

TEACHING HEALTH SOCIAL SCIENCE

BANGLADESH CASE STUDY

S. M. Nurul Alam, Ph.D

**Professor of Anthropology
Jahangirnagar University
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Editor
MA Rahim

Managing Editor
M. Shamsul Islam Khan

Cover Design
MA Rahim

Computer Assistance
Talat Solaiman

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(ICDDR,B, GPO Box 128, Dhaka 1000, Bangladesh)

Tel.: (880 2) 871751-60 (10 lines)
Fax: (880 2) 883116, 886050
Cable: CHOLERA DHAKA
Telex: 675612 ICDD BJ
E-mail: msik%cholera@external.ait.ac.th

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1.0 INTRODUCTION AND METHODOLOGY

The main objectives of this case study are to describe the current state of health social science, its need, concerns, and future priorities in Bangladesh. Although Bangladesh has a long history of social science teaching and research, health social science is still an ignored area barely understood among the social scientists in the universities. This case study attempts to identify whether any elements of health and related issues are incorporated in the teaching of social science, and the perception and views of the faculties of different universities regarding the prospect of the incorporation of health social sciences within the existing framework of the social science program.

In this case study the author extensively reviewed the common social science curricula of four universities: Dhaka University, Rajshahi University, Chittagong University and Jahangirnagar University. The curricula of undergraduate medical education in these universities and of the National Institute of Preventive and Social Medicine (NIPSOM) were thoroughly examined. The author also interviewed numerous people involved in social science teaching, research and those associated with medical education (*Appendix-1*).

1.1 Organization of the Study

This case study begins with a brief description of the country in general, development problems, general state of health and the reasons why the study of health is important. The state of health science education, its focus and prospects of social science in medical colleges is discussed in Section 3. The fourth section contains discussion on various issues relating to health social science, current social science curriculum in the universities, their focus, future need and prospects. The fifth section describes the present condition of social science research on health and the organizations involved in conducting and guiding such research. A framework for teaching social science, nature of support needed, and the career prospects of health social scientists are described in Section 6.

2.0 THE COUNTRY: GENERAL PROFILE

2.1 Socio-economic Features

Bangladesh is a small country with a land area of 56,977 sq. miles (or 1,47,570 sq. kilometers) and an estimated population of 119.7 million, which makes it the 9th most populous country of the world. The GDP at the current price index has been estimated at \$ 229 in 1991-92. Agriculture and aquaculture are the dominant occupational activities in the country. Agriculture is characterized by traditional methods of cultivation and low agricultural productivity that contributes to increasing poverty and hunger. About 83% of the population live in the country's 68,000 villages, and it is estimated that 60 to 85 percent of the people live in absolute poverty.

Bangladesh is also known as land of rivers. The major rivers are the Ganges, the Brahmaputra and the Meghna – their 250 tributaries and distributaries creating a riverine environment that shapes the daily life of the majority of people. The basic diet of the people is dependent on abundant sources of water and the flora and fauna within. There is always the perennial threat of floods, but people are well-adapted to this threat and survive the onslaught of floods every year. Apart from floods, Bangladesh is also affected by cyclones, droughts, pest-attacks and riverbank erosion that make Bangladesh one of the most disaster-prone countries of the world.

Education is a major factor not only in socio-economic development but also in the human development of the country. Only 2.0 percent of the GNP is allocated to the education sector in Bangladesh. The number of different educational institutions is inadequate for the size of the population (Table 1), and enrollment in educational institutions is still low (Table 2). Bangladesh ranks very low in literacy with an overall adult literacy rate of 35 percent. Over 44 percent of the adult males and 26 percent of adult females are literate. The initial enrollment of males and females at the primary level is 84 percent and 74 percent respectively, dropping at the secondary level to 22.6 percent for males and 12 percent for females (Haider et. al 1995). In recent years a massive literacy program has been undertaken by the Government and by NGOs. It is expected that, with increase in the literacy situation, the overall socio-economic indicators of country's development will improve.

Table 1: Educational Institutions

Type	Number
Public University	11
Private University	6
Government Medical College	13
Private Medical College	4
Dental College	1
Engineering College	4
College	1,046
Secondary School	9,892
Primary School	49,964
Madrasha (<i>religious school</i>)	6,205

Source: BBS, 1993

Table 2: Enrollment in Educational Institutions

Type	Male ('000s)	Female
Primary	6574.6	5365.3
Secondary and Higher Secondary	2123.7	1110.0
Graduation and above	610.0	188.8

Source: BBS, 1993

2.2 Problems of Development

The road to development in Bangladesh is not an easy one; problems are deep-rooted and embedded in the age-old socio-cultural and economic institutions in the country. By development we would mean not only economic but also social and human development.

It is, therefore, important to take a human approach to development. The demands, needs, and aspirations of different groups by gender, class, profession, and ethnic identity should be properly understood. Development cannot be real or people-oriented unless the people's needs are properly assessed and understood. Having made this observation regarding constraints, the general health situation and problems in Bangladesh will be described.

The major problems of development include the following:

A. Structural

- General poverty
- High level of illiteracy
- High growth of population
- Limited availability of land
- Unequal distribution of wealth
- System of land tenure
- Lack of employment opportunities
- Bureaucratic and urban bias in development

B. Socio-cultural and Economic

- Family and kinship pattern
- Religious beliefs and values
- Traditional values, norms, and world views
- Low level of achievement orientation
- Higher propensity to consume
- Level of technological development
- Lack of awareness about health
- Ethnic problems

C. Economic and Environmental

- Lack of capital
- Low capital formation
- Low capital-output ratio
- High rate of population growth
- Low land-man ratio
- Rural-urban migration
- Declining ecological reserves
- Deforestation
- Over-exploitation of common property resources
- Frequent occurrence of natural disasters
- Vulnerability and insecurity
- Inadequate facilities for water and sanitation
- Poor health care facilities

2.3 General Health Situation and Problems

The general health situation is significantly linked with lack of awareness among people about health care and their access to health care facilities. Many important health problems in Bangladesh are associated with inadequate nutrition, poor environmental

sanitation and lack of safe drinking water, which lead to various types of water-borne diseases, respiratory diseases, high prevalence of infectious diseases, such as tetanus and measles and complications at childbirth (Box 1).

Box: 1 Health problems in Bangladesh

- ◇ Lack of knowledge about different diseases
- ◇ Poor access to health care facilities
- ◇ Urban-biased medical facilities
- ◇ Poor quality of medical services
- ◇ Severe malnutrition
- ◇ Poor and inadequate sanitation
- ◇ Unsafe water supplies
- ◇ Diarrhoeal and respiratory diseases
- ◇ Obstetric complications
- ◇ High maternal mortality
- ◇ High incidence of infant mortality
- ◇ Deficiency of micro-nutrients such as vitamin A
- ◇ Low number of female health professionals
- ◇ Inability of people to obtain health services
- ◇ Problems of communication with medical practitioners
- ◇ Lack of awareness about basic health problems

The average life expectancy in Bangladesh is only 58 years. Infant and maternal mortality is among the highest in the world. The effects of morbidity and illness episodes on both quality and productivity of the life of survivors are enormous and often ignored. The consequences of anemia, heavy intestinal parasite infestation and deficiencies of micronutrients such as vitamin A constitute public health problems in the country (Cohen 1980). There are many other diseases, the magnitude of which can be reduced by creating public awareness and making health services available to the public.

The crux of the problem is that a large majority of the population is either not covered by the official (or modern) health care systems, or people do not use those services. It is critical that we should realize and appreciate that a very popular and highly developed indigenous system of health care exists, parallel to government health services. A large number of *kabiraj*, traditional midwives (known as *dais*) herbal healers, homeopaths and *ayurvedic* specialists provide the basis of the local (or indigenous) system of health care in the country. The important questions that remain to be answered are: Why do people rely so much on the indigenous system? What is their perception of disease and cure? How do we integrate the modern with the indigenous health system? These are some of the issues that require due consideration in formulating a broad-based, pro-people system of medical care in Bangladesh.

2.4 Why Does Health Matter?

Good health is a crucial part of human well-being. There is a close relationship between good health and the economic and social advancement of a nation. In a country like Bangladesh the loss of productivity from ill health and repeated illness episodes is quite high and cannot be overlooked. "Health is a basic requirement to lead a socially and economically productive life. Socio-economic development and welfare of a nation are greatly dependent on the state of health enjoyed by people" (GOB 1991). The importance of health can be justified on purely economic grounds also. I quote below from the World Development Report 1993 to emphasize on the economic importance of health:

"Improved health contributes to economic growth in four ways: it reduces production losses caused by workers' illness; it permits the use of natural resources that have been totally or nearly inaccessible because of disease; it increases the enrollment of children in school and makes them better able to learn; and it frees up alternative use of resources that would otherwise have to be spent on treating illness. The economic gains are relatively greater for poor people, who are typically most handicapped by ill health". (World Bank 1993: 17-18)

3.0 STATE OF HEALTH SCIENCE EDUCATION

3.1 Features and Framework of Undergraduate Teaching

There are 13 government and 4 private medical colleges in Bangladesh. Although private medical colleges are a new phenomenon in the teaching of health sciences in Bangladesh, government medical colleges still provide the opportunities for training the majority of doctors in Bangladesh. The medical education course lasts for five years. A common curriculum, accepted by the universities in 1988-89, is followed in all the medical colleges for undergraduate medical education. Since one common curriculum is followed in all the government medical colleges, our discussion is applicable for the whole of Bangladesh. In writing the foreword for curriculum, the Principal of Dhaka Medical College wrote:

"This curriculum is printed with a view to informing the details of the tasks they (students) will require to undertake during the five years of course period. Equally this will allow the teachers to understand volume of teaching that they will have to deliver to the students within specified period. They will have to prioritize the topics on the basis of community need. The theme of the course is to make community doctor rather than to make an institutional doctor only."

The last two sentences regarding prioritizing the topics on the basis of "community need" and the need to create "community doctors" rather than "institutional doctors" are important and require due consideration. Given the content and approach of the present curriculum, it is difficult to perceive how the community need will be met by training community doctors. A look at the content of courses shows that, in many respects, these are similar to the sort of courses that have been developed to train students in the industrialized countries, particularly UK (Cohen 1980:16). We have not noticed any

endeavor to contextualize and link this to the reality in Bangladesh. The students are required to study foundation subjects such as anatomy, physiology, and biochemistry in the first two years of their program. The last three years are earmarked for gaining some clinical experience with rotations in such specialized fields as medicine, surgery and child care. The Community Medicine course is offered from the 1st to the 5th year classes and is designed to offer "an understanding of the subjects and topics with a view to promoting better understanding and learning of the students." We delineate several features of undergraduate medical training in Bangladesh in Box: 2.

Box: 2 Features of Undergraduate Medical Teaching

- ◇ Traditional courses
- ◇ Courses developed in line with industrialized countries, particularly UK
- ◇ Emphasis on book learning
- ◇ Emphasis on disease, not on health
- ◇ Concentration on curative rather than preventive aspects of care
- ◇ Identification with clinical and individual-centered roles
- ◇ Compartmentalization of separate subject areas
- ◇ Lack of community-based practical training
- ◇ Very narrow views regarding medical training to the exclusion of behavioral and human issues
- ◇ No attempt to link behavioral, social and cultural issues/problems with medical problems
- ◇ Hospital-centered teaching
- ◇ Absence of need-based and contextual research
- ◇ Absence of collaborative research between medical and social sciences
- ◇ Less emphasis on public health issues
- ◇ No attempt to identify the local vocabulary of disease and link this to teaching

Medical students think that their curriculum is loaded with basic courses. They consider these as the main prerequisites to becoming a good doctor. They do not at all realize the importance and relevance of social science in their program of study. Students consider community medicine as redundant, unnecessary and an additional burden in their already overburdened program. Many undergraduate medical students believe that their main task is to identify the causes of disease, make diagnoses and prescribe treatment. For this they argue that they need to know more about the technical and physical aspects of medical sciences. It has been rightly pointed out that:

"The initial division of subjects, and what has come across to us of the philosophical background, points to the conclusion that the aim of the course is the preparation of students for a hospital-centered and almost solely curative focused practice" (Cohen 1989 : 17)

The attitude of medical students is quite understandable and is rooted in the system of medical teaching in this country. Those who are involved in developing the curriculum and teaching and training doctors lack a community approach and do not realize and

appreciate the importance of human issues involved in the medical profession. As a result health science education in this country is entirely geared to the teaching of basics of medical and health sciences. There is no attempt to rise beyond this narrow view of medical sciences to include social science and community perspectives within medical education. It can be said that medical education in this country is an extremely parochial and closed type of system.

All the medical colleges of the country have a Department of Community Medicine. In spite of the importance of community medicine, this is not seriously taught and pursued by the medical colleges. In most cases community medicine is taught by doctors who are well-trained in medical and other technical issues but not in community and social issues. This issue will be discussed later in this section.

3.2 Established Image of a Doctor

I would suggest that indifference and lack of interest in seriously pursuing community and social issues are very much rooted in the way society perceives a doctor. The important questions in this respect are: How does society perceive a doctor? What are the general and established image of a doctor? A doctor is a person who has a degree, normally MBBS, from a medical college, has a stethoscope around his neck, writes prescriptions and knows how to treat diseases. A good doctor is one who can cure diseases quickly, can attract a large number of patients and earn money. Therefore, the important prerequisites of a successful doctor are: curing disease, attracting a large number of patients, and earning money.

An understanding of social, cultural and economic contexts of diseases is not considered important in building what I would call an ideal image of a doctor. Those who get a chance to study medicine after facing severe competition in the entry examination consider themselves lucky and privileged because very few get this opportunity. Indeed, this provides them the chance to become "doctor *shaheb*," earn money, obtain social status and perhaps even to work abroad. This societal and cultural construction of the image of a doctor act as a hindrance to train 'community doctors' or what I would call 'doctor with a community and humane outlook.'

3.3 Community Medicine in the Medical Colleges

The community medicine taught at the undergraduate level of medical colleges has close affinity with social sciences. It is the only linkage of social science with medical teaching in the country. The following paragraph will make the relation clear:

"Community medicine is not only the province of physicians or those with immediate experience in health work: also involved are economists, demographers, social scientists, statisticians, agriculturists and anthropologists."

The focus of community medicine is population and public health rather than individuals and diseases. The ideological roots of the community movement can be found in the public health medicine of the industrialized West, where people become more concerned with environmental and social approaches to health realize to what extent desired results

in health improvement programs and policies can be achieved through curative treatment. Now, the questions are: to what extent community medicine is thought to be useful and how the teaching of community medicine is handled in Bangladesh.

The community medicine section of the medical course is new. Considering its importance, the course has been redesigned and is now offered from the 1st to the 5th year classes. The objective of the course is "to provide community-oriented and need-based medical education to produce good basic doctors dedicated to attain health for all by the year 2000 through effective Primary Health Care" (DMC: 1989). It is expected that through this course a student is likely to get exposure to the following (Box 3):

Box: 3 Course Expectation

- ◇ Detailed knowledge about common and easily preventable diseases in Bangladesh.
- ◇ Changed attitude to preventive and promotive health and medical practice in solving health problems in Bangladesh, that is, to become community doctors for the country.
- ◇ Changed behavior to deal with patients as a social human being having personal as well as social needs.
- ◇ Changed responsibility to be a teacher, trainer and team leader for the community health workers always ready to give managerial leadership in the community along with professional duties.
- ◇ Knowledge about how to control epidemics and manage health problems in order to face emergencies after natural calamities.
- ◇ Knowledge about the importance of referral system for proper health care in the community.
- ◇ Develop skill to purify drinking water, vaccination, application of MCH-FP (Mother and Child Health and Family Planning) strategies, assessment of nutritional status, ORS reparation, etc.

The subject of community medicine is divided into three main parts as follows:

- Community health, behavioral sciences, biostatistics, demography, public health administration, international health organizations, international health regulations, health laws of Bangladesh, national health policy, organogram of health services of Bangladesh and primary health care.
- Environment and health, occupational health, personal health, MCH-FP, food and nutrition, health education, epidemiology of common communicable and non-communicable diseases in Bangladesh and medical etymology.
- Deficiency diseases, preventive and social medicine including pediatrics, obstetrics, geriatrics, mental health, genetic counseling, and community surgery.

Although the new curriculum is an improvement both in contents and approach, this is not enough to have a desirable impact on medical education. This is due to several reasons. Community medicine requires team teaching with social scientists. It requires an understanding of the history of medicine, medical ethics, medical jurisprudence, social and preventive medicine. Lack of joint teaching and service involvement cuts off the

subject area from clinical relevance and operational reality. Theory becomes overstressed (Cohen 1980: 21).

In Bangladesh, community medicine is taught by medical doctors with little or no exposure to social science. The department of community medicine is still considered a minor department. Most students consider this course an additional burden and do not find any relevance to basic medical courses they take. Fieldwork constitutes a small segment of the course while lectures constitute the main mode of teaching. Above all, an interest in community medicine is constrained by the established notion of becoming a doctor.

It is an irony in Bangladesh, perhaps in other countries of the region as well, that social scientists and medical scientists rarely collaborate and enrich themselves by collaborative teaching and research. We can hardly cite any example of collaborative research. I will finish this section by quoting an excellent observation by Cohen 1980:

"The subject is poorly placed in terms of conceptual understanding, relationship to the framework of the whole educational system, factual content and methodology. There is little opportunity for the students to see relevance of the subject area at first hand and the career opportunities, therefore, appear as marginal and limited to them" (p.24).

3.4 National Institute of Preventive and Social Medicine (NIPSOM)

The Government interest in Community Medicine was manifested through the establishment of NIPSOM in 1974. The establishment of this institution grew out of the need to ensure efficient and effective implementation of various health programs, and to fulfill the need for well-trained health professionals. The main goal of NIPSOM is to develop health manpower at the postgraduate level in the Public Health disciplines and to provide research, advisory and consultancy services thereof. The objectives of NIPSOM follow (Box 4):

Box: 4 Objectives of NIPSOM

- ◇ Conduct academic courses leading to postgraduate and doctoral degree and diplomas in the disciplines of public health;
- ◇ Organize in service and continuing education/training programs for different categories of health personnel;
- ◇ Promote and undertake health service research as an instrument of public health practice and development;
- ◇ Provide technical advisory/consultancy services in the field of public health;

The overall administration and program guidance at NIPSOM are provided by a Director. There are 12 departments at NIPSOM. These include: Department of Epidemiology; Community Medicine; Occupational and Environmental Health; Public Health and Hospital Administration; Nutrition and Biochemistry; Maternal and Child Health;

Microbiology; Parasitology; Health Education; Entomology; Population Dynamics and Biostatistics. The Institute offers both M. Phil. and various diploma courses in public health, community medicine, industrial health, maternal and child health and family planning.

NIPSOM also provides in-service training to different groups of health personnel at various layers of health administration. These personnel include civil surgeons, deputy civil surgeons, medical officers posted at the thana health complex and thana family planning officers. NIPSOM also conducts orientation courses in Primary Health Care, certificate courses on environmental health, Biostatistics, and Epidemiology. Although this type of training is needed and provides a good exposure of health administrators to different issues regarding human aspects of health problems at the grassroots levels, we are not sure to what extent they apply their knowledge in the practical field. To our knowledge no independent assessment has been made to date to assess the impact of short-term training on community medicine.

The courses that are now being offered at NIPSOM are wide-ranging and have significant practical implications. The courses on community health and primary health care, tropical medicine, environmental health, occupational health, health education and medical sociology and anthropology are no doubt useful, but most faculty members are doctors. Some of them have MPH degrees. NIPSOM is engaged in training focused on public health, and it has less clinical value. Those who teach do not have the scope to earn money like the doctors of medical colleges. For this reason the assignment at NIPSOM is not considered seriously by all. There is no permanent position for behavioral and social scientists at NIPSOM. We may identify the following limitations regarding the activities of NIPSOM (Box 5):

Box: 5 Limitations of NIPSOM

- ◇ Inadequate number of faculty members
- ◇ Complete reliance on staff trained in medical or biological science
- ◇ No permanent position for social and behavioral scientists
- ◇ Courses over-oriented towards theory and methodology
- ◇ Less emphasis on practical training and problem-solving exercises
- ◇ Little use of project-focused or group learning initiatives
- ◇ Unequal importance of the faculty compared to the faculty of medical colleges
- ◇ Negligible emphasis on research
- ◇ Inadequate resources for research on public health matters
- ◇ No clear relationship between medical doctors, health administrators, and health policy planners

The establishment of NIPSOM two decades ago was undoubtedly a significant step in creating manpower with a public health perspective. Although NIPSOM has marginally helped in promoting the social science component in training public health professionals,

it cannot be said to have contributed significantly in the teaching of health social science in Bangladesh. There are other organizations apart from NIPSOM, that provide training and conduct research on family planning, population and other related issues.

The National Institute of Population Research and Training (NIPORT) was created in 1977 with the following mandate (Haider et. al 1995: 126):

- Provide task-oriented Maternal and Child Health (MCH), family planning and management training for all categories of MCH-FP personnel from administrative and technical officers at the district and thana levels to field workers at the village level; and
- Conduct training-related and operations research, together with population studies, and incorporate the findings of such research into MCH-FP policy making and service delivery.

NIPORT also provides management training to a large number of program officials from the district and thana levels that include Civil Surgeons, Deputy Directors of FP, Thana Health and FP officers, and Medical Officers posted at the thana health complex. These training courses are mostly directed toward improving the management efficiency, quality of services and problems faced in the field and other related matters.

Family Planning Services and Training Centre (FPSTC) was created by a Government Order in 1979 as the executing agency of Family Planning Council of Voluntary Organizations. The main objective of this organization is to promote the activities of local NGOs and to extend systematic and sustained financial and technical assistance to them.

From our review of programs of health science education in the medical colleges and other institutions involved in training doctors and health professionals, we notice a discouraging picture of the role of social sciences within these programs. The field of community medicine, which has been included as a face saver and to create an impression that medical education in Bangladesh is not devoid of community and social reality, could not make a significant breakthrough due to what I would call a traditional approach in training doctors in Bangladesh.

I would further add that I do not see any prospect of a major breakthrough in the medical programs that might take into consideration the social science component of health issues soon. Our medical scientists should rise above their narrow outlook of theoretical, curative and hospital-based medical training and help create what one of their colleagues calls 'community doctors' or what I would call "doctors with a humane and social outlook."

4.0 SOCIAL SCIENCES IN BANGLADESH

4.1 Social Science Disciplines

The main disciplines of social science are anthropology, economics, geography, political science and sociology, including closely related specialized disciplines, such as agricultural economics, social history, education and social welfare, which are extensively pursued in

Bangladesh. These social sciences are taught in the universities and university colleges in the country. The universities, however, enjoy more freedom in designing new courses and undertaking research in the relevant areas of social sciences.

The development of social sciences in Bangladesh has been uneven. There has been a long tradition of good scholarship in economics since the late 1930s. The Political Science Department at Dhaka University was established in 1938-39. Sociology was introduced in the late 1960s with a historical rather than empirical emphasis. The first department of anthropology in the country was established in 1986 at Jahangirnagar University and has gained reputation through its teaching excellence and research. The disciplinary demarcation among social sciences is very rigid. This hampers the growth of multidisciplinary teaching and research.

The social sciences in every country develop out of that particular society and its problems (Nicholas 1973). Unfortunately, in Bangladesh social science still represents an alien tradition and lacks an identity and character of its own that would be need-oriented, relevant to this society and serving its needs.

4.2 Social Science Curriculum: Current Position and Focus

In the next few paragraphs we will attempt to review the course contents of four main universities in the country and find out to what extent (if any) health and other related matters are incorporated within their program.

I will begin with Dhaka University (DU) which is the oldest and the largest university in the country. In the Social Science faculty of DU, there are five departments, i.e. Anthropology, Sociology, Economics, Public Administration, and Political Science. A review of curriculum of these departments shows that teaching health social science is yet to receive due attention from the teachers of different departments of the faculty. Most courses are traditional and are not updated to keep pace with the changes that are occurring in those fields. The Dean of Social Science complains that, in spite of repeated reminders and encouragement, he rarely gets new suggestions or proposals for introducing new courses in the different subject areas.

The Department of Sociology offers one course on Sociology of Medicine at the master's level. This is a very elementary course and incorporates topics that may be considered as typical of any medical sociology course. This course does not consider the

practical utility or possible contribution that this kind of course may make in understanding the health and other related public health issues in Bangladesh. We provide an outline of the Sociology of Medicine course below:

Definition, scope and importance of sociology of medicine; Theories and concepts of medical sociology; Methods of studying medical sociology; Folk medicine; Social and personal components of illness; Healing practices; Social structure and their relation with epidemiology. Conformity and deviant behavior of patient; Sociological analysis of complex organizations; Recent strategy and tactics applied in sociology of medicine.

Two other courses that are offered at the master's level are : Sociology of Fertility and Population, and Development and Politics. Some topics that have been included in the Sociology of Fertility course are:

Definitions and measures of fertility; Fertility in historical perspective; Demographic change; Perspective of fertility decline; Measurement of human fertility; Correlates and determinants of fertility; Fertility regulation and family planning.

Although there are some topics that can be linked with health issues and socio-cultural issues, this course has basically been designed in the tradition of demography. Some other courses that are also currently offered in sociology are Social Demography; Women and Development; Family, Marriage and Kinship; Sociology of Education, and Environmental Sociology.

The courses that are taught in the Economics Department are highly theoretical and mostly represent mainstream economic courses. There is plenty of scope to include courses on health economics, environmental and resource economics, etc. The Anthropology Department of DU, which was established three years ago, is contemplating the introduction of a course on medical anthropology soon. The Chairperson of the department understands the need for such a course but the department lacks trained teachers to design or teach the course.

My observations above are more or less applicable in the case of different departments of the Social Science Faculty of Chittagong University (CU). Chittagong University, the third largest general university in the country, has many highly-trained faculty members with a wide range of interest. However, I am inclined to say that I have not seen any new, innovative and application-oriented courses in their program. The curriculum reflects the mainstream trend of different disciplines.

The Sociology Department of CU has a number of sociologists with background and training in health and population studies. Although they have conducted some research in the field of family planning, health, nutrition and other issues, no concrete attempt is made to incorporate courses on these and other medical and health-related issues. It is pertinent here to mention that CU has a faculty member who, to my knowledge, is the first trained medical anthropologist in the country. This particular person has a Ph.D. in Medical Anthropology from the University of Illinois at

Carbondale. His thesis was entitled "Culture Change, Stress and Epidemiological Transition in Bangladesh."

The department has two persons with M.Ph degrees. Unfortunately, their contribution in developing new curriculum and teaching health social science is nil. Some teachers are quite enthusiastic about the prospect of courses on health matters but they point out that the realization about the importance of health in social science is a new phenomenon and many teachers, including some senior teachers, may raise objection about the need of such courses. Many faculty members are tradition-bound and since health and other related issues do not constitute the primary focus of the field, questions are raised as to what extent the incorporation of health, environment and other issues will serve the cause of mainstream sociology. A course titled Sociology of Health and Environment could not be incorporated within the sociology curriculum because of strong opposition from some of the senior faculty members. There is a possibility that a course titled Anthropology of Health will be incorporated within the curriculum of anthropology when a new department of anthropology is established next year.

In the economics, political science, and public administration departments no courses on health and other issues are offered. There is no possibility of introducing courses in these areas soon.

The situation at Rajshahi University (RU), which is the second largest general university in the country, is similar to the other two universities as far as the teaching of health social science is concerned. Most courses are traditional and lack orientation to application. A comparison of courses offered within the different departments of the social science faculty shows that over the years the introduction of new courses is very limited.

RU has an institute known as the Institute of Bangladesh Studies (IBS). In the mid-1970s IBS at RU exhibited dynamism by introducing new courses on humanities and social sciences. Many scholars like Clarence Maloney, Peter Bertocci, Joana Kirk Patrick and Naomi Owens, among others, were involved in the academic activities of IBS. However, in the past few years this institute has become dormant and we do not hear much about its activities.

Jahangirnagar University (JU), which is the only residential university in the country, opened some departments that were not in existence in other universities in the country. In the last few years JU established full-fledged Anthropology, Archaeology and Dramatics departments. In the JU social science faculty all the major subjects, e.g. Anthropology, Government and Politics, Economics, Geography, and Business Administration, are taught. Several new courses on environment, resource economics, women and development have been introduced in some departments. The Geography department teaches courses on population, environment, and disaster.

Some courses on methodology are offered in the Government and Politics and Geography departments. In general the methodology courses are not very strong and are mainly biased toward a quantitative rather than a qualitative orientation. Given the

situation that the JU social science program is already overloaded, there is scant scope for further inclusion of new courses unless some old courses are dropped, or some existing courses are made optional courses.

4.3 Anthropology in Jahangirnagar University

One exception in the social science faculty of JU is the Department of Anthropology, which is contemplating the incorporation of an Applied Anthropology Program emphasizing Medical and Environmental Anthropology through support of the Ford Foundation. Before we describe the future applied program, it will be pertinent to say something about the Anthropology Department in JU.

The Department of Anthropology in JU was the first such department in the country until 1992 when Dhaka University opened a new Anthropology Department. Currently, the JU Anthropology Department offers three-year honors and one-year master's degree programs. The anthropology syllabi, both at honors and master's levels, have been designed to give students a good exposure to theory, methods, ethnography and to various contemporary issues in anthropology. The current honors syllabus also represents an integrated program where, in addition to core anthropology courses, students are required to take courses in introductory economics, cultural geography, and political institutions.

The department is endeavoring to develop disciplinary and faculty interests around certain contemporary themes that include development, health, environment, and gender. It may be further mentioned that JU offers courses on gender and class inequality, cultural ecology, environment and medical anthropology, which are yet to receive due attention in the curricula of other social sciences.

In recent years both medical and environmental issues have become dominant contemporary concerns. Anthropologists' interest in these areas is a recent development. In Bangladesh, where the study of anthropology began only in 1986, the country is yet to develop manpower and research capacity in these fields. The need for trained manpower in these fields is acutely felt by NGOs, government agencies, research institutes, and by international organizations.

The study and research of health-related issues are gradually gaining importance. The input of social scientists in these areas, to date, is extremely meager and is dominated by demographers, doctors, public health practitioners and other scientists. Many issues can be included within the purview of health-related research. These include disease, illness, health care-seeking behavior, women's roles and status, reproductive health and child survival, maternal and child care practices. Although there is no dearth of demographic and health-related data, the field of medical anthropology is likely to improve the database by providing qualitative data in relevant areas.

It is critical that efforts be made to develop a local capacity for undertaking the task ahead. For this purpose the incorporation of health and environment-related issues into the anthropology graduate program is essential. The training of anthropology

graduates with thorough exposure to these fields is a sine-qua-non for developing local capacity in applied anthropology. To train the prospective graduates we also need faculty with strong backgrounds and training in methodology and in the relevant fields of health and environment. Adequate training in methodology is a pre-condition for a strong background in applied anthropology. There is a lack of adequate attention to training in methodology. It is expected that the proposed applied anthropology program will be able to fill the gap in this respect.

Currently, in the anthropology curriculum there is provision for courses in Anthropological Research Methods, Methods in Applied Social Sciences, Biological Anthropology and Medical Anthropology. In future more courses will be introduced that will meet the need of health social science in Bangladesh. At present, the following topics are taught in the Medical Anthropology course (Box 6):

Box: 6 Topics Covered in Medical Anthropology

- ◇ Basic concepts and theoretical paradigms of Medical Anthropology and their relationship with other health sciences;
- ◇ Biologicistic approach (or biomedical Framework), Ecological approach, and Epidemiological approach;
- ◇ Research tools of medical anthropology
- ◇ Retrospective method, Prospective method, Case-control method, Longitudinal method.
- ◇ Pathogenesis and prognosis of diseases - estimates of risk factors, prevalence rate, incidence rate, point prevalence rate, morbidity rate;
- ◇ Diagnostic criteria for health disorders. Parameters of health and disease in a population;
- ◇ Health problems and disease patterns in rural environments with reference to Bangladesh;
- ◇ Malnutrition, causes of child mortality, and maternal mortality;
- ◇ Women's reproductive health;
- ◇ Health care-seeking behavior;
- ◇ Preventive and curative medicine;
- ◇ Utilization of health care services;
- ◇ Evaluation of existing health care facilities provided by the Government and NGOs; EPI, FP services, nutrition education;
- ◇ Folk-medical beliefs : Ethnophysiology and Ethnomedicine.
- ◇ Indigenous knowledge of medicine;
- ◇ Traditional medicine (Homeopathy, Ayurvedic, Unani) vs. modern scientific medicine;
- ◇ Public Health Programs
- ◇ Relevance of Medical Anthropology to the context of Bangladesh society;
- ◇ Inter-disciplinary collaborative actions research and intervention strategies;
- ◇ International health package for coping with emerging threats of AIDS and drug addiction.

4.4 Health Economics

Another neglected area in teaching health social science is Health Economics (HE). No courses in HE are offered in the Department of Economics in the universities of Bangladesh. Although HE is a relatively new subject it can be widely applied to assess, plan and optimize the use of money and services used in the public health sector. Recently, the Government of Bangladesh through the Ministry of Health and Family Welfare has undertaken a Health Economics Project (HEP) under the Fourth Population and Health Umbrella project of the World Bank with the British Overseas Development Administration (ODA) as co-financier.

The project aims at developing an overall HE capability and skill in the country. The major activities of the project include: training (both local and overseas), research, the provision of policy recommendations upon request and networking with the aim of developing human resources in the field of HE. (Holiday, September 8, 1995). The project has a component for capacity building through training and has processed 16 fellowships for higher training in the UK universities that include Ph.D., master's and short courses. It is also planned that appropriate materials and curriculum for in-country training in HE will be developed. The HEP is no doubt an appropriate step in the right direction and will fill a vacuum in the social science input in the health sector, especially in the background of the massive primary Health Care program that the Government is implementing for attaining the Health for All goal by the year 2000.

It appears that the HEP is a one-shot project that mainly aims at developing and strengthening institutional capacity at the government level in a given time period. It is not clear who will take the responsibility for training and regular flow of manpower in the sphere of HE. The country will need a regular supply of health economist professionals to meet the thriving demand of the health sector in the years to come. No attempt is being made in the HEP to institutionalize the training component by linking this with an academic institution. Since the importance of HE is well-understood by donors, health professionals, policy planners and other concerned people, attempts should be made by the Government to persuade the universities to incorporate health economics and other relevant topics within the curriculum of teaching economics. It is also important that Government makes some special grant to create new positions in health economics and for making provisions for higher study in this area.

4.5 Teaching Health Social Science: Reasons for Slow Development

One of the main reasons why teaching of health social science does not get deserved attention within the social sciences is the preoccupation of the social sciences with some traditional topics and issues within the respective subject areas. One professor of economics in Chittagong University very candidly described the situation in the following way:

"In the social sciences we do not develop any course independently. We only develop courses on issues which we learn from abroad or just replicate from outside. Sometime agenda for higher education and research are dictated by

donors and international agencies. The collaborative (or link) programs with foreign universities do have significant influence in the development of the curriculum of many subjects. The critical questions that we should ask ourselves are: have we opened our eyes to the needs of our society? What is the role of social scientists in this respect?"

In fact from the late 1960s, when social science teaching and research have been gradually taking shape within the universities of Bangladesh, nobody thought health could be a subject area within social science. For example, economics since the late 1960s has been very preoccupied with rural and agricultural development, agricultural subsidy, economics of irrigation, food policy and other related issues.

Box: 7 Current State of Social Science Teaching

- ◇ Traditional courses
- ◇ Emphasis on theory with little attempt to apply these to reality
- ◇ Debate centering around academic vs. applied social sciences
- ◇ Less focus on applied issues
- ◇ Inadequate attention on courses on methodology in general and methodology of applied social sciences in particular
- ◇ Old course outline and slow updating
- ◇ Less emphasis on research
- ◇ Lack of trained faculty to design and handle new courses
- ◇ Limited contact and exposure of faculty with the academic world outside Bangladesh
- ◇ Narrow focus of different disciplines
- ◇ Lack of initiatives and leadership on the part of seniors to introduce new and innovative courses.

One sociology teacher said: "we were so absorbed with the mainstream sociology and we are so quick in replicating (or introducing) what we learnt from abroad that it did not at all crop up in our mind that health could be an issue of sociological teaching and research." "It was not at all an attractive topic just a few years back," remarked another economics teacher.

However, many social scientists stated that teaching of health social science even in Europe and North America is a recent phenomenon. Since all over the world there has been a significant shift in focus from agriculture and rural development to more human aspects of development, their welfare, and health, it is also likely to affect the orientation and focus of social sciences everywhere. Although Bangladesh is slow in responding to these changes, it will come soon.

In spite of slow response some social scientists have taken the initiative to introduce courses on issues of contemporary concern, such as health, environment, resource economics, etc. However, their efforts could not be successful for three reasons. Firstly, university administrators and other concerned quarters could not appreciate these

efforts; secondly, many senior faculty members could not rise above their narrow disciplinary boundary and created obstacles, and finally, also due to lack of resources university administrations discourage any attempt to introduce new courses.

4.6 Why Does Teaching of Health Social Science matter?

The health problems in a country like Bangladesh require an understanding of social, economic and cultural factors which influence improvements in health-related behavior (health care-seeking and others) in a variety of ways. One of the main reasons why policies concerning the improvement in health situations and providing support through various services to the population could not attain the expected results is that all these programs have been approached from bio-medical and epidemiological perspectives without considering the socio-cultural and economic problems that may affect the people's health care-seeking behavior.

In the treatment of disease an understanding of the person's perception of disease, world view, behavioral pattern, vocabulary used in describing the disease and the level of confidence in the system is a sine-qua-non for a proper approach to treatment. It is critical to appreciate and understand the socio-cultural context within which people live and make decisions regarding various problems of their life. What I am trying to emphasize is on the need for cultural construction of the various issues and problems related to health.

In recent years Primary Health Care (PHC) has become a top agendum of government health programs in Bangladesh. It should be realized that providing PHC facilities to people is not enough. It requires a deep understanding of the following issues, critical for the success of PHC Programs:

- Who do need PHC?
- To what extent do people have access to PHC?
- Is there any difference in the vocabulary and language between the provider and solicitor of service?
- Why are people shy in availing the opportunities of modern medical services?
- Are these economic or social or cultural problems or all of these?

In Bangladesh, for example, we constantly talk about malnutrition which contributes significantly to high maternal and child mortality in Bangladesh (Rahman 1989, UNICEF 1990) and the possible ways to overcome this problem. It is important that we understand why malnutrition occurs; who suffers most and why; what the various proximate links between poverty and malnutrition are. Therefore, problems of malnutrition should be approached from the bottom, which requires a realization and consideration of the whole gamut of social, cultural and economic issues.

The importance of class, of poverty and of ethnicity in terms of health risks must not be considered so simply (Heggenhougen 1995 : 282). There are close interconnections that require due attention not only by health administrators but also by health professionals.

In the preceding paragraphs, an attempt has been made to establish a case for a social science approach to health in Bangladesh that is either ignored, bypassed or given less attention by health professionals, policy planners, physicians and other concerned groups. As a result, we find the absence of application of social science methods and theories to the study of health. There is no concerted attempt to train social scientists in various health-related issues. I will end this section by quoting Heggenhougen (1995) who highlighted the contribution of medical anthropology in the field of public health:

"By and large medical anthropologists working within public health and in collaboration with epidemiologists have concentrated on the significance of cultural factors in explaining epidemiological patterns and in promoting successful public health interventions. In the most negative sense anthropologists have been used to finding the culturally relevant buttons to push to market preconceived effective and necessary public health interventions. In a more positive light, anthropologists have been interpreters and intermediaries ensuring that public health interventions are mutually agreed upon and culturally appropriate."

4.7 Social Science Research: Issues, Focus, and Institutions Involved

Since the teaching of health social science is yet to gain due momentum and recognition in Bangladesh, it is quite natural that research on health-related issues by social scientists will be very negligible. Some social scientists (i.e. sociologists and anthropologists) conduct research on their initiative. A number of expatriate social scientists have also carried out research, some of which is academic while some is consultancy research.

Compared to social scientists, demographers and statisticians have conducted extensive research related to population, health and family planning in Bangladesh. Research and study on these issues have been classified under four broad heads (Haider et. al 1995):

- Bio-medical, including contraceptives
- Socio-cultural and behavioral
- Demography and fertility
- Program evaluation

Several hundred studies conducted during 1950-81 have been identified by a World Bank publication in 1983 on a variety of subjects relating to fertility and family planning (Box 8). Many of these studies were given funding support from the Government and from the national and international agencies. These research studies were conducted with the purpose of specific policy and programmatic needs. It is pertinent to mention here that some of these studies are very rich in content and analysis and are conducted with a social science input despite the fact that there is a dearth of social scientists with a background and training in health, population studies, and family planning.

The Bangladesh Institute of Development Studies (BIDS), an autonomous research body, conducts research and disseminates information on development

economics, demography and other social sciences. The institute also organizes short-term training on development economics, demography and social sciences for professionals. Currently, BIDS has 63 researchers who represent disciplines, such as economics, demography, sociology, and statistics. Most BIDS researchers are economists. The research relating to health and other related issues have been conducted through the Population and Health Studies Division of BIDS. This division is headed by a demographer, and most researchers in this division are specialized in demography and population studies.

Box: 8 Focus of Health and Family Planning Research

- ◇ Development, fertility and family planning
- ◇ Women's status and family planning
- ◇ Contraceptive methods
- ◇ Family planning norms, values, and cultural factors
- ◇ Family planning services
- ◇ Delivery of family planning services
- ◇ Demographic and population surveys
- ◇ Fertility and mortality
- ◇ Fertility levels and trends
- ◇ Methodological studies

Source: World Bank Report quoted in Haider et. al. 1995

The International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B) is one of the forerunners in Population, Family Planning and Community Health research in Bangladesh. ICDDR,B implements various research projects through the Population and Family Planning and Community Health Divisions with the funding support from international donors. The major focus of the Population and Family Planning Division are: population research on mortality, birth interval, effects of gender preference, fertility, nuptiality, health and methodological research. To date ICDDR,B has conducted over 500 research studies in the areas of health, population, and MCH.

Recently, ICDDR,B took an important step to integrate the social and behavioral sciences with biomedicine, and to advance social science agenda. In June 1993, the Centre's trustees approved plans for the reorganization of the scientific divisions within the Centre to include a Social and Behavioral Sciences (SBS) program in the Community Health Division. It is hoped that the SBS program will help attain the following objectives:

"The SBS program will play a critical role in defining and articulating the role of the social sciences at the Centre, and in implementing the Centre's strategic plan for the years 1995-2000. The ultimate goal is to create a strong, creative and enduring social science research capacity at the Centre" (ICDDR,B 1995:2)

The SBS program will also endeavor to develop expertise in social and behavioral sciences through a learn-by-doing strategy. Although the Center is not mandated to give formal degree-oriented training, the training and support of young SBS staff under the

guidance of senior staff members constitutes initial capacity-building and will go a long way in creating a group of health social scientists. They will be able to take on the challenges of social science research in health both in and outside the Center.

Non-governmental organizations (NGOs) are also involved in research on health-related issues. Some NGOs also conduct short-term training and workshops for personnel engaged in NGO activities. Among the NGOs, Bangladesh Rural Advancement Committee (BRAC) through its Research and Evaluation Division (RED) has been conducting research on some important themes that include health, population control, nutrition, human resource development and empowerment of the poor (BRAC:1994). The Director (RED) of BRAC strongly emphasizes the need for qualitative data but points out that there is shortage of anthropologists and sociologists who are competent to design and undertake independent research. BRAC is recruiting young researchers to strengthen the qualitative component of its research program. The Director (RED) feels that methodology and other practical issues in fieldwork are not properly taught in the educational institutions of Bangladesh.

It is possible to say from our above discussion that in spite of lack of formal training in health social sciences, several organizations and many independent researchers are conducting research on health-related matters. I should further point out that public sector involvement both in teaching health social science as well as promoting research is not praiseworthy.

5.0 SUGGESTED FRAMEWORK FOR TEACHING HEALTH SOCIAL SCIENCE

I have already discussed at length the state of social science teaching and its focus in the main universities of Bangladesh. We have already pointed out that in the curriculum of social sciences no provision has been made for teaching health social science. Many faculties of different social science departments in the universities realize the importance of the field but they do not foresee its incorporation within their present curriculum for reasons already discussed.

In this section, I will try to provide a framework for teaching health social science in Bangladesh. In doing so, I will argue for the inclusion of health social science within the purview of applied social science. This is because health problems throughout the world constitute a sector of applied research that is by nature interdisciplinary (Pelto and Pelto: Ms). Currently at JU, we are in the process of introducing an applied anthropology program focusing on health problems; therefore, my suggested framework has been prepared keeping in view the need of anthropology and the ways anthropology may contribute in this field.

It would be beneficial if the JU program could be designed as an interdisciplinary program in collaboration with other disciplines. I am not sure to what extent this would be feasible given the rigid boundary that each discipline maintains. The following courses

may be incorporated within the purview of the applied anthropology health program at JU (Box 9). I also provide a list of areas where social science may be useful (Box 10).

I have provided tentative titles of courses that may be useful in introducing a program of applied anthropology in health. One important point that requires consideration is that any applied anthropology program concerning health must be designed to reflect the contemporary needs of society, and the students who are likely to study this should be able to apply this in practical field work.

5.1 Training in Methodology

I would specifically emphasize on the importance of methodological training that is the foundation of a program of anthropology of health vis-a-vis applied anthropology. Applied anthropologists are most often hired as data gatherers, data managers, and data analysts by persons who know very little, and care very little about anthropological theory. The common meeting ground with policy makers in NGOs, as well as with professionals from other disciplines, is in the area of useful, practical research data. In the worldwide development of applied anthropology, regardless of topical area, anthropologists have found themselves respected to the degree that they are able to communicate expertise in collecting and handling useful information (Pelto: 1993).

5.2 Nature and Type of Support Needed

The introduction of the applied anthropology program that we have proposed above would require financial, academic and logistic support from outside. One of the problems that may act as a hindrance to introducing new areas of learning are the inadequate resources and lack of manpower to handle such a program. Therefore, I would suggest that the following support will be helpful in introducing an applied anthropology program on health:

Curriculum Development: Since this is a new area support will be required for curriculum development. Existing courses also need updating and reorganization. Some anthropologists with reputation and experience may be invited to help design the courses. Similarly, faculty members from Bangladesh may also visit institutions that have good programs in these areas.

Faculty Development and Training: To conduct teaching and research in applied anthropology, it is essential that the faculty members be trained beyond the masters level. Training may be of both short and long-term duration. Areas of training may be determined considering the objectives and needs of the program as well as the interest of the particular faculty member. Methodological training should be given due importance in the training of faculty members. Financial support will also be necessary to procure equipment, computers, books, and journals.

Now the big question is how and from where do we get necessary support and funds for this kind of program? From our experience, the prospect of getting additional funds from the university system and the University Grants Commission (UGC) is bleak.

Therefore, funding support from external agencies will be necessary. The proposed JU applied anthropology program will obtain financial support from the Ford Foundation.

In this respect, cooperation and an exchange program between different institutions will be useful. I understand some countries in the region have significant experience in social science teaching of health and research. These countries may provide intellectual and academic support to less experienced countries and to the countries who are contemplating the introduction of programs in health social science. Therefore, I propose the establishment of a regional network that will not only act as a forum for exchanging ideas but also provide necessary academic support whenever it is necessary.

Some activities of the network may be to:

- organize an exchange program of researchers and academicians to provide support in curriculum development and faculty training;
- organize short-term training program involving experts of different countries to build local capacity; and also
- arrange seminar and workshops for dissemination of research results and share the progress in the field;

Box: 9 Proposed Courses of Health Social Science Program

- ◇ Anthropological theory
- ◇ Biological anthropology
- ◇ Medical anthropology
- ◇ Major health care/medical systems
- ◇ Pluralistic health system and individual decision-making
- ◇ Cultural, cognitive and explanatory models of illness
- ◇ Poverty and disease
- ◇ Tropical diseases and cultural context
- ◇ Nutritional issues and health
- ◇ Primary health care

Considering the importance of health problems the countries of the region may jointly apply for funds for organizing this network to support the development of Health Social Science.

5.3 Prospects of Career Opportunities for Social Scientists in Health Sector

Like many other countries in the region, the prospect of employment of social scientists is not very bright in Bangladesh. This is in spite of the fact that many organizations are continually on the lookout for social scientists with background and training in applied

social sciences and methodology. In recent years the extremely rapid growth of development activities by the Government and NGOs together with the requirements of international donor agencies in Bangladesh, has created a demand for suitably trained social scientists. Furthermore, the high level of demand for the kinds of methodological and conceptual skills associated with anthropology was not being met.

Box: 10 Possible Focus of Social Science Teaching

- ◇ Health and social phenomena
- ◇ Health in nature
- ◇ Cross-cultural conditions of health
- ◇ Politics of health
- ◇ Cost effectiveness of health care facilities
- ◇ Population and health
- ◇ Genetic vs. non-genetic diseases: how are these affected by environmental and social phenomenon?
- ◇ Health and environment
- ◇ Nutrition and population links
- ◇ Gender, sexuality, and health
- ◇ Primary health care: prospects and problems
- ◇ Family planning: Social, cultural and economic context
- ◇ Indigenous knowledge about health
- ◇ Health care-seeking behavior
- ◇ Contraceptive use and cultural context
- ◇ Women's status and family planning
- ◇ Women's empowerment and population control
- ◇ Psychology of health and well-being
- ◇ Population, development and politics
- ◇ Methodology in applied social science
- ◇ Methodology in health social sciences
- ◇ Community participation in health care system
- ◇ Role of NGOs in the delivery of health service
- ◇ Society, health and disease: Cross-cultural perspective
- ◇ Poverty and disease
- ◇ Anthropological research methods
- ◇ Methodology in applied social sciences

As far as anthropologists are concerned there is an unfilled need for anthropologists with soundly based empirical training and a familiarity with a range of field work methods. Bangladesh continues to lack a solid corpus of empirical work on micro-demographic

processes, such as household and family formation and on the social and cultural components of agrarian change. This is a consequence of the absence of a strong field work-based tradition of social science inquiry in Bangladesh. There is also a further shortage of trained women researchers and field-level workers. NGOs working in fields such as health and family planning and those working actively with women are rarely able to recruit sufficient numbers of qualified women.

Health and related issues have become critical areas of concern in Bangladesh. It is likely that in the future a large number of social scientists with training and experience in health matters will be needed. The demand will come not only from Government but also from NGOs. It is expected that social scientists with training in health social sciences will be absorbed in government, NGOs, research organizations, consultancy firms, and international agencies.

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Appendix - 1 : List of Persons Contacted

Dhaka University

- ◆ Dr. Shahed Hasan, Department of Anthropology
- ◆ Mr. Sahedur Rashid, Department of Anthropology
- ◆ Ms. Nasima Sultana, Department of Anthropology
- ◆ Prof. Ishrat Shamim, Department of Sociology
- ◆ Dr. Asauzzaman, Dean of the Faculty of Social Sciences
- ◆ Dr. Kibraul Khaleque, Department of Sociology

Chittagong University

- ◆ Prof. M. Sikandar Khan, Department of Economics
- ◆ Prof. Syeda Tahera, Department of Economics
- ◆ Dr. Salehuddin, Department of Economics
- ◆ Dr. Nitai Nag, Department of Economics
- ◆ Dr. Irshad Kamal Khan, Department of Economics
- ◆ Prof. Nasiruddin, Department of Economics
- ◆ Dr. Fazle Hasan Chowdhury, Department of Sociology
- ◆ Prof. Hasanuzzman Chowdhury, Department of Sociology
- ◆ Mr. Abul Hossain Bhuiyan, Department of Sociology

Contacts Attempted

- ◆ Prof. Abdul Hakim, Dean of the Faculty of Social Sciences
- ◆ Dr. Imam Ali, Department of Sociology

Jahangirnagar University

- ◆ Prof. Abdul Bayes, Dean of the faculty of Social Sciences
- ◆ Dr. Amin Md. Ali, Department of Economics
- ◆ Dr. Moudud Elahi, Department of Geography
- ◆ Ms. Rasheda Aktar, Department of Anthropology
- ◆ Ms. Ainoon Nahar, Department of Anthropology
- ◆ Dr. Shah Jalal, Department of Anthropology

Other Contacts

- ◆ Dr. Mahmudur Rahman, NIPSOM
- ◆ Dr. Shahaduzzman, MBBS, MPH
- ◆ Dr. Jim Ross, ICDDR,B
- ◆ Dr. Bert Peltó, Consultant, WHO
- ◆ Dr. Mushtaque Chowdhury, BRAC
- ◆ Mr. Gulam Sattar, BRAC
- ◆ Mr. Faziul Karim, BRAC
- ◆ Mr. Manzurul Mannan, BRAC
- ◆ Dr. Shahed Ahmed Chowdhury, MBBS
- ◆ Discussion with a group of students of Dhaka Medical Colleges
- ◆ Several doctors

Contacts Attempted

- ◆ Director, NIPSOM (unavailable)
- ◆ Head of the Department of Community Medicine, Dhaka Medical College

Appendix - 2 : List of Syllabi and Curricula Reviewed

- Curriculum of Undergraduate Medical Education
- Syllabus for Integrated BSS (Honors) course session 1993-94, Chittagong University
- Syllabus of the Department of Sociology for BSS Subsidiary, honors and MSS courses, Dhaka University
- Syllabus of the Department of Economics, Dhaka University
- Syllabus for the Department of Political Science for the MSS course, Dhaka University
- Syllabus for the Department of Anthropology for BSS Honors and MSS course, Dhaka University
- Syllabus for BSS (Honors) of all departments of the Faculty of Social Sciences, Jahangirnagar University
- Syllabus for MSS for all departments of the Faculty of Social Sciences, Jahangirnagar University

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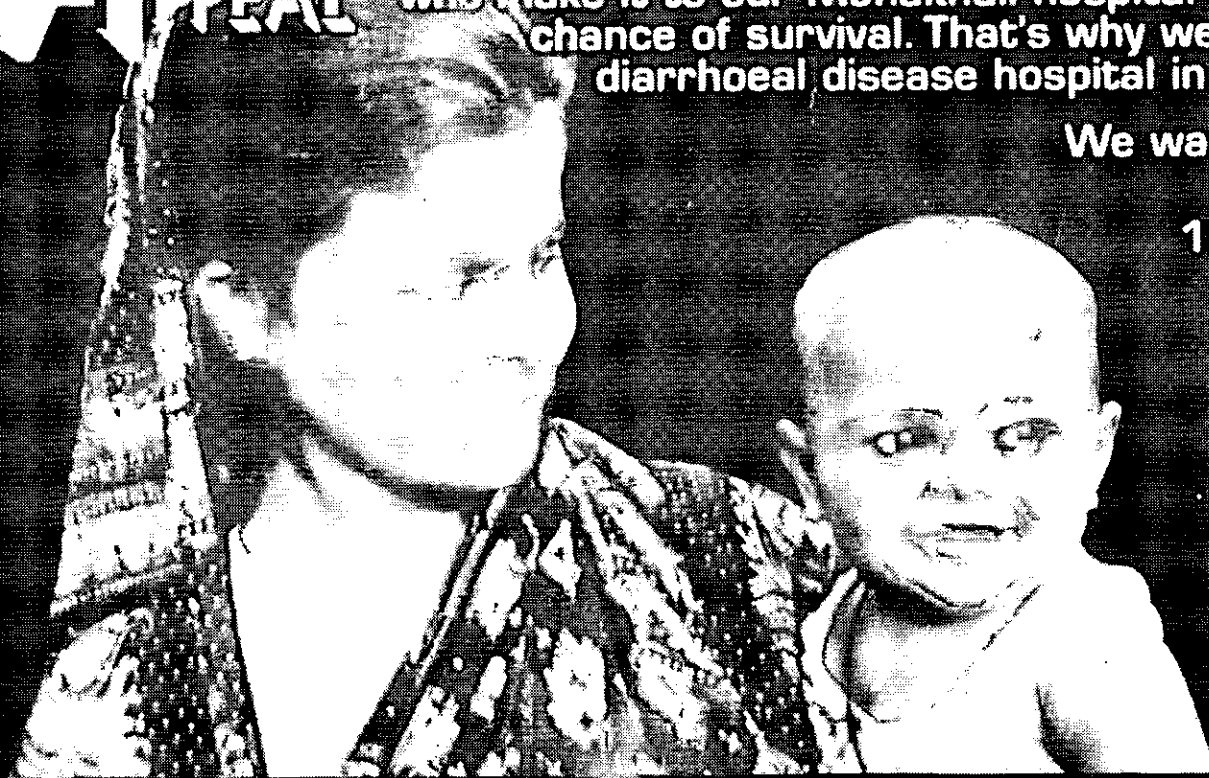
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