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chapter 11

MEANINGS, STRUCTURES AND CULTURAL CONTEXTS
DISCOURSES OF TRADITIONAL HEALERS IN RURAL BANGLADESH

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Health is constituted culturally, at the intersections of local contexts and culturally situated communicative processes through which health, illness, healing, and curing are understood (Dutta, 2008; Lupton, 1994). Attending to cultural constructions of health, particularly in spiritual/religious contexts, opens up the discursive spaces of health communication to alternative cosmologies of health, illness, and curing that are active ingredients in the lives of millions of people across the globe. In contrast to the dominant biomedical model that may focus solely on physiological indicators, and thereby marginalize the feelings and social experiences of the patients, attending to religious and spiritual aspects of cultural health beliefs addresses patients holistically (du Pre, 2005).

Unfortunately, health communication theorizing has been slow to recognize the critical role of culture, including religion and spirituality, on health communication in diverse contexts. In contrast, a culture-centered approach highlights the importance of understanding health in the realm of experiences and meanings that are continuously negotiated in dynamic contexts (Basu & Dutta, 2007; Dutta, 2008; Dutta & Basu, 2007). The culture-centered approach critically interrogates the top-down nature of the dominant approaches to health communication that emphasize strategic deployment of messages in order to address health problems as seen through the lens of the biomedical model (Basu & Dutta, 2007; Dutta, 2008; Dutta & Zoller, 2008; Lupton, 1994). The emphasis on culturally based cosmologies of health suggests that we look beyond the predominantly studied biomed-

ical model of health communication to develop an understanding of globally diverse ways of approaching health (see Dutta, 2008; Dutta & Zoller, 2008). The culture-centered approach is grounded in the notion that health is not simply universal as located within the biomedical model; instead it is made meaningful within the logics of culture, understood through the lived experiences of cultural members (Dutta, 2008; Lupton, 1994).

A culture-centered reading of health communication begins with the emphasis on listening respectfully to cultural narratives of individuals, groups, and communities on how they come to understand health and participate in local, national, and global processes to meet their own health needs. Entering into dialogues with local communities foregrounds the agency of such communities in developing locally situated interpretations of health and in participating in everyday choices guided by these local understandings (Basu & Dutta, 2007; Dutta, 2008). The focus on local understandings situated in the realm of continually shifting cultural contexts offers entry points for diverse ways of knowing surrounding health, illness, healing, and curing (Basu & Dutta, 2007). That is, dialogic research methodologies that co-construct meanings of health through in-depth interviews with cultural communities offer entry points for developing understandings of health situated in ways of knowing that depart from the biomedical model (Basu & Dutta, 2007; Dutta, 2008; Lupton, 1994).

One such alternative entry point to the narratives of healing is traditional healing as constituted in geographically diverse cultural spaces. Engaging in dialogues with traditional forms of healing steps out beyond the biomedical model for understanding the ways in which alternative rationalities are constituted in articulating meanings of health, understanding healing practices, and actively participating in health-related choices (Traphagan, 2005), rupturing the universal constructions of health and illness in the biomedical model that emphasize the locus of health in the individual body. In this project, we engage in in-depth interviews and informal conversations with spiritual healers in rural Bangladesh. Our discursive journey with the spiritual healers offers an entry point toward understanding the fragmented and contested nature of health meanings as religion, biomedicine, and culture are negotiated in the realm of healing (Basu & Dutta, 2007; Lupton, 1994). Our description of the communicative practices of the healers we interviewed does not attempt to provide a comprehensive picture of the broad range of activities in which these healers engage. It is intended only to provide a backdrop for highlighting several issues that arise in one non-Western health context.

HEALTH MEANINGS AND RELIGION: THE CULTURE-CENTERED APPROACH

Attending to cultural constructions of health, particularly in spiritual/religious contexts, opens up the discursive spaces of health communication to alternative cosmologies of health, illness, healing, and curing that are active ingredients in the lives of cultural participants across the globe.

In contrast to the dominant biomedical model that uses medical tests and observations that can be logically examined and analyzed, while marginalizing the feelings and social experiences of the patients, spirituality offers a broader cosmology that guides the values, beliefs, morals, and actions of cultural members (du Pré, 2005; Eliade, 2004). For example, scholars studying Native American health beliefs articulate the centrality of the spirit to the wellness of individuals in the Native American worldview (Gilgun, 2002; Lowery, 1998). Drawing on the example of *Ayurveda*, Dutta (2008) notes the intrinsic tie between religious beliefs and health perceptions. This line of work demonstrates the ways in which the cosmology of *Ayurveda* constructs health as balance. The interpretations that cultural members make of their health and illness are embedded within the religiospiritual worldviews that they hold. Furthermore, the practices of healing utilized by traditional and spiritual healers provide new insights into communication of health in nonbiomedical contexts (see Dutta, 2008).

Despite the extensive scholarship exploring the relations between religion and physical health, the study of religious and spiritual intersections in health communication has been minimal. In a special issue of *Health Communication*, Parrott described the study of religious faith and spirituality from health communication perspective to be "sparse to none" (Parrott, 2004, p. 2). However, the growing body of research linking religion and spirituality to health outcomes comes mostly from the Western setting focusing on Western Judeo-Christian religious discourse, with few studies on non-Western cosmologies of healing (Al kandari, 2003; Chaaya, Sibai, Fayad, El-Roueiheb, 2007; Soweid, Khawaja, & Salem, 2004; Ypinazar & Margolis, 2006). There is therefore a need to enlarge our understanding of health interpretations by listening to the health needs and aspirations of other cultural and religious groups that often lie at the margins of West-centric health communication discourse (Dutta, 2008).

To illustrate the heterogeneity of health meaning that can arise when alternative voices from non-Western discursive spaces are allowed to enter into health communication scholarship, we present in this chapter the case of traditional healers in rural Bangladesh. Because health and illness are culturally constructed experiences, located within complexly situated worldviews (Dutta, 2008; Kleinman, Eisenberg, & Good, 1978), some background information on the Bangladeshi context is required.

CONTEXT OF BANGLADESHI TRADITIONAL HEALING

Bangladesh is a small Southeast Asian country bordered on three sides by India, on a small corner by Burma (Myanmar), and by the Bay of Bengal in the south. Like many other countries in South Asia, Bangladesh was a British colony. Today, it is one of the most densely populated countries in the world and has an estimated population of about 156 million, which is growing at 1.29% each year (Central Intelligence Agency, 2008). About 73% of the population live in rural areas in moderate to severe poverty and do not experience the consumerism and modernization that is common in the urban parts of the country. Access to what would be considered basic health care in these areas is extremely limited, and traditional healers are a major source of health care (Sen, 2000, 2001).

Traditional healing in Bangladesh is an umbrella term that includes various forms of local healing and treatment practices (Karim, 1988). In common parlance, it includes anything from magicospiritual healing to the administering of herbs and minerals (Karim, 1988). The prevalence of traditional healing is due to two major factors in the lives of rural Bangladeshis: (a) limited access to biomedical care on account of poverty (Karim, 1988; Lessa & Vogt, 1979), and (b) a syncretistic worldview about health composed of elements of Islam, folk religions, and Hindu spiritual cosmology (Huque & Akhter, 1987; Karim, 1988).

The inability to access health is a key marker of poverty, and poor health often drives individuals and families even deeper into poverty as they struggle to find the money for treatment (Rahman & Razzaque, 2000; Sen, 2000, 2001). Additionally, in places where accessing a doctor can take an inordinate amount of time (e.g., remote villages), one medical visit can result in an unaffordable loss of income. This is especially true in the cases of households in which the man is the sole earner in the family. For such families, a medical consultation may result in an entire day's work being lost because of the time it can take a man to reach the doctor, wait to see him or her or accompany a child to do so, and then return home. One missed day of earning can literally mean starvation for a family of four or more people (see Dutta-Bergman, 2004a, 2004b). In underserved areas, therefore, traditional healers provide a network of close and affordable healing and curing, especially for certain categories of ailments that fall within their spiritual cosmology. In many rural areas, traditional healers are the first point of contact for any health care-related scenario (Karim, 1988); in the most remote areas of the country, they are the only source of health care available.

Traditional healing is also consonant with the spiritual worldview of rural Bangladeshis. From this perspective, healing is situated as one aspect of following a spiritual path in life. Rural residents tend to hold the view that

God has given health and God will provide healing if it is within the divine will (Lessa & Vogt, 1979). Many rural Bangladeshis also believe that disease, illness, and death are caused by supernatural beings or evil spirits. Traditional healers are understood by villagers to serve as mediators between the community and the supernatural. Also referred to as shamans because of their magicoreligious beliefs and practices, traditional healers specialize in treating spirit illnesses and spirit possessions. They are conversant with the movement of heavenly bodies, which they consider to be deities and may heal through the use of mystic numbers, mystic chants, and rituals (Karim, 1988). In the cosmology of shamanic healing in Bangladesh, it is believed that the traditional healer can see the spirits, can him or herself behave like the spirits, and can roam in the world of the spirits. The shaman sees the root cause of the disease through his or her mystic insights and can cure the disease through the use of spiritual healing techniques.

There are several categories of traditional healers in rural Bangladesh, representing a wide array of practices and performances in their healing rituals and addressing a range of diseases, including snake bites, childhood illnesses, and hydrophobia (Karim, 1988). Each type of healer addresses people's health problems in specific preferred ways, but all employ a combination of spiritual healing and herbal remedies (Kakar, 1983; Karim, 1988). *Kabirajs* deal primarily with curative plants and roots. A *kabiraj*, for instance, will prescribe herbal medicines as a cure for a stomach ache, but at the same time hope that God will help alleviate the pain. *Gunin/ojha* are rural healers who focus on *mantras* to drive away the spirits causing ailments. They may also massage affected body parts to reduce pain and drive out bad spirits. *Pir/faqir* are religious people who recite verses from the Holy Qur'an to cure people's illnesses. They also prescribe charms and amulets, and they assure patients that God will be kind enough to take away the problem. All three types of healers view patients' ill health as stemming from either a bad practice (e.g., eating habit) or from the work of a bad spirit, and their healing practices accordingly juxtapose both spiritual and physical treatment regimens.

METHODOLOGY

The data for our case study were collected through in-depth interviews in the historic northwestern Bangladesh district of Sylhet. People from all over Bangladesh have traditionally journeyed to Sylhet to find work, visit holy places, and pay respect and tribute to the Aauliyas (religious preachers). The district is so rich in its religious background that even today all political leaders start their election campaigns from Sylhet. Nine out of the 11 interviews

recorded for this research were conducted in the remote village of Kadamhata, in the Sylhet district, and the other 2 about 25 kilometers away from Kadamhata in a remote place with little transportation access, near a tea estate. We collected data in the area from May 2009 to July 2009. Ethical approval for the study was obtained from the authors' university of affiliation.

The interviewees were located via snowball sampling. Respondents ranged in age from 25 to 70 years. Most of the healers practiced their healing as a side job. All of them except two were involved in agriculture, working in the fields during harvesting seasons, and finding other daily jobs when the harvesting season was over. Of the two who did not work in agriculture, one was a retired tea garden employee, and the other worked for the local post office. On average, the highest level of education completed by interviewees was between 5th and 8th grade. All interviewees in this study were male. Although female healers do practice in the district, males are more numerous primarily because the job involves a great deal of travel to remote places, something that is difficult for women to undertake. Furthermore, those women who do practice traditional healing in rural Bangladesh are difficult to locate because they are more reticent about performing healing in public than are men.

Interviews lasted 40 minutes to 1 hour. Each interview was preceded by obtaining oral consent. Interviewees chose the language they were most comfortable with for the interview—either the national language of Bangla or the Sylhety dialect. Nine chose Sylhety and two elected to speak in Bangla. The interviews were mostly conducted in outside sitting rooms or *Tongi ghor*, built a little away from the main house to receive people from outside of the family. This helped maintain full privacy of the interviews without distraction, and facilitated audio recording. All interviews were recorded with participant permission, and recordings were translated into English during transcription. Transcripts totaled about 100 double-spaced pages. We analyzed data using the co-constructed grounded theory method of analysis (Charmaz, 2000; Strauss & Corbin, 1990).

Data analysis commenced with open coding to identify concepts that could be easily labeled and sorted. We picked up chunks of data that appeared to speak to distinct categories as our units of analysis. Relationships were then formulated within and among the categories through axial coding. At this point, we also referred to our field notes and journal entries to enhance theoretical sensitivity of our analysis, also connecting our analytical frames to the ongoing in-depth interviews (Lincoln & Guba, 1985; Peshkin, 1993; Strauss & Corbin, 1990). Transcription, data analysis, and data gathering continued side by side until theoretical saturation was reached. Building on the goals of the co-constructive grounded theory approach, we revisited the themes with the participants to ensure the trustworthiness of our analysis (Charmaz, 2000; Lindlof, 1995).

RESULTS

Our results indicate that the communicative practices of traditional healing in rural Bangladesh find meaning on the canvass of the competing tensions between tradition and modernity. Even as our interviewees described their traditional training and practices, they frequently contrasted their profession with that of biomedical health care providers, with whose methods and background they were at least somewhat familiar. Although in some cases participants suggested that their own healing rituals and experiences were superior to those of Western-style physicians, more frequently they cast their own abilities as constrained by lack of financial resources to obtain the advanced instruction that characterized the biomedical healing culture.

In the following sections, we briefly explicate three aspects of the traditional healing articulated by our participants that are in contrast with the biomedical model: traditional healing as spiritual versus biological, traditional healing as locally versus institutionally situated, and traditional healing as adequate versus inadequate.

Traditional Healing as Spiritual Versus Biological

In the world described by our interviewees, disease happens because the spirits are displeased or because a spirit enters the body of the patient. Healing is tied to appeasing the spirit, exorcising the spirit, and bringing the body and soul into balance. Participants recounted a wide range of narratives of healing in which engaging the spiritual world was essential for bodily healing to take place. For instance, tradition defines certain manifestations of disease as spirit possession. The communicative practice of *jharphuk* is a ritual sweeping away of the evil spirit from the body of the patient, and it involves a literal sweeping of the body accompanied by chants. This traditional practice is supplemented with the prescription of traditional medicines. Yet another manifestation of communication with the spiritual world toward healing is the use of *mantras*, that is, incantations that are chanted during the performance of the healing ritual. The *mantras* connect the material world with the world of the spirit and reflect the specialized knowledge of the spiritual healer.

Several participants explained that to treat snakebites the spiritual healer (*ojha*) shakes himself violently and falls into a trance. In this state of trance, whichever part of the patient's body the *ojha*'s hand catches hold of, the venom is considered to have spread to that part. The body part then is tied off to stop the spread of the venom, and the *ojha* continues to chant incantations, rubbing the body between the bandage and the point of injury

until he declares that the venom has come down to the point of injury. Once the venom has come down, he collects seven *kachu* (Arum) leaves, cuts the place of injury, and takes out sufficient quantity of blood to be collected on the *kachu* leaves. He then declares the patient out of danger. The *ojha* remains in the trance state throughout the entire healing ritual.

As this narrative exemplifies, our interviewees reported not only employing spiritual healing (*ojhagiri*) techniques but also herbal remedies (*kabiraji*). According to their reports, they shifted back and forth between these frameworks, in many instances utilizing them simultaneously. In fact, at times during our interviews, participants freely interchanged the terms *kabiraji* and *ojhagiri* depending on the context and the particular healing performance. The combinations of these methods offered a polymorphic framework for solving the health problem at hand, syncretically drawing on the various magicoreligious traditions of rural Bangladesh. That is, healing emerged as both complementary and contradictory, going back and forth between the different nodes that coexist and compete within a dynamic cultural space.

In comparing their culturally situated methodology to biomedical practice, some interviewees expressed a notion of purity and authenticity, in which the herbal remedies of traditional healers were cast as pure originals and the pharmaceuticals of medical doctors' poor derivatives. For instance, one interviewee explained:

> Also, among other things, according to doctor's formula, you have to use medicines. For us, it is herbal (*bonaji*) kind of stuff. For example, you study and get a title and become a doctor, then for you it is a different line/strategy (*podhdhoti*). For us, it is the *kobiraji* that we got traditionally, these kinds of plants etc. We have to get result based on that, and make it successful. Besides this, we do not have any other way of making you healthy. The doctor provides medicine which is made of leaves, but I give pure leaves.

Traditional Healing as Locally Versus Institutionally Situated

For this type of healing to be efficacious, the patient, his or her family, and the community enter into a relationship of respect with the healer. They must trust his or her ability to navigate the world of spirits and magic to see the root cause of the disease and address it. It is the sacredness of the healing rituals and the chants used in healing that defines the relationship between the healer and the patient; patients and families must fill their prescribed roles if healing is to take place.

This network operates in a localized community of trust and has a relationship of respect with other members. Ideally the credibility of a certificate

earned for a medical education is replaced in such instances by the community-based mutual regard that is communicatively constituted and negotiated in the domain of local relationships. This web of relationships is strengthened by the fact that most healers come from a family of healers. For Bangladeshis, traditional healing is a calling that is passed down from one generation to the next within a family. A consistent theme among our interviewees was that such knowledge is communicated within the boundaries of kinship through oral tradition and observation, rather than propositional instruction. Thus, the sharing of familial history becomes a resource for the passing down of expert knowledge of the healing practice. Oral traditions in rural Bangladesh serve as the repository of resources; the specificity of the local highlights the continual nature of healing as an artifact that connects the generations.

For instance, one of our participants, Idrish bhai, described learning about healing from his grandfather: "My maternal grandfather was an *ojha*, and he said he will take me under his wings. He said, 'I will take a little less of what I will earn and give that to you.' So I had started to learn from him. I learned *kobiraji* and *ojhagiri*." The performances of healing rituals are thus constituted in the domain of expert knowledge that is sacred and is shared within the domains of trust between the teacher and the disciple. Another interviewee, Ishmail, stated that the practice of *kabiraji* has stayed within his family for generations:

> Yes, as I was saying, my father and his father and so on, our work as Kabiraj has come down for 1100 years. I got this information from my father who talked about it. My grandfather talked about it also. I got to hear about the history of the family from him as well.

For some of our inteviewees, training in spiritual healing took place under the guidance of a mentor outside of the family circle. For an interviewee named Rahim, working with a master taught him how to heal patients for certain health problems: "I get all information from my master. His name is Jalaluddin. He taught me how to treat people for disease. He taught me how to treat for snake bite, pain, and other disease." Another participant name Saqeeb similarly explained, "Because of this, I understand that helping people in the ways their fathers and fore fathers have treated them by using medicines they have prescribed, following those instructions. Yeah this is it, the lesson I learnt by watching . . ."

Traditional Healing as Adequate Versus Inadequate

Our participants repeatedly articulated their understanding of healing against the backdrop of expectations of modern medicine. Some contrasted

modern medicine, which is learned under institutional structures that require enormous economic resources, with training in traditional healing that can be obtained through a relational network at little cost. They often attached greater credibility to biomedical knowledge than they did to their own practices. The following comment by Kareem Bhai regarding medical doctors is illustrative:

> The difference is if someone comes to me for a pain, I have only one solution to cure it. However, if he goes to modern doctor, he has a lot of solutions for it. Because he has experience and he is knowledgeable. I am illiterate. I do not have enough knowledge.

Some interviewees identified their lack of financial resources as a barrier to attaining a degree and, therefore, to practicing on a larger scale:

> Well, [in practicing] *kabiraji* I don't understand much. . . . And I don't have a certificate either since I don't have money. If I had money I would have gone to a higher level or gotten a certificate. Because of this, I didn't open a store. What I make is in very small amounts for one person. People who like it take it, and if they don't like it, they don't.

If some participants expressed regret at being excluded from medical training for economic reasons, others pointed out that the biomedical realm also excluded many of their patients from treatment. Participant Abdul Bhai explained: "The difference between me and a doctor is money. They have to pay one *taka* [Bangldeshi currency] for a doctor and they will pay one *paisa* [100 *paisa* make up one *taka*] for me."

The healers described continually competing with the dominant structures of the biomedical model and simultaneously situate themselves in the backdrop of the educational qualifications necessitated by such a model.

IMPLICATIONS

The narratives of traditional healers of rural Bangladesh underscore both the intersections of, and the contrast between, the local and the global. For the traditional healers, healing is a tradition that is passed down through the generations and is situated within the spaces of trust constituted in local communities. The cost of such training is minimal. In fact, among our interviewees, mention was made of the older generation sharing their profits with their apprentices. The actual process of training in healing entails ongoing close observation of a master healer. In contrast, training in Western bio-

medical healing requires leaving the local community and joining the medical fraternity. Instruction takes place in institutional and classroom contexts and is offered by individuals one is not only not related to but whom one probably has never met before. Participants continually highlighted the economic resources necessary to participate in the marketplace of biomedicine in opposition to the closely linked web of networks and relationships through which knowledge of traditional healing is learned and circulated.

Furthermore, traditional and biomedical healing as they were described by our participants operate under the influence of vastly different ontological assumptions. The emphasis on spiritual causes of illness by traditional healers offers a cosmology that departs from the monolithic understanding of health and illness as solely biomedical (Dutta, 2008; Egbert, Mickley, & Coeling, 2004; Gilgun, 2002; Hodge, Limb, & Cross, 2009; Lowery, 1998). The narratives of the traditional healers in Bangladesh introduce discourses that challenge the assumptions of the mainstream, inviting us to engage with cosmologies that articulate health in the realm of the spirit and healing as a spiritual act.

Also evident in the interview narratives is the tension between tradition and modernity. The participants understand their roles as traditional healers through the lens of modernity, evaluating their skills in the backdrop of the efficacy of modern medicine and the education required to acquire the skill sets to become a medical doctor. Not having a degree is seen as an important barrier to setting up a large-scale practice and being able to offer a range of treatments. Tradition and modernity are continually negotiated, as the healers constitute the self, its identity, and its relationships within a complex terrain, marked with competing symbols of tradition and modernity in a postcolonial context (Dutta, 2008).

One of the limitations of this project lies in the choice of the snowball sampling technique. Snowball sampling introduces possible biases into a project including biases of cooperative subjects, biases of masking, and oversampling certain subsegments of the population (see van Meter, 1990). Despite these biases, snowball sampling offers a valuable entry point for in-depth qualitative research emphasizing subjective articulations in local contexts that are hard to reach. Given the nature of traditional healing as a profession and the rural location of their practice, the snowball sampling method offered the only feasible means of connecting with them.

In summary, as health communication scholars respond to increasing global flows and migration patterns, attention needs to be paid to the fragmented and continually negotiated nature of health meanings, disrupting the universal appeal of the biomedical model. The locally situated narratives of health draw attention to the local nature of the universal, pointing out that the universal logic of biomedicine is also a cultural construction that operates on the basis of certain sets of assumptions. The co-constructions in this

project offer entry points for envisioning health communication programs that negotiate the relationships between the local and the global by listening to the voices of local community members. For instance, culturally centered health communication should focus on creating spaces for listening to the voices of participants at the margins, thus creating openings for shaping health care systems that are responsive to the local cosmological frameworks of the participants, working with these frameworks, listening to these frameworks, and developing creative spaces that are responsive to the local cosmology and its constructions of health, healing and curing. Here, a culture-centered reading of health communication suggests that we look beyond the goal of co-opting traditional healing as an agent of biomedical interventions to developing a sincere commitment to listening to the voices of traditional healers and their cosmologies. Such a shift in the dominant epistemology of health communication would have to be constituted by embodying the fundamental principles of respect, humility, and listening that appreciates multiple worldviews of health and healing.

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