

A Culture-Centered Exploration of Health: Constructions From Rural Bangladesh

Raihan Jamil and Mohan J. Dutta

*Department of Communication
Purdue University*

The traditional approach in health communication has historically adopted a linear model to explore and study health, without considering the voices of the subaltern sectors in academic discourse. Such linear models prescribe one-way knowledge, information, and transmission of beliefs from the core health sectors to the subalterns at the margins. The culture-centered approach to health focuses on co-constructing meanings of health through dialogic engagement with communities that are situated at the margins of mainstream discursive spaces. This co-constructive research investigates how members of a Bangladeshi rural community define, construct, and negotiate health issues in their everyday lives through their narratives of health, illness, and healing. The findings explicate how the community participants negotiate their health in terms of poverty, work, and structure, and highlights how the participants negotiate their marginalization through communicative practices. The in-depth narratives on their construction of health underscore possible entry points into constructing culture-centered praxis, pointing toward spaces of change.

Karimana¹ is a woman in her early thirties who lives in a remote village of Bangladesh. She and her husband have seven children. Karimana sometimes does part-time work here and there, and does not have any education at all. She wants to work more and contribute toward her family income and needs, but cannot find work. Money is extremely tight in her family and being sick is not an option for her or her seven children or her husband. She rarely goes to see a doctor, she says, and only does so when she is “really, really sick and can manage some money” for the doctor’s fees. Her core belief about illness, perhaps because of her struggles and limitations in life, is that God gives illness and if HE wants to cure it, HE will, and otherwise there is nothing much one can do about it. Karimana is not alone in her situation in life, and there are many others like her in rural Bangladesh who articulate the meanings of health in the backdrop of poverty

(see Dutta, 2008; Dutta & Basu, 2007; Jamil, 2009; Jamil & Dutta, in press).

The traditional approach to health communication has been critiqued for adopting a linear model to study health without considering the subaltern² participants’ voices in meaningful ways (Airhihenbuwa, 1995; Dutta-Bergman, 2004a; 2004b; Mokros & Deetz, 1996; Sharf & Kahler, 1996). Such linear models prescribe one-way knowledge, information, and transmission of beliefs from the core health sectors to the subalterns in the margins, with concepts and models being developed at the academic centers of knowledge production to be diffused into the subaltern peripheries. The culture-centered approach is offered in this backdrop of erasure of subaltern voices, “foregrounding the importance of understanding the articulations of health by engaging subaltern voices in the marginalized sectors of the world” (Dutta & Basu, 2007, p. 38).

The culture-centered approach focuses on co-constructing locally situated meanings of health through dialogic methodologies in the backdrop of disputing the prevalent biomedical approaches of health communication

¹All names used in this article have been changed to protect the respondents’ identities, although, none of them had any objection about using their own names.

Correspondence should be addressed to Raihan Jamil, Department of Communication, Brian Lamb School of Communication, Purdue University, Beering Hall #2296, 100 N. University Street, West Lafayette, IN 47907. E-mail: rjamil@purdue.edu

²Subalternity refers to the condition of being hidden or being erased from dominant discursive spaces of knowledge production.

(Dutta, 2008; Yehya & Dutta, 2010). The purpose of this research is to understand how members of a Bangladeshi rural community, who live in the material margins of mainstream Bangladeshi society, define, construct, and negotiate health meanings in their everyday lives.³ We note the subalternity of members from this Bangladeshi rural community because of their erasure from policy and intervention platforms (Dutta, 2008). Subalternity therefore, is marked in the fundamentally communicative nature of erasures and absences from discursive platforms in the mainstream that define development and progress (Dutta, 2008). The “subaltern” status of the community is intrinsically tied to the depiction of rural Bangladeshi populations as passive recipients of top-down policies and interventions, often configured by the hegemonic nexus of local elites, international campaign planners, and international funding agencies. This dialogic engagement with subaltern Bangladeshi voices seeks to reduce the information and policy gap between the health care professionals and policymakers of Bangladesh and the rural populations who often emerge as targets of such policies (Dutta-Bergman, 2004a; 2004b; Sobhan, 2002).

DOMINANT APPROACHES TO HEALTH COMMUNICATION

The biomedical model of health lies at the heart of the dominant approach to health communication, defining the scope and objectives of health promotion campaigns that are historically directed toward the global South under the rubric of health development programs (Dutta-Bergman, 2005). Bangladesh emerges into this discourse as a recipient country, as a marker of pathology that can be changed through the projects of health interventions carried out by agencies and donors situated in the West/North. The Eurocentric knowledge base of health communication presents and promotes the dominant model as the only viable source and way of understanding and explaining health problems and outcomes, and situates health and wellness within the modernist elements of the Enlightenment project (Comaroff, 1982; Good, 1994). Furthermore, drawing on individualistic models of cognitive decision making, dominant approaches situate marginalized spaces and their members as lacking agency to choose or to decide their own outcomes,

³We engage dialogically with the participatory articulations of community members in one Bangladeshi rural community. Therefore, our engagement with the voices of local community members in this particular rural community is highly localized, attending to the specifics of the particular. However, as noted by Dutta-Bergman (2004a; 2004b), it is precisely in this engagement with the localized particular that we need to aggregate participant responses in order to interject mainstream policy discourses, thus moving toward strategically working with the localized voices in disrupting the silences in policy discourses, and creating entry points for social change in health-related policymaking as well as program planning.

therefore marking them as “primitive” or “backward” target audiences of top-down interventions (Airhihenbuwa, 1995; Dutta-Bergman, 2005). It is in this backdrop that the culture-centered approach emerges as a methodology for narrating the stories of subaltern participants, to render visible their accounts, and to create legitimate entry points into the discursive spaces of knowledge production and policymaking for subaltern voices that have hitherto been erased by totalizing moves of Eurocentric knowledge production.

Culture-Centered Approach to Health Communication

Airhihenbuwa (1995) criticizes the existing trends in studying health communication and argues that health communication should be guided by culture. Carrying this thread further, the culture-centered approach (CCA) to health communication views culture as constantly metamorphosing, constitutive, and transformative in the domain of health meanings (Dutta-Bergman, 2004a). The CCA proposes that cultural contexts are entry points to theoretical insights into how health decisions and meanings are negotiated in cultural communities, and therefore offer legitimate theoretical frameworks for developing grass-roots-driven health policies and programs (Dutta, 2008). It is only through engagement in dialogue with the cultural insider that the local meanings of health can be articulated and understood, continually negotiating the spaces between the local sites and global platforms (Dutta & Pal, 2010). The periphery emerges onto the discursive spaces of the core through dialogues of solidarity, simultaneously rendering impure the conceptual categories of the core (Dutta, 2011). Dialogues with the margins bring to question conceptual categories such as “locus of control” and “fatalism” that are often utilized to categorize target populations and bombard them with interventions (Dutta, 2008).

The CCA suggests that to understand what really matters to an individual, one needs to “begin by creating spaces for those voices [that have been] systematically silenced through our [the dominant experts’] expertise and elicitation” (Dutta, 2008, p. 45). It is by creating spaces for listening to the voices from the margins that CCA tries to introduce theoretical guidelines in understanding the culture-structure-agency interactions (Dutta, 2008). Culture here is defined as a complex web of meanings (Geertz, 1973) and shared practices, beliefs, and values. So culture is fluid and dynamic, and draws from the past, is constituted in the present, and is modifiable in the future. Structures refer to the material realities that constrain and enable human action, and it is within these constraints that cultural insiders enact their agency (Dutta, 2008). So in this aspect, “structures define the realm of possibilities in the context of health . . . [and] it is through the enactment of agency in relationship with structure that individuals, communities and societies come to experience health” (p. 56).

In negotiating structures, the CCA attempts to deconstruct the taken-for-granted attitudes and assumptions of the dominant knowledge base, and tries to co-construct meanings and discursive spaces from the perspectives of cultural insiders. Essential to the creation of such spaces is the fostering of a bottom-up structure for articulating experiences and meanings. Drawing the linkages of CCA to the Subaltern Studies project, Dutta and Pal (2010) note:

Dialog with the subaltern is constituted as a mediation that brings subaltern narratives into mainstream structures/sites of knowledge. Such dialog is founded on consistent skepticism toward the co-optive politics of dialog that serves neoliberal agendas. Of particular relevance for subaltern studies are the ways in which dialog is constituted in the realm of power, difference, inequality, marginalization, and resistance. (p. 364)

Dialogue in the framework of the CCA is tied to the politics of change and structural transformation it participates in. This article engages with the CCA to co-construct the meanings of health through the Bangladeshi rural people's narratives that originate from their own discursive spaces in rural Bangladesh, situated amid the marginalizing structures of contemporary economics (Sobhan, 2002). The narratives that appear in this article are stories shared with us by the Bangladeshi participants who live in the villages at the social and economic margins of the urban cities, marked by the economic and communicative inaccess to resources (Dutta, 2008). In this co-construction, we engage in dialogues about the rural conceptions of health that encompass their everyday lives, asking the following research question (RQ): How do Bangladeshi rural participants construct the meanings of health?

METHOD

Context: Bangladeshi Rural Population

Bangladesh is a small Southeast Asian country that is roughly the size of the U.S. state of Iowa. Bangladesh is bordered by India on three sides, and by the Bay of Bengal and Burma on the other side. As a part of undivided India, the British colonized Bangladesh for almost 200 years till 1947, at which point Bangladesh became part of Pakistan, and then in 1971 became an independent country. According to the most recent census, almost 73% of the people of Bangladesh live in rural areas ("Rural population," 2010). As a developing country, Bangladesh faces key national issues such as limited economic opportunities, lack of health care, low economic growth, etc., and they are all joined by natural disasters such as flood every few years. High density of population and population growth in this country of almost 155 million people are often used as markers to define Bangladesh (CIA, 2008). According

to the World Health Organization, high levels of population growth lead to resource shortages (in terms of land, deforestation, clean water, etc.) and sometimes cause the prevalence of diseases such as tuberculosis, malaria, and hepatitis A/E (World Health Organization, 2008). There are about 3,800 people for every doctor available in Bangladesh (Jacobs, 2007), including both public and private physicians. On top of that, the hospital bed to patient ratio in 2005 was 1 to 2,500 ("Hospital beds in Bangladesh," 2010). Health resources are heavily biased toward the urban cities and populations, leaving rural Bangladeshis in shortage of basic health care needs and facilities, and playing out large disparities in access to health (Sobhan, 2002). Noting this inaccess to mainstream resources of health, we seek to embark on this project of co-constructing local meanings of health with rural Bangladeshis in order to create entry points for listening to the voices of those at the margins of contemporary Bangladeshi health care. Here is an excerpt from one of our field notes that sets up the backdrop of this project:

I have returned to Bangladesh after thirteen years. Thirteen years have passed by and there are parts of Dhaka that I can't even recognize. The familiar landmarks have gone, new roads, new apartment complexes, and flashy signs of development all around me. The picture in rural Bangladesh though has not changed much. At least not to my eyes, based on my initial impressions. The poverty is on my face, and I know I am noticing it more because I have for so long been away in the US, navigating through sanitized spaces that work so seamlessly to hide the images of poverty.

Research Design

Our interest in this co-constructive project lies in centering the voices of a Bangladeshi rural population living at the margins of Bangladeshi society. This interest is configured among our understanding of the contradictions in our lived experiences growing up in Bengal (one of us grew up in West Bengal and the other grew up in Bangladesh) juxtaposed in the backdrop of the lessons we picked up in our Health Communication classes about target populations in the Third World. Here's an excerpt from one of our journal entries:

Today we read about *Lerner's* understanding of the primitive society. The professor talked about how Communication started as a field targeting the Third World with development programs. He talked about how Third World people are passive, backward, and therefore in need of modernization. And yet, this very story that makes up the main body of work in Communication is so untrue, so out-of-touch with the realities of the people I have grown up amidst. I have seen people in the so-called Third World live with courage in the midst of not having resources. I have seen them work really hard to make ends meet. Where are these voices? Where are these stories?

It is this search for engaging with the local voices of community participants that drives our methodology. Therefore, we engaged in in-depth interviews, both individually and in groups, in order to create entry points for local articulations of health.

The research procedure and a sample interview questionnaire were submitted to the institutional review board (IRB) at the authors' university of affiliation and were approved by the IRB. Each interview was preceded by an oral consent process. Oral consent was used for three reasons: (1) Many participants were not literate enough to fully read or understand the meanings of the written text in a consent form; (2) people in Bangladesh, irrespective of education level, tend to shy away from signing documents even if the document purposes are made clear to them; and (3) people trust/rely on their reference points as to how they have come to talk to the researchers, or who has referred them to the researchers. So when a participant hears the need for the data communicated orally, the participant evaluates the sincerity in the communication and decides whether he or she is willing to consent and participate.

The participation of the individuals was voluntary and they were free to not answer any question they did not like. The participants were also informed that they could stop the interview at any time they wanted to. Additionally, the interviewees were in full control of the language of choice for the interviews, and everyone used their mother tongue of Bangla. The interviews were conducted by one of the researchers in Bangla, and the protocol was developed in collaboration between the researchers, both of whom are conversant in Bengali. The interviews began with an open-ended question about meanings of health, "What does health mean to you?" and then emerged as a back-and-forth dialogue. Here's an excerpt:

What does health mean to you?

What health means to me ... health is physical condition that is weak or good. If I have sickness I feel weak, feel good means health is good. What else? All in all that is health. I am fine, I am sick, I am ok that is health.

When you say, you feel good, what does it mean to you?

Well, that means today I feel fine then I am ok. I have no sickness. Tomorrow I get illness, then I am not fine. I am sick, weak that's it. Somehow it is also related with the mind. When I feel tense then I feel weak too. When I am not ok with food, medicine, child and other things, I have tension about these then how my health can be ok. Tension causes weakness, headache, create uncomfortable feelings, so from this diseases and physical problems start increasing.

What makes you feel tension?

It's my happiness, my family and household issues, my children, husband; and my income source. If I earn today I get food but if I can't earn tomorrow I will not have food. When I can't earn properly it is a tension. My children have sickness but I can't take them to doctor, this is also a tension. How can I live, how can I get food these are big tension.

When you feel tension what did you do?

What can I do? Nothing, I can't do anything. When I do thinking about these I feel unstable. So I have to reduce this tension from mind.

These conversations also became the entry points for our reflexive journaling, weaving our personal narratives and lived experiences with the narratives that were being articulated by the participants.

Participants

Each interview thus recorded was translated during transcription. The respondents were all everyday people living in the villages of Bangladesh, perhaps for their entire lives. The three villages that were chosen for this study are located in the outskirts of Dhaka. The interview subjects were chosen using the snowballing technique, where one respondent referred the researcher to another one. Each of the 19 interviews ranged between 30 minutes and 90 minutes in length, focusing on local meanings of health. There were 12 female and 7 male participants who participated in this project, and their age ranged from 20 years to 45 years. Almost all of them were daily laborers or assistants at very small grocery stores.

It is worth noting here that although our culture-centered dialogues with community members sought to emphasize the localized particulars of health meanings in three villages in the outskirts of Dhaka, we continually struggled with our emphasis on these particularized localized narratives as entry points for the structural transformations that were referred to in the interviews. For us to discuss the possibilities of structural transformations, we struggled with the impetus to generalize to the villages and then more broadly to the overall context of rural Bangladesh. In going back and forth between the localized narratives and the broader articulations of health meanings in discursive spaces of the academic literature, we strategically attended to the need for aggregation in referring to the structural violence experienced at the rural margins of Bangladesh, foregrounding the materiality of inaccess that runs as a thread through the narratives in this project.

Data Analysis

The grounded theory method was used to analyze the data collected from the interviews (Charmaz, 2000; Strauss & Corbin, 1990). The interviews used for this article comprised 19 interviews totaling 90 single-spaced pages of translated text. The data were analyzed using open, axial, and selective coding as suggested by Charmaz (2000). Open coding identified the concepts that were explicit from the interviewees' responses. In the next step of axial coding, commonalities were taken from the open coding and related categories were formed. Finally, these categories were bound together

to form theoretical integration (Strauss & Corbin, 1990). We established rigor through the process of double coding (both of us coded and recoded the data), and by bringing back our key analytic codes to six of our participants to double-check with them. Three themes emerged through our conversations: (1) health, poverty, and lack of resources; (2) working amid structures; and (3) negotiating health options and work.

RESULTS

Culture-centered articulations of health meanings situate health in the backdrop of the structures of poverty, where poverty emerges as the defining feature of the experiences of health in rural Bangladesh. Locally centered meanings of health therefore continually draw attention to the structures of inequality and inaccess, and note the relevance of situating contemporary theorizing of health amid articulations of material inaccess in the subaltern sectors of the globe. It is in this contextual backdrop of limited access to health resources that participants discuss the various ways in which they enact their agency, rationing health choices, taking preventive measures, and seeking out work that would give them access to a source of income.

Health, Poverty, and Lack of Resources

The participants in this project articulated their need and experiences with health in terms of their shortage and need for money; meanings of health were determined by the axis of affordability, narrated in the stories of “*abhab*”⁴ (meaning the absence of basic resource capacities experienced by individuals, by families, and by local communities of rural Bangladesh). Almost every single interview we conducted brought out the participants’ needs for money as a necessity for health. They often pointed first and foremost to the absence of money when asked about their meanings of health (*abhab* therefore is noted as this everyday experience of not having enough money to meet basic needs), which in turn is tied to the absence of health from the everyday lives of the Bangladeshi rural participants. Here is an articulation from Paboni:

Money. Money is the first thing for good health. I don’t have money I have problem of everything. I have money, I can buy good food then I have no tension. I have tension about children’s education, husband’s job, and so many things. This

is the cause of every problem. I have shortage so I can’t do anything. If I have money nothing is problem.

Health as understood as having access to food then is intrinsically tied to not having money to buy food. Health is also tied to the experiences of the stress constituted around other access questions such as children’s education, husband’s job, not having enough food, and not having the money to pay for things. Health overall, then, is reflected in this continual state of shortage of resources (the Bengali reference to *abhab*).

Kusum Rani, a mother of four, and a part-time floor mat maker, echoes the sentiments and articulations of Karimana given earlier. She talks about how earning and living hand-to-mouth creates tensions in her life. She says:

If I earn today I get food but if I can’t earn tomorrow I will not have food. When I can’t earn properly it creates [mental] tension in me. My children have illnesses but I can’t take them to the doctor—this also creates tension. How can I live, how can I get food, these are big tensions that I constantly worry about.

For *Kusum Rani*, the story of health is situated amid the absence of food, the absence of access to a doctor, and the continual tension about how one is going to be able to manage resources and having enough to eat. Worth noting here is the stress created around not being able to take the children to the doctor. Aslam Bhai noted, “It hurts me the most when my children are in pain and I can’t do anything for them. I know that it is urgent to take to the doctor. This worry eats away at me.” Many interviewees voiced their increased mental tension in life because of the financial limitations experienced in their families, and this they articulated as the absence of health. “You can’t be healthy when you are always worried about how to make a living,” said Rani. Similarly, Atisha observed that “I can’t be healthy because I am always worried about money, where it is going to come from and what am I going to feed my children.” The participants shared with us about how their financial limitations cause tension and worries in their lives, and how such mental tensions make them further worried, leading to poor health. Rani also added, “Tension does not go away. When I think about these things, my body feels restless. The body feels weak, and so you have to drive this away from the mind.” *Abhab* therefore plays out in its continual presence in the lives of rural participants, in making its existence felt in the continual shortage of resources, and in the accompanying stress that is centered on the everyday worry about where resources for food, health care, and education are going to come from. Karimana says that her biggest health problem is this tension of the mind. She says:

So my biggest health risks are my worries and tensions. Physically I am okay. I have *chintar beram* [illness of worries]. I worry what I will do and how I will do it. Again, I know it is bad to worry so much because worries bring

⁴In cases where specific terms were used in Bangla language, they are used here inside quotation marks for the richness of understanding. “*Abhab*” is a term that is used in Bangla to refer to the consistent absence of resources from the poorer sectors of communities. The term emerges often in literary and popular cultures of rural Bengal to articulate a space where absences mark the everyday lived experiences of individuals and their families.

“tension” and that is bad for health. People may even die from worrying too much.

The illness of worries is continually tied to *abhab*. Even in instances where the lack of resources is not explicitly articulated by participants in the context of the illness of worries (*chintar beram*), it gets tied with the ability to secure health resources. Ramzan Ali says his financial situation does not affect his health or his family’s health. Ali, a 23-year-old male who chauffeurs private cars by profession, says his health is not affected much by his low financial and social status. However, when asked to expand on this, Ali says sometimes he feels more money would have been better. He says:

Though sometimes I feel that, if I had more money, I would have done this thing and that. Perhaps my health would have been good. For example, if I had money, I could have eaten something good, or done something good, perhaps, if my mind was “fresh” my health would have been good. Eating good, or hanging out with good people, or if I had money I would have led a better life. Perhaps I could have consulted a better doctor . . . if I had a house and a car, my mind would have been good, and thus my health.

So it is interesting to see that Ramzan Ali feels his financial hardship does not affect his health outcomes, and yet his articulations paint a contrasting picture. Ali believes he would have a better life and better health if he had access to greater financial resources, but he seems content with what he has. Additionally, Ali brings out other issues such as mixing with good people and owning a house and cars as factors contributing to having good health.

Overall, the participants in our project voiced their opinions and their lived reality of living amid financial hardships that define, shape, and construct their health choices and outcomes. Poverty stands out as the fundamental barrier to health, and foregrounds all that is critical about health to the rural population of Bangladesh. Perhaps all of this is summarized well by Sultana Banu. Banu, a 20-year-old woman and a mother of three, says, “For me it [barrier to health] is poverty . . . if I am supposed to have three meals a day but can only manage one, how do I get health?”

Most of the participants talked about how they have very few choices in terms of seeking medical attention, and how such choices are constrained by the harsh realities of poverty and other structural barriers that draw the boundaries of their lives. They enunciate their structural barriers in the context of not being able to send their children to school, buy books for them, consume healthy and nutritious foods, engage in healthy lifestyles, or seek medical attention whenever needed. Roshma’s excerpt illustrates this reality of structural limitations. Her husband can only work for 15 days in a month, as there is another person at work who works for the other half of the month. She says, “Money is the first thing for good health. I cannot buy good food, or pay for my children’s books or tuition. That’s all because of money.” So for

Roshma, the lack of money in the family to spend is the root cause of all her problems. If the restaurant could employ her husband for the full month, perhaps money would not have been such a huge barrier. But that is not the case. Rani worries constantly about how she will manage the family needs with what her husband earns. She knows the importance of eating good food, and feeding her children healthy food. But this is not even an option for her when she has to worry about meeting her basic needs.

Another participant, Zahed Molla, shared with us how he cannot afford good food because of his poor income and how that restricts his achieving good health. He says that one needs to eat fruits and other good food to stay healthy, but “We cannot get those. We get bad [our health]. Being able to eat vegetables, fish, egg, banana, milk, chicken, and meat will keep our health good.” Molla knows the importance of eating these types of food, but he simply cannot afford them with his income.

The lack of basic health resources for struggling people such as Zahed Molla goes hand in hand with their lack of access to medical resources. Kareem shared his frustration with us about not having access to good medicine. He says:

If we go to the doctors, they give us bad medicine and do not give us the good ones. We cannot get good medicine. Doctors give us bad medicine. Doctors know we are poor and cannot afford good medicine. Doctors give rich people good medicine. The doctors give bad medicine for poor class people like us. They also charge more even if they give us good medicine. If one file of medicine cost Taka 80–90, they will charge us Taka 200–250. We earn daily Taka 100 and if the body gets sick, then how will we pay? If one file costs 200–250, how can we pay? We do not have the *toufique* [ability] to pay that. So the doctors give us bad and low cost medicine that may not work for our illnesses. The medicines are bad because they cost less.

Kareem indicates how the health care services available are not accessible for poor people such as him, situated within a market economics of profit and health for the rich. Good medications and good treatments are reserved only for the solvent people, and not for people like Kareem who come from the lower classes. He shared with us how he feels marginalized communicatively as the doctors make it obvious with their attitude and behavior that good health care is reserved for the financially affluent, and that people like him from poorer backgrounds don’t deserve to be treated well in the hands of doctors. Rashed Miah illustrates this point:

About five or six months ago, I had malaria. Once that happened, I went anywhere and everywhere that people told me to. I went to many doctors—whoever others recommended. I used all of their medications. That was a bad decision. I went to one doctor and he gave me medication for three days. I took them for three days. But that did not work. So I went to another doctor. His medications also did not work. I went to another doctor and he was a Hindu doctor. When

I went to him, he said I needed to run some tests. I have to do a blood test. So I did the blood test and took the report to him the next day. When I went the next day to show him the blood test report, I found that his office is closed. His chamber is closed. So I called him and he said he went to his village home. His village home is in Comilla. So I told him that you have given me this “slip” [prescription] and gave me an appointment at 11, and now I came to your chamber and found it locked . . . Why is that? So he told me to come the next day, as he is not available.

Rashed Miah’s experience is a good example of how communication practices and structures get intertwined, and such forces further marginalize the voices and needs of the subaltern. Miah sighed in disappointment and told us quite simply how this situation could have been avoided only if he had the money to consult a good physician. A good physician to him is a doctor who has a private practice and charges a lot of money for consultation. Government facilities such as village community clinics do not have good or sufficient doctors, note many of our respondents. Karimana says, “Village doctors have nothing with them. But if things get really bad . . . we are forced to go to them. They give us tablets and oral saline, and stuff like that. We have less money and earn little, so we suffer.” Karimana says very eloquently what others note as well—“we have less money so we suffer.” The participants are in a constant struggle to have access to money, the key structural resource that guides the flow of medical and health resources in the context of the lived experiences of the rural poor in Bangladesh.

Working Amid Structures: Enacting Agency

The participants spoke about how they rationed limited resources when they could not afford to even think about going to a doctor unless they are extremely sick, or unless it is one of their family members, especially a child, who is sick. For rural community members lacking financial and economic resources, making every attempt to stay healthy is the way to avoid a visit to the doctor. Tasmeena Bibi says, “I avoid going to the doctor as I know I will not be able to pay. So I do things at home, like eating properly when I can, eating on proper time, and that way I can prevent my visit to the doctor.” Individual health choices of participants are enacted within this profound awareness of the limited structural resources available to participants. Worth articulating here are the paradoxes in the depiction of agency in this theme in terms of behaviors such as eating properly in the backdrop of the previous section that foregrounds the structural constraints negotiated by the participants in securing access to health resources such as food. Notes Rahim, “I really watch what I eat and try to stay healthy. That way I can avoid having to go to the doctor. I always think what can I do to make sure that I am healthy. And then I try to do those things.” Similarly, Abeer notes, “We do everything we can to keep the children healthy. We have to give them good food

and fruits and vegetables so they are healthy and don’t fall sick. This is very important.” Once again, this articulation of seeking our good fruits and vegetables within the limited structural resources is negotiated amid not having enough resources to buy the fruits and vegetables, as noted in the earlier theme.

Karimana, our participant from the introduction earlier, illustrates this rationing of resources as follows:

When I am very sick, only then I go to hospital. I do not go frequently. I only go when I am really really sick and can manage some money to go to the hospital, only then I go. You know, we are poor and cannot manage the money . . . As I don’t have enough money, I can’t do anything for my health. “I live in crisis” . . . We have less money and earn little, so we suffer.

So for Karimana, seeking medical attention is a last resort, situated amid interpretations of being “really really sick.” When she has no other choice, and she cannot tolerate the illness any more, only then she considers consulting a physician or going to a hospital. Even at this stage, Karimana keeps in mind her financial limitations and (in)abilities and decides who she should consult—whether to consult a village doctor or a government hospital. Her health gets backgrounded to the needs of her family and her children, and primarily to the resource allocation of her family of nine. Similarly, Jahanara points out:

I don’t go to take health care services. I am a mother of three children, I never went to them because if I did, then my children will not have anything to eat. Even if I have sickness, I don’t go because I don’t have money. We have a village doctor; I visit him, that’s enough for us. Some village doctor is good, some not. Some don’t have real education, and they can’t trace the diseases. If they trace diseases, they give medicine, so I don’t need to go to town. So in order to save the limited money we have for my family, I never went to a city doctor.

Participants shared with us their efforts and practices trying to stay healthy, amid all the barriers they perceive and endure in their everyday lives; health is seen as a precursor to avoiding financial crises and hardships. They specifically pointed toward several different lifestyle-related practices as their attempts at staying healthy so they could maintain their work and continue earning for their families; here, staying healthy was a way to ensure the flow of work and for staying out of poverty. Some of these activities include brushing their teeth, eating vegetables, sleeping and eating on time (when possible), bathing regularly, and practicing a proper diet. However, these choices were situated with negotiating with limited structural resources. One of the participants, Ishmail, also said he has heard that remaining cheerful drives away ailments of the heart, and so he tries to remain cheerful all the time. Sultana Banu shared that “If I am not clean properly, it causes illness. If I wash my hands properly, take clean food, then I will never get affected by any disease. Another

way of getting ill would be when mosquitoes or flies sit on your food and lay eggs.” So she keeps these things in mind and tries to stay healthy.

Negotiating Health Options and Work

Interviewees repeatedly expressed their need to stay healthy, as that meant being able to work and earn a living; this in turn ensured that they were able to access resources of medical treatment during times of crises. Falling ill is not an option for them and it would mean losing earning directly or indirectly, thus impacting the economic viability for the entire family. For the participants, their health was the thin thread that held their lives and families together in the context of making a living, and poor health would acutely hamper that. The importance of having an income to the well being of the entire family is shared by Rashed Miah:

If my health is ok I can work. If I feel sick I can't work, even no body can't work. So health is physical strength and energy . . . I have money, I get food, I have nothing to worry about, and then nothing can hamper my health. If I can't be able to buy healthy food, it is a tension, and if I have it, my health is never going to be ok. So if I have income I don't have to worry. If I don't have any earning, I have to worry about it and that will impact my health.

Therefore, participants point toward the cyclical relationship between health and work. On one hand, they refer to the necessity of work in order to ensure a stable source of income, which in turn is necessary to make sure that one has access to the basic resources of health; on the other hand, they refer to the necessity for having good health in order to be able to work.

If they lose a day's work for being sick, then they will directly lose that day's income, although if they fall ill and it is their spouse or children who work, then they will not be able to take care of their spouse/children properly, who may miss work as a result. In a country where there is no certainty of getting next day's work, falling ill and missing a day's work bring extraordinary hardships into the lives of the subaltern classes. As a result, the need to support one's self and family and the mandatory need to work are characterized by a dialectical tension between health and work. Abdul Kuddus, a private car driver by profession, illustrates this as follows:

I believe my whole family depends on my health. Though my wife works, my whole family is dependent on me. There won't be anyone to look after my family if I become sick. So that's why I always want to be of sound health and for me it is the most important thing in my life. To have a sound health we need to maintain a lot of things. But often it is not possible to maintain because of my job.

So for Kuddus, falling ill is not an option as his whole family is dependent on his income. On one hand, he needs his job to remain healthy; on the other hand, the stressors of the job

and the struggles of everyday living make it difficult for him to maintain his health. Kuddus is not alone in this scenario. Ramzan Ali, the chauffeur who is based outside of the capital city of Dhaka, says that sometimes his job requires him to spend nights in Dhaka, and that forces him to be away from his family. This makes him upset and that affects his health, he says, but there is nothing he can do about it as this is part of his job, and his job is the key source of income for his family of seven. Kuddus added he had some physical ailments, especially in one of his ears, but because it will cost him a lot, he has still not consulted a doctor—whatever he earns from his job, he has to put toward his family's needs. Health here is situated amid the necessities of work, familial needs, and familial duties.

Examples such as these testify to the importance of staying healthy for the participants. Participants report how staying healthy is directly interlinked with the health and wellness of their families and dependents. This urgency in the need to stay healthy, however, has to be negotiated by the participants against the backdrop of work-related structural barriers. These barriers conflict with the participants' practices of staying healthy. Again, the dialectical tensions emerging from the work-related discourses on health become visible here. Participants have to stay healthy in order to find a job, earn a living, and maintain the job. However, the requirements and demands of such jobs sometime restrict their individual practices of staying healthy. It is important to remain healthy and keep the job, but at the same time it becomes necessary at times to overlook or ignore the pain and suffering that may come with not being able to follow healthy practices because of the demands of one's job. Ali has to say this about his situation:

I try to overcome these barriers [lack of sleep and staying away from family due to his job] but I cannot do this because of my family. If I try to overcome these barriers, I will not be able to earn and if I can't earn, there is no means to have this dream [having a healthy and economically solvent life with his family]. Dream means to overcome from the barriers. So, even if I want to conquer my obstacles, I cannot, because I have to continue with my job.

So Ali finds it necessary to sleep on time and stay close to family in order to remain healthy, but his job requirements restrict him from following them. He adds that because of long journeys that he has to make for his employer, sometimes he barely gets to sleep at night, but still he has to wake up early in the morning, as he does not get enough time to make up for his lost sleep. But there is nothing he can do about this, as he has to keep the job. So time manifests itself as a crucial and critical work-related structural barrier for people like Ali and becomes part of his basic need to work and earn a living.

DISCUSSION

This research co-constructed the narratives of health in dialogue with the rural participants from three villages of Bangladesh, engaging in conversations about their negotiations and constructions of health meanings, their practices of health-oriented behaviors, and their understandings of the structural barriers that constrain and restrict their health choices, thus offering the axis for localized meaning making (Dutta, 2008). For this community of rural Bangladeshis, health is seen in terms of poverty that acts as their primary decisional component in seeking out and practicing health care; health is connected with this constraint and the urgency of finding and maintaining work to earn a living that would support their families and households. Health therefore emerges as a dialectic that is intrinsically connected to work: On one hand, participants need to be healthy in order to work, and work is essential to securing access to health for oneself and for one's family. Furthermore, the health-work relationship is situated amid the dialectics of work as imposing structural constraints on health and work as a necessity for health. Although, on one hand, the kinds of work that rural participants end up finding in order to make a living impose structural constraints on health because of travel, timing, etc., on the other hand, it is through finding access to such types of work that participants can ensure access to health resources for their families. It is precisely in this backdrop that health is understood within the broader ambits of structure, drawing its meanings in the local context through the lens of poverty (Dutta-Bergman, 2004a; 2004b). The structural constraints experienced in the lives of participants living at the margins of Bangladeshi society point toward the continual presence of poverty in the everyday negotiations of health. Although these constructions are specific to the rural population of Bangladesh, they underscore issues that may be practical heuristics for understanding and exploring health constructions and health beliefs in local contexts at the margins of contemporary neoliberal configurations of structural adjustment programs (SAPs) across the globe that have displaced agricultural communities and increasingly created pressures on the rural sectors (Dutta, 2011). In centralizing the interactions among culture, structure, and agency as entry points for co-creating meanings of health, the voices of the participants from the rural Bangladeshi communities attend to the need for revising the agendas of health communication scholarship in foregrounding the structures that underlie poverty and resource inaccess, and in working toward culture-centered politics of change through solidarity with communities at the margins.

When participants were asked to share their understanding of health, almost all of them talked about health against the backdrop of their financial resource limitations, noting a localized narrative of health that is situated in the midst of poverty, articulating health as "*abhav*," the fundamental

absence of basic resources of health. *Abhav* is experienced as the inaccess to resources for living and is experienced amidst the everyday struggles to secure access to these resources. In addition, the relationship between *abhav* and health is played out in the tensions, worries, and anxieties that are constituted around the everyday struggles for securing resources, for securing work, and the uncertainties around access to work. Therefore, the localized cultural story of *abhav* is situated amid the structural constraints of Bangladeshi political economy, scripted within the broader narrative of neoliberal reform (Dutta, 2011; Sobhan, 2002). Worth noting here is the articulation that although "*abhav*" is culturally constituted in the cultural narratives of poverty and inaccess in rural Bangladesh, this cultural narrative is situated in the context of the broader structures of poverty and inequality attached to globalization politics (Dutta, 2010). The participants talked about how they cannot consult a physician whenever they want to or whenever the need arises, or how they cannot eat food that is good for their health. In these instances, the stories of health are understood as the absence of access to health resources and the inability to seek out these resources because of one's economic marginalization. The participants perceive health in terms of how much money they have to spend for the needs of their family, which in most cases are extended to parents and siblings as well. Traditionally, Bangladeshi families have joint family structures, including members from three generations or more at a time. Only in times of dire needs does an individual seek professional health care, but even then, she/he may look for cheap alternatives as money trumps everything else. Participants, however, pointed out that if it is their children or parents who are sick, then they would borrow money from any available sources to seek health care. For health scholars using the culture-centered approach, these are important and useful heuristics that might help develop policies or implement new ones that might take these into considerations of inaccess (Dutta, 2008; Dutta & Basu, 2007). Health policies and interventions emerging from the co-constructions of these projects therefore point toward foregrounding the voices of local community participants from the subaltern sectors of the globe. In centering structures as entry points to health meanings, local voices in this project point toward programs of structural transformations that are directed at addressing poverty. Furthermore, the social and family structures and the prioritization of illness among family members are factors that might prove useful for long-term and sustainable health care developments, particularly attending to the relational, familial, and collectivist roots of health meanings. Therefore, from a theory-building standpoint, the local voices of the participants suggest the need for theorizing at the collective levels of decision making. Along the lines of Dutta and Pal's (2010) call for re-theorizing health communication based on localized narratives that render the categories of the mainstream impure, collective-based spaces of decision making fundamentally point toward

the need for revising health communication from individually driven message-based top-down interventions to process-based structurally directed programs that attend to the collective spaces of decision making about health.

The financial limitations of the participants lead well into their articulations of finding and maintaining jobs so they may earn their living; health is situated amid the interpenetrating web of familial responsibilities, finding and maintaining a job, and negotiating the tensions that come with the struggles to make a living amidst poverty. The participants could only support their families' health and welfare financially by working; therefore, they need to be in good health so they may be able to continue working. The tensions around the search for jobs and attempts to make ends meet for the family are perceived by the participants as threatening to their health. Such functional construction of health supports previous similar articulations of health in terms of economic resources, such as working without taking any time off (Hughner & Kleine, 2004; McKague & Verhoef, 2003). The interpenetrations of health and work draw attention to the paradoxical relationship between these constructs in marginalized contexts. Although health is conceptualized as an invaluable resource necessary to continue working, the possibilities of health are limited by the types of work participants engage in for earning a living. The stressors of finding and keeping a job relate to the articulations of tension as threat to health and well-being. Therefore, future health communication work ought to pay greater attention to studying and understanding the stressors attached to the structural violence imposed by neoliberal agendas. Attention to stressors in rural contexts of the Third World create alternative entry points for understanding meanings of health amid structural deprivations, also creating entry points for projects of social change that are driven by the localized narratives of participants organized within the frames of social justice and health as human rights.

Finally, our co-cultural participants live their lives in the midst of poverty. They not only explicitly talked about how poverty limits their choices and options regarding health, but also their articulations of other concerns in life related to health propagated in the discursive space implicitly focused on poverty. Time and again participants talked about how they would wait to visit a doctor till the very last moment, how they would avoid buying medicines, or how they would not be able to buy any fruits or vegetables because of their exorbitant prices, even though they understood the importance of having them. Even then, participants articulated the health practices they adhere to in order to maintain good health. Surely, these practices were limited by their economic constraints that influence almost all of their everyday decision making process in rural Bangladesh. Amid all of this, what stood out is the fact that the participants may be willing to sacrifice their health care for different reasons, but they are not willing to sacrifice health care for their children, and sometimes for their elderly parents. This

sense of family, dependability, and responsibility contradicts existing literature "that portrays the subaltern classes in terms of external locus of control and with a low sense of self-efficacy" (Dutta & Basu, 2007). It is through this acknowledgment of the agency of the subaltern participants that we propose entry points for challenging the top-down framework of health communication campaigns within the development communication framework that begin on the basis of the assumptions of passivity of target audiences in the subaltern sectors (Dutta, 2008). Returning the gaze through the centering of subaltern narratives, and in this case narrated through the stories of *abhab*, is a precursor to the politics of social change by disrupting the top-down colonial narratives of subaltern passivity and primitiveness that circulate in development discourse (Dutta-Bergman, 2005). The acknowledgment of subaltern agency as an active site of meaning making and rationing resources amid structural deprivation turns dominant concepts such as "locus of control" and "fatalism," typically used to describe subaltern cultures, on their head.

A key limitation of this study was the snowball sampling technique used to collect the data. Such a sampling technique opens doors for possible biases into a project in terms of cooperative subjects, oversampling of certain subgroups of research population, and masking biases (van Meter, 1990). Despite such limitations, snowball sampling techniques offer good entry points into in-depth qualitative narratives of research participants in marginalized contexts, underscoring their subjective experiences in their local contexts that may be hard to reach otherwise. It was the nature of this research and its generative promise that dictated the usage of the snowball sampling method. Also, the culture-centered method engaged in this project continually struggles between localized narratives and aggregation of these narratives to suggest entry points for change. Ultimately for structural transformations to take place, we were increasingly sensitized to the processes of aggregating experiences of health among rural Bangladeshis in order to draw attention to the commonalities in the experiences of oppression and structural violence situated amid specific political and economic structures in Bangladesh.

In conclusion, this research suggests entry points for co-constructing health communication projects with the local community participants by listening to their voices that may otherwise be marginalized, and completely silenced at times. Thus, a culture-centered approach to health communication co-constructs and reconstructs the existing cosmologies of health through dialogues with local participants, through their participation in material discourses that interrupt the structural violence written into these discourses. The intersections of culture and structure create entry points for local narratives to enter into structural spaces, to interrupt these spaces through the articulation of structural oppressions, and to draw attention to structurally directed policies that frame health in the realm of human rights, social equity, and social

justice (Dutta, 2008; 2011). For the rural Bangladeshis living at the margins of modernist discourses of health, using a culture-centered approach to health suggests looking beyond the dominant approaches to health care that pathologize Third World subjects as primitive and agencyless target audiences, and reconceptualizes health at the margins by listening to the voices of the marginalized. Our dialogic co-constructions suggest that new discursive spaces need to be created for more dialogue with the margins, and these spaces in turn create entry points for imagining alternative worlds. It is through these dialogues that alternative frames can be created for positioning health as a fundamental human right, offering the foundations for projects of health activism that are directed at structural transformations and changes in neoliberal policies of governance that have contributed to the increasing inequalities across the globe (Dutta, 2011).

REFERENCES

- Airhihenbuwa, C. (1995). *Health and culture: Beyond the Western paradigm*. Thousand Oaks, CA: Sage.
- Charmaz, K. (2000). Grounded theory: Objectivist and constructivist methods. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp. 509–535). Thousand Oaks, CA: Sage.
- CIA. (2008). *The world factbook—Bangladesh*. Retrieved from <https://www.cia.gov/library/publications/the-world-factbook/geos/bg.html>
- Comaroff, J. (1982). Medicine: Symbol and ideology. In P. Wright & A. Treacher (Eds.), *The problem of medical knowledge* (pp. 49–68). Edinburgh: Edinburgh University Press.
- Dutta, M. J. (2008). *Communicating health: A culture-centered approach*. London: Polity Press.
- Dutta, M. (2010). The critical cultural turn in health communication: Reflexivity, solidarity, and praxis. *Health Communication*, 25, 534–539.
- Dutta, M. J. (2011). *Communicating social change: Culture, structure, agency*. New York, NY: Routledge.
- Dutta, M. J., & Basu, A. (2007). Health among men in rural Bengal: Exploring meanings through a culture-centered approach. *Qualitative Health Research*, 17, 38–48.
- Dutta, M. J., & Pal, M. (2010). Dialog theory in marginalized settings: A Subaltern studies approach. *Communication Theory*, 20(4), 363–386.
- Dutta-Bergman, M. (2004a). Poverty, structural barriers and health: A Santali narrative of health communication. *Qualitative Health Research*, 14, 1107–1122.
- Dutta-Bergman, M. (2004b). The unheard voices of Santalis: Communicating about health from the margins of India. *Communication Theory*, 14, 237–263.
- Dutta-Bergman, M. (2005). Theory and practice in health communication campaigns: A critical interrogation. *Health Communication*, 18, 103–112.
- Escobar, A. (1995). *Encountering development: The making and unmaking of the third world*. Princeton, NJ: Princeton University Press.
- Good, B. (1994). *Medicine, rationality, and experience: An anthropological perspective*. Cambridge: Cambridge University Press.
- Hospital beds (per 1,000 people) in Bangladesh. (2010). Retrieved from <http://www.tradingeconomics.com/bangladesh/hospital-beds-per-1-000-people-wb-data.html>
- Hughner, R. S., & Kleine, S. S. (2004). Views of health in the lay sector: A compilation and review of how individuals think about health. *Health: An Interdisciplinary Journal for the Study of Health, Illness, and Medicine*, 8, 395–422.
- Jacobs, F. (2007, October 16). *The patients per doctor map of the world*. Retrieved from <http://bigthink.com/ideas/21237>
- Jamil, R. (2009). *Dissecting institutional communication roadblocks: An exploratory study of the public healthcare system of Bangladesh*. Saarbrücken, Germany: Lambert Academic Publishing.
- Jamil, R., & Dutta, M. (in press). Structural and cultural constructions of spirit healing in rural Bangladesh: A culture-centered approach. In D. L. Rubin & A. N. Miller (Eds.), *Health communication and faith-based communities*.
- McKague, M., & Verhoef, M. (2003). Understandings of health and its determinants among clients and providers at an urban community health center. *Qualitative Health Research*, 13, 703–717.
- Mokros, H. B., & Deetz, S. (1996). What counts as real? A constitutive view of communication and the disenfranchised in the context of health. In E. B. Ray (Ed.), *Communication and disenfranchisement: Social issues and implications* (pp. 29–44). Mahwah, NJ: Lawrence Erlbaum Associates.
- Peshkin, A. (1993). The goodness of qualitative research. *Educational Researcher*, 22(2), 24–30.
- Rural population (% of total population) in Bangladesh. (2010). Retrieved from <http://www.tradingeconomics.com/bangladesh/rural-population-percent-of-total-population-wb-data.html>
- Sharf, B. F., & Kahler, J. (1996). Victims of the franchise: A culturally-sensitive model of teaching patient-doctor communication in the inner city. In E. B. Ray (Ed.), *Communication and disenfranchisement: Social health issues and implications* (pp. 95–115). Mahwah, NJ: Lawrence Erlbaum Associates.
- Sobhan, R. (2002). *The political economy of the state and market in Bangladesh*. Dhaka, Bangladesh: Center for Policy Dialogue.
- Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Thousand Oaks, CA: Sage.
- van Meter, K. M. (1990). Methodological and design issues: Techniques for assessing the representativeness of snowball samples. In E. Y. Lambert (Ed.), *Collection and interpretation of data from hidden populations*, Research Monograph Series (Vol. 98, pp. 31–43). Rockville, MD: National Institute on Drug Abuse.
- World Health Organization. (2008). *Bangladesh*. Retrieved from WHO World Health Organization website <http://www.who.int/countries/bgd/en>
- Yehya, N., & Dutta, M. (2010). Health, religion, and meaning: A culture-centered study of Druze women. *Qualitative Health Research*, 20, 845–858.

Copyright of Health Communication is the property of Taylor & Francis Ltd and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use.