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Patterns and Practices of Health Information in Rural Society: A Study on a Village in Bangladesh

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Abstract: *The study has been undertaken to determine the sources of health information, its pattern and practices as well as people's health information needs in a typical village of Bangladesh. Mainly survey method has been used to carry out the study. Bonkul village under Shibganj upazila of Chapainawabganj district has been selected purposively for the study. The study shows that access to mass media is quite significant in the village where a large number of people listen to radio. It also reveals that 50.48 percent of families go to hospital or use modern health care systems when family members become ill. The villagers take various types of treatments include homeopathic (16.19%), ayurvedic (19.05%) and magic healing (jhar-fuk) (14.28%) along with taking modern medicare system. The study shows that people in the village get health information mostly from interpersonal contact (42.86%) followed by individual media (34.29%), mass media (28.57%) and group media (23.81%)(multiple responses). It says that 66.66 percent of respondents seek information about various chronic diseases. The study concludes that pattern and practices of health information in the village depend particularly on the traditional or indigenous health care system alongside modern health care practices. Therefore the study suggests that traditional health care knowledge and practices from the older sources should be reproduced or renovated systematically along with welcoming the modern health care practices. The study also suggests that dissemination of health information about the chronic diseases should be increased.*

Introduction

According to the WHO definition, health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. For sustaining health, people need health information, which is disseminated through different sources and media. Information can change their awareness, attitude and behaviour toward a certain health issue. Within the health communication field, communication is conceptualized as the central social process in the provision of health care delivery and the promotion of public health. The centrality of the process of communication is based upon the pervasive roles communication performs in creating, gathering, and sharing "health information"(Kreps et al, 1998). Health information is the most important resource in health care and health promotion because it is essential in guiding strategic health behaviors, treatments, and decisions (Kreps, 1988). In the context

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of Bangladesh, health information or health communication is very important to supplement the existing insufficient health facilities or health infrastructures. Extreme density of population, massive poverty, a low rate of literacy and insufficient medical health care infrastructures are pushing the country's people towards various diseases and health risks. In such an aggravated situation, various health information channels, media or sources are active in meeting the challenges of such health risks. To meet the challenges of the health risks or taking alternative measures against the insufficien medical facilities effectively, peoples' health information utilization pattern and practices in the rural setting should investigate properly. But no mentionable attention is given to studying the patterns and practices of health information in rural society. A comprehensive village study is needed in this regard as 80 percent people of Bangladesh live in the rural setting. This study aims to fill this gap and help formulate a policy on this issue. Therefore, the main objective of this study was to discover sources of health information, its patterns and practices as well as health information needs in rural society.

Specific objectives of the study are

- to know the socio-economic status and,media utilisation habits of people in the study village;
- to explore health care system and practices of the rural people;
- to find out sources of health information used by rural people;
- to asses people's health information needs in the village;

Review of Literature

Healthcare practices can be broadly classified into (i) traditional and (ii) modern systems. Traditional system is an art of healing based on traditional use of plants, animals, and other natural substances, and cultural habits, social practices, religious beliefs, and in many cases, superstitions of the present and previous generations of people (Ghani, 1990).

The traditional healthcare systems practiced in Bangladesh include Ayurvedic, Unani, Homeopathic, and Folk medicine systems. Both Ayurvedic and Unani systems of traditional healthcare have taken firm roots in Bangladesh and are widely practiced all over the country. Homeopathic system of healthcare is very popular in many Asian countries including Bangladesh (Banglapedia, 2006).

Folk medical practice, a simple form of traditional medical practice, offers healthcare services to the rural people with or without the use of medicinal preparations. Folk medicine is widely practiced in rural and even urban areas of Bangladesh (Banglapedia, 2006).

Modern system is the highly advanced system of health management used in Bangladesh and the rest of the world. Organised and well-equipped hospitals and clinics have been developed to effectively and properly offer healthcare services to people under this system. However, because of inadequacy of medical equipment and shortage of manpower and infra-structural facilities, benefits of modern system of healthcare services cannot be extended to rural areas as adequately as needed. The cost involved in offering healthcare services under this system is also much higher than that of any other system of healthcare services available in Bangladesh (Ghani 1990).

According to World Health Organization more than 80 percent of people, mostly in less developed countries, depend on traditional medicines for their primary health care needs. Neglected over the last century, village poor in Bangladesh rely on a traditional medicine system, known as the Kaviraji system, for primary health care (Zuberi, 2000).

A study by Begum et al (1996-97), using participatory rural appraisal (PRA) techniques, identified ninety-three species of plants during the study as having medicinal value for rural people. The respondents reported thirty-nine different diseases that could be treated with local medicines. It also found that villagers also use local plants to control conditions such as high blood pressure and arthritis. The study also reveals that women aged above 30 years suffer particularly various diseases, evidencing symptoms of iron deficiency, liquirria, sutika and so on, and rely on some eight species of plants to control them and other problems specific to women, notably gynecological ones.

In Bangladesh, the rural societies are medically pluralistic providing people with a wide variety of choices and constraints for healthcare options. Here the local healthcare knowledge and the social context mutually influence the treatment seeking behavior. Again discrepancy occurs in the process of seeking options because the patient is not only one involve in the decision-making process; family members and neighbors are also included (Begum et al (1996-97).

A study by Shafie (2000) with applying of analytical an methodological tools of medical anthropology in Ruppur village in Pabna district found

that strategies for seeking healthcare options are dependent upon many factors such as perceived disease causation, cost/benefit in a culturally constructed framework, and accessibility to services in the geographical, economic and cultural sense.

Chowdhury et al. (1996) documented 42 folk formularies, which had long been used traditionally against dysentery and diarrhea in Bangladesh.

Another study by Alam et al. (1996) also documented 143 folk formularies against 53 common diseases from Bangladesh.

A study by Rashid and Rashid (2000) found that different plants are widely used in tropical disease control and their own mood preparation.

A study by Stokoe (1997) revealed that knowledge about wild vegetables and its benefit were acquired by the respondents from a number of sources: kaviraj, piranee, family, and village doctors, health centres and so on. It also revealed that individuals may obtain knowledge from media sources (such as TV and radio) and through involvement in training by Non-Government Organization (NGOs).

Most of the rural people are deprived of modern Medicare facilities trying to get low cost treatment and counseling or health information from 'kaviraj', magic healer and old woman.

Researches suggest that people often learn about health issues from the mass media, but determine how to act through interpersonal communication with family, friends and doctors (Reardon, 1987).

Many studies have reported benefit of joint mass media and interpersonal health campaigns (Maccoby & Farquhar, 1975; Best, 1980; Danaher et al 1982; Cook & Flay, 1978). This above studies contended that interpersonal communication is more important for ensuring the maintenance or persistence of changes in health behavior.

All the collective inputs of preventive and curative health care systems fail to gear up peoples' health condition in rural society. Because,

> *"Information alone is not enough to bring about modifications in attitudes and behavior or to produce the kind of changes that development demands. Access to information by itself will not open any magic doors. There must be opportunities for discussion and interchange, in order to deal with existing and new information, to relate different or contradictory viewpoints and opinions, to feed a communication process where people can become aware of what they are thinking and what they are doing, weigh the various information and points of view exchanged, and take their own decisions" (Bessette, 1997).*

Conceptualization of Health Information

Health information may be defined as information on a continuum between health education and health promotion. Therefore, access to health information may contribute to health education and promote healthy lifestyle choices.

> *"Information is the first step to every healthy choice. Improvements in our health depend on our taking control over, and responsibility for, health as an important component of our everyday lives. This active participation requires full and continuing access to information: information about our bodies, their workings in health and illness, and the services available to us in treatment and care, support and co-operation (Gann, 1986)."*

The term 'health information' means any information, whether oral or recorded in any form or medium, that is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual (Online, nd).

Health information is the knowledge gleaned from patient interviews and laboratory tests that is used to diagnose health problems. It is the precedents developed from clinical research and practice used to determine the best available treatment strategies for a specific health threat. Health information is the data gathered in check-ups used to assess the efficacy of health care treatments (Kreps et al, 1998).

The process of communication also enables health promotion specialists to develop persuasive messages for dissemination over salient channels to provide target audiences with relevant health information to influence their health knowledge, attitudes, and behaviors (Kreps et al, 1998).

In this study, health information refers to the information or messages, which are disseminated by different media or sources intentionally or unintentionally for promoting peoples' health and for reducing their health risks and hazards.

Materials and Methods

Bonkul village, a typical village in Shibganj upazila under Chapainawabganj district, was selected purposively for the unit of analysis. Every household was taken under the study to know extensively about the feature of a typical village of Bangladesh in terms of socio-economic condition, media utilisation habits as well as the patterns and practices of health information. Mainly survey method was followed to know the basic information about the households. House to house surveys were conducted in the village using an interview schedule containing both closed and open-ended questions. 105 respondents were selected from 105 families (khana) in the village. One respondent from each family was interviewed about their family. Similarly, observation method was applied to explore overall health seeking behavour and health information practices in the village. During an unstructured observation period, the researcher also talked to the villagers especially with the elderly and took important notes. Both quantitative and qualitative analysis methods were followed for the study (Table-1).

Table 1: Materials and Methods used for the Study According to Its Objectives

Objectives of the study	Method	Source used	Tool used	Reporting method
to know the socio – economic status and media utilization habit of the people in the study village	Survey	Primary sources	Interview schedule	Qualitative and quantitative
To know the health care system and practices of the rural people	Survey/ Observation	Primary sources	Interview schedule/ note taking	Qualitative and quantitative
To find out sources of health information used by the rural people	Survey	Primary sources	Interview schedule	Qualitative and quantitative
To investigate people's health information need in the village	Survey	Primary sources	Interview schedule/ note taking	Qualitative and quantitative

Result And Discussion

A total of 700 people live in 105 households in Bonkul village. Out of the total population, 53 percent (371) were male while the rest were female. There were three mosques and one NGO's office in the village. There were three secondary level educational institutions, six primary schools, one government college and two eidgahs (where Muslims gather for Eid congregation) as well as two local markets within a kilometer radius of the village.

Socio-economic Conditions of the Village

A total of 105 households live in the village. Of them, 69.52 percent of families (73) were nuclear while 25.71 percent (27) joint families. The total number of earning persons in the village was 150. Among them, 34 percent (51) were engaged in farming, 20 percent (30) were service holders employed in different government and non- governmental organisations while 32 percent (48) were engaged in small business and 14 percent (21) in other professions.

The earning amount of the households ranged from Tk 2,000 to Tk 20.000 per month. It was found that Tk 2,000 was earned by 18.10 percent households (19) in a month while Tk 3,000 by 20.95 percent (22), Tk 4,000 by 15.24 percent (16), Tk 5,000 by 16.19 percent (17), Tk 6,000 by 20 percent (21), Tk 7,000 by 4.76 percent (5), Tk 10,000 by 2.86 percent (3) and over Tk 20,000 by 1.90 percent households (2).

It was found that 31.43 percent households (33) had one bigha (33 decimals) of land property and 39.05 percent (41) had land ranging from one to five bighas, 18.10 percent (19) from six to ten bighas, 5.71 percent (6) from 11 to 15 bighas, 4.76 percent (5) from 16 to 20 bighas while only one household had possessed above 20 bighas of land property.

The literacy rate of the village was 63 percent. It was found that the overall socio-economic status of the villagers was similar to other villages in Bangladesh.

Note : Figures in parenthesis represents number of respondent

Access to Media and its Use in the Village

Availability and access to mass media in the village was found to be quite significant. Radio was widely used and the most popular medium in the village. Out of the total 105 households, 39 families owned radio sets while 19 families had TV sets. It was found that only five daily newspapers and one magazine were subscribed to the village.

Respondents' education

Table-2 Percentage Distribution of the Respondents according to their level of education

Level of education	Number	Percentage
Can't read and write	29	27.62
Can sign only	37	35.24
Primary	18	17.14
Lower Secondary	12	11.43
Secondary	6	5.71
Higher Secondary	3	2.86
Higher education	0	0
Total	105	100

Source: Field Survey

Table-2 showed that of the total respondents, 27.62 percent couldn't read and write, 35.24 percent could write only their name while 17.14 percent had primary (classes I to V) level of education, 11.43 percent lower secondary (classes VI to VIII), 5.71 percent secondary (classes IX to X) and 2.86 percent higher secondary (classes XI to XII). No respondent was found in higher education (above classes XII) level.

Table 3 Percentage Distribution of the Respondents according to their Mass Media (Radio & TV) Utilization Habits

Radio						**Television**					
Total Listeners	Listening Habits		Listening Purposes			Total Viewers	Watching Habits		Watching Purposes		
	Everyday	Occasionally	Entertainment	Education	News		Everyday	Occasionally	Entertainment	Education	News
35.24% (37)	54.05%(20)	45.94%(17)	32.43%(12)	40.54%(15)	27.03%(10)	31.43%(33)	90.91%(30)	9.09%(3)	60.61%(20)	15.15%(5)	27.03%(8)

Source: Field Survey
Figures in parenthesis rep. sents number of respondent

Table-3 showed that 35.24 percent respondents (37) had listened to radio. Of them, 54.05 percent (20) listened to it everyday while 45.94 percent (17) occasionally. 31.43 percent (33) of the total 105 respondents in the village had watched TV. Among the total television viewers (33), 90.91 percent (30) had watched it everyday while the rest of the respondents (3) occasionally.

It was found that 32.43 percent respondents (12) of the total 37 listeners had listened to the radio mainly for enjoying entertainment, 40.54 percent (15) mainly for news while 27.03 percent (10) mainly for education or learning various issues.

60.61 percent of respondents (20) had watched TV mainly for enjoying entertainment and 15.15 percent (5) mainly for education or learning purpose while 24.24 percent (8) watched TV mainly for news.

The village had various folk communication channels included 'kechchha' (folk tales), 'alkap gaan' (folk song), 'Islamic jalsa' and 'waaj mahfil' (Islamic meeting), 'kirtan' (poetic description of the life and philosophies of Lord Krishna), meeting, village arbitration and jatra (folk theatre). Most of the respondents took part in meetings, village arbitrations, waaj mahfils etc.

Health Care Systems

Various types of health care systems and practices were found in the village. Apart from modern medicare system, indigenous or folk health care system were widely used in the village.

Table 4: Health Care Practices of the Households

Health care practice	Number of households	Percentage (%)
Modern medicare system	53	50.48
Homeopathic	17	16.19
Ayurvedic/Unani	20	19.05
Jhar-fuk and others	15	14.28
Total	105	100

Source: Field Survey

The survey data revealed that 50.48 percent of families (53) had gone to hospital or used modern health care systems when family members became ill. Alongside taking modern medicare system, the villagers had used various types of treatments, including homeopathic (16.19%), ayurvedic (19.05%) and magic healing (jhar-fuk) (14.28%).

Usually, the villagers took homeopathic medicine when suffering from skin diseases, diarrhoea, sinusitis, fever, stomach pain and jaundice. Most respondents said that an 'ojha' (magic healer) should be called to cure snakebites.

It was found that despite massive exposure to campaign against diarrhoea, 73.33 percent households (77) were using traditional measures alongside taking modern healthcare method when their family members affected by the waterborne disease. It was found that at first the villagers were trying to be cured of diarrhoea following traditional health care practices.

Some indigenous knowledge had been followed in the village for recovering from diarrhoea. The indigenous knowledge include taking soft boiled food, beverage of molasses, curry of green banana (kathali kola), cooked atab rice (atab chaler vat), beverage of lemon, juice of immature pomegranate, boiled eggs of duck, hand-made saline, water of green coconut, leaf juice of wood apple, water of onion and cumin, leaf juice of berry and banana cones. The patients were not allowed to eat stale food, hard food, food with sour and acrid as well as fish, meat, milk and eggs while they had been suffering from diarrhea.

Some 76.19 percent families had followed various traditional health care systems when their family members had been suffering from fever or cold. These included taking bread, dry food, parching rice with acrid, hot milk, garlic, a mixture of hot oil and onion, a mixture of honey and lime, a mixture of oil and turmeric, a mixture of honey and leaf juice of basil. They also used hot mustard oil to massage the patient's body during such an illness.

About 70.48 percent of families (74) had used traditional measures to recover from injuries resulting from cuts, pain or swelling. They smeared the injured part of the body with the ash of burnt clothes, a mixture of lime and catechu, a mixture of lime and burnt tobacco (gool), surface part of a green bamboo, leaf juice of a pomegranate tree, toothpowders and mobil.

The villagers put bandages on broken bones and used onion, root of chitta (a kind of herb), garlic and various medicinal plants.

For recovering from burn injuries, they smeared the body with soil, juice of a banana tree, cow dung, water, juice of sugarcane, kerosene oil, sand, a mixture of onion and garlic, mobil, juice of chili's leaf and eggs etc.

Some 67.62 percent households (71) had used maduli or tabiz or taken Jhar-fuk (exorcising system) when their babies suffered from diarrhoea, fever and cold. They also followed this system when their babies cried excessively.

Some 87.62 percent of the families (92) had fed their babies "panch mishali misti" (a mixture of different types of sweets which are bought from local market) in a bid to cure them of measles.

Some 90.48 percent of the families (95) had the belief of taking Jhar-Fuk from an ojha to recover from snakebites.

It was observed that only economic hardship kept people from taking continuous traditional health practices in the village. As a result, adequate food and nutrition practices were unsatisfactory. Most of the families couldn't take required quantity of fish, meat, milk, egg and fruits every day due to low income.

Health Information Sources/Media Used

The study population used a variety of sources to meet their health information needs. People of the rural society get health information from various media, including family planning workers, government health workers, NGO workers, doctors, homeopathy practitioners and 'kaviraj' (traditional health care providers) and so forth.

It was found that radio, TV and newspapers and books were the sources of health information in the village. It was known from the villagers that family planning (FP) workers used to make house-to-house visits and maintained continuous links to the housewives and provided them with information about birth control and FP devices. Health workers contacted the children at the time of immunisation. The NGO workers played a vital role in providing necessary health information and messages to the rural people. They disseminated health communication messages or information to their Samiti members through group-meetings or by interpersonal contact, posters and saving cards.

It was observed that all the villagers got health information or messages from above media directly or indirectly as well as intentionally or unintentionally. The sources of health information in the village were grouped into four categories and four groups were then divided into the following sub categories.

i. Individual media: Family planning workers, health workers, NGO workers, doctors, kaviraj, ojha, and traditional birth attendant (TBA or Dai) etc;

ii. Interpersonal media: Parent, friend (s), relative (s) and neighbour (s);

iii. Group media: Meetings (NGO), waaj mahfil and khutba (discussion by Imam at mosque before Friday juma prayers);

iv. Mass Media: Radio, TV, newspapers, posters, NGO's savings cards and books.

When asked whether they get any health related information or messages from the above sources, the respondents stated positively that are given in the Table-5

Table 5 : Percentage distribution of the respondents whether they get any health information or messages from the media or sources

Health Information Media	Number of Respondents	Percentage
Individual Media	36	34.29
Interpersonal Media	45	42.86
Group Media	25	23.81
Mass Media	30	28.57
Total	136*	

Source: Filed Survey
Note: Multiple responses as one respondent replied to more than one medium

Table 5 showed that people in the village received health information mostly from interpersonal contact with friends, relatives and neighbours (42.86%) followed by individual media such FP worker, health worker, NGO worker and doctor (34.29%), mass media like radio, TV, newspaper, saving card and book (28.57%) and group media such NGO's meeting (23.81%).

Health Information Needs in the Village

When asked, the respondents sought various health information about some particular diseases as he or she or their family members had been suffering from those diseases. As a result, most of the respondents wanted to know the recovery process from various diseases include gastric, skin diseases, headache, stomach pain, cardiac complain, dental diseases, sexual diseases, blood pressure, paralysis, diabetics, asthma, jaundice, dysentery, cold and diarrhoea. It was found that 66.66 percent of respondents (70) had sought information about the above mentioned diseases.

Conclusion and Recommendations

In the study village, people were involved in broader networks for meeting their everyday needs, including health information. They received health information from government and non-government development workers as well as mass media and other interpersonal contacts. The rural people were also intentionally or unintentionally exposed to the various sources of health information. This study showed that individual and interpersonal media collectively were the major sources of health information because of traditional beliefs and superstitions as well as having less access to mass media and regular communication by NGO workers, FP workers, doctors and koviraj. There is an acute shortage of modern health services--doctors, nurses and medicines--in rural areas. Therefire, the traditional health care practices were found in the study village as dominating one. The village people wanted to get appropriate health information what they believed for curing them from disease and infirmity. It was observed that people's health seeking behaviour had been raised significantly in the village as NGOs and mass media had been disseminating various messages in a bid to reduce older beliefs and superstitions. As a result, people mostly wanted to know more about the specific causes and curative measures of various chronic diseases like gastric, cancer and skin diseases.

It may also be concluded that the entire health information pattern and practices in the village had depended particularly on the traditional or indigenous health care system though the modern system also existed there. So, traditional health care knowledge and practices from the older sources should be r produced or renovated systematically while welcoming the modern health care practices. The study suggests that disseminating health information about the chronic diseases should be increased on a priority basis. The frequency of health information or messages should be determined practically on the basis of people's needs. People's economic hardship should be solved to ensure positive health care practices in rural society. Government should place a deliberate emphasis on formulating effective health communication strategy to reduce health risks and hazards of the rural people.

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