Local Healing Practices and Women's Healthcare in Rural Bangladesh: A Case Study from Magura District

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ABSTRACT

This paper focuses on the local healing practices adopted by women and the women's healthcare system in a rural area of the Magura district. This paper also investigates the reasons for selecting local healing practices as an alternative to modern healthcare services. Qualitative research has been used in this study to get a comprehensive view of the health care system of rural women. The study found that rural women mostly choose Palli Chikitshaks (Rural Medical Practitioners) for their medical treatment. The penchant for choosing other local healing practitioners i.e., Kabiraj (traditional healers), Mollas and Fakirs (religious healers), and Hakims (plant-based medical practitioners) several factors are responsible for choosing local healers including insolvency, faith, norms of Purdah (veil), economic dependency and lack of decision-making power of women in health care. In addition, the customary reputation, attentive nature of care, good behavior, and lower fees charged by the local healers draw the attention of the rural women.

Keywords: Healing, Health care, Women, Rural area.

INTRODUCTION

The health care system mirrors the socio-economic and technological advancement of a nation. The most crucial factor of the healthcare system of a country is its availability and accessibility of different healthcare services. In Bangladesh, there exist notable disparities in accessing the fruit of modern healthcare services. Ensuring healthcare for the marginalized population is the biggest challenge of NHP of the government of Bangladesh. Since 80% of the population of Bangladesh lives in rural areas, it is the responsibility of the government to provide them with proper healthcare services to materialize the third goal of SDGs- "Good Health and Well-being". Though the majority of the population lives in rural areas, they are in a vulnerable position in accessing the outcome of modern medical services. Women are the most neglected group of the rural population who are denied the minimum requirement of proper healthcare services. In this era of modern medicine, many people, especially women still depend on the practices of local healers and traditional practitioners. This traditional belief of common people about the village quacks leads to their frequent visits to such practitioners in case of any kind of medical emergency. Due to financial, social, and psychological impacts, the rural poor people, especially women are bound within the traditional method of treatment available in rural areas. Modern health services are characterized by urban/rural, regional, rich/poor, and other disparities and existing services are often erratic and inadequate to the needs (WHO,2020). A study found that the ratio of the hospital bed to the population is 0.79 in Bangladesh (World Bank, 2016). The pluralistic nature of the health care system and various forms of ethnomedical treatments have been developed over time as an alternative to modern medicine in the context of Bangladesh (Zaman, 2005). In this era of modern medicine, many people, especially women still depend on the practices of local healers and traditional practitioners. In this context, this research focuses on the local healing practices adopted by the women and women health care system in Saziara village of the Magura district. The study also investigates the reasons and perceptions regarding selecting local healing practices as an alternative to available modern healthcare services.

Objective of the Study

The general objective of the study is to Local Healing Practices and Women Health Care System in a Rural Area in Magura District and the specific objectives are

1. To know the demographic condition of the respondents.
2. To investigate the reasons for selecting local healing practices as an alternative to available modern health care services;
3. To provide recommendations for addressing the factors leading women to opt for local healing practices instead of available modern healthcare services.

METHODOLOGY

Considering the nature of the study this research was designed as the qualitative approach which provides deeper insights and discursive aspects of the phenomenon. To do so appropriate qualitative tools have been employed in the designing phase. Both primary and secondary data are used in the research which helps to get a more comprehensive understanding of the context. The secondary data provided an overview of the problem, while primary data served as firsthand evidence which enriched the research by providing narratives, case studies, and a more holistic understanding of the problem. The study location selected for the study is Saziara village of Magura Sadar Upazila of Magura district under the Khulna division. The key methods of data collection in this respect have been Focus Group Discussion (FGD), In-depth Interviews (IDI), Key Informant Interviews (KII), participant observation, and discussion. The study comprised 02 FGDs (each with 8 participants of a homogeneous nature), 08 IDIs, and 06 KIIs. The age group selected for the study is 15-60. The data were collected over a month in a reflexive and participatory manner. The data collection tools utilized in this study are open-ended and semi-structured questionnaires. All research ethics and protocols have been maintained during the fieldwork.

Ethical Consideration of the Study

Ethics has become a cornerstone for conducting effective and meaningful research. The dignity, rights, safety, and well-being of participants are the paramount considerations in any research endeavor. Ethical concerns often arise due to the characteristics inherent in qualitative or field methodologies, which typically involve prolonged and intimate personal engagement, interviewing, and participant observation. However, the challenges inherent in qualitative research can be mitigated through awareness and adherence to well-established ethical principles. Ethical principles can be used to guide the research in addressing the initial and ongoing issues arising from qualitative research to meet the goals of the research as well as to maintain the rights of the research participants. While these principles do not guarantee ethical research, they significantly contribute to the understanding that ethical responsibility in qualitative research is an ongoing process. Thus, qualitative researchers should report the incidents and ethical issues encountered in their studies to ensure discussion, analysis, and prevention of future mistakes. Qualitative research involves data that are recorded in narrative descriptions, not numbers. Researchers use qualitative methods to observe and describe conditions rather than control them. A basic ethical principle for qualitative researchers is this: Do not tamper with the natural setting under study. Participant and nonparticipant observations are integral components of qualitative research and are used widely in the fields of education, sociology, and anthropology. Each presents unique ethical issues regarding consent, privacy, and deception (Brinkmann & Kvale, 2005; Haverkamp, 2005). Ethics can be thought of as the study of good conduct and of the grounds for making judgments about what is good conduct. The ethical issues that have been addressed in the present study included informed consent, confidentiality, and anonymity. As informed consent is one of the most important tools for ensuring respect for persons during research, everyone who participated in this study freely consented to participation, without being coerced or unfairly pressurized. Research ethics deals primarily with the interaction between researchers and the people they study. Because qualitative research is conversational, the researcher needs to maintain clear boundaries between what they are told by participants and what they tell participants. Therefore, the sensitivity of the data in the view of the individual being studied was considered and data were treated with appropriate confidentiality in conducting the research. In cases where the participants were willing to be interviewed but did not prefer the tape recording, writing down exact quotations supplemented by comments was followed. Again, responses from one interviewee have been kept confidential from the other. In addition, it is necessary to assure the participants that the data will be held in strict confidence to protect anonymity. So, the respondents have been given pseudonyms such as A, B, C, and D in the study. It was also ensured that

research participants were protected from undue intrusion, distress, indignity, physical discomfort, personal embarrassment, or psychological or other harm.

THEORETICAL FRAMEWORK

The Health Belief Model (HBM) is a framework used to understand the behavior of health in light of personal beliefs and the perception regarding the disease and follow the strategies available to have the optimum reduction of the occurrence of the particular disease (Hayden, 2019). It was developed in the 1950s as a way to explain why medical screening programs offered by the U.S. Public Health Service, particularly for tuberculosis, were not that successful (DiClemente, et al, 2013). The underlying concept of the original HBM is that health behavior is determined by personal beliefs or perceptions about a disease and the strategies available to decrease its occurrence (Green, Murphy, and Gryboski, 2020). Joana Aboyoun Heyden (2019) described HBM theory as the construct of **perceived seriousness** that speaks to an individual's belief about the seriousness or severity of the disease. While the perception of seriousness is often based on medical information or knowledge, it may also come from beliefs a person has about the difficulties a disease would create or the effects it would have on his or her life in general (Mccormic-Brown, 1999 cited in Heyden, 2014). **Perceived susceptibility** is one of the more powerful perceptions that is promoting people to adopt healthier behaviors. The greater the perceived risk is the greater the likelihood of engaging in behaviors to decrease the risk. **Perceived benefits** are a person's opinion of the value or usefulness of new behavior in decreasing the risk of developing a disease. **Perceived barriers** are an individual own evaluation of the obstacles in the way of his or her adopting a new behavior. Of all the constructs, perceived barriers are the most significant in determining behavior change (Shields, Synnot, and Barr, 2012). The four major constructs of perception are modified by other variables, such as culture, education level, past experiences, skill, and motivation, to name a few. These are individual characteristics that influence personal perceptions (Shields, Synnot, and Barr, 2012). The HBM suggests that behavior is also influenced by cues to action. Cues to action are events, people, or things that move people to change their behavior. Examples include the illness of a family member, media reports (Jones, Smith, and Llewellyn, (2014), mass media campaigns, advice from others, reminder postcards from a healthcare provider, or health warning labels on a product. Later after decades, self-efficacy was added to the original beliefs of the HBM. Self-efficacy is the belief in one's ability to do something

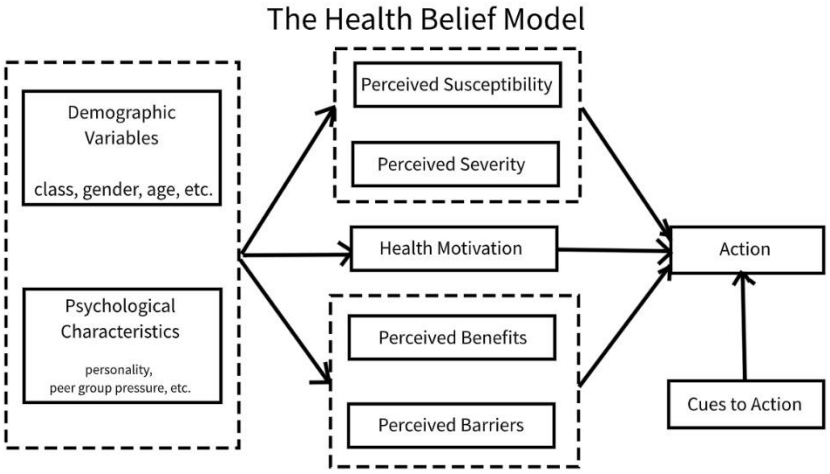

Figure 1: Green, E.C., Murphy, E.M. and Gryboski, K., 2020. The Health Belief Model. The Wiley Encyclopedia of Health Psychology, pp.211-214.

Brown, (2018) illustrates that feminist theories and models are influential in determining healthcare and other livelihood decisions, especially among rural illiterate or semiliterate women. The model in this study aims to effect change to provide healthcare facilities to rural women and to seek social transformation. Four major themes recur in this model: symmetry in provider-patient relationships, access to information, shared decision-making, and social change. This theory describes ways in which clinicians can integrate these themes into

practice. Suggestions for maintaining symmetry in the traditional power relationship include decreasing physical, social, and personal barriers and attentive listening to patients' stories. Shared decision-making is central to feminist practice and is attainable when patients, especially women are empowered and knowledgeable about their healthcare needs. Das and Baruah (2020) assert that liberal feminists intend to ensure equal opportunity for both males and females "within the system", advocating for equal opportunity and employment for women in healthcare, and criticizing the patronizing attitudes of physicians. Radical feminists, on the other hand, reject "the system" as inherently oppressive towards women and strive to establish alternative structures to fulfill their needs. They see the division between men and women as the primary contradiction in society and patriarchy as its fundamental institution.

Feminist theory serves as a primary tool for evaluating the types of medical care available to women in rural areas of the southern part of Asia including Bangladesh, India, and other regions. The concept of equality, particularly gender equality, also influences women's treatment preferences, as highlighted in Karnyski's study (2009). According to the research, equality holds significant importance in Indian culture.

The salience of feminism can be seen as a reflection of ways to enhance women's lives, including healthcare, through contribution. The concept is illustrated in the figure below.

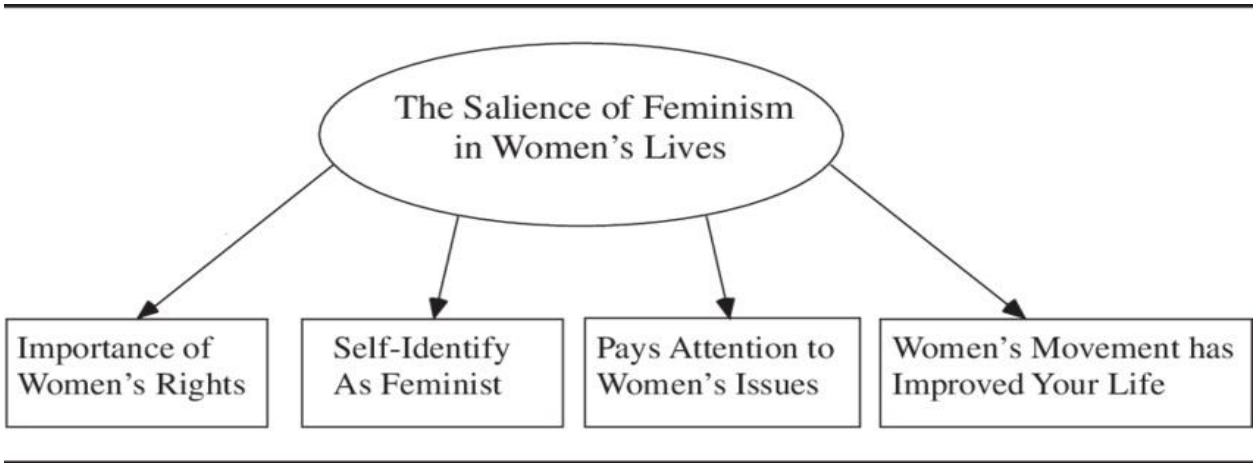

Figure 2: Ryan, B., 2013. Feminism and the women's movement: Dynamics of change in social movement ideology and activism. Routledge.

FINDINGS AND ANALYSIS OF THE STUDY

Local Health Care System of Women

Ethno-medical Care

The study found that one of the local healthcare practices of women is ethnomedical care. Ethno-medicine is related to indigenous cultural development such as traditional medicine, Ayurvedic medicine, and medicine prepared from plants, leaves, herbs, oil, fruits, etc. The summary of the statement can be drawn from the statement: Ayub Ali, who has no institutional education, lives in the village and practices ethnomedicine as a Kabiraj. His father was also a practitioner of medicine (indigenous) and was very popular during his time among the villagers. Ayub Ali acquired medical knowledge from his father, who passed down the tradition. While other family members also possess some understanding of medicine, Ayub Ali is the sole practitioner among them. He prepares medicine from plants, leaves, herbs, oil, fruits, and flowers, which he collects daily in the morning. He makes 'Bori' or 'Botka' (small balls), syrups, and emulsions from the extraction of plants and leaves for his patients. He is a man of 'Tularashi' (libra). As a man of Tula Rashi, he believes in his ability to heal and solve various problems, a belief shared by the villagers. The majority of his patients are elderly individuals suffering from chronic ailments and acute orthopedic problems, while a few do not have any specific disorders. Sick persons visit him irregularly for treatment. Although He charges money for the medicine he provides, there is no fixed rate; people generally pay the fee according to their financial ability.

The study also found that women in this village frequently depend on faith-based ethnomedical care provided by local religious experts. For instance, Habibur Rahman is an Imam (one who leads Muslim worshippers in their prayers) of the Saziara village's mosque guides sick individuals regarding the ingredients, proportions, and applications of medicines, rather than dispensing prepared medicine. He takes no money for his consultation and is highly respected within the community. Instead, he offers Tabij—a piece of paper inscribed with verses from the Holy Quran or Hadith by the Imam—to his patients. Mostly women visit him for gynecological and other illnesses for themselves and their young female members of the family.

Sometimes consulting a woman ethnomedical care provider is more comfortable for rural women rather than a male provider. The response below can be the evidence of the conclusion drawn above as Kohinoor Begum; 75 years old is a 'Kabiraj'. She lives in the village; and practices Kabiraji (medical consultancy) midwifery and 'Jhar-Phuk' (oral incantation). She is frequently visited by patients willing to terminate an unwanted pregnancy. She claimed that she knows many social secrets and perceives herself as powerful. Among her patients' the majority are with chronic disorders and mostly female patients complain after her treatment. Patients visit her irregularly. She receives money and rice for the treatment but not at any fixed rate. In exchange for treating sick persons, she also collects vegetables, and sweets from the villagers.

Homeopath Care

The research revealed that homeopath care is another important and widely used local healthcare practice for women. Homeopath care is widely used for its low cost, availability, and no-side effects nature. Homeopath care providers in the study area often practice it as their supplementary profession. Some of them are untrained and lack of formal qualifications. For instance, the response of one of the respondents Abdur Rahim (age 37) is an Imam of a local mosque in the village and an untrained homeopathic practitioner. He is also a 'Hafez' and operates the roles of faith healer and homeopathic healer. But he is more regarded as a homeopath. He has no formal qualification in homeopathic medicine. The majority of his patients are children and women. He does not charge a fixed fee for a consultation. He gives medicine on credit to be repaid later during 'Halkhata' (a yearly ceremony on the last day of the Bangla month Chaitra when they settle all the dues). Kalim Uddin is a school teacher who is also a homeopathic practitioner. He is a graduate but has no formal qualification as a medical practitioner. He claimed himself as a self-taught homeopath practitioner. Most of his patients are children and women.

Religious Healing Practices:

Women in the study area believe that religion plays a prime role in curing diseases. They perform different religious rituals to cure diseases. Religious rituals serve as remedies in various forms, such as Tabij (a written verse of the Holy Quran inserted into Khol, a metal object), which is utilized as a remedy. Other healing practices include Pani Pora (charmed water), Milad (a Muslim religious ritual often arranged to cure disease), and Manot (women offering vows to the poor in the name of Allah). Manot also involves arranging food for the poor, donating money to a mosque, performing Nafal Namaj (a non-mandatory prayer in Islam), and fasting by Muslims. Additionally, there is a belief that if someone offers something during another person's illness and fails to fulfill their offerings, they may encounter significant problems in the future. In the Hindu religion, individuals wear Poita, a chain made of Tulshi (basil plant). Tulshi is cut into small parts and arranged into a chain-like form. They believe wearing this helps them avoid accidents. Additionally, they worship God Norshingah for their safety, considering him as the deity who looks after their well-being. Hindu devotees also engage in Manot as a religious ritual. If someone falls ill, they sacrifice a goat in the name of Debota (God) at the kali bari (Temple of Goddes Kali). Furthermore, they believe that lighting incense and engaging in regular worship ensures them a safe and disease-free life.

Modern Medical Care for Women

In the rural areas of Bangladesh, the available healthcare services include the Upazila Health Complex (UHC), also known as the Thana Health Complex, and the Union Health and Family Welfare Centre (UNFWC). At the village level (covering several villages) there are community clinics (which are yet to be installed and are functioning in many proposed areas).

Rural Medical Practitioners (Palli Chikitshaks):

In the study area, women extensively rely on Palli Chikitshaks (Rural Medical Practitioners) for medical treatment. One such practitioner is Mojibur Rahman, who initially worked as a compounder under an MBBS doctor before completing a training course to become a certified Rural Medical Practitioner. His clientele includes individuals of all ages and genders, and he addresses various health issues within the village community. For complex cases, where he deems additional assistance necessary, Rahman refers patients to the Upazila Health Complex (UHC) or the Magura 250-bed District Hospital (widely known as Magura Sadar Hospital in this area).

Another woman named Sultana Akhter is a non-trained village doctor. She was a compounder of an MBBS 'Dr. Sokena Khanam Beli'. Now she is a gynecologist practicing independently. Her patients come from nearby communities. Most of the visitors are around his lineage and house. She considers that she is learning and gathering experiences now.

Upazila Health Complex (UHC)

One of the public health services includes Upazila Health Complex (UHC) which provides health services for women. However, this study shows that women's healing practices like the birthing of a child in this area are generally done by traditional birth attendants (dais) or elderly experienced female kin members or neighbors. Although the Upazila Health Complex (UHC) offers healthcare services for women, these services are deemed inadequate and insufficient for rural women. Several factors contribute to women's inability to access these services, including financial dependency on male counterparts, dependency in making a decision about taking any healing processes, lack of information and knowledge, etc. Respondents noted that the Upazila Health Complex in this area provides limited services and has insufficient capacity to cater to women's needs. Additionally, there is a shortage of experts, including doctors, nurses, and administrators.

Saleha Begum (36) said that 'doctors in UHC and Sadar hospital don't want to hear the problem of their patient care but suggest a private clinic, and in private clinic the similar doctors are very conscious about their patients,'

Magura 250-bed District Hospital:

District Hospitals are the heart of the health services in Bangladesh. However, rural women often Some respondents stated that they frequently seek medical treatment from Magura 250-bed District Hospital. However, this decision is influenced by various factors such as education level, awareness, type and severity of the disease, and financial capability. The following response is from Poli Rani Paul, a 28-year-old homemaker who completed intermediate-level education: "I believe we should consult a specialist even for minor illnesses. If I fall ill, I first visit the emergency section of Magura Sadar Hospital to consult with doctors and buy medicine from local dispensaries".

District's hospitals are overcrowded and sometimes not women-friendly. For instance, "Khadija shared her experience "I was surprised when the doctor issued me a prescription without hearing me properly, but I had to wait in line to collect the entrance slip, it was so painful to stand in a long line. I should go to a Fakir/Kabiraj rather than a hospital because Kabiraj understands my pain and hears me attentively".

Women are more prone to various diseases due to a combination of different physical, socio-cultural, and economic factors including income, financial dependency, etc. For instance, during the pregnancy period and the post-natal period, necessary food and medical care for women of a rural household, particularly from the poorer section, are generally very inadequate and insufficient (C. Chen et al,1981). In Bangladesh, rural women often face different barriers to the accessibility of medical care. That may develop because of location, financial requirements, bureaucratic responses to the patient, the social distance between client and provider, and the sex of providers (Hossen and Westhues,2011). In the study area, poor women engage in various local healing practices, and there are several reasons behind their preference for these practices over modern health

services. Gender-based inequality is a pervasive issue within the healthcare system for women in Bangladesh, and Magura is not an exception.

Local Dispensaries:

Another significant finding of this study is that women in the study area often resort to consulting allopathic medicine sellers at local dispensaries as a form of healing practice. Many of these sellers lack formal institutional knowledge about modern medical treatment, thus they rely on information provided by agents from various pharmaceutical companies. However, due to the complex socioeconomic factors, rural women consider consulting with dispensary owners and taking medicine as a feasible healing practice. Some respondents reported facing various health complications due to taking incorrect medicine and doses from dispensaries. This study also revealed that rural women lack information and awareness about health-related issues and modern medical practices.

Non-Governmental Organizations (NGOs):

In the rural areas of Bangladesh, another significant source of modern medical care for women comes from primary health and medical services provided by Non-Governmental Organizations (NGOs). In the study area, respondents indicated that they receive medical knowledge and medication from these NGOs. For example, organizations like the Bangladesh Rural Advancement Committee (BRAC) offer services such as family planning, and basic pregnancy-related care.

Reasons for Selecting Local Healing Practices Instead of Available Modern Health Services:

Modern healthcare facilities are delivered to the women of Saziara village, Magura through Upazila Health Care Center (UHC) (also called Thana Health Complex), Union Health and Family Welfare Centre (UHFWC), Palli-Chikitshak, MBBS doctors, pharmacy, and NGOs. This study also found that women in the area tend to rely on local healing practices instead of available healthcare facilities for various reasons. These include discrimination rooted in social stratification, unequal access to modern medical services, and economic dependence on male members or others. Within the patriarchal system, men typically hold dominance over women, and decision-making power within households is often vested in males. Respondents noted that men's attitudes toward women are more often indifferent and lacking in care regarding female health issues. Furthermore, women's perceptions of these systems vary among respondents based on their personal experiences. Women in rural areas, including villages like Saziara in Magura, are frequently excluded from hospital healthcare services for various reasons. As a result, they rely on local healing practices rather than utilizing available healthcare facilities.

Limitations of the available modern health care system influence the health-seeking behavior of rural women. Respondents added their past experiences as primary reasons for selecting local healing practices over available modern healthcare services, highlighting various limitations of the modern healthcare system in rural areas. These limitations include doctors' lack of attentiveness to their problems, insufficient provision of medication, prioritization of wealthy patients, high costs associated with private consultations, and personnel displaying rudeness towards rural, poor, and uneducated patients. Additionally, respondents mentioned doctors' frequent absence from the Upazila Health Complex (UHC), the long distance of health centers from their homes, and a lack of faith in modern medicine. The above-stated reasons can be supported by the arguments in response collected from the respondents:

Monira Khatun, aged 25, shared her experience by stating, "At the Upazila Health Complex (UHC) or Sadar Hospital Doctors don't want to listen carefully to their patients. However, at private clinics, the same doctors are attentive and listen carefully to their patients. Unfortunately, we cannot afford the 600- or 1000-taka visiting fees required for appointments at private clinics in Magura town. Therefore, we generally resort to homeopathic medicine for illnesses including fever and pain. Additionally, we rely on local healers, such as Kabiraj, who provide 'Pani Pora' (charmed water). Moreover, we consume the juice of Thankuni (Centella Asiatica) leaves when we get affected by dysentery''. Another respondent Firoza Akhter (27) shared her experience, stating, "After having diarrhea and fever I went to Magura Sadar hospital. To have a ticket I had to

stand in a line for a long time and got an appointment to consult with a doctor. The doctor started writing prescriptions without asking anything about my disease. Moreover, I don't prefer to take allopathic medicine due to its harmful side effects. I think homeopathy is better than allopathic medicine".

Since women have special healthcare needs or issues that require special focus, certain aspects need to be prioritized to ensure proper women's healthcare. These include enhancing the responsiveness of the healthcare system to women's needs, recognizing and addressing differences between the healthcare needs of women and men, identifying and eliminating disparities in the healthcare system, and providing necessary evidence-based information to empower women in making healthcare decisions.

Gender-based inequalities in the healthcare system in Saziara village can be one of the reasons for selecting local healing practices instead of the available modern healthcare system. Due to patriarchy, women are not treated equally to men, and accordingly. Discrimination against women is visible in different spheres of life such as education, social status, power, freedom, and health care (Walton, Maria, and Schbley, 2013). Under the patriarchal system, males dominate women, household decision-making power generally lies with the males. Males' attitudes toward women are also indifferent and not that careful regarding women's health, food, and other necessities. Some of the important social and cultural barriers embedded in the patriarchal norms of the society create obstacles for the rural women in Saziara village in Magura. For instance, Asma Khatun, a local woman said "My husband and in-laws always advise me to do household chores and stay inside the home. If I have pain in my belly or my shoulder or a headache my mother-in-law asks why at this early age you are affected by such diseases. So, no need to visit any doctor. My mother-in-law has brought Tabij (amulet) for me from Hujur (an Islamic religious expert described by the local people)". Whenever females encounter diseases (menstrual infection, pregnancy-related complications, etc) they have to depend on their husbands or fathers for their treatment but women feel too shy to disclose their female disease to male members of the family. As a result, they select local healing practices instead of modern health care services.

The study also found that lack of participation in decision-making about health-related issues is another reason that influences the matter of taking local healing practices. The process of decision-making about taking modern or local healing is influenced by gender inequality and the subordinate position of women in society. The head of the family, generally a man decides the treatment process of the family members including female members. Unfortunately, the male's attitude is not that positive regarding women's health, food, and other necessities. These aspects increase women's dependency on local healing practices. One of the respondents Shefali Begum, aged 34, asserted, "Who am I the decision-maker in this family? If we fall ill with certain diseases, we usually recover by taking medicinal leaves and other traditional remedies available in our village. However, for certain diseases, we must seek medical treatment from a doctor. In such cases, either my son or my husband accompanies me to the doctor".

Poverty and financial dependency of women on male members restrict the women in the study area from the availability of modern healthcare services. It is also observed that only in an emergency, women are taken to village doctors, clinics, hospitals, or health complexes. Women suffer from malnutrition largely because of poverty, financial incapability, and powerlessness. One of our respondents Sajeda who resided in the Saziara at Magura added her experience, stating, "I was diagnosed with Kidney related disease five years ago. Sometimes the pain was so intense that it seemed to me to go to the doctor alone. Since I had no money, I had to depend on my husband."

Lack of education and women's knowledge and information about cure alternatives is another reason for selecting local healing practices. Respondents of this study generally have little or no institutional education and tremendously lack medically sound health awareness. Moreover, this study explored that in rural society, there are various prejudices and stigma related to the female body and health-related issues are embedded in the social norms and practices. As a result, the shyness and concealing tendency of rural women about health-related problems make the situation even more problematic. For instance, a girl who experienced her menstruation hardly ever discusses her problems. As for irregular menstruation or reproductive complexities, the mothers of these girls generally do not share with male members of the family. In this situation, the mother consults with local healers for her daughters for treatment. Girls have no choice over taking local medicine from local healers and sometimes it creates complications for their health. Amirun Nisa remembered, "Once I

had pain due to menstrual cycle and took medicine made of roots of some trees that caused me to diarrhea." Additionally, Pregnant women also conceal minor pregnancy-related problems and they take local healing medicine as the elderly women advise.

In some cases, social norms of Purdah (a custom practiced in some Muslim and Hindu societies, in which women either remain in a special part of the house or cover their faces and bodies to avoid being seen by men who are not related to them) work as a barrier for rural women in taking modern health care services. Since Purdah maintenance is socially important for rural women in the study area, women usually feel uncomfortable taking services from male practitioners and do not go out of their homes without male accompany. Nevertheless, a significant portion of the poor female population has begun to challenge this barrier and engage in income-earning activities in the public sphere. Despite the importance of Purdah maintenance for preserving prestige, women typically attempt to limit their mobility (Rozario, 2003). In this context, the study reveals that Sajeda Khatun who is 49 years old and whose husband is a teacher of a local madrasah, remembered her experiences as, "I faced a kidney problem for the first time in 1996 when my youngest daughter was 2 years old. Since I always maintain purdah strictly, I had no chance to learn anything about the outside world like the market or hospital. I could not go out without my husband. When my health condition was getting worse, my husband took me to the hospital due to the request of my neighbors and relatives,"

While it is deemed very urgent or emergency, women visit a doctor in a nearby or distant health care center or hospital. Also, 2 respondents responded that they do not generally discuss their health-related problems with the male members of the household. For post-natal health care, instead of going to the Upazila level health and family welfare center, women prefer to seek advice from dais (traditional birth attendants, Kabiraj, or Fakir). One of the respondents Fatema Yeasmin described this way, "I never visited any doctor when I was pregnant. I took homeopathy and Tabij (amulet) from Sharif's mother (female Fakir). I was in good health in my pregnancy time with the mercy of almighty".

Ingrained belief systems play a vital role in practicing local healing practices. In rural areas, some local healing practices resorted to religious rituals and used verses of holy books in healing, which required a firm belief of patients for the treatment to be effective. One of the respondents named Arjina, aged 38 reported that some diseases are caused by evil influence. Moreover, she believes that these diseases are not curable by modern medicine. It needs faith-based healing practices to be cured such as 'Pani-Pora' (Charmed water), 'Tabij' (amulet), etc.

MAJOR DISCUSSION

Among the healing practices of rural women, ethnomedical care is a popular practice chosen by rural women where medicines are prepared from plants, herbs, fruits, and leaves. One of the main reasons for seeking the services of local healing practitioners, such as Kabiraj (traditional practitioners), is the affordability of medicine, which is often tailored to the patient's financial capabilities. Faith-based ethnomedical care is provided by religious practitioners, such as Imams, who inscribe verses from the Quran and Hadith onto a Tabij for patients to carry. Women, particularly, feel comfortable consulting with female ethnomedical care providers regarding menstrual and pregnancy-related issues. On the other hand, Homeopathic care is a popular choice among rural women due to its affordability, accessibility, and perceived lack of side effects. Along with women, children are also taken to homeopathic care providers who mostly have no formal qualifications as medical practitioners. In rural areas, diverse religious healing practices are practiced by people of different religions. In the case of Muslims, they depend on the belief of charm water, donating money to the mosque, and writing holy verses. Whereas, the Hindu people focus on performing Manot and special Pujas (prayers). Though women nowadays are developing the practice of adopting modern healthcare services from the Upazila Health Complex (UHC) and local community clinics, there exists an information gap, negligence, and scarcity of manpower in these medical healthcare centers. Women of rural areas are thus deprived of the services of Magura 250-bed District Hospital as a consequence of their lack of awareness and education, financial dependency, and gender-based inequality existing in society. Hesitancy, dependency on men, and the norms of the veil incarcerate rural women from selecting modern health care services.

CONCLUSION

In the context of Bangladesh, local healing practices can contribute to women's health to achieve the third goal of SDG which includes “to ensure healthy lives and promote well-being for all at all ages” and to achieve universal health coverage as WHO suggests traditional and complementary (T&CM) medicine can make an important contribution by being included in the health care provisions (WHO, 2019). Since the modern medical care system cannot meet the greater medical care demand of a large group of women in the rural context, it is important to consider traditional healing practices as an alternative. Local healing practices can be a sustainable and culturally sensitive healthcare system if equal access to safe, quality, and effective traditional Medicine can be ensured (WHO, 2019). The study found that decision-making for healing practices of women is influenced mostly by their male counterparts, heads of the family, and neighbors. Financial dependency acts as an actor behind this. The other reasons are the perceived absence of side effects of traditional medicine, the warm empathy of the traditional healers, the good reputation of the healers, and the lower charges for consulting with the local healers rather than the medically trained doctors. Another factor is that women lack knowledge and information about cure alternatives for illness for decision making so at the primary level of illness, women resorted to self-care. Since, the trend of healing practices is influenced by various significant factors i.e., disease, age, gender, education, economic condition, distance of the health care centers, beliefs, and overall patient-practitioner relationship, etc. A holistic approach is required for further intervention.

REFERENCES

1. GREEN, E.C., Murphy, E.M. and Gryboski, K., 2020. The Health Belief Model. The Wiley Encyclopedia of Health Psychology, pp.211-214.
2. DAS, M. and Baruah, D.T., 2020. Supernatural Deities and Spirit of Health—A Study among the Monpas of Arunachal Pradesh.
3. WHO global report on traditional and complementary medicine 2019. Geneva: World Health Organization; 2019. Licence: CC BY-NC-SA 3.0 IGO.
4. NG, M.W.S., 2019. Medical Education in East Asia: Past and Future ed. by Lincoln C. Chen, MICHAEL R. Reich, and Jennifer Ryan. Canadian Journal of History, 54(3), pp.391-393.
5. HAQUE, M.I., Chowdhury, A.A., Shahjahan, M. and Harun, M.G.D., 2018. Traditional healing practices in rural Bangladesh: a qualitative investigation. BMC complementary and alternative medicine, 18(1), pp.1-15.
6. BROWN, L.S., 2018. Feminist therapy. American Psychological Association.
7. SHAHABUDDIN, A., Nöstlinger, C., Delvaux, T., Sarker, M., Delamou, A., Bardají, A., Broerse, J.E. and De Brouwere, V., 2017. Exploring maternal health care-seeking behavior of married adolescent girls in Bangladesh: a social-ecological approach. PLoS One, 12(1), p. e0169109.
8. YAYA, S., Bishwajit, G. and Ekholuenetale, M., 2017. Factors associated with the utilization of institutional delivery services in Bangladesh. PloS one, 12(2), p. e 0171573.
9. SARKER, B.K., Rahman, M., Rahman, T., Hossain, J., Reichenbach, L. and Mitra, D.K., 2016. Reasons for preference of home delivery with traditional birth attendants (TBAs) in rural Bangladesh: a qualitative exploration. PloS one, 11(1), p. e0146161.
10. DICTIONARY, C.E., 2014. Collins english dictionary. Complete & Unabridged
11. JONES, C.J., Smith, H. and Llewellyn, C., 2014. Evaluating the effectiveness of health belief model interventions in improving adherence: a systematic review. Health psychology review, 8(3), pp.253-269.
12. WALTON, D.P.T., Maria, L. and Schbley, M.S.W., 2013. Maternal healthcare in Bangladesh and gender equity: a review article. Online Journal of Health Ethics, 9(1), p.8.
13. RYAN, B., 2013. Feminism and the women's movement: Dynamics of change in social movement ideology and activism. Routledge.
14. DICLEMENTE, Crosby, R.A., R.J., Salazar, L.F. 2013. Health behavior theory for public health: Principles, foundations, and applications. Jones & Bartlett Publishers.
15. ROSS, A.C., Caballero, B., Cousins, R.J., Tucker, K.L. and Ziegler, T.R., 2012. Modern nutrition in health and disease (No. Ed. 11). Lippincott Williams & Wilkins.

16. SHIELDS, N., Synnot, A.J. and Barr, M., 2012. Perceived barriers and facilitators to physical activity for children with disability: a systematic review. British journal of sports medicine, 46(14), pp.989-997.
17. FERREE, M., 2012. Varieties of feminism: German gender politics in global perspective. Stanford University Press.
18. HOSSAIN, M. A., & Westhues, A. (2011). Rural women's access to health care in Bangladesh: swimming against the tide? Social work in public health, 26(3), 278-293.
19. HOSSAIN, A. A. (2010). VIOLENCE AGAINST WOMEN IN BANGLADESH (Doctoral dissertation, Stamford University Bangladesh).
20. KARNYSKI, M.A., 2009. Ethnomedical and biomedical health care and healing practices among the Rathwa adivasi of Kadipani village, Gujarat State, India.
21. CHIU, L., Morrow, M., Ganesan, S., & Clark, N. (2005). Spirituality and treatment choices by South and East Asian women with serious mental illness. Transcultural Psychiatry, 42(4), 630-656.
22. ZAMAN, S., 2005. Broken limbs, broken lives: Ethnography of a hospital ward in Bangladesh. Amsterdam: Het Spinhuis.
23. CHEN, D'Souza's & L.C., E., (1981). Sex bias in the family allocation of food and health care in rural Bangladesh. Population and development review, 55-70.