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Health Seeking Behavior for Garo Children of *Madhupur*, Bangladesh

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Abstract

This master's thesis explores the health seeking behaviors for children in the Garo indigenous community of Bangladesh drawing on medical pluralism theoretical framework. The thesis is based on one month-long fieldwork in a northern village of the country, *Sainamari*. In this village, different health care systems co-exist: the scientific medical system (missionary clinics, pharmacist, hospitals, village doctors, clinics), the traditional herbalists (*Kabiraj*), the spiritual healer (*Khamal*), and the use of household treatment system like home-remedies. This study analyzes how the parents define illnesses and seek therapies for their children's health and use their indigenous cultural practices to health maintenance for their future generation. Although bio-medicine became the dominant model in terms of health care practices around the world, the Garo indigenous community still highly depends on self-treatments, like home-remedies and folk healers like the *Kabiraj* and the *Khamal*. The findings of this thesis contributes to the understanding of how the Garo people's child healthcare in Bangladesh works.

Keywords: health seeking behavior, Garo, children

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Glossary

Auto-Rickshaw -Tricycle with motor

Amwa-The ritual for healing for illness *Medti Kamor*

Atpolash-An herb

Bangfang- A symbolic deity which represented the *Ganchu Metdi*, used in healing ritual

Bangfang- An evil deity according to Garo traditional religion

Bazar-Small market

Bengali- The majority population of Bangladesh, also the language of Bengali people

Boshonta- Local term of chicken pox disease

Chepa-Basuli- An herb

Chikin Thappa- A kind of insect house

Chini Medti- An evil deity according to Garo traditional religion

Chu- Traditional rice juice or rice beer

Dai -Midwife

Dudhi- A symbolic peacock used in healing ritual

Dungas- Small offer plates made by stem of a banana plant

Eid-Ul-Fitr- Muslim religious festival

Esthi-The left over rice after making the rice beer, *Chu*

Fura -Rice powder

Ganchu- An evil deity according to Garo traditional religion

Gashanto –Herbal medicine

Gadaful-An herb

Hawasham- An herb

Jadu-Magic

Jasthi Modhu- An herb

Jhupri – A house made of mud and roof with straw/hay

Kabiraj -Traditional herbalist

Khamal -Spiritual healer

Kadam- Symbolic deities used in healing ritual

Kan Fota-A ritual with *Mantra* and herbs

Khasbandha-Treatment of Amulet

Kiring- An herb

Kali puja- A healing ritual for illness caused by water deity

Kutcha house- A house constructed with mud and tin roof

Ludu- An indoor game

Mandi- Local term of Garo indigenous community, also the language of Garos

Mantras- Special religious words

Maddak- Helper of *Khamal*

Mayla Kha- An illness where the child body get polluted by evil wind or evil spirits

Medti- Deity of Garo traditional religion

Medti Kamor-An illness which is caused by evil deity

Mendi-henna plant, An herb

Mimang Kacchi- An herb

Namaskar-Gesture of respect to deities

Nakthip- A place where the essential herbs and symbolic deities would be placed during the performance of the healing ritual

Nagdana- An herb

Neem- An herb

Owafak- Lamp used in healing ritual

Paras - Segments of village area

Pucka house- A house made with bricks and concrete

Pangshi- Instrument for diagnosis process made by many white threads hanging by a tiny bamboo bark

Pathorkuchi-An herb

Panipora-Healing water

Piri-Lower height wooden stool

Pardeshi Doctor- Foreigner doctor

Puja Pali- Prayer of traditional Garo religion

Rickshaw van -Tricycle

Torai – An illness where affected person get scared by seeing invisible spirits

Telpora- Healing oil

Thiborong Bigil- Jackfruit bark, an herb

Tulsi- An herb

Sangrarek- Garo traditional religion

Samsrok -An herb

Semi-*Pucka* house-A house built with bricks and the tin roof

Simmanea- The diagnosis process to find out which deity caused illness

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

It was a late afternoon in the *Sainamari* village of *Madhupur* in Bangladesh. I was conducting an interview with a mother of the Garo indigenous community, Nilu Simsang. We sat in front of her house. Nilu was telling me about a boy in her neighborhood who had been misdiagnosed by a doctor. This had led to an unsuccessful treatment afterwards. The boy's name was Thengrak, he was only 11 years old. The boy had broken his right hand falling from a tree. His elder brother, Tilok, had immediately taken him to the doctor in the town of *Madhupur*. There, the doctor had taken some X-ray pictures of the boy's hand and made plaster of Paris (POP). The doctor had told the boy's family that he had to keep the plaster for three months and they had followed this instruction. It had been nine months after they had opened the plaster. However, due to the wrong treatment by the doctor, the boy still could not straighten his hand, Nilu lamented. The boy was unable to use his right hand, which had greatly affected his education and regular activities. While narrating this about Thengrak she also shared another fracture-healing episode about her own son, who also had had a fracture after falling. She stated that during the previous year, her son Tarun had broken his leg when he had fallen from a tree. She said, 'I took him to *Kabiraj*, a traditional herbalist. *Kabiraj* examined the leg by hand and applied some *Gashanto* (herbal medicine) on my boy's leg. After two weeks, the boy was healed and started playing without any pain'. Nilu indicated that comparatively, Thengrak's family had made a wrong choice about their son's health by going to a doctor, instead of making use of *Gashanto*. Nilu Simsang told that the modern biomedical treatment sometime went wrong in which case using *Gashanto* would be harmless as it took less time to heal and also did not cost much.

This study seeks to explore the choices parents make concerning the health of their children and the different medical systems they use within the Garo community. The health and general well-being of children is one of the main responsibilities of the parents all around the world. Various health programs and intervention strategies are thus implemented both nationally and regionally to ensure the proper well-being of children. This objective is contained in the UN Millennium

Development Goals (MDGs) and several other UNICEF[1] programs. However, despite the advances made in biomedicine and the progressive development of traditional medical systems globally, many parents are faced with the challenge of making the best choices for the healthcare needs of their children. As shown by the two stories of health seeking behavior for the children in the narrative above, many Garo mothers think that *Gashanto* is more reliable than the modern biomedical treatment.

In Bangladesh, as in most developing countries of Asia, there is a myriad of healthcare systems and medical providers. They range from biomedicine based on Western medical practices provided either by the government or by mission centers to traditional and indigenous medical services provider by traditional healers and spiritualists, either within some traditional shrines or at private homes, to home remedies practiced by parents, based on their lived experiences and belief systems (Rahman et al. 2012). The people of the Garo indigenous community in the *Sainamari* village use alternative medicine or healing system which are more popular than modern biomedical treatments, because of several factors. As the society is matrilineal and it is coupled with its inadequate modern health facilities, realness as well as the livelihood activities of the community, many mothers try to make appropriate decisions concerning the health of their children in a very optimal way. Based on the nature of illness and the available resources, different healthcare systems, which I will discuss later, are utilized. The aim of this project is, therefore, to explore the health-seeking behaviors of the parents of the Garo community for their children of Bangladesh. Considering that the health care seeking behavior is the first step towards the cure of any health problem (Islam et al. 2009:62), this study will examine the various options available for parents to fulfill the healthcare needs of their children as there is no research about this issue.

1.2 Problem Statement

In Bangladesh, according to government census, there are twenty-nine indigenous groups which correspond to approximately 1.2 million people and represents 1.13% of the total population (Census Report 1991). The indigenous communities of Bangladesh are identified by different terms such as 'Tribal', *'Upajati'* (sub class), *'Adivasi'* (ancient people), ethnic minorities and *'Kudra Nri-gosthi'* (small ethnic groups) while the indigenous peoples are also identified by different

[1] The United Nations Children's Fund

names such as *'Pahari'* (hill people), '*Jumma'* (people who does tradition shifting cultivation or slash and burn cultivation, thus *Jumm*). There is no constitutional recognition of the indigenous peoples, in fact they are just known as the 'Backward Sections of Citizens' in the constitution of Bangladesh. There seems to be no exact figures regarding the number of the different indigenous inhabitants. The figures within official written documents about the number of indigenous groups in Bangladesh vary from twelve to forty-six. Reasons for this uncertainty of the exact number of indigenous groups include: the different ways of spelling the names of the indigenous groups, the categorization of the sub-groups as separate groups and also the increasing number of groups identifying themselves as indigenous (International Labor Organization [ILO] 2009). However, the ethnic communities themselves estimate the number of indigenous communities to be more than 45. Again, other scholars have identified the number to be about 73 indigenous communities in Bangladesh (Gain 2011). These indigenous people have distinct culture, language, values, rituals and health practices which are different from the dominant Bangladeshi culture.

Among the indigenous groups of Bangladesh, the Garo is a matrilineal indigenous community. In the Garo indigenous community, each Garo person belong to the kinship group of their mother. The daughters of the Garo family are given property through inheritance and the right to run the households. They live in the north-eastern parts of the country, especially in *Gagipur, Mymensingh, Netrokona, Tangail, Sheerpur, Jamalpur* and some others are in the *Sylhet* districts, closer to the Indian border (Burling: 1997). The Garo live on a territory near southern part of the Garo hills, most of which lies on the Indian side of the borders and the lowlands of *Mymensingh,* south of the Garo hills (Bleie 2005).

Although the people are called Garos, they prefer to call themselves '*Mandis*', which means person or people. In the *Madhupu*r forest area, a number between 15,000 to 20,000 Garo people live in the cities of *Mymensingh* and *Tangail* (Burling 1997). According to the 1991 census, the total number of Garo people is 64,280 but the Garo people state that there are almost 100,000 Garos in Bangladesh (Bal 2000). There is no more recent census about the current population of the Garo people.

Little is known about the origin of the Garo indigenous community. The inhabitants of *Madhupur* region suggest that their ancestors are from the Garo Hills of Meghalaya. However, there is no

record of the time when they settled in this area. There is evidence of Garo settlements in the *Madhupur* area in the early 19th century British record (Burling 1997).

The older Garo traditional religion was '*Sangrarek'* where have traditions to sacrifice animals in different festivals and rituals. The majority of the Garos now profess Christianity, with most of them in *Madhupur* being either Catholics or Baptists. The Christian missionaries influenced the Garos with new religion, education facilities and better medical assistance. The indigenous identity of Garos is now influenced by their Christian identity (Burling 1997). The lifestyle of the Garo indigenous community has changed a lot with the influence of Christianity and a higher rate of education. The majority of them are now leaving the rural areas to the capital city for better opportunities. The Garo community lacks a lot of social facilities including adequate and properly functioning healthcare facilities. They travel for a longer distance to access healthcare in the government hospitals in neighboring districts. Most of the Mission clinics around the community do not have proper medical facilities which is a problem affecting more the rural areas of Bangladesh (Gain 2011). Hence, most of them rely on traditional or home remedies for their healthcare needs. This study aims at exploring the choices parents make concerning the healthcare needs of their children. In particular, the study will examine the various factors that influence the health decision that parents make about their children health, the challenges they go through in accessing healthcare for their children, as well as the effectiveness of the different medical systems they use when seeking healthcare for their children.

1.3 Objective and Research Questions

My aim in this study is to explore the different facets that contribute to child's health seeking behavior in an indigenous cultural context, which is not explored yet in previous research. To understand this broad objective, the following are the objectives the study seeks to achieve.

- To examine how Garo parents categorize different illnesses when seeking healthcare.
- To examine the options of treatment available for their children.
- To investigate the factors that influence Garo parents' choices of treatment options for their children.

In order to achieve the study aim and objectives, the following are the research questions to guide the entire study.

- How do Garo parents categorize different illnesses when seeking healthcare?
- What are the options of treatment available for their children?
- What factors influence their health seeking behavior for their children health needs?

1.4 Relevance of the Study

My study will investigate how parents take care of their future generation in terms of their health issue and the factors responsible for the choices parents make in this regard. This will contribute to the understanding of how the indigenous health perspective in Bangladesh works, especially in relation to the parents' role in child healthcare issues. From the indigenous perspectives, this research aims at helping to document their traditional way of health care practices and rituals regarding child health care. My hope is that the can be useful for the health system of Bangladesh and add new perspectives to child healthcare and hopefully to potentially influence the health system and policy, by encouraging medical pluralism. This project on health seeking behavior of the Garo children aims at providing knowledge about indigenous health issue in the field of indigenous studies, medical anthropology and similar studies, particularly in maternal and child health.

1.5 Thesis Outline

This thesis is organized in seven chapters. In the first chapter I define the background, problem statement, objective and research questions and the relevance to be addressed in the thesis. The second chapter addresses the conceptual and theoretical framework for the thesis. This chapter also presents literature reviews which are relevant to this thesis. In the third chapter, I present the methodological approaches with different primary and secondary data gathering methods. This chapter also deals with the data management, reflexivity and ethics. In the fourth chapter, I present the Garo village *Sainamari*, to give an overview of the field situation. The fifth chapter focuses on birth and illness categories of the Garo children. This chapter explains about the birth pattern, birth ritual, choice of different health care providers during birth etc. Also, I include the illness categorization in this chapter. The sixth chapter focuses on different health care providers including household treatment of home remedies, herbalists, spiritual healers and bio-medical practitioners. I also discuss here the factors that influence the choice of different health care providers. The seventh chapter contains the summary of findings, conclusion and further research perspectives.

CHAPTER TWO

CONCEPT, THEORY AND REVIEW OF RELEVANT LITERATURE

The way in which different societies see health and the ways they respond to ill health largely depend on their health beliefs, culture and the available health infrastructures. This chapter discusses the theoretical frame that underlie this study and how those theories and concepts help me to analyze the data, in order to present a clear understanding of the health seeking behavior of the Garo parents about the healthcare needs of their children. This chapter also presents a review of the relevant literature. Here, firstly I discuss the concept and theory before I present the review of literature.

2.1 Concept of Health-Seeking Behavior

This thesis uses the concept of health-seeking behavior. Noel Chrisman stated that 'the health seeking process' is the first step towards recognition of symptoms of sickness. The sickness symptoms and their interpretations are based on people cultural construct, which defines the normal well-being, the causes and contexts of sickness. Thus, people evaluate symptoms of sickness including dangerous condition of a patient from their cultural understanding and health beliefs (Chrisman 1978).

Health-seeking behavior refers to the process whereby people who are seeking medical assistance select the health care systems and practitioners. Information on such behavior is important for public health programs aimed at disease prevention and treatment. Health beliefs may influence treatment decisions; explanatory models alone are not good predictors of people's observed patterns of health seeking. This is because, as anthropologist has long noted, there is often a significant difference between cultural ideals- what people say they do -and real (observable) behavior (Peter J. Brown 1998)

In her article *theoretical and applied issues in cross-cultural health research* Elisa J. Sobo stated, household is the key unit which decides the therapy seeking outcomes when the members of the household become ill. Numerous factors may influence the decision of household such as resource allocation, care-provision, individual problem or relation of patient-healer (Sobo). The concept of health seeking behavior is thus a robust analytical tool which will guide me to investigate the

choices parents make as well as what factors influence those choices when seeking care for their children.

2.2 Medical Pluralism

The theory of medical pluralism has gained wider applicability within health care discourses across the world. Given the fact that different societies and their people have different etiological models where different medical systems have to be used in their care practices and processes, medical pluralism became essential. As Kleinman states, health care ‘described as a local cultural system composed of three overlapping parts: the popular, the professional and folk sectors’ (Kleinman 1980). So, medical pluralism means the coexistence of multiple traditions of medicine. According to Kleinman explanation these three overlapping parts can be shown in the following Venn diagram:

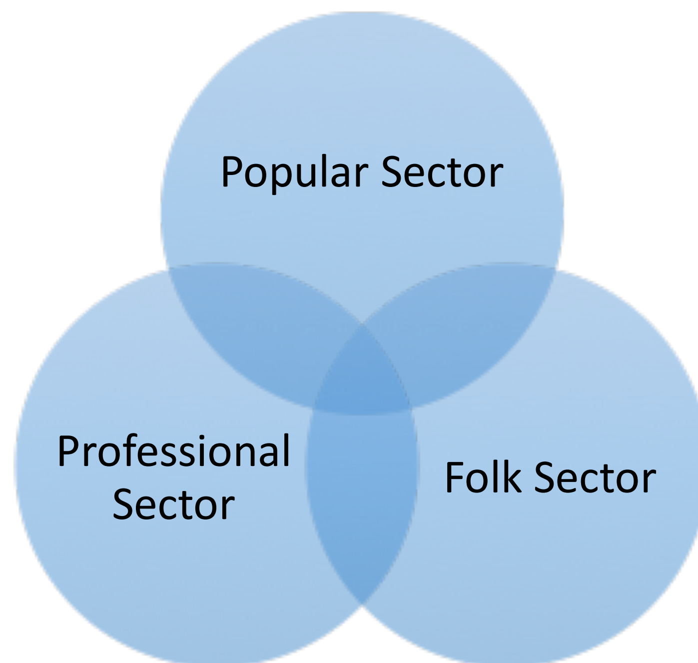

Figure 1: Venn Diagram of Kleinman’s Medical Pluralism (Oberhelman 2013)

The popular sector includes all the therapeutic options that people utilize, without any payment and without consulting either folk healers or medical practitioners. Among these options are self-treatment or self-medication, advice or treatment given by a relative, friend, neighbor or workmate,

or consultation with another person who has special experience in dealing with a particular disorder (Helman 2007).

The folk sector is especially large in non-industrialized societies; certain individuals specialize in forms of healing that are either sacred or secular or a mixture of two. These healers are not part of the official medical system and occupy an intermediate position between the popular and professional sectors (Helman 2007).

The professional sector comprises the organized, legally sanctioned healing professions, such as modern Western scientific medicine, also known as allopathic or biomedicine (Helman 2007). As Kleinman states 'so dominant has the modern medical profession become in the health care systems of most societies (developing and developed) that studies of health care often equate modern medicine with the entire system of health care' (Kleinman 1980).

As this study focuses on the cultural beliefs and practices in a plural setting thus the theory of Medical Pluralism is useful as it helps to understand the coexistence of multiple traditions of health care practices that parents combine to meet the healthcare needs of their children in the Garo community of *Sainamari* village.

2.3 Related literatures

In this subsection of the chapter, I present some of the literature related to this project and evaluate their relative impact on the analysis that I present later.

In *Culture, Health and Illness*, Helman (2007) provides an overview of a rapidly growing subject and demonstrates how different cultural, social or ethnic groups explain the cause of ill health and types of treatment they believe in. Culture is a set of guideline, which the members inherit from that particular society they reside in. This book also states that culture is not the only factor that influences our life and health. There are also individual factors (age, genes, and gender), educational factors and socio-economic factors. All societies have a number of ways of helping sick persons to help themselves or to seek help from others. Helman observed that for instance, people might try to cure themselves, consult friends, a religious authority, healers or a doctor. These healthcare options co-exist but can differ, in their origin, from each other. As my study focuses on the perceptions about ill health and types of treatment people believe in, Helman's perspective is very relevant because it gives the view of how culture and other factors influence human life and

their health seeking behaviors. The author's conceptions and analyses of issues though cut across varying contexts and backgrounds and it still offers me a stimulating and critical overview of the health beliefs, conceptions and situations elsewhere.

In examining the relative success of indigenous medical practices, in his article *Why indigenous practitioners successfully heal?* Kielmann (1979) discuss the various medical conditions indigenous healers provide medical services for. The author noted that the indigenous practitioners primarily treat three types of disorders: 1) Acute, self-limiting diseases 2) Nonlife threatening chronic disease in which management of the illness is a larger component of clinical management than biological treatment of disease and 3) Secondary somatic manifestations of minor psychological disorders and interpersonal problems. Kielmann asserts that the treatment of diseases plays a minor role in the case of these disorders but that as indigenous practitioners treat illness they are quite effective in these instances. The author concludes that what is needed in the modern health care system, in both developed and developing societies, is a systematic reorganization and treatment of psychological and cultural features of the illness.

Major A. Playfair, (1909) was the deputy commissioner of Eastern Bengal and Assam. He wrote a book *The Garos*. In his book, he gave a brief description about the habitat, origin, appearance, geographical distribution, domestic life, laws and customs, religion, folklore and language of Mandis. He also mentioned that there is a probability that Mandis may be related to Koch, Kacharis, Nagas etc. They have language and belief similarity. The book has become one of the most important sources of information and data about the Garos. Not only it contains a brief presentation of the Mandis, but it is also very important because it was written before the division of the subcontinent in 1947. Since it was written before 1947, it helps us a lot to know about the situation of the Mandis and their social, cultural and economic lifestyles before the division. Now the Mandis have lost a lot of their traditions, rituals, and customs, which as we are told, they had before the subdivision. The book is surely a very important work about the Mandis since it also contains information about their health issues and medical practices are also reported.

In the book, *The strong women of Madhupur*, Robins Burling (1997), focused on the entire Mandi society of Madhupur. He also tried to do some comparison between Rengsanggri and Madhupur. He found both similarities and differences between the Mandis of these two places. He noted gender discrimination in Madhupur, which he did not find in Rengsanggri. According to him,

'becoming educated was to become Christian. It was almost an inevitable step to becoming modern. One could stop being a Songsarek, but that did not imply that one would stop being a Garo.' (Burling, Robins: 1997). This book is relevant to this project as it shows the culture, religious syncretism of Garos and the position of woman in this matrilineal society.

In the book, *They Ask If We Eat Frogs: Garo Ethnicity in Bangladesh*, by Ellen Bal (2007), the researcher brought together the fields of history and anthropology. In this book, he examined the historical evolution of Garo the ethnicity in progressive parameters. In Bangladesh, the Bengalis comprise 98% of the total population and Garos form little less than 10% of the 'other peoples' of Bangladesh. This book provides a more comprehensive insight into how social life in Bangladesh has evolved and how the current discourse of tribal policy and healthcare issues have been neglected.

The research on *Antenatal and Postnatal care seeking behavior in a matrilineal society: a study on the Garo tribe of Bangladesh* conducted by Islam, Ahmed and Banowary (2009) provides statistical data with the analysis that antenatal and postnatal care seeking behavior among the Garo community is higher than the mainstream Bangladeshi society. The Garos are one of the few remaining matrilineal societies in the neighborhood. As it is a matrilineal society, the Garo women's decision-making power regarding their health issues, the high literacy rate and the availability of different private health service centers along with Christian missionary hospitals play an important role for the better health care of the Garo women than of the non- Garo women in the researched area. The work gives an overview of antenatal and postnatal care seeking behavior of the Garo women, which is highly central in the case of my study since antenatal and more particularly postnatal care both relate to child health and the role mothers play in this, the focus of my study different illnesses of children, treatment options, parents' decision regarding different health care providers, and combination of indigenous and biomedical treatment for the treatment of children's health issues.

In the article, *Healthcare-seeking behavior among the tribal people of Bangladesh* (2012) Rahman SA et al. provide insights about the health of tribal people of Bangladesh. The findings of the study suggest that the tribal communities may differ for their health needs from Bengali pre dominant population. This article mentions that traditional healers are very popular among indigenous communities of Bangladesh. The present health service system is largely based on needs and

priority of plain land population which is not favorable for indigenous people. This article is useful for my thesis as it shows different healthcare providers, reasons, choices among tribal people of Bangladesh including Garo indigenous community.

2.4 Summary:

In this chapter I focused on the conceptual framework, theoretical framework and the relevant literature review. This thesis is based on the concept of health seeking behavior and theory of medical pluralism. There are few books and articles relevant to my thesis topic which also presented in this chapter.

CHAPTER THREE

RESEARCH METHODOLOGY

Methodology 'refers to the choices we make about case to study, methods of data gathering, forms of data analysis etc. in planning and executing a research study' (Silverman 2009:110). This chapter will present the research methodology and my fieldwork experience. The chapter begins with narratives and descriptions of my initial preparation before my fieldwork and before accessing the community. It continues with a presentation of how I entered the field and how I established a relation with the Garo community to be allowed to collect the information through the direct contact with the community members using various information collection methods. I describe the methodological approaches and the various methods of indigenous studies primary data collection which I chose for my work. The chapter ends with the data management processes I went through, issues of reflexivity as a researcher and how I navigate the different ethical consideration during my research.

3.1 Initial Preparation and Accessing the Community

When I decided to work with the Garo indigenous community, I thought I should better use their native language during my research. Language is very important for culture as it influences the thinking, judgement and manners of the speech community (Chilisa 2012:131). In the Garo community most of the people understand Bengali (the native language of the majority population) but they also speak their own *Mandi* language, which they use for their day-to-day activities. So, for the comfort of informants and as an act of kindness to avoid forcing them to use Bengali language (a sign of respect and reflexive as well as an ethnical gesture) I sought the help of an interpreter. The interpreter, as well as my research assistant, Glory Ruram who worked in this project is a member of the Garo community but lives in the capital city as a Master's student of anthropology. I know her because she was my junior in previous university. For this thesis project I contacted her through Facebook from Norway. As Glory comes from the same community she helped me to find a household to stay in the *Sainamari* village. She helped me to get access to the Garo community as she had many kin relatives in that village. Although I took initial preparation like drafting a survey questionnaire, making interview guidelines, thinking of focused group discussion topics and other preparatory activities before fieldwork, I also shared my work with her

and asked for suggestions, as she is an anthropologist. At the same time, working with an insider research assistant helped me to understand the customs and community protocol of the Garo society and in many situations she guided me to make the right decision.

I wanted to document the interviews and observation of healing rituals so that I could use the collected data later on, when writing my thesis. During my Masters study I took an elective course on Visual Cultural Studies. However, even after this course I lacked competence and skills in filming and video making. Further, the community where I lived did not have electricity. I had to seek for help so that someone could handle the video camera and also to help to recharge the batteries and save the video documents on a laptop by staying in next village with electricity facility. As far as these technical issues are concerned, I had to ask for help to a friend of mine with the hobby of photography. He agreed to voluntarily help me with video camera. Before going to the village I rented a camera for video recording. After all these preparatory activities I started my field work on 17th of June 2015, accompanied by Glory and my friend Abdullah Al Sayem.

3.2 Building Up Relation with the People *Sainamari* Village

The *Sainamari* village of *Madhupur* is approximately 150 kilometers away from the capital city Dhaka. We were three people travelling to the *Sainamari* village that Friday morning, which is a weekend day in Bangladesh: Glory, Sayem and I. We traveled by bus, tricycle and motorbike. It was raining when we started the journey and there was also a huge traffic jam. So, it took almost a day to reach the village. It was helpful to have a male member in group because in Bangladesh it is not safe for women to travel alone.

When I reached the village it was night time. We were welcomed by Mrs. Linu Simsang who was going to host me for the entire fieldwork's period. She served snacks and tea to us. This was the first time to meet her and the family, since Glory had made the arrangements. I introduced myself to them and told them about my purpose of coming there and living with them. They also asked me questions about my family, place of living and few general questions. In the Bangladeshi culture it is very common to ask about family and general questions to guests, because kin ties are very important for a person's identity.

The household, situated in *Maddhapara* (center of village), was run by four sisters who are married and have children. They live in separate rooms and share one common yard in the middle and one

kitchen. They gave me their guest room to stay, which they usually used to host their relatives who come to visit them for few days.

The next day morning was my first official day in the community. I decided to see the village as part of the research process. Together with Glory and my host Linu Simsang we walked through the village. We obviously looked like stranger among the people and they were asking Linu Simsang about me. As a host she introduced me and told them about my purpose of coming and staying in the village. Before going into the field, I learned a few introductory sentences to communicate with them like *'Na me dangya ma?'* (How are you?), *'Baca reanga?'* (Where are you going?), *'Mitthela'* (Thank you) and their kinship terminology to address them according to their culture. First, I tried to get closer to the household members I was living with by sitting quietly when they were relaxing and chatting in the evening while having *'Chu'* (traditional rice juice or rice beer). I also had some with them and I took advantage to learn about their food preparation processes by sitting beside them in the kitchen, observing the procedure of preparing *'Chu'* or playing *Ludu* (an indoor games) with the young girls of the household, and sharing their food habits and daily lives. In the household where I lived, they treated me as a guest and they took care of me.

I observed that the village tea stall was a good place to interact with people and build up relation. There I met many people who asked me about my purpose of staying with their community. This offered me the opportunity to further explain them about my purpose of staying with them. At the beginning few of them thought I was a journalist, as they are used to see only journalists working by using a video camera. However, I explained them that I was a Masters student and a researcher. Most of the people were welcoming. Other members of the village also treated me as a guest of Linu Simsang as she introduced me to them.

After a few days, I started conducting sample household surveys with the help of a semi-structured questionnaire. This gave me an opportunity to interact with various household members and at the same time to get to know about their interests and willingness to participate in my study. To conduct the sample household surveys, I had to walk through the entire village. The village was quite big to be covered by walking. Some roads were so muddy that it was a challenge to walk on. After a week in the village the people started to talk to me and to get used to see me around in the village. Some started to invite me to their houses for food. I accepted these invitations to show respect to them. That is how I built rapport between me and the villagers of *Sainamari*.

3.3 Methodological Approach

In this study, I combined various research methods within anthropology and indigenous studies. The indigenous methodology seeks to decolonize research and re-center indigenous knowledge and culture into dominant research discourses in order to connect the indigenous knowledge with academic sphere (Clilisa 2012; Smith 2012). As argued, research methods are the tools used for gathering data and as such, they are important components of methodology of research (Chilisa 2012). My major research method was the fieldwork. Fieldwork methods are considered essential for this type of study since my aim was to gain a deeper understanding of child health seeking behavior among the Garo parents, different health care providers as well as to assess the actual behavior of the people (Jenkins 1994: 436; Keeing 1987:163).

During the first phase of my fieldwork, I went to *Sainamari* village of *Madhupur* in Bangladesh on June 17th of 2015 and stayed there until 7th July of 2015. I left the village for some days to celebrate the *Eid-Ul-Fitr* festival with my family. On the eve of this religious festival the roads become very busy and this caused a huge traffic jam, and also it would be difficult to get tickets for the bus during that time. Therefore, I left earlier with Glory and Sayem. We went back to *Sainamari* village on 25th July of 2015 and stayed up to 3rd August of 2015 for the second phase of the fieldwork.

This project is descriptive and explanatory in nature. Both primary and secondary data is used for this research project.

3.4 Primary Data Gathering Methods

Sample Household Survey

I conducted sample household surveys as one of the methods. The reason for this choice was that surveys would give the background data of the respondents and an overview of the health seeking behavior for the Garo children. In this sample household survey, the respondents were the parents of children aged around 0-12 years. This sample household survey was based on purposive sampling. Purposive sampling helps to select information based on accessibility, availability and willingness of the participants (Chilisa 2012:170). For this survey, the purposive sampling was used based on the availability of the household members. In total I contacted forty-six households, using a semi-structured questionnaire to obtain data about health issues of 120 children.

Interviews

Interviews were another method used during my fieldwork. Interviews allow participants to tell their stories. I conducted 16 interviews with the parents of children aged around 0-12 years and 9 interviews with different health care providers. The selection of parents was based on the information obtained from 46 sample household surveys data. As I got to know about the background of household overview of health issues through the survey, I did purposive sampling to choose parents from those households for the interviews. Through these interviews, I tried to explore the health seeking behavior for the Garo children in the *Sainamari* village. I used a semi-structured interview guide during the conversations. This interview guide helped me to narrow down the focus of my research and at the same time it allowed the informants to talk informally and more freely about their experiences. I also used purposive sampling for choosing different heath care providers and used separate interview guide to obtain information about their medical practices and the various illnesses they treat. All interviews provided data about the individual experiences, opinions, beliefs, relationships and feelings.

In total, I conducted interviews with 10 mothers, 6 fathers, 1 village doctor, 2 nurses of the Christian missionary clinic, 1 midwife, 1 *Khamal* (spiritual healer), 4 *Kabiraj* (traditional herbalist). Most of the interviews were recorded through the use of a video camera with the permission of informants.

Participant Observation

During my stay in the *Sainamari* village, participant observation was one of the methods I used to observe people's daily life and their activities. Asking about their lives, listening to them and participating in their daily activities gave me detailed knowledge about the community. Participant observation is noted to involve detailed, nonjudgmental, concrete descriptions of events and behaviors of people and artifacts in a particular social setting (Marshall and Rossman 2006).

Focused Group Discussion

Another method I used for data collection was focused group discussion which helps to obtain information on relatively unstudied topics for which the full range of relevant domains is not known and the dynamic interaction among participants is of interest. As a researcher I got benefit from the dynamic that is created through group discussion (Goldman & Borkan 2013: 3) This discussion enable researchers to examine people's different viewpoints in a social network (Barbour and Kitzinger 1999: 5). This method provided data about group dynamics and parents' perceptions

about the sickness of their children, actions they take concerning the condition of their sick children and their choices for different health care providers. I conducted one focused group discussion during my second phase of fieldwork with mothers. Limitation of this focused group discussion is the father was not present there. Also, I could not manage to do more than one focused group interview. It was difficult to gather the respondents at the same time. The focused group discussion took place in the church corridor of the village and after a Sunday service. Twelve mothers participated at focus group discussion. This focus group discussion also provided the opportunity to crosscheck the data gathered by in-depth interviews and validity of the data from the different perceptions of the same social setting in Garo indigenous community. Through the interviews, I got the personal narratives of individuals and during the focused group discussion; I got the various opinions from different people regarding child health of Garo community.

Key Informant Interview

Key-informant interview was used in my fieldwork although it was not pre planned before going to the field. According to Fetterman, key informant interviews are excellent sources of information and important session boarding for ethnographers (Fetterman 1989:58). During my fieldwork, the key informant, who was my host, a forty-four-year-old mother of three children. As she was born in the *Sainamari* village, she knew every family of this village. Fetterman also argues that a key informant is more than someone who possesses a lot of information about a culture and willing to talk (Fetterman 1989:166). My key informant introduced me to few households with children as her guest. She shared with me her knowledge that she had gained from her own experience and from her neighbors' regarding health-seeking behavior for children. Her key-informant interview was very helpful as she told me about the treatment options and how the parents choose different health care providers for their sick children, especially how the beliefs of parents determine the choice of various health care providers.

Use of Visual Data

During this fieldwork, I used a video camera to capture interviews and healing rituals. The use of the video camera helped me to gain visual and audio data and to observe more hidden details about the community life. This also helped me to make a short documentation of collected data. As there was a language barrier for me, the use of the video camera provided better documentation of data

for further observation after the fieldwork. I also took photographs to capture many moments during fieldwork as well as during my personal observation of the community activities.

3.5 Secondary Data Gathering Method

My secondary data came from different sources. I have used published academic articles and books related to my research aim, reports and other documents from the library of the university and from Bangladesh. Reviewing the existing theoretical books and journal articles on health seeking behavior for the children of Garo the indigenous community gave me an overview of previous research on this topic.

3.6 Data Management

To manage the data, I gathered during my fieldwork, firstly the recorded interviews were translated manually. I got help for translations of my interviews from a few young Garo people living in the capital city. Thus, these young Garo people have contributed for data management. This also helped me to cross check the data collected in the fieldwork. They helped me to transcribe and translate from the Garo language to Bengali language. Getting closer to these young Garo people living in the city also gave me other perspectives. The young generation who live in the city does not have the practice of using the traditional healing. They use only bio-medical treatments for themselves and their family members living in the city. But they know about the traditional healing practices of their community, although I did not think of that comparative perspectives in child health seeking behavior among urban Garo mothers.

The sample household survey, the transcribed interviews, the field notes of the interviews, observations and focused group discussion were all subjected to content and thematic analyses. I performed coding of the transcribed interviews to obtain the themes, concept of health seeking behavior for the Garo children and organize the data. Then I used data analysis incorporating them under a thematic heading, to form a basic topic which forms the findings of the study. The major analytical chapters are chapter 5, chapter 6 and chapter 7. As I used different methods to collect data about health seeking behavior for the Garo children, it gave me the opportunity to triangulate the data sources, to ensure the reliability and the validity of the data. As I used a video recorder as a method, I also made a short video clip that gives a visual display of my findings.

3.7 Reflexivity and Researcher's Positionality

Reflexivity is a concept that is used to help ensure that the involvement of the researcher is not a threat to the integrity of the study participants and their community (Chilisa 2012). As a female researcher, I was aware of the gender sensitive issues so I tried not be affected by gender biases. Accordingly, I got information from the male informants as well and tried to be non-biased in terms of gender issues. In this project, I read books and articles where indigenous people were pictured as primitive and backward people in the western knowledge system. But as a student of the Indigenous Master's program, I used the indigenous methodology and give proper recognition and respect to the informants and the community I worked with by first spending some days to build rapport with them, asking for their informed consent to video record their interviews and some healing practices.

Within the context of indigenous studies, the positions a researcher assumes could have some consequences on both the research process and as well on the research analysis and findings. As a Bangladeshi, I belong to the majority group and could possibly be seen as an outsider in the Garo community. I do not speak the Garo language. I am a female graduate student from the University of Tromsø (Norway). All these elements could possibly make me be perceived as an outsider by community members. On the other hand, I share the same nationality with the people. I was a woman who was concerned with how mothers make health decisions about their children health. I performed my fieldwork within a matrilineal society, where women have more authority and saying in how things are done in the community; I stayed with the member in the village: this possibly brought me closer to the people. However, as Linda Smith states "we have often allowed our histories to be told, and we have become outsiders as we have heard them being retold" (Smith 1999:33). Islam also assert that “due to extensive research undertaken in Bangladesh, people are distrusting of outsider visitors [with] the believe that reserachers are insterested in their own gain [but not] to improve the circumstances of the local people” (Islam et al 2015:90-91). Therefore, bearing Linda Smith's assertion in mind and in order not to make the Garo parents look like outsiders whose narratives are retold in my study, I engaged them through the use of various research technics.

3.7 Ethical Considerations

Ethics require that the researcher acts as a transformative healer with responsibilities towards others. These responsibilities involve application of theories along with four general principles of relational accountability, respectful representation, reciprocal appropriation and rights and regulations (Chilisa 2012). During this research, informants' informed consent was taken by informing them about the purpose of this research and they were assured that no harm would be caused by this research. They were also told that this thesis would be a document of indigenous health care practices which can be contribution to their revitalization. The confidentiality of the data was ensured by keeping participants anonymous, because they did not want their names to be known. I have used pseudonyms during my writing. No video record of any informant was taken without their permission. Informants were asked before recording their statement and only after having their consent, interviews were recorded. Moreover, the informants were given the opportunity to withdraw at any time during the interviews or in the process of research. Among the 25 interviewees, 4 of them did not want me to video record them, so I did not use any recording during those interviews. During the video recording of a healing ritual, there was a point when the healer and my research assistant did not want me to continue the recording, so I stopped the recording process according to their wishes. They did not want me to do the recording because they believed if I would video record from that part of ritual the patient would not be healed.

As a student, I followed the university ethical code regarding confidentiality of the information, respecting informants culture, personality and safe storage of the data. I also respected the local norms, rules and community protocol of the Garo community. Since this study is related to children, I took permission from the parents for taking photographs of children. The children were not directly involved as research participants, except under situations where they were going through some healing rituals that I was obliged to video tape, in which case permission was taken from both the healer and the guardian of the child.

CHAPTER FOUR

GARO COMMUNITY PROFILE

Like many other villages of Bangladesh, *Sainamari* is a quiet place with fewer inhabitants than urban areas of Bangladesh. The members of the *Sainamari* village mainly depend on agriculture for their economic income. The people of *Sainamari* love their peaceful life in the village, they do not like the busy and crowded urban life. The key informant Linu Simsang went to Dhaka, capital city to live with her elder daughter for few months. She explained how she felt about that:

> *'When I go to Dhaka, I feel suffocated. Everyone is busy and there is no one to talk to. I couldn't take a walk in open place to enjoy the fresh air like Sainamari. I belong to my village and I can't live in urban places.'*

This chapter covers the community background and profile of the search site. Here, I present the community geographical data and physical location as well as the community structure and layout. The demographic composition of the community, their social and economic livelihood modes as well as the basic social services available in the community are all discussed. This is to give detailed information about the Garo community and how some of their socio-economic factors may affect parents' health seeking behavior for their children. It will also give the overview of the village so as to understand their living style that has influence on their health situation.

4.1 Geographical location of village

The *Sainamari* village is located in ward number 1 of *Aranakhola* Union[2], *Madupur Upazila*[3] of *Tangail Zila* or district[4]. *Tangail Zila* or district is located in between 24°01' and 24°47' N latitudes and in between 89°44' and 90°18' E longitudes. *Madhupur Upazila* is approximately 150 kilometers away from the capital city Dhaka. It is bounded by *Jamalpur* district to the North, *Dhaka* and *Manikganj* districts to the South, *Mymensingh* and *Gazipur* districts to the East, and *Sirajganj* district to the West. *Tangail* district has 12 *Upazilas* and 110 Unions. Among the 12 *Upazilas* of

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[2] A union is smallest administrative unit comprising several villages.

[3] A Upazila is the second lowest unit of regional administration in Bangladesh comprising of several unions.

[4] The administration of Bangladesh is divided into 64 zilas or districts , each district comprising of several upazilas

Tangail, the *Madupur Upazila* is 370.47km^2. It has 6 unions and 171 villages. The total population of *Madupur Upazila* is 2,96,729 million people and has a total of 75,903 households. Out of this main population, ethnic population is 16,408 comprising of members of 13,599 Garo indigenous community, 285 Coach indigenous community, 2,369 Barmon indigenous community and 155 other indigenous communities (Bangladesh Population Census 2011, Bangladesh Bureau of Statistics). Figure 4.1 below shows the *Tangail* District in the map of Bangladesh.

Figure 2: The *Tangail* District in the map of Bangladesh

Source: http://en.banglapedia.org/index.php?title=Tangail_District (accessed December 2, 2015)

4.2 *Sainamari* Village Structure and Communication System

As I pointed out earlier, I had one focus group interview after a Sunday church service with some mothers. After the focused group discussion, I asked the women to help me mark the community structure on the ground as a way of mapping the village. The participants marked out important physical structures of village which included the map of the *Sainamri* village. They described the segments of the village. Minika Simgasang, the headmistress of *Sainamari* School, played a vital role by describing details of the village map. She was born in the village and had extensive knowledge about village structure. I also observed that she was a respected person in the *Sainamari*: she is active with church services, social activities and also an educationist. I drew on my notebook the outline of the map marked out on the ground while asking them to clarify the locations as they described and also to confirm that my sketch was right. Figure 4.2 shows structure of the village.

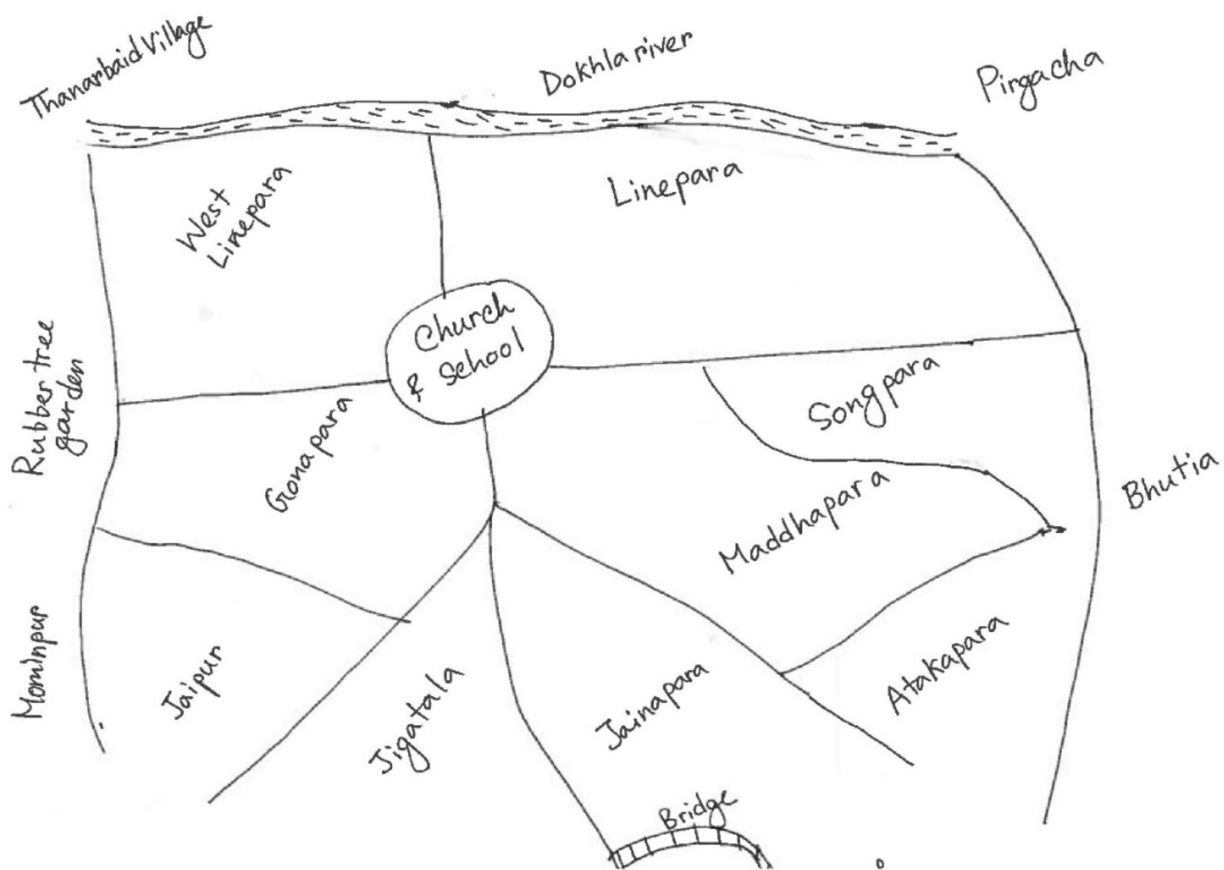

Figure 3: Map of the *Sainamari* village

Source: Obtained during fieldwork, 2015

According to them the *Sainamari* village has 9 *paras* (segments of village area) named *West Line para, Line para, Gona para, Maddha para, Song para, Ataka para, Jaina para, Jigatala, Jaipur* and *Gonapara*. At the North of the *Sainamari* village there is a river called *Dokhla*. The Northeastern part is called *Pirgacha* area and the Eastern is the *Bhuti*a area. The Northwestern section of the village is named *Thanarbaid*, the Western area has rubber tree garden while the Southwestern section is known as *Mominpur* area. Lastly, there is a bridge in the Southern section of village.

The distance from *Sainamari* to *Madhupur Upazilla* (nearest big town) is almost 16 kilometers and to *Bhutia* (nearest big market) is 2 kilometers while *Pirgacha* is 2.5 kilometers away. The main transportation from *Sainamari* village to those places is by the use of only motor bikes. The Bus or *Auto-rickshaws* (tricycle with motor) and even the *rickshaw van* (tricycle) cannot get into the roads of *Sainamari* because of the bad condition of the road. Thus, the cost of travelling is not very cheap for daily travelers; the cost per person for taking the motorbike to the nearest market *Bhutia* or *Pirgacha* is 50-70 BDT (0.58-0.81 Euro). The members of the village can hire the motor bike from the *bazar* (small market) in the *Sainamar*i. The *bazar* is the only place where villagers buy the products they need on a daily basis. It has tea-stalls, which are similar to a meeting place for gossip among the villagers. However, there are times their only means of transport, the motor bikes, are not available in bazar in which case the people have to call them through mobile phone whenever they need them urgently. If someone needs to go to the *Madhupur* town, they have to either go by motor bike or they can go from *Bhutia* or *Pirgacha* by *Auto-rickshaws*. The tricycle, however, will cost each person 150-200 BDT (1.73-2.31 Euro) for one way ride. If someone has to go to the capital city Dhaka, then the Bus is available only in *Madhupur* town. Each bus ride for Dhaka will cost 300-400 BDT (3.47-4.63 Euro) per person from *Madhupur* town.

The landscape of the region as well as the spatial distribution of communication routes and available means of transportation have profound impacts on the health seeking behavior of parents in this community. Apart from the difficulty in getting comfortable means of transportation during ill health, the cost of using the available of means of transportation to the nearest mission clinic is simply not affordable by everyone. Rahman have made a similar observation, when they assert that "transport cost, travel time, and distance were important barriers to healthcare seeking for rural

tribal members" (Rahman et al 2012). As a result, parents of *Sainamari* may be forced to use the available medical system within their reach to fulfill the healthcare needs of their children. This topic will be further detailed and described in the analysis chapter.

4.4 Demography

According to the population census of BBS[5]- 2011 the *Sainamari* village counts 1335 inhabitants, 695 of whom are males and 640 females. The population census does not have any separate figure regarding the number of Garo people living in the *Sainamari* village. Table 4.1 below shows the population distribution of the community.

Table 1: Population statistics about the Sainamari community

Category	Population
Male	695
Female	640
Total	**1335**
Household	313

Source: (BBS, Population census 2011)

[5] BBS is Bangladesh Bureau of Statistics

The percentage distribution of all the age groups of the population is shown in Table 4.2 below.

Table 2: Age percentage distribution of Sainamari population.

Age groups	0-4	5-9	10-14	15-19	20-24	25-29	30-49	50-59	60-64	65+
Percentage (%)	23.5	28.7	22.7	12.7	14.8	13.4	52.4	13.2	5.5	13.1

Source: (BBS, Population census 2011)

Population data of the Garo community in the *Sainamari* village gives a clearer picture about the Garo people living in the *Sainamari* community. The school headmistress kept a record of Garo population up to December 2014 which I collected during fieldwork. According to the the data obtained from school headmistress the total Garo population in the *Sainamari* village was 800 including 262 males, 306 females, 130 boys and 102 girls. The population of boys and girls was that of those under age 10 years. The distribution of the Garo population in the *Sainamari* community is shown in Table 4.3 below.

Table 3: Garo population in the Sainamari at December 2014.

Category	**Population**	**Total**
Male	262	568
Female	306	
Boys (0-10 years)	130	232
Girls (0-10 years)	102	
Household		142

Source: Record of Primary School Headmistress. Accessed 2015

As shown above population distribution of the Garo people in the *Sainamari*, children form about 29% of the entire Garo population. This statistic could reveal some interesting insights into child health among the Garo people although I did not pay much attention to that in this study. The percentage of boys and girls under the age of 10 is pretty important and this shows that my research regards a high number of people.

4.5 Employment and Economy

The majority of the population in the *Sainamari* village are involved in agriculture as their job. According to the BBS Population census 2011, 185 males and 146 female work in the agricultural field. Also, in this village there are 2 males and 1 female working in industry and 15 males and 5 females are engaged the public and private sectors. The distribution of occupation by population of *Sainamari* inhabitants is shown in Table 4.4 below.

Table 4: The occupational characteristics of Sainamari people

Agriculture		Industry		Service	
Male	Female	Male	Female	Male	Female
185	146	2	1	15	5

Source: BBS Population census 2011

The occupational characteristics of the inhabitants of *Sainamari* community shows that the majority of them engage agricultural activities most on subsistence bases, i.e. to simply survive and let their family have enough food. Even though agriculture is a lucrative business in most developed countries where farmers are among the wealthy people, the same is not true in developing countries, particularly among the rural inhabitants. These people in the *Sainamari* community are only able to produce what is enough for their daily consumption but not to make money. Accordingly, poverty is widespread among the Garo community; this is a factor which strongly affects ability to afford hospital treatment in case they need hospitalization or treatment. Rahman also found that comparatively low household incomes and dependency on cultivation as a major source of revenue, coupled with other factors are mentioned as the obstacles to seeking care (Rahman et al 2012:5).

4.6 Household Structure, Drinking Water and Electricity

The household structure usually shows the economic condition and living standard of a community. According to the BBS Population census data, only 0.2% of the inhabitants in the *Sainamari* village have *Pucka* houses made with bricks and concrete, 0.65% have *Semi-Pucka* houses built with bricks and the roof is in tin, 97.15% have *Kutcha* houses constructed with mud and roof with tin while 1.95% live in *Jhupri* made of mud and roof with straw/hay. The Table below shows the distribution of household type in the *Sainamari* community.

Table 5:Percentage distribution of households by their materials of construction in the Sainamari

Household type	*Pucka*	*Semi-pucka*	*Kutcha*	*Jhupri*
Percentage	0.2	0.65	97.15	1.95

Source: (BBS, Population census 2011)

According to the BBS, Population census 2011, in the *Sainamari* village most of the villagers forming about 82.3% drink water obtained from the tube-well. In my findings *Pirgacha Mission* has made a greater contribution by establishing the tube-well in the *Sainamari* village. Only 17.7% of the villagers use other sources for drinking water like river or canal. In the *Sainamari* village, there is electricity connection to about 23.4% households. In recent times, thus about 2-3 years back, many houses got solar electricity system in their households, but there were some limitations in its uses. The table below shows the distribution of general households Source of drinking water and electricity connection in percentage (%) within the *Sainamari* village.

Table 6: Percentage distribution of sources of drinking water and electricity connection in the Sainamari

Source of Drinking Water (%)			**Electricity Connection (%)**
Tap	Tube-Well	Others	
0	82.3	17.7	23.4

Source: BBS, Population census 2011

The sources through which the community inhabitants obtain their drinking water can also have some impact on the health of the people, more particularly on children. For example, waterborne

diseases like diarrheal disease are caused by unsafe drinking water. According to WHO[6] diarrhea kills around 760 000 children aged under five every year. It is also stated by WHO that diarrheal disease can be prevented through safe drinking-water and adequate hygiene (WHO 2013).

4.7 Summary:

In this chapter I gave a comprehensive picture of the Sainamari village of Garo indigenous community to understand the field situation. This chapter explored its geographical location, village structure, communication system, demography, occupation, economy, household structure, drinking water and electricity facilities etc.

[6] WHO is World Health Organization

CHAPTER FIVE

BIRTH AND ILLNESS CATEGORIES

In many cultures, more particularly within indigenous societies, parents have a lot of concerns about child health and, therefore, start making certain preparations when a mother is pregnant. In Garo community the anticipation is that the wellbeing of the pregnant mother leads to healthy birth and childhood. In this chapter, firstly I discuss birth patterns, birth rituals and the choice of different health care during birth process. This chapter also present some birth related issues of Garo community. In the second part of the chapter, I then present the findings about how parents categorize different kinds of illnesses.

5.1 Birth Pattern and Choice of Different Health Care Providers During Birth Process

It was a Sunday; I went to church in morning to attend the service with the people of the *Sainamari* village. The school headmistress, Minika Simsang, who conducted the church service on that day, invited me. I was told that the father (priest), who lives in *Pirgacha Mission*, usually conducts the service once a month. She however, conducts service on other Sundays. This was a Catholic church. Most of the Garo people of the *Sainamari* village were Catholic Christian. This supports Kibriaul Khaleque's findings that the Christian missions, the Baptist, and subsequently Catholic Missions were established in the Garo area of Bangladesh during the last quarter of nineteenth century. These Christian missions brought to the Garo people a new religion as well as modern education (Khaleque 1982).

The church building is situated beside the primary school in the center of the village for the easy access by the community. This Catholic church is a one floor building. The floor inside the church was covered with mats where Christians can sit during the service. During the service the priest stands in front the community. Although around one thousand people can attend the service in the Church that Sunday around forty women attended the service together with their children. I noticed that there were no men in the church that day. I was told later on that men only attend the Sunday services during religious festival like Christmas, Easter Sunday or when the Father (priest) comes in Church.

During the service, Minika Simsang read from the Bible while the others were listening. Then she gave a sermon to explain the verse she read from the Bible and how to follow the Bible in their daily lives. After the sermon, they sang praise songs all together. The whole service was conducted for almost an hour. Minika Simsang announced during the service to inform the mothers to stay for the discussion afterwards. Some of the mothers who attended the service stayed to attend the focused group discussion meeting which took place in the church corridor because the corridor was spacious enough for meeting and it also was a place where we could draw the village map on the floor. Only mothers were participating in this meeting. I had asked some fathers to come and join in the meeting but no one showed up.

Attending a church service conducted by a woman also fascinated me because in my religion (Islam) I had never seen a woman conducting religious services. It showed the empowering position of women in the Garo community, which is a matrilineal society. This supports Harbison, Khaleque and Robinson finding that the Garo woman occupy an important position in their society who play significant role in the labor force and in family decision making (Harbison, Khaleque and Robinson 1989:1002).

In my earlier days of fieldwork, I conducted a sample household survey. During this survey I went to 47 households with total number of 120 children, to obtain information about the health situation of children. The first part of the survey focused on the birth pattern. From this survey, I found out that 94 out of the 120 children had been born at home which corresponds to approximately 78.33% of the total number of children. During the focused group discussion, this information was confirmed by women. They told that their children were born at home. They believe childbirth is a natural process and mothers always give birth in their own house as a Garo tradition. As one of mothers said: ‘Giving birth at home is courageous and a symbol of our strength.’ This confirms (Rozario 1995) and (Rahman et al 2012) findings that almost all births in rural Bangladesh take place at home, where the cases handled by *dai* (midwife) and the family members themselves.

Household surveys, interviews and the discussion show that most of the Garo mothers of *Sainamari* experienced home birth during their child delivery. Afsana and Rashid also found that poor women of Bangladesh prefer home birthing. The authors even showed how indigenous knowledge of birth is marginalized by modern practice of bio-medical facility. She mentioned two different quotes from other scholars which indicated the relationship of home birth and hospital birth. Afsana and

Rashid mentioned Jordan's comment about hospital birth, “she is not giving birth, she is delivered.” On the other hand, she mentioned Rothman's statement. “A woman at home is not delivered, she gives birth” (Afsana and Rashid 2009).

The above mentioned survey results show that 26 (21.67%) out of the 120 children’s birth had taken place in a hospital, a private clinic or in the *Pirgacha* Mission clinic. This also shows that traditional midwives, who also have formal training helped in 86 home births which is approximately 91.49%. Only 8 children, almost 8.5% were born with the help of the mother’s relatives at home without the support of a midwife. Among the 94 home births, 30 cases, almost 32% were taken to different health care providers due to complications during delivery, 22 cases (23.4%) were taken to doctor or hospitals; 7 cases (7.45%) were taken to *Kabiraj* and 1 case (1%) was taken to the *Khamal* due to complications. So, during the childbirth event most of the parents choose midwife as their health care provider and most children are born at home. In some cases, they go to hospital or clinic, where they get modern biomedical practitioners to help mothers in child delivery. When there are complications in home birth or the health situation of mother or child gets worse, then the pregnant mother is taken to doctor, *Kabiraj* or *Khamal*.

Even though the Garo culture recommends home delivery of babies, according to my observation and findings of interviews the situation could also be compounded by the apparent lack of modern healthcare facilities in the areas or the long distances pregnant mothers have to travel before they can access a modern health facility where the cost is even simply unaffordable. In a research Rozario also observes that birth pollution, food restriction, female seclusion, family honor, and eveil spirits are some cultural notions that define birth in Bangladeshi villages. The author further notes that the cost of travelling to hospitals and for treatment are highly coupled with arrogant and dismissive attitude of hospital staff towards poor rural women are among other factors that is forcing many women to deliver at home (Rozario 1995:147).

5.2 Meeting with A Midwife

In the *Sainamari* village there are three midwives to help mothers during home birth. During the fieldwork I met the Pramila Rema, a 58-years-old midwife. One late afternoon, while having conversation with me in her house she told me that she used to work as a traditional midwife without any formal training. She was later sent for formal training as a result of the request of a community member, Minika Simsang, who also works with the church and primary school.

Accordingly, in 2007 she took training as a midwife and worked in Mother Theresa Asram, a missionary hospital at *Jalchatrak* for few years. She explained that many years ago, there were only traditional midwives in the Garo community in the *Sainamari*. With time the community managed to get training for all midwives from missionary hospital. The midwives now not only assist during delivery but also help in birth registration of infants, informing the mothers on how to take care of their babies, taking weight of infant, informing mothers about when to go for vaccination and much more information. They also have the necessary kits for child delivery at home. The midwives are up to date with the information about the pregnant mothers of the village. They also conduct regular check-ups of the pregnant mother during the last few months of their pregnancy. So, this interview shows that the formal training gave the traditional midwives more efficiency to help mothers during child birth, because they can use both their traditional knowledge and experiences, and the modern training to help during home births. This was confirmed by Pramila when she stated that 'after formal training as a midwife I can tell better about the position of baby in the womb and suggest to the family to take the mother to hospital if there are any complications during delivery. It is better to have more knowledge as a midwife, which I gained through my formal training.' This research also found that the Catholic Church has great influence to provide the traditional midwives with training in missionary hospitals.

5.3 Birth Ritual and Homely Atmosphere

Pramila Rema talked about the birth ritual in the Garo community, which starts by making *Chu*[7] with the family members before delivery time. Usually on the day of home birth the female family members and midwife stays with pregnant mother during her labor pain. When the child is born at home, they celebrate the joy by opening the jar of *Chu* and share it among family members including new mother and midwife. Just after the birth of a newborn, they give a drop of *Chu* in the mouth of the newborn. They believe that *Chu* gives strength to the mother after delivery. It is also a ritual to welcome an infant in the Garo community with a drop of *Chu*. Pramila also stated that this ritual of giving *Chu* to newborn has been changed. Many families do not give *Chu* to newborn nowadays.

[7] *Chu* is the homemade rice beer

When the child is born healthy, the family gives a cock and *Chu* to the midwife as a gift; if they are unable to give a cock, they will give food and *Chu* to her, as a tradition. If the mother gives birth to a stillborn (dead infant) or if the infant dies immediately after delivery, the family becomes sad. According to their tradition, they will give a bath to the dead infant with the *Chu* they made before delivery and bury the dead body. Usually if a dead child is born that becomes a humiliation for the reputation of the midwife and she gets nothing from the family and also other families will choose not to call her for help during home birth.

According to the narration of Pramila Rema, the birth ritual of the Garo community is connected with the house. The atmosphere of the house, with family members preparing *Chu* and gathering before delivery, as well as waiting for new the member, is more comfortable and relaxing for the mother to give birth at home rather than to deliver in the hospital. Again, the midwife plays an important supporting role during home delivery. Furthermore, the family member, especially the female kin relatives, provide emotional support to the mother during home delivery. In the work of Afsana and Rashid, they found that midwives' role is very important in home birth. They argued that midwives' mutual communication, sharing of knowledge, encouragement, touch and familiar rituals gives physical and mental support to poor rural women in Bangladesh. The role of other female relative is also crucial for the entire birthing process to give confidence to mother for giving birth. Rural women share their bodily experiences by telling stories and providing emotional support during home delivery, which they claim is missing in the formal setting of hospital delivery (Afsana and Rashid 2009). In the *Sainamari*, also the formal setting of hospital is not the preferred place to give birth in the Garo community. They prefer home births. Also the interviews and focused group discussion findings confirmed that there is no mentionable case of stillborn in last few years during the home births.

5.4 Children Illness Categories and Selection of Health Care Providers

According to Kleinman 'neither disease nor illness is a thing, an entity, instead they are different ways of explaining sickness, different social constructions of reality' (Kleinman 1978:88, as cited in Begum, 2015). According to Kleinman's statement different societies have different explanations for ill health. Whereas some of these are general and known among the people, others are specific and based on individual personal beliefs and cultural notions. In the *Sainamari* village I observed that parents have four categorizations of their children's illnesses which influences the

choice of different health care providers. My fieldwork highlighted that the cause /origin of the illness determines the treatment process. Also, Foster stated that 'if we are given a clear description of what people believe to be causes of illness, we can in broad outline fill in the other elements in that medical system' (Foster 1998).

5.4.1 Natural Causes

'Disease is thought to stem […] from such natural forces or conditions as cold, heat, winds, dampness, and above all, by an upset in the balance of the basic body elements' (Foster 1998, as cited in Begum, 2015). In the *Sainamari* village the Garo parents explained that one of the main causes of illness among children are natural conditions. Thirty-nine years old Kabita, a mother of three, talked about her younger son who became ill after getting wet in the rain a week before and got fever and cold. She gave him medicine from the pharmacy and gave him warm water with tulsi leaf and honey to drink as home remedies. She noted: `children usually get affected by cold, rain, heat, germs, lack of personal hygiene or poor nutrition`. Another mother, Pinika Simsang, who has one daughter told me that bad weather and food affect children's health. She observed that sometimes accidents like falling from trees, snake bite, etc. can cause injuries and serious trouble to children. She explained how her daughter got minor injuries or cuts on her body after playing outside as she was very restless and naughty. Here, Pinika indicated how children's carelessness leads to minor injuries and accidents. Pinika also talked about food intake: if a child does not eat properly for growth, she/he might get sick. She also told me that due to poverty parents cannot give proper food to children, which leads to malnutrition and sickness. Here, it was found that poverty deeply affects children's health.

During the focused group discussion, Minika Simsang said that food has impact on health and they always provide fresh food. They never eat rotten food, and never give the children rotten food. During that same discussion another mother, Reshma Manthin, said Garos eat a lot of fresh vegetables which are produced by household in organic way, they eat less meat. They never eat fruit or vegetables that have been grown using chemical fertilizers or pesticides. They only eat what the forest gives them without any artificial fertilizer. She also thinks consumption of healthy food is a big reason for the healthiness of children. Nurse Felisita told during interview that food contributes for healthy living and less illness. Garos never eat rotten or left-over food. If the rice is cooked in the morning, then they will not eat it in the afternoon. Usually they give the leftover food

to pigs or other domestic animals of household. Felisita also compared the food habits of Bengali and Garos. According to her, Bengali people do not always eat fresh food, they even eat the one day older left over food, which is not healthy. The left-over food may cause stomach problems to children.

Nurse Hanna said personal hygiene is a major requirement to healthy living and Garos are mostly neat and clean according to her observation. She told me that cleanliness and proper nutrition are key factors which play an important role for healthiness of the Garo children.

Suman Simgsang works in a factory. He is thirty-six years old and father of two sons. He narrated about how his elder son once suffered from infection and was taken to doctor for treatment, during interview. He said: `My first son got an infection in the naval area (belly) when he was only seven days old. I decided to take him to a child specialist in *Madhupur* town. The doctor gave him antibiotics and he was alright`. Furthermore, Suman indicated that the boy was once bitten by a dog when he was five years old. That time he took him to the doctor and the doctor gave him injections to prevent disease caused by animal bite. Moreover, both of Suman's sons get cold many times year round and whenever they got cold he gave them medicine from the pharmacy, or he gave home remedies like ginger (herb) and *Tulsi* (herb) tea. Along with Suman's interview, I observed during other interviews that for severe illnesses caused by natural factors like infections or accidents, the children are taken to doctors, but for minor illnesses like cold or normal fever, parents seek medicine from the pharmacy or use home herbal remedies.

5.4.2 Supernatural Causes

Garo parents categorize different supernatural causes for their illness of children. *Torai, Mayla Kha* and *Metdi Kamor* are three different illnesses caused by supernatural force.

Torai and Mayla Kha

In the *Sainamari*, *Torai* and *Mayla Kha* are two different kinds of illnesses, that only affect children caused by supernatural force. In *Torai* children get scared by seeing invisible spirits, and suffer from illnesses like fever. *Torai* can happen at any age among children.

Krisna *Kabiraj,* explained as follow the causation of illness *Torai* and how he treats it. Eighty years old folk healer Krisna started practicing *Kabiraji* (traditional herbal treatment) when he got the

names of herbs in his dream 25 years ago. He usually gets most of the herbs from the forest, but few other herbs he buys from the market to make the medicine. He noted:

> *'Batash or torai (evil wind) may affect a child anytime. Torai is thus a spiritual illness where a child gets scared by seeing something supernatural. At that moment, the child catches a fever, and cries a lot'.*

Mayla Kha is another spiritual illness where the child body get polluted by evil wind or evil spirits. Mostly, *Mayla Kha* affects infants who are between one-day old and forty days. A twenty-three years old mother, Mili Nakrek, is a homemaker. She has a son who is 3 years old and a daughter of 1 year. She went to *Kabiraj* when *Mayla Kha* affected her first child during his first month after birth. According to her during the *Mayla Kha* the symptoms of the child's illness would be fever, diarrhea, unwillingness to eat anything and continuous crying. When a child shows these symptoms, her mother-in-law told her it was *Mayla Kha*. Then she discussed with her husband and went to *Kabiraj* for treatment. Here, I found that along with the parents, the elderly members of the family also know about children illness causation. The parents and elderly members of the family decide the cause of illnesses through their cultural knowledge. So, my research found the knowledge and experience of older family members influence to find the cause of illness and seek treatment. This finding has similarity with Kleinman's statement, 'Patients and families, even when they incorporate terms from the former, talk about sickness in a culture-wide language of experience'(Kleinman 1978:88).

Many parents go to Krisna *Kabiraj* for the treatment of *Torai* and *Mayla Kha* of their children. According to this folk healer, evil spirit or evil winds attacks the children mostly as they are not strong and are more vulnerable. It happens mostly around the period of one to forty days age in the newborn life cycle, which is very much their vulnerable times. During this period evil spirits affect children. I found in interviews and sample household surveys that many children of *Sainamari* suffered from *Torai* and *Mayla Kha*. For these supernatural caused illnesses, the only healer is *Kabiraj* where parents seek treatment. It has been noted that illnesses caused by supernatural forces, biomedical treatment cannot heal them.

Medti Kamor

Another cause of illness among children of *Sainamari* is *Medti Kamor* which means patient is affected by evil deity. Although this causal factor is similar to the previous one, here the particular

force or spirit being is one of the deities of traditional Garo religion *Sangsarek*. There is a strong belief among the Garo community that the evil deities inflict illness on anyone, especially among children. According to Khaleque

> *'The Garo believe in supernatural beings whom they call 'Mite'/Medti….means both gods and spirits. The creation of world as well as the creatures in it, the control of the natural phenomena, such as rain, water, wind, the growing of crops, the giving of health, wealth, and happiness to mankind etc. are attributed to some Mite, while illness, disease and other trouble is attributed to other Mite' (Khaleque 1982).*

For *Medti Kamor* the Garo children are taken to *Khamal* who performs *Amwa* (ritual for healing). According to parents, this illness, like many other spiritually caused illnesses by evil deity, cannot be cured by modern medical treatment nor by *Kabiraj*. It is only *Amwa* performed by *Khamal* that can cure the affected person. This means that only *Khamal* who is the traditional priest for these deities can identify which particular deity responsible for the illness and provide treatment. Even though *Kabiraj* also heals spiritual illnesses, he is only positive for spiritual illnesses caused by other evil spirits but not deities.

Palinush Nakrek, a father, narrated how his 10-year-old daughter was once affected by *Chini Medti* (water deity). When they observed the symptoms they directly went to *Khamal*. During the interview, he explained that the observed symptoms could include vomiting, diarrhea and headache. If they are not able to attribute it to any naturally caused illness like fever or cold, then they will assume that it is *Medti Kamor*, in which case they went for *Simmanea* (diagnosis process to find out which deity caused illness) from *Khamal*. It was not necessary to bring the child for diagnosis, *Khamal* could understand from *Pangshi* (instrument for diagnosis process) what the illness is and which deity is responsible. When *Khamal* got to know that it was caused by *Chini Medti,* they decided to perform *Kali puja* (a healing ritual) as instructed by *Khamal*.

There is only one *Khamal* in Garo community of the *Sainamari* village. During my interview with him at his homestead, *Khamal* Naresh Mri, talked about the illnesses of children in the *Sainamari* village. According to him children are mostly affected by three evil deities named *Bangfang*, *Chini Medti* and *Ganchu*. These deities might affect them if they go under the trees or places cursed by deities or by eating fruits that were cursed by deities.

Although most of the Garo have converted to Christianity, I observed that they still believe in deities of their traditional religion *Sangsarek*. Evil deities can cause illnesses to children and then only *Khamal* can help in diagnosis and performing healing ritual for the treatment.

5.4.3 Man Made Cause: *Jadu*

One other cause of children's illnesses is *Jadu* (magic) which is manmade used to harm children. Sometime the enemy targets the children to harm the family indirectly. During my fieldwork only one of the informant talked about it and told me not to use her name. I assumed it is not a very common issue. *Jadu* is an idea of secrecy in the community, so most of the people did not talk about it. According to this informant, usually in the *Sainamari,* they believe few people can do *Jadu* and mostly it is done by use of herbs and *Mantras* (special religious words). Few people have knowledge about the harmful herbs for human body and mind. If they have an enemy or if someone is jealous of someone, they use *Jadu* to affect the family and sometimes the children. She also said that people who do not have knowledge about herbs sometime convince *Kabiraj* to do harm to their enemy by using *Jadu*. There is only one *Kabiraj* in this village so people might use those in nearby villages, who will take money and use *Jadu* to harm children. Sometimes if *Jadu* harms a child*,* he behaves like a psychological patient. The child becomes so sick and may not get cure until the *Jadu* is removed. Usually if *Jadu* affects someone, they go to *Kabiraj* for treatment. Accordingly, children's illness can be caused by manmade magic which can be cured by *Kabiraj*. My findings about *Jadu* among Garo community opposes Khaleque's findings where he mentioned that Garo do not believe in magic. They also believe that man cannot cause harm to their fellow man (Khaleque 1982).

5.5 Summary

In the first part of this chapter I focused on the birth-related issues. According to survey data and interviews the majority of children in the *Sainamari* were born at home. The major percentage (78.33%) of children were born at home, but there were also 32% of complicated cases when the mother needed to take to different health care providers like doctor or hospital, *Kabiraj* or *Khamal.* In most cases of home births midwives play important role, they combine both traditional knowledge and modern training to help the mother. In the Garo community birth ritual is very important and they prefer home atmosphere for child birth rather than hospital birth.

The second part of this chapter observes how parents and health care providers explain different illnesses of children. In the *Sainamari*, the categories of illnesses are natural causes, supernatural forces like *Torai* and *Mayla Kha*, *Medti Kamor* and man-made cause *Jadu*. These findings are relevant for Foster's illness causations, where he mentioned natural factors are responsible for diseases. Foster also defined illnesses as outcome of 'the active, purposeful intervention of an agent, who may be human (a witch or sorcerer), non-human (a ghost, an ancestor, or an evil spirit), or supernatural (a deity or other very powerful being)' (Foster 1998, as cited in Begum, 2015). The finding shows that the parents seek bio-medical practitioners only for the natural causes of illnesses and for other illnesses related with spirits, deity and magic they seek alternative healers like *Kabiraj* or *Khamal.*

CHAPTER SIX

HEALTH SEEKING BEHAVIOR AND INFLUENCIAL FACTORS

This chapter present both analysis and discussion of the four different health care providers like home remedies by household, *Kabiraj* (herbalist), *Khamal* (spiritual healer) and biomedical practitioners of *Sainamari* village. In later part of this chapter, I also discuss the factors influence parents' health seeking behavior.

6.1 Home Remedies by Household

Parents, mostly mothers use herbal home remedies or medicine from drug store as primary treatment of few illnesses of children. For many illnesses this kind of treatment functions and children get better. The data from sample household survey about the illnesses the Garo people use home treatment or home remedies for are presented in the table below. According to survey, children are mostly treated at household for the illness like measles, fever, stomach problem and diarrhea. Parents both use herbs or medicine from drug store for household primary treatment.

Table 7: Illnesses that are treated with home remedies

Illness	Number of affected children	Treatment
Measles	18	Herbal home remedies
Fever	14	Medicine from drug store
Stomach Problem	5	Herbal home remedies
Diarrhea	4	Oral Saline from drug store
Cold	2	Herbal home remedies
Fever	2	Herbal home remedies

Pneumonia	1	Herbal home remedies
Allergy	1	Herbal home remedies

Source: Sample household survey data, fieldwork 2015

During one interview, Jhuma Nakrek, a mother of four children, told me about the home remedies Garo mothers use for her children's illnesses. She said that she went to the doctor when her first child had pneumonia and the treatment was expensive. She did not go to the doctor for treatment with her third child, her daughter, had pneumonia too. However, she used some herbs as home remedies for treatment. She used *Chepa-Basuli* (an herb) for pneumonia and her daughter got better by using it. Again one of her children had *Boshonta* (chicken pox), and once again she decided not give him any medicine. She only gave him sour food and pickles to eat, which helped him to cure.

During the focus group a mother, called Ranila Mree, explained their use of few common home remedies to treat their children for common illnesses. She said they use few herbs as first aid for different illnesses. She said, for stomach ache they use '*Nagdana*' (an herb), for diarrhea they use '*Pathorkuch*i' (an herb), for cold and cough they use ginger and *Tulsi* leaf (an herb), for cuts they use '*Gadaful*' (an herb), for hepatitis they use '*Kiring* and *Mimang Kacchi'* (herbs). She also thinks that all the flowers and plants have herbal power to cure the body, and as *Mandi or Garo*, they are using herbs for many generations.

During my interview with a father Sumon Simsang he talked about the home remedies they use for their children during few illnesses. He said when children get scared, they use a thing called *Chikin Thappa* (a kind of insect house) which they can collect from roof of their house. First they apply heat over *Chikin Thappa* and soak it in water. Then they give the concoction to the affected child. Suman also said honey is very good for children, among his three sons: he believes that his second son can memorize better than others as he was given honey regularly in his earlier age. He said most of the time for the treatment of cold they usually use herbs at home. He narrated that they use honey, ginger (an herb) and *Tulsi* (an herb) for treatment of cold.

In the *Sainamari*, home remedies by household are considered a very primary health care system, which is common in other societies as well. In many societies in both western and non-western societies family health care provide primary treatments with the materials. For example, Brazilian

Amazon women have specialized knowledge about local plants and herbs about treatment (Helman 2007).

6.2 *Kabiraj* (Traditional Herbalist)

Before the British colonization period (1757-1947), traditional medicine was common health care facility in Bangladesh. During this period, traditional medicine was discouraged to introduce Western medical system (Osman 2004). However, use of traditional medicine is still a part of Bangladeshi health care system, and it is also present in Garo indigenous community. There are four *Kabirajs* in the *Sainamari* village and in nearby villages there are also few *Kabirajs*. My finding says most of the *Kabiraj* got their knowledge about treatment from their ancestors. Only one *Kabiraj* mentioned that he got his knowledge in dream.

The data from sample household survey about children illnesses that *Kabiraj* handles is presented in table below. According to the survey data, parents take their children to *Kabiraj* mostly for illnesses like *Torai, Mayla Kha*, fever, hepatitis, and breaking bones. This shows *Kabiraj* is most preferable healer when the illness is caused by supernatural power, even though he they also handle other common natural illnesses.

Table 8: Children illnesses that are handled by Kabiraj (Herbalist)

Illness type	Number of affected children	Treatment
Torai (getting scared)	20	Amulet and *Telpora* (healing oil)
Mayla Kha (effected by evil spirit)	19	Amulet
Fever	10	*Khasbandha*(treatment of Amulet) and *Panipora*(healing water)
Hepatitis	4	Herbs

Fracture (hands and legs)	3	Herbs
Eye Problem	1	Herbs
Skin disease	1	*Telpora* (healing oil)
Weakness	1	*Kan Fota* (a ritual with *Mantra* and herbs)

Source: Sample household survey data, fieldwork 2015

From the interview and survey data, *Mayla Kha* illness affects mostly infants. Most of the parents I interviewed indicated that their children were affected by *Mayla Kha* during their early age. They went to *Kabiraj* to seek treatment for this illness. During the interview with Mili Nakrek, at her homestead, she said her first child was affected by *Mayla Kha* during his first month after birth. The *Kabiraj* gave *Tabbez* (amulet) filled with herbal medicine to hang on her child's neck. He also gave a medicine that she needed to soak into water and give the water to the child. She continued this treatment for a week and the child was cured.

The symptoms of another illness *Torai*, is that the child would get scared, have fever and cry a lot. While taking an interview with 80 years old Krisna Kabiraj in his house, he told me that he got the knowledge of herbs in his dreams 14 years ago. First he used these herbs to treat his own children and kin relatives. Later he became successful as *Kabiraj* and people from distant places started to come to him. He explained the treatment for *Torai* during this interview. He said he gives the affected child *Telpora* (oil for healing) to rub on the chest of child. He also gives *Tabeez* (amulet) by which the body gets protected from evil spirits. He uses herbs of seven different plants to make this *Tabeez* for *Torai* treatment. He would tell the parents to put this *Tabeez* on the affected child's body for a week. He claims that if parents put *Tabeez* on the neck, hand or waist of their children for seven days, the child would get better gradually.

I also interviewed another *Kabiraj*, Nakul Nakrek who lives in the *Sainamari* village. The 65 years old Nakul is a *Kabiraj* and also works as a *Maddak* (helper of *Khamal*). While talking to him in his house, he told me that he started his *Kabiraji* profession 15 years ago because he wanted to help

people. He mentioned the treatment for Hepatitis disease, which is considered not curable by biomedicine. He did not want to disclose the full list of the herbs as he uses, because this is confidential information. He listed only a few names of the herbs named *Thiborong Bigil* (jackfruit bark), *Mendi* (henna plant), *Nagdana, Mimang Kacchi, Jasthi Modhu* the ones he uses to produce medicaments to treat hepatitis. Then he grinds these herbs together to make the medicine. Nakul claims that all types of hepatitis disease will get cured if the medicaments are taken regularly. The affected child has to take this medicine with a glass of water before he eats anything every morning. Although Nakul said few names of herbs, he did not disclose all names of the herbs as he wanted to maintain the secrecy of his indigenous knowledge. He did not want everyone to know about this secret medicine for which patients come to him and rely on his treatment.

From Nakul's interview I found out that parents come to him usually for many illnesses of their children like *Mayla Kha, Torai*, toothache, hepatitis, fever, burns, *Metdi* (deity) illness for treatment. As he is a *Maddok*, he can also perform few *Amwa* for few illnesses. Usually he helps *Khamal* in *Amwa* preparation and he is still learning it. However, if the *Khamal* is not in village he can perform *Amwa* for patients.

Nakul also told me that the procedures to produce medicaments and collecting herbs has to undergo many rituals. During his interview, he stated that when making medicine for toothache, he collects the herb by stopping his breathe and by being barefooted. Sometimes when using *Kabiraji* medicine, the patients have to follow some rules. For the treatment of toothache the herb should be tied on patient's neck with thread, which with time makes the teeth to get stronger by this treatment. There are also sometimes food restrictions during *Kabiraji* treatment. During the treatment of toothache, the child is not allowed to eat salt and sour foods. Nakul also told me about the treatment of burning, for burns he uses the leaf of sweet potatoes, which he applies on the burnt area and advises the patient to put the fat of hen on the burnt area every day until it heals. Nakul narrated:

> *'Every disease, except Cancer, can be cured by using Gashanto (herbs). Nature has all cure to diseases. He saw how his ancestors used herbs and now he following their knowledge when using herbs for different treatment of illnesses.'*

Another *Kabiraj,* Nikolas, said he got his knowledge of *Kabiraji*, from his grandfather 15 years ago. He took it as a profession to help the people as a health care provider. Mostly children come

to him for *Torai* illness. Once a boy of 5 months named Dibbo was brought to him with Torai illness by his grandparents. The boy had stopped eating, he got fever and he was crying all time. By knowing those symptoms, he was sure it was due to *Torai* and gave him *Telpora* (healing oil) to rub on his chest. Nikolas said just after half an hour of treatment the boy was cured and started playing on the ground.

Kabiraj Nilem Richil, learned his knowledge about herbs and *Kabiraji* from his father. During conversation at his home stead he showed a herb named *Hawasham* which is used for illnesses due to evil wind to me. He also showed me the *Atpolash* herb which is used to treat broken bones and *Samsrok* herb for the treatment of *Jadu*.

Kabirajs use their indigenous knowledge about herbs to cure the patients. They believe that the *Kabiraj* can treat both illnesses whose origin are either of natural and supernatural nature. In some illnesses where biomedicine cannot help, *Kabiraj* can heal those diseases, for example Hepatitis disease is mentioned in one interview. The *Gashantas* (herbal medicine) are used by Garo *Kabiraj* from generations to generations and people go to *Kabirajs* as they are reliable, available and offer effective treatment.

6.3 *Khamal* (Spiritual Healer)

In the *Sainamari* village, there is one *Khamal* (spiritual healer) who performs spiritual healing rituals for the ill children. The parents usually go to him when the biomedicine and *Kabiraji* fails to heal their sick child. Sometimes they go directly to *Khamal* if they think the symptoms of the illness are unusual and can be caused by a deity. There are 101 deities according to the *Sangsarek,* traditional religion of Garos. To make diagnosis *Khamal* use a diagnosis tool name *Pangshi* to perform *Simmanea* (diagnosis process) to know which *Metdi* (deity) is causing illness of the patient. When he understands the reason of the illness of the patient, he suggests to the parents to get prepared for *Amwa*. The rituals of *Amwa* are also different for different deities.

The data from sample household survey about the illnesses treatment by *Khamal* at the time of my fieldwork is presented in the table below. From the survey data, parents take their sick children to *Khamal* when they get illness of *Metdi Kamor* and *Khamal* will perform *Amwa* for the treatment. Only in one case a child was taken to him with a broken bone and *Khamal* treated him using oil massage with *Mantra*.

Table 9: Illnesses treated by Khamal

Illness	Number of affected children	Treatment
Metdi Kamor (Affected by deity)	8	*Amwa* (Healing ritual)
Broken bones (hands or legs)	1	Oil massage with Mantra (religious recitations)

Source: Sample household survey, fieldwork 2015

6.3.1 Naresh Mri as The Village's *Khamal*

Naresh Mri is a seventy-five years old man. I met him first in the village tea stall where Linu Simsang introduced me to him, on the day I had introduced myself into the community. After a short conversation he invited me to his house. When I visited him in his house and got the opportunity to present my research and my interest about his profession, he was willing to help me. He also asked few questions about my personal life and about my illnesses. During the visit, he told the story of how he became a *Khamal*. He is the third generation as *Khamal* in his descent. Naresh's grandfather was a *Khamal*, his father too. He explained that becoming *Khamal* is not a profession that shifts with descendants but it has close link with spirits.

Naresh Mri was a follower of the *Sangsarek*, traditional Garo religion. He became Christian after his marriage. Once his first daughter was seriously ill, they went to several doctors and *Kabiraj* for treatment. But she was not getting better. Then the sick girl was taken to his own father who was a *Khamal*. Naresh Mri's father found that she was affected by *Metdi* (deity) and he did *Amwa* for the sick girl. After the *Amwa* she got better. Since then Naresh Mri gained a stronger belief in the power of *Amwa*. He had always believed in the *Metdi* but he had never thought of becoming a *Khamal* by then.

He became a *Khamal* because of his youngest daughter's illness. One day when his youngest daughter was sitting near a jackfruit tree and having her food, there was suddenly a thunderstorm that struck the jackfruit tree and the tree was burnt. Naresh got so scared of that incident and made prayer to the deities: 'Oh God, I still believe in you. Why do you harm me? I believe in you from

heart even though I am a Christian. I cannot disbelieve you.' He ran to his daughter that he found her in shock. The day after that incident he discovered that she had become blind after seeing the thunderstorm. Together with his wife, they took the child to missionary hospital. Then they shifted her to town hospital for better treatment. One day his daughter had a dream where someone was telling her to do an *Amwa* for her blindness She told her parents about her dream, and then Naresh became sure that it was the deity who was causing her blindness. They went to Naresh Mri's father, *Khamal* of the village. They told him about the dream she had. The same day *Khamal* performed a *Shimmaniya* (diagnosis) for her and prepared *Amwa* immediately. The girl got cured and she never had problem with her eyesight afterwards. Naresh Mri decided from that day to become a *Khamal* like his father to help people. He became aware of how important it is to have a *Khamal* in the community after the accident of his daughter. *Amwa* saved his daughter's eyesight. He thought he might help someone else too in the future. He then asked his father the permission to become a *Khamal* after him and he got the permission to become a *Khamal* after his death. The knowledge of *Khamal* cannot just be learnt from seniors or transferred through inheritance; it also has to be acquired through spiritual calling. The deities have to accept the person as *Khamal* too. And also he has to be accepted by the community to perform as *Khamal*. He said he gained that position in society by his success in healing through *Amwa*. Naresh Mri said that now not only patients from Garo community come to him but also patients from different place and different religion come to him for treatment.

Palinush Nakrek, a father, was telling about how his 10-year-old daughter was once treated by *Khamal* when she was affected by *Chini Medti* (water deity). He said he arranged a goat for sacrifice in *Amwa* by *Khamal's* recommendation. On the day of *Amwa* he went to the nearby river by late afternoon with *Khamal* and few guests and *Khamal* performed the ritual there. Then they sacrificed a goat for *Amwa* and *Khamal* floated a small boat made of banana leaf filled with rice, hibiscus flower, organs of the sacrificed goat like the ear and blood, leaf of wood apple as a part of the ritual. Then they made food with that goat's meat to feed *Khamal* and the guests. Only his daughter did not eat that food. He also mentioned that for this *Amwa* the number of guests should be odd in numbers.

Khamal Naresh Mri was telling about the illnesses of children and how he diagnosed them to find the reason of illness by *Pangshi* (Instrument for diagnosis process made by many white threads

hanging by a tiny bamboo bark). He said while diagnosing he asks the deities if that deity is the one who is causing such suffering to the patient. And if the reply is positive, the *Pangshi* would move clock wise, and if the answer is negative, the *Pangshi* would move counter clock wise. He usually calls the name of 101 deities until one responds. He told that the treatment of *Amwa* is strongly related to belief. He said, 'those who do not believe will never be healed. It works for most of the people who truly believe it.' Linu Simsang, the key informant told that *Amwa* has great impact on the health when it is concerned with deities and it is based on their belief. If someone believes, his illness will begin to heal as soon as the *Amwa* will be performed. For the treatment of *Metdi Kamor* only *Amwa* performed by *Khamal* is not enough. The person who would conduct the *Amwa* should also believe in the power of *Amwa*. The spiritual healing therapies performed by *Khamal* confirms that, he is successful as a healer because patients get cure from illness by his treatment. This confirm the findings of Kleinman who stated, 'One reason why indigenous folk healers do not disappear when modernization creates modern professional medical systems is that they often are skilled at treating illness' (Kleinman 1978:88).

6.3.2 A Healing Ritual with *Khamal*

On a Friday early morning, I was conducting an interview with a mother of one child to find out about the different facets that contribute to her child's care seeking behavior. The interview took place at her homestead. During the interview, I was informed that a boy was sick and *Khamal* Naresh Mri was going to perform *Amwa*, a healing ritual, on that day late in the afternoon. Earlier, when I had met *Khamal*, I had asked him to let me know when he would be performing a healing ritual and allow us to observe it. Later I also asked for permission to take video recording of some parts of the ritual if possible. He informed us that he was going to start the preparation for the *Amwa* at late afternoon at the patient grandparents' house.

I was really waiting for that moment since healing ritual only happens occasionally, I was quite excited to get a chance to attend one. After finishing the interview, we went back home and prepared to attend the ritual. I checked the battery charge of the camera, took extra battery and extra memory card for safety. I asked Linu Simsang, the host and key informant about the direction of the patient's house, she offered to accompany us since the location where the ritual was going to be performed was far from where I was living and it would be dark and difficult to get back home. Linu Simsang usually looks after her grocery shop every day, but that day she offered to

accompany us by leaving her shop over her assistant to help me as host. I agreed happily and told her that we would like to go early as I did not want to miss the preparation of the ritual.

Preparing the *Amwa* Ritual:

After taking a lunch at 2.00 pm, we went to the house where the ritual would take place. It was located at the eastern part of the village. It was nearly one hour of walking distance using a shortcut way to reach there. When we reached the place, the *Khamal* was already there. He told us he arrived just 10 minutes before we reached there. Linu Simsang introduced us to the grandparents of the patient. I explained to the family why we were there and asked for permission to attend the ritual and carry out the video recording of it. The *Khamal* told us about the preparation of the ritual and some parts of the ritual could be recorded. We were not allowed to record the entire ritual, because if we did, then the ritual would not be effective on the patient. He did not either allow me to see the sacrifice part which took place in the jungle. I complied with his restrictions and ensured that I would respect their decisions.

The patient's household members treated me as a guest. They took out the big wooden chair from inside of their house to provide the sitting arrangements on the outside homestead, where the ritual would take place. At around 3.30 pm, the *Khamal* started the preparation for the *Amwa*. He explained that, this particular ritual should be performed before sunset. The whole preparation and the ritual happened in the homestead of the house. In the beginning, *Khamal* made the *Kadam*, which is the symbolic deities. The number of *Kadam* should be always an odd in numbers, so he was making three *Kadams*. He was using dry hay by tiding them with rope to give structure of symbolic deities. He was using a sharp local chopper while making them.

While the *Khamal* was making the *Kadams*, the grandfather of the sick boy was making three *Owafak* (lamp) with bamboo at approximately ten feet distance from the *Khamal*. First the sharp and tiny top part of the bamboo was cut to make the lamps with the sharp chopper, then he decorated the outer part of the lamp by making few marks on it. Then he twirled tiny ropes with his hand with mastered oil and placed into the lamps.

While observing the preparation I was also talking to the grandmother of the sick child. She explained that her grandson Raj, who was 10 years old lived with them. The parents of the boy lived at the city where they work. Raj was having problem with his sleeping for few weeks. He

barely slept, did not play or talk much and also did not want to stay in the house. He even tried to run away from home once. They became very worried about him and they assumed it was caused by an evil deity. The week before the ritual, the grandfather of the boy went to *Khamal*, and told him about the symptoms and asked for help. Then *Khamal* diagnosed by using *Pangshi* at dawn. Usually this diagnosis process by *Pangshi* should be done during dawn. He found that one of the evil deities named *Ganchu Metdi* affected the boy. Therefore, his grandparents arranged *Amwa* for him as *Khamal* advised them to do. They decided to sacrifice two roosters and a duck for this ritual and also they arranged a feast with *Chu* (local homemade beer) and food made with sacrificed animal afterwards.

After making the lamps the grandfather made a squared structure with four bamboo barks at the east side of the homestead in front of the kitchen. When I asked about the meaning of what he made he said it was a place called *Nakthip* where the essential herbs and symbolic deities would be placed during the performance of the ritual. They selected that place as *Nakthip* because the boy would be seated there by facing the sun, which was setting down. After making that structure of *Nakthip* he started to make another symbol of deity by taking a bamboo stick of four feet and took a few pieces of cloth of tiny shape. Then he made a cross on the top of the bamboo stick and tied four pieces of tiny cloth at each edge of the crosses. This symbol was called *Bangfang*, which represented the *Ganchu Metdi* (the evil deity who affected the sick boy).

At the same time *Khamal* was making a symbolic peacock which they called *Dudhi* with tiny long pieces of bamboo bark. It took a bit long time to make the form of peacock but in the end it became a wonderful craft by *Khamal*. After making the structure of *Dudhi* using bamboo bark, *Khamal* decorated the peacock feathers with *Neem* leaf (a herb) and placed a red chili in its mouth. He was explained that this *Dudhi* would take away the disease from the patient after the healing ritual was done. He also made few *Dungas* (small offer plates) from the stem of a banana plant.

Then *Khamal* started to place the *Kadams, Dudhi*, *Neem* leaf and other herbs near the *Nakthip* and the grandfather of the boy started to clean the *Nakthip* with water. He put some water on the mud floor and wiped it with his hands. Then he marked the boundary of it with *Fura* (rice powder) and designed nine squares inside the *Nakthip* with *Fura*. Then *Khamal* began to put different essential elements of the ritual near the *Nakthip*. He placed *Kadams* and *Dunga* in front of the *Nakthip* and hanged the *Dudhi* above it. He then kept red chili, neem leaf, local cigarette, and some herbs named

Dikki inside the *Nakthip*. After all these preparations were done, they threw some bamboo bark or other materials, which were left over after this ritual into water. *Khamal* explained that as these were taken for the ritual, they cannot use it for other purposes and it should be thrown in the water.

Performing the Ritual on the Sick Boy

For *Amwa*, the grandmother called the sick boy. During the preparation he was inside the house accompanied by his aunt. He sat on a *Piri* (lower height wooden stool) near the *Nakthip* facing the west to see the setting sun during the ritual. A rooster was kept in front of the boy. Then *Khamal* started the ritual. First, he burnt few *Neem* leaf with rice husk to make smoke and made a *Namaskar* (gesture of respect to deities) to the east and west. Then he took the *Banfang* and a glass of water in one hand and a rooster in another hand. After that he took water in his mouth and sprayed the water from his mouth over the boy's head once by reciting *Mantras*. He recited *Mantras* for a while and then rotated the rooster clockwise over the head of the boy once. He took the same rooster into the forest with the boy's grandfather and sacrificed it in the name of the *Ganchu* deity. I could not go with them to observe the sacrifices, but later *Khamal* showed me the place where he sacrificed the animals to satisfy the deity and explained how he performed the ritual there. He came back from the forest with bare hands. The boy was not willing to sit the whole time, he wanted to go from there, but his grandmother scolded him and did not allow him to go from there until they had finished the ritual. I assumed the boy was missing his parents and it might be hard for him to stay with grandparents and also the restrictions might be hard for him to obey.

Again *Khamal* came back to the boy and took another rooster and a duck in one hand; *Dudhi* and a glass of water in the another hand. He took water in his mouth and sprayed the water from his mouth over the boy's head by reciting *Mantras* for a while. Then he rotated the rooster and duck clockwise over the head of the boy once. Then *Khamal* himself rotated around the boy once clockwise with the rooster and a duck in one hand and *Dudhi* in another hand while reciting *Mantras*. Then he went to the forest to sacrifice the rooster and duck in the name of three *Kadams*. That is how the major part of the ritual ended. After the ritual *Khamal* sent the sacrificed roosters and the duck to the kitchen to cook them for the feast.

The ritual of sacrificing animals happened in a nearby forest. Only the *Khamal* and the patient's grandfather were present there. When the sacrifice was done, the *Khamal* took me to the place

where they sacrificed the roosters and duck. It was a forest behind the house. I went there with *Khamal. Khamal* warned me not to step on the blood of sacrificed animals or the materials used for the ritual. The boy could be seriously harmed if someone walk on the materials that were offered to the deity. After a little walk we reached the place where the sacrifice ritual was held. There was blood on the ground. There the *Khamal* started to explain what they did. The first time when he went to the forest with a rooster and *Banfang*, the grandfather of sick boy was also present there. The grandfather placed three *Kadams* under a tree and lit three *Owafak* in front of the *Kadams*. Then the *Khamal* killed the rooster while reciting *Mantras* and placed the head of the rooster on the top of *Banfang* and the intestine of the rooster over a banana leaf and some feather on the feet of *Banfang*. Then, when they went to jungle for the second time to sacrifice the other rooster and the duck, he killed them while reciting *Mantras*. He also placed the *Dudhi* on the top of *Kadams* on the tree so that it could take away the illness of the patient. Then he took out the intestine of the rooster and separated the duck's bile and placed them on the feet of *Kadams* on *Dunga*. He also used the blood of the sacrificed animals and *Esthi* (the left over rice after making *Chu*) and *Fura* (rice powder) over *Kadams* and *Dudhi* with *Mantras*. I asked if I could take some pictures there, and *Khamal* said as the ritual was over I could take pictures. So, I took a few pictures and came back to the homestead soon as it was getting dark in forest. These pictures and the video recording of ritual helped me to better analyze and summarize the ritual, and to interpret of that event afterwards when I was writing my thesis and helped me lot to memorize the event. By the end of the ritual, the sun had already set and it was dark around.

The Feast

At the homestead everyone was waiting for us, the grandfather opened a new jar of *Chu* that he made for the ritual in previous days. I saw there were nine guests there to join for the *Chu* and feast afterwards. I got to know that some of the guests were kin relatives and some were neighbors. The grandmother brought glasses and started to serve the guests. First she took one glass of *Chu* and dropped a bit of *Chu* on the ground and gave that glass to *Khamal. Khamal* also dropped a bit of *Chu* to the ground before having it. When I asked why they were dropping *Chu* to the ground then *Khamal* answered that they offered the deities to have the *Chu* before they consume it, which was also a ritual. Then everyone was served *Chu* and was chatting with one another. The entire situation resembled a lot a family gathering where everyone was having a good time. Meanwhile, we were

told that the food was ready for the feast. First, *Khamal* went to the kitchen and came out with food in his hands on a banana leaf and went to the forest, where he conducted the sacrifice ritual. Later he told me that there he offered the food to the *Ganchu Metdi* as the first guest of the feast. After he came back he said if the deity starts to accept the sacrificed animal's blood and food that offered to him, the patient starts to heal as well. I found that *Khamal* plays a vital role to establish the relation between spiritual world of deities and humans living in Garo community. Every part of *Amwa* has a specific meaning in relation to cosmology and spirituality. *Khamal* is very respected person in community and he was center of this event.

Then we were all called to join the dinner inside the kitchen. In the kitchen a kin member arranged the foods for the feast in big pots over two mud stoves. The guests were seated on the ground over a jute cloth and were served the food over banana leaf. They made rice and curry of roosters and duck those were sacrificed for *Amwa*. The grandmother was taking care of the guests and of me as well. Although I was not a kin member or a family friend like other guests, they really treated me with warm heart and took care of me as a guest. The boy did not eat the meal that was served for guests. While having dinner with them I asked the grandmother about her grandson, whether he was joining the feast. The grandmother said that as they sacrificed animals in his name he was forbidden to take foods made by those animals. They made separate food for him and he already had his dinner inside the house. She also told that his aunt took care of him. By observing the ritual and feast, I found that the gender differences exist in *Amwa*. In this event, the grandfather of sick boy actively took part in most of the rituals and helped *Khamal* directly. He was the only person who was allowed to help and also was only one present in ritual of sacrificing animals. But on the other hand the grandmother of the boy was not directly involved in ritual. Also, when I later asked *Khamal* if a woman can be *Khamal*, he informed me that *Khamal* is always a man, a woman cannot be *Khamal*. So, it is found that in spiritual healing practices only man can be healer or actively take part in ritual even in a matrilineal community like Garo indigenous community.

After finishing the dinner, I came back to the homestead and sat there for a while. Other family members and guests were also sitting there and having *Chu* after dinner. This feast and drinking *Chu* ritual plays important role in social bond among kin members and neighbors. They were talking in *Mandi* language and also talking to me sometimes in *Bengali*. By this time, it was already half past nine at night, so we thought to get going. I thanked the *Khamal*, grandfather and

grandmother for their time and amazing host. Afterwards, Linu Simsang showed the way back home with a torch light and I followed her. While going back I came to know from Linu Simsang that *Khamal* never accepts money for doing *Amwa* from the patient's family. Due to his position in the society and his role as *Khamal* he performs rituals to heal the sick people as his social responsibility. Although it had been a long day, I was satisfied with the recorded data and the opportunity to directly witness a large part of the healing ritual, which is generally performed less than once in a month. After few days, when I asked about patient Raj's health, I came to know that he was healed.

6.4 Bio-Medical Practitioners

The public health system of Bangladesh is based on bio-medicine. The history of the Bangladesh health system has its roots in the British colonial rule as well as the Pakistani rule. The British colonial administration introduced Western medicine and started Indian Medical Service in 1714 on a limited scale. As consequence of the colonial rules Bangladesh inherited an urban biased, elite biased and curative health care system which was based on bio-medicine (Osman 2004). However, the *Sainamari* village does not have any doctor or hospital. If a child gets seriously ill and needs to go to hospital, parents take them to a nearby village clinic or to the town hospital. The nearest big town *Madhupur Sadar* is 16 kilometers away from the *Sainamari* village, where the government hospital and specialist doctors are available. A village doctor, who owns a drug store sometimes comes to *Sainamari*. Parents also go to the *Pirgacha mission* (a Christian mission which is 2.5 kilometers away from *Sainamari*) which has a small clinic to provide free medical treatment for primary illnesses. Although the bio-medical facilities are not available in the *Sainamari* village almost every parent has used bio-medicine or go to bio-medicine practitioners for the health needs of their children.

The sample household survey conducted with parents during fieldwork provides information about the illness categories and health seeking behavior for children of *Sainamari* village of 120 children. The data from sample household survey about the illnesses and treatment from bio-medical practitioner is presented in the table below. In the survey, I found that mothers mostly go to biomedical practitioner for illnesses caused by nature such as cold, fever, accidents like cut or break body parts, typhoid, pneumonia, toothache, etc. Mostly, doctors, nurses or other physicians, in the

hospital or clinic, carry out the treatment for these illnesses. Only twice parents referred to Homeopathic[8] doctor for treatment seeking for help to treat tumor and ear infection illnesses.

Table 10: Categories of children illnesses treated through the use of biomedicine

Illness category	Number of affected children	Treatment
Cold	25	Medicine
Fever	23	Medicine
Cut hands or legs	2	Stitch and medicine
Fracture (hands and legs)	2	Operation or plaster
Typhoid	2	Medicine
Pneumonia	2	Medicine
Toothache	2	Medicine
Measles	1	Medicine
Eye Problem	1	Medicine and eye glass
Tumor	1	Homeopathic medicine

[8] Homeopathic treatment is a kind of treatment which has holistic and natural approach

Ear infection	1	Homeopathic medicine
Infection on belly	1	Medicine
Headache	1	Medicine
Appendix	1	Operation
Dog bite	1	Injections

Source: Sample household survey data, during fieldwork 2015

Tanu Simsang, a 38-year-old mother, discussed about the illnesses of her two daughters during the interview in her homestead. She works in her own agricultural farm. Her first daughter is 12 years old and the second daughter is 10 years old. She said her first daughter suffered from typhoid once. Then she was taken to a clinic in *Thanarbaid* (next village), where she was admitted for one week. The doctor gave her medicine for 28 days. After taking medicine for almost a month she was fine. Tanu also explained how her second daughter, who suffered from cold, fever, cough and allergy several times since childhood, was treated. In most of these kinds of primary illnesses she went to the mission clinic at *Pirgacha*, where she got free medicines for treatment. During another interview, a couple described the events of going to hospital for their son. A father, Palinush Nakrek who is a farmer and Puini Mri, a housewife has three children. Their firstborn son is 11 years old, first daughter is 10 years old and second daughter is 6 years old. Palinush Nakrek and Puini Mri explained how their son has suffered due to appendicitis and had severe stomach ache. As there was no doctor in the village, they went to a hospital in *Madhupur* town, which took almost 2 hours to reach from village. They said their son had stomachache for a whole day and night. The next day when they went to the hospital the doctor suspected it was appendicitis and suggested an operation. Then after a check-up, the operation was performed immediately. These two interviews indicate that for serious illnesses like typhoid or appendicitis parents go to a clinic or to hospital, and for minor illnesses, as I indicated earlier, parents sometimes depend on medicine they get from the clinic of *Pirgacha mission*.

A village doctor, Harun-Ur-Rashid, who is known as *Pardeshi Doctor* (foreigner doctor) owns a drug store at *Bhutia* market. He is called *Pardeshi Doctor* because he is not originally from that place. He came to *Bhutia* 15 years ago, there he got married and settled down. The members of *Sainamari* village go to his drugstore for medicine and for consultation, as it is the nearest one. Sometimes *Pardeshi Doctor* goes to *Sainamari* village on call to provide treatment and suggestions regarding health problems if the patient cannot come to his drug store. Jhuma Nakrek, a 45-years-old homemaker and mother of four children talked about how she got treatment from *Pardeshi Doctor* when her 11-years-old son was suffering from pneumonia. During the interview, she said for pneumonia she went to *Pardeshi Doctor* for some tests to be performed on her son. He confirmed that it was pneumonia. Then he consulted with the specialist doctor about the treatment through a telephone conversation and the specialist suggested injections. Jhuma asked *Pardeshi Doctor* to collect the injections from the *Madhupur* town and come to her house to inject her son, as it was required to give few injections in a week. Then doctor came to their house three times to give injections to the child. He only was paid for the cost of injections; he was not paid any fee for his consultation or transport fare for coming to her house in the *Sainamari* village.

Harun-Ur-Rashid owns a drug store and also delivers basic medicines to a local grocery shop of *Sainamari* village for emergency need of the villagers. After finishing his higher secondary college education, he took a training from an NGO at *Jamalpur* (North district of Bangladesh) as a village doctor. He worked in *Jamalpur* for a few years, then settled down in *Bhutia* for the last 15 years. During the interview in his drug store at *Bhutia*, when I asked about the common disease children from *Sainamari* village are brought to him for treatment, he said in most cases children are brought to him with breathing problems, fever, skin diseases, chest pains, cold and similar minor affections. Parents bring their children with some assumptions. He said when parents take a child to him for fever he checks with a thermometer and stethoscope then gives them paracetamol. If the child does not get better after taking the paracetamol within 3-4 days, but still has high fever then he gets the confirmation that the child has Typhoid[9] disease. He will suggest for injections which the parents have to buy from *Madhupur* town. Also, Diarrhea is a very common health problem for children. When parent come to him with this illness, he gives them oral saline and medicaments. If a child

[9] Typhoid is an infectious, often fatal, febrile disease which is usually introduced with food or drink

gets Measles, then he gives him Antihistamine and Paracetamol. Also, Chicken Pox is treated as Measles. The village doctor, Harun-Ur-Rashid mostly gives treatment for common illnesses and provides the necessary medicaments from his drug store. If he cannot treat a child, or thinks the patient is serious, he refers them to hospital or specialist doctors at *Madhupur* town. I observed that *Pardeshi Doctor* is popular in the *Sainamari* village and for many years as he has providing almost free health check-up and diagnosis for the villagers. He just charges the cost of the medicaments, but does not charge anything for his consultation services.

Pirgacha St. Paul's Parish is a Catholic mission run by the Holy Cross Fathers. It is a mission among the Garo indigenous people. This mission has a small clinic with three nurses and they are from Garo community. Most of people involved with the mission are Garo. Father Homrich started the clinic in 1993 for the healthcare needs of local people and to spread modern medical facilities among mostly Garo community members. Treatment of ordinary sickness is performed in this small clinic where they also provide free medicine for the poor. During my interview at the *Pirgacha* mission clinic, when I asked about the common diseases they handle, two nurses who work with mission, Hanna Dalbat and Falisita Nakrek, stated cold and cough are the most common diseases in children aged between 0 and 2. Sometimes they suffer from diarrhea and measles as well, but now as they get vaccine, they suffer less from measles. Two to five years old children suffer from almost the same. Moreover, this clinic provides them with the medicaments necessary to cure hookworm diseases, which children have to take every six months. Now the government provides support to buy drugs to fight hookworms too. Generally, children within this age group suffer from fever and headache. According to them, children from five to twelve years old suffer mostly from diarrhea. When I asked about the medicine distribution by the mission, the nurse, Felisita Nakrek, said that the Father of the mission provides money for medicines. They order medicine through representatives of pharmaceutical companies, which they then distribute for free to the poor patients. Generally, they provide medicine like Paracetamol and Amodis which are the most commonly used drugs. She mentioned that Amodis is given for diarrhea treatment and Paracetamols for fever. And also they provide medicine for gastric problems. Felisita also added that generally they provide primary treatments in the clinic. As they do not have specialized doctors, they cannot prescribe other medicines. So, for serious illnesses they refer the sick children to hospitals or clinics in the big towns.

As the employees in this mission are from the Garo community and the medicines are given free of charge, many parents of *Sainamari* village prefer to go there. Usually the clinic offers treatment for primary illnesses and provides medicine where they do not need any doctor's prescription.

6.5 Factors Influence the Choice of Different Health Care Providers

The Perception about Nature of Illness

Considering that they are different medical systems, each with its own practices and belief systems, Garo parents have to choose which medical system to use and why those choices. Through my focus group interview and other individual interviews, I collected information according to which the choice is influenced by the perception about the nature of illness.

Most of times, when they believe or know that the illness is caused by natural factors parents tend to refer to bio-medical practitioners. Parents tend to choose *Kabiraj* if they believe that the illness is caused by supernatural causes and occasionally also if they believe illness are originated by natural causes. And they choose *Khamal* only when they think the child is affected by deity of traditional religion *Sangsarek*.

Religious Belief

Religious belief induces the parents to choose different health care provider for their children. A mother, called Maria, told that her belief in Christianity also influences her decisions whether to use spiritual therapy or not, such as the belief in *Metdi*. She said: 'Christians do not believe in *Metdis*, we just only go to doctor.' Another participant, Kuheli Simsang, said she believes in treatment of *Kabiraj* and doctor. When her children get ill, first she goes to the doctor and then, if it does not work she goes to *Kabiraj*. But she does not believe in deities. According to her only those people goes to *Khamal* who depends on the *Amwa* or *Puja Pali* (prayer of traditional Garo religion) regularly. She even thinks that there are some deities, for example *Chini Medti* (water deity), that do not affect everyone but only affects the people who believe in it. Based on these assertions, it appears that the belief systems of individual mothers, to some extent, influence their choices for medical systems and practitioners during the healthcare needs of their children. And there is religious syncretism among them which blends traditional Garo religion and Christianity.

Another mother, Jhuma Nakrek, did not agree with Pinika Simsang. She said that even those who do not believe in *Metdi* can be affected by *Medti*. She is a Christian, but she still believes in *Metdi*.

She thinks that Garo people go to *Kabiraj* and *Khamal* for the treatment of their children. She does not prefer doctors always for herself or her children. *Metdi* affected her child once and *Khamal* healed her and this lead her to believe in *Medti*.

Key informant Linu Simsang is a Christian but she is also a strong believer in *Metdis*. During the interview I asked her information about parents' choice or their health seeking behavior for children and she told me that she believes both in doctors and traditional healers. According to her experience people first go to the doctor, then if they do not get better, they go to *Kabiraj*. If the *Kabiraj* fails then they go to *Khamal.* Linu Simsang thinks the parents' choice among different health care providers depends on their beliefs. Many people might tell that they disbelieve the *Metdis*. But she saw in her experience that when their child was ill and all doctors and *Kabiraj* failed, they went to go to *Khamal* for the treatment because that was the last option of treatment. And she thinks *Khamal* never fails, if the illness is caused by *Metdi* and the *Amwa* is performed successfully.

During the discussion there were disagreements among the mothers in the group based on their beliefs. Some said that they never go to *Khamal* and it is only for those people who believe it and they even get sick by *Metdi* because of their belief. On the other hand, there are mothers who believe in the healing practices of *Khamal* and they went to *Khamal* for their children.

Expected Effectiveness of Different Treatment

There were few parents who had different experiences and had gone to several health care providers for treatment and the effectiveness of different treatment. A mother, Anita Dalbot, told her experience of going to every health care provider for her children. She said that once her child had fever and she went to the doctor; when the doctor failed then she went to *Kabiraj*. When *Kabiraj* failed then she went to *Khamal*. She is ready to refer to all kind of health care provider where she believes that the child would be cured.

Another mother, Sheuli Simgsang expressed a different opinion. She prefers to go to *Kabiraj* usually and if the *Kabiraj* fails to heal the illness she then would refer to other health care providers. Sheuli said she goes to *Kabiraj* most of the time for her child. However, if sometimes the child does not get cured, then she has to go to all kinds of health care providers for treatment, because

nothing is more important than her child's health. Another mother, Reshma Manthin, also agreed with Sheuli's last statement. Reshma stated-

> *'We will go to anyone, where the child gets cured. Parents can go anywhere where their child get better result of treatment for the sicknesses.'*

The effectiveness of first treatment by health care provider determine look for second option of treatment. In my research findings, parents move from one treatment to another treatment when the first therapy failed to cure the illness of children. This situation confirms the idea of chronological therapy seeking has been elaborated by Rumanucci-Ross who argued that people chose therapy or therapies chronologically in a plural setting, creating a hierarchy of resort. Sometimes people began their treatment with “modern” medicine, and sequentially moved toward the earlier modes of treatment, creating an “acculturative hierarchy of resort”. In some cases, people began their treatment with the earlier modes of treatment and gradually moved toward the “modern” medicine, creating a “counter-acculturative hierarchy of resort”. People chose therapies chronologically according to the perceived success or effectiveness of the treatment. They moved from one kind of therapy to the another when the first therapy failed to cure the illness (Rumanucci-Ross 1977, as cited in Begum, 2015).

Financial Obstacle and Poverty

The cost of using biomedicine to treat some illnesses is not affordable for everyone. During the interview Jhuma Nakrek, a 45-year-old mother, said she found that the bio-medical treatment was expensive when her older child had pneumonia. So, she did not continue the total treatment due to their poverty. She said for the treatment of pneumonia the *Pardeshi Doctor* suggested to give injections to the child. As the injections were not available nearby, he said he could get it from the nearby town. The cost of each injections was 150-200 BDT (1.71-2.28 Euro), which was not affordable for Jhuma's family. The doctor suggested to give 5 injections to the child. As they could not afford, they only took 3 injections. They could not take all 5 injections as the doctor suggested; this reported episode suggests that sometimes parents are compelled to make different health care choices for their children, not based on beliefs or wishes, but in line with their economic situation.

Few parents went to hospital or clinic for their children's treatment. In those cases, they had to pay consultation fee, diagnosis test fee, medicine cost and also travel cost. The treatment costs can be

different for different illnesses. Sometimes if a child needs to be operated then it becomes very expensive treatment. As mentioned earlier in this chapter Palinush went to hospital so that his son could be operated for appendicitis. During that treatment, the cost of treatment and travel cost to the hospital took more than 3000 BDT (34.27 Euro), which was quite a lot of money for a peasant farmer.

Parents who wish to access bio-medical treatment for their children also have to travel from Sainamari village. As it is mentioned in chapter four, the travel cost is also a big factor in terms of affordability of biomedical facilities for patients.

The data I collected indicate that the costs of *Kabiraji* medicine or treatment differs for different illnesses: they take very less amount of money like 10 BDT (0.11 Euro). Sometimes they even provide free medicine or treatment to known patients. However, for few treatments the medicine cost can range from 50 BDT to 100 BDT (0.57-1.14 Euro). However, during the focused group discussion when there were different opinions about expenses of different treatment. One mother, Kuheli Simsang, said spiritual healing or *Amwa* is expensive. Sometimes to have *Amwa*, they have to sacrifice a pig or goat, which is not affordable for everyone.

But a mother Jhuma said during the same discussion, in most household they raise domestic animals like cows, pigs, goats, pigeons, ducks and cocks. These animals are mostly use for household consumption. So, even for *Amwa*, they use their own domestic animals most of the time, only in few cases they need to buy from market. The discussion provided me with information which suggest that although the cost of animals that required for *Amwa* is high and not affordable for everyone. However, as most of the households raise domestic animals for their own consumption they can actually manage to sacrifice the animals for *Amwa*. As, *Khamal* do not take any money the family need to arrange the feast for *Khamal* and for guests.

The financial obstacle is one of the major issues for the choice of different heath care providers in the *Sainamari* village community. Parents prefer to go for the cheaper treatment for different sicknesses of their children. This research shows that the bio-medicine is expensive than the treatment of folk healers like *Kabiraj* or *Khamal* or use of home remedies. According to research findings of Young and Garro usually people begin with the lowest-cost alternative. They argued that costs along with the seriousness of illness dominated the decision-making process among

Mexican villagers. Young and Garro observed that “even though people would prefer first to choose the highest likelihood of cure, economic limitations constrain their choices in favor of lowest estimated cost, approximating a cost- ordered sequence” (Young and Garro 1981:168, as cited in Begum, 2015).

Accessibility and Availability

During an interview; a mother, Pinika Simsang, indicated that they use home remedies first when a child got ill. They use herbs obtained from their gardens or from the forest or get medicine from pharmacy for the treatment of common illnesses. However, if the child does not get well then they go to doctor or other health care providers like *Kabiraj* or *Khamal*.

This research finds that the home remedies are the most available treatment for the parents which they use as first aid. Then they go to folk healers or bio-medical practitioners. In the *Sainamari* village *Kabiraj* and *Khamal* are available. But for the bio-medical treatment parents need to go outside of village to seek doctors, hospitals or clinics. In another research it is also found that inaccessibility to healthcare services hinder people’s use of these services in rural Mexico. Young and Garro emphasize, ’Accessibility ... is the principle factor facilitating or constraining decisions to seek a physician’s treatment’ (Young and Garro 1982:1453, as cited in Begum, 2015).

Decision Making of Choosing Health Care Providers

When I asked during the focused group discussion about the decision regarding choosing health care providers for children Kuheli Simsang said regarding decision of where to take the children for treatment, both the father and mother make a joint decision together. She also said the mothers understand better about child's condition. But mostly both parents do discussion about choosing the health care provider when the child is ill.

A father, Sumon Simsang, told during the interview that his wife believes in *Kabiraj* and *Khamal,* but he does not believe in them. He thinks in Christianity there is no scope to believe in *Kabiraji* or *Amwa*. The time is modern now, so he believes in modern treatment which is given by only doctors. Only once one of their child was taken to *Kabiraj* because he was not at home and his wife decided to go to *Kabiraj*. But he strongly disliked that when he came to know about it. Otherwise, they always take their children to doctors if the home remedies do not help to cure.

Although the Garo community is a matrilineal society, in decision making of family issues like choosing health care provider is taken by the father in some families while in some families both parents take this decision by discussion.

6.6 Summary

Garo parents depend on medical pluralistic health care system for their children's health problems, which includes several kinds of treatments like household home remedies, traditional herbal treatment by *Kabiraj*, spiritual healing by *Khamal* and biomedical treatment by village doctor, midwife, missionary clinic or hospital. Thus, although the Garo indigenous community use biomedical treatment, still they largely depend on indigenous healing practices like use of home remedies, treatment of herbalist and spiritual healer. This finding confirms the study of Rahman which state that 'traditional healers are still very popular among the tribal population in Bangladesh' (Rahman et al. 2012). The factors that influence the choice of health care system include the perception of the nature of the illness, religious belief, the expected effectiveness of different treatments, financial obstacles and poverty, accessibility, the availability of health care services and the decision family members etc.

CHAPTER SEVEN

SUMMARY AND CONCLUSION

This study has explored the health seeking behavior for children in the Garo indigenous community of Bangladesh. In this chapter I intend to summarize the main findings with relevance to medical pluralism theory and draw some conclusions with reference to the research questions regarding how Garo parents categorize different illnesses when seeking healthcare, what the available options of treatment for their children are, and what factors influence their health seeking behavior for their children health needs.

7.1 Summary of Findings

My research allowed me to obtain and elaborate significant data regarding the Garo community. Such information is particularly relevant of their health seeking behavior, in particular with reference to children. The fieldwork allowed me to live in the community, to collect first-hand, information from the local people. The research indicates that the Garo society relies on a medical pluralistic health care system, which includes several kinds of treatments, i.e.: home remedies, traditional herbal treatment and spiritual healing and biomedical treatment.

In most societies, there is a number of ways for seeking help for sickness or illness. In both western and non-western societies, there is health care pluralism where modern or scientific medicine is one form of health care, together with alternative systems such as herbalism, spiritual healing, homeopathic etc., which Helman calls health care subcultures (Helman 2007: 81). Within the Garo community, different health care systems co-exist: the scientific medical system (missionary health care, village doctor, drug store, hospitals, clinics, midwives), *Kabiraj* (the traditional herbalist), *Khamal* (the spiritual healer), as well as the use of home-remedies.

In Kleinman's Medical Pluralism theory the health care is divided in three different sectors: the popular sector, the folk sector and the professional sector. These categories show some similarities with the Garo people health care systems in the *Sainamari* village. The use of home remedies belong to the popular sector, the treatments provided by the *Kabiraj* and *Khamal* belong to the folk

sector and the scientific medical system belong to the professional sector. These health care systems in the Garo community of the *Sainamari* village is shown in the figure below.

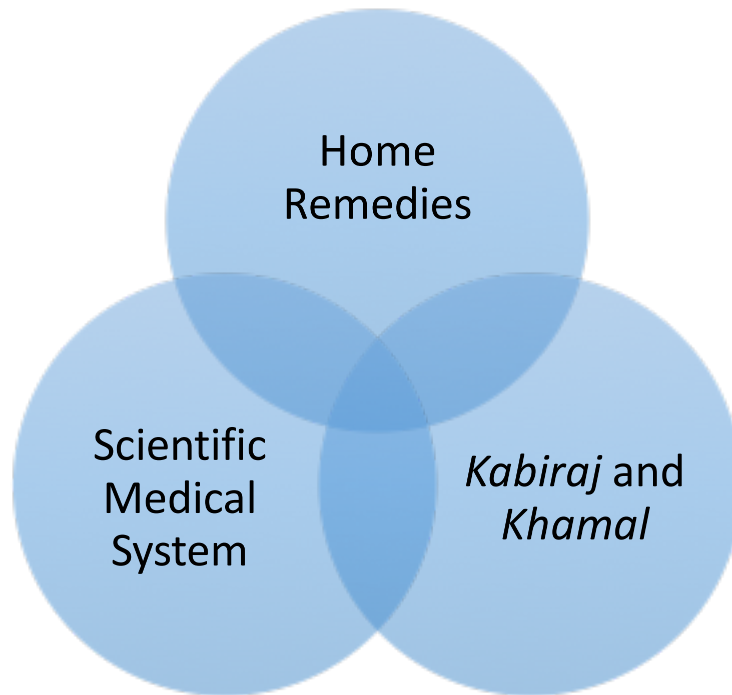

Figure 4: Health care systems in the Garo community

Source: Obtained during fieldwork, 2015

Home Remedies

The popular sector of health care includes self-treatment, advice regarding treatment, self-help group, and consultation with experienced person. In this popular sector, the main arena of health care is the family. In both western and non-western societies most of the time mothers or grandmothers diagnose common illnesses and treat them with available materials (Helman 2007:82). In the *Sainamari* village I observed that parents, mostly mothers, use home remedies for different illnesses of their children. When a child gets sick parents immediately try to use available home remedies before going to any other health care providers. They they use various herbal remedies or sometimes get medicine from the drug store assuming the illness as household treatment.

Traditional Herbal Treatment and Spiritual Healing

The folk sector of health care is mainly very common in non-industrialized societies. The folk sector has various forms of healing like bone-setters, midwives, herbalist, spiritual healers, shamans and so on. Also in western countries alternative medicine or complementary medicine is used, which sometimes overlaps both folk and professional sector (Helman 2007). In the *Sainamari* village they have both a *Kabiraj* (traditional herbalist) and a *Khamal* (spiritual healer) as folk healers. The parents of the Garo children are sent or brought to the *Kabiraj* for various illnesses, like what they believe to be the effects of an evil spirit or an evil wind, broken legs, hepatitis, fever, stomach pain etc.

The Garo people living in the *Sainamari* village have converted to Christianity. Nevertheless, they still believe in deities of their traditional religion *Sangsarek*. For many illnesses the Garo children are often taken to *Khamal* to perform *Amwa* (ritual for healing). There is a strong belief that anyone can get affected by the evil deities and get sick. For those illnesses the modern medical treatment is not effective and therefore they cannot cure what evil deities cause. It is only *Amwa* performed by *Khamal* that can cure the affected person from illness. In the *Sainamari* village, there is one *Khamal* (spiritual healer) who performs spiritual healing rituals for the ill children.

Biomedical Treatment

The western scientific medicine biomedicine is considered as a professional sector of health care. Although there is no doctor nor hospital in the *Sainamari* village, parents sometimes get biomedical treatment from a village doctor of the nearby village, hospitals of the town of *Madhupur* or clinic of *Pirgacha Mission*. There are three midwives in village who have both indigenous knowledge and formal training to help pregnant mothers in home birth.

7.2 Conclusions

The parents of the Garo indigenous community categorize the illnesses according to what they believe their origin or cause is. They believe that the illnesses can be caused by natural elements, such as cold, heat, winds, dampness etc. Parents also think children get sick by supernatural forces which cause them *Torai*, *Mayla Kha and Medti Kamor* illnesses. Children may also get affected by man-made causes like *Jadu*. The illness causation of Garo community people is influenced by their indigenous culture. Thus, they believe in supernatural and man-made causes of illnesses which have no scientific explanation in the modern biomedical system. The findings show that

Garo beliefs about illnesses are alien from the modern biomedical explanations of illnesses. The indigenous knowledge bases its own explanations about causation of different illnesses on different knowledge, as it is also stated by Hughes: 'those beliefs and practices relating to disease which are the products of indigenous cultural development and are not explicitly derived from the conceptual framework of modern medicine' (Hughes 1968:99). Also Tulving states 'knowledge of the world that is independent of a person's identity and past' (Tulving 1983:9). According to findings in fieldwork, the knowledge of Garo community of the *Sainamari* village is based on their indigenous identity, culture and previous experiences. And their cultural knowledge of different illnesses determines the choice of the health care providers.

This research found that for minor illnesses parents use home remedies as primary treatment at home. The use of herbs in household treatment is based on their indigenous knowledge. According to research findings almost every mother has knowledge about the home-remedies. This village is located near the *Madhupur* forest which provides various herbs which is used by the Garo community over decades. Moreover, during my fieldwork I observed that many households have gardens in their homestead with herbal plants that are often used as home remedies. If the home-remedies fail, they seek other health care providers. For biomedical treatment parents go to a village doctor of another village or to hospitals of the town or clinic of mission. Missionary activities have influence on health care practice like sending traditional midwives to formal training, establishing tube wells for pure drinking water and encouraging using bio-medical treatment. In the focus group discussion, they also mentioned that, because they are Christian they believe only in bio medicine, not in folk healers. We can therefore infer that religion may have an impact on few parents who are prompted into choosing bio-medicine. Although there is use of bio-medical treatment but the findings of this thesis clearly shows that the Garo indigenous community highly depends on self-treatment like home-remedies and folk healers like *Kabiraj* and *Khamal*. It is very a common practice for parents to take their children to *Kabiraj* for various illnesses caused by natural and supernatural factors. *Kabirajs* are very available healers in this village. They provide effective and less expensive treatment. Also *Khamal* is a spiritual healer who gives treatment of illnesses caused by the deities of the Garo traditional religion *Sangsarek*.

There are several factors that may influence the choice of different health care providers which include: the perception of the nature of the illness, religious belief, the expected effectiveness of

different treatments, financial obstacles and poverty, accessibility, the availability of health care services and the decision making of choosing health care providers by family members. Despite these factors, cultural construction of Garo indigenous community influences their perception about illnesses, use of household treatment, choice of different health care provider and decision making.

This research found that modern professional health care system cannot treat the illnesses caused by supernatural or man-made factors. Only folk healers can treat those illnesses. Thus, folk healers play important role in health care system of the Garo community of *Sainamari* village. Parents largely depend on these indigenous healing practices and they are effective as well. This confirms the findings of Kleinman who stated 'Indigenous practitioners provide culturally legitimated treatment of illness; they must heal' (Kleinman 1979).

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Appendix 1: Sample Household Questionnaire

A. General information:

Name (household head) :	
Age:	
Occupation:	
Monthly income:	
Name of 1st child:	
Age and gender of 1st child:	
Name of 2nd child:	
Age and gender of 2nd child:	
Name of 3rd child:	
Age and gender of 3rd child:	

B. Socio-Economic profile:

Serial	Name of household members	Gender	Age	Education	Relation with child	Occupation 1	Occupation 2

Amount of property:

Birth history of child:

	Where is the birth place of your child?	Who helped in delivery? (midwife/doctor/other)	Was there any problem during the delivery? What did you do that time?	To whom did you take your child during problem of delivery?(Doctor/ Kabiraj/other)
1st child				
2nd child				
3rd child				

Growing up of child:

	Which diseases or sicknesses has your child suffered from from birth till now?	Where/To whom did you go for treatment? Did you use any home remedies?	Why did you choose that specific health care provider?
1st child			
2nd child			
3rd child			

Appendix 2: In depth interview questionnaire for parents

1. Which illnesses and diseases has your child suffered from till now?
2. What are your beliefs and rituals regarding different illnesses of children? (Why do you think your child fall ill?)
3. What are the options of treatment available for them?
4. Why do you choose different healthcare providers to treat/cure different illnesses?
5. For which specific diseases or illnesses do you take your child to doctors or hospital? Why?
6. For which specific diseases or illnesses do you take your child to traditional healer or religious healer? Why?
7. How are the bio-medicine and indigenous medicine are functioning together in health care seeking behavior of children's health?
8. Who takes the decision regarding the treatment of children?

Appendix 3: In depth interview questionnaire for health care provider

1. Background of starting their career as health care provider.
2. For which diseases do parents usually come to you for treatment?
3. What do the parents think about the causes of sickness and what do you think about the causes?
4. How do you diagnose the illness? What is the process?
5. How do you treat the ill child for different diseases?
6. How do you provide medicine?
7. How do parents feel about your treatment regarding their children?
8. Can you say that the Garo children are healthier than the non-Garo children, and if so, to what extent? What is your observation as health care provider?

Appendix 4: Focused group discussion questions

1. Where was your children born? Why did you choose to have their birth at home or at the hospital?
2. Why do your children get sick?
3. What kind of diseases do your children suffer most?
4. Where do you go for treatment?
5. What home remedies do you use for primary treatment of children?