DM 5.6

RF/DM-1/EPR(B)-7/SUDHA (7)

Important observations regarding the effect of social, cultural and religious factors on the concepts of health and disease among the Refugees from Bangladesh - and the relation of these factors to the acceptance of the medical relief programme.

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In order to understand the reactions and the beliefs of the refugees regarding our health programme it is necessary to try and define the population we were dealing with -

i) The refugees were mostly from the lower classes, since many of the people of the upper stratas preferred to reside with their relations and friends in neighbouring villages and towns

ii) The majority of them were farmers, fisherman and small traders

iii) They all spoke only Bengali except a few of the traders who understood Hindi

iv) The majority of them were Hindus with a smattering of the other religious groups including Muslims.

v) To many of them a medical clinic was a new experience - and so also was Western Medicine

vi) Along with the refugees a few of their own non-medical village doctors had come and they continued to carry on their work as much as the circumstances would allow.

The health facilities available to the residents of the camps were

i) An out-patient dispensary and a 6 bed treatment unit run by us under the CARITAS relief programme.

ii) A government health unit-of the "sulphadizine - aspirin" type run by a compounder. This unit was also in charge of the small pox and cholera innoculations

iii) Refugee 'doctors' mentioned above

iv) Medical practitioners practicing in neighbouring villages and towns

During the course of our work we were faced with many problems where we discovered that for a solution to be obtained a proper understanding of the social traditions of the people of Bangladesh would be necessary. Many of these belief we found were common to the rural populations in our own country. Here are a few of them and how we attempted to over come them.

1. We were often requested by some of the refugees to give them an injection for their complaints. They offered us comparitively large fees and most of them held the view that a single injection was the best cure. This built in faith of the efficacy of an injection over oral treatment is found in most rural populations.

2. Often it was very difficult to make the patients understand that oral drugs were to be taken regularly and as many times a day as prescribed. The following were common reactions

   i) As soon as symptoms disappeared they stopped treatment or

   ii) If they felt better they took the entire 2-3 days dosage at one go believing that a stronger dose would have a quicker effect. One can imagine the possible dangers of such a procedure and therefore we made it a rule in our dispensary to give drugs for a maximum of 2 days at a time. This was not always effective

3. We were often requested in the initial week of our work to send one of our sisters to attend to a delivery case in the huts. Our sisters found this a rather trying experience because of the unhygienic conditions and the shortage of space. No amount of verbal persuasion could convince the women to come for their deliveries to our treatment room since the presence of male doctors made it taboo. We thought up a motivation factors which proved successful. One of our sisters was able to bring one of the women to our clinic for a check-up and to our luck she was found to be in labour

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and delivered a few hours later. When the woman left out dispensary that evening she took back with her 2 dresses for her little child , a few nappies and bibs, a bottle of vitamin drops and some milk powder. The news soon spread and from the next day we had a regular stream of women coming for their deliveries and walking out with their gift parcels. Thanks to a steady flow of aid in the form of clothes we were able to maintain this motivation.

4. The concepts of disease in the traditional school are often contrary to those of modern medicine e.g. The belief is that in an attack of diarrhoea or dyssentery a patient loses bad water from his system and if he drinks fluid at this time he will only increase the output of fluids and so fluid intake is cut down. We had great difficulty in explaining our concept and often the patient only ate up the salt we gave in packets but never the required quantity of fluid which we advised, making handling of such cases rather difficult.

5. Another belief was that a child with rash should never be shown to a doctor. This explained the fact that we did not see as many cases of measles as we ought to have but saw a number of cases of bronchopneumonia preceded by a history of rash.

6. Practices with regard to Infant feeding were also causing problems

i) Children in East Bengal are breastfed to a very late age upto 3 years or more. When a mother has children of say 3, 2, 1 years which is often the case the elder ones feed more often and vigorously and the younger ones are deprived of their only source of nutrition thus resulting in malnutrition in the infants..

ii) Often when we gave milk powder to be mixed with water regularly and given to the infants-we found on health visiting that large part of the milk was drunk by the adult male - members of the family-since in the East Bengal tradition the wage-earners of the family is first fed and the women and children eat the left over.

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7. Beliefs regarding auspicious times of entering and leaving the dispensary, quite common in most parts of India, did not interfere with our work. Except in one case when a women was brought in with prolonged labour due to hand prolapse and when we advised transfer to the nearest district hospital, her relatives insisted her on taking her back to the hut and then starting the journey to hospital again since the belief is that if a patient is asked to leave a hospital and go to another with being given any treatment then the doctor has given up hope and i.e., a bad omen.

The above observations helped us to understand the people we were working with and in any such situation this is becoming a very important factor. Dr. John Seaman in his paper in the Lancet (ii) (1972) P866 echoes this need when he lists the following as the first lesson learnt from the Bangladesh experience He says much more detailed information should be available about the nature of the society involved and that our ignorance of the society and attitudes of the poor people was a problem felt by all doctors in the camps.