year by rich alluvium. The homesteads are normally not inundated except during big floods. The plains are lower that the homestead lands and where topography is little sloppy, they are used for agriculture. Mostly double cropping is done here. In very small patches single, triple or even quadruple cropping is done. The main agricultural product in the village is

[8] These are the name of Bengali month.
[9] A kind of paddy grows in rainy season.

rice but the villagers also produce wheat, potato, chilly, onion and garlic in different seasons.

The villagers of Char Nilokhi are socially divided into several *baris*[10] such as *Prodhan, Master, Sarder, Sareng, Mollah*, etc. In Char Nilokhi village *bari* is a type of domestic group. Generally the descendants of a common ancestor dwell in separate homes but within the same homestead area and they are collectively called a *bari*. Every *bari* and the genealogical connections living there are called by the surname of their common ancestor for example: *Nurul Mollah* of *Mollah bari*, *Situ Sarkar* of *Sarkar bari*. It is said that the ancestors of these *baris* were involved in certain profession or occupation and hence the name of their profession became a part of their names. As for instances, one ancestor of *Mollah bari* was involved in religious activities in the village so he used this title *Mollah* (religious leader) and his residence became known as *Mollah bari*. There are six *baris* in Char Nilokhi village and these are not of the same status. Locally social stratification occurs on the basis of status and prestige of these *baris*.

Most of the households of Char Nilokhi are directly or indirectly involved with farming, but there is a sort of economic hierarchy. The rich landowners are called *grihostho* and they don't usually cultivate themselves. They lease out or give out their land for share cropping or sometimes they hire labours to do the farming. Many villagers do salaried jobs and like *grihostho* this is another dignified occupation in the village. However, majority of the villagers is day labours and their work is seasonal, depending on seasons and availability of work. Most of the day labourers are agrilabourer during harvesting and planting seasons of crop. All year long there are some other jobs available for them such as thatching roof, cleaning trees, earthwork or making houses, etc. Some residents of Char Nilokhi village earn their income as rickshaw puller, shopkeeper, petty trader, etc.

Social position of the women in the village is no longer exception than the other areas in Bangladesh. Although in addition to household work, the women in the village are

[10] Cluster of several homesteads based on kingroup.

engaged in different income earning activities on irregular basis. It has been observe that rearing domestics is common phenomenon among both the rich and poor women, but they do not do it commercially. It provides them cash for everyday emergency need. Rearing is also done in share where the rearer gets the newborn of the domestics. Poor women occasionally do household work for the rich and get food for one time or rice as payment. Sometimes they work as agrilabours in the *boro* (winter rice) and *rabi*[11] season; their wage is given in kind. Inconsiderable number of women are seldom involved in small trading of handicrafts and home made food, they usually sell these during lean period in Matlab bazaar through their husband or grown up sons. BRAC (an NGO) also arranges some employment for women as schoolteacher, *shastho sebika* (health assistance), chick rearer, shopkeeper, etc. Through Village Organization (VO) BRAC provides loan to the member women but mostly the loan is used by their husband or other adult male person in their household. Now a day, some young women of the village are found of doing salaried job outside Matlab in garment factories and sending a part of their income to their families in the village.

Since the village is very close by to Matlab Sador the villagers can easily avail the service of the government hospital which is almost free of charge. For emergency diarrhoeal cases they usually attain services from ICDDR,B[12] hospital. The ICDDR,B also has an MCH-FP component which handle complicated delivery cases. But allopathic treatment mainly concern with men in the village. As the hospital schedule does not match with the free time of the village women, they are not very inclined to visit there. Additionally, for observing purdah they are not willing and sometimes are not allowed to exposed to an unknown person, especially male doctor. The women in the village occasionally receive allopathic treatment, but they hardly examined by the Medical doctors. In this case mostly their husbands buy medicine from 'bazaar dakter' (compounder/pharmacist) of Matlab town. It is true for their children as well. Although a substantial number of village women go to 'shadhana' an ayurvedic medicine shop for the remedies of their different hidden

[11] Different types of crops such as potato, wheat, mustard, etc. grow and harvest in this season.
[12] International center for diarrhoeal disease research, Bangladesh. It has been working for more than thirty years in Matlab in Bangladesh.

disease[13]. The women prefer traditional treatment (*kabiraji chikitsha*) for themselves and their child. They apply these remedies for their certain ailments particularly illness related to reproductive organs and child birth and illness cause by spiritual being.

Overall education rate in Matlab Thana is 57.9 percent and in Char Nilokhi village about 52.5 percent of the villager are educated[14]. Among them 26.7 percent is male and 24.8 percent is female. The small children of the village use to go the village Govt. primary school for their primary education but for the higher level they are found to go to the High school of the neighbouring village. For continuation of education after secondary level both boys and girls attend the Government College of Matlab Sador. For religious activities there is a mosque in the village which is established by the villagers.

[13] According to the women in the village some disease are not expressible to others. As for example white discharge.

[14] Information obtained from the seasonal survey in 1995-96 of BRAC ICDDR,B Matlab research project.

Chapter six

Respondents' profile and prevailing situation of *shutika*

This part of the dissertation mainly deals with the quantitative results of the study. In this chapter I shall attempt to present respondents' profile in brief and also the situation of *shutika* illness among the respondents. In respondents' profile, in addition to some of the socioeconomic aspects I shall provide their reproductive history as well. In the following section of prevailing situation of *shutika* the prevalence of *shutika* among the women in the study area will be assessed. In respect to the issue I shall also make an effort to present whether there is any association between *shutika* and other demographic factors like age, education, socioeconomic class, gavidity and parity of the women in the village.

Respondents' Profile

The study population comprised pregnant and lactating women in Char Nilokhi village (the study area). An overview of respondents' profile is given in table 3.

Around 40% of the study population were in the age group 20-24. Most of the respondents (46.7%) were illiterate. Of the remaining, 15.6% women attended secondary school and 37.8% women attended only primary school. Accordingly to the socioeconomic categories same proportion of women belongs to poorest of the poor and middle class (31.1%).

Reproductive history of the pregnant and lactating women is shown separately in table 4. A subsequent number of pregnant women were in 4-6 months of their pregnancy (58.3%). Again, in terms of lactating period majority of the mother consisted of the lactation period of 5-9 months (36.4%).

Table 3. Respondents' Profile.

Characteristics	No. of women (N=45)	Percentage
Age		
15-19	3	6.7
20-24	18	40.0
25-29	7	15.6
30-34	12	26.7
35-39	4	8.9
40+	1	2.2
Education		
Illiterate	21	46.7
Primary	17	37.8
Secondary	7	15.6
Socio-economic class		
Rich	7	15.6
Middle	14	31.1
Poor	10	22.2
Poorest of the poor	14	31.1

Table 4. Reproductive history of the respondents.

Characteristics	Pregnant women (N=12)		Lactating women (N=33)		Total	
	Number	Percent	Number	Percent	Number	Percent
Gravidity						
1-2	6	13.3	16	35.6	22	48.9
3-4	5	11.1	5	11.1	10	22.2
5+	1	2.2	12	26.7	13	28.9
No. living birth						
0-2	10	22.3	16	35.5	26	57.8
3-5	2	4.4	12	26.7	14	31.1
6+	-		5	11.1	5	11.1
Parity						
0	4	8.9	-	-	4	8.9
1-2	7	15.6	16	35.6	23	51.1
3-4	1	8.3	8	24.2	9	20.0
5+	-	-	9	20.0	9	20.0

Prevailing situation of *shutika* in Char Nilokhi village

Prevalence of *shutika* during the study period (June-July 1998) among the pregnant and lactating women in the study village is shown in table 5. As can be seen the prevalence of *shutika* in the study population during the reference period was relatively high. Overall 33.3% among the pregnant women and 48.5% among the lactating mother were suffering from *shutika* at the time of survey. Ten women (83.3%) from the pregnancy category were sick by different illnesses like fever, backache, vertigo, pain in abdomen, *shutika*, etc. and four women of them (40%) had *shutika* illness. In the lactating category twenty seven women reported different sickness and among these women 59.25% were suffering from *shutika*. Most of the women in pregnant and lactating categories were suffering from *shutika* for 1-4 months during the study period (Table 5). All pregnant women who had *shutika* informed that the onset of their illness was during 1-3 months (first trimester) of their pregnancy period. In fact, from the discussion of the women in the village it also appears that the pregnant women usually get *shutika* during the first trimester of their pregnancy. Besides, according to them sometimes women who had had *shutika* before their pregnancy, mostly continued after getting pregnant as well. However, the survey result shows that majority of the lactating women (62.5%) started to suffer from *shutika* during 1-3 months of their lactation period. Table 5 shows the onset of illness and length of suffering of pregnant and lactating women who had *shutika* at the time of data collection.

Association of *shutika* illness with different socio-economic and demographic factors is presented in table 6. In exploring the relation between women's age and *shutika* illness it was found in the survey that generally, women of 20-24 age group (both pregnant and lactating) were suffering from *shutika* during that period. Level of education was correlated significantly with the prevalence of *shutika* in the study area. Regardless of socioeconomic status women from pregnant and lactating group were suffering from *shutika*. Although women from the poorest of the poor group were the majority in this regard. 16.7% pregnant women and 18.2% lactating women from this socioeconomic

group reported about *shutika*, but the difference between several classes was not significant. According to the survey result it can be mentioned that irrespective of socio-economic classes women can suffer from *shutika*.

Table 5. Situation of shutika among the women in the study area.

Situation	Pregnant women N=12		Lactating women N=33	
	Number	Percent	Number	Percent
Prevalence				
Yes	4	33.3	16	48.5
No	8	66.7	17	51.5
Onset of illness				
1-3 months	4	100	10	62.5
4-6 months	-	-	2	12.5
7-9 months	-	-	2	12.5
10+ months	-	-	2	12.5
Length of suffering				
1-4 months	2	50	9	56.3
5-9 months	1	25	5	31.4
10+ months	1	25	2	12.5

In terms of gavidity the survey result indicates that mostly the women who had one to two times pregnancy suffered from *shutika* (pregnant women 16.7% and lactating women 33.3%). However, some women from lactating category who had more than five pregnancy also suffered from *shutika*, although the number was nominal (12.1%). Regarding parity, it is clear from table 6 that women who had 1-2 children reported mostly about *shutika*. Even though the result was not significant but 25% pregnant and 33% lactating women in this parity group were mostly suffering from *shutika*.

The analysis of the survey result implies that irrespective of age, socioeconomic classes, parity and gravidity the women in the study area were suffering from *shutika*. Nonetheless it is obvious that the young illiterate women were the most sufferer in this regard.

Table 6. Association of shutika with socioeconomic and demographic factors.

Socioeconomic demographic factors	Pregnant women N=12				Lactating women N=33			
	Number		Percent		Number		Percent	
	Yes	No	Yes	No	Yes	No	Yes	No
Age								
15-19	-	1	-	8.3	1	1	3.0	3.0
20-24	2	4	16.7	33.3	8	4	24.2	12.1
25-29	1	2	8.3	16.7	1	3	3.0	9.1
30-34	-	1	-	8.3	5	6	15.2	18.2
35+	1	-	8.3	-	-	3	-	9.1
Education								
Illiterate	4	1	33.3*	8.3	7	9	21.2*	27.3
Primary	-	5	-	41.7	4	8	12.1	24.2
Secondary	-	2	-	16.7	5	-	15.2	-
Socio-economic class								
Rich	-	2	-	16.7	3	2	9.1	6.1
Middle	1	2	8.3	16.7	4	7	12.1	21.2
Poor	1	3	8.3	25.0	3	3	9.1	9.1
Poorest of the poor	2	1	16.7	8.3	6	5	18.2	15..2
Gravidity								
1-2	2	4	16.7	33.3	11	5	33.3	15.2
3-4	1	4	8.3	3.3	1	4	3.0	12.1
5+	1	-	8.3	-	4	8	12.1	24.2
No. of living birth								
0-2	3	7	25.0	58.4	11	5	33.3	15.2
3-5	1	1	8.3	8.3	4	8	12.1	24.2
6+	-	-	-	-	1	4	3.0	12.1
Parity								
0	1	3	8.3	25.0	-	-	-	-
1-2	3	4	25.0	33.3	11	5	33.3	15.2
3-4	-	1	-	8.3	2	6	6.1	18.2
5+	-	-	-	-	3	6	9.1	18.2

- Significant at $p<0.05$

Chapter Seven

Cultural interpretation of *shutika*

Shutika as illness entity

Shutika as an illness entity has been constructed in the study village from generation to generation. Interpretation of the origin and significance of the event of *shutika* illness might vary from person to person because the presentation of illness is determined by the sociocultural factors. Still the study women have almost similar notion about *shutika* as they experience or observe. During the study they interpret every stage of the development of illness from beginning to end in their own way. Along with explaining the indigenous construction of the illness they also state theirs coping mechanism with every stage of illness development. The process begins with the feeling of unwell or ill health. Then the women try to find out the cause of this unwellness and develop a pattern of the illness. According to their diagnosis of the sign and symptom, they identify the illness.

However, according to the study women *shutika* is an illness related to pregnancy and delivery. In case of *shutika* women generally experience vertigo, pain in limbs, anorexia, a strange feeling in the abdomen in addition to pain and fever. Gradually the women become weak and thinner than before. They also clarify that only the pregnant and lactating women are susceptible to this illness and if the lactating period is over the women have no risk of getting *shutika*. They further say, "*same symptoms can be happen to another women but we don't identify the condition as shutika if the woman is not either pregnant or lactating.*"

The key informants sketch the classification of *shutika* in detail. As one of *kabiraj* (traditional healer) who had been treating *shutika* for long time state, "*there are two types of shutika, which are clearly distinct from each other. Gorvo shutika usually happens to the pregnant women and the symptoms are loose motion associated with flatulence,*

anorexia, feeling of fatigue and vertigo. We also call it lamani[15] *shutika as the women who are suffering from this type of shutika have loose motion.*"

In explaining another type of *shutika* one kabiraj (traditional healer) says -- "*hukna/shukna shutika generally happens to the lactating mother*". She recognizes the condition as – "*the woman who has hukna shutika usually experience vertigo, anorexia, pain in limbs, insomnia, feeling of fatigue; her body becomes thinner and eyes get sunken. This shukna shutika lingers more than gorvo shutika* ". Most of the key informants mention though they know that specific type of *shutika* happens to particular group of women but sometimes the condition continues for quite a long period. In that regard it is not true always that a specific type of *shutika* will be limited to a particular group of women. For example, they say -"*gorvo shutika can be continued after pregnancy period and then the woman is no more gorvoboti (pregnant) but we still termed the illness as gorvo shutika. Therefore, in many times a lactating woman may have gorvo shutika and a pregnant woman can get hukna shutika. So that we often don't term the illness according to the status of the women (whether they are pregnant or lactating), rather we identify the condition in terms of sign and symptoms.*" According to the study women, likewise the distinct symptoms of these two types of *shutika,* the coping mechanisms of the women are also different. Since *gorvo shutika* is sometimes more stigmatize[16] to the women in the community, the coping mechanism in this regard was different from the situation of *hukna/shukna shutika.*

In the study it is surprising that the women do not relate loose motion with the disorder of postpartum period. Indeed, they attach the symptom with a disorder of ante natal period whereas the doctors often refer *shutika* as postpartum diarrhoea. Clearly to the women diarrhoea and *shutika* are two distinct disorders. However, in explaining the dissimilarity one aged women point out –" *In case of diarrhoea the patient has frequent loose motion*

[15] *Lamani* means loose motion in local dialect.

[16] In the village stigma does not apply to *gorvo shutika* only. It is relevant for any other illnesses during pregnancy Indeed, women are supposed to be fit and healthy during their pregnancy period, especially in their first pregnancy.

during a day, her pulse becomes slow and palms and feet gradually turn cold. Then we understand that the patient should immediately be taken to the hospital. On the other hand during suffering from shutika the women do not have loose motion so frequent. The frequency of getting loose motions gradually increases with time. On the onset of illness the women go to toilet one to two times in a day and as soon as the illness progress the number of getting loose motion becomes higher, even the women are found to get loose motion more than five to six times in a day. A part from loose motion they also experience regurgitation (chuna dhekur otha) and flatulence." Another *dai* (mid wife) of the village add –"*gorvo shutika is a condition we called—mukhe khai ponde hage (whenever they eat something, they pass it instantly through their anus). In fact, the women can not digest any thing they eat.*" She addresses diarrhoea as *fouzdari* (criminal case) which needed urgent attention but *gorvo* or *lamani shutika* was as *adaloti* (civil case) which would exist forever.

During survey the women who experienced *shutika* in pregnant and lactating group determined symptoms that defined and distinguished *shutika* as an illness. In reporting the common symptoms of *shutika* the pregnant and lactating group were mostly identical. Mostly the women from both of these groups talked about vertigo, burning sensation in limbs and weakness as symptoms of *shutika* they experienced (Table 7). The survey result is, to certain extent inconsistent with in-depth interviews. As for instance, loose motion was identified in in-depth interviews as one of the symptoms of *shutika* during pregnancy but in survey no woman reported loose motion as a symptoms of their illness. Rather, in survey some women from lactating group informed (31.3%) about having loose motion during their shutika episode (Table 7). In this case perhaps the later explanation of the study women can be considered that, these women who reported about loose motion might get *shutika* during their pregnancy and continued the disorder during their lactation period.

Table 7. Reported symptoms of *shutika* illness[17] in survey.

Reported symptoms **Pregnant women (No of case: 4)**	No. of answer	Percent
Vertigo	3	75.0
Anorexia	1	25.0
Burning sensation in limbs	3	75.0
Pain in abdomen	1	25.0
Weakness	2	50.0
Burning sensation in body	1	25.0
Body becomes thinner	1	25.0
Lactating women (No of case: 16)		
Vertigo	15	93.8
Pain in limbs	1	6.3
Loose motion	5	31.3
Anorexia	2	12.5
Burning sensation in limb	9	56.3
Pain in abdomen	2	12.5
Weakness	6	37.5
Tingling sensation in limb	1	6.3
White discharge	1	6.3
Burning sensation in body	1	6.3
Indigestion	1	6.3
Feeling of fatigue	3	18.8
Body becomes thinner	5	31.3

Illness identification and labeling

While the women in Char Nilokhi village gradually encounter certain ill health conditions concerning shutika which I mentioned earlier they try to identify the illness by consulting with the other women in their encircling[18]. They describe them the situation like –"*I am having anorexia, vertigo, burning sensation in limb, insomnia in these days. I do not get any strength to work and my body also becoming thinner day by day.*" After considering

[17] Multiple answer considered.

[18] The women in the surroundings are mainly : mother, sister, aunt. Brother's wife, sister-in-law, mother-in-law, aunt-in-law and other neighbouring women.

the situation the other women who are consulted with label the illness as –"*under this circumstances it is clear that you get shutika.*" Although, most of the time women do not want to express freely about their illness to the other women in the village, especially regarding the sickness during pregnancy and thus *gorvo shutika* as well. In fact according to one key informant, when a woman notice the signs and symptoms of *shutika* during pregnancy she does her best to cope with the condition as long as possible. Just out of fear and uneasiness she is very unwilling to express anybody else in her in-laws' house. She cited the case of Mina as an example:

> Mina is a young housewife in Char Nilokhi village. In certain time of her pregnancy period she started to experience loose motion two/three times in a day and always felt strange sound in her abdomen. After passing of few days she gradually encountered vertigo, burning sensation in limb, anorexia and frequent loose motion just after having meal. Then she was so in panic that she did not want to get any meal at all as she thought if she did not get food, loose motion would not happen to her. She was newly married that time and did not know whom to consult with in her in-laws house and also if it was proper or not. Finally, when her body became severely weak she told her mother-in-law with hesitation about her ill health condition. After listening her problem her mother-in-law identified that she got *shutika,* she did not know about *shutika* illness before so she wondered why this illness happened to her. She also consulted her sisters-in-law (husband's brother's wives)and aunt-in-law, they also confirmed the illness as *shutika.*

The situation given above does not happen always. Sometimes the neighbours and the other women in in–laws' house notice the weaken condition of the woman with *shutika* as well. They call her to ask –"*why you are looking so pale? what happens to you? Your body is looking thin and eyes are seemed sunken. Do you have insomnia at night or having burning sensation in your limb? do you get strange sound in your abdomen and have regurgitation?*" Then if the woman agrees with them they immediately recognize – "*you must have got shutika then.*"

Although the women are not always found to depend on other for this illness identification. Indeed, Jorina another young house wife state–" *It is not true that we do not know about shutika at all from the beginning. In many times before marriage we hear from our grand mother or other aged women of our parent's house that some times during pregnancy or after child birth women get such type of illness which is known as shutika.*"

In case of *shukna shutika* the women behaved slightly different. In this regard they mostly talk frankly about their health problems with the women of their in-laws' house and other women in their community. Anyway, *shutika* of any type is found to be identified sometimes by the *kabiraj* (traditional healer) also. The *kabirajs* claim that that they can diagnosis the illness by watching the face and eyes of the women who are suffering from *shutika*. Again, in terms of identifying the illness a woman who has *shutika* says –"*after child birth while I was encountering the physical problems I went to a kabiraj in our village and by holding my little finger she could understand that I got shutika. Besides through realizing the condition of my health I was also confirm that shutika happened to me.*"

Notion of cause and prevention

"*Shutika happens to the women just because of their behavioural fault (shutika hoy shudhu matro choltir doshe). Women can prevent shutika by observing certain restrictions and food taboos*" a *dai* (midwife) in the village comments while speaking about the cause of *shutika*. In describing the cause of *shutika* the village women mention that the reasons of *gorvo shutika* and *shukna shutika* are different in the sense that, women can avoid *gorvo shutika* through following some restrictions on mobility and food intake during pregnancy. Conversely, violation of food taboos in postpartum period is mainly responsible for *shukna shutika*. During the survey the women reported certain causes of *shutika* which is presented in table 8. along with the contrast of pregnant and lactating women.

Table 8. Reported causes of shutika illness[19] in survey.

Reported causes **Pregnant women (No of case: 4)**	**No. of answer**	**Percent**
Weakness	1	33.3
Violation of food taboos	1	33.3
Evil eye	1	33.3
Do not know	1	33.3
Lactating women (No of case:16)		
Weakness	9	56.3
Violation of food taboos	3	18.8
Irregular bath	2	12.5
Evil wind	1	6.3
Evil eye	2	12.5

There is a general belief among the women in the village that the main reason of *gorvo shutika* is nozor laga (evil eye). They explained the situation like, "*a pregnant woman should be very careful in times of having meal. If she eats her meal in front of another person, the evil entities can give evil eye through that person and soon after that the women will get the problem of indigestion, loose motion and strange feeling in abdomen.*" In this regard Rekha mentioned her experience.

> When I was two moths pregnant one day I was in hurry to go to the field to help my husband because it was harvesting season. Before going to the field I was rapidly taking my meal and I did not notice that a woman from our neighbourhood was watching me. As a result of her *nazar dawa* from the very next day I felt strange sound in my abdomen and experienced loose motion. Gradually my body became weak. Thus *gorvo shutika* occurred to me.

In illustrating the condition the women also explain the concept of *nazar laga. Nazar* is eye and when an evil spirit keeps on giving evil eye from a distant is called nazar *dewa* and *nazar laga* is if that evil eye touches the human body. The people in the village belief,

[19] Multiple answers considered.

there are three types of evil spirit who give *nazar* or *dristi* to women and due to them several illnesses happen to the women. In case of *gorvo shutika,* if a woman passes through the places where one of the evil spirit stays it adopts her body and having meal in presence of that particular women is unsafe, especially for the pregnant women.

Batas laga (evil wind) is identified as another cause of *gorvo shutika.* Here *batas* is also an evil entity. According to the aged village women –"The *pregnant women should not move around latrine, ponds or goes to the bamboo-grove behind the homestead, joints of the three roads and the ridge of earth set up around a agricultural land in the evening, mid noon and very early in the morning. Because then alga, a type of evil entity may hit their body through a gusty wind and keeps on nazar deywa (giving evil eye) from a distant. Soon after that, the women experience the symptoms of gorvo shutika.*" They elaborate the characteristics of the evil wind as –"*The evil wind is felt slightly hot and it makes the body shuddering. In many times, banaduli (whirlwind) carries the evil entity as well and if this whirlwind touches the left side of the body, the women will get sick.*" Indeed the concepts of *batas laga* and *dristi laga* are identical in a sense that both happen through the evil entities and they exercise their power by the wind. A village woman explains the matter further that `*nazarer pay bataser upor*' meant that as the evil eye (nazar) is borne by the evil wind (batas), that wind is harmful.

The *dais* (midwives) of Char Nilokhi assure that *gorvo shutika* can be prevented if the pregnant women practice the restrictions such as not to go out in mid noon, just before the evening and before the Azan in the morning and to avoid prohibited places. Additionally, They have to be cautious at the time of having meal, so that the evil spirit does not get any opportunity to provide evil eye on the food through any other women.

In course of discussion most of the key informants and aged women in the village mentioned over eating during pregnancy as a significant cause of *gorvo shutika.* In their opinion, a pregnant woman should eat less and frequent food intake makes her body loose and resulting indigestion and loose motion. In this regard, a mother-in-law grumbles –"*the*

daughters-in-law of this days do not maintain any restriction on food intake. They take food frequently and always make themselves stuffed. They behave like, as if they are experiencing the pregnancy alone and we did not do it before. They learn from the radio and television that a pregnant woman needs plenty of food so they do not want to eat less. They never listen to us. So they suffer from shutika more than we did in our days."

Food taboo is the central point in assessing the cause of *shukna shutika* and diversified discourses have been emerged from the issue. According to the survey result most of the women, experiencing shutika during lactating period, perceive that *durbolota* (weakness) was the reason of their physical discomfort. As they interpret the concept— "*lack of strength is weakness or durbolota. If there is not sufficient blood in the body, the body becomes anemic (rokto shunnota) and a woman does not feel any strength with an anemic body.*" The main features of durbolota are, feeling of fatigue and numbness, anorexia, feverish, sweating while doing work, unable to perform any work or move around, and every time it has been wished to lie down in the bed. Concerning the idea a young woman Kulsum says – "*to avoid durbolota, we should take green vegetable and protein enrich food daily and there should be consistency in between our work and diet. A pregnant mother should take adequate of food during her pregnancy or even after delivery.* Some other women also mention that *'frequent childbirth results loss of blood from the body that makes a body durbol (lack of strength).*" In their opinion, from this durbolota, shutika develops gradually. As for example they state Shirina's story.

> Shirina's father was a landless agrilabourer and he was the only earning person in the family. His earning was not sufficient for their large family and they could not afford three time's meals in a day. Therefore, they used to take small amount of rice twice a day, so that she had a poor health before her marriage. After getting marriage she and her husband lived in her in-laws house. Their family was also large and since they had small amount of land, the income was low. However, whatever was cooked for meal Shirina used to get the least share, as because being a daughter-in-law, she had to eat at the end when everybody in the household finished their meal. Besides, her mother-in-law had the control over the kitchen and most of the time she deliberately deprived her from having good meal. Even when she was pregnant she did not allow her to get

adequate food. Shirina often said with grief—" *everybody needs to eat stomach full of rice for survival (beche thakte holay pet bhore bhat khete hoy). Again, fish and vegetable are also necessary for good health. I never had adequate food; moreover I was married and became pregnant in early age and I also could not manage to buy vitamin syrup, which is essential to recover the health condition after childbirth. Consequently, I had shutika immediately after my childbirth.*"

The young women in the village often talk about *dorbolota* in connection with food taboo after childbirth. To understand the causal relation it is needed to know about the existing postpartum practices in the village. After childbirth the women are presumed to abide by particular rules and regulation to prevent certain illness like *shutika* and to protect their child from duder aga[20], cold and pneumonia. The *dais* of the village clarify the situation that –" *the mother of a new born baby is not allowed to eat vegetables, keshari pulses, lentil, certain type of small fish (pui, taki, gojar), sweet pumpkin, red spinach (lal shak), sweet potato, tamarind, beef and even milk. Because after childbirth the uterus remains raw (kacha nar) and due to raw uterus the food mentioned above are indigestible to the women. Violation of these food regulations may cause nari paka/nari pocha (infected uterus). It is the condition when foul discharge along with blood (the colour of the blood is like white pus) passed from vagina during this illness and it lasts long even for three to four months. The women also experience fever with body ache. In the course of time nari paka/nari pocha leads to shukna/hukna shutika.*"

The concept of hot and cold food is relevant in this regard. According to the local knowledge the cold foods are, sour taste food, leftover food, *panta bhat* [21]. These cold foods are strictly prohibited for the new mother (*kacka chuitkar maa*). These make the uterus rotten, besides, *dais* of the village think certain illness like -- feeling feverish after delivery, dysentery, etc., are also the outcome of taking cold foods. On the contrary, hot

[20] It is a type of child diarrhoea which is locally known as duder aga. In this condition the breast feed child gets loose motion. The consistency of the stool is thin like water and the colour is white as milk. The *kabiraj* and other aged experience women can identify the disorder by observing mother's condition. If a child gets duder aga his/her mother's breast will be heavier with milk in comparing to other day. The child will get plenty of milk in that day. By correlating both of the condition they usually come into conclusion that duder aga happens to the child.

foods aid the uterus to become dry. As the women consider, that a new mother should take hot food until forty-five days (considered as seclusion period) after delivery. The hot foods are, hot fresh rice and curry, tea and *jhaler naru*[22], *painna chora*[23]. Among all the hot food *jhaler naru* and *painna chora* are particularly significant to the new mothers, because these protect the uterus from rotting (*nari paka*) and stop the abnormal passage of blood. Therefore the midwife of the village always suggested the new mothers to eat *jhaler naru* and *painna chora* during seclusion period. On that account, the hot foods prevent *nari paka/nari pocha* and thus *shutika* as well.

A part from observing food taboos the women are also advised to have "good foods". About "good foods" Nasima a middle aged woman remarks, "*mother of a new born needs to have good food like, meat of chicken and pigeon, moog pulses, shing and koi fish, eggs, green papaya and green banana.*" The "good foods" will keep their body healthy and also prevent *shutika*. At the same time *dais* and other aged women in the village alert them that if they do not able to manage these type of food after childbirth they will keep on maintaining food taboos and eat rice only with cumin powder, *panch forong*[24] powder and salt through out the postpartum period. Although many women believe that the food restriction should be maintained until the weaning period. In Char Nilokhi village usually the children only survive on breast feeding up to one year. So it is obvious that the mothers are supposed to observe the taboos till one year after childbirth. In this regard an aged *kabiraj* of the village shares her experience –"*my child did not take any solid food till two and half years and lived on breast milk only. During that period my daily meal was rice with cumin powder or rice with salt. Thus I observed the taboo and saved my life too.*"

[21]Rice cooked overnight and kept steeped in water.
[22]A type of ball made by puffed rice, molasses, chili powder and other spices.
[23] It is a liquid mixture of ginger, some hot spices like cinnamon, clove and molasses. The women are suggested to drink it like warm tea.
[24] Combination of five seeds. These are: cumin, fenugreek, coriander seed, black cumin (*kalo jira*), aniseed (*mouri*).

Nevertheless, a key informant Janu comments, "*There is less chance of getting shutika if a woman gives birth in her natal place.*" She justifies her remark as -- "*mothers take proper care after childbirth. They try to provide 'good food' to their daughter to the extent that they can afford. On the other hand mothers- in-laws do not pay much attention to their daughters-in-law. They intentionally make them working hard and do not allow them to get their meal in right time. They do not even provide proper diet to them during postpartum period. Their latent grievance is that, their daughters also suffer in their in-laws' house after their childbirth in this way. So why should they bother about their daughters-in-law!*" Even the women in the village stress that the postpartum practices in in-laws' house should be taken into account to understand the cause of *shutika* after childbirth.

Generally, immediate after childbirth the mothers-in-law provide rice with only cumin power and salt to the women as meal. After three to four days they provide green banana and *moog* pulses in addition to former food. At the end of five days they cook *niramish* (mix vegetable curry) for them. On that day they also give chicken to their daughters-in-law. "*The reason of their generosity is.....*" as Fatema a young daughter-in-law states "*for maintaining the formalities the parents come to visit their daughter and grand child in her in-laws' house. So it is a kind of show off that they are taking care their daughter.* " After that the mothers-in-law again continue the previous meal - *jirar guri* and *lobon tala bhat* (rice with cumin power and salt). Indeed, the aged women in the village believe this type of meal keeps the body tight and active. Unless protein enrich and large quantity of foods make the body flabby after child birth and inevitably the daughters-in-law become idle. Besides, due to disobey of food taboos *shutika* also happens to them. Moreover, it is fairy common in the village that the mothers of new born child are not allowed to get meals for three times. They usually get their first meal of the day at eleven o'clock in the morning and the second meal at five o'clock in the evening.

Food taboos are interrelated with child's health and illness. There is a belief in the village that if the mother of a breast feeding child violates the taboos and take sweet pumpkin,

vegetables, certain small fish and kheshari pulses; her breast milk will be contaminated. Hence, the child will suffer from duder aga. In respect to the issue a young mother mentions –"d*ue to complication when a woman gives birth in ICDDR,B hospital; the doctors advise her to take all type of foods. Besides, while staying in hospital the women can not be selective regarding food intake as they provide them meal. In those cases we have never heard of shutika and duder aga. Then what is the meaning of observing food taboos!*" Still, the mothers-in-law emphasis the point. Even, no sooner they find a child is dying of loose motion, they announce to the other mothers in the village that as the mother of the sick child did not observed the food taboos *duder aga* has happened to that child.

It is noted that even though the new mothers are unwilling to observe the restrictions after child birth; the mothers-in-law sometimes make them bound to obey. As the child belongs to their family, their prime concern is child's well-being. In this context, Shomiron's situation is an appropriate example:

> Shomiron gave birth in her in-laws' house. Up to three months after her childbirth her mother-in-law provided her rice with cumin power or salt and molasses. She could not eat rice with satisfaction and often she remained hungry. As she said -- *"I felt like crying at the of having my meal. I just swallowed the food with water."* She also complained to her husband about the meal but he did not pay any heed to her rather ordered to listen to his mother unless she would be sent to her parents' house. She further said -- *"I attained school up to secondary level and I read in my home economics book that the lactating mother needs extra food. Yet I could not argue with my mother-in-law because then she would have stopped my meal in her house. So, in order to maintain peace in the family I observed all the food restrictions. Precisely, my mother-in-law made me observer the taboos for the sake of my son*, as he is a part of their bongsho (clan)." She lamented that – "al*though I realized that I was getting weak day by day but I was helpless."* She said that her mother-in-law used to scold her that –*"I wonder what type of mother you are! You want to satisfy you tongue but never think of your child health. If our grandson gets duder aga because of your food habit, I will not allow you to live in my house and also tell my son to abandon you."* Concurrently, her mother-in-law did not

allow her to have bath everyday as well, by reasoning that the child would get pneumonia. In explaining the situation she said -- "*I could not get sound sleep with an empty stomach. Besides, I had to get up early in the morning to prepare food for my husband. I yearn for having bath early in the morning to avoid the dizzy condition. But I was not allowed to have even my regular bath. Inevitably, I gradually experienced vertigo and anorexia because of my food practices and irregular bath made the condition worsen. Finally, shutika occurred to me. Provided I would get sufficient good food and was permitted to have regular bath I would not have suffered from Shutika. It could be prevented.*"

In relation to above story the women in the village clarify a concept '*kosha*' which is relevant to *shutika*. According to them it is a condition of the body that happened due to lack of sufficient food and fluid (water, juice, etc.). It has a connection with weakness, cleanliness and coolness. The young women in the village think because irregular bath and inadequate food after childbirth their body becomes dehydrated and thin, so ultimately, they are prone to *shutika*.

Undoubtedly, some women in the village believe that as they could not observe food taboos properly so *shutika* has occurred to them. As for instance one women Fulbanu admits, "*I have eaten the head of taki fish through sucking in my seclusion period. As a result my body also gets thinner (amar shorir chuishya gache) and I am suffering from shutika.*" Still, in several cases of *shutika* the women mainly complain that they have been suffering from *shutika* due to *durbolota* which is the result to inadequate diet and work load. Many women grumble that they were obliged to resume their household work just two/three days after their childbirth. Therefore they were deprived of their due rest, that also better down their condition.

Illness progression, social and family reaction and women's behaviour

Through case studies it has been appeared that social and family attitude have an inevitable affect on the illness situation. It is clear from women's description that as soon as the

illness condition aggravates they encounter various social and family reactions. In this context they compel to develop their own way of coping with the situation. However, through several signs of physical discomfort the women in the village can understand the severity of the illness and in this regard they divide the deteriorating condition into certain levels. In coping with the severity, consistency between their behaviour and different levels of illness progression is notable. As an aged woman Shomiron state –" *women are likely to be adapted with the condition as far as possible since they have no place to go except their husband's or in-laws' house.*" The key informants and the other women in the village sketch a detail about the stages of illness progression along with the family and social reaction and women's behaviour.

In respect to illness progression, a young house wife Pori say –"*in early stage the women experiencing shutika, does not feel that sick, but she suffers from anorexia and for that can not eat anything. Gradually she becomes weak. This weakness causes white discharge, as a result the condition gets worsen. Finally, she experience severe vertigo and her eyes become sunken and her face turns in pale. Then it is visible from her condition she will immediately die.*" The village women admit that since the *gorvo shutika* and *shukna shutika* are distinct by nature, women's behaviour regarding the severity of these two *shutika* is also different.

Concerning *gorvo shutika* at the primary stage of illness development the women usually experience strange sound in the abdomen and have one to two times loose motion in a day. Considering this sign the women think that –"*I must over eat today, so that it is happening to me.*" They do not pay much attention to the physical discomfort. In fact, they are found to overlook the condition. In the second stage, the frequency of loose motion increases, it begins to happen after every meal intake and the women feel slightly weaker. During this condition they do not feel like doing any household work and prefer to lie down. They manage the situation as, taking an interval after doing some works. Still they conceal their sickness from others. Rather, they try to heed which foods cause loose motion and they start to avoid those foods.

At the third and final stage of illness development accompanying frequent loose motion the women experience severe weakness, anorexia and regurgitation. Out of fear they totally stop eating or eat as less as possible, as they think –"*if I eat, that strange sound in abdomen and regurgitation will happen to me again.*" At this level the other women from the neighbourhood notice the physical condition and inquire –" *What happened to you? you are supposed to be in a good condition as a pregnant woman.*" Therewith, as they know the woman has gorvo shutika they advise her to do some self care in home in addition to consult with a good *kabiraj* (traditional healer).

The women express that while they pass through the third level their mothers-in-law clearly manifest their discontent and say –"*I warned you repeatedly but you did not listen to me. A pregnant woman should eat less but you always make yourself stuffed, consequently you are suffering from this illness.*" In this case if they seek consolation from their husband, mostly they reply like, "*why did not you listen to my mother, you should obey the advice of aged women, they know better than you. Now what I can do for you! you have to tolerate her reproaches, I can not leave my mother for you.*" The neighbours and relatives are very sympathetic to a woman suffering from *gorvo shutika* and say –" *you need not be to worried, gorvo shutika will exists as long as you will be pregnant. You will come round automatically after your childbirth.*" They also advise to ask her husband for buying tablet from the pharmacy in Matlab bazaar that will help to stop loose motion.

In case of *shukna shutika* it is revealed from the women that at early stage they experience mild vertigo, anorexia and insomnia. At this level they counsel with the knowledgeable women in their neighbourhood. In many times they also ask their mothers-in-law and sisters-in-law (husband's sister) about the discomforts as they live with them. Otherwise, they prefer to consult their mother and *bhabi* (brother's wife) about the ill health condition.

When the illness progresses a little, vertigo increases, body starts to get thinner and eyes become sunken. At this level the child also does not get adequate breast milk. During this stage the women undertake some initiatives to get relief. As Masuma mention –"*when the condition aggravate the women seek solution. According to the other knowledgeable women they try to get comfort through some self care. They take bath in the morning and apply oil on their scull. As they think it will reduce vertigo and tingling sensation of scull.* " In elaborating the point Renu a lactating mother shares her experience. She says –"*after happening shutika as I experienced burning sensation in scull and limb, vertigo, anorexia and insomnia; I also took bath early in the morning and apply oil to my scull to keep it cool. Even, while taking bath I washed the root of my umbilicus repeatedly with water as I heard it would make the abdomen cool and reduce the burning sensation of the body as well. When the situation further deteriorated I needed to apply oil and cold water on my scull frequently but my mother-in-law did not allow me to do so. She thought my child would get pneumonia through it. So I always waited for the opportunity, whenever she went out from the house I did it to get comfort.*"

Finally, when the illness turns in severity, the women do not feel any strength in the body therefore they do not able to do any household work. They wish to lie down all the time and their eyes seem utterly sunken. Above all they lose their appetite at all. They are found to take a sour preparation of tamarind (*tetuler tok*) as a remedy to resume their appetite. Simultaneously, they also look for effective treatments.

Since the women feel utterly sick at this stage they take rest for a while in the middle of their household work and in this regard Rozina told her story.

> Although I felt severely sick after getting *shutika* but I tried to unimpeded my activities. Still, sometimes I was so unable to continue my work that I needed to take rest for a short time. In the beginning my mother-in-law and other sisters-in-law (husband's sisters) assisted me in my work to see my condition. After passing few days their unwillingness in helping became explicit and sometimes they reacted so harshly that I got afraid to even sit in the middle of

my work. I knew that if I did not work my husband would not feed me and the daughters-in-law were not also supposed to pass days in idleness at their in-law's house *(ami jani kaj na korle shami bhat debe na, tachara porer barite shuie boshe thaka jay na)*. In this adverse situation to consider my condition my mother and younger sister came to help me in my household work. They stayed for some days but my husband and my mother-in-law did not like it and they took it as an extra burden on household expenditure. Additionally my mother-in-law constantly remarked rudely that –"*you did not maintain the food taboos and get shutika. It is your fault so why your are making difficulties for us*!" At the same time her husband said –" *I do not know shutika but I can understand that due to idleness you are neglecting the household work.*" But my aunt-in-law always tried to console me and said –" *there are many fish except pui, taki and gojer for which taboos are not applicable, you could have taken those fish during your postpartum period. Those would make your body fit and healthy.*"

The social and family reactions are very explicit in above case. According to the women mostly the husbands are not considerate at all to the women who are having *shutika* and it is common that after returning home from work they want their food to be ready under any condition. Out of fear the women try to cook rice for their husband with their sick and weak body unless they will become violent and beat their wife. Often if the condition is worsen they request their neighbouring women to do the cooking for them. The neighbouring women and other *jals* (husband's brothers' wives) in the *bari* (kin group) never refuse to help them in cooking and say any unpleasant word to them.

About condemning husbands a woman Dalia who lives in a join family remarks— "*We can not always accuse our husbands, sometimes they are powerless.*" She further say-- "*we are economically dependent on my in-laws and my husband has no power in the household. So he scares of his parents and can not protest against his mother and sisters. He is not able to do anything in my support.*" She dreamt –"*when I will have a separate household in future, I will not accountable to anybody for my work and take food according to my wish. My physical condition will improve and I will not have*

shutika any more." However, some women think that mostly the men are not able to understand women's illness so it is not their fault to be inconsiderate in this situation.

Sometimes the women seek the opportunity to escape to their parents' house. There they can recover their health condition by getting enough rest and proper diet. As Tahamina said –" *when I can not stand the strain I flee to my father's house. There all the times my mother tells me to lie down on the bed and asks me what do I wish to eat so that she can prepare it for me. Even my father brings vitamin syrup for me from Matlab bazaar.*"

Chapter Eight

Treatment seeking behaviour

It is very explicit from the previous chapter that the women suffering from *shutika* seek treatment almost at the advanced stage of illness when they no longer cope with the situation. After the illness identification, in the intermediately level the women try with some suggested self care to reduce the sufferings. Among all types of self care which I mentioned earlier, having bathe early in the morning is mostly practiced. In mentioning the importance of the practice a woman Jori says – "*It helps to get relief from the ill health feeling of shutika. In fact we feel fresh if we manage to get bathe early in the morning after spending sleepless night due to take care of the child.*"

Nonetheless, it is appeared in the study that self care provide temporary comfort to the women. After the failure of the self care, the women are found to more concerned about the condition. Therewith, they start to ask the other women in their surroundings about the treatment of *shutika* as they can think of. From the survey result it is very prominent that the women in the village who are suffering from *shutika* usually consult about the treatment with the other women[25] which can be noted as an evidence that less stigma is attached to this particular illness. As it is revealed in another study that in case of other illnesses like prolapse the village women do not discuss with one another in general as it is highly stigmatize in the society (Mahbub and Ahmed 1997).

In table 9 in the following it is clear that the village women mostly consulted with their mothers about the treatment of *shutika*. The underlying reason is most probably they consider their mothers the closest persons to discuss the matter freely in this regard. Besides, to them the mothers also try their best to help their daughters as children's well-being is the most desirable to them. A substantial number of women recount that they also talk about the therapies with their relatives like sister, bother's wife, aunt, aunt-in-law, etc.

[25] In the survey only one lactating woman reported that she did not consulted with anybody about the treatment of her illness.

Although some women mention that they ask for advice to their mothers-in-law but it is clear from the case studies and in-depth interviews that they are not very in favour of asking the suggestion to their mother-in-law.

Table 9. The persons consulted with during seeking treatments of *shutika*[26].

Person consulted with	No. of answer	Percent
Pregnant women (No. of case 4)		
Neighbour	2	50.0
Relatives	3	75.0
Mother-in-law	3	75.0
Mother	3	75.0
Husband	3	75.0
Lactating women (No. of case 16)		
Neighbour	1	6.7
Relatives	8	53.3
Mother-in-law	5	33.3
Mother	9	60.0
Husband	7	46.7

In this respect the behaviour and attitude of mother-in-law should be taken into account. As one of the key informant Janu clarifies –" *Since the daughters-in-law usually live with their mothers-in-law and count them as a superior person, normally they ask for solution to them after illness identification. But the mothers-in-law are not very incline to inform about the treatment of shutika to the women.*" In elaborating the point she mentions Rikhia's story.

> Rikhia lives in her in-law's house. While she was encountering the ill health condition of *shutika* her other sisters-in-law (wives of husband's brothers) suggested her some self care to get relief. After the failure of all efforts she asked her mother-in-law as a superior in the household that whether she knew about any *kabiraj* who prescribed remedies for *shutika*. Her mother-in-law

replied that she was not knowledgeable about it. According to Rikhia "*every woman in the village knows that there are two kabirajs who are known as providing treatment for shutika. My mother-in-law do not want to inform me about them because as soon as she will tell me about the healers it will become their responsibility to carry on the cost of my treatments as I am living with them. Rather she suggests very technically that I better seek in my natal village and do my treatment there. In that case my parents will be oblige to bear the cost.*" Additionally, she said her neighbours and other women in her in-laws' house did not speak about the *kabirajs* as well. As they were afraid if they informed her, the mother-in-law would quarrel with them by saying – "*are you more concerned about the health of my daughter-in-law than me? I do not understand what is your interest about it!* " Under the circumstances Rikhia is presently planning to go to her parent's house for treatment.

The women in the village state that very often the mother-in-law deal with their daughter-in-law so harshly that they fright to ask for the relevant treatment. As for instance Moiful a pregnant women mention –"*I have been suffering from shutika from quite a long period. Still my mother-in-law does not pay any attention to my condition. Even it is very painful for me when she remarks that I have brought the illness from my parent's house. According to her as my father was a poor day labourer he could not manage to feed me nutritious food. Eventually, I have been suffering from this disorder.*"

Considering the attitudes of the in-laws the women become very depress and look upon themselves as helpless in seeking treatments of *shutika*. In this case it is noted that some women try to accumulate the cost of the treatment from their small income. For instances Aasma a young house wife say –"*When my condition tuned in worse and I could no longer cope with the unfavourable situation in my in-law's house I went to my natal village to consult with my mother about solution. My mother and brother's wife advised me to do kabiraji treatment*[27]*t for it and they also informed me about the kabiraj. After*

[26] Multiple answers considered.
[27] Treatment done by traditional healers. Traditional healers mainly gives amulet and herbs for treatment and sometimes also exorcise the patient through uttering charms.

returning to my in-law's house I collected the money for my treatment by selling eggs of my own poultry."

It is very common in the village that the women take shelter to their parents as a last resort if they can not arrange money themselves at all. In this regard Shonavan's statement is very relevant –" *I am not able to suffer any more so I have planned to go to my mother for my treatment. As I know my mother has the ability to provide the treatment cost. My brother sends her money from abroad.*" However, the women also admit that it is not very easy for them to go to their parents' house for treatment since they are not allowed to get release so often from their household works. Sometimes they attempt to send massages to their parents for informing them about their illness so the parents can at least come to visit them. Yet that is very difficult as well. To portray the situation Mahmuda tell her case.

> I had been suffering for a long time from *shutika.* As usual my mother-in-law and husband did not pay any attention to my condition and I had to carry out all of my household activities for them. Finally when I realized that they would never do my treatment, I decided to go to my parents' house. As my parents live in a very distant village I requested my husband to escort me to their place but he gave excuse of his work. Even he could have arranged it with other person like his younger brother but he did not do it also. Since I do not know how to read and write I told him to write a letter for me but he never showed any interest at all. Then I understood that their (husband and in-laws) vested interest is not allowing me to communicate with my parents. Then finding no other way, I tried to convinced my neighbour's son to go to my parent's house. After getting the information they came to visit me and considering my condition they took me with them.

In respect to above situation the women express that many women are not as lucky as Mahmuda. Because most often the economic condition of the parents are not so well-enough that they can able to bear the expenditure of the treatment of their daughter, though they are very much willing to.

Therapeutic choice and reasons

The women in Char Nilokhi village seek medical treatment according to their own way of explaining and diagnosing the physical discomforts. It is noted that in case of every illness they have a particular therapeutic choice depending on its expected efficacy. To illustrate the therapeutic choice of the women regarding *shutika* two issue are needed to be focused:

- Therapeutic options available for the women in the village.
- Utilization of available services particularly for *shutika* and the reasons there of.

It is obvious the women in the village learn about the remedies through the social network and the knowledge also transfer from generation to generation. An impression about available medical services is given below followed by the therapeutic choice of the women regarding *shutika* and the reasons there of.

Available therapeutic options for the women in the village

The women generally use those health services which are easily available to them. The therapeutic options they have: *kabiraji, bonaji*[28], allopathic treatment from the medical doctors of the government hospital and ICDDR, B hospital, services from midwives in the village, to certain extent homeopathy and home remedies.

The women commonly prefer *kabiraji* treatment for certain ailments such as *shutika,* congestion in breast, *bhute dhora, jine dhora*[29], etc. There are two to three *kabiraj* in Char Nilokhi village who are aged women. They do not treat all type of illness, but specialized for those illnesses mentioned earlier. But the local women visit to another kabiraj of the neighbouring villages also. Both the women and the traditional healers are

[28]Herbal medicine.
[29] Illnesses cause by spiritual beings.

observed to share similar assumptions about the cause and symptom of the illness. The women rely on the traditional healers because they have faith on the method and efficacy of the treatment. Most kabirajs claim that they have obtained the treatment procedure (the herb or the charms) through dream. The others had learned it from their ancestors or from a powerful spiritual being like *jin.* The traditional healers are very much confident about their treatment.

There are some *dais* (midwives) in Char Nilokhi village and the village women favour the aged ones as they are experienced. In addition to attending deliveries, the midwives give advice about the mobility and diet of the women during pregnancy and postpartum period. These midwives have learned birth attending process and the treatment of some obstetrical illnesses either from any aged midwife or from their mothers.

The village women confide in *bonaji* treatment for some illnesses as well. ~~Although~~ *bonaji* treatments are given by *kabirajs* and sometimes advised by the neighbours or relatives. Herb, leaves and roots of certain plants are regarded as the element of *bonaji chikissha* (herbal treatment).

Apart from these traditional treatments the women are also found to take modern medicine for certain purposes, but in those cases mainly their husbands buy medicine from the pharmacy of Matlab town. Homeopathic treatment is not very common among the women. Only a few women mention that they have done homeopathic treatment for some selected illnesses.

BRAC's *shastya shebika* (health assistant in the community) also provides allopathic medicines for ten diseases. Those are: diarrhoea, dysentery, fever, common cold, anemia, worm infection, gastric ulcer, allergic reaction, scabies and ring worm infection. She also imparts health education messages to the village women. A change is noted among the women due to BRAC's intervention. As the medicines are easily available through *shastya shebika*, they tend to use these more for relevant diseases rather than *kabiraji* medicine which they use to take previously.

Utilization of available health services regarding shutika

In the village the women hardly stick on only one treatment for a particular illness, which is true for *shutika* as well. Though the therapeutic option of the village women is seemingly complex, but from the preliminary condition of the discomfort the women fairly know what to do and where to go for treatment as there is a clear reason behind every option. Generally, the options of several treatments are determined by economic condition, availability, particular beliefs, previous experience or knowledge from others' experience and finally faith on specific type of resort.

During survey it is appeared that the women mostly adopt allopathic and *kabiraji* treatment for their *shutika* illness. According to the survey result, nearly all of the pregnant women suffering from *shutika* (75%) preferred *kabiraji* treatment. Although half of the women (50%) mentioned about doing allopathic treatment as well while they were sick. On the other hand the lactating women spoke about allopathic treatment (33.3%) and *kabiraji* (26.7%). However, the survey data implies that the pregnant women mostly selected *kabiraji* remedies for their illness where as the lactating women choose allopathic treatment.

In the opinion of the key informants, *kabiraji* and *bonaji* are the most preferable treatments of *shutika* among the women as they believe these are much effective than the other treatments. Besides the women in the village have been practicing these treatments from generation to generation. In this regard the statement of a middle aged woman Kohinoor is notable. She says –"*We have never visited to a medical doctor for our shutika illness. The medical doctors do not understand shutika illness. After physical examination they usually provide medicine in their way and tell us to eat everything without observing any food taboos. That is completely inconsistent with our explanation of illness and we believe, it rather aggravates the condition. Additionally if we listen to the doctors and start to eat everything that may cause also duder aga of our children.*" In course of discussion the midwives of the village point that in case of *shutika* they

usually suggest allopathic medicine for the pregnant women as they are in risk condition. They elaborate the sense that a medical doctor can handle the condition better and prescribe medicine which is not harmful for the women and their babies as well. But for lactating mothers they always counsel for *kabiraji* and *bonaji* remedies.

Table 10. The treatments are adopted for *shutika* illness[30].

Type of treatment	No. of answer	Percent
Pregnant women (No. of case 4)		
Allopathic	2	50.0
Herbal	1	25.0
Kabiraji	3	75.0
Self care	1	25.0
Lactating women (No. of case 16)		
Allopathic	5	33.3
Herbal	2	13.3
Kabiraji	4	26.7
Homeopathy	1	6.7
Self care	1	6.7

"*In respect to the treatment of shutika a series of effort has been observed*" as comments a key informant Janu. She interprets the idea in the sense that the women in the village primarily make an effort with the *kabiraji* and *bonaji* medication then they decide to visit the medical doctors. Although finally, they are found to come round by allopathic treatment, but in the beginning all the women in the surrounding advise them to apply *kabiraji* and *bonaji* treatment. It is also notable that they try the medicine from *shadhana*[31] before they visit to a doctor. So it is obvious that, through social network the women learn about traditional medicine of *shutika* and as it has been practiced from generation to generation they already have a faith on the remedies. Moreover, the healers

[30] Multiple answers considered.
[31] An ayrvedic medicine shop.

in the village who provides traditional medicine share similar explanation about the illness which is quite convincing for the women.

Although the *kabiraji* and *bonaji* treatment are provided by the healers who are in fact identical. Still in the opinion of the women there are some distinction. The differences are explicit in their description of *kabiraji* and *bonaji* treatment.

Concerning *kabiraji* treatment the women reckon sanctified water, sanctified jute or black thread (*kalo dhaga*) are considerably significant. Yet they prioritize the importance of *tabiz* (amulet) in terms of efficacy that contains herbal medicine. As they describe the *kabiraj* provides *tabiz* to the women suffering from *shutika* and advice to tie it with the hair on the left side of the head. As it is traditional that the women are always suppose to use the *tabiz* at the left side of their body and the men will use it on the contrary. A part from using *tabiz* the women are also given *panpora* (sanctified betel leaf) which is commonly used as well. There is a ritual about using the medicine. As the women describe –" *The woman who are suppose to take the remedy will have bathe early in the morning and after changing the wet cloth. She will go straight to the backward of the house and without watching behind she will place her used wet cloth on the roof and then right at that condition she will eat the sanctified betel leaf. She will not wash that cloth and the cloth will dry up in that condition. In next morning she will ware that cloth after getting bathe and do the same activities. She is suppose to continue the ritual up to three days and then gradually she will get cure.*"

In terms of *bonaji* treatment the women identified two different herbal remedies. First of all, they talk about an herbal medicine which is also given by the *kabiraj* in the village. According to them the *kabiraj* makes the medicine by crushing some special kind of herbs on grinding stone and afterwards mixes it with some water. Secondly, they mention another type of medicine that is also provided by the *kabiraj*. In this regard they describe, kabiraj pores incest inside *karki kola* (a kind of banana) and gives them to eat. The women are supposed to eat those type of three bananas in three days. Then they will recover

gradually, but for the rest of the life they will abstain from eating that *korki kola* and if they break the restriction they will suffer from *shutika* again. However, apart from this herbal and *kabiraji* remedies the women also mentioned about ayurvedic medicine from shadhana shop where they go themselves and ask like "*medicine for shutika*".

The women are found to do allopathic treatment basically for weakness and nausea. They clearly state that *kabiraji* and *bonaji* medicine do not help to recover from weakness and restore body strength so they prefer some vitamin syrup for it. Although one key informant Janu say –"*the women do allopathic treatment and follow doctor's advice as last resort. At the same time according to the advice they start to eat everything without observing food taboos and finally they get recover through it.*" She also mentions that occasionally the women prefer homeopathic medicine which is mild. As they think allopathic medicine may affect their breast milk and consequently their child will be sick. In this regard the homeopathy doctors also advised them to be selective about food intake and they specially discourage to take any kind of sour food, beef, shrimp, sweet pumpkin and vegetable.

Evaluation of the treatment

During survey fifty percent of the pregnant women and thirty one percent of the lactating women[32] report that the treatment they have done for their disorder is effective (Table no. 11) in the sense that they feel better than earlier. On the other hand almost half of the women (50% pregnant women and 31% lactating women) who have done any of the treatment mention about ineffectiveness of their treatment. In respect to inefficacy of the treatments they point some reasons. The women mostly point that as they could not continue the treatment because of their fragile financial condition, the medicine did not make any effect on them. The remaining women blame themselves for irregular intake of medicine in talking about the ineffectiveness of treatment.

[32] It should be taken into consideration that thirty eight percent women did not do any treatment for their *shutika* illness for several reasons at that time.

Table 11. Evaluation of treatment regarding *shutika*.

Efficacy of treatment	No. of answer	Percent
Pregnant women (No. of case 4)		
Effective	2	50.0
Ineffective	2	50.0
Lactating women (No. of case 16)		
Effective	5	31.25
Ineffective	5	31.25
Have not done any treatment	6	37.50

In terms of effectiveness an ambiguity is found among the women. As for instance, the women who have done allopathic treatment mention that it seems to be effective because they are not encountering nausea and weakness any more. Still for *shutika* illness they want to adopt *kabiraji* or *bonaji* medicine. As Sorifun a woman in the village states – "*after having allopathic medicine my health condition is improving. I do not feel nausea and weakness that much, but for shutika I have to visit a kabiraj immediately unless it will be permanent in my body (amar shorile mishe jabe).*" From Sorifun's statement it is explicit that to the women *shutika* as an illness has its own entity and for that reason particular initiatives should be undertaken to get cure. To elaborate the sense more Ratna's story is much relevant here.

> In the beginning of her illness Ratna requested her husband to consult a *bazaar dakter*[33] about the illness and buy some medicine for her. Her husband did accordingly and bought a vitamin syrup for Tk. 180. After drinking that syrup she felt better gradually. She was not experiencing any anorexia, vertigo and weakness. She was able to do her household work properly. Still, she felt uneasiness in her body. By observing her condition her mother-in-law said – "*your shutika has not disappeared from you body, it is still in you. You must*

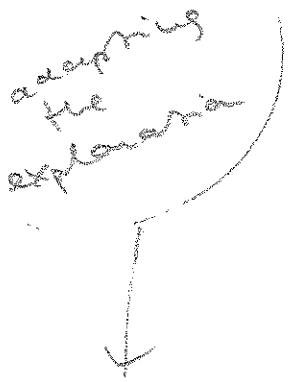
[33] The shopkeeper of a pharmacy is called as bazaar dakter. They are not qualified doctor but the villagers think since they are dealing with the medicine they are able to prescribe medicine as well.

visit a kabiraj for it." The other women in the house also supported her and said –"*allopathic treatment can reduce weakness, but it does not help to get rid of shutika.*"

Yet, during in-depth interview an altered view also appears. In speaking about the efficacy of the allopathic medicine some of the women state that they have heard from the doctors that weakness is the main cause of *shutika*. So they point out if allopathic medicine helps to get recover from weakness then at the same time it cures *shutika* as well. Therefore, they no longer need to go to a *kabiraj* for further remedies.

Still, it is unusual to hear from the women that the *kabiraji* or *bonaji* treatments do not work out well, although some exceptions are there. In this regard Rabya's case is mentionable.

> *Shutika* happened twice to Rabya. First time she visited to a nearby *kabiraj* he gave her some sanctified jute and told her to tie it on her wrist. After tying that jute on her wrist she got relief from her physical discomforts. Later on she lost that somehow when she was having her bath one day. Eventually, *shutika* occurred again during her second pregnancy. Again she visited that *kabiraj* and asked for *pat pora* (sanctified jute). But this time that *kabiraj pat pora* appeared to be ineffective. Rabya could not find out any reason of that . She consulted with her mother and sisters. They explained –"*when you had shutika last time you were a lactating mother and you had shutika for certain reasons. But this time it is obviously hereditary because most of the women in our family has a history of getting shutika during their pregnancy. So if the pat pora is not working that does not mean that it is not effective. It is ineffective for the time being and we know you will come round after your child birth with out any remedies.*"



Apparently the women in the village do not usually lose their faith on the efficacy of the treatment. Somewhat, they try to justify the ineffectiveness of particular treatment of *shutika*, which is very important to consider their perspective in evaluating the efficacy of treatment.

Chapter Nine

Discussion and conclusion

The present study was initiated to explore the cultural interpretation of *shutika* and to understand the coping mechanism of the women regarding this specific illness in rural Bangladesh. Concurrently, the study attempt to assess the prevalence of *shutika* among the women in the study area.

Women's health is comparatively new domain for research in Bangladesh and attention on emic approaches to reproductive morbidities is meager. However, in several studies on maternal morbidity in Bangladesh, *shutika* has been recognized as a common health problem among women after childbirth. Among these two studies mainly concentrated on child bearing and postpartum practices in rural Bangladesh and identified *shutika* as a health problem during those periods (Ynus et al. 1994, Goodburn et al. 1984, Gazi et al. 1995). Another study described women's perspective towards *shutika* in brief along with other illnesses (Mahbub and Ahmed 1997). Still information particularly regarding *shutika* as a common folk illness was inadequate and in those studies, *shutika* was often explained from biomedical point of view. In my present study my focus was exclusively on *shutika* as a reproductive illness and relevant behavioural aspects of the women in a rural community. Indeed, I through the study aspired to present simultaneously both of the biomedical explanation and cultural interpretation of the illness. It also shows the interrelated sociocultural and demographic factors regarding *shutika* and reflects coping pattern of the women in adverse situation.

During the study my primary consideration was to conceptualize the problem through insider's view and basically I went through the illness episodes (case studies) as a precise context for exploring the cultural interpretation and coping mechanisms. The study stressed on semantic analysis[34] of the illness because I presumed it would assist me to

[34] Semantic analysis is set off from the study of linguistic actors, the context of verbal behaviour, and the pragmatics of communication (Good 1977:52).

understand symbolic pathways of words, feelings, values, expectations, beliefs and the like which connect cultural events and forms with affective and physiological processes (Kleinman 1973:209).

The study revealed that there was an inconsistency between biomedical explanation and cultural interpretation of *shutika*. The medical doctors usually identified the illness as a syndromic condition which happened to nursing mothers due to chronic malnutrition. Whereas *shutika* as an illness had specific entity to the women in the study village. They systematically classified the illness into two categories depending on different signs and symptoms and in context of women's condition (pregnant or lactating). Through recognizing the meaning of signs and symptoms in relation to women's condition they were found to label the illness. The women usually constructed the causal relation of the illness through certain existing humoral ideas such as evil eyes, food taboos, etc.

The explanation of the women was incompatible with biomedicine and they were unwilling to visit a medical doctor for *shutika* illness. In the study they clearly stated their aversion to allopathic treatment in this respect. Nevertheless, they were found to use allopathic medicine specially for vertigo and weakness which were the symptoms of *shutika*. Still, it was noted in the study that the illness as a whole required traditional remedies to get cure. In fact in this regard "illness specific" health seeking behaviour was observed as the women were tend depend on traditional remedies to heal up *shutika*. However, since the cases of illness episodes were more or less chronic "hierarchy of resort" was explicit in every cases. The women were not found to rely on only one treatment throughout the episode. Rather they tried one by one accessible medical services and sometimes repeated the previous one.

Health seeking behaviour of the women in the village indeed had a practical meaning of their particular belief about the illness. In that way they were rationale. It leads us to Young's point that an actor's behaviour is rationale if it can be shown that his/her beliefs

about what his/her behaviour can do are more or less consistent with what it does, as he/she observes the result (Young 1981:379).

Faith on expected efficacy of the traditional treatment was very obvious in terms of evaluation of the treatment for *shutika*. It was remarkable that the women in the village took it for granted that the traditional medicines were always effective for *shutika*. In case of explaining the failure of the treatment mostly they were found to blame themselves for irregular intake of remedy. Otherwise sometimes they also justified that it was ineffective for the time being for certain conditions.

Shutika as a folk illness indicates different cultural factors of the society and it compasses social, moral, economical and psychological aspects of the suffer. It is quite transparent in women's description about the situation of *shutika* particularly in different discourses of cause. The young women often emphasized the point that *shutika* happened to them because they did not get proper diet in their in-laws' house. The mothers-in-law often imposed the food taboos and other practices after childbirth without their inclination and if they did not do it they were harshly criticized about their motherhood. Yet the mothers-in-law justified the behaviour by saying that their daughters were also being treated the same in their in-laws' house. So they had not done any thing exceptional with their daughters-in-law.

It is notable that the prominent point in different discourses regarding cause of *shutika* is 'condemnation'. In the study the elderly women in the village were found to view *shutika* as a punishment to the young women for not observing the food taboos and certain practices. Conversely, the young women were heard to complain about weakness as main cause which was due to inadequate food during pregnancy and lactating period. In fact during survey also most of the women perceived weakness as the cause of their *shutika* illness.

Indeed the explanatory models of the illness manifest the sociocultural aspects of the society. Especially these draw our attention to the intra power relations in the society which is vitally between mother-in-law and daughter-in-law. According to the norms of the society the daughters-in-law are always subordinate to their mothers-in-law unless they have their own household. In this regard if we consider malnutrition is the cause of *shutika* which is considerably deep-rooted in food taboos then the young daughters-in-law have the enormous possibility of getting the illness. Since after marriage up to certain period majority of the women in Bangladesh usually live with their in-laws. During that period they are supposed to carry out all the instructions given by the mothers-in-law. The survey data of the present study also supported the assumption as substantial number of women in the village got *shutika* around age ranges from 20 to 24, and 20 is the standard age of marriage for the women in that locality. Nonetheless, education of the women is a considerable factor here as it has an impact on women's personality. In this respect the survey data shows that level of education of the women had significant association with *shutika*.

Emergence of the above outlook from the explanatory models of the women allows us to analyze critically the social origins of the illness which is derive from the gender relation as a form of sufferings. In that regard a question may be appeared that whether *shutika* is only an illness or the utterance of dissatisfaction of the women about their position in the household!

In conclusion I would like to place following recommendation for the policy makers of BRAC on the basis of my findings:

BRAC could develop certain health education messages regarding *shutika* in a cultural sensitive way as a part of its Essential Health Program (EHC). The health education messages can incorporate the inter generational aspect of the problem as well. Since the *shasthya sebikas* (health assistant in the community) live inside the community and they are quite popular among the village women; BRAC can imparted the message through

them. BRAC can also provide the *shasthya sebikas* new knowledge on the early treatment of *shutika* as a syndromic condition.

References

Akhter, H.H
1996 *A cross-sectional study on maternal morbidity in Bangladesh.* Dhaka: BIRPERHT.

Akhter, H.H.
1990 *Overview of maternal mortality and morbidity studies in Bangladesh.* Dhaka: BIRPERHT.

Akther, H.H.
1985 *Women health and socio-cultural environment.* Paper for national conference on women and health, Dhaka.

American Anthropological Association.
1997 *Code of ethics of the American anthropological association.* Final draft.

Aziz, K.M.A. and Maloney, C.
1985 *Life stages gender and fertility in Bangladesh.* Dhaka: ICDDR, B.

Aziz, K.M.A.
1994 *Cultural perceptions about childbearing in Matlab in Vincent Fauveau (ed.), Matlab: Women, children and health.* Dhaka: ICDDR, B.

Blanchet, T.
1984 *Meaning and rituals of birth in rural Bangladesh.* Dhaka: University press limited.

Blanchet, T.
1988 *Maternal mortality in Bangladesh.* Anthropological assessment report. Bangladesh: NORAD.

BIRPERHT.
1994 Prevalence of maternal morbidity. Briefing paper: *Maternal morbidity in Bangladesh.* Vol. 1. Dhaka.

Chen, L. et al.
1981 Bias in the family allocation of food and health care in rural Bangladesh. *Population development review* 7(1), March.

Coggon, C., Rose, G. and Barker, DJP.
1997 *Epidemiology for the uninitiated (4th ed.).* BMJ publishing group.

Das Roy, R.
1995 *Pilot study on intra-household food distribution at Matlab.* Dhaka: Research and Evaluation Division, BRAC.

Dixon-Mueller, R. and Wasserheit, J.
1991 *The culture of silence: Reproductive tract infections among women in the third world.* New York: International women's health coalition.

Fauveau, V. and Chakraborty, J.
1994 Women's health and maternity care in Matlab. In Vincent Fauveau (ed.), *Matlab: Women, children and health.* Dhaka: ICDDR, B.

Ford, K. et al.
1988 Nutrition, infant feeding and post-partum amenorrhoea in rural Bangladesh. *Journal of Biosocial science,* 20 (4), P. 461-469.

Gazi, R. et al.
1995 *Case studies on practices during post-partum period in rural Bangladesh.* Dhaka: Research and Evaluation Division, BRAC.

Good, B. J.
1977 The heart of what's the matter: The semantics of illness in Iran. *Cult. Med. Psychiatry* 1. P. 25-58.

Good, B. J.
1994 Illness representation in medical anthropology: A reading of the field. In *Medicine rationality and experience: An anthropological perspective.* Cambridge: Cambridge university press.

Goodburn, E.A. et al.
1994 *Maternal morbidity in rural Bangladesh.* Dhaka: Research and Evaluation Division, BRAC.

Hardon, A. et al. (ed.)
1995 *Applied health research.* Amsterdam: Het spinhuis publisher.

Helman, C.G.
1995 *Culture health and illness (3rd ed.).* Oxford: Butterworth-Heinemann.

Huffman, S.L. et al.
1985 Nutrition and fertility in Bangladesh: Nutritional status of non-pregnant women. *American journal of clinical nutrition* 42 (4), P. 725-738.

Islam, M.
1980 *Folk medicine and rural women in Bangladesh.* Dhaka: Women for women.

Jorgensen, V.
1983 *Poor women and health in Bangladesh.* Stockholm: SIDA.

Khattab, H.
1992 *Silent endurance: The social condition of women's reproductive health.* Amman: UNICEF.

Kleiman, A.
1973 Medicine's symbolic reality: On a central problem in the philosophy of medicine. *Inquiry* 16. P. 206-213.

Kleiman, A.
1978 Concepts and a model for the comparison of medical systems as cultural systems. *Social science and medicine* 12. P. 85-93.

Kleiman, A.
1980 *Patient and healers in the context of culture.* Barkley: University of California press.

Koeing, M.A. et al.
1987 Trends in family size preferences and contraceptive use in Matlab, Bangladesh. *Studies in family planning* 18(3). P. 117-27.

Madrigal, L.
1998 *Statistics for Anthropology.* Cambridge: Cambridge university press.

Mahbub, A. and Das Roy, R.
1997 *An emic towards well-being.* Dhaka: BRAC-ICDDR, B working paper series no.20.

Mahbub, A. and Masud, S.M.
1997 *Women's perspective about their own illness.* Dhaka: BRAC-ICDDR, B working paper series no.16.

Pelto and Pelto.
1978 *Anthropological research (2nd ed.).* Cambridge: Cambridge university press.

P.L. and Manderson, L. (ed.)
1996 *Maternity and reproductive health in Asian societies.* Harwood academic publishers.

Pool, R.
1989 *There must have been something...Interpretation of illness and misfortune in a Cameroon village.* Ph. D. dissertation, University van Amsterdam.

Ross, J.
1994 *Bangladesh country report.* Dhaka: ICDDR, B.

Rubel, A. J.
1977 The epidemiology of a folk illness: Susto in Hispanic America. In Landy D. (ed.), *Culture disease and healing: Studies in medical anthropology*. New York: Macmillan.

Stones, W. et al.
1991 An investigation of maternal morbidity with identification of life-threatening 'near miss' episode. *Health trends* 23 (1). P. 13-15.

Susan, C. et al.
1994 An epidemiological description of a folk illness: A study of empacho in Guatemala. In Mark Nichter (ed.), *Anthropological approaches to the study of ethnomedicine*. Amsterdam: Gordon and Breach science publisher.

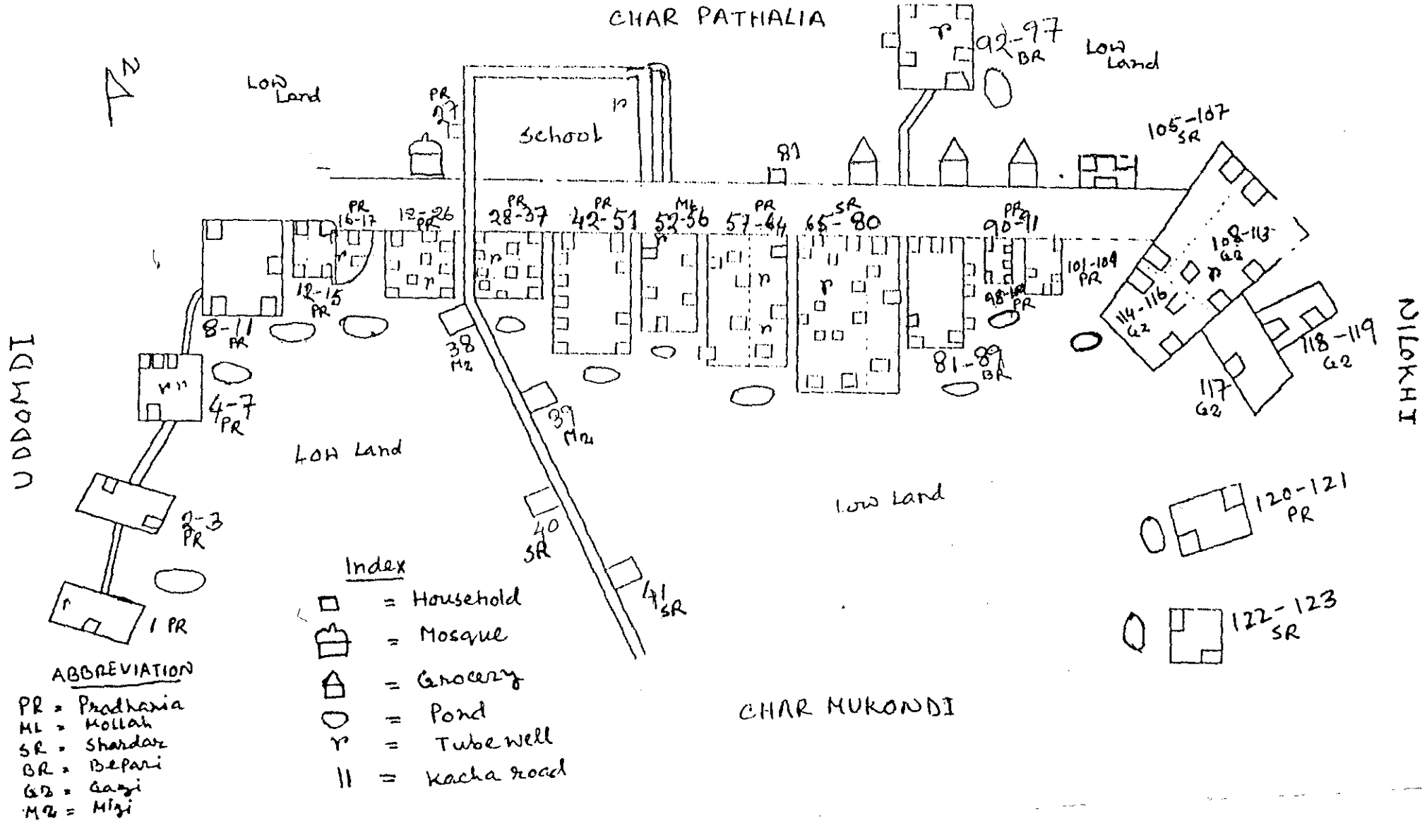
World Bank.
1993 *World development report: Investigating in Health.* Washington DC: The World Bank.

Yunus, M., Aziz, K.M.A. and Islam, S. M.
1994 Perception of health and disease in the Matlab community. In Vincent Fauveau (ed.), *Matlab: Women, children and health*. Dhaka: ICDDR, B.

Young, A.
1981 the creation of medical knowledge: Some problem in interpretation. *Social science and medicine* 15B. P. 379-86.

Zarayk, H. et al.
1993 Concept and measures of reproductive morbidity. *Health transitional review* 3 (1). P. 17-38.

Annex 1. Social map of the village Char Nilokhi (done by the villagers).



Annex 2. Concise table on village profile.

Total Households	123
Total population	749
Average family size	6.9
Household land holding	
Yes	94
No	27
Level of education of the household head	
Cannot read or write	65
Class 1-5	25
Class 6-9	21
S.S.C	10
Types of income by the earning members (multiple)	
Farmer	51
Service	50
Rickshaw puller/Boat man	19
Daylabourer	16
Business	16
Others	6
Food Security	
No	27
Below 6 months	18
6 to 9 months	29
10 to 12 months	25
Surplus	24
BRAC membership	41
Non member	82

Source: Mahbub, A. and Das Roy, R., An emic towards well-being, working paper no. 20, BRAC-ICDDR, B joint research project, Dhaka. 1997.

Annex 3. Concise table on women's perception about shutika.

	Shutika	
	Gorvo/lamani shutika	**Shukna/hukna shutika**
Period of getting the illness	Throughout the pregnancy period.	Immediate after childbirth to until the weaning period of the child.
Symptoms	Anorexia, Indigestion, loose motion, strange sound in the abdomen, vertigo, weakness.	Vertigo, weakness, feeling of fatigue, burning sensation in body, anorexia, body becomes thinner.
Cause	Evil eye, evil wind, over eating.	Violation of food taboos, weakness.
Prevention	Restrictions on mobility, avoid overeating.	Observe food taboos, take rest for a while after having meal during postpartum period, have bath early in the morning, intake of "good food" after childbirth, have three bottles of shadhana syrup.
Treatment	Amulet for evil eye and evil wind, allopathic tablet for weakness and loose motion.	Exorcise with uttering charms, amulet, sanctified betel leaf, sanctified jute, herbal remedies, shadhana syrup.
Assessment of the illness	More stigmatize, does not cause many difficulties in doing household work, temporary disorder (mainly limited in pregnancy period).	Less stigmatize, affected women do not able to household work properly, exits for comparatively long period.

Source: Key informants of the village.

Annex 4. Questionnaire for the survey.

Survey questionnaire regarding shutika illness of the women

Date:

Name of the interviewer:

Section I

1. Name of the respondent: ----------.
2. Age: ---------- Years.
3. Educational qualification: I. Illiterate [1] II. Primary [2] III. Secondary [3] IV. Higher secondary and above [4].
4. Name of the household where she lives in: ---------- Bari.
5. Name of that household head: ----------.
6. Her relationship with the household head ----------.
7. Wealth category of the household: ----------.

Section II

8. Number of currently surviving children: ----------.
9. Total number of pregnancy: ----------.
10. Number of children born alive ----------.
11. Present status: I. Pregnant [1] II. Lactating [2].

(For the pregnant women please ask question from section III. But if the status is lactating please go to section IV.)

Section III

(Questions for pregnant women)

12. How many months you are pregnant? ----------months.
13. Have been ill during this pregnancy period? I. Yes [1] II. No [2].

(If the answer is yes, please continue the next question)

14. What are you suffering from? (Please probe –anything else?)

15. (If it is shutika) How long you have been suffering from this illness?

----------months.

16. When did it start?

17. What are the symptoms of your shutika illness?

18. What do you think is the cause of your shutika illness?

19. What kind of treatment have you had for shutika?

(More answers are allowed)

I. Allopathic	Yes [1]	No [2]
II. Kabiraji (traditional)	Yes [1]	No [2]
III. Bonaji (herbal)	Yes [1]	No [2]
IV. Homeopathy	Yes [1]	No [2]
V. Self /home	Yes [1]	No [2]
VI. Others (please mention)	Yes [1]	No [2]

20. Have you consulted with anybody about the treatment? I. Yes [1] II. No [2].

21. (If yes) With whom?

(More answers are allowed)

I. Friends/neighbours	Yes [1]	No [2]
II. Relatives	Yes [1]	No [2]
III. Mother	Yes [1]	No [2]
IV. Mother-in-law	Yes [1]	No [2]
V. Husband	Yes [1]	No [2]
VI. Others (please mention)	Yes [1]	No [2]

22. What are the reasons of your choosing this particular treatment?

23. What is your opinion about the treatment? I. Effective [1] II. Ineffective [2].

24. Please mention your reasons.

Section IV.

(Question for lactating women)

25. How old is your present lactating child? ----------months.

26. Until now have you had any health problem after your this childbirth?

27. Yes [1] II. No [2]. (If yes, please continue)

28. What are you suffering from? (Please probe –anything else?)

29. (If it is shutika) How long you have been suffering from this illness?

----------months.

30. When did it start?

31. What are the symptoms of your shutika illness?

32. What do you think is the cause of your shutika illness?

33. What kind of treatment have you had for shutika?

(More answers are allowed)

I. Allopathic	Yes [1]	No [2]
II. Kabiraji (traditional)	Yes [1]	No [2]
III. Bonaji (herbal)	Yes [1]	No [2]
IV. Homeopathy	Yes [1]	No [2]
V. Self /home	Yes [1]	No [2]
VI. Others (please mention)	Yes [1]	No [2]

34. Have you consulted with anybody about the treatment? I. Yes [1] II. No [2].

35. (If yes) With whom?

(More answers are allowed)

Friends/neighbours	Yes [1]	No [2]
Relatives	Yes [1]	No [2]
Mother	Yes [1]	No [2]
Mother-in-law	Yes [1]	No [2]
Husband	Yes [1]	No [2]
Others (please mention)	Yes [1]	No [2]

36. What are the reasons of your choosing this particular treatment?

37. What is your opinion about the treatment? I. Effective [1] II. Ineffective [2].

38. Please mention your reasons.