ON MRU WOMEN HEALTH BELIEFS AND PRACTICES AND ON THEIR NON-USE OF HEALTH SERVICES

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SUMMARY

The Mru are one of the smallest of the twelve ethnic minority groups of the Chittagong Hill Tracts (CHT) of Bangladesh. Living in the remote and hard to reach areas of the CHT, the Mru are relatively isolated from the rest of the population. Because of conflicts between the government and the ethnic groups, the area was closed to outsiders for many years in the past. This has contributed significantly to the scarcity of studies and knowledge of the Mru world, including their health related beliefs and practices.

This thesis sheds some light on the Mru women’s health beliefs and practices, and discusses some of the reasons for their apparent non-use of biomedical health services, which are provided by the government. The thesis argues that there are cultural barriers to Mru women’s use of biomedical health services (the perception and significance of pain and its management), but also other important factors are at play. Political economy, for instance, influences their decision to take their sick to the doctor in the lowlands. And it is stressed that Mru women do not reject biomedicine per se, but find its delivery system unacceptable and do not trust the providers.

The government health services in Alikadam do not exist in a cultural vacuum but are “over-determined” (a Freudian concept). In this case, the government health services happen to: a) Use a western allopathic understanding of pathology, etiology and treatment; b) Be operated by health staff from a different culture that has its own normative values, its own perception of what is to be respected and not respected, what is development, what are the criteria to be considered civilized, etc. and c) Be associated with the Government of Bangladesh that has a 20-year history of oppression of the minority groups of the Chittagong Hill Tracts.

Finally, the thesis offers the following recommendations.

1. Further research studies have to be conducted to shed light on the health seeking beliefs, knowledge and practices of the Mru as well as other groups of the CHT. The role of perceived or real pain in cultural acceptance of services should be recognized and dealt with.

2. Efforts have to be made at registration and training of TBAs and other traditional healers from ethnic minority groups, including those living in remote areas.

3. Efforts have to be made on the part of the Government and NGO health providers to bring health services and information to the communities. Knowledge of a service may very well improve its use. Health staff has to be encouraged to go to remote places and equipped with the necessary mosquito nets and antimalaria prophylaxis, given the endemicity of malaria in the area.
4. NGOs and the government should make efforts in identifying and training ethnic health workers and Mru-speaking individuals. This is very important in building trust and openness to what a friendlier health system has to offer.
ACRONYMS

CHT – Chittagong Hill Tracts
UHFPO – Union Health and Family Planning Officer
IOCH – Immunization and Other child Health Project, USAID-funded
TBA – Traditional Birth Attendant
DC – District Commissioner
Upazilla – Administrative unit of about 300 000 people
Sadar - Headquarters
1. INTRODUCTION

Two years ago, Shima cut her foot on a piece of bamboo while working in the paddy fields. The little cut grew larger over time, and eventually the wound covered almost her entire foot and part of her ankle. Shima consulted a sra\(^1\) and through a series of rituals and the use of the pooi,\(^2\) the responsible spirit was found. It was Mahatalanam, the jhum\(^3\) spirit that inflicted this condition on her. She must have fallen under his influence when she was working in the jhum. Nowadays, Shima continues to treat the wound by performing natt (a ritual involving animal sacrifice) regularly, and applies vitamin powder, which is essentially a crushed painkiller tablet. When Shima runs out of vitamin powder, she pays the karbari\(^4\) in Taka\(^5\) to buy the tablets at the nearest market on the bazaar day. Shima is satisfied with the treatment she has been following for the last two years because performing natt and applying vitamin powder takes away the pain and allows her to perform her everyday activities.

Shima was the first woman I met when I arrived in the Mru village, where I conducted my study. Unlike the other adult women, Shima no longer goes to the jhum. She stays behind to take care of her younger children and of the housework while her elder daughter and her husband work in the field. Two weeks after my arrival in the village, I asked Shima if she would consider going to the doctor at the Alikadam hospital with me to explore other treatment options for her foot, since the wound had still not healed and appeared to be growing bigger. From the start, she was reluctant to visit the hospital.

S: - It is too far to walk to the hospital.
M: - We could walk very slowly 'til the main road and from there I can take you in my car to the hospital.
S: - I don’t have the money to pay the doctor.
M: - Don’t worry about the money. Let’s see, maybe I can do something about it.
S: - Well, why don’t you give me the money and I will treat my foot myself?

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\(^1\) Master of certain activities, usually in the area of religion (definition from Brauns and Loffler, 1990)
\(^2\) Ritual instrument used by sra to determine the cause of an illness
\(^3\) Plots of land on the slope of hills, where the Mru grow their rice etc.
\(^4\) Head of hamlets (paras)
\(^5\) The currency of Bangladesh, in 2003 $1 US = 58 Takas.
M: - You have been trying your treatment for so long, let’s try the doctor and see how that works.
S: - I will have to talk to my husband about it first…

I said I would come back the next day to see what her husband said about my suggestion. The next day she said that she would go, but it was very clear from the way she spoke that she was not looking forward to it. We agreed that we would descend into town the next bazaar day, when her husband would be home to look after the children.

When the day came, I went to Shima’s house with my assistants. Shima asked me if I had any medicine against fever for her daughter. Instead of giving her medicine I suggested that her daughter come with us, too. Shima and her husband thought it was a good idea because in addition to getting treatment for her fever, the girl would accompany her mother.

At the hospital, while waiting for a doctor we were soon surrounded by Bengali people. The empty waiting area in front of the doctor’s chamber was soon filled with a crowd of hospital staff, patients and visitors who were all very curious about what the women were suffering from and for how long. There were two reasons for their curiosity. First, it is rare to see Mru at the hospital. If they attend, it must be very serious and, therefore, a subject worth exploring. Second, the presence of a foreigner is almost as rare as that of a Mru in the hospital, and always attracts a curious crowd wanting to ask a few questions. Thus, two Mru women in the company of a foreigner would attract a lot of attention. Shima and her daughter were clearly not pleased to draw so much attention. They were unusually quiet and stared at the floor. Around us were male and female nurses and lab technicians, women with their sick children in their arms and children in their early teens. This Bengali crowd first asked the women if they spoke Bangla. They spoke in a manner usually used to talk to people with hearing impediments. When they were told that Shima alone spoke a little Bangla, the tone of voice and the questioning did not change.
After getting answers to a few questions, the hospital staff started discussing loudly Shima’s condition in front of all of us. One of them said that it was gangrene. Luckily Shima didn’t know the meaning of the word. The more people expressed their concern, the more worried she looked. Although she couldn’t understand everything that was said, she could read facial expressions of pity and disgust. We waited in the midst of the crowd for about fifteen minutes before the doctor came to see us. These long fifteen minutes, no doubt, were as important to Shima and her daughter as the doctor’s consultation.

The young doctor we saw had been assigned to the Alikadam Hospital only two weeks earlier from the Chittagong Medical College. The doctor was unsure about the diagnosis but speculated that it could be a “cancerous ulcer.” The consultation lasted about five minutes, during which the doctor told us that the wound had to be cleaned before applying an ointment and dressing. We were sent to one of the male nurses for the cleaning and also for a blood test for Shima’s daughter.

Entering the dressing room we saw a male nurse and a lab technician hovering over a boy of about six years old. The nurse was applying stitches to the boy’s chin while the technician was holding down the crying boy. They were not using anesthetics because none were available.

After the boy was finished, it was Shima’s turn. She was helped to lie on the same bed that the boy was on. I have not visited many dressing rooms in hospitals in Bangladesh but have seen some in other countries. Being used to seeing dressing tables covered with cloth or paper, which is changed after each patient, my attention was drawn to the fact that this dressing table was not covered with anything, nor was it cleaned after the boy’s cuts were stitched.

The nurse started by removing the pus and the painkiller powder with a piece of gauze held with a pair of forceps. No anesthetics were used and the cleaning of the wound caused Shima a lot of pain. She was shouting out in pain. After scrubbing the pus and powder off, the nurse poured a foaming antiseptic solution over the raw wound, which
caused more pain and made Shima shout and kick even more. Before resuming the scrubbing, the nurse decided that it was too difficult for him to work with the patient moving her legs while he worked. He asked the lab technician to help him hold down Shima’s legs. Her daughter, already frightened, stood by her mother’s side throughout the procedure and held her hand.

The nurse and the lab technician expressed their surprise and disapproval at how long Shima had let her foot go unattended by medical professionals. Their sense of disapproval was conveyed indirectly to her. Other hospital staff came into the room either for their own business or just to see the foreigner and the screaming Mru woman. They told her to quiet down or stop moving as it was not as bad as her behavior insinuated. The staff members were shaking their heads and saying, “If you had come earlier, you wouldn’t have had to go through this.” At the end, Shima was told to come back to clean the wound every three days if she didn’t want it “to turn into gangrene and lose the leg.” This was communicated to her not by the doctor, but by the male nurse that cleaned her wound.

We brought her back to the village late that afternoon. When we came back the next morning to see how Shima was doing, the dressing was gone and the wound was covered with a white powder again. She said she removed the dressing and applied vitamin powder a couple of hours after she came back from the hospital. She explained, “The dressing had a very bad smell and it hurt too much.” Three days later when I returned to her house she refused to go back to the hospital. She said the pain was too much to bear and the cleaning did not cure her anyway.

After the hospital visit, at Shima’s request, a sra consulted the pooi and Shima was told to perform a sacrifice in the jhum. The animal for the sacrifice had to be a pig with only one testicle. Fortunately Shima had an animal that fit the qualifications and her husband performed the necessary natt in hopes of quick recovery.
Shima also continued her self-prescribed *vitamin* powder treatments. The pain was significantly reduced by the frequent applications of the painkiller and she could return to her normal activities.

Shima was skeptical from the start about the outcome of the visit to the hospital doctor. She made the difficult decision of trying the hospital doctor’s treatment, because I promised to stay with her at all times and she gave me her trust. I had only one thing in mind, how to treat her wound, and ignored other important factors that had to be considered. Did she think her own treatment was working? What did she think of going to the hospital and what were her expectations of this treatment? What did she know, if anything, of the hospital environment? The doctor’s treatment did not have an immediate effect. It didn’t cure her foot nor did the ointment or bandage remove the pain. Shima did not experience much pain prior to her visit to the hospital, and the treatment she received in the hospital caused her more pain and discomfort than before. Shima’s experience confirmed her belief that the doctor’s treatment not only failed to cure her, but also caused more harm than good. All my attempts to convince her that the wound had to be cleaned and the ointment applied at least for several days failed.

Shima and her daughter are the only two women from their village, who have ever gone to an hospital for treatment. Their personal negative experience will not shape only their own view of biomedical health facilities and providers but also the perceptions of those living in the village. My good intention to help Shima ended up providing me with new insights -- it was my first exposure to the central role of pain in how the Mru perceive illness as well as to the fundamentally alien nature of the allopathic curative services offered by the dominant and culturally different Bengalis.
2. BACKGROUND

My first contact with the Mru took place in 1999, when I decided to see for myself one of the last tribal groups of Bangladesh to have remained “pure” and “unspoiled,” according to national and international accounts in various journals and informal conversations. Bangladeshis even go as far as calling the Mru “primitive.” Local tourist agencies use the Mru as a cultural attraction. Not all that is said about the Mru, however, is true. Coming from a marginalized group myself⁶, I refused to accept the stereotypical image of these people and decided to have a clearer understanding of the Mru and their culture.

What I discovered was quite different from the popular perceptions held by many in Bangladesh. To begin with, not all the Mru are as isolated as they are portrayed. Villages are located on hilltops, some taking hours or days to reach, but many are only a few hours walk from small municipalities like Alikadam. Many of the Mru are in regular contact with the Bengalis as they come down once a week to the town markets to sell, buy, and exchange goods. This increased exposure to the Bengalis has significant implications, which are further explained below.

Contrary to the belief that all Mru are animists, many are Buddhist, Christian and Khrama⁷. Religious conversion is related to prolonged contact with missionaries, reinforcing the fact that no “pure culture” exists. Furthermore, many of the Mru who converted to various religions still often incorporate aspects of their old religion into their newer practices. For instance, those who follow Buddhism and Christianity still perform animal sacrifices.

To a large extent the newly learned religions have caused changes in the Mru way of life. For example, lungis (traditional Bengali cloth) and shirts replaced men’s loincloths. Burmese sarongs and petticoats have replaced Mru women’s short skirts, as too much exposed skin was considered inappropriate by the non-Mru. Prior to the introduction of

⁶ I belong to a minority group from the Pamir mountains of Tajik Badakhshan in Tajikistan
⁷ This religion emerged about 20 years ago and resembles Christianity in many ways. There are no reliable statistics available on religious affiliations.
different “new” religions, the Mru did not have official religious spaces or monuments. When churches and temples arose, the Mru were expected to cover their bodies before entering them. Those who follow Khrama are now forbidden to sing, dance, and drink beer, despite the fact that all of these activities were previously an integral part of the Mru culture. New religious beliefs brought new social norms and values.\(^8\)

In addition, the Chittagong Hill Tracts are becoming a popular place for tourists to visit despite the relative security restrictions. Tour agencies offer trekking trips of several days to spend among the Mru. Cultural organizations promote Mru song and dance. The French Cultural Center even organized a trip for a group of Mru villagers to go to Paris for a singing performance\(^9\). CDs of Mru music and songs were produced and are found in music stores throughout France. Virtual Internet groups exist for those interested in the Mru.

“Modern technology” is easily visible among the Mru. Traditional wooden hair combs are no longer carved and have instead been replaced by plastic ones bought at weekly markets; cigarettes are preferred over rolled cigars; flip-flops cover bare feet. Almost everyone wears electronic watches and listens to battery operated radios. What I saw inspired me to document through photographs how the present day Mru really live with the hope of dispelling some of the most egregious stereotypes.

Earlier images of the Mru were found either in old books or in advertisements for tourists. The current images we see in tourist brochures (people with “unchanged culture” and “unspoiled by civilization”) are commercially convenient misrepresentations (used for commercial gain) of people who are not immune to change. For four years, from the beginning of 1999 to September of 2002, I worked on a non-commissioned photographic project on the Mru. The focus of the project was to document the changes in the Mru way of life: dress, daily activities, rituals, etc. I attempted to distinguish myself from

\(^8\) This is not unique to the Mru. The Garos of Banagladesh, for instance, have been evangelized by Catholic priests and Baptist pastors. The Catholic Garos make and drink beer and have kept many of their traditions whereas the Baptist Garos have not.

\(^9\) Talking to the group about what they saw and experienced in Paris could be a research topic on its own.
other photographers of the Mru by not being selective. I did not search for the most exotic looking people. I did not ask people to take off their watches or hide their radios before photographing them. I sent copies of every photograph to the people, and remain in close contact with many of them.

2.1 Who are the Mru?

The Chittagong Hill Tracts are located in the South-East of Bangladesh (see map p.6), and are inhabited by different ethnic groups. The area of CHT is different from the rest of Bangladesh (a flat delta) in many ways due to hills, ravines, and cliffs, still covered in some places by dense jungles. These hills are inhabited by twelve major ethnic groups (Rafi and Chowdhury 2001). The Mru are one of the smaller and more isolated groups of the region. The CHT consist of three districts, Rangamati, Khagrachari and Bandarban. Most of the Mru live in Bandarban (in Alikadam Upazila) but few live in the two other districts as well. To this day very little is known about the group’s health related knowledge and behavior due to the lack of studies. Because of conflicts between the government-sponsored Bengali settlers and the indigenous people, the CHT were closed to foreigners.

The Mru are believed to have come to the region a few hundred years ago from the state of Arakan in Myanmar (Barua 2001, Brauns and Loffler 1990). Their language belongs to the Tibeto-Burman family of languages. Different sources give different figures on the number of Mru actually living in Bangladesh. According to the Bangladesh Population Census (BBS 1992), there were 22,167 Mru living in the CHT of Bangladesh. Today, the exact number of the Mru population in Bangladesh is not known. They live in small settlements (paras) consisting on average of 16.4 households compared to 54.3 for Bengali villages. The average size of Mru households is 5.8, while that of Bengalis is 5.3 (Rafi & Chowdhury 2001: 43). The paras are isolated from each other by hills, which are often impassable during the monsoon season. It is estimated that over 93% of Mru paras

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10 For insights on the issue of exploitation of the Mru by photographers and anthropologists see van Schendel’s work.
are more than a mile away from a primary school compared to 18% for Bengalis. If we compare male/female primary school enrollment ratio of the Mru with the major group, it is 28/3 for the Mru and 98/96 for the Bengalis.\textsuperscript{11}

Mru houses are built on bamboo stilts similar to many dwellings in South East Asia. The height protects the inhabitants from wild animals and monsoon floods and allows the domestic animals to shelter underneath the house. Most importantly, the house can be built anywhere on the uneven land of the hills by using stilts of different length. Bamboo canes are made into flat, wide strips and are used to weave the floors and walls of the house. The woven floors and walls allow air circulation in the hot summer. While washing dishes or cooking, one does not have to leave the house. The water as well as leftovers of food can be thrown through the gaps in the floor. It does not accumulate underneath the house as it is immediately eaten by the domestic animals.

The houses usually consist of a common room, an inner room and a terrace. A Mru house can always be extended if a son in the family gets married. The central room serves as the

\textsuperscript{11} The study sample was 30 villages only with 510 households. The villages selected may have been the closest ones to the lowlands.
kitchen, the dining room and the guestroom. No one except the family members may enter the inside room. All the family’s valuable possessions are kept in this room; the most precious of their possessions is their stock of rice stored in a huge woven basket.

2.2 The importance of rice

The Mru, like many other groups in the Chittagong Hill Tracts, practice the so-called slash-and-burn agriculture. They clear slopes of hills by cutting and burning all vegetation to plant paddy or sometimes cotton, tobacco and a few fruit trees and vegetables. The fields have to be changed every three to four years to let the land recover. Because of high demand for land and the necessity to shift from hillside to hillside, some villagers have to walk for hours daily crossing numerous hills to reach their paddy fields or jhums.

Rice is the main staple food for the Mru. They eat freshly cooked rice three times a day. Everything else, meat, vegetables or fish is considered to be a side dish (Brauns and Loffler, 1990: 125-130). Those who go to the paddy fields for the day wrap their portion of cooked rice in banana leaves and carry it with them. The family knows what they will have for dinner with their evening rice only when everybody returns from the jhum. The Mru bring home vegetables, snails, fruits or other little animals that are found in the jungle. These are boiled in water with salt and nappi. Sometimes the family members come home empty handed, in which case dinner will consist of rice alone.

Paddy is grown once a year and harvested in the month of September. Sacrificial rituals are performed before and after the harvest is collected. Many families run out of rice before the harvest and for Mru families it is vital to complete the jhum work in time. There is a clear labor division in Mru society. Women do most of the work in the jhums. This is one of the reasons why the girl should be older than the boy she marries. She is expected to be of help to the family of her husband by doing a lot of hard work around the house and in the jhum. The men of the family busy themselves with cutting bamboo

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12 Nappi is a paste prepared with ground dry fish, an important ingredient in every Mru dish.
and collecting other fruits to sell on the bazaar in the lowlands, particularly during the pre-harvest months. During this period the prices on the local bazaar go up because rice venders know of the pahari’s (a term used for all non-Bengali inhabitants of the hills (Bal, 2000:7)) rice shortage.

When discussing health, women mentioned each time that to be able to grow rice, one needs to work hard but to work hard one needs strength; and to achieve strength one needs to eat rice. If we had to draw a diagram to illustrate the importance of rice in these statements, it would be very close to the following:

![Diagram of Rice, Hard Work, and Strength]

The importance of rice is also demonstrated in the link between the paddy fields and Mru customs and rituals, and how Mru life is built around the jhum work. Sacrifices are performed to appease the paddy spirits and taboos are observed to not anger them. During the days when women are kept in ritual isolation after delivery, villagers would not bring anything from the jhum into the village. It is said that if anything is brought in, the villagers will “lose the rice to rats or the rice may rot.” Everything that is collected in the jhum is left on the ground across the stream at the bottom of the hill for three days. It is brought into the village only after the woman is ritually “reintroduced” into the community.

It is well known that social and economic change have an impact on population’s nutrition all over the world (Helman, 2001). Strangely enough, very little dietary change has taken place among the Mru. With the exception of dry fish, tea on the market day and the occasional candy or biscuit, their diet remains the same. The Mru keep chicken, pigs
and cows, all of which are only kept for the meat. Cows are not milked and the eggs are eaten rarely because they are most often left to hatch. But if you ask the Mru what they eat, they would say they eat everything. “Everything” means all edible vegetables, fruits and any living creature that nature has to offer, including insects, rodents, and birds (big or small). And none of the sick domestic animals go to waste. One morning, Sheila’s younger stepdaughter discovered that one of the chicks was limping. Without any hesitation, the five-year old held the chick by the legs and hit it on the head several times with a piece of wood until the creature went limp. Then she put the chick on the fire to burn the feathers off, after which she put it over the fire place. The chick was to be cooked for dinner.
3. AVAILABILITY OF HEALTH SERVICES IN THE MRU AREAS

There are government-run hospitals in each Upazila in Bangladesh. In Alikadam, the Thana headquarters, there is a health center and a thirty-bed hospital. During the monsoon season, malaria is widespread and the hospital admits a significant number of malaria patients. In mid June, when my assistant was admitted to the hospital for malaria, the doctor on duty said that patients with malaria occupied twenty-six out of the thirty beds. Out of these 26 cases only two were cases of cerebral malaria.

The description of my visit with my sick assistant will provide some additional insights on the reality of the curative services. Once in the hospital, we were told that the doctor on duty was upstairs, in the doctor’s room, which was located on the first floor of the hospital building in between two long rooms. The room to the left was the male ward and the room to the right was the female ward. The doctor admitted us to his office. He had many files in front of him and asked us to wait while he signed them all. After signing about twenty files, he examined my assistant. After a blood test he concluded that she suffered from malaria and was in need of relevant treatment and rehydration, and therefore had to be admitted to the hospital. He assured us that we would be given the best bed in the female ward. Inside the ward, next to the entrance door was a small cubicle designated for the nurse on duty with a desk and a chair. The toilet and bathroom were located at the other end of the ward and were shared by all the ward patients. Each ward had fifteen beds in two straight rows. There were no partitions between the beds, nor were any of the beds or windows equipped with mosquito nets. The best bed in the ward turned out to be the first one next to the nurse’s room. We realized that what made it the best bed was actually its relative remoteness from the common toilet, which was situated at the end of the room. All the other beds in the ward were occupied. Except my Mru assistant, all the other patients were Bengalis. Some of the patients were very young children accompanied by their mothers. Many had visitors. The visitors were male as well as female. No one spoke to us, but the entire ward was simply staring at my assistant and talking among themselves. The ward was quite a noisy place and it was not clear if there were precise visiting hours or whether or not anybody could just come in any time.
and spend the entire day. My assistant was given saline IV and malaria treatment in form of injections. She spent the first night in the hospital.

The next day my assistant asked to be discharged, even though she was far from recovery. She complained about the lack of privacy, the bad smell in the ward, the noise that prevented her from sleeping, and other unpleasant aspects of the hospital. The doctor suggested that she stay at least one more night in order to complete her IV drips, and, consequently, she reluctantly agreed. Towards the evening of the same day she announced that she was leaving the hospital at once and there was no way she was going to stay another night in the ward where a child just died. The doctor prescribed a course of oral treatment, which we bought at the hospital pharmacy. We then brought my assistant to her family. Witnessing the death of a child was the final straw before my assistant decided to leave the hospital, but the lack of privacy and the general state of the ward were enough of a reason to leave.

The doctors working in the government hospital are assigned to the post by the Ministry of Health. In a country like Bangladesh, jobs in the big cities are preferred and remote locations like Alikadam are avoided. One has to have good connections to be assigned to a “good” place (an urban location). Very often the newly graduates are sent to very remote areas.

Usually, the doctors have private chambers outside the hospital, where they provide consultations and also sell drugs. These chambers are accessible to a very small part of the population due to the costs involved. For the larger part of the population there are privately owned pharmacies and drugstores, which are usually located close to or inside the bazaar. These drugstore owners prescribe and sell medicines on the spot either by listening to the descriptions of the symptoms or simply selling the requested medicine.

Rafy and Chowdhury reported the mean distance of health facilities from the study villages were 11 miles for the Mru and 3.2 miles for the Bengalis (2001). Unfortunately the study does not say how long it takes to cover this distance at different times of the
year, which would shed light on the road conditions and availability of transportation. The same study found that out of all the Mru study villages only 6.7% were in close proximity to a medicine store.

The people of Kawringpara do not go to doctors; instead they buy medicines themselves at the drug stores that are located in the bazaar. Usually the karbari is given money and asked to buy the medicine on the bazaar day. Women gave their inability to communicate with health providers as one of the most important reasons for not going to the hospital. The hospital staff is dominantly Bengali. It is true that the Mru women have very little contact with their Bengali neighbors, which explains why they do not speak Bangla. Mru men, on the other hand, speak some Bangla and could be of help to their wives if they need to go to the hospital. But for one spouse to go outside the village for the day (that is the minimum amount of time it will take to go into town and come back), the other spouse has to stay home to look after the children and feed the animals. But Mru women do not go to the hospital if they can be taken care of at home, whether they are ill or in labor. Delivery is an event that has to be kept private, because it is considered to be shameful to be seen in labor. Because of the notion of shame the Mru women wait until the last minute before seeking help from biomedical health providers. Unless it is clear that the life of the woman is in grave danger and that the sra and petsra cannot do anything about it, the doctor will not be called (like in the example given above). Transporting the woman from the village to the hospital is practically impossible. Because the Mru live in hard-to-reach areas and often on steep hills, it is difficult to imagine that a hospital doctor or nurse would undertake such a journey, particularly if it happens during the monsoon season or at night.

Despite the difficult access to health facilities, the Mru in the study village did not have any medicine in stock in their houses. Only if it is decided that medicine is needed for a given illness, it is bought and used immediately. This is again because of lack of funds. Furthermore, the medicines are sold not by packages but by tablets. The owner of a medicine shop would make the diagnosis and prescribe the medicine and the length of treatment, and sell only the prescribed number of tablets or capsules. I also learned that
these medicines are not only painkillers but also antibiotics. A man in the village cut his foot with a knife and had a minor infection which caused him pain when he walked. He asked karbari to get him some medicine from the bazaar. The karbari described the situation to the shopkeeper, who gave him two kinds of medicines. When we went to the men’s house to interview his wife, he showed us his foot and the medicines. One was an analgesic and the second one was an antibiotic. The analgesic he was told to crush and apply to his infected cut whenever he had pain and the antibiotic he was to take by mouth for three days. When I asked the man if he knew exactly what the two medicines were and what was the difference between them, he said that all he knew was that both medicines were against pain.
4. METHODOLOGY

4.1 Theoretical approach

I started this thesis with what Geertz calls “thick description” (1973) of a particular situation. By describing how I convinced Shim a to come to the doctor with me and what happened during and after the hospital visit, the Mru women’s health seeking behavior and their beliefs concerning modern Western health care are introduced. I then tried to further describe the Mru health seeking practices and my interaction with them with as much detail as possible. This thesis will try to provide an emic view of the Mru’s perception of health and health seeking behavior.

For the illness framework, I use the naturalistic and personalistic explanations of illness, a classification first formulated by Foster in 1976.

In my analysis I will look at the lowlands of Alikadam as the periphery of the modern western medicine (practiced by Bengali government and private allopathic doctors) and, the Mru hills as its frontier as suggested by Streefland (1985): “We may call the geographic areas of concentration the core areas or center(s) of medical systems and the remaining areas their periphery.” The frontier of a medical system he defines as “…that part of the periphery where the presence of the system is increasing.” Streefland used these definitions to describe and analyze the spreading of modern Western medicine (or what he called later Cosmopolitan medicine (1994)) in Nepal and its relations to other medical systems. Given the similarities of the situation in the hills of Nepal to the Chittagong hills of Bangladesh, I will use the same explanatory framework. Streefland points out, that contextual factors play a significant role in the degree of presence of modern Western medicine in its frontiers. Among other factors he talks about the role of missions and other expatriate and local private organizations, the role of migration and tourism, the ethnic, religious and class composition of villages and, geographical conditions. I will draw some parallels between the contextual factors shaping the
situation on the frontiers of medical systems in the example of Nepal and the CHT of Bangladesh.

4.2 Time and location of fieldwork

The fieldwork was conducted in the first two months of the 2003 monsoon season (May and June). The heavy rains and storms make it difficult to reach Mru villages as the rains wash out the little mud paths and make them slippery and dangerous to climb up and down the hill. This is also the period when malaria is widespread and it is advisable to take malaria prophylaxis. The months of May, June and July are also the last three months before the Mru harvest their annual rice, and during which many families run out of rice. This is a very busy period for the Mru as they have to work hard to ensure a good harvest and, at the same time, try to find ways to earn a little money to buy extra rice from the bazaar.

For the selection of the village I took advantage of a bilateral assistance project\textsuperscript{13} survey of tribal settlements several months earlier. I added some specific questions to the survey questionnaire on the presence of pregnant women in these paras (settlements) and their expected date of delivery. I identified a village close enough to the town of Alikadam, for reasons explained in the section Ethical Considerations, which had a pregnant woman with the delivery falling in the months of June and July. The fieldwork was conducted in the village I will call Kawringpara.

Although I realized that my study sample might be small, I decided to concentrate on only one village for the following reasons. The Mru, unlike the Bengalis, are culturally very shy and private. From experience, I have learned that it takes at least a week for the people to get acquainted to strangers and feel more or less comfortable around them. At first I had to convince the people of the village that I was not a Bengali (only one of my assistants was) and that she had nothing to do with the government or the hospital.

\textsuperscript{13} The IOCH project conducted a 30-cluster immunization survey of 12-23 months-old children in the study area.
Furthermore, it was the season of hard work in the *jhums*, which meant that people were available in their villages only in the evenings. That alone had put limitations to my contact with the people. If I had chosen to work in two villages, I would have had to spend only half of my time in Kawringpara, which might have not allowed the people enough time to learn to trust me. I would also have to run the risk of missing the delivery. (I did miss the delivery any way but for a different reason explained later.)

**4.3 The Village of Kawringpara**

The village of Kawringpara is situated North-West of Alikadam on the top of a hill. Four years ago the village was located on a much smaller hill closer to the lowlands, but the inhabitants decided to move away because newly arrived Bengali settlers were killing their pigs as the “unclean” pigs of the Mru were perceived to be polluting the Bengalis’ rice fields. The Mru had to move to avoid conflicts.

In Kawringpara, there are eleven households in the village with seventy inhabitants. Twenty-three are male and forty-seven are female. Only twenty people fall into the childbearing age group of 15 to 49 years old. There was one pregnant woman in the village, whose pregnancy term fitted the same time period as this stud. Her name was Sheila and she was near term at the time of the fieldwork. Nine out of the fourteen adult women with childbearing experience agreed to be part of the study. Three of the women didn’t want to be part of the research and two young women were not allowed by their mothers in law to be distracted from their daily work. In addition to these nine women I had interviews with the TBA (*petsra*) from a different village, who usually is called upon when women go into labor in Kawringpara, as no recognized TBA resides there.

**4.4 Tools**

A review of literature was undertaken during the writing of the fieldwork proposal. Prior to the start of the fieldwork more documents were reviewed at the ICDDR,B library in
Dhaka and added later on in the process of writing the thesis. All references are included in the Bibliography.

Briefings were organized with the Union Health and Family Planning Officer (UHFPO) of Alikadam and other hospital staff members on the purpose and methodology of the fieldwork before going into the field. It was agreed that a summary of the findings would be shared with the UHFPO.

Data on conception, pregnancy, birth and general health seeking behavior were gathered through FGDs, informal conversations, open-ended semi structured interviews and participant observation. Because people were not always available interviews took place only in the evenings and on Mondays (the weekly day of rest) during the day. A total of seven FGDs took place because women agreed to hold them only on Sunday late evenings (the next day was not jhum day). At the beginning of each FGD women were asked questions (Annex II) and the discussions were allowed to go on matters women were most comfortable talking about but were re-focused, whenever necessary. The study was focused on the experiences and perceptions of Mru women. It took some effort to make the men understand that the FGDs were intended for the women only. It was particularly difficult to make the teenage boys leave because they were very curious to listen to women talk. After several explanations the entire village accepted that these tea evenings (organized by the researcher) were about women’s matters and that all men had to leave right after drinking tea with chanachur14. Later in the fieldwork the women expressed satisfaction at having regular Sunday discussions over tea because these brought a change to the weekly routine and provided opportunities to chat.

When we started conducting interviews, women were not very comfortable answering multiple personal questions. After being given numerous opportunities to ask my assistants and myself questions, the women felt much more at ease to talk about their experiences and knowledge of conception, pregnancy and birth. The fact that one of my assistants and me had children played an important role in talking about childbearing.

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14 Spicy snack food, very popular in India and Bangladesh, usually offered with drinks
The conversations soon became more like exchange of experiences. During individual conversations and FGDs women often answered my questions with questions of their own or would ask “What about yourself?” After a couple of discussions, women volunteered information or pointed out points for discussions that could be of interest. For instance, they had heard from some foreigner that women abroad carry their children only five months, after which the baby is put on oxygen. These same foreigners told them that foreign women don’t have to go through the normal process of childbirth because the doctors “…do everything for them”.

In the village, Mondays are the days off and are spent at the bazaar or visiting relatives. This was the day when most of the women could be found and interviewed. Women were reluctant to be interviewed in their own houses because of the presence of husbands. Thus conversations took place either inside the house when the husband was not present or outside if the husband was home. A total of twenty six interviews took place.

During FGDs published and unpublished photographic work was used to initiate discussions on changes in the Mru culture and customs. The researcher used her own photographic work of the previous years as well as the book of Brauns and Loffler (1990).

Hypothetical situations were given to women along with questions and the answers clarified and discussed (see examples in Annex II). The researcher had to make very clear that the situations were hypothetical and only for the purpose of getting an idea of the women’s views and choices. One of the women asked if we were asking those questions because somebody was planning to build a hospital in their village.

Interviews and FGDs were recorded with the permission of the women. On one or two occasions, during individual interviews women did not answer the researcher’s question, when asked if they didn’t want to be recorded. This was taken as a negative answer and only notes were taken. Notes of main points were taken also during the recorded discussions.
4.5 Research Assistants

Although the researcher had a basic knowledge of Bangla, it was necessary to recruit an assistant for the translation from Bangla to English and English to Bangla. A young Bengali woman was recruited. After three days of field work she asked to be allowed to leave. Unaccustomed to climbing hills and the living conditions of the hill people she found it impossible to continue the work for a month and a half. After several days the researcher was able to recruit another young woman, who happened to belong to one of the ethnic minority groups of Bangladesh, the Garo. A first-year anthropology student from the Dhaka University, Sharon found the fieldwork of great interest and did her part very well.

Two Mru women, Ruychum and Chamrum, did the Mru-Bangla translation. Ruychum got sick with malaria and had to be taken to the hospital and brought home within the first week. Chamrum replaced her and her skills as well as her childbearing practice proved to be of great help to the field research. Ruychum joined us again three weeks later and worked on the verification of the translation by listening to the recordings. This was found to be very useful with FGD recordings. When several women speak at the same time, the interpreter may pick up only some points and leave out others.

5. ETHICAL CONSIDERATIONS

Security is tight in the CHT. After receiving an official authorization from the DC to enter the CHT, every foreigner is accompanied by a police escort consisting of seven or eight policemen to enter the villages. To avoid being given police escort, we selected one of the closest villages with a pregnant woman. Because of a history of conflicts between the ethnic minorities and Bangladeshis and, because the Mru are very shy and are very slow to get friendly with outsiders, the presence of the police would have made it impossible for the researcher to gain the trust of the community and would have influenced the outcome of the fieldwork.
My two assistants and I met the karbari of the para in the town of Alikadam on one bazaar day. We explained our intentions and the purpose of the research. We asked for his permission to conduct the research in his village, which he kindly granted us. We agreed on the day for our arrival in the village and Kawring karbari said he would talk to the pregnant woman and her husband to ask permission for us to live with them.

On the day of our arrival we moved into the house with the pregnant woman. We introduced ourselves to the villagers later that evening at a community meeting. We explained the reason for our presence and the purpose of the research as well as the methodology involved. We also made it very clear to the women that they were free to refuse to be part of the research or withdraw any time they wished.

Consent forms were read to the women and translated (see Annex I).

My assistants and I were given permission to be present during Sheila’s delivery. We kept close to her as much as we could and did not let her out of our sight for long. In the end we could not attend the delivery because one of my assistants got sick with malaria and I had to take her to the hospital. As the assistant was a young Mru woman from a different town and with no relatives in Alikadam, I stayed with her to make sure she received proper care and was brought safely home to her family. Sheila delivered during the same evening we spent in the hospital.

6. RESEARCH QUESTIONS

Culture is dynamic and prone to change but some components are undergoing faster changes than others. I had initially considered studying the changes in the Mru women beliefs and practices related to childbearing. My earlier experiences at the government hospital of the interaction between Mru women and the health staff and patients were a revelator of what should be the research questions. Although Mru women are still the focus of my research, I now explore the Mru women’s health-seeking behavior and the reasons for their non-utilization of the government health services.
The government health services in Alikadam do not exist in a cultural vacuum but are “over-determined,” to use a Freudian concept. In this case, the government health services happen to: a) Use a western allopathic understanding of pathology, etiology and treatment; b) Be operated by health staff from a different culture that has its own values, its own perception of what is to be respected and not respected, what is development, what are the criteria to be considered civilized, etc. and c) Be associated with the Government of Bangladesh that has a 20-year history of oppression of the minority groups of the Chittagong Hill Tracts.

I will therefore attempt to dissect the determinants of Mru women’s attitude towards the health services offered in Alikadam to better understand what it is that they are rejecting. Are they rejecting Western allopathic treatment specifically? Or would they reject any alien health system? Is it useful, as an approach, to dissociate the most obvious benefit of the “other” health services (the medicines) from the system that provides it? Is it possible that Mru women accept the allopathic tablets or ointments when they are obtained in a non-threatening context (like in pharmacies) but refuse exposure to the health institutions because of negative experiences of being abused because they are illiterate Mru? Is there an additional dimension at work, i.e. a different understanding between two cultures of what illness is and what is treatment?

I hope that my exploratory fieldwork and the written thesis will contribute to a better understanding of a community seldom studied, and often misunderstood, by Bangladeshis and foreigners.
7. FINDINGS

7.1 PAIN AND ILLNESS

Illness explanations often vary from culture to culture. In the same way, the ways considered acceptable for curing illness in one culture may be rejected by another. These differences can be broadly generalized in terms of two explanatory traditions – naturalistic and personalistic.

The naturalistic explanation of illness is based on the assumption that illness occurs due to impersonal causes, such as micro-organisms, unbalanced body fluids, and injuries, which can be understood and cured through scientific methods.

The personalistic explanation is based on the assumption that illnesses are caused by the intervention of other people or supernatural being and forces, such as spirits. The Mru are one of those societies, which give a personalistic explanation to illness or other misfortunes.

At the beginning of the fieldwork, with the help of my assistants I familiarized myself with some Mru terms. Thanks to my knowledge of a few relevant terms, I realized that my Mru assistant was translating “to be sick” as “having pain” or “being in pain”. I talked to her the first time to explain that what she was translating was not what I meant. After a long conversation it became clear that in the Mru language “having pain” or “being in pain” is “being sick.” After making this important discovery, I asked the women to list all illnesses that they knew of or had suffered from.

“There is rau (pain) – back pain, stomach pain, head pain and other pains. There is pikrau (fever) and, there is tosher (diarrhea).” Despite further inquiries, the list ended there. Pain, fever and diarrhea are the only three conditions that Mru women define as illness. Spirits are responsible for inflicting these conditions on adults and children. Different spirits exist – Setsee, the spirit that lives in gorges and ravines, Amarnam, the spirit of the

*Rau* (pain) can affect adults and children, but most often it is the elderly who are affected. “*We, the old ones, always need medicine for pain because we have pain more than others,*” said Sheila’s mother.

There are different categories of pain, depending on which part of the body is affected. The treatment however is not different if it is a headache or foot ache.

In many cultures, because pain is seen as only one type of suffering within the wider spectrum of misfortune, it is *linked* with other forms of suffering in a number of ways. These include having a common cause (such as divine punishment or witchcraft), and therefore requiring a similar form of treatment (prayer, penitence or exorcism). (Helman, 2001: 130)

This is certainly true in the case of the Mru. Pain is treated the same way as other conditions because all illnesses are inflicted upon people by spirits.

*Pikrau* (fever) literally means skin (*pik*) pain (*rau*), because of the burning sensation to the skin. One of the village women explained that when children suffer from fever, it can turn into *ramklaa*. She explained, “*Ramklaa is when the child is not moving and looks like if he was dead but is not. Girls can get ramklaa up to five years and boys up to seven years of age.*” Often adults and children with fever sit by the fire and drink hot water as part of treatment for *pikrau*. “*Our doctor is hot water and our medicine is also hot water*,” explained one woman.

*Tosher* (diarrhea) can affect anybody but the source may differ. One of the women mentioned teething in young children as a reason why they have diarrhea. In adults diarrhea can be caused by incorrect diet. After delivery, a woman is not allowed to eat anything but salted rice and hot water. Anything else would give her diarrhea and “*…when she eats rice, it will go straight out of her and she will be very weak.*” The
relationship between rice and physical strength came up many times in our conversations about health, illness and diet. Strength and weakness are assessed by one’s ability to work, so the old and the very young are considered to be weak. Spirits are more likely to inflict pain, fever or diarrhea on the elderly and the very young.

A person suffering from any of these conditions usually goes for help to a sra (see diagram on p.41). Informants mentioned two cases of ill people who went to see the hospital doctor. One of these was a man suffering from diarrhea. The man was brought to the hospital after his attempts at self-medication through taking drugs and doing natt failed. But as Sheila’s husband concluded, “We brought him to the hospital but he still died.”

The second case involved the previous wife of Sheila’s husband during her pregnancy. In the words of the petsra and her assistants, “The woman had only three contractions and after that nothing happened. Only the tip of the head of the baby came out, so I couldn’t even pull the baby by the head. I couldn’t get a grip... My helpers pressed on her belly but even that didn’t help. After that the woman’s belly started swelling more and more. The sra brought some pahari medicine (a powerful herb that makes women deliver within a few minutes) that we tied around the woman’s belly but it didn’t work either. In the end we called the doctor and he couldn’t help her. A spirit caught the baby... It was in her destiny to die.”

For the Mru, allopathic health providers are a last resort. This also means that by the time an ill person reaches the health facility the illness is most likely in its advanced stage, and, perhaps too late for biomedicine to help. These occasional experiences with the hospital resulting in negative outcomes also reinforce the people’s doubts about the effectiveness of biomedical treatment. Moreover, like in many other parts of rural Bangladesh, hospitals become associated with death.
7.2 SPIRITS, SRAS AND PETSRAS

All societies have their own health-care system consisting of specific beliefs, customs, and practitioners that provide cure and relief. The Mru are no exception.

**Spirits**

For the Mru spirits are responsible for all illnesses. *Turai* alone can control the spirits. *Turai* is the Mru God, who controls all the spirits. *Turai* distributed languages, religions and cultures at the beginning of times. According to the Mru legend, he sent messengers to different people with laws and rules of life as well as alphabets and languages. To the Mru *Turai* sent a cow with his message written on a leaf. The cow got very tired, hungry and thirsty on its way and ate the leaf. The animal could not give the Mru the correct messages of *Turai*. Many things were lost and many others were wrongly perceived. That is why the Mru don’t have a written language and that is why their rice growing and harvesting is so different from other groups. For instance, the Bengalis weed once and harvest three times a year and the Mru weed three times and harvest only once. In revenge, the Mru celebrate the harvest with cow killing festivals every year. After the cow is killed with a spear, its tongue is cut off and nailed to the bamboo pole (Brauns and Loffler, 1990).

**Sra**

A society’s explanation for an illness is important in regard to treatment. If illnesses have personalistic causes, shamans, diviners, and other magic or religious specialists are involved. These specialists employ different techniques to find out the cause and treatment of the illness.

*Sra* is usually a man, who is knowledgeable in religious matters and the person that is called upon when an illness occurs. The *sra* consults his *pooi*. *Pooi* is an instrument in the shape of a small bow with a string made of cotton thread. It is used to determine which
spirit is responsible for the condition and what needs to be done to appease the responsible spirit and deliver the sufferer from his/her condition. The sra holds the pooi by the string with its wooden side hanging over the affected person or part of the body and a few questions are asked. Depending on the movement of the pooi, the answers are interpreted as yes or no. The pooi usually tells the people how many sacrifices are to be performed, where exactly and what kind of animal is to be sacrificed.15

While the sra consults the pooi, the ill person will take some allopathic medicines as well (see diagram p. 42). If the medicines do not cure the diarrhea, fever or pain immediately, it is decided that the medicine has no effect and more sacrifices are to be made. When a spirit is appeased or controlled by Turai it takes away the inflicted condition, therefore the effect must be immediate. That is why the Mru expect immediate results from medicines.

The Mru explanation for their simultaneous use of both, ritual sacrifices and allopathic medicines can be summarized in the words of the petsra, who said, “the spirits make sure that the medicine we take works. If the spirit isn’t happy, the medicine will not work.” One does not prevent them from using the other. On the contrary, performing natt not only may relieve the sufferer but also has power over the effectiveness of the medicine.

**Petsra**

In each culture, women skilled and knowledgeable on deliveries assist other women. A rich literature exists on the so-called traditional birth attendants and their role and status in communities (Laderman, 1983, Blanchet, 1984, Jeffery and Jeffery, 1993, Lefeber, 1994, Rozario and Samuel, 2002). Most of the studies done in countries like India and Bangladesh have documented that the process of birth itself is considered to be polluting. Since TBAs have to deal with culturally defined “unclean” services, such as removing the

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15 Evans Pritchard describes similar practices in his work on the Azande. The pooi can be compared to the oracles (19).
umbilical cord and the placenta, cleaning the baby, the mother and the place where the delivery took place, they do not enjoy a high status in many societies.

Petsra is usually an elderly woman who assists women during deliveries. Not every village has a petsra so each petsra serves two or three villages. The petsra has one or two assistants in each village she covers. These are older women who help the petsra during the “difficult” deliveries. This is the way women learn the trade and replace the petsra after her death or retirement. If the delivery is not fast enough or easy enough according to the petsra, these helpers usually put pressure on the woman’s stomach while the petsra sits between the legs and receives or pulls the baby. Helpers play the role of the petsra only if the delivery is too sudden or the petsra cannot assist for some other reason. In Kawringpara, there is one such assistant. Champa has been assisting in twelve deliveries over the last decade and is very proud that all twelve children are still alive and well.

Paume, the petsra from Saykopara helps women in Kawringpara and several other villages that are not far from her own village. Although Kawringpara is quite far from Paume’s village, she is still called upon when there is a delivery. This is because the two villages were initially located very close to each other. But four years ago, the inhabitants of Kawringpara decided to move further away.

Any woman can become petsra “if she doesn’t mind the blood and is not afraid.” Both, Paume and Champa belong to poor families in their paras. It can be said that poor women undertake the “unclean” responsibility for the income it brings. Normally, the petsra gets paid for her services. She receives her dues only after the baby is named. Sometimes the baby is not named immediately after his/her birth because the family can’t afford to pay the petsra and her helpers. In these cases it may take several months before the baby receives his name. In practice, the baby is given a name but he is not called by that name until the official day of payment. When the baby receives his/her name, a meal is prepared and the petsra and her helpers are invited. At the end of the meal the petsra will be given Taka 100, a chicken or a pig, a ball of cotton thread and, two bottles of rice
wheat. If the family cannot afford to give a pig, they may buy dry fish (shutki) on the bazaar and offer to the petsra. The helpers get a meal and Taka 20 each.

7.3 CONCEPTION AND INFERTILITY

Fate or fortune plays a determinant role in the life of the Mru. For a baby to be conceived the man’s tooy (the word is also used for water/liquid) has to be combined with the woman’s tooy. A couple’s fortune dictates whether they will have children or not. The fate or fortune of a person depends on Turai. Turai has power over everything, so if a couple cannot have children, this may mean, “… that Turai is not happy with the couple”. There is no way of finding out why Turai is not happy with them and there is nothing the couple can do about it. In the village, there are two families that are unable to have children. In both cases the women have been married before and have had children but were unable to conceive in the second marriage. They explained that it was the husbands who were infertile. As it was clear during the FGDs, the women of the village were convinced that when a couple is unable to have children “… if it is in the people’s fortune not to have children they will not have children even if they sleep together every night. And if such is their fortune the man is missing something in his tooy. That’s why they will not have children.” They were unable to explain what exactly lacks in the men’s tooy.

7.4 CHILDBIRTH

Pregnancy

The women said that they know they are pregnant when they stop menstruating and crave very spicy and sour food. Some pregnancies last nine months and others ten. When asked why and what determines the length of pregnancies, the answers were “it is the wish of Turai” or “that’s what is in my fortune”. These two statements came up numerous times as explanations of events or conditions. When I asked Sheila, how long she thought her pregnancy would last, she said,
“If it is in my fortune to have a nine-month baby; my pregnancy will be nine months, and if it is in my fortune to have a ten-month baby, it will be ten months.”

But she said she would prefer to deliver at nine months because “…at ten months the baby is bigger and more difficult to deliver.”

When talking about the baby’s exact location inside the mother, the women said the following: “The baby is inside the bai (placenta), of course. We know that because when there is a miscarriage, the bai comes out with the baby in it. We can see that in pigs also. So it’s probably the same with people…”

The how (amniotic bag) is thought to be a small bag filled with water, which is situated between the baby and the vagina. It is believed that part of the water that women drink goes into the how, which has to be broken to clear the passage for the baby to come out. The sooner the how is broken, the sooner the baby will be delivered.

Sheila has been married before but divorced her first husband. She had a child with her previous husband but the child died in infancy. Her current husband’s previous wife died in childbirth the year before. He has two daughters of fourteen and five years old and had hoped for his third child to be a boy. Sheila continued to work in the jhum till the last day of her pregnancy and said she had no restrictions in diet or activities. “Why should a pregnant woman not eat? She needs to eat a lot so she can be strong. She will need her strength on the day of delivery.” That is what I heard frequently from all of the women including Sheila herself, until one evening I invited her to drink tea with us. She said that she was not supposed to drink tea because it might make her delivery difficult. She could not explain to me why, but she said she would drink tea with us because she herself did not believe in what was just “an old belief”. Although I could not find out why tea was harmful then, I found out that after delivery she was not to take, among other things, anything that has a red color, including red meat or vegetables.

To identify what is allowed and what is not during pregnancy would have demanded listing or offering different kinds of products, a time consuming process, which was not
possible due to the limited time allocated for this research. Women didn’t mention tea, for example, because it is not part of their daily diet. The Mru don’t drink tea because for them it is a luxury they cannot afford. They don’t eat beef (except once a year during the harvest festival), eggs, milk etc. The normal Mru diet consists of rice, vegetables, fruits, and dry fish and, rarely chicken. It is therefore normal for them not to think of products which some of them have perhaps never eaten.

**Delivery**

“I think about it, of course. Will it go well or will I die?” reflects Sheila on her delivery.

The only preparations made for the delivery are a woven cloth, which will be used to carry the baby over the shoulder and glass bead necklaces for the mother to wear so the baby can hold on to these while breast-feeding. Sheila wove the cloth herself and her mother bought the beads on the bazaar and made the necklaces. Only one woman said that she brought home a piece of wood to support her back during the delivery. Deliveries usually take place in the inside room of the house on the floor. The floor is not covered with anything and is simply washed with water after the delivery.

The *petsra*, very often, begins by pinching the *how* (amniotic bag) with her nails to break the water to speed up the delivery. The *petsra* puts her hand inside the woman to determine the position of the baby as well as the time it may take for it to be delivered. Sometimes, she may have to pull the baby by the head or the chin to help the baby come out. After the baby is out, he/she is put on the floor and the *petsra* waits for the placenta to be delivered. If she feels that it is taking time, she will pull on the umbilical cord and if that doesn’t help she will hit the woman on the lower back a few times. If after pulling the umbilical cord and hitting the woman on the back the placenta doesn’t come out, the *petsra* pulls downwards the folds of the woman’s skin on her stomach. She may also insert her hand in”… *to clear the way that may be blocked by the bad blood.*”
The umbilical cord (*dayrooy*) is cut only after the placenta is delivered. The women explained that keeping the baby attached to the placenta prevents the placenta from going up into the back of the woman and causing her death. The *petsra* folds a cotton thread seven times and applies turmeric paste to the thread, which is then used to tie the umbilical cord. “*Petsra* puts all of the air into the baby before she ties the *dayrooy* and cuts it”. She milks the umbilical cord in the direction of the baby. It is believed the placenta contains air, which keeps the baby alive inside the woman and gives him/her strength after he/she is born. Then the *petsra* measures the *dayrooy* with her four fingers and cuts it leaving a four finger long *dayrooy* attached to the baby. She uses a sliver of bamboo to cut the *dayrooy* and the cotton thread. Paume, the *petsra*, talked about how difficult it is to use bamboo for the purpose: “*When I cut the cotton thread, it hurts the baby because the bamboo is not sharp enough. If I had a blade, the baby would feel no pain.*”

After the *dayrooy* is cut, she cleans the floor and puts the placenta into a basket or a plastic bag and disposes of it outside the village. It is either left hanging on a branch of a tree or just thrown away in the jungle to be eaten by wild animals. The *petsra* also told me that “…before people used to throw the bai under the house for the pigs and dogs to eat.”

Once the room is cleaned, the fire is lit and hot water is prepared. The new mother and child are given a bath and they take their place by the fire. “*After she drinks hot water she will have milk in her breast,*” explained the women.
Paume shows how she cuts the cotton thread around the umbilical cord with a sliver of bamboo.

The baby is not breastfed right after birth. The woman will wait until the baby cries. “Only after the bath, when he cries he will receive breast. But if he doesn’t cry he will not be fed,” we were told. We were also told that the woman has to wait until the baby cries even if it takes a day or two. In the meantime the mother will chew on some cooked rice and feed it to the baby.

The petsra is called upon only at the time of delivery. She is not consulted during the pregnancy or after the delivery. Her only responsibility is to deliver the baby, clean the room afterwards and, dispose of the bai.\footnote{Mru word for placenta}

If there are any complications during the delivery, the petsra sends somebody for the Sra. Then a course of actions is determined after consulting his pooi. In the village there was only one woman known to have needed the help of a Sra during labor.
A pregnant woman may not take any medicine by mouth as they say it may cause the death of the child inside her. The woman may receive an injection because the medicine given through injection does not harm the baby. In practice, Mru women don’t consult allopathic doctors when they are ill.

No other pregnancy related taboos were mentioned or observed and no rituals were performed. In cases of pain, fever and diarrhea the pregnant woman sees the sra, who consults his pooy as with other people and sacrificial rituals are performed accordingly.

The delivery that we missed

All the descriptive data on delivery were obtained from conversations with the women. As mentioned earlier, we were unable to witness a delivery due to my assistant’s illness. We had asked Sheila’s husband to let us know as soon as the labor pains start but he did not do so. When we returned to the village we found out that the delivery had taken place the evening before. As the customs dictate, we were not allowed to enter the house and our bags had to be moved into the house next door from where we could observe the house with the new born. Although we could observe the woman inside the house, we were not allowed to talk to her for three days.

We were told that labor pains started late at night and very suddenly and Sheila’s husband barely had time to notify the petsra and bring her to the village. We learned from the petsra that she was notified at the beginning of the afternoon and the baby was born only late that evening. Later on, it became clear that deliveries are considered to be shameful and very private events, during which only the petsra is present and, only if necessary, her assistants. This became clear during FGDs when the women were answering questions about a hypothetical situation, in which they had a choice between delivering at home and delivering at a hospital next door (in reality, the hospital is about two hours away by foot). Among other reasons shame was one of the most important ones. “We would feel ashamed to deliver in the presence of strangers. And what if the
doctor is a man? Even our husbands are not allowed to be in the room when we are in labor!” said one of the women.

**Postpartum care**

After the delivery, the woman is not to leave the inner room for several days. She will sit by the fire, drink hot water, take hot baths and put hot compresses on her stomach. Drinking hot water brings milk to the breast of the woman and keeps her healthy. In this case, hot water is used as prevention, but in other circumstances, it is also used as part of a treatment. It is very important for the woman to stay by the fire. Fire prevents the dirty blood (khoooy) from going up her body. Very often she is not to sleep more than an hour or two for fear that the dirty blood will go up. If khoooy goes up into the head, one woman told me, the woman might go mad. According to several other women “If khiyooy goes into the woman’s head her body and face will swell and turn white, her eyes will turn red and her head will spin. Then she will die after several days.” The woman must be extremely lucky to recover from this condition but the unfortunate ones will die, as there is no cure.

The fireplace in the inner room, where Sheila had to stay for three days. The blue hammock serves as the baby’s cradle. The black piece of wood in the wall on the right protects the mother and child from spirits.
The dirty blood, it is said, accumulates in the body from the moment a woman becomes pregnant. It comes out of the body after the delivery. Sitting by the fire dries the inside of the woman and drains it of the dirty blood. The fire and hot compresses also help the skin to “…shrink and go back to normal again.”

The petsra explained the reason why women stay isolated for several days after delivery, “After the child is born, the woman bleeds for several days. If she comes out of the house, men will see it, children will see it... It is a shameful thing for her. That’s why she should stay inside till she dries.” The women of the village gave more reasons, “Because the baby is too small to be taken out. If she [the mother] comes out, bad spirits will catch her and the baby. The woman needs to take rest and also she has to dry, stop bleeding.” To protect the woman and her baby from spirits a knife and the wooden part of Mru tension loom, called the sword, is inserted into the bamboo wall of the room where the woman had her delivery and is to stay confined.

“The woman has to sit by the fire and drink hot water, she should not eat salt, chilies etc. because it was decided so by the very old, a long time ago. That’s why we have to follow it. It is our tradition. Those are our laws. Like the trees have their laws. When a tree is cut, it grows back but when a bamboo is cut it doesn’t grow back, because that is the law of the trees. We, the Mru, have our laws just like the trees,” explained the petsra.

While the Mru woman stays inside the room no one except a female relative is allowed to come in for fear of bringing bad spirits in, which may harm the baby. Only the villagers are allowed to enter the house. The front of the house is marked with bamboo decorations to make it known that the house is “closed” to outsiders. However, those who do not belong to the village, but are present in the village during the time of the delivery are allowed to come into the house. But if, for instance, the parents or other relatives of the woman were not in the village when the delivery took place, then they would not be allowed to see the mother and her new born for several days. The definition of being an “outsider” is therefore determined by the physical location of the person at the time of delivery (inside/outside the para).
If the child is the first child, the woman has to stay in isolation for nine days and, if it is not, isolation will last only six days. However there is flexibility and the final decision on how many days should the woman stay in the inside room of the house rests with the TBA (*petsra*) after taking into consideration the family situation. Paume told Sheila to stay inside for three days only because with Sheila’s husband and stepdaughter working in the *jhum*, there was no one else to look after the household and prepare the meals. The younger stepdaughter (only five years old) did already a lot of work around the house but was not able to do everything. Similar practices of confinement have been observed by Van Schoor (2003) in East Timor and are present to varying degrees in other parts of South East Asia. Women are found to tie their abdomens after delivery to try and decrease its size in East Timor (Van Schoor, 2003) as well as other parts of the world. This practice is absent among Mru women. The size of their bellies is not an issue. In fact the large size of abdomens was something that struck me when I first visited Mru villages. Because the people obtain their drinking water from ponds of rainwater or streams, I attributed the size of the abdomens in both, children and adults, to worms. Rajput makes a reference to the unusually large size of the abdomens of Mru people he came in contact with (1964). Although he blames it on the diet by saying that it is a consequence of eating a lot of red rice and drinking of a large amount of water.

**Ritual Reintroduction of the New Mother Into Everyday Life**

It was five o’clock in the morning. We had to take our torchlight’s because it was still very dark. We climbed down the stairs and stood in front of the entrance to Sheila’s house, five meters away. Our hostess, one of the oldest women in the village, had some bamboo leaves and a large knife in her hands. She put the bamboo leaves on the stairs and waited for Sheila to climb down. Sheila came out of the house with her baby in her arms. Around the baby was the piece of cotton cloth with simple patterns on it woven by Sheila before the birth. The two ends of the cotton cloth were tied in a knot. This allowed the mother to carry it over one shoulder. This way the woman can breastfeed the baby and do other chores at the same time. Not a word was said. We were still forbidden to
talk to her, but I was allowed to take a couple of photographs, which I did. After walking on each leaf on the stairs, Sheila had to step on the knife. At the end of the simple ritual she picked up the knife and climbed back onto the terrace of the house. This was to protect her against spirits, outside the house. Knives and bamboo are often used for protection against bad spirits.

When the husband woke up later that morning, he removed the bamboo decorations from the entrance to his house, which signified that the house was now open. We visited Sheila later that morning to talk about her delivery. She was sitting by the fire in the common room with the baby on her lap. The baby was breastfeeding. While he sucked on his mother’s breast, Sheila put some ashes on his belly button. I also noticed that the baby had a thick black line drawn on his forehead. I asked Sheila what it was and she explained: “He doesn’t sleep at night. I put some black sooth from the kettle on his forehead to help him sleep.” When we started talking about her delivery, she said she was sorry we missed it because she knew how much we wanted to attend it. We assured...
her that we were happy just to hear about it from her and she didn’t have to be sorry about it. Despite my absence during the delivery the women of the village called the newborn “the one with the two mothers.” Every time we heard the baby cry women would tell me that my baby was crying. Sheila herself told me not to forget my baby after I leave the village.

When we left the village, Sheila’s baby still was not officially named. The family did not have enough rice for the wine and money for the petsra and her helper’s fees.

**Prevention**

During the discussion on miscarriages with one of the women, she said that before having her miscarriage a spirit appeared to her in her dream in the disguise of a Bengali man. The man was begging and she gave him a handful of rice. She knew right away what the dream meant. Two days later she started bleeding and by the evening she had a miscarriage. I asked if there was a way to prevent miscarriages once a woman had a dream with that meaning. She answered, “There is nothing you can do. If you are to have a miscarriage, you will have a miscarriage. What can you do?” This rhetorical question came up every time I attempted to talk about prevention even on the last day of my presence in the village. Before leaving, I spoke to Sheila about the benefits of vaccination for children. I asked her at the end if she was going to take her newborn baby to Alikadam for vaccination. She said the following: “If he is not sick, I will not give him medicine. Why should I give him injections if he is not sick?” The Mru do not make the distinction between using medicine for treatment and using vaccine for prevention, although the notion of prevention does exist in the Mru system of beliefs. The practices of isolation of women and their newborns, sitting by the fire, drinking hot water and bathing in hot water, food taboos after delivery are to prevent the woman and her child from being affected by spirits and from illnesses. The sacrifices performed in the jhum before the harvest is also a form of prevention. These are performed to thank the spirit for the cultivated rice, thus preventing possible harm to the harvest.

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17 On a similar belief in the Bengali culture involving bhut or spirit see Blanchet, 1984
Why don’t Mru women use biomedical doctors? (a factor)

Mru classification of illnesses

Pain  Fever  Diarrhea

Sra

Allopathic medicine bought on bazaar

Source of illness

Sacrificial rituals

Delivery related complications

Delivery

Petsra

Modern Western Medicine

When all else fails & condition deteriorates

Source of illness

Diarrhea

Petra

Delivery

Modern Western Medicine
8. NATT OR HOSPITAL: Are We Asking the Right Questions?

After shedding some light on the situation of the availability of health facilities, I am proposing that Alikadam sadar (the municipal headquarters of Alikadam upazilla) might be called the periphery and the areas of Mru settlements the frontiers of modern Western medical system as per definitions borrowed from Streefland (1985). According to Streefland contextual factors play a significant role in shaping the situation at the frontiers. In the case of Nepal he lists several factors, some of which could be applied to the situation in the surroundings of Alikadam. Let’s discuss some of these as well as other relevant to the Mru factors.

Geographical location and conditions contribute to the spread and use of a medical system. The topography and the scattered pattern of settlements (described earlier) in the areas of Mru residence make it quite difficult to have road communications between the lowlands and the hills. This, in combination with seasonal conditions (namely heavy monsoon rains), makes travel between the hills and between hills and lowlands sometimes impossible. If the sick person lives miles away from a health facility, he/she will turn to more accessible options. In this case it is normal that the heath facility would be looked upon as the last option.

Political economic factors are at play in the situation of biomedicine use in the CHT. Walking to the bazaar to buy medicines is much cheaper than transporting a sick person to the hospital. In addition to the transport, the cost of treatment also has to be covered. The Mru’s only source of livelihood is their jhum. They spend more than half the year working in the jhum. Most of what they grow is rice and it is for their own consumption. The little bamboo, tobacco, vegetables and fruits that they grow is also mostly for their own consumption. But they sell some of it to buy medicines, torchlight’s, batteries etc. An ordinary Mru family is always cash-short and does not have more than a few Takas in its possession. A poor family would not be able to afford transportation or treatment for a sick member.
An important role is played by multilateral and bilateral programs. An example of these programs is IOCH, a bilateral aid program, which conducted vaccination surveys and campaigns in particularly hard to reach areas in the upazilla of Alikadam. These hard to reach areas included the Mru inhabited areas. The campaigns provided vaccination to children and women as well as vitamin A capsules with the collaboration of the government health authorities (see Availability of Health Services in the Mru Areas chapter). The efforts were part of the Polio eradication program.

**Example of Vaccination Among the Mru: Why Low Use?**

Perhaps the only intervention that is delivered to the homes of people in most of the world is vaccination, the results of which may be a good indication and example of logistical difficulties and how widely biomedicine is accepted. Again, the difficulties of access contribute to the low coverage of vaccination in the CHT. The outreach vaccinators are not motivated enough to go by foot to hill paras. Their salaries are low and living conditions of the Mru and their practice of keeping pigs around the house are not acceptable to the Bengali vaccinators. The Mru do not come down to the lowlands to receive vaccination because they are not aware of the benefits of vaccination or its purpose to that matter. Vaccinators do not take the time to explain to people why children have to be vaccinated and the possible side effects that may occur. Fear of pain makes people avoid health service providers. In studies on vaccination it was shown that parents don’t get their children vaccinated because the injection hurts but also the fever or local reaction to the vaccine makes their children suffer (Chowdhury et al. 1999). The study cited above found that only 7.6% of children were fully immunized in the Mru study villages. The major reasons for non-vaccination were found to be parental unawareness (65.9) and vaccination providers not coming (18.7%). These two reasons also play an important role in the general health seeking choices of the Mru. Very often people are not aware what health services/treatments exist and if people are aware, these services are simply unavailable to them.
**Is Trust a Factor?**

In the context of Alikadam the class composition of villages does not play such an important role as does the ethnicity. The Mru being one of the smallest and least developed (in terms of degree of integration of modern technology into daily life), are looked upon as the least intelligent people by the largest ethnic groups. Their cultural practices and beliefs are subject to laughter and disapproval by the outsiders. As a result, the Mru are often treated in disrespectful ways ranging from the men being slapped on the buttocks in public\(^{18}\) and told to cover themselves to being blamed and/or shouted at by health providers. This brings me to the most important issue, the issue of trust.

Trust is defined by Gilson as a relational notion, which “generally lies between – people, people and organizations, people and events.” An important point made by Gilson is that trust is not equally distributed and it is easier for those with power and more resources to trust than those with fewer resources (2003). Poverty may have well shaped the Mru’s worldview but “… learning is important to the development of trust” (Gilson, 2003). Learning from past history and experiences play an important role in shaping the worldview of a people.

From the early years of the creation of the state of Bangladesh, the ethnic minority’s rights to the land in the CHT have been a subject of debate within the Government. The issue of land has been one of the reasons behind the conflicts that have become an important part of the history of the CHT in the past 20 years. To this day, the Mru, like many other hill people lose land to Bengali settlers (e.g. Kawringpara forced change of location). Minorities are uncertain about the situation of land rights because every new ruling party changes what was passed as a law by the previous ruling party. This breeds distrust towards the government and, by extension towards all institutions associated with the government, including health facilities and providers, who are almost exclusively Bengali. In other words, services provided by the same government that supported

\(^{18}\) Traditionally Mru men have only a loincloth on.
Bengali settlers to take over tribal land would not gain much popularity and trust among the so called tribal.

Streefland says that it makes a big difference for people by whom and how they are introduced to the Western biomedicine. “… those who come into contact with a medical system at its frontier, only get to know one specific “face” of it, depending on whom they meet and which services they get” (Streefland, 1985).

If this is applied to the Mru, then there is no surprise that the Mru, women in particular, do not use biomedical health facilities. First, it is being introduced by Bengalis through, mainly vaccination. And as we know, vaccination campaigns are surrounded with rumors of government plots attempting to sterilize minorities\(^\text{19}\) as well as unwillingness on the part of populations to undergo pain and discomfort. Second, in the example of the study village, the only known cases of people going to the doctors are those with a very negative outcome. If every time “doctors” go to their homes with injection and medicine is to secretly sterilize them, and every known case of hospital visit by a patient ended by his death, it is rather natural to avoid both case scenarios.

Pain or fear of pain is stressed by the Mru and it appears to be a significant reason why the Mru don’t seek help from biomedical doctors. Health personnel involuntarily inflict pain on patients, whether through injections, blood tests or cleaning of a wound. And if a treatment inflicts pain, instead of taking the pain away, it must not be curing but further harming. Treatment is supposed to take the pain away, not cause it. Even when it comes to labor pains, the petsra breaks the amniotic bag to accelerate the delivery process and reduce the amount of pain the woman has to endure. As pain is one of the categories in the Mru classification of illnesses, naturally pain, any kind of pain is to be avoided, reduced or treated.

\(^{19}\) The role of rumors in vaccination is again demonstrated in the refusal of the Northern populations of Nigeria to participate in polio vaccination campaign in early 2004.
Clearly the Mru see benefits in the so-called biomedicine. They buy medicine at the local market and use them regularly along with their own traditional ways of heeling. Then why are medicines bought on the market acceptable but going to the hospital is not? When a Mru person buys medicine on the market from a shop keeper, it is a transaction in which both parties stand on an equal footing. It is an exchange of money for the goods. The shopkeeper does not make the Mru feel inferior nor does he blame him for neglecting his health. In fact, the medicine may not even be for the one that purchases it and the real patient may never even enter the picture as very often it is the karbari that comes down for medicine. Weather it is the patient or somebody else, it is in the interest of the shopkeeper to have good relation with the client and make him feel at ease for him to keep coming back. Let’s look at the benefits in this situation from the Mru point of view. First, the patient doesn’t have to leave his house and go through the trouble of walking for hours to the lowlands. Second, the bazaar is a relatively neutral ground for everyone and no one feels out of place or in a foreign territory because everyone has more or less equal rights – exchange of money for goods or barter. Third, there is no blame, shame or aggression involved. Fourth, the shopkeeper is not really representing a medical system but like everyone else on the bazaar, he is selling a commodity – medicines. Therefore the Mru client can refuse to buy the recommended medicine, which means that he is in control of the situation.

Now, let’s compare this situation to that of Shima in the hospital. She enters a foreign for her territory – the hospital and deals with doctors and nurses that clearly represent the medical system and are aggressively defending and promoting it. Shima is being blamed and reprimanded and is exposed to a lot of pain and discomfort. In addition to the pain, Shima had to endure other humiliations. She experiences shame at being exposed to so many people at once, who witnessed her reaction to the treatment of her wound – a rather vulnerable situation. She was scrutinized by a crowd of people, who, she knows well, disapprove of her way of dressing, religion, even the food she eats. Shima had to lie on a bed to treat her leg while people walked in and out of the room, most of them being male. She was reprimanded instead of being offered compassion.
Before going to the doctor, Shima performed *natt* and applied medicine, which worked thanks to the rituals performed. She was not willing to go to the hospital but because I, a foreigner, was going to be with her, she hoped things would turn out different. Things turned out to be exactly what she was afraid of. Further more, the treatment itself didn’t prove to be effective. Shima was not in much pain before she went to the hospital. The treatment in the hospital caused her immense pain and the result was more pain and discomfort. Therefore this was another proof for Shima that the doctor’s treatment not only failed but also caused more harm, physically and mentally/emotionally.

In conclusion, it is clear that there are cultural barriers to Mru women use of biomedical health services. But the practical aspects of it are as important. The Mru’s geographical location and their lifestyle do not allow them to leave their homes for long hours. But a more important point to stress is that perhaps Mru women are not avoiding the so-called biomedicine as such. The delivery system and the provider but most importantly, the provider’s attitudes towards the Mru are the unacceptable issues. It is the system that is distrusted and rejected. It is therefore necessary to make a distinction between biomedicine and health services delivery system. It seems that for the Mru these are two different issues. And the acceptance of the medicines bought on the market can very well be explained by the fact that in this case it is possible to benefit from biomedicine without having to deal with the unfriendly system itself.

This study has lead to the following recommendations directed toward the government, NGOs as well as bilateral and multilateral programs:

1. Before implementing any interventions, Government and NGO health providers should obtain knowledge on cultural health beliefs and practices of groups as these may play a key role in determining their attitudes towards the interventions. Further research studies have to be conducted to shed light on the health seeking beliefs, knowledge and practices of the Mru as well as other groups of the CHT. The role of perceived or real pain in cultural acceptance of services should be recognized and dealt with.
2. Efforts have to be made at registration and training of TBAs and other traditional healers from ethnic minority groups, including those living in remote areas. Timing and location for these trainings have to be carefully chosen. It has to be kept in mind that people following the slash-and-burn agricultural system will find it impossible to leave their work during the jhum season. It is recommended that training sessions are held in the months of November – April because the workload is much less.

3. Because people don’t leave their villages when they are sick, efforts have to be made on the part of the Government and NGO health providers to bring health services and information to the communities. Knowledge of a service may very well improve its use. Health staff has to be encouraged to go to remote places and equipped with the necessary mosquito nets and antimalaria prophylaxis, given the endemicity of malaria in the area. Compensation for their hard work may encourage health workers to go these remote areas.

4. NGOs and the government should make efforts in identifying and training ethnic health workers and Mru-speaking individuals. This is very important in building trust and openness to what a friendlier health system has to offer.
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Introduction/Purpose: You are being asked to participate in a research study that is part of a Master’s degree course, which will enable better understanding of the childbearing practices and beliefs of the Mru women and their ways of dealing with reproduction related conditions before and now. You are being asked to participate in this study because you are a woman who has had a child or is currently pregnant, therefore has an experience and knowledge of practices related to childbearing. The purpose of this study is to understand the ways and reasons for the existing childbearing behavior of the younger women and that of the older women.

Procedure: As a participant in this study you will be asked a series of questions in interviews about your perceptions of the body, conception, pregnancy, birth, and infertility. The interviews will be audio taped. Your participation in this study is voluntary and interviews will be conducted at the convenient for you time and place.

Risks: There is a possibility that the interview might be overheard while being conducted.

Benefits: There may be no direct benefit to you by your participation in this research study. The study may aid in understanding the ways women deal with pregnancy and birth in your community.

Alternatives: You have the alternative to choose not to participate in this research study. No harm will come to you if you refuse to participate.

Confidentiality: Your participation in this research study will be confidential. You will be identified by number and not by name so that your identity and personal information will be kept as confidential as possible. However, there is a risk that your community members may overhear our conversations and this may lead to loss of privacy.

Unless required by law, only the study investigator, members of the investigator’s staff, the researcher’s advisors will have authority to review your study records. They are required to maintain confidentiality regarding your identity.

Your research materials of the interview and survey will not be directly linked to your identity. All research materials will be held in strictest confidence until the study is completed, at which point all research material will be destroyed.
The results of this study may be published or presented at scientific meetings; however, participants will be identified in these reports by number and not by name.

The researchers will keep information about you as confidential as possible, but complete confidentiality cannot be guaranteed. Your name will not be used in any published reports about this study. On rare occasions, courts have subpoenaed research records.

**Financial Information:** You will receive Tk.25.00 for your participation in each interview and FGD. It will be paid in cash upon completion of the interview or FGD.

**Subjects’ Rights:** Your participation in this study is voluntary and you are free to withdraw at any time. Participation or withdrawal will not affect any rights to which you are entitled.

**Contact Persons:** Any questions you may have about this study may be directed to the researcher, who can be contacted by phone at 988 08 94 or at the following address: House 99, Road 4-B, Banani, Dhaka 1213

**Consent**

I agree to participate in the research study described above. I understand that the interviews 5/23/03 will be audio taped. I will receive a copy of this consent form.

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Annex II

Example of questions asked during fieldwork in discussions with women. Some of the questions may appear leading, however they were asked only after the respondent brought the subject up or gave the information in answer to a previous question. Not all the questions were asked exactly in the same way as they appear below.

- How many children do you have?
- How many pregnancies have you had?
- What was the outcome of each of these pregnancies?
- How did the miscarriage occur?
- Why do you think you had a miscarriage?
- Is there any way to prevent a miscarriage?
- How old was you child when he/she died?
- Do you know what your child died of?
- What was done to cure the child/prevent his/her death? How it was done and why the choice?

Example of questions asked during interviews with the *petsra*:

- What is an easy pregnancy and what is a difficult one?
- Have you had to deal with a difficult delivery?
- If according to you the delivery is taking too long, what do you do?
- Why does the amniotic bag have to be broken and how do you do it?
- Have you ever had to insert your hand inside the woman during the delivery?
- How long do you wait before bringing the baby out?
- How exactly do you bring the baby out?
- Do you cut the umbilical cord before or after the placenta is delivered?
- Why must the umbilical cord be cut only after the placenta is out?
- What do you use to cut the umbilical cord?
- What do you do with the placenta after it has been delivered?
- What kind of problems have you encountered in your years of being *petsra*?
- What happened and what did you do? How and why?

Example of hypothetical situations used in discussions:

Situation:
Suppose this house next to yours is a hospital. You are pregnant and about to deliver.

Questions:
- Would you deliver at home or would you go to the hospital? Why?
- Would you call the doctor to assist you in your delivery? Why?
- If it was very easy to get the doctor visit and there were complications in your delivery, who would you prefer to call – the doctor or the sra? Why?
Annex III

Chittagong Hill Tracts

Legend
- District HQ
- Upazila HQ
- International boundary
- District boundary
- Upazila boundary
- Major road
- Rural road
- Water-bodies