Dynamics of Healer Choice in a Medically Pluralistic Society: A Study on Urban Youths in Dhaka City

Jalal Uddin*
Shafiqul Islam**

Abstract: *The choice of a healer in a medically pluralistic society is a complex process. This paper examines the usefulness of Health Belief Model (HBM) and other confounding factors in determining healer choice of the urban youths and tested four components of HBM in relation to socio-demographic characteristics and preferred treatment mode of the respondents. The study revealed that socio-demographic characteristics - sex, years of schooling, household income, marital status, occupation, listening to radio, watching television have been found significantly associated with preferred treatment choice of the respondents. Perceived Severity is moderately associated with the preferred treatment mode ($p<0.05$). In addition, respondents with higher levels of education and income are more likely to have higher levels of Perceived Susceptibility, Severity and Benefits. The study findings indicate that youths with greater economic vulnerability tend to choose traditional healer for getting treatment.*

Background

Adolescents and youths comprise the largest segment of the population of Bangladesh. Nearly one-third (32%) of the country's population is composed of adolescents and youths (10-24 years) (BBS, 2008). Despite this huge population of this category very little is known about their treatment choice behaviour. The choice of a healer in a medically pluralistic society is a complex process. It depends on a great variety of conditions such as the severity of the disease, patient's perceived risk of the disease, relative proximity of the healer, cost of health care, transportation facilities, gender of the patient, patient's attitude toward different systems of medicine, past experience of the patients, perception on illness, belief system on disease causation and the like (Helman, 1995; Kleinman, 1980). Every society has its own beliefs and practices regarding health and disease. Perception of illness, customs, and practices shape and direct health seeking behaviour of the community. Socio-cultural pattern of the community is one of the major factors towards the availability and use of different kinds of treatment. Health and disease are related to sociological and cultural resources of a community in a specific environment. The treatment of disease in any particular society depends on the world view of the people concerned- it is directly related to the attitude of the general public in respect of looking at the universe.

There has been the hegemony of rational decision making paradigms in analysing many public health issues such as health threats of HIV/AIDS, immunization practices, family planning, adolescent reproductive health behavior and so forth. In the recent past, in

* Co-researcher, Human Development Research Centre, Dhaka
** Assistant Professor, ASA University Bangladesh, Dhaka

explaining any social or health problems various socio-psychological and cultural variables have been identified as the core determinants of health behavior of the individual actors. Research in the areas of health seeking behaviour in relation to different acute and chronic diseases has been wide internationally. In spite of the apparent abundance of health related literatures, nonetheless, very little attention has been devoted to health seeking behaviour of the urban youths in Bangladesh. One of the obvious reasons might be the funding of the research. In a wave of donor-driven health studies, thorough empirical research has become a far cry in this area. In Bangladesh only a few studies have made an effort to explore the interpersonal, socio-psychological and cultural factors that affect an individual's health seeking behaviour. In this context, this study is a modest endeavor to explore factors affecting choice of treatment seeking; ascertain the level of association between selected socio-demographic characteristics and health seeking behaviour of the urban youths. The present study also examines the applicability of Health Belief Model in explaining the behavior related to health seeking behaviour of the urban youths in Dhaka city.

Objectives of the study: The specific objectives of the study include:

1. To understand the dynamics of perception of illness of urban youths;
2. To explore different therapeutic channels generally used by urban youths;
3. To examine health belief systems of urban youths; and
4. To explore the level of perceived susceptibility, perceived severity, perceived benefit and perceived barriers of the youths in relation to the diseases suffered last time.

Health Care System in Bangladesh: Medical Pluralism

The existence of several therapeutic traditions in the same cultural setting is an important feature of health care in the transitional society like Bangladesh. It is because patients may feel uncertain as to what type of care provider can cure their illness, leading them to consult different therapists. Otherwise, they may think that treatment of certain illness requires more than one type of assistance. In addition, patients have differential beliefs on disease causation and perception of illness. The daily life of health and healing of the urban population comprised a wide range of medical beliefs, knowledge, practices and of distinctive categories of healers. A wide range of therapeutic choices is available, from self-care to folk and western medicine (allopathic). The box-1 presents different cadre of health care providers in Bangladesh.

Box-1: Different cadre of health care providers in Bangladesh (adopted from Ahmed, 2005)

Self-care: expanding from no medication other than rest and nursing to instances when common home-remedies (e.g. oral saline), over-the-counter (OTC) drugs, or herbal preparations are taken without consultation with any healthcare provider including drug store salesmen.

Drug store salesman (unqualified allopathic): when consultation is made to seek diagnosis and treatment from a drug store salesman; these drug retail outlets are mostly unlicensed and unregulated and only few of the salespeople may have 4 to 6 weeks certificate course on dispensing drugs.

Traditional: when treatment is sought from herbalists (*Kabiraj/totka*) and spiritual healers; also included are homeopathic practitioners, negligible in proportion.

Para-professional (semi-qualified allopathic): when seeking treatment from: a) village doctors with short training in diagnosis and treating common ailments, mostly from private institutions of questionable quality; b) medical assistants who complete a three-year medical assistant training programme and family–welfare visitors who complete eighteen months training in pregnancy and delivery care, from a public institution; and c) various government and non-government community health workers who have some basic preventive and curative health training.

Professional allopath: comprised allopathic practitioners who have undergone six years of professional training and one year internship (MBBS doctors) and registered under BMDC.

Study Design And Data Collection

The study was designed as descriptive cross-sectional study and the fieldwork for data collection was done during January and February 2010 and took approximately 22 days. Both quantitative and qualitative approaches were adopted to conduct the present study. A structured questionnaire survey was administered in order to obtain quantitative data from the sampled respondents. In addition, qualitative tools were also used in order to validate quantitative findings and to understand depth and breadth of the phenomenon being studied. Qualitative data gained through using tools of informal conversations, occasional observation and individual interviews with key informant. The study was conducted in different zones within Dhaka metropolitan areas. With an aim to organize this work in a representative manner, the study areas (Dhaka Metropolitan areas) were divided into 33 zones on the basis of *Thana* (a local administrative area) boundary. From these zones, eight zones were selected for the sample survey. In this regard, various factors, such as, geographical location, concentration of differential youths in particular zones, their occupational status (e.g. students, service holder) etc were considered in selecting sampled zones. Once a zone is selected, the required number of respondents was drawn from it following a simple random sampling technique. Youth for the present study is defined as the 15-24 year age group following the definition of United Nations, 1997 and WHO, 1989).

Data Analysis and Ethical Issues

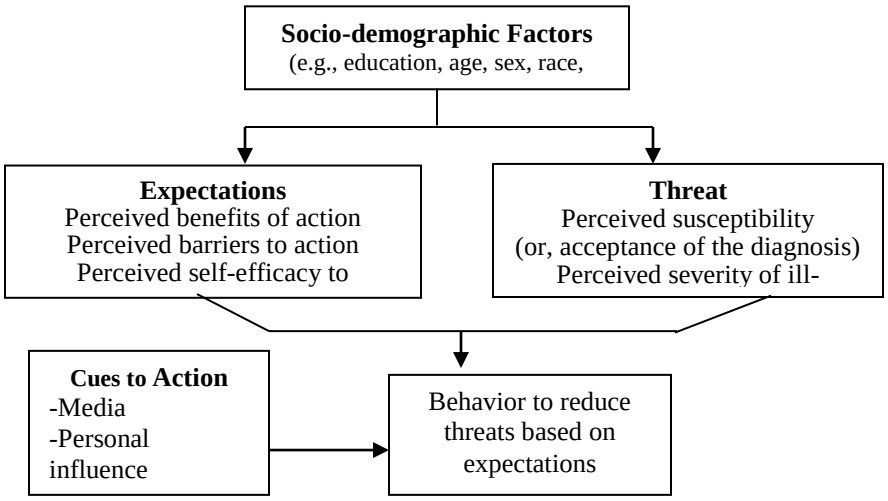
Answers relating to etiology of diseases, perception of illness and answers relating to four components of Health Belief Model were listed and coded. Statistical significance of associations was evaluated using chi-square (χ^2) for categorical variables and Cramer's V for categorical variables having any cell frequency less than five. Statistical analysis used

SPSS for Windows. Voluntary participation of the respondents as well as the confidentiality of their information was maintained. Oral consent from each respondent was obtained for administering interviews with them. Any hint of coercion was strictly avoided in both getting their consent and interviewing. Privacy during the interview process was safeguarded.

Theoretical Framework: The Health Belief Model

The Health Belief Model (HBM) is one of the oldest social cognition models. The HBM aims to predict whether individuals choose to engage in a healthy action in order to prevent the chances of diseases or the health threats. According to HBM, there are two main types of beliefs that influence people to take appropriate preventive action. These include beliefs related to readiness to take action and beliefs related to modifying factors that facilitate or inhibit action. The variables that are used to measure readiness to take action are *perceived susceptibility* to the illness or any health threats and the *perceived severity* of the illness. *Perceived benefits* (i.e. the perceived advantages of taking action) and *perceived barriers* (i.e. the perceived costs or constraints of the specific action) are the main modifying variables (Rosenstock, 1990; Norman and Brain, 2005). When individuals are faced with a potential threat to their health they consider their susceptibility to, and the severity of, the health threat.

Fig-1: A schematic outline of the *Health Belief Model* proposed by Rosenstock, 1990



According to HBM, once an individual perceives a threat to his/her health and is simultaneously cued to action, and his/her perceived benefits outweigh his/her perceived threats, then the individual is most likely to undertake the recommended preventive health action. Thus, as Rosenstock notes in describing this model, "The combined levels of susceptibility and severity provided the energy or force to act and the perception of benefits (less barriers) provided a preferred path of action" (Rosenstock, 1966). For instances, when applied to parents' immunization behavior, the HBM suggests that

Socio-demographic characteristics	N	%

simply having knowledge and awareness about infectious diseases will not necessarily result in increased visits to a hospital for vaccinations. Instead, the model specifies four related elements that must be present for knowledge about disease to be translated into preventative action. First, an individual must perceive that he or she is susceptible to an infectious disease, and second, that person must also perceive that the disease is a serious condition. Third, he or she must believe that there are benefits in taking preventive action. Finally, the individual must also perceive that any potential barriers to taking preventive actions are outweighed by potential benefits (Matsuda, 2002; Norman and Brain, 2005; Onta, 1998). More recently, the concept of "self-efficacy" has been added to some versions of the HBM (Bandura, 1992). In this respect, Rosenstock suggests that self-efficacy was not explicitly incorporated into early versions of the HBM because the original focus was on circumscribed preventive actions, such as receiving an immunization or accepting a screening test. He proposes that self-efficacy is more useful in understanding behaviors, such as those related to chronic illness/diseases, which occur over a period of time and require lifelong changes in behaviors. There have been a number of attempts to relate the variables in HBM to a variety of health behaviors including adolescent's HIV/AIDS-risk (usually sexual) behavior, parents' immunization behavior, drug use, breast self-examination among women and so on (Amanullah, 2002; Matsuda, 2002; Norman and Brain, 2005). In several studies it has been found that socio-demographic variables are related to the various health behaviors and components of HBM (Matsuda, 2002; Ahmed, 2005; Ratanasuwan et. al., 2005; Norman and Brain, 2005). Some community psychologists have used HBM variables as a base for developing educational and BCC strategies and intervention programs.

Results and Discussions

Characteristics of the respondents

A total of 255 youths from different zones of Dhaka city are interviewed for this study. Respondents are predominantly Muslim (96.1%), male (69%) and unmarried (73%). The average household size is 5.41, the average age being 21 with a standard deviation of 4.1. The average monthly household income is Tk. 17940 with a standard deviation of Tk. 3038. In terms of the occupation, 32 percent is students, 25 percent day labour or household worker, 16 percent government and non-government service holder, 13 per cent petty businessman, 11 percent rickshaw puller and 4 per cent homemaker. In terms of education, 18 percent respondents have no formal education; 29 percent have some primary level schooling; nearly 23 percent attend secondary or higher level schooling and 30 percent attend tertiary level of education. In terms of the media exposure of the youths, 61 percent listen to radio while 88 per cent watch television (see table-1).

Sex	Male	177	69.4
	Female	78	30.6
Religion	Islam	245	96.1
	Hinduism	10	3.9
Marital status	Unmarried	187	73.3
	Married	64	25.1
	Divorced	4	1.6
Occupation	Student	81	31.8
	Petty Business	32	12.5
	Govt./NGO Service	41	16.0
	Day labor/ Household worker	63	24.7
	Rickshaw puller	28	11.0
	Homemaker	10	3.9
Monthly family income	Less than 10,000	129	50.6
	10,000-20,000	45	17.6
	20,000-30,000	42	16.5
	30,000-40,000	14	5.5
	More than 40,000	25	9.8
Level of Education	No formal education	46	18.0
	Primary	75	29.4
	Secondary/Higher secondary	58	22.7
	Tertiary	76	29.8
Listening to radio	Yes	156	61.2
	No	99	38.8
Watching television	Yes	225	88.2
	No	30	11.8

Table 1: Socio-demographic characteristics of the respondents

Perception of Illness

While conducting occasional field observation and unstructured interviews with youths of different occupations, they usually spoke of illnesses that they themselves or members of their family suffered. It is important to note that few youths sometimes overlapped the concept of illness with disease. Regardless of religion, illness is perceived when an individual a) is unable to perform his/her daily activities (e. g. working in the field, doing domestic works, going outside for business etc.) due to pain or discomfort b) suffers from pain in different parts of his/her body, c) loses appetite, d) suffers from headache, e) loses his/her weights, power of eye sight and physical strength to work in the rice field.

Etiology of Illness

While doing fieldwork, youths of different occupations were asked about the causes of different illnesses. Most of the youths regardless of their occupation and socio-economic condition, believe that most of the illnesses occur due to external causes such as exposure to cold or to heat, insufficient diet, rapid changes in the weather, use of fertilizer or chemical in the production of vegetables/fruits etc. Regardless of the religion and occupation, youths of the study areas mentioned the following causes of illnesses: a) working under hot sun and heavy rain, b) drinking unclean or impure water, c) working hard in the agricultural field, d) using of fertilizer/chemicals in production of vegetables or fruits, due to virus/bacteria, e) due to frequent weather change, f) due to extreme cold, g) due to insufficient diet, h) due to immense pressure in occupational duties, i) due to habit of using computer/other technology for long hours. However, a few youths from lower socio-economic stratum and having low level of education give a personalistic explanation of illness. To a certain extent, illness is the result of the intervention of bad sprits (e.g. '*jin', 'voot'*) people usually cannot watch. It is also evident in their treatment of some illnesses for which youths often rely on faith healers, religious specialist or '*Kobiraj'* (local traditional healer).

Dynamics of Treatment Seeking Behaviour

In order to explore the choice of treatment, all of the youths are asked about the treatment they sought for their last episode of illness. It is found that 30% youth go to pharmacists for receiving treatment. In our occasional observation it is found that youths of every stratum go to pharmacists for receiving treatment. It is observed that most of the youth initially go to pharmacists for taking medicine and advice for any given illness. They want to come round quickly by taking modern allopathic medicines. Often they become cured with the treatment of the pharmacists too. However, pharmacists are paid hardly for the treatment or advice youths received. In this way a good relation is built among pharmacists and youths. For this reason, the youth become dependent on pharmacy to some extent. A pharmacy is not only medicine selling centre but also a centre of gossiping of the youth. Often one or multiple youth proprietor or youth salespeople are found working in pharmacy. Many youths come here for their company. In this way they get mixed with pharmacists, gossip with them and get advice about their illness at the initial stage. Sometimes, pharmacists suggest the youth to go to MBBS doctor or hospital if they fail to give proper treatment.

Table 2: types of treatment sought for the last episode of illness

Types of treatment sought	Frequency	Percent
Unqualified allopaths	76	29.8
Qualified allopaths	82	32.2
Para-professionals	46	18.0
Traditional healer	26	10.2
No treatment	25	9.8
Total	255	100.0

In the study it is found that 32 per cent youth go to qualified allopathic practitioners for getting treatment. That is, they go to MBBS doctor's private chambers or medical doctors working in government or non government hospital. Though MBBS doctors who are practicing in private chambers are costly for youth but in order to get better treatment a significant number of youths go to them. Besides, many poor youths, for instance, day labourers or rickshaw pullers tend to receive treatment from government hospitals. It is because that these poor youth have less financial capability. However, youths with more financial solvency and higher level of education tend to visit clinics or chamber of private allopathic practitioners. It is found that 10 percent youths go to traditional healer for receiving treatment. It means they go to ayurvedic, unani, herbalists, faith healer, religious healer, homeopathic practitioners etc. Some youths think medicines provided by the traditional healers have less reaction and treatment cost is very low compared to modern allopathic treatment. A significant number of youths (10%) did not seek any treatment during the last episode of illness. Though they didn't take any medicine, they got family serving during their illness. In such cases, they received home therapy or self care.

Socio-demographic Characteristics and Components of HBM

A number of Chi-square (χ^2) and Cramer's V coefficients[1] were computed to examine the links of socio-demographic characteristics with the components of the HBM and preferred treatment mode followed by the youth for their last episode of illness. Some of the demographic characteristics were found to have association with the components of the HBM such as occupation and watching television of the respondents were moderately associated with all the components of HBM, while years of schooling, monthly family income and marital status have been associated with three components of HBM-perceived susceptibility, perceived severity and perceived barriers (see table 3).

These test coefficients also reveal that level of perceived susceptibility, perceived severity and perceived benefit was higher for the respondents with higher income and higher level of educational attainment. It is, thus, easily understandable that such respondents as service holders, graduate/undergraduate students and businesspeople perceived higher level of susceptibility severity and benefit due to their better economic position than those of rickshaw pullers, home maids, and day labourers. The HBM is a psychosocial model, it accounts for only as much of the variance in health behaviors as can be explained by attitudes and beliefs that are obvious to and consciously evaluated by individuals.

Other extraneous factors related to the individual, such as personality factors, social support, previous health experiences, culturally constructed beliefs and myths may play a role in determining behavior. Unfortunately, they are not an explicit part of this model. In

[1] Given the predominance of nominal level variables Chi-square (χ^2) and Cramer's V test is used. Chi-square is used for cross-table having all cell frequency above 5. While for cross-table having cell frequency less than 5, Cramer's V is applied. (For details about the criteria on applying measures of association, see Bryman, A., 2004. *Social Research Methods*, Oxford University Press, pp. 230-240.)

addition, concepts reflective of the larger social structure, such as institutional or public policy, poverty, and social isolation that may affect access to health care, are not included in the HBM. Norman and Brain (2005) and Matsuda (2002) showed that demographic

Table 3: Association between socio-demographic characteristics and components of HBM

Component of HBM	Socio-demographic characteristics							
	Sex	Years of schooling	Family income	Marital status	Occupation	Age	Listening to radio	Watching television
Perceived Susceptibility	V=0.26**	V=0.40**	V=0.35**	V=0.32*	V=0.29**	χ^2 = 4.29 df = 3	χ^2 =5.32 df = 3	V=0.22*
Perceived Severity	χ^2 =.629 df = 3	V=0.43**	V=0.27**	V=0.45**	V=0.51**	χ^2 = 2.29 df = 2	χ^2 =2.17 df = 3	V=0.20*
Perceived Benefit	χ^2 =3.95* df = 3	V=0.22**	V=0.58**	V=0.40**	V=0.36**	V = 0.15	χ^2= 27** df = 3	χ^2 = 12** df = 1
Perceived Barriers	χ^2 =2.38 df = 1	V=0.17	V=0.18	V=0.16	V=0.47**	V = 0.17	χ^2 = 12* df = 3	χ^2 =27** df = 3

* Significant at the 0.05 level, ** Significant at the 0.01 level

variables had only minimal impact on the strength of the components of HBM, when it was applied as a theoretical background in a study related to immunization behaviors of the parents in Nepal.

Socio-demographic characteristics and preferred treatment mode

Seven socio-demographic characteristics have been found significantly associated with preferred treatment choice of the respondents. These characteristics include sex, years of schooling, family income, marital status, occupation, listening to radio, watching television (table 4). Rational decision-making models, which include the health belief model and the theory of reasoned action, are models that conceptualize human behavior (in this case healer choice) as purposive, rational and intentional rather than mindless pathological or deviant.

Table 4: Cramer's V values for preferred treatment mode and socio-demographic characteristics

Socio-demographic characteristics	Preferred treatment mode
Sex	V=28**
Years of schooling	V=0.51**
Family income	V=32**
Marital status	V=0.30*
Occupation	V=0.44**
Listening to radio	V=0.39*
Watching television	V=0.47**

* Cramer's V is significant at the 0.05 level ** Cramer's V is significant at the 0.01 level

These theoretical models also believe as underlying principle that human behavior is influenced by imposed knowledge, that is, knowledge helps persons to make decisions rationally, which results in consequently the changes in attitude and practice. But the findings related to treatment choice in this study didn't support the conventional flow of rational decision-making paradigms (Table 5).

Table 5: Cramer's V values for components of HBM and preferred treatment mode

Components of HBM	Preferred treatment mode
Perceived Susceptibility	V=0.18
Perceived Severity	V=0.32*
Perceived Benefit	V=0.14
Perceived Barriers	V=0.12

* Cramer's V is significant at the 0.01 level

It was hypothesized that level of perceived susceptibility, perceived severity, perceived severity and perceived barriers determined choices of treatment. But only perceived severity of the illness was found having association with the treatment choice of the youth (Table 5). It has been found that psychological constructs (e.g. perceived susceptibility) cannot merely change the behavior. For instances, when applied to parents' immunization behavior and commercial sex workers' health behaviors, the findings suggest that simply perceiving susceptibility and severity about diseases will not necessarily result in increased visits to a hospital for vaccinations and taking preventive measures like consistent condom use (Matsuda, 2002; Amanullah, 2002).

Conclusion

The theoretical model on which this study is predominately based is a psychosocial framework, which can only account for as much of the variance in health behaviors as can be explained by attitudes and beliefs that are apparent to and consciously evaluated by individuals. Other factors related to the individual, such as demographic variables, personality factors, social support, previous health experiences, poverty, social isolation or stigma, cultural norms and myths may play a role in influencing individuals' behavior. Unfortunately they are not an explicit part of this model. Taken together, the results of this study indicate the importance of looking beyond the traditional framework of HBM in order to achieve a more culturally sensitive context for understanding health seeking behaviors and risk perceptions of the concerned individuals. In addition to the salient components of the Health Belief Model and the statistically significant demographics, culture specific knowledge, beliefs and experiences must also be considered if future educational or structural interventions are to be successful.

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