Power, People and Politics : An ethnographic study of health crisis in Rolpa district of Nepal.

Thesis Submitted to the

Jawaharlal Nehru University for the Award of the Degree of

DOCTOR OF PHILOSOPHY

Submitted by

Sachin Kumar Ghimire

Supervised by

Prof. Dr. Rama V Baru / Prof. Dr. Mohan Rao

Centre of Social Medicine and Community Health

School of Social Sciences

Jawaharlal Nehru University

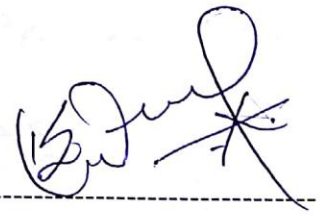
New Delhi, India

CENTRE OF SOCIAL MEDICINE & COMMUNITY HEALTH
SCHOOL OF SOCIAL SCIENCES
JAWAHARLAL NEHRU UNIVERSITY
NEW DELHI - 110067

Date : November 27, 2017

DECLARATION

I hereby, declared that the thesis entitled, ***"Power, People and Politics: An ethnographic study of health crisis in Rolpa district of Nepal"*** submitted to Jawaharlal Nehru University, New Delhi to fulfill the partial requirement of the award of the degree of **DOCTOR OF PHILOSOPHY** under the supervision of **Prof. Dr. Rama V Baru and Prof. Dr. Mohan Rao,** from Centre of Social Medicine and Community health, School of Social sciences, is a record of original research work. I further declare that the research has not been submitted for the awards of any degree in this or any other university.



Sachin Kumar Ghimire
Godavari-13, Jharuwarasi
Lalitpur, Nepal

Telefax: +91-(11) 2670 4420 (Direct), 26742676, 26741557 (Ext. 4420), E-mail: csmchjnu@gmail.com
Web:http://www.jnu.ac.in/SSS/CSMCH/

CENTRE OF SOCIAL MEDICINE & COMMUNITY HEALTH
SCHOOL OF SOCIAL SCIENCES
JAWAHARLAL NEHRU UNIVERSITY
NEW DELHI - 110067

Date : November 27, 2017

CERTIFICATE

We certify that the thesis entitled, ***"Power, People and Politics: An ethnographic study of health crisis in Rolpa district of Nepal"*** submitted to Jawaharlal Nehru University, New Delhi to fulfill the requirement of the award of the degree of **DOCTOR OF PHILOSOPHY** in Social Medicine and Community Health under our supervision is a record of original research work carried by him. We further declare that the research has not been submitted for the awards of any degree in this or any other university or any other institutions of higher learning.

Rama V. Baru

Prof. Dr. Rama V. Baru
Supervisor
CSMCJ/ JNU

Professor Rama V Baru
Centre of Social Medicine
& Community Health
School of Social Sciences-II
JNU, New Delhi 110067

Mohan Rao

Prof. Dr. Mohan Rao
Co- Supervisor
CSMCH/ JNU

Prof. Mohan Rao
Centre of Social Medicine & Community Health
School of Social Sciences
Jawaharlal Nehru University
New Delhi - 110067

Ramila Bisht

Prof..Dr. Ramila Bisht
Chairperson (CSMCH/ JNU)

CHAIRPERSON
Centre of Social Medicine & Community Health
School of Social Sciences
Jawaharlal Nehru University
New Delhi-110067

Telefax: +91-(11) 2670 4420 (Direct), 26742676, 26741557 (Ext. 4420), E-mail: csmchjnu@gmail.com
Web:http//www.jnu.ac.in/SSS/CSMCH/

iii

Acknowledgment

First of all I would like to extend my sincere gratitude and appreciation to my supervisor Prof. Dr. Rama B. Baru and co-supervisor Prof. Dr. Mohan Rao, Centre for Social Medicine and Community Health for their constructive comments, valuable suggestions, and regular encouragement. Their rigorous supervision, intellectual guidance, and warm coordination are the building blocks of this Thesis. I owe them true respect for their academic input. Similarly, a genuine word of thanks goes to all the professors and the staffs of the Centre for Social Medicine and Community Health. Forever grateful towards my professors Debabar Banarji, Prof. Dr. Imrana Quadeer, Prof. Dr. Ritu Priya, Dr. Sanghamitra Shil Acharya, Dr. Sunita Reddy, Dr. Rajiv Das Gupta, Prof. Dr. KR Nayar, Dr. Ramila Bisht for their intellectual steer, and inspiration. Their instructive advice has been of great significance in the completion of this research work.

I have used the resource of, Centre for Social Medicine and Community Health (CSMCH), Central library (JNU) and Cyber Library (JNU). Therefore I would especially like to thank Dinesh Joshi (CSMCH) for his regular help to get resources on time. Likewise, for the use of space and the resources of Patan Academy for Health Sciences (PAHS) in Kathmandu, a word of appreciation to Prof. Dr. Kedar Baral, Librarian Machakaji Maharjan, Anil Sharma, and Sushila Rai for their kind cooperation. I am very grateful towards all the staffs of district hospital and other staffs of PHC, HP and SHPs and also for spending a couple of days in the Commune hotel at Thabang and Ghorneti Model hospital in Oat VDC. In Kathmandu, I want to express my thankfulness to Bam Kumari Gharti Magar, Balaram Gharti Magar, Devendra Subedi, Jhakku Subedi, Govinda Bista, Navin Bhibas, Sharada Prasad Dahal, Krishna Bahadur Mahara, Manojmani Acharya, Dr. Sishir Dahal for providing interviews and their help in many different ways. Alike in Rolpa, cordial thanks to Ghanashyam Acharya, Narayan Subedi, Bhola Nath Acharya, Yogendra Rijal, Gokarna Pun, Chandra Dangi, Himal Dangi , Kaman Singh, Gangaram Dangi, Bishnu Dangi (Jinabang), Dhaniram Sharma, YS Oli, Dr. Yubaraj Pokherel , Kashiram Dangi, Khem Budha, Keshav Acharya, Gokarna Pun and Ramila Gurung and her mother for their spontaneous help in different occasions. In Thabang, a reminder of thanks to Mahesh Budhamagar, Roshani Budha Magar, Comrade Pratap Rokka Magar, Resham Shah, Sutra Bahadur Nepali, Subrato Mukheerji for their kind support. Likewise, my gratitude to the vaccinators Ratna Mahara and

Sutra Bahadur Nepali who helped me to reach the remote places of Rolpa. I am obliged to Buddhi Bahadur from Thabang high school who helped me several times to cross the river in many places. An admiring and warm word of thanks to all Rolpali people for heartily welcoming me in their community. I owe them true appreciation for their help in this research.

Very special thanks to Fraser Sugden (Edinburgh University), Mark van Ommeran (WHO), Egbert Ogburt (London School Of Medicine and Tropical Hygiene) , Wietse A. Tol (Department of Public Health and Research, VU University Medical centre) Branden A. Kohrt (Emory University), Sonal Singh (Johns Hopkins University) Anil Bhattarai (Toronto University), Jacob Rinck (Yale University), Diana Ludwing (Bielefeld University), Katherine Potter (University of Washington), Dave Beine (Summer Institute of Linguists) and Dr. Ryuiki Ishida for giving me valuable comments and for providing me with their research work and related information about conflict and health in Nepal. Likewise, I am thankful to my Dutch friend Loes Huybrechts who has sacrificed and dedicated, always with pleasure, her sufficient time to edit this Thesis. A similar thanks to my other supporting editors Rafael Stempleweski, Fraser Sugden, Jo weaver Meak, Oliver Sudbrink and JNUites like Barun Adhikari, Ranvir Singh and Prabhat Lama for providing me editorial footing in my chapters.

In JNU, A very special thanks to my classmates Atreyee, Susrita, Lakshmi, Kirti, Rima, Prasad, Poukindin, Yasir, Mercian, Anindya, LalhimPuii, Vidwan , Sandeep, Gopal Krishan for helping me directly and indirectly. Similarly, a grateful thanks to Deepak Bhatt, Dinesh Prasain, Rajan Bhattarai, Uddhav Pyakurel, Sadanada Kandel, Indra Pyakurel Keshav Bashyal, Lalita Bashyal Udhhav Khadka, Roshan Baral, Shiva Lal Nepal, Sudeep Shrestha, Deepa Shrestha, Krishna Panta, Laxmi Prasad Joshi, Bamdev Subedi, Sabita Gurung, Devi Gurung and Pratichha Chettri. They have regularly encouraged me and provided me with the necessary materials to complete this Thesis. After my reregistration , I frequently stayed in JNU for the final completion of this Thesis. Therefore to my country mates Laxmi raj Joshi, Arjun Aidi, Bamdev Subedi, Ambika Prashad Joshi who provided me shelter in JNU, thank you all! Similarly, to my other country mates like Akash, Iswori, Dinesh, Vikash, Sohan, Rakshya, Monalisa, Pragya, Avashna, Sandeep, Kumud, Chandan, Vedha and Komal JB Singh, your moral support was great! Thanks.

This accomplishment would not have been possible without the compassion and care of all my family members. I would not have been able to compose this dissertation in its present form. The economic and moral support of my parents to continue my study cannot be

explained in words, and most certainly the non-interventional silence of my father has always pressurized me like a shadow to accomplish this work on time. And I will be eternally thankful to my mother for her unconditional loving support and believe. She always kept motivating me to submit my Phd Thesis as soon as possible, despite her weak health condition and suffering due to the last stage of cancer.

To the cornerstone of my life, my dear wife Shamvabi Sharma, the sacrifices you made were extraordinary. Your unfailing devotion, love and encouragement were the finishing touch of this dissertation. A special thanks to my brother Sashishekhar and my sister-in-law Asmita Rijal Ghimire for their patience and understanding concerning the volume of the television, during the editing process of this Thesis. Last but not least, a profound gratitude to the treasures in my life, my kids Shisham, Seliya and Samrakchan, thanks for the huge and unbelievable effort you made for me, you were magnificent. Motivated and inspired by all this vital support and my pertinacious passion for anthropology, I can now proudly present this Thesis, and finally be academically liberated.

Sachin K Ghimire
Godawari Municipality-
13, Jharuwarashi,
Lalitpur, Nepal

Table of the Contents

Chapter III.

Chapter IV.

Chapter V

Chapter VI

Acronyms

AAA	American Anthropological Association
ACR	Asia Child Rights
AD	anno Domini
AIDS	Acquired Immune Deficiency Syndrome.
AI	Amnesty International
ADHS	Analyzing Disrupted Health Sector
AHW	Auxiliary health worker.
ARV	AntiRetroviral Therapy.
APF	Armed-police force
ANPHWU(R)	All Nepal Public Health Workers Union (Revolutionary).
BC	Before Christ
CA	Constituent Assembly
CMA	Community Medical Assistant
CMA	Critical Medical Anthropology
CDO	Chief District Officer
CPN(M)	Communist Party Of Nepal(Maoist)
CPN(UML)	Communist Party Of Nepal (United Marxist Leninist)
CPN – ML	Communist Party Of Nepal (Marxist Leninist)
CAC	Comprehensive Abortion Care
CHP	Country Health Planning.
DDA	Department of Drug Administration
DDC	District Development Committee
DFID	Department for International Development
DHO	District Health office
DOTS	Direct Observation Treatment Centre.
DRC	Democratic Republic of Congo
DSM	Diagnostic and Statistical Manual of Mental Disorders
DUDBC	Department of Urban Development and Building Construction
EPI	Expanded Program of Immunization.
FCHV	Female Community Health Volunteers.
FLTHP	First Long term Health plan

FM	Frequency Modulation
FCHV	Female Community Health Volunteer
GDP	Gross Domestic product
HA	Health Assistant
Hbsag	Hepatitis B serum Antigen.
HP	Health Post
HIV	Human Immunodeficiency Virus.
HP	Health Post
HQ	Head quarter
HRDC	Hospital and Rehabilitation Centre for Disabled Children.
HRH	Human Resource For Health.
HRW	Human Rights watch
HSS	Health Service System.
ICHP	The Integrated Community Health Program
ICU	Intensive Care Unit
IDMC	Internally Displaced Monitoring Committee.
IDP	Internally Displaced People
ICRC	International Committee of Red Cross.
IOM	Institute of Medicine
IMF.	International Monetary Fund
IMR	Infant Mortality Rate
INGO	International Non-governmental organization.
INSEC	Informal Sector Service Centre.
ICRC	International Red Cross
IRC	International Rescue Committee
IRIN	Integrated Regional Information Networks
IRDP	Integrated Rural development Project.
ISDP	Internal Security Development Plan.
KM	Kilometer
LDO	Local Development Officer.
LTTE	Liberation Tiger for Tamil Elem.
MCHW	Maternal and Child Health Worker
MDG	Millennium Development Goal
MSF	Médecins Sans Frontières

MJF	Madhesi Janadhikar Forum
MMR	Maternal Mortality Rate
NAMS	National Academy of Medical Science
NNTA	Nepal National Teachers Association
NSMP	Nepal Society for Medical Practitioners
NC	Nepali Congress
NGO	Nepal Governmental Organization
NICU	Neonatal Intensive Care Unit
OMSA	Ordinary Medium Secondary Advance.
OPD	Out Patient Department.
OT	Operation Theatre
PBN	Population Bureau Of Nepal.
PEMA	Political Economic Medical Anthropology.
PLA	People´s Liberation Army
PHC	Primary Health Care
PHR	Physicians for Health Rights
PTSD	Post Traumatic Stress Disorder.
PLA	People's liberation Army
RNA	Royal Nepal Army.
RBC	Red Blood Cell
SAFHR	South Asia forum for Human rights.
SBA	Skilled Birth Attendants
SBM	The Socio-behavioral Model
SHP	Sub Health Post
SMA	Society for Medical Anthropology
STD	Sexually Transmitted Diseases.
TBA	Trained Birth Attendant
TADA	Terrorist and Disruptive Ordinance
UAE	United Arab Emirates.
UCPN (M)	United Communist Party of Nepal (Maoist)
UNHCR	United Nation High Commission for Refugee.
USAID	The United States Agency for International Development
UN	United Nation
ULF	United Liberation Front

UML	United Marxist Leninist
USA	United States of America
UCPN(Maoists)	United Communist party of Nepal (Maoists)
UNAIDS	United Nation Programme on HIV and AIDS
UNHCR	United Nation High Commissions for Refugee.
UNICEF	The United Nations Children's Fund.
VCT	Volunteer Counseling and Test.
VDC	Village Development Committee.
VDRL	Venereal Disease Research Laboratory.
VHW	Village Health Worker.
WB	World Bank
WHO	World Health Organization

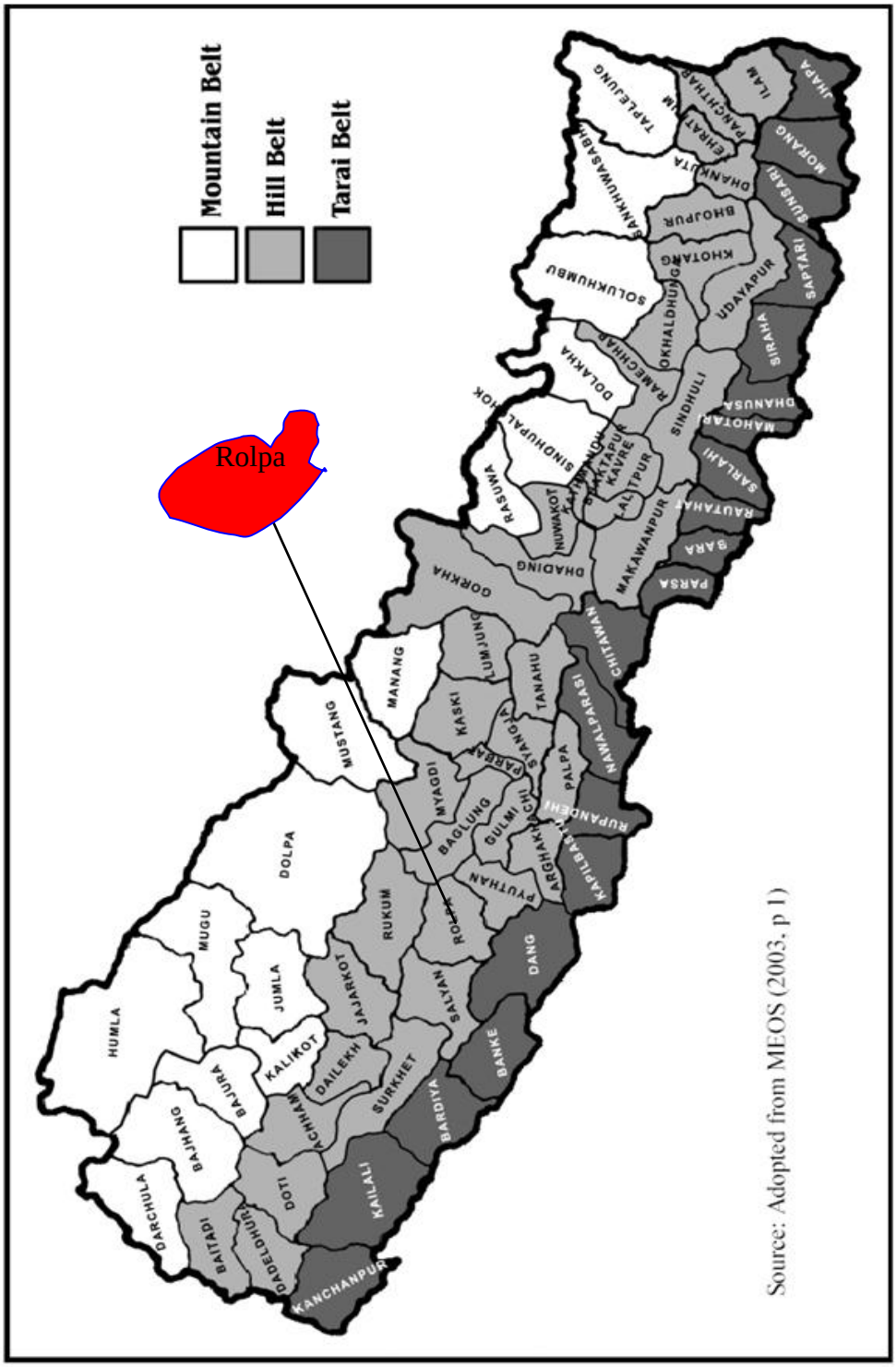
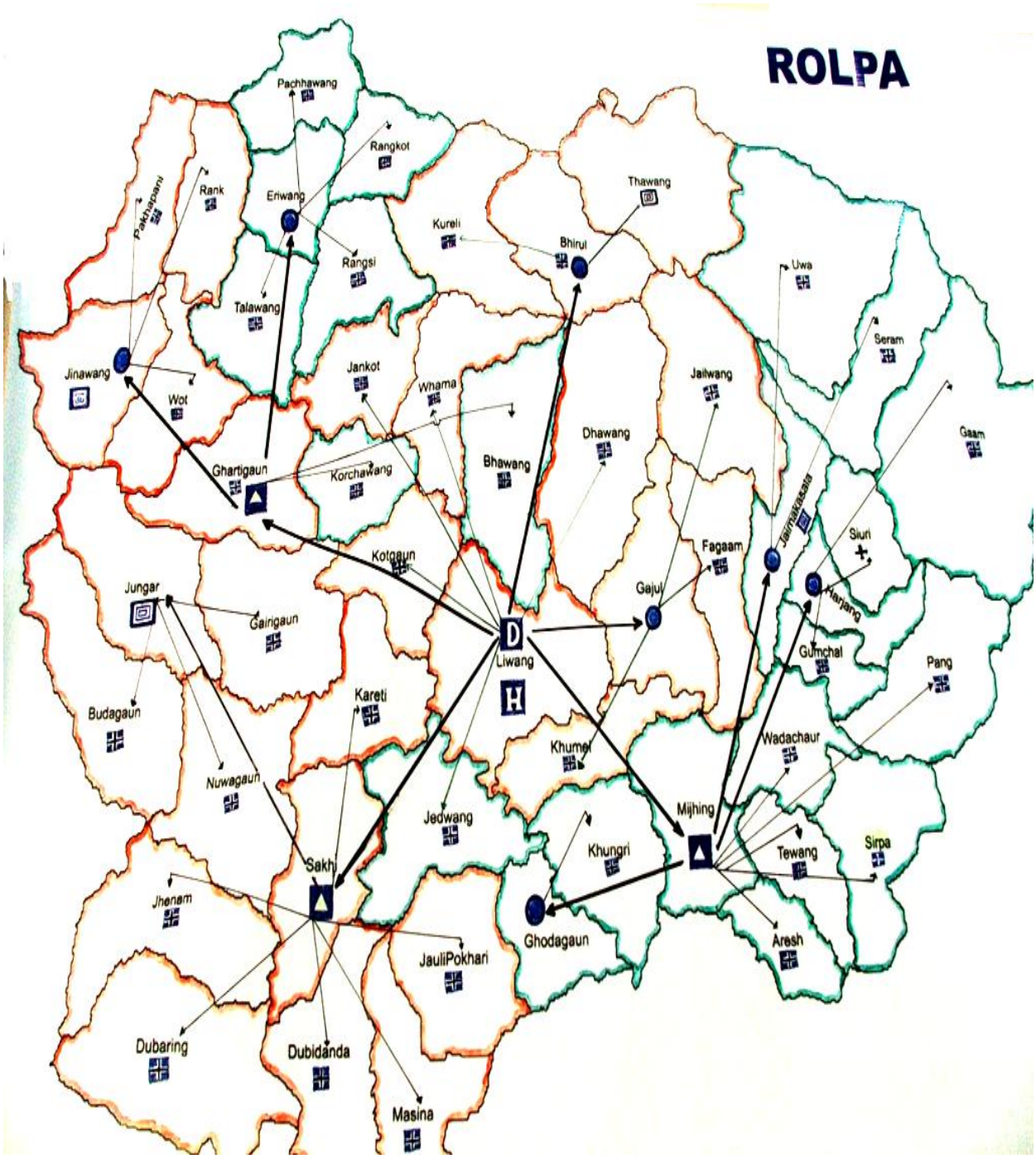


Figure 1: A Map of Nepal with the Administrative Districts Division

Geo-political Map of Nepal



District map of Rolpa

...dedicated to war affected victims of Nepal and all over the world...

CHAPTER I

Introduction

1.1 Political development in Nepal: A Historical Overview.

Important background features.

Nepal is the oldest nation-state in South Asia. The history of the modern nation state building process had been initiated after king Prithivi Narayan Shah from Gorkha (a western hill district of Nepal) completed the 'unification' process of Kathmandu Valley in 1768-1769 AD. Before the rise of the Shah dynasty, that became a mainstream ruling power in the country, the political structure of Nepal had been transformed through different phases of dynastic episodes. The first recorded dynasty was that of Gopal Bansi (900-700 BC) followed by Mahishpal (700 to 625 BC) and by the Kirat Kings (625 B.C. to 100 A.D). At the end of the 5th century, the Lichchhavi dynasty emerged as a new ruling power and achieved overall economic prosperity and self-sufficiency. Therefore this particular period earned the sobriquet of Nepal's "golden age"[1]. After defeating the Malla dynasty (c. 1201-1769 AD) and other princely states, Prithivi Narayan Shah's endeavors were continued by his progeny. They expanded the frontiers of the kingdom up to river Tista in the east and Kangda to the west up to the borders of India. In 1814, the expansionist will of the Gorkha Empire and the colonial rise of mercantile power led by the English East India Company caused a mutual challenge to expand and protect one's interest of power maximization. During the Anglo-Nepal war, the East India Company and Nepalese army could not defeat each other. So eventually the official ending of the war had to be declared after signing the Sugauli treaty with the East India Company in 1815-16 AD. Since the process of territorial expansion had been ceased, moreover, the question of modern state building had been confined in the shadow of both internal and external geopolitical contradiction faced by the country for a long time.

Although the nation state building process was initiated by the Shah dynasty, it became undermined and forcefully overruled by the dominant figure of Jung Bahadur Rana, a powerful member of the Rana family. He had led an army coup (1846 A.D) against the Shah

[1] In this period, Nepal had self-sufficiency in resources and there used to be substantive export of different Nepali goods in neighboring states.

rulers and declared the supreme of the nation. Political immaturity, underage kings, resources and power conflicts among the Shah families are some of the general reasons, which were responsible to evolve crisis in the Shah Dynasty. During the Rana regime (1846-1950), the role of the Shah Kings were minimized to a rubber stamp and the country was completely under authoritarian power structure of the Rana prime ministers for hundred and four years. During this period, people were excluded from basic education, general information and restricted to perform any kind of activities that could result in political awareness against the Rana Oligarchy. To change this cruel and harsh situation, the Nepalese people revolted against that authoritarian Rana government and again placed Shah King back to the throne. After the abolishment of the Rana regime in 1950, the Nepalese people became sovereign citizens and there had been a declaration of democracy for the first time in Nepal. Subsequently, Bishweshwar Prasad Koirala became the first elected prime minister of democratic Nepal and the Shah King remained as a constitutional monarch. After a decade, playing with contradictions at a Juvenile stage of democracy, King Mahendra performed a political coup against the democracy in 1960. As a byproduct of this political coup, the Panchayat system imposed many non-democratic effects like curtailing of basic human rights. Freedom of speech, rights to create political parties and rights for information were rudely cut off for thirty years (1960-1990). In 1990, with growing aspiration to see change and progress like in other developed countries, Nepalese people had made a long-term protest against the autocratic Panchayat system led by the Nepali Congress and united left front (*Sanyukta Bammorcha*). After a month of demonstrations and losing many people's lives, the Shah King Birendra was forced to declare himself as a constitutional monarch. Subsequently, one of the senior leaders of the Nepali Congress, Krishna Prasad Bhattarai became first interim prime minister of Nepal after re-establishment of the democracy in 1990. Although there had been a political change from monocracy (*Panchayat*) to democracy (*Prajatantra*), lack of policies and programs to minimize chronic stage of mass deprivation, the post 1990 era could not bring substantive changes in the general living standard of the deprived and marginalized class. In order to bring radical transformation in Nepalese society, pressurizing the immediate fulfillment of a forty points socio-political, cultural and economic demands mentioned in their political manifesto, the CPN (Maoist) submitted their demands to Sher Bahadur Deuba led Nepali Congress government in 1995. Since Congress government had not shown any effort to fulfill all those demands. In February 1996, the Communist Party of Nepal (Maoist) declared a “People’s War” against the “old state authority” to “completely transform” the Nepalese socio-political structure.

During the CPN (Maoist) arm led insurrection against the state, approximately 15, 000 people were killed. Along with many other hundreds of people who had disappeared, been displaced or tortured. The decade long civil war ended in 2006 with the signing of a comprehensive peace accord between the governments of Nepal led by Girija Prasad Koirala and the CPN (Maoist) led by Pushpakamal Dahal aka Prachanda. Similarly, the first constitutional assembly held in 2008 had declared the abolishment of the monarchy from the ruling structure of Nepal, consequently following the decision Shah Monarch Gyanendra who had to depart from the royal throne in June 2008.

After the constituent assembly (CA) election that was held in April 2007, the CPN (Maoist) emerged as a new political power and Pushpa Kamal Dahal aka Prachanda became prime minister of Nepal. After running a nine months long coalition government with Madheshi Janadhikar Forum (MJF) and the Communist party of Nepal, United Marxist Leninist (CPN UML), Prime minister Pushpakamal Dahal aka Prachanda from UCPN (Maoist) resigned from the government in May 2009. This same month the CPN (UML) formed another coalition government led by Madhav Kumar Nepal with support of other parties like the Nepali Congress and MJF. There had been a sharp pressure created by opponent's parties to Madhav Kumar Nepal government to step down and create a situation to develop multi-party consensus. Meanwhile, CPN (UML) Prime Minister Madhav Kumar Nepal had to resign from the post of prime minister in June 1990 and the country was again in long-term political turmoil. After seven months of political deadlock, by following the seven points agreement, Nepal again had a new prime minister, and once again, Jhalanath Khanal from CPN (UML) became the acting head of the government for nine months in February 2011, who led the coalition government formed among UCPN Maoist[2] and the Madheshi Janadhikar Forum. Since the government led by Jhalanath Khanal was not being able to forward the political process, Madheshi parties left its political support to the Khanal government and developed political alliance with UCPN (Maoist). Furthermore, to develop multi-party political consensus Baburam Bhattarai became next prime minister from UCPN (Maoist) in August 2011 and led the coalition government with MJF. It was a major challenge and responsibility for Baburam Bhattarai's government to implement the long awaiting constitution of the republic of Nepal. However the Baburam Bhattarai government had to dissolve the constitutional assembly in May 2012 and the constitution writing process

[2] After unification with Narayan Kaji Shrestha aka Prakash led Communist party of Nepal (Unified), CPN (Maoist)
became UCPN (Maoist)

had been further delayed. The resignation process of Baburam Bhattarai could not bring substantive solution in the long run, at the end Nepal had to go for a new kind of political experiment like in Bangladesh. By nominating chief justice as an executive head of the country and various chief secretaries that were supposed to perform their duty as acting ministers in different ministries. The mandate of the caretaker government formed with the support of bureaucratic personalities was to hold the constituent assembly election to continue the mandate of the peace accord signed between the CPN (Maoist) and the Nepal government.

Though the primarily mandate is to forward the constitution writing process, different parties had forwarded their political agendas on the battleground of the election. Since the country had already declared to divide its political geography according to a following of a federal structure, there had been a heated debate in terms of modality of the federal system. The Nepali Congress, one of the oldest parties had forwarded its election manifesto proposing non-ethnic based federal model and CPN (UML) had forwarded a mixed model in terms of federal structure. Other parties like the Rastriya Prajatantra party (RPP) overtly forwarded their agenda to restore the monarchy as a symbol of unification in Nepal and took an anti-federalism stand. Similarly, other parties like the Madheshi Janadhikar forum, the Terai Madhesh Loktantrik party and the Shanghiya Samajbadi party have proposed their political agendas to restructure the federal state of Nepal on the basis of ethnicity developing at least two federal states in the plain region of Nepal. The newly split fraction of the Nepal communist party-Maoist led by Mohan Biadhya (Kiran) from UCPN Maoist chose to boycott the constituent assembly election. Furthermore, there had been a second constituent assembly election in 2013. As a result, the Nepali Congress and the United Marxist Leninist won the majority of the Constituent Assembly (CA) seats and the Maoists were set back on third position. After the CA election, since Nepali Congress won majority of seats in CA, Sushil Koirala from the Nepali Congress party became the Prime Minister with support of the United Marxist Leninist (UML). Moreover, accepting its defeat in the election, the UCPN (Maoist) became the third largest party and choose to remain in opposition. Ironically, the second CA also could not draft the constitution because it failed to solve many conflicts among the political parties regarding the issue of federalism and the nature of ruling systems. On top of that, the failures of the second CA had been reflected in the process of political deadlock in which people seemed destined to celebrate the awkward moments of uncertainty for a long time. In between, a forceful earthquake that hit Nepal had suspended the political agenda, which became a strong divergence point to begin a debate of reconstruction and

recovery. Along with this program of recovery, the coalition government run by the Nepali Congress and the UML had promulgated Nepal's constitution with the support of the CPN (Maoist) in September 2015, which declared the country as a federal republic system. Since there had been a political instability on a national level, such crisis of the state mechanism and its failures reflecting in sub systems like education, health, public transportation, bureaucracy and other welfare facilities. In Nepal, as Sugden (2011) writes, subsequent years have been characterized by a strong sense of disillusionment within the populace regarding the slow pace of change, arrested expectations and confusion over the potential direction of transition. Last but not least, political instability, visionless leadership and low political will, slow pace for change and underutilized resources are some of the factors in Nepal that are playing adverse roles to fulfill its dream to move toward to one of the most prosperous countries in the world.

Rolpa: A forgotten district

Rolpa, a hill district in mid-western Nepal is bordered by the districts of Dang to the south, Pyuthan to the east, Salyan to the west and Rukum to the North. The administrative region of the present district of Rolpa has been developed based on *Thum*[3] division, which is supposed to cover different sub divisions like Kalases, Byaishkhuwa, Darmapot, and Rolpa. The name of the Rolpa district, where "Ro" means *Sashan* (ruling) and "Pa" means *Chettra* (region) has been given after Rolpa Thum to represent both Kalases Thum (eastern region) and Baiishkhuwa Thum (western region) of the same district. Similarly, Rolpa Thum used to be also known as Ridhi, center of the Magarat region, which means both western and eastern regions where "*Ri"* means Gorachettra[4] (western region) and *dhi* means "Kalachettra" (eastern region). Most part of the district is covered with hills, valleys and rivers, geography is yet another challenge in this district to produce sufficient agricultural outcome in Rolpa. Since agriculture is one of the most important occupations in Rolpa, according to 2011 census, 81.85 percentages of people are engaged in agriculture as a major occupation. The presence of non-irrigated land and being a hill district, the production of barley, millet and

[3] District concept was developed in Rana reign. *Thum* is a certain area within the district. *Mauja* is a smaller unit of the district and *Gam* is the smallest unit of district. There are other *Thum*s like Madikhola Thum, Udayapur Thum, and Swargadwari *Thum* in Rolpa.

[4] Though the Cultural activist Bam Kumari Gahrti Magar claimed that the districts like Gorakha and Palpa is regarded as Gorasesh and Molpa is regarded as Kala Chettra. One of the senior politicians Balaram Gharti Magar denied that there is no concept of Gorasesh, only to understand the geography of Kalasesh, this concept had been developed by the people as a contrasting terminology to make day-to-day communication easier.

maize are insufficient in Rolpa. But there is a upcoming trend to cultivate rice, maize, barley, and millet. Besides this there is a growing interest in vegetable and fruit farming. According to the census of 2011, total population of Rolpa is 2,24,506, among them, 1,03,100 are males and 1,21,406 are females (PBN 2013/ 14). As Kalases or Kalachettra is popularly known as the place which belongs to the Magar caste group, the indigenous Kham Magar (43.78%) is predominant in Rolpa. Similarly the composition of Brahmin and Kshatriyas consists of (33.38%) and so-called untouchables (16 %), other caste groups (6.87%). Nepali is the most widely spoken language in Rolpa that is followed by the Kham Magar language in the Magar dominant regions. In 1961 AD, the administrative division of Nepal developed a newly formulated district of Rolpa which occupies 1,879 square kilometers of the country.

There are substantial presences of Rolpali males in the Nepal Army, Indian Army, and British Army and even in the People's Liberation Army during the time of the civil war. This was an lesser opportunity for other alternative employment in Rolpa. However, some educated people are employed in different NGOs, schools and other government offices in the district headquarters. Similarly, going to India to work as a seasonal or permanent roustabout is another widespread trend in this district. Rolpa was the birthplace of the Nepalese civil war (1995-2006) popularly known as the " people's war" or the "Maoist Movement of Nepal." To suppress the armed insurrection initiated by the Communist Party of Nepal (Maoist), the Nepalese state launched various counter-insurgency operations against the Maoists. Many people from different villages of Rolpa lost their lives in these kinds of army operations. According to the record of the Informal Sector Service Centre (INSEC) in Rolpa, the total number of people killed by the state is 610 and there are over 400 hundred families who lost their loved ones during this war. In addition, the numbers of casual killings by bomb blasts stands at 48, while the Maoists killed 115 people. Meanwhile 52 persons "disappeared" and the circumstances of 10 others are still unknown. They have either been killed during this war or buried somewhere by the security forces.

At present, Rolpa has 1 district hospital, 2 primary health centers, 10 health posts and 16 sub health posts. The Rolpa district does not have academic institutions that offer any kind of medical or paramedical courses on health related subjects. The general condition of communication, education, agriculture, roads and transportation is not satisfactory in Rolpa. Above all sanitation is far below reasonable human living standards. According to the report of the District health office (DHO) of Rolpa, among 43,735 households, 34,267 households are living without toilet facilities, which is always prone to spread communicable diseases. Similarly, different governmental institutions such as the District Development Committee

(DDC), the Chief District officer (CDO), and the post office, as well as the Village Development Committee (VDC) buildings are also not well equipped in Rolpa. Contextually, expressing the frustration against the centralized ruling mechanism for not having general facilities to live a life of a normal human, many local people have mentioned that Rolpa is also known as the "forgotten district" of Nepal.

1.3 Problematizing the empirical context

Stagnation rather than transformation: A critical reflection

The history of health service development in Rolpa has been marked by different kinds of sociopolitical upheavals in different political systems. In the context of pre-conflict power relationships, created by local political tussles and backed up by national political figures, a delay of more than twenty-five years was build up to complete the infrastructure of the district hospital. In Rolpa, either it could be hospital, airport, road, bridge or other physical infrastructures, many people had grievances that those were surveyed, designed and built to fulfill the interest of politically powerful people. During the civil war in Rolpa, the Royal Nepal Army and Communist Party of Nepal (Maoist) fought for control over the health service system. Forced "donations", constrained involvement in medical care (to benefit the belligerents) and the contradictions of performing dual roles simply to stay alive. This discouraged health workers from remaining in the war-affected region (Ghimire 2009). It is evident that long-term absenteeism, unskilled human resources, poor diagnostic technologies, lack of sufficient supervision and conflict-induced burdens are adversely affecting human health in Rolpa. The decade long civil war had many tangible and intangible impacts in Rolpa. Moreover, this war has created a negative impact on families, communities, and the pattern of forced migration had made both men and women's life more vulnerable. The existing trend of pressurized migration had increased the agony and vulnerability to different communicable and non-communicable diseases. Specifically, in war affected districts like Rolpa. Historical exclusion, difficult geography, shortsighted governance and poorly functioning bureaucracy are some of the reasons that people´s expectations remained unheard. On top of this many people still do have a strong belief in malpractices of shamanism and irrational medical practices. So the presence of illness and sickness generated by conflict-induced conditions are not treated and many people are still struggling with those burdens of diseases. As Ghimire (2009) writes, factors like indebtedness, medical loans, alcoholism, chronic illness, and conflict-induced depression are directly playing an adverse role of increasing incidences of suicide by hanging and swallowing poison in Rolpa.

At the national level, though there have been frequent changes in the political system, there has been very slow change in terms of people's living standard. Lack of political commitment to improve health conditions are overlooked in agendas. And therefore eventually stealing all hope for change and people carry on with the burden of surviving with silent sufferings. Since the government health service system has not been able to provide satisfactory services at the primary care level, people are forced to make long journeys to access health services in Rolpa. Similarly, the influx of patients from non-functional primary facilities represents a burden on tertiary care centers. At present, the deplorable state of the public health system is supporting a chronic situation of medical dependency. Due to poverty and conflict induced migration, remittances are increasing in Rolpa. The failure of primary health care is playing an adverse role in reducing rural surplus. The lack of essential health service delivery has ultimately forced many people to follow the chain of forced medical tourism to different cities of Nepal and India.

The signing of the peace agreement between the Nepal government and CPN Maoists in 2006 was a historical juncture to transform the Nepali society. In the post conflict context, the lack of regular pro-people activities by the government and other line agencies has resulted in severe frustration among the general population in Rolpa. Political lingering in a 'transitional period' is fatal for managing the day-to-day challenges and 'hand-to-mouth' needs for many people. In Rolpa, although living conditions are comparatively safer than during the active war period, political transition and the slogan of "New Nepal" is still unable to ensure adequate livelihoods for the people. Similarly, due to the pre-conflict and active conflict situation, the superficial changes in political structure have not penetrated the life of ordinary people. In terms of physical infrastructure development and to realize other beneficiaries, the transition in Nepali politics is in no way any different from the active conflict period in Rolpa. In particular the poorest of the poor are always excluded, marginalized, suppressed, and living without availability of basic health facilities and therefore with silent sufferings.

1.4 Conceptual framework

Good (1994) has discussed different forms of theoretical orientations such as the empiricist paradigm, the cognitive paradigm, the meaning-centered and the critical paradigms prevalent in the field of medical anthropology. This research is focused on the critical paradigm to nurture the counter hegemonic ideas in the field of health science. Bhaskar (1998) mentions, the positivist vision of science pivoted on a monistic theory of scientific

development and a deductivist theory of scientific structure. According to his viewpoint, unlike positivism, post positivism does not believe that it is possible to maintain absolute detachment from the research subject without showing any biases. Therefore, respecting the level of positive social biases like justice, equality and transformation, I have kept myself in a 'value critical approach' and chosen critical theories which are basically supportive to develop counter hegemonic ideas against the existing trend of domination and subordination. Singer (2003) writes, that hegemony refers to the process by which one class exerts control of the cognitive and intellectual life of society by structural means as opposed to coercive ones. Hegemony is achieved through the diffusion and constant reinforcement throughout the key institutions of society of certain values, attitudes, beliefs, social norms, and legal precepts. Moreover, a critical perspective is necessary to raise the critical queries against the dominant and hegemonic societies where different socio-historical forces are intentionally mobilized to sideline real necessity of society by forcefully imposing certain types of values and ideas which eventually become supportive to fulfill their own class interests. In many studies, an attempt of representing totality with the use of holistic theories has not been appropriately demonstrated macro to micro layers of social realities. As a result, there are sufficient loopholes to criticize the structural perspectives by using an individualist approach. Similarly, partial and narrow focus of an individualist approach has been increasingly sidelining larger structural determinants of the society. In this kind of reality, Han and Ballis (2007) elucidate :

> *Critiques of the medical anthropology of political economy argue that focusing on socio political concerns depersonalizes and prevents people's voices from being heard. In the same way that predominantly structural perspectives do not fully capture the social reality as it is experienced by individual actors, the range of interpretive theories provide only a partial perspectives of the same reality viewed through the micro focus of an interpretative lens, medical anthropology remains mystified because interpretive explanations seriously downplay the given context in which individual health seeking behaviors occur.*

Hence, to develop a nuanced understanding between agent-structure power relationships, this research will borrow the idea from both Marxian and Focauldian ideas of critical medical anthropology (CMA). Moreover, in the Marxian approach, to interpret the empirical dynamics most of the perspectives are derived from contributors of critical politico-economic theorists, which have its epistemological origin in the Frankfurt school of thought. Specifically, by applying the political economic approach, I am more interested to explore how politics as a moral choice determines production, distribution and consumption of the resources and its further impact on everyday life of the people. As well as in the Focauldian perspectives have been derived from Mitchel Foucault's and his follower's contributions.

Especially on power, body politics and governance. Here, according to McHoul and Grace (1993 : 84), "Power is nothing more and nothing less than the multiplicity of force relations extant within the social body. Power's condition of possibility actually consists of moving substrate of force relations. The struggle, the confrontations, contradictions, inequalities, transformations and integrations of these force relations". Therefore, the fulfillment of people's expectations and institutional performances is based on a strategic power relationship, where capacity to access the health related resources is determined according to the class position of the people, which they deserve in the society. In this case, both systems, world and life world demonstrate each other's socio political power, however, in such context, power of the life world is always deceitful because it's the people who give legitimacy to the system world. Moreover, Higgs and Jones in Scambler (2013 :153) write, "The system world is involved in the distribution of power and resources while the life-world is concerned with the reproduction of values and culture." The dynamics of a power relationship operate from micro to macro level in the 'system world' and directly govern and form the choices in the 'life world' of the people by controlling the level of resource allocations. Shaping the priorities of the people and constructing their sociocultural values and perceptions in relation to people's health related expectations. Furthermore, critical realism has been used to question the inherent role of some common factors in the institutional generative mechanisms and its further implication in power structure. As Bhaskar (1989) has mentioned, critical realism is an alternative philosophical perspective and other possible research designs, which are realistic approaches to social research but adopting a critical or activist principle. In this context, as Bhaskar (1989) mentions, the principal research question for critical realism in social science, specifically for health promotion is the identification and elucidation of the nature of generative mechanisms. How do they cause their effects? What triggers them? What inhibits them? How are they reproduced and maintained? Are they politically and ethically legitimate? If not? How can they be changed? In order to change the system and raise the critical voice against the malformation of the health service system, critical realist inquiry has a high degree of theoretical relevance in this research. Likewise, Banerji (1985) has mentioned that both the health problems and the health practices of a community are deeply embedded within its ecological, social and political systems...political forces play a dominant role...that the health service of any country can be studied only in terms of an understanding of this force. As Banerji defined, the construction and development process of the health service system has been influenced and affected by different kind of political and economic forces. Navarro (1976) writes, that same

political and economic forces that determine the nature of capitalism and imperialism, also determine the underdevelopment of health and health resources.

In a broader sense, as Minkler, Wallace and McDonalds (1995) have mentioned, political economy is a theoretical framework which can help to understand the many economic, political and socio-historical forces which shape contemporary health problems and our approaches to these problems. Critical medical anthropology is primarily a politico-economic theory emerged in the field of medical anthropology, which used to be also known as political economic medical anthropology (PEMA). As Singer (1995) has conceptualized, critical medical anthropology is "systematically anthropological" and "consciously political," because it attempts to explore holistic, historical, social, cultural and political dimensions of diseases, illnesses and health seeking behavior and criticizes existing conditions of health service systems and policies of the government. In this research, CMA has been used as a major perspective to critically interpret social realities. Hence, "CMA as a specialized branch of medical anthropology can be defined as a theoretical and practical effort to understand and respond to issues and problems of health, illness, and treatment in terms of the interaction between the macro-level of political economy, the national level of political and class structure, the institutional level of the health care system. As well as the community level of popular and folk beliefs and actions, the micro-level of illness experience, behavior, meaning, human physiology, and environmental factors" (Baer, Hans A. Scheder 1988; Singer 1986, 1990a cited in Singer 1995 : 201). Thus, CMA as a theoretical framework gives conceptual understanding to view the politico-economic relations between the agents and structures in all four levels like individual, micro social, intermediate and macro social. The struggle of any individual to access better healthcare facilities is not purely an individual choice where one can freely avail the care as per her/his necessity. On the medical market, these choices are guided by availability, affordability and accessibility of the health care services, which are shaped mostly by profit making motives of involved actors. CMA defines, "economic forces of capitalism are manifest not only at international and national levels, but in local settings and local relationships as well, resulting in unequal societal distribution of sickness and healing" (Singer et.al 1995:196). Not surprisingly, in this kind of intentionally produced social vulnerability, the chronic failure of a government system is reproducing individual pain and sufferings, and furthermore market forces operating as an ultimate pseudo-rescuer. Consequently production and reproduction of suffering in any individual is a window to analyze and judge the quality of the health service system from local to national level. From the perspective of CMA, health can be defined as access to and control over the basic

material and nonmaterial resources that sustain and promote life at a high level of satisfaction. Health is not some absolute state of being but an elastic concept that must be evaluated in a larger sociocultural context (Baer et. al 2004). The way people's health condition has been largely shaped by larger socio-cultural determinants the same kind of socio-cultural pattern influenced the development process of the health care system. As Kleinman (1980) writes, beside cultures, other factors shape the configuration of the health care system. These factors can be separated into those that are part of the internal structure of the system and those external to it. According to the author, external factors include political, economic and social structural, historical and environmental determinants. Thus, I believe the study of the health service system exist in any society and cannot be conceptualized as a geographically isolated, structurally homogeneous or conceptually fragmented task. In contrast the performance of the health service system has intrinsic and extrinsic connections with larger sociopolitical determinants operating from grass root to global level.

To understand the cost of human suffering and its relation to political and economic power, one has to go beyond the immediate and proximal factors, in this sense, the relevancy of political and economic power is emerging and its widespread use has been done to explore the unequally distributed resources in the pre-capitalist countries. Cant and Sharma (1999 : 4) write, "Healers differ in the degree of credibility and esteem they can command, and even though biomedicine is weakly developed in many countries of the South, it still bears an authority and prestige derived from various sources, not least its international dimension, its relationship with the state, and its perceived success in controlling certain life threatening conditions through modern drug and technology". Sundar Rajan (2006 : 13) has mentioned, "political economy as a consequential not because it is a political and economic system of exchange but because it is a foundational epistemology that allows us the very possibility of thinking about such a system as system of valuation". Therefore, the systems' perspectives are important because health behavior is not merely a function of micro level interpersonal interactions of family and community; they are also affected by our meso systems linkages between our micro level interpersonal relations and the macro level resources such as political power and societal resources that affect health (Winkelman 2009). Additionally, Focauldian notion of biopolitics involves a government-population-political- economy relationship, referring to a dynamic of force that establishes a new relationship between ontology and politics. Thus, in this context, deconstruction of powerful fictions (mainly one-sided and partial truths produced by powerful people) overlapping human sufferings and reconstruction of alternative truths, which express the hidden social realities, are important to

amplify the voices of silent sufferers. In this research, illness narratives and subjective experiences are the powerful manifestations of such realities, which are interpreted to understand the alternative voices.

Likewise, Sinha (1997:81) writes, "from the health perspective, violence is seen as any act of verbal or physical force or life threatening deprivation directed at an individual, that causes physical or psychological harm, humiliations and that perpetuates subordination". In this context violence is an act of demonstrating power either caused by the state or any other groups. The conflicts of interests that are expressed through violence ultimately have impact on human health, because, as Sinha (1997:81) writes, violence is a cause of 'non health' and death. Ill health is an unavoidable consequence of armed hostility. In this setting, ill health can be considered a repercussion of bio politics perpetuated by the violent state. Sunder Rajan (2006) has further elaborated that biopolitics do not just refer to the ways in which politics impact on everyday life, or in which debates over life impact politics, but rather points to the ways in which our ability to comprehend life and economy in their modernist guises is shaped by particular epistemologies that are simultaneously enabled by, and in turn enable, particular forms of institutional structures (Sundar Rajan 2006). Institutional structures of the state and supportive agencies manifest power in the form of different modernist guises like globalization, liberalization and privatization to control the people's choice in the name of individual freedom. In war-affected countries like Nepal, the state power as a "modernist guise" is reflected in the oppression, suppression and control of the people's expectations and alternative ideologies. In this kind of suppression, as Nordstrom (1998) mentions, "terror and warfare attacks not only the body, not only the body politics; it attacks the core definition of humanity. Such attacks on the human bodies perpetuate social sufferings because this kind of "social suffering results from what political, economic, and institutional power does to people and, reciprocally, how these forms of power themselves influence responses to social problems" (Kleinman, Das and Lock 1997). Furthermore, CMA assumes that social suffering and construction of illness at an individual level is also directly linked to political, economic and institutional structures because as Hahn (1995) writes, the human benefits of interaction with the physical environment are unequally distributed in the society. Singer (1995) has conceptualized that CMA cannot create artificial separation between micro population and local setting with wider political economic context. Therefore, the application of CMA as a counterhegemonic ideology is basically against hegemonic forms of propositions on people's health forwarded by powerful forces of biomedicine who are strategically capitalizing the emotions, subjectivities and sufferings of the people

operating in the micro-social context. Thus, CMA explores those unequally distributed determinants of the health services affecting people's aspirations to live a healthy life with hygienic living conditions and the factors impeding the establishment of health as a universal human right.

1.5 Conceptualization of the study

In Rolpa, historical degeneration and a politic of exclusion have played a significant role to affect the socio-political determinants of health. The nature of underdevelopment and the history of resource politics have created a situation of institutional crisis and are important in the Rolpa health service system. Consequently, there has been a low level of performances in both promotive and preventive services. As well as curative services that were also very poorly developed. It has been observed that due to the unhealthy kind of political contestations and lack of mature political leadership there has been a long-term stagnation, while constructing the important public health infrastructures like a district hospital and other health posts residing at peripheral levels. Above that, the clashes of power between the people of this district, having different kinds of political orientations caused interruption of the natural growth of the health system, that ultimately supported the vested interests of control over resources. Specifically, within the Panchayat system there were many different political coteries who were interested to design and implement public infrastructures as per their interest. Such kind of vested interest had largely served the tiny section of the people rather than benefitting for the larger mass of the society. As critical realism defines, such "vested interests" operating in the past are the causal powers and this research seeks the relations between those constructs to critically analyze the foundational history of such generative mechanisms and asks questions about the legitimacy of such a system. As Urry and Wakeford (1973) cited in Marshal (1994) mentions, such kind of power involves not only decision making but also non decision making, not only overtly but covertly also. In Rolpa, mainly in the pre conflict context, the manipulative form of local power supported by central rulers and in the development of sociopolitical determinants of the health system development has played an unintended role in fulfilling the expectations of the people. The act of surveying, designing and building a hospital, airport, roads, or other physical infrastructures, as per the interest of politically powerful actors means sidelining the expectations of general people by using political power. This is the demonstration of influential "political forces" as explained by Banerji or "political and economic forces", as termed by Singer and Hans (1995) and Navarro (1976), and acts of manifesting "causal

powers" defined by critical realists. Such kind of unhealthy demonstration of power has paralyzed the socio-political and institutional growth of this district, leading to the production and reproduction of ill health, poverty frustration and widespread grievances among the people. Like, Qadeer (1985) has mentioned, the health service system is part of the political system. Similarly, political systems should be an integral part of the health system. It has been mentioned during pilot surveys that because of active conflict many primary and secondary level health centers were not constructed and upgraded for a long time. Similarly, during the war, the act of blasting health posts at the Thabang VDC by the state security forces could be considered as a demonstration of state power to control the population. For a long time, this health post was not reconstructed and people had to make extremely long journeys to reach basic primary facilities. This kind of "non-decision making" to upgrade and construct the destroyed health infrastructures is also the manifestation of power that has deprived people from their basic rights of accessing state sponsored facilities. In this case, as Banerji has mentioned, political forces played a vital role. Such kind of power affected the decisions by the state concerning resource allocation, workforce policy, choice of technology and the degree to which health services are made available and accessible to different segments of the society. In Rolpa, historical exclusion by a central ruling structure, irresponsible leadership, local level power conflicts and people's health as a notice failure has affected the construction and distribution pattern of the health service system.In addition the political violence became responsible for influencing the production, distribution and consumption of the health related resources in the society. But despite that one has to seek the reasons of such violence and its structural nexus in local, national and global level. In the specific context of Rolpa, conflict induced consequences like the destruction of health services, unavailability of health related materials and medicines, torture and killing of health workers, pressure of regular donations, long-term absenteeism, and non-utilization of the allocated budget prove to be detrimental to human health. The historical ignorance of not constructing and upgrading the health infrastructures on time, disturbances because of war, and regular ignorance by the ruling government are some of the reasons that the district hospital in Rolpa is not able to perform as a tertiary care centre as expected. People are forced to travel long distances to seek better health services. Thus, the health service system in Rolpa has failed to address three common goals such as improving health, responding to the non-medical expectations of the population and enhancing financial risk protection. It is obvious that causal powers and historical forces operating in the generative mechanisms of the institutional building process in this district are responsible for creating these kinds of

failures. As critical realists suggest, these failures are important to study and analyze by raising the question of political and ethical legitimacy in order to bring the necessary changes in the society.

Similarly, violence was being perpetuated either by the state or by any other "organized group". In this case, the notion of 'biopolitics' operationally gets manifested in the form of violence and perpetuates social sufferings at an individual level. In Rolpa, many human rights violations of torture, death, and sexual violence have been perpetuated by the state and fighting opponents. Many people were forced to find alternative means of survival outside their homeland. The crisis of primary health care constrained many people to travel long distances to access better health care. Likewise, in Rolpa, malpractices by private practitioners, irrational prescription of drugs and diagnostic technologies by both government and private practitioners also demonstrate the profit making interest of the medical market. CMA argues, in this context, that the economic forces of capitalism are manifesting not only at international and national levels, but in local settings and relationships as well. The long-term inefficiency of the government health centers eventually forced people to visit other expensive health centers in Kathmandu or different cities in India. In this context, many people often had to sell their lands, livestock and ornaments. Otherwise those people who could not afford to access expensive health services were compelled to survive with chronic illness and silent sufferings. As Qadeer (1985) mentions, such kind of 'health services' had an exchange value but not necessarily a use value, since it does not always produce good health but only suppresses the symptoms of ill-health. The act of suppressing ill health has its root cause in structural exclusion confounded by heterogeneous forces prevailing in a war-affected districts like Rolpa.

1.6. Objectives of the study

The broad objective of this research is to study the sociopolitical determinants of the health service system development and people's experiences of accessing health services in the Rolpa district of Nepal. Moreover, in this research, I have chosen to explore the nature of social sufferings and the entrenched power relations embedded in politics of underdevelopment since the political existence of this district.

Specifically, this research aims to:

(1) Critically map the social history of Rolpa specifically focusing on the development of socio-political and educational institutions in Rolpa.

(2) Study the social history and politico-economic dimension of health services at a primary, secondary and tertiary level.
(3) Study the structural dimension of social sufferings and health seeking behavior in the post conflict context in Rolpa.

1.7 Operational definitions

1.7.1 Social history: The contextual understanding of social history in this research is the study of the evolutionary development of political, economic and educational institutions in this district. In this study, sociopolitical and economic history has been critically analyzed in relation to the success and failure of the growth process of political, economic and educational institutions that are directly related to the improvement of human health. While exploring the sociopolitical and economic history, the concept of social determinants of health as developed by the commission of social determinants of health has been used as a central area of focus acknowledging the major components like (1) socioeconomic and political context, (2) structural determinants of health inequities (3) intermediary determinants of health. More specifically, in this research it has been attempted to understand the basic conceptual apparatus like what it means by 'politics' at local level. Whether use and misuse of 'politics' in a local context is only focused to control the resources as a normal profit, maximizing greed of humans or different dynamics are operating at a local setting. Moreover, I am explicitly focused to explore how performances of certain institutions are paused, interrupted and how certain institutions are growing effectively in its performance level. Therefore, in order to understand larger social determinants in relation to the institutional performance, this research has explored social determinants of health institutions in Rolpa.

1.7.2 Health Service System: As Lancet (2009) editorial writes, the six building blocks of the WHO framework for health systems are service delivery, workforce, information, medical products and technologies, financing, leadership, governance and stewardship. In this study the development of health service systems has been analyzed only by exploring specific components like infrastructure development, human workforce, service availability and stewardship. Respecting the notion of medical pluralism, the condition and service availability of the Ayurvedic hospital in this district has been discussed and analyzed in the relevant context during the data analysis process. According to WHO framework, the three major goals of the health service systems such as improving the health of the people,

reducing health related costs and responding to non-medical expectations would be a central focus during the data exploration and analysis.

1.7.3 Social Sufferings: Sufferers experiences are important if one is to understand how a particular human being experiences pain and sufferings in a particular context. The concept of social sufferings defined in Kleinman, Das and Lock (1997) has been used to develop the contextual understanding of pain, illness and other kinds of social tragedies in this research. Since this research is exploring the agent-structural relationship from power relation and politico-economic perspectives, social sufferings is a more appropriate terminology than using illness, pain or other kinds of reflections.

1.7.4 Health Seeking Behavior:

This study follows the holistic pattern of ill health and the structural dimension of vulnerability. In this context, assuming individual health seeking behaviors are a socially patterned and structurally conditioned phenomena. This study has followed the fusion of "four As" (Four As are: Availability, Accessibility, Affordability and Acceptability) and 3 D model (3 D means, delay in seeking care, delay in reaching care and delay in delivering care). Likewise, in terms of availability, the geographical dimension and distribution of health facilities has been explored and accessibility consists of transport facilities and other physical facilities like roads and bridges. Moreover, in this research medical and non-medical costs related to health services are explored to address the issue of affordability. Similarly, the notion of acceptability as described by Alma Ata (1978) has been used to understand the acceptance of available technology and health service facilities by local communities. All 3 Ds aspects of health seeking behavior have been analyzed by focusing on the structural dimension of ill health and its holistic interpretations.

1.8 Methodological Framework.

Operationalization of the study

1.8.1 Critical Ethnography.

Critical ethnography is necessary for studies of resource contestation, conflicts of interests, and exercise of power over suppressed and oppressed groups. Pains, sufferings, tragedies and social fragmentation cannot be isolated from their social context in any study of human beings. Acknowledging the methods of critical ethnography, this study has followed the exploratory and descriptive research design. Moreover, holistic ethnography has been done to

identify the agent-structure relationship. This study has explored the dimensions of social determinants of the health service system, the civil war, the post conflict context and social sufferings from an emic perspective (looking through the eyes of insiders) by doing direct participant observations for a period of six months.

This research has followed both primary and secondary method of data collection. To collect primary data, open-ended interviews (by using an unstructured checklist), participant observation (observation, diary, notes and memo), group discussions, key informants, case studies, and in-depth interviews (autobiographical exploration and narratives) of respondents have been conducted. Similarly, for secondary data, literature review, policy documents, available academic materials have been used to fulfill the objectives of the research. To collect primary data, open-ended interviews have been carried out (by using a checklist) using purposive and snowballing[5] sampling techniques, as well as interviews with key informants, with the aim of developing rich case studies.

1.8.2 Universe

In this research, the Rolpa district is regarded as a complete universal ground for this study , moreover, concerned authorities and respondents related to the whole district and the issues related to this thesis are regarded as a unit of the study. To fulfill the objectives of this proposed research, health professionals, social activists, academics, journalists, policy makers, politicians, patients visiting health centers, drug distributors, village health workers, non-governmental and international non- governmental organization health workers, immunizers, private practitioners, independent scholars have been regarded as units. Local people, civil society members, political leaders, bureaucrats, retired staffs and teachers from Rolpa have been regarded as respondents of this study. Interviews and observations have been done during sixth months of ethnographic fieldwork in Rolpa and an additional three months of fieldwork in Kathmandu.

1.8.3 Techniques of data collection (Sampling) :

Primary data

i) To fulfill the first research objective, 24 in-depth interviews have been conducted with key informants. Among those interviews with politicians, administrators, civil society members

[5] According to researchgate.net, snowball-sampling means a group of people regarded as potential participants for the study, or directly recruiting them for the study. Those participants then recommend additional participants, and so on, thus building up like a snowball rolling down a hill.

and local people have been conducted. Among politicians, the researcher has to balance cautiously to represent the views from all major political parties like the Nepali Congress, United Marxist Leninist (UML), UCPN (Maoists) and Rastriya Prajatantra Party (RPP). Among politicians, some of them have been chosen from the Panchayat period (before 1990) and others have been interviewed from the post Panchayat period (after 1990). Among administrators, both retired and current staffs have been selected. Likewise, amidst civil society representatives, respondents have been chosen from different fields like human rights, media, law and education. Local people from Rolpa and different villages have been selected in accordance with the diversity of age, sex, and class and caste composition.

ii) To fulfill second research objective, ten institutions have been purposively selected. According to the distributions of the health service system, one district hospital (Reugha*)* in the district headquarters, one primary health care centre (Holleri PHC*)* located in the western and eastern direction of the district has been chosen. Similarly, four health posts (Nehrpa HP, Jinabang HP, Thabang HP, Gajul HP) out of ten and two sub health posts (Gairigaon, Oat) out of sixteen have been selected. Similarly, the Ayurvedic institution in Libang has been selected to respect the notion of medical pluralism. The Ghorneti Model Hospital has been selected as a distinct model of a health care institution evolving during the context of the civil war. Health institutions are selected on the basis of ups and downs in their evolutionary history. Among them, one district hospital is automatically selected as tertiary care centre. Primary health centres have been selected to represent the mid-level of a referral centre of the district. Regarding the four health posts and two-sub health posts, those institutions had faced the issue of corruption, disturbance and destructions due to civil war and they had also faced the problem of long term institutional stagnation. They all have been selected through the process of snowballing. Primary data has been collected with the concerned authorities that are directly linked with formulation, direction and implementation of the health service system. In addition, all total 54 interviews with the members of management committees of selected organizations have been conducted. Within these samples, proportionate representatives from political parties, civil society and local people have been selected to explore diverse viewpoints.

ii) To fulfill the third research objective, 28 in-depth interviews with different kinds of patients at selected institutions have been conducted. Patients have been selected from two rounds of purposive sampling to match the criteria. In the first phase, general interviews have been conducted to select the patients suffering from long-term chronic illness and those with a history of outside visits from the district to access tertiary services. In this case, information

regarding potential respondents has been collected from health workers also. In the village, setting after identifying a few patients with a long-term history, snowballing has been conducted to identify other potential patients. Those patients, who had visited a particular institution more than two times with their chronic health conditions, had been selected as respondents of this study. To address the gender, caste and class background, male patients and female patients have been interviewed. Moreover, among selected males and females, the caste factor has been acknowledged as per the caste distribution of the villages. However, since most of the villages in this district have an egalitarian structure, the class dimension has not been used to include or exclude any patients in this study. Similarly, consciously, age and education factor of the respondents has been also ignored to select the respondents. While doing in-depth interviews, the researcher has tried to explore the diverse experiences of illness, sickness and sufferings in relation to poverty, conflict and migration. Similarly, the record of the district police office has been analyzed to explore the suicide cases and its structural dimension. In addition, interviews with Shamans and faith healers as well as private medical practitioners from adjoining areas of selected health institutions have been performed. Interviews have been conducted unless the data has been sufficient from the point of view of the researcher.

1.8.4 Further interviews and secondary data

To develop the broader understanding of the development of the health service system in Nepal, 12 interviews have been conducted with academics, policy makers, health activists, public health officers and representatives from different international donor organizations working in Rolpa. Similarly, for secondary data, a literature review has been conducted along with the analysis of policy documents prepared by central and local administration, official archival sources and government reports. Likewise, different search engines such as JSTOR, Pub med and other web portals have been visited to explore relevant scientific publications and books.

Rationale of the study

(i) The emergence of CMA in the field of medical anthropology has given critical framework to understand the dynamics of people's health and other determining forces that condition the health related behavior. The epistemological rationale of merging critical medical anthropology, critical realism and the Focauldian concept of biopolitics in this research is to analyze both the diachronic and synchronic picture of social realities. In the synchronic

approach, the conjunction between CMA and Focauldian biopolitics explores both proximal and distal determinants, those are responsible to create pain and social sufferings as an adverse impact of an existing power relation. Likewise, in a diachronic approach, the conjunction between CMA and critical realism explores the casualties of factors (past to present), those that are historically responsible for influencing and preventing the regular growth of the health service system.

ii) In the global context of medical anthropology, the introduction of critical realism is a very new area of study. The conjunction of critical medical anthropology, biopolitics and critical realism is a completely new invention of this research until date. Therefore, this study has both, an element of academic innovation and equally a policy level impact. Moreover, this study will provide a guideline to those researchers and academicians who are interested in conducting anthropological studies on similar issues.

(iii) In the context of Nepal, there are many medical colleges and public health institutions offering epidemiological and biostatistics dominated courses on public health and community medicine. Until date, Nepal does not have any institutions that offer critical interdisciplinary courses on health science related fields. Therefore, very little research has been done on the political-economic dimension of health. Especially in relation to conflict, sociopolitical history and the health service system, this is the first research of its kind. This research work is a pioneer and significant step to fulfill the under researched condition of Nepal especially in the politico-economic analysis of health issues.

In the context of Rolpa, there are substantial articles published on the cause of civil war and other socio-political dimensions. However, there is no study that has been conducted on conflict and health issue in Rolpa. Therefore, this research is the first of its kind that explores the interconnection of socio-political history, conflict and health service system and production and reproduction of social sufferings in a war affected district like Rolpa. Likewise, the researcher assumes this study will be a reference to those who are interested to understand the structural dimensions related to conflict and health in the context of rural hill districts like Rolpa.

I believe, from the perspectives of the academic and policy formulation point of view, the performance-expectations gap between service providers and service users are significantly important to understand the dynamics of any health institution as a matter of historical and contemporary relevance. Before understanding the growth and stagnation of grass root and district level health service development it is equally important to understand the nature and dynamics of the national level health service development. It has inevitable interconnections

and many web of significances to the grass root and district level institutions, reciprocal to each other. In this context, different forms of situational and structural factors occurring within the development process of the health service system are important to understand how health institutions are systematically manipulated by involved actors manifesting their conflicting values and roles to put control over the resources.

Limitation of the study:

In the severe lack of proper evidences documented by the state or any other scholars, the researcher has faced difficulties to explore different kinds of intrinsic and extrinsic dynamics. Those are continuously penetrating the performance level of the health service system in Rolpa. The findings of this research are based on ten selected institutions in Rolpa. Therefore, there have been methodological limitations in making large-scale generalizations from these findings. The social sufferings and health seeking behavior of the patients have been analyzed based on purposive and snowballing sampling. Therefore, it is not possible for this research to cover every kind of social suffering and health seeking behavior operating in different social conditions.

Both time and financial constraints have limited this study. To acquire a regular academic degree, this research work must be completed within a fixed deadline. Financially, as a student, it was not possible to collect every type of material and documents required for conducting this study. The lack of accurate scientific data regarding the health care delivery and the difficult geographical setting of Rolpa has also affected this study.

Furthermore, there is always the risk of the researcher developing a false sense of certainty about his/her own conclusions. Similarly, 'subjectivity' also can influence the research. Researchers have shown utmost sincerity to maintain rigor in research by avoiding the 'subjective biasness', 'value laden interpretation', 'false sense of certainty' ideological inclination" of the research and the findings as well.

1.11 Ethical issues

According to the Oxford textbook of public health[6], "health care ethics is best discussed in terms of five principles-non malevolence, beneficence, and respect for autonomy, justice and

[6] Detels Roger, Mcowen James, Beanglehole and Heizo Tanka, Oxford Textbook of Public Health, Fourth Edition 2004, Oxford University Press.

utility." For the sake of this research, the researcher has agreed to acknowledge the different ethical issues such as anonymity, confidentiality and informed consent has been followed. Specifically, to maintain the ethical sincerity the researcher has followed following dimensions specifically :

The researcher was committed to maintain proper rapport building with the concerned authorities and respondents.

Any disadvantageous activities that may harm the concerned authorities of this research have not been performed.

Prior to conducting research, the researcher has clarified the interest and purpose of research amongst respondents.

After conducting the research, the outcomes will be shared through media, journals and public discussion forums. Moreover, all the concerned authorities are eligible to get a copy of the research as per their interest.

No interviews and materials have been taken without the authority of the concerned authorities. Similarly, researcher has not given any incentive or other physical goods to conduct interview or to collect necessary documents.

No recorders or any other electronic devices and camera have been used without taking approval with the respondents.

The researcher has not accepted any kinds of funds, grants and incentives from any of the authorities that may directly or indirectly influence this research.

The researcher has not displayed any photographs, names and case studies of respondents/patients, which may create further harm.

The researcher has maintained the value of academic research, and fully committed to avoid plagiarism in this research work.

CHAPTER II

2. Review of the literature

War and its devastating consequences are key concerns in public health. The analysis of war and health from social science perspectives explore the deeper dynamics of war that goes beyond simply counting of dead bodies as a repercussion of war. There has been a growing trend to understand multidimensional facets of armed conflicts and their health related consequences in academic disciplines like social medicine, public health, conflict epidemiology and medical anthropology. Similarly, conflict and health is one of the emerging areas of study in the field of health sciences. The major objective of this chapter is to review the available literatures on conflict and health related to both international and national context. Specifically, I have reviewed the dynamics like conflict and its relationship with the health service system, mental morbidities, war related physical injuries, post conflict reconstruction and availability of HRH in a war related context. Singer and Erickson (2014 : 228) write, "seeing war through the lens of public health takes us immediate injury and death, by focusing attention on war's full toll and pathology, including its immediate and longer-term impacts on human wellbeing, the wide range of ways it causes damage across gender, age, subgroups, and environments, and the ability of war to trigger other threats to human life". Since war and violence induce physical and mental morbidities at the population level, the study of war-induced mental morbidities is an equally important dimension for understanding human suffering. As Kleinman (1980:34) writes, "although many ethnographies and comparative studies now begin with a holistic conception of medicine in society and examine the impact of culture on medicine, most anthropological psychiatric and public health researchers still isolate individual components of health care systems for study without exploring their linkages with the system as a whole or with its other components." In this regard, there is an importance of holistic notion to understand human health related problems and the response of the system to address the health care needs of the population. Kleinman (1988:28) further writes, "Ethnography, biography, history, and psychotherapy – these are the appropriate research methods to create knowledge about the personal world of suffering. These methods enable us to grasp, behind the simple sounds of bodily pain and psychiatric symptoms, the complex inner language of hurt, desperation, and moral pain of living and illness." Therefore, in order to understand the dynamics of suffering in conflict-

affected people, it is important to understand the dynamics of conflict and health from an holistic point of view which captures larger social determinants of war and its impact on health systems and its capacity to induce human suffering. As Pool (2005 :4) (cited from Howard Waitzkin) writes, "major problems in medicine are also problems of society; the health system is so intimately tied to the broader society that attempts to study one without the other are misleading. Difficulties in health and medical care emerge from social contradictions and rarely can be separated from those contradictions". Moreover, Inhorn (2008) in Singer et al (2014) writes, that to study "structural violence" is not a sufficient goal in and of itself because war creates poverty, but it also creates many other forms of embodied suffering that require anthropological attention and concern. In this chapter, through analysing available literatures in the domain of conflict, health, political economy and social suffering, I am trying to understand how health practices and beliefs are shaped by political-economic forces operating from global to local levels and the role of those forces in inducing human suffering. Moreover, this chapter will analyse substantive literatures related to conflict, health service systems, and social suffering in order to understand people's health vulnerabilities and the effects of war on health service systems.

2.1 War, health and human tragedies: A global overview

Analysing the literatures on armed conflicts across the world shows that there is a significant relationship between war as a human-made disaster and the decay of human civilization. Duffield (1998) explains that in a globalized world, crises are interconnected. Some emergencies become "noisy" while others remain "silent," and Duffield observes that the gap between noisy and silent emergencies is widening. The level of power possessed by actors involved producing and perpetuating war determines which emergencies are "made noisy" and which "remain silent." According to him, worldwide 31 state-based armed conflicts affecting twenty three countries were registered in 2005, and are occurring mostly in underdeveloped countries struggling to meet basic human needs. Struggles around ethnicity, suppression, access to resources, and disputes over country borders are some of the key reasons that conflict tends to continue in present days (Duffield 1998). In most of the cases unequal distribution of power and resources and a continuous sense of marginalization get escalated as conflicts happen between advantaged and non-advantaged groups. Moreover, Gass (1997) explains that conflict situations can be caused by many factors such as differences in political ideologies, legal and economic systems, ethnic and social particularities, human rights issues, state-sponsored terrorism, cross-border environmental

problems, territorial and resource claims, etc. Most of these conflicts emerge from specific socio-historical and ecological processes that promote notions of "differences" among humans rather than developing common ground to understand each other. Lee's (2008) study mentions that internal conflicts are pursued by ''multiple actors with interdependent interests'' and are driven by ideology and the desire to control resources, ethnicity, religion, greed, power distribution and leadership issues. In such cases, violence becomes the means of demonstrating power to both state and non-state actors by either promoting redistribution of public resources or to maintaining status quo in the society with its authoritative power and domination. Similarly, Berry (1997) highlights that hatred is abound in the world and is seemingly more about ethnic, linguistic and religious differences than it is about clashing national interests. Sometimes, the manifestation of extreme forms of hatred in the form of communal violence even leads to clashes of national interests. One such example is the India-Pakistan partition, which was predicated mainly on a religious segregation of Hindus and Muslims, and the further separation of Bangladesh from Pakistan based on separation of Bangla and Urdu speakers. A study conducted by Sinha (1997) describes that communal violence is perhaps the most frightening form of social conflict. When the members of ethnic or religious groups turn on the members of another, atrocities are inevitable. She further writes that relationship between such violence and mass displacements can be seen in India with the Partition of 1947, when clashes between Muslims and Hindus forced eight million people to move to the new state of Pakistan, while more than six million people made the journey in the opposite direction (Sinha 1997). In this case, apart from underlying socio-political dynamics, religion and language were powerfully mobilized as key criteria upon which to achieve the target of conflicting parties to separate the countries.

Reviewing the literatures shows that every form of physical violence has eventually perpetuated social suffering and interpersonal hostility. Malinowski has mentioned that war is an armed contest between two independent political units, by means of organized military force, in pursuit of tribal or national policy (cited in Powell 1970). Likewise, according to Mack and Snyder (1957) and Ross (1986), conflict is an integral aspect of political life. It involves efforts of two or more mutually opposed parties to obtain scarce resources at each other's expense through destroying, injuring, thwarting, or otherwise controlling other parties. Similarly, Helle elucidates that skeletal trauma and weaponry in various archaeological contexts can be taken as a direct or indirect evidence of the presence of war and violence with everything that implies in terms of cultural meaning, agency, and human suffering (Helle 2003). Similarly, Helle (2003) further argues that power, dominance and coercion almost

inevitably connect to warfare and its principal actors, soldiers and warriors. War is, in other words, a central ingredient in social reproduction and change, but it brutally interferes with human existence everywhere in our late modern world. In most modern wars, the political-economic interests of global players directly and indirectly influence the intensity of the war. Those global players could be economically rich and politically powerful countries and could be giant weapon companies. Bhatt's (2006) study observes that conflict plays such a role in the international politics that countries having the most advanced weapons of mass destruction are considered the most powerful nations (Bhatt 2006). The brutal application of such kind of weapons is a demonstration of military power in order to suppress the powerless and to gain control over resources and stake claim to territories. The Analyzing Disrupted Health Sector (ADHS) manual (2009) writes that part of the problem is that we tend to regard conflicts as a simple breakdown in a particular system, rather than the emergence of another, alternative system of profit and power (Keen 1996; Duffield 1998).Moreover, Berry (1997) points out that war makes history by creating and destroying states, making and unmaking governments, shifting territorial boundaries and validating the ideologies of the winners and discrediting those of the losers. Thus, war is a bad social engineer, where a few winners celebrate at the cost of many losers. In many cases, it is the large section of politically neutral people who have to face adverse consequences of war such as mass displacement. Macklin (2008) writes that people migrate to avoid anticipated conflict, to flee on-going conflict and to escape the consequences of past conflict, which supports the concept by Berry (1997) who has mentioned that war is a loud and ugly thing. In every form of large scale violence, the actual pain and sufferings is always more complex and deeper than statistics can reflect. When opponents do not find common ground to negotiate their incompatible values, then it could be considered a "rational" strategy to continue violence from their perspectives, however, it could be equally "irrational" from the point of view of the large section of the neutral people in the society who have to bear direct and indirect consequences of war and violence.

2.2 War, health and diseases

Research conducted all over the world shows war and violence is directly responsible for an array of physical and mental morbidities and war related mortalities. Singh *et al.* (2007) writes that war is one of the world's most serious threats to public health. The lives of millions around the world are caught in the vicious spiral of violent conflict and poor health. Oskar and Ron's (2007) and Thoms and Ron's (2007) studies show that the civil war in

Congo was the main reason for the sharp increase of acute respiratory infections, diarrheal diseases, maternal and neonatal morbidity, tuberculosis, and vector-borne diseases such as malaria. They have further discussed that overcrowding and inadequate shelter, malnutrition, insufficient vaccination, poor water and sanitation conditions create a favourable situation to get exposure to "new" diseases, for which affected populations have not developed immunity. Similarly, they write, lack of or delay in treatment can increase the disease risk in complex emergencies. This study shows that substandard living conditions, under-performance of the health service system, and social determinants existing since pre-war condition is responsible to face increased vulnerability during complex emergencies. Moreover, Jong *et al.*'s (2007) study in Chechnya found that people suffering from chronic or traumatic stress often report nonspecific complaints such as headaches, stomach problems, general body pain, dizziness or palpitations. In this study, chronic exposure to traumatic events was associated with higher levels of mental health problems and poorer physical health. Witnessing extreme violence was also associated with psychosocial and mental health problems, including depression, generalized anxiety disorder, and post-traumatic stress disorder. Therefore, it appears that in settings of both high intensity warfare or low intensity warfare, the devastating effects of conflict manifest as different kinds of psychosomatic problems among the war affected population. Bhatt's (2006) study done in Jammu and Kashmir shows the adverse impact of conflict that has resulted in limited public health facilities, high prevalence of diseases, low sex ratio, unemployment, and rising crime, collectively leading to high mental stress and other related problems. Though Bhatt's study shows the relationship between high prevalence of diseases and low sex ratio in Jammu and Kashmir, it should be noted that the study limits to establish strong causality between these two variables. As cited in Bhatt (2006), Tool and Waldman (1997) write that populations affected by armed conflict have experienced severe public health consequences mediated by population displacement, food scarcity, and the collapse of basic health services, giving rise to the term complex humanitarian emergencies.

Duffield (1998) writes that given the long duration of many conflicts, displacement may become a chronic, semi-permanent condition for most affected people. Displacement involves the breakdown of family, decreasing social well-being and isolation from permanent social surroundings. Nagai *et al*. (2007) have cited the United Nations High Commissioner for Refugees (UNHCR) report which mentions that over 60,000 people lost their lives, 200,000 fled abroad and nearly 80,000 were displaced within Sri Lanka. After a displacement, these people do not always obtain access to better facilities. In fact in many cases their vulnerability becomes more intensified by the post-displacement. Supporting this

argument, in the medical journal *The Lancet* (2009), an editorial entitled 'Medical emergency in Sri Lanka' reported that conditions in the conflict zone were grim. Civilians were forcibly being prevented from leaving by the LTTE, who were opening fire on those who tried to escape. Many were sheltering in dirty bunkers and under plastic sheeting with little access to sanitation, food, and clean water, and were at increased risk of infectious diseases. In such conditions, lack of minimum facilities and irregular humanitarian assistance becomes the fertile zone for many opportunistic infections. Jong *et al*. (2007) showed that in a 2003 survey carried out by *Médecins Sans Frontières* (MSF), 54% of the families interviewed in tent camps in Ingushetia stated that their tents leaked, they did not have protection from the cold, or had no flooring in conditions where temperatures regularly fall below -20° C in Chechnya.

Together, these studies clearly demonstrate that armed conflict and displacement directly attacks human benefits and people have to live a separated and more vulnerable life that further harms their wellbeing and livelihood. Many displaced populations have to cope for their survival in temporary settlements that are physically unhealthy and mentally disturbing. Moreover, displacement gives new identity in new places and crisis of identity is another common attribute of displaced population. Displaced people are labeled as refugees, victims, war affected population and treated as "others" by original inhabitants. For instance, Bhatt (2006) has cited a morbidity survey which was done in Kashmir migrants camps at Jammu. A survey conducted on three dwellings in migrant camps at *Muthi* phase I and II found 30 cases of asthma, 46 cases of heart ailments, 98 cases of neurotic disorders, 105 cases of diabetes, 80 cases of high blood pressure, and 208 cases of depression (Bhatt 2006). Even after 18 years of being refugees, the local people of Jammu had not accepted the Kashmiri Pundits. There had been a sense of othering towards the Kashmiri Pundits by the local people of Jammu. Moreover, Bhatt (2006) summarizes that mental tensions induced by stressful circumstances such as lack of access to education, changed lifestyle, loss of employment, loss of property, loss of standard of living and loss of many lives have led to mental and physical morbidities. Similarly, Bury (2005) has cited the study done in the USA by the authors Faris and Dunham (1965, 1939) and Hollingshead and Reddich (1958) which attempted to show that mental disorders were not random events, dependent solely on an individual's biological characteristics, but were patterned by social circumstances and social class as well.

In comparison to males, women and children have to face multiple kinds of disadvantages during war. In societies where patriarchal values dominate, the conjunction of

war-induced conditions and the restrictive values of patriarchy limit the mobility of women. Macklin (2008) points out that in conflict situations, women are less mobile than men because of their responsibilities for children, elderly or disabled kin, and obstacles to travel without male accompaniment. Describing the negative consequences of war, Petchesky (2008) observes that although armed conflict today kills more men and boys than women and girls, when it comes to many other costs of war, women and girls suffer particular and often very great burdens. For instance, Macklin (2008) states that abduction and rape by militia is recognized as chronic and widespread, especially when women leave the camp to collect firewood or water. As Wayte *et al.* (2008) highlights, complex emergencies intensify reproductive health risks. They decrease access to health facilities and emergency obstetric care, and often exacerbate the risk of sexually transmitted infections. Similarly, Mullany *et al.* (2008) also reports that in conflict settings, women are disproportionately affected and have poorer pregnancy outcomes than women living in stable areas. Since war and displacement interrupt the regularity of society, they disturb both health seeking behaviour and also the function of service providers. Hoffer (1943) writes that the effect of war on established families is also far-reaching. In many instances, it produces family separation, as husbands and sons are called to military service while wives and mothers remain at home. Typically, the harassments and exploitation women face due to war related conditions are not legally compensated. An editorial in *Reproductive Health Matters* (2008) writes on the situation of Sierra Leone that during 11 years of civil war, more than 50% of the country's women suffered sexual violence, yet only 11 suspects were indicted. Thousands of women will never see their rapists brought to justice, but they look to the Special Court for hope of ending the impunity. Moreover, epidemiological studies can also generate important evidence for policy decisions, as witnessed in the case of the Democratic Republic of Congo (DRC), where surveys by the International Rescue Committee (IRC) have called attention to the country's on-going humanitarian crisis by discovering vast numbers of indirect, war-related deaths (Oskar and Rons 2007).

2.3 War and health service system

War and violence have profound effects on health service systems and their delivery mechanisms all over the world. As Rita *et al* (2009) mentions, conflict is a hazard to health, not only because it causes injury, death and disability, but also because it increases physical displacement, discrimination and marginalization, and prevents access to health services. The constant exposure to life-threatening situations in a conflict setting is an additional, specific

social determinant of health, which can lead to diseases (Giacamen *et al* 2009). Similarly, a study done by Wayte *et al* (2008) also describes, in East Timor, there was a 50% reduction in the number of births at the National Hospital during the crisis, which probably reflects a combination of the reluctance of women in Deli to attend the hospital due to security fears, the reduced number of pregnant women in Deli and the refusal by some women to be referred to the National Hospital. In same study Wayte *et al.* reported that in East Timor, the 2006 crisis resulted in another cycle of forced migration, for health workers and managers as well as for the general population. There was a breakdown of social structures as real or perceived tensions between the *Loromonu* (Westerners) and the *Lorosae* (Easterners) took hold. Access to health services was reduced across the country due to lack of mobility and security fears. Furthermore, Abbas's (2008) study shows that the health system in Iraq underwent progressive decline after the embargo that followed the second Gulf War in 1991. The war in 2003 exacerbated this by causing further damage to the basic infrastructure such as electricity, resulting in increased concerns around security and making medically necessary drug distribution unsafe. Henttonen's (2008) report based in Uganda mentions that the conflict has greatly disrupted the multiple health systems in the Gulu district, which are provided by a network of the public sector, private sector and non-governmental organizations, as well as informal practitioners and traditional healers.

War's multi-dimensional effects in the society creates adverse impacts to both formal and informal health service systems all over the world. A study done by Ford (2007) points out armed conflict has hampered the international polio eradication campaign, particularly in Somalia and Afghanistan, areas of persistent polio infection and high insecurity. Moreover, Simunovic's (2007) study shows the impact of war on the health service system in Bosnia and Herzegovina. Before war took hold in the region, the standards and skills of the clinicians were mostly satisfactory. Routine diagnostic and treatment procedures were performed in accordance with the standards applied in more developed countries. Simunovic points out that although there were not many internationally renowned physicians, a few received at least part of their training in the best medical centres in the world. The main health indicators, such as newborn mortality rate of 14.5/1,000 live births, were comparable to those in Western European countries. Additionally, during the Communist ruling, the health care system in the former Yugoslavia was centralized. Primary health care was provided by general practitioners at municipal health centres. Similarly, secondary health care was provided at both municipal health centres and regional hospitals, while tertiary level health care was provided at teaching hospitals linked to universities. However, during the

1992–1995 war, all sectors of the region's healthcare system were negatively impacted. According to Simunovic, no preparations were made such as stockpiling of medications or developing a reorganization plan to brace the country for wartime conditions. As a result, the hospitals in Sarajevo ran out of basic surgical materials (dressings, bandages, sutures, cleaning solutions, and similar) within the first three months of the siege. Essential medications, oxygen, and anesthetic gases were at a premium, and the power and water supply were cut off after several months. In contrast to the situation of Bosnia and Herzegovina, Nagai *et al.*'s (2007) study shows that in spite of a long-term conflict in Sri Lanka, a longitudinal analysis of the country's health service systems over 20 years reveals the steady improvement of basic health indicators at the national level and specifically for underprivileged areas in Sri Lanka. The authors argue that well-designed social service systems which had been established before the conflict, and the continuous provision of social services during the conflict, made this steady improvement possible. Nagai and colleagues note that in comparison to the Sinhalese-dominated area, the Northern Province dominated by LTTE had shown worse health indicators, such as high maternal mortality, significant shortage of human resources for health (HRH), and inadequate water and sanitation systems, insufficient health awareness programs for inhabitants, and mental health problems. The frequent incidents of attacks against health workers and continuous life-threatening conditions discouraged many health workers from remaining the area, such that many HRH were displaced internally. It further enforced the rise of medical migration to other countries, and many people had to survive without basic health facilities.

During war, it is not only the ordinary civilians who faced an enormous level of pain and suffering, in many cases health workers were also tortured, abducted and killed by both fighting parties. The act of placing landmines to discourage the mobility of enemies eventually discouraged the mobility of ordinary civilians, including health workers, in conflict zones. Duffield (1998) mentions that landmines put a heavy burden on health services, which had to provide expensive surgical and prosthetic care to the victims. Similarly, in many places all over the world, health workers have been abducted, killed and harassed by the establishments in accusation for developing solidarity with fighting opponents. In the case of India, Roy (2009) writes, Dr. Binayek Sen had been in prison for 22 months, arrested under one of India's most "draconian laws", the Chhattisgarh Special Public Security Act. The act had such vague and diffused definitions of 'Unlawful Activity' that every person could be found guilty unless he or she could definitively prove their innocence. In this case, Dr.Sen was accused for providing treatment for "rebellion" forces in

Chhattisgarh. The Indian government had claimed that Dr. Sen was developing solidarity with the fighting opponents and was arrested.

War hampers health service delivery and also affects the mobility of health workers and service users. Simunovic's (2007) study from Bosnia and Herzegovina demonstrates the shortage of human resources because of war and its effect on health care delivery services. The author reports that when the war began, the health professionals were divided into two groups: those who stayed and those who left. The estimates are that the number of people employed in the healthcare sector dropped from around 19,300 in 1991 to 11,857 in 1996. By the end of the war in the south-west part of the country, the number of local physicians and nurses had decreased to 1,200 and 3,752, respectively. None of them were either prepared or trained to work under war conditions. Therefore, war related conditions create unintended damages in many layers of the society that paralyze function of health service systems and human resource for health. In war, when military forces besiege a town, in addition to sacking buildings and destroying infrastructure they often persecute and kill health care workers, teachers, administrators, and other service people (Nordstrom 1998). Jong *et al*. (2007) reports that in Chechnya, years of conflict have resulted in severe destruction of the health infrastructure. Many doctors left the country, while those who remained in Chechnya often feared for their personal safety. Lack of experienced medical personnel, especially in remote rural districts, is one of the biggest problems facing Chechnya's health system.

Thus, in Sri Lanka, Chechnya, and Bosnia Herzegovina, high intensity conflict has created barriers to health workers performing their duties. These barriers resulted in the out-migration of health workers, long-term absenteeism and high level of medical migration. The ICRC (International Community of Red Cross) is especially prominent in armed conflict because its mandate is guided by international humanitarian laws, which specifically focuses on the laws of war in relation to civilians and combatants (Macklin 2008). However, as Berry (1997) has highlighted, in Burundi three ICRC delegates were fired upon and killed in their vehicle on June 4, 1996, after delivering water, medicines and supplies to an isolated area that was destructively hit by ethnic fighting. In this incident, fighting parties have seriously violated the fundamental principles and the code of conduct of the ICRC that follows standards of political neutrality and impartiality in its involvement in both international and internal war missions.

2.4 War and post conflict reconstruction

Studying the post conflict condition of war-affected population is one of the major dimensions of conflict and health studies. The study done by Thoms and Ron (2007) discussed the study done by Physicians for health rights (PHR) in Chiapas, Mexico, after the armed rebellion. Based on the survey of 2,997 households in 46 communities, they discovered that health conditions had in fact deteriorated alarmingly, including some communities that were systematically denied healthcare for political reasons. According to the authors, the PHR study shows that while the Chiapas' war had ended, health conditions were in fact getting worse, not better. In other cases, however, strong political will had been used to deliver health as a fundamental human right, resulting in an extraordinary improvement of the health service systems in post-conflict contexts. Nagai *et al.*'s (2007) study from Sri Lanka shows the political commitment and substantial attention to the reconstruction of a destroyed health service system during the conflict period. The government had created several initiatives to remedy the HRH shortage such as prioritized the development of the rural health infrastructure, recruiting candidates from rural areas and also reforming medical education to include compulsory public services, financial incentives. Equal opportunities of rural physicians for post-graduate training and career advancement and further recognition and improvement of the social status of rural physicians. Such government programs have encouraged many health workers to upgrade their education and also accept rural posting as a dignified and dynamic career path. While work remains to be done, especially in the Northern Province with its prolonged conflict, in most of Sri Lanka HRH development and allocation had been one of the most crucial strategies for effective reconstruction. In contrast, in the case of Bosnia and Herzegovina, the study by Simunovic (2007 : 3) describes how after the war, various international health organizations, governmental health agencies, and countless non-governmental organizations entered the scene. Both western and eastern oil-rich countries were earnestly declaring their intention to pour dollars into the devastated health care system and build a new one, better than any other in the world. Everybody was determined to implement nothing less than "the world's best practice" according to "European standards." Yet, the author writes, these heroes in white transformed themselves remarkably quickly into an interest group offering minimal service for maximal gain under the new market rules, while showing little compassion for the impoverished population. A large number of private practices, some legal but most illegal, opened, charging the same fees to the haves and the have-nots. Attending the first group representing only 5 per cent of the population. Even professional solidarity among colleagues

disappeared. The authors attribute this failure to the lack of strong government and low level of commitment to deliver health facilities to its citizens. As such, the health care system in Bosnia and Herzegovina felt the dire consequences of the turbulent transition and war, from which it has still not recovered. Simunovic further reports that with the arrival of democracy, this health care system remained more or less the same. The only thing that changed was the criteria for selecting people occupying key positions within the Ministry of Health and health care system: ethnic and ideological affiliations were suddenly more important credentials than professional competence, knowledge, and experience. In the post-conflict situation, the issues of reconstruction and repatriation is one of the most important and challenging aspects. As Gleditsch *et al.* (2002) write, even if there is an agreement, occasional violence may continue for some time. Likewise, Jong *et al*. (2007) reports, that 'repatriation' was pushed forward despite the fact that people did not want to return to Chechnya due to the continuation of the conflict and insecurity, and the lack of proper shelter and adequate health services there. As the ADHS Manual (2009) writes, stability can be promoted through growth and sustainable development while political violence can be eradicated with co-operative integration and education.

2.5 Conflict and health in Nepal

Substantial literatures from all over the world have explored the role of conflict and its multidimensional effects on human health. However, very little literature has focused on the relationship between civil war and health service systems in Nepal. As noted by Ghimire (2008), the Nepalese state is clearly not fulfilling its responsibilities to ensure citizens the right to health and the satisfaction of other basic human needs. Ghimire (2008) further writes, Nepal has one of the weakest health service systems in the world. The country is evading responsibilities to ensure the rights to health and other welfare facilities for its citizens. Thus, right to health in Nepal has become a highly commoditized agenda rather than a matter of welfare offered by the government. In a comparative analysis of four countries from South Asia, Baru (2003) argues that though countries like India, Sri Lanka, Pakistan and Bangladesh have vowed to provide welfare services for health, all, except Sri Lanka failed to make the required investment in the welfare sector. She had argued that by participating in structural adjustment policies and privatization as its by-product, the state allowed multinational companies to influence the national policies in key areas like defining priorities for diseases control programs, provisioning of healthcare and medical research through multilateral agencies like the World Health Organization, World Trade Organization and

World Bank. In this context interests of the "outsiders" became dominant in shaping the country-specific health policy which curtails the rights of the people to access welfare facilities. Also, a policy paper published by Jones (2010) writes,

> *The period since the second Popular Movement that ended direct royal rule in April 2006 and has led to the establishment of a federal republic has seen the dominance of the left in Nepali politics and the implementation of a program for the health sector based on the enshrining of rights to free health care in the Constitution, further increases in public spending on health and the progressive reduction and elimination of user fees for essential health service.*

As Jones (2010-13) observes, in the broader context of Nepal, according to this report the effective and responsive delivery of health services requires effective systems for procurement, human resources management, budgeting and the timely release and flow of funds, management and provision of drugs and equipment, reporting and accountability relationships. All of these are affected by the interests and incentives facing key stakeholders, particularly those working within the public health system. In this context, Jones (2010) further writes, the lack of a political consensus on the long-term financing strategy for health services to update or replace the clear vision that was articulated in the Second Long Term Health Plan in 1997. The second is the development of an adequate policy and legal basis to govern the relationship between the public and the private sectors in health service delivery and financing". The low funding for health related public expenditure and lack of critical input to develop effective health policies suggest that political commitment to gear up the existing condition of health related investment has not been discharged appropriately. Collins (2006) also highlights the poor condition of human health among the Nepalese citizens. He writes, "Nepal is the 12th poorest country in the world. Its notoriously unstable politics and mountainous terrain hinder development…health indicators vary widely in Nepal, often mirroring the distribution of power and resources. Life expectancy is 74 years in Kathmandu, but only 37 years in the mountainous district of Mugu in the mid-western region. And empowerment varies with caste, ethnicity, and gender (Collins 2006:907)." Likewise, a report published from WB (2005:1) writes, "Nepal has made significant improvements in the health outcomes over the past 15 years, but the direct and indirect impact of the conflict on the health system delivery is a cause for concern." The decade-long civil war in Nepal has affected its health service system, hampered the delivery of health services, and involved attacks and killings of health workers justified by their supposed allegiance to armed insurgent groups. Singh (2005) shows that war in Nepal had led to widespread destruction of limited infrastructure and had adversely impacted access to health-care services and

personnel, affecting family planning, maternal and child health programs, and immunization services throughout the country. WHO (2009 :599) writes, “Resources are often allocated on a geographical basis, reflecting both logistic issues such as distance, topography and transport as well as the tendency for political power to be concentrated in urban areas or particular regions.” Like Singh *et al.* (2007) shows that fighting, kidnappings, blockades and curfews have crippled medical services and cut off supplies of drugs and other essentials. Attacks had damaged many health facilities, and staff were often reluctant or unable to travel in rural areas. Many women were reported to have died during childbirth because they could not reach emergency obstetric care.

Ghimire and Pun (2006) also highlight the disturbances in the Health Service System (HSS) during war. According to these authors, 40 health posts were completely destroyed between January 2002 and December 2004, and tens of others were rendered unusable. Some of these health posts were attached to the offices of the village development committee, which were the Maoists’ favourite targets. Maoists also destroyed the electrical supply to Okhaldhunga hospital, a small hospital in eastern Nepal, because an army camp nearby was using electricity from the same source. Similarly, IDMC (2008) reports, in Taplejung, the CPN/M routinely confiscated 40% of the government medical supplies administered through the health posts in order to use for their injured combatants during war. In Panchthar, approximately 25% of the supplies were taken. One sub-health post in Taplejung was burnt down with the VDC building six years ago and still has not subsequently been re-constructed. DFID *et al* (2003) writes, "Despite the health system's appearance of being well organized from a theoretical management perspective, its day to day management is easily disrupted due to extended supply lines, unreliable communication, isolated outposts, absenteeism of health workers and general lack of accountability.” As well as, Thapa and Sijapati (2003) write in the Ministry of Finance's Economic Survey of 2001/ 02 reported that not a single hospital, health post, or health centre was added during the review period. The number of primary health centres only rose by 20 while the number of sub health posts actually went down from 3171 to 3161. Since sub health posts are a primary point of contact to many people in Nepal, this has directly impacted the people's expectations to avail health services in their vicinity. Most of the literature reveals the fact that armed conflict has played a negative role against the health delivery system in Nepal. However, prior to the conflict also, the health service system was ill funded and not properly built. As a supplement to this argument, Potter (2007:41) writes, "though the conflict severely worsened the government health care system, it is important to note that it was not a well-functioning system prior to

the conflict either. It will likely suffer most of the same inadequacies in the future that it did ten years ago". As predicted by Potter, apart from launching few programs, the overall health service system had seen no significant changes in Nepal's post-conflict period. Martinez (2003) writes, health education programs conducted by the district public health offices and other private organizations are on the decline due to Maoist and government threats. Health-care workers fear a rise in communicable diseases and several organizations, including *Médecins Sans Frontières* (MSF), have had to scale back their activities in rural Nepal as a result of the insurgency. Similarly, Potter (2007) writes that one of the chief causes of project delays was the Maoist-announced *bandhas* (transportation closures/strikes), where roads and highways could be shut down at any time, sometimes for hours, sometimes weeks. Those who refused to adhere to the closures risked facing consequences ranging from verbal warnings to explosive devices on highways. As a result, many staff could not travel to and from field sites, supplies were not always delivered on time and project-related trainings were occasionally postponed. This created nasty situations, where someone suffering from even a minor disease had to go to the capital city for treatment (IDMC 2008). The increasing cases of curfew and strikes had an adverse impact on the health of the people who were dying for missing timely treatment.

Murshed (2002) writes that conflict in low-income countries makes the objective of poverty reduction all the more difficult, since not only the growth is retarded, public money is taken for military spending from basic social services, and the poor are themselves disproportionately the victims of conflict. Similar to this argument, Ghimire and Pun's (2006) study shows that during the fiscal year 2005/06, of the total Nepalese Rs 7·68 (approximately 9.8 % of total budget) billion allocated for health, only 2·64 billion (34·5%) had been spent. The authors claim that the remainder was taken away for security purposes. In Nepal, civil societies have severely criticized the misallocation of funds to buy weapons and other security related materials that was originally allocated for health. WB (2005) further reported that special campaigns such as national immunization days for polio and Measles immunization, biannual Vitamin A supplementation and deworming programs, as well as family planning sterilization camps were not much effective because these programs were supported by FCHVs who have strong ties with the community. Moreover, Martinez's (2003) study shows, the presence of multiple military checkpoints (which significantly increases traveling time), strict curfews, destroyed bridges and roadblocks are only some of the problems people face when traveling to a health facility seeking medical care. Others were related to fear of traveling because of the risk of being shot at either by the Maoists or

by the security forces, and the presence of some "sealed" areas where the Maoists do not allow people to travel to the district headquarters, or medical supplies to get in.

2.6 Human resource for health during war

Martinez (2003) writes in her study that the regular harassment of health workers by both the Maoists and the Security Force in Nepal and the disruption to the delivery of essential medical supplies indicate that both parties, the state security force and fighting opponents should follow human rights and humanitarian principles. Likewise, the International Red Cross had also criticized the government for not delivering prompt medical treatment to those severely injured in the fighting. Stevenson (2002) explains that a committee was formed to provide necessary treatment at the earliest possible opportunity to anybody who approaches a health centre after being injured, and that the patient must be treated immediately without inquiring where and how he or she was wounded or fell sick. However, it was not easy for health workers to do their jobs during the insurgency. WB (2005) writes that the insurgency had affected health services due to a large number of undesirable factors noted in the field, such as: intimidation, harassment, extortion and threats. Most of the health workers reported that they were compelled to pay levy and donations to the insurgents. Health workers reported that they were also facing problems by security forces, which would pressure the health workers not to treat the insurgents. Ghimire and Pun (2005) elucidate that the government issued a directive to all health workers not to treat Maoists without notification of security personnel. In cases of defiance, doctors were to be regarded as supporters of terrorism and punished accordingly. It was impossible to work under such conditions when Maoists demanded treatment for their wounded. Moreover, a directive from Nepal's Ministry of Health was issued, that instructed all doctors to immediately provide information to security officials about individuals seeking treatment for wounds linked to the conflict, mainly bullet wounds and injuries caused by explosions. Doctors who disobeyed this directive were considered supporters of terrorists according to the 2001 Terrorist and Disruptive Ordinance act and liable to arrest and imprisonment. This act was severely criticized by civil society, media and international agencies. The problems for medical professionals had been almost impossible to manage as the numbers of injured multiplied, and doctors, improperly trained in the treatment of severe trauma injuries, were faced increasingly with patients presenting shrapnel and bullet wounds (Stevenson 2002). Likewise, IDMC (2008) writes, one health worker shared the experience of being severely threatened and verbally abused by the security forces. In addition, all health workers reported

that they were pressed to pay a one-day salary per month in tax to the CPN (Maoist). Under such pressure, health workers were severely frustrated. Similarly, Stevenson's (2002) study shows, that during the civil war, because of crossfire between two government militaries and Maoist militants it was very dangerous for village medical professionals to administer medical care to the wounded because both sides were abusing medical facilities and staff. The government was giving close attention to prevent insurgents from benefiting from government resources. Moreover, in the villages also, the situation was not secure for health professionals. Stevenson (2002) writes that during the civil war Maoist insurgents arrested by the Nepalese army were severely beaten up and they used to force doctors to write the report explaining death in crossfire though the person had died because of severe torture in army custody. Similarly, DFID (2004) writes, there had been cases of health staff that had treated Maoists being picked up by the security forces. All these government workers were the target for Maoist extortion, and the whole was staff being taxed up to 30 per cent of their salaries. Similarly, IDMC (2008) reported that rural health workers had experienced a similar situation in their inevitable interaction with the CPN/M and the security forces. The mission met with several health workers. Many were reportedly under pressure from the CPN/M to provide 25% of the government allotted medicines to the insurgents, as well as 7% of their salaries. They also reported being forced to provide 'intelligence' reports on CPN/M activities to the security forces when traveling to the district headquarters. In the same period**,** AI (2004) reports, CPN (Maoist) retaliated against the alleged extra-judicial executions on the 1st of September 2003 in Ramechap by killing the village's senior rural health worker Reli Maya Moktan (wife of Chandika Lal Moktan) and Bhim Bahadur Shrestha, a member of the Nepali Congress Party. The two victims were charged with having passed on information to the army about Maoist movements in the area, thus precipitating the army attack of 17 August. DFID (2004) also reports that Maoists demanded treatment and drugs from health posts, plus 5 per cent of health workers' salaries. Those who remained in posts were liable to be suspected as Maoists sympathizers by the security forces and risked to be arrested and detained. Same reports highlight that there were examples where Maoist pressure had decreased corruption, improving drug supplies to the periphery and pressuring health committees to ensure that staff were available at the facilities. Likewise, Potter (2006) reports, Maoist demands for money, materials and services were found to cause stress and anxiety amongst health workers. These emotions were amplified by government security personnel who often accused community health workers of supporting "insurgents" by providing them with medical care or use of health facilities. The consequences for assumed

conspiracy ranged from verbal or physical harassment to imprisonment or torture. In some Maoist-controlled areas, health post staff were threatened with reprisals if they did not stay at their posts. In other areas, staffs have fled their posts since the beginning of the conflict, both for fear of their lives and because of heavy "taxation" of government employees by the Maoists (Martinez, 2003).

Though WB (2005) has fairly appreciated the performances of immunization and vitamin distribution programs, in contrast Martinez's (2003) study documents that several components of the EPI program were dysfunctional throughout the country due to the conflict in a direct or indirect way, including the chronic lack of maintenance of equipment. Blood banks and blood testing facilities were almost non-existent in many districts, and the health workers had migrated to safer places fearing attacks by the Maoists. Moreover, IDMC (2008) further writes, Maoists forced the health workers to work for them and threatened them with torture, abduct or physically harm if they did not do what they said. The supply of medicines, which used to be distributed free by the government, had stopped. The few existing private drug stores transported whatever medicines they could and sold them to the people. During the active conflict period, the government followed rigorous security checks to control the "mis-utilization" of the medicines and other items. In one of the reports it was mentioned that the increased access to the Nepal Society for Medical Practitioners (NSMP) depended on a functioning health system for referral, but the health system in rural areas was increasingly under stress. As a result, the expected growth in utilization had not been realized. There was a decrease in patient flows at night and when there was a *bandh*. Health workers were intimidated by both sides in the conflict and in practice they were offered no formal protection (DFID 2004).

To summarize, in the time of conflict, the directive stated that all health professionals were to deny treatment to suspected Maoists. Health professionals who did not report alleged "terrorists" were at risk of imprisonment. The lack of confidentiality and arbitrary detention by security forces of people seeking health care led to a reduction of help seeking at medical facilities. As Singh (2006) writes, the government's directive that health professionals who provided treatment for injuries without appropriate notification could be prosecuted as supporters of terrorism had created a difficult scenario for health workers, risking incarceration. Moreover, Thapa and Sijapati (2003) further highlight that the government had prepared its Integrated Internal Security and Development Plan (ISDP) for the districts most affected by the Maoist insurgency. It was to be implemented with security provided by the army. As Hutt (2004) writes, that is probably the reason why the army is attempting to win the public's trust by establishing health camps in villages.

2.7 War, torture and mental morbidities

Torture is one of the means of perpetuating violence. As Sinha (1997) writes, that violence is a widespread phenomenon with great hazards to the health and wellbeing of those concerned. The study done by Jordans *et al.* (2007) states that torture in Nepal consists of severe beating while in police custody or by the army, together with death threats, humiliation, isolation from family members and deprivation of basic needs. Specific methods included prolonged beating on the soles of the foot, severe pressure on limbs with bamboo sticks, suspension, fingernail extraction, exposure to painful substances (stinging nettles, chili peppers) in orifices/open wounds, torture with electronic wires, and sexual violence. AI (2004) further reports that the Maoist rebellion also threatened child development through a number of pathways. Children were impacted through forced separation when caregivers were killed or abducted. Children were forced to watch the humiliation of adults by Maoist insurgents, often consisting of violent harassment of teachers and caregivers. Moreover, IDMC (2008) writes, children who remained with their families were not that better off. Their access to education and health services had been severely affected as there were hardly any healthcare service providers and teachers in the remote and conflict affected areas. Children had also suffered from the social and economic disruption caused by the conflict, including the psychological impact of seeing family and community members killed or tortured, destruction of family units, illness due to malnutrition and lack of health services, cessation of their education, and in some documented cases among girls, sexual abuse from either Maoists or security forces. Those children who had encountered direct violence were more affected by harassment and torture, and this trauma could further affect the personal development and mental cognition of many children. Similarly, Amnesty International continues to receive reports of torture, including rape, of those in army and police custody. A large number of those people released from detention in army barracks, between August and April 2004, reported being subjected to beatings, denial of food, and having water poured over their faces, making it difficult for them to breathe (AI 2004). Stevenson (2002) reports that many Nepalese lived in fear of random imprisonment, extra-judicial executions, torture, and severe injury or death if caught in a crossfire between government forces and Maoist rebels.

In short, the situation in Nepal has involved the gross violation of human rights in absolute disregard to international humanitarian principles. Although DFID *et al.* (2003) writes that the rights of individuals are protected by the incorporation of the international fundamental human rights provisions into the constitution of Nepal, many human rights violations have

been perpetuated and no war criminals have been identified or prosecuted. Additionally, equally poor is the record of Nepal's Armed Police Force and the Royal Nepalese Army (RNA), with evidence of their participation in arbitrary arrests, detentions, disappearances, tortures and summary executions (IRIN 2005). A UNICEF study found that 30 percent of children and youth interviewed in prisons reported psychological problems related to torture, including sleeping disorders, nightmares, anxiety, palpitations, and uncertainty about their lives (HRW 2007). Arrested children and youths were subjected to torture and harassments, and the deplorable conditions of living in custody had worsened the situation for many political prisoners. HRW (2007) also reported that hundreds of children suffered as a result of the landmines and unexploded devices left behind by the warring sides. These explosions can inflict both physical and mental damages which may create long-term psychosocial problems among children and adults. According to UNICEF, Nepali children suffered the second highest rate of injuries caused by explosives in the world. The probability of touching and playing with unknown substances is always higher among children who risk their life, because many of them cannot identify such substances as risky devices which may explode and create harm. Singh *et al.*'s (2007) study shows that the conflict had a particularly harsh impact on the lives of adolescent boys and girls. Gunmen frequently invaded schools or ordered them closed. Teachers were kidnapped and intimidated. Students traveling to and from schools were routinely captured and forced to transport supplies for the rebels. Fear led many to drop out and flee to safer areas. Moreover, Singh *et al.*'s (2007) study explains, the conflict has had an impact on the physical and mental health of the displaced. According to them, a recent cross-sectional survey among 290 internally displaced people in Nepal found high rates of post-traumatic stress disorder (53.4 per cent), anxiety (80.7 per cent) and depression (80.3 per cent). These kind of mental morbidities are higher in most conflict affected districts of mid-western and far western regions. In this case, Singh (2006) writes, regarding the perceived increase in psychological distress, doctors at a rural hospital reported increased presentations of psychological complaints during the conflict period despite the overall decrease in hospital presentations for fear of referral to security forces. Since government health systems lack specialized mental health services in most of the rural regions, the true picture of mental morbidities due to war is obscured. Moreover, Kohrt (2010) has presented paper at the conference of 2010 American Anthropological Association which shows the impact of the war upon mental health based on interdisciplinary analysis from the perspectives of medical anthropology, epidemiology, endocrinology, and gene-by-environment interactions in a sample of 800 adults in post-conflict rural Nepal. He has argued

that, while research on local frameworks for experiencing psychological trauma has been increasing, epidemiological and biological research continues to be dominated by Western psychiatric models. There is a gap in bridging local phenomenological research with assessments of prevalence, risk factors, and putative biological pathways underlying posttraumatic stress disorder (PTSD). Local ethno-psychological models of psychological trauma are more heterogeneous than DSM-IV PTSD criteria. Chart further argued that trauma survivors reported acute daily stressors, anger and aggression, and chronic frustrations in addition to specific traumatic events. Kohrt (2010) highlighted the importance of acknowledging local ethno-psychological models and their heterogeneity, but acknowledged that local models should be equally questioned because in many cases the trial and error methods followed by local practitioners can risk the lives of many patients and intensify chronicity. In addition, the research that has been conducted in Rukum Rolpa, Salyan and Jajarkot by Jordans *et al.* (2007) has shown that help-seeking non-refugee torture survivors in mid-western Nepal showed high prevalence of psychiatric symptomatology. This study points to the clinical relevance of PTSD and anxiety symptoms for Nepali torture survivors, these complaints were strongly related to disability. Since districts of mid-western hill regions were those most affected during the civil war, the presence of unreported mental morbidities could be significantly higher than reported cases. However, in terms of coping strategies, Jong *et al.* (2007) further write, although nearly all people confronted with war will suffer various negative responses such as nightmares, fears, startle reactions and despair, not everybody will develop mental disorders.

2.8 War, food insecurity and displacement

War, food insecurity and large scale displacement are an interdependent phenomena. The IDMC (2008) report shows that life had been very difficult in the mid-western and the far-western regions of Nepal because of the violence. It writes, many people had to cope with food scarcity during normal times and during the conflict period, such scarcity had reached extreme heights. The hilly areas suffered from food scarcity for almost half a year and with the security forces and the Maoists imposing bans and the latter's looting, food scarcity in the areas only worsened. The villages had also suffered from scarcity of medicines. The government reduced the supply of medicines to the districts fearing looting by the Maoists. IDMC (2008) writes, mid-western Region and the Far-western region had been particularly affected by the violence and the food/medicine scarcity. Singh (2006) writes, Children faced food insecurities due to frequent blockades and cutbacks in local food production caused by

the exodus of merchants from rural areas, lack of access to markets, and the displacement of able members of some households. The situation of malnutrition was particularly serious in many parts of the mid-western region, which were badly affected by the conflict, with the Humla district having the highest rate of malnourishment in the country (cited in Martinez 2003). IRIN (2005) notes that Nepal's cities had also experienced food and medicine shortages. A record number of children suffered from malnutrition. A UNICEF report stated that about 48 percent of children under the age of five were underweight. Moreover, ACR (2006) writes, the highest numbers of malnourished children were found in the *Rajhena* internally displaced persons (IDPs) camp (73%) near the southern border city of Nepalgunj. At least 55 percent were suffering from common illnesses like diarrhoea, fever, acute respiratory infections and skin ailments, the report adds that malnutrition rates and prevalence of common illnesses were very high (affecting 82%) in small children, especially in *Rajhena*. IDMC (2008) writes that a combination of drought with government restrictions on supply of food and medicines to areas controlled by the Maoists on the one hand and restrictions imposed by the Maoists on the transport of food to district headquarters on the other, has led to increasing concern among development and aid organizations. It is therefore not only the CPN (Maoist), but also the state security forces that contribute to the creation of insecure condition for many people. IDMC (2008) explains that reports of abductions, extortion and recruitment by the CPN-Maoists had increased. Attempts to interfere in the humanitarian development programs continued. Due to security concerns, for the time being most persons displaced by the conflict had been reluctant to return. Collins (2006) writes, a ceasefire had now been declared and a source close to the Maoists assured that they guaranteed the safety of health workers and of internally displaced people who wished to return home. However, displaced people were still reluctant to return home and many commitments of the peace accord remained unfulfilled (Martinez 2003).

In many places, conflict had fuelled the existing trend of food insecurity in Nepal. The decade-long civil war in Nepal forced many people to leave their homelands and seek shelter either in city areas in India or in European countries as asylum seekers. Singh *et al.* (2007) mentioned that there was a lack of systematic and accurate information available for the internally displaced in Nepal. The authors further write that Nepal had witnessed a humanitarian crisis since the Maoist conflict began ten years ago, but the plight of internally displaced persons (IDPs) in Nepal had received little international attention despite being rated one of the worst displacement scenarios in the world. An estimated 200,000 people have been displaced as a result of the conflict, with the far-western districts of Nepal being

the worst affected. Internal displacement had stretched the carrying capacity of several cities with adverse physical and mental health consequences for the displaced. Vulnerable women and children had been the worst affected. The displaced women and children lack access to medical personnel and basic health services such as immunization. In a society where most women already suffer from discrimination, in particular those who lost their husbands were highly vulnerable to further impoverishment and as a consequence they were often exposed to significant safety and health risks (IDMC 2008). Though numerous studies have been done to highlight the physical and mental morbidities induced from war related displacement, the large scale documentation in order to provide accurate information about displaced population is always challenging in the context where most of the displacement goes unreported. IRIN (2005) highlights that assessments of Internally Displaced People (IDPs) in Kathmandu and Nepalgunj indicate especially poor nutritional status and vulnerability. Women are thought particularly vulnerable, with local Non-Governmental Organizations (NGOs) reporting a rise in sex work and trafficking as displaced women struggle to make a living. Beine (2006) in his paper presented for Society for Medical Anthropology conference held in Canada, claimed that although there is probably no way to quantify the exact impact that the conflict has had upon the spread of HIV/AIDS in Nepal, there are some interesting secondary indicators. Beine argues that as a repercussion of war, child migration from certain districts had increased as had the number of commercial sex workers due to conflict. This would suggest that (by a rough measure) the conflict may have promoted the spread of HIV/AIDS (Beine 2006). Though there are numbers of speculative studies which shows that after displacement due to war, women from marginalized groups joined to do commercial sex work in order to maintain their bare survival, no studies in the context of Nepal were found that show strong correlations between war, displacement, and rising trends of sex work among displaced population. There is some research which claims that conflict-induced migration might also be fuelling a localized HIV epidemic in Nepal (cited in Singh *et al*. 2007). IDMC (2008) explains that by 2004, NGOs working with displaced women were warning that the combination of conflict, displacement and prostitution had contributed to the spread of HIV/AIDS in Nepal. Most of the above studies have shown speculative data regarding displacement and rise of HIV infected rate. Since before the conflict, most of the mid-western and far western regions also had labour migrants, working in Indian cities like Delhi and Bombay, coming back home with an infected status is a continuous scenario in pre- and post-war conditions for such individuals. It therefore becomes difficult to determine the actual percentage of HIV infections among migrant labourers that can be attributed to the

growing intensity of war specifically. IRIN (2005) writes that UNAIDS has reported that at least 10 percent of 2-3 million Nepali migrant workers in India are estimated to be HIV-positive, and many infect their spouses when they return home. This has been seen most notably in Maoist-controlled districts such as Achham, Kailali and Doti, where around 6-10 percent of migrant labourers were reported to be HIV-positive. Most of the studies on migrant populations and their relation to communicable diseases like HIV include simplistic assumptions that all migrant populations have absolutely no awareness regarding HIV and other STIs, overlooking cultural values and personal choices which actually steer people away from HIV risk behaviours. Similarly, Singh *et al.* (2007) mentioned, ordinary civilians constitute a large proportion of those displaced, the displaced include the affluent landowners, government officials and teachers who were threatened by the Maoists as well as the poorer civilians who have fled violence and insecurity, including young men and women who have fled their villages for fear of forced recruitment and harassment by the Maoists and intimidation by the security forces.

2.9 . Theoretical review

The application of political economic perspectives raises questions about the forceful domination, imposed hegemony, unfair public distribution and irrational consumption of the resources and arbitrary exercises of power over the people by those forces operating in institutional, national and global levels. As cited in Baer *et al.* (2004), McNeil (1976) writes that critical medical anthropology (CMA) is important to understand the relationship between causality of disease as a kind of "micro parasitism" and social relationships of exploitation as a form of "macro parasitism," where one has to consciously incorporate the micro–macro nexus to understand the layers of power relationship operating in different strata of the society. Political economic theories in the field of medical anthropology helps to develop nuanced understandings of the relationships between global forces and their further impact on individual health-related beliefs and treatment practices. Baer *et al.* (2003) in their book have discussed how human beings develop both individual and collective perceptions and coping strategies in terms of health, injury and diseases in relation to existing social structures, cultural patterns and contemporary dominant discourses of world systems. Dealing with theoretical and methodological variants of medical anthropology, this book has discussed CMA as a political economic theory of medical anthropology. It is increasingly relevant to understand the characteristics and contradictions of health beliefs, individual experiences of health and nature of health service development, not only in pre-capitalist, indigenous or

capitalist societies, but also in post-revolutionary or socialist-oriented societies.

Similarly, Baer and colleagues (2003) discuss the concept of critical anthropological realism. According to this concept any object, social being, or socio-cultural and political event exists in the society independent of our conception. Therefore, rather than seeking to understand the society and its inherent dynamics from the perspectives of 'sophomoric relativism' (which advocates that every ideology is equally valid) or following wholesale skepticism (rejecting any kind of truth), this book strongly advocates a critical stand on any kind of belief, practices, behaviours and structural hierarchy of the society which further allows us to understand the nature of powerful forces directly and indirectly perpetuating violence and social suffering. Singer *et al*. (2014) observes that the current generation of senior medical anthropologists, influenced by social movements and broader cultural realignments in the 1960s/1970s, argued that the prevailing theoretical models tended to ignore crosscutting political economic influences on health and on human decision-making and action in the health arena. As a solution to fulfill the gap, the authors propose that while interpretive or meaning-centered medical anthropology focuses on local symbolic significances and networks of meaning, critical medical anthropology (CMA) advocates a materialist approach. One that prioritizes the examination of power structures that underlay dominant cultural constructions, and questions the ways in which power gets deployed. In doing so, CMA seeks not only to expose local power dynamics but also to reveal how outside interests, whether regional, national, or global, affect local conditions.

Moreover, Baer *et al.* (2004) mention that in terms of treating sick people, physicians perform two key functions in the encompassing social system and its existing distribution of power. According to this argument, though physicians may shape and limit the sick role by using their professional power to label them using 'sick category,' many times patients do not necessarily follow the expert opinions and instead place their faith in lay knowledge from the popular sector to get treatment for their sickness. Secondly, in the process of medicalizing distress, many times physicians overlook the broader social determinants like war, famine, hunger, poverty, political instability, and mass unemployment. According to the authors, ignoring these factors that are responsible for creating personal illness, perpetuates biomedicines suppression of the individual subjectivities of the people. Baer *et al.* (2004) states that since the aggressive domination of biomedicine has been realized in all popular, professional and folk sectors of treatment practices, both state and non-state actors are promoting the power of biomedicine through its hegemonic propositions of being "scientific", "rationale" and "objective." These assumptions about biomedicine, however,

should be critically challenged. Baer et al (2003) write that CMA ultimately argues that the achievement of health with authentically holistic and pluralistic health care systems requires the transcendence of global capitalism. They argue for the construction of a global democratic eco-socialist order that combines principles of public ownership of the means of production, social equality, centralism, decentralization, representative and participatory democracy, and environmental sustainability. Likewise, Doyal and Pennell (1976) argue that the substantial amount of mortality has not decreased in the underdeveloped world while the cost of medical care is increasing. The blame goes not only to "greedy doctors" but also to larger systems of capitalism that place a profit-generating burden on these doctors. The authors further argue that underdeveloped infrastructure in third world countries is largely responsible for infections, malnutrition, and other environmentally produced illnesses such as airborne diseases and vector borne diseases.

In order to understand the social production of illness, we have to view the problem in the context of the historical development of imperialism and in its by-product of capitalism or vice versa. The early effects of colonial expansion have had devastating consequences in terms of infectious diseases. Doyal and Pennell state that to sustain the exploitative form of capitalism, so-called western science, western medicine, and a third-world bourgeoisie are crucial. Moreover, Pool (2005) has argued that transformation of a political problem into a medical one is often akin to 'neutralizing' critical consciousness and thus serves the interests of the hegemonic class. Analysis of illness representations therefore requires a critical unmasking of the dominant interests, and an exposure of the mechanisms by which they are supported by authorized discourse. The author further writes that a critical medical anthropology forcefully poses the question of when illness representations are actually *misrepresentations* that serve the interests of those in power, be they colonial powers, elites within a society, the medical profession, or other empowered men. Forms of suffering grounded in social relations can be defined as illness, medicalised, and brought under the authority of the medical profession and the state (Pool 2005).

There are many episodes where misrepresentations of illness have served the interest of the dominant class and interpretation of political problems as a technical issue has side-lined the sufferings of the people. Winkleman (2008) writes, economic institutions, business activities, and political decisions not only affect who gets diseases and access to health resources, but also actively produce disease through creating contaminants and other risks. Powerful institutions operating globally influence national policies where peoples have been forced to accept curtailed civic rights. Contextually highlighting the role of powerful institutions to

shape the design of health care systems, in the edited volume by Baru (2015), she has argued that multinational agencies like the World Bank played influential roles in shaping the agenda of health as a part of structural adjustment policies, which eventually privileged market forces and relegated the role of the state from its responsibility. She further argued that the influence of bilateral organizations, international NGOs, scientific and professional bodies sharing the same ideological orientations have strategically dominated the design of health sector reform programs, and alternative voices were unheard and dismissed. Under such a system, it becomes easy for private medical practitioners to capture the bodies of patients as potential consumer of the market, thus exploiting the unequal distribution of health care.

Kennedy and Kennedy (2010) elucidate that in order to interpret and reinterpret social issues like moral panicking, binge drinking, alcohol addiction and obesity, the sociology of medicine itself relied on bio medicalization. They further argued that the way social scientists use conceptual frameworks to explore the medicalization in a negative light would create different causal implications to medical practitioners, social movements and policy makers. In the chapter dealing with moral panics and medicalization, their arguments about 'fear entrepreneurship' unmasks the corporate culture of selling fear in order to maximize their profit interests. This section highlights how fear entrepreneurship promotes the culture of fear and moral panic in order to sell security through marketing of life insurance, medical insurance and recommending unnecessary vaccinations claiming their importance in order to live a risk-free life. Similarly, they further mention that the social construction and medicalization of obesity as a dangerous state of health risk is produced and reproduced by a range of social factors, including both the medical and social discourses. As a result, Bakx (1991) mentioned, biomedicine is in danger of losing both its actual and ideological hegemony: firstly, it has culturally distanced itself from the consumers of its services, secondly it has failed to match its propaganda policies with real breakthroughs, thirdly patients have become further alienated by negative physical and psychic experiences at the hands of the biomedical practitioners themselves (Bakx 1991 cited in Cant and Sharma 1999). Similarly, in the book "Political Economy of Health Care," McKinley (1984) promotes a structural analysis of the overall health care system and of the political and economic forces that influence its shape and content, both in the western and in developing countries. Jack Salmon discusses the rise of the corporate sector in commercializing health and illness and driving out small-scale operators and individual entrepreneurs. He has mentioned that capitalism is getting support from new organizational forms and health care corporations are becoming transnational. Likewise, Thomas Bodenheimer deals with the

issue of the accumulation of capital through the maldistribution of so-called scientific advancement. According to the author, pharmaceutical companies have been successful in accumulating enormous wealth by patenting the drugs and maintaining a monopoly over the technology. Moreover, Charles Derber has mentioned that a new political-economic relationship is arising and new powerful class forces are controlling medical costs. He has discussed the role of physicians and their roles in influencing the market principals of the hospitals. In final chapter, Banerji (1984) argues that the process of colonialism promotes dependency towards the western oriented medicines and its health workforce, which is after all a result of the structural constraints of the political and social systems of most of the third world countries.

Roy Bhaskar's transcendental realism provides an alternative to positivism which allows us both to recognize the cumulative character of scientific knowledge without collapsing this into a monism, and also to acknowledge a surplus component in scientific theory without sliding into subjectivism. Bhaskar (1998) argues that positivism could sustain neither the necessity nor the universality - and in particular the transfactual (in open and closed systems alike) - of laws; and for an ontology (1) that was irreducible to epistemology; (2) that did not identify the domains of the real, the actual and the empirical; and (3) that was both stratified, allowing emergence, and differentiated. That is, ontological depth, may be summarized with the concepts of intransitivity, transfactual and stratification (Bhaskar 1998). Therefore, the author further writes, social structure is both the ever-present condition and the continually reproduced outcome of intentional human agency. Specifically, Bhaskar shows how the intelligibility of experiments presupposes that reality is constituted not only by experiences and the course of actual events, but also by structures, powers, mechanisms and tendencies - by aspects of reality that underpin, generate or facilitate the actual phenomena that we may (or may not) experience, but that are typically out of phase with them.

Archar (1995) further mentions that reality is produced and reproduced by causal powers of generative mechanisms, whether these are our activities and attitudes or our encounters with social structures. Such encounters include conflicts of interest, voices against suppression, and inquiry against domination during the process of institutional growth. Moreover, causal power plays an influential role in maintaining domination and hegemony. In addition to the understanding of persons who are interacting within a specific context, critical realism brings a requirement to understand the generative mechanisms (historically) which have produced the situation. Critical realism defines the foundational history of such generative mechanisms and asks questions about the legitimacy of such a system. Thus, critical realism can serve as a

means of understanding, the reality of the social world, the economic cultural and political generative mechanisms, and their interaction with embodied identities (personal being, or social self and our physiological being) (Harre 1979, 1983, 1994).

2.10. Health Seeking Behaviour

Medical anthropologists have tried to understand people's health seeking behaviours in different regions and contexts across the world. Health seeking is a dynamic process; people constantly re-evaluate their symptoms and revise their healthcare plans (Chrisman, 1978 cited in Ember and Ember 2004). People's health seeking behaviour has been studied in many ways. Some studies have shown that individual perceptions are important to influence and shape individuals' health decisions. However, literatures based on structural interpretations primarily focus on socio-cultural and economic barriers to shape people's health seeking behaviour. Winkleman (2008) writes, "Culture affects patients' and providers' perceptions of health conditions and appropriate treatments. Culture also affects behaviours that expose us to disease and the reasons prompting us to seek care, how we describe our symptoms and our compliance with treatments." E. B Taylor's classic conceptualization of culture as a complex whole which includes knowledge, beliefs, practices, values and other capabilities acquired by a human as a member of society is relevant to understand the dynamics of shamanistic knowledge and beliefs that affect healers' and patients' conceptions of aetiology and treatment compliance.

People have different kinds of choices and priorities in accessing healthcare, and these include static and changing social norms. For instance, Pomales (2013) has written about the changing contraceptive discourses in Costa Rica and further discussed the changing hegemonic views about masculinity. According to the author, because of the existing cultural construction of the Machista (macho man) in Costa Rica, many males were reluctant to get vasectomies. However, Costa Rican males are getting vasectomies despite culturally dominant views of this surgery as negative. According to the author, this represents a process of destabilization of current cultural systems in Costa Rica and construction of an 'alternative techno sociality' which for men involves 'embodying emergent masculinities' that are focused around being a responsible man. Likewise, Kowalweski *et al.* (2000) in a study from Southern Tanzania elucidates the community perception of barriers to using referral-level care. According to this study, the main obstacles as reported by mothers attending health services fall into the following categories: (1) geographical and financial accessibility; (2) traditional family structures and poverty; (3) perception of care and fear of the hospital

environment; and (4) community perception of severity and causes of pregnancy-related problems. This study indicates that besides well-known geographical and financial barriers, pregnant women have different perceptions and interpretations of danger signs. Rural women avoid the hospital because they fear discrimination. Another study conducted by Ngom *et al.* (2003) in Northern Ghana states that among the Kassena-Nankana people of northern Ghana, women's mobility is constrained resulting in delays for the treatment of illnesses. They have been identified as barriers to the transition towards better health, especially for women and children. These studies suggest strongly that delays are caused by the fact that populations try a series of traditional therapeutic options for their patients, and biomedical treatment is often a last resort. According to the authors, such patterns of health seeking behaviour can be compared with those found in other developing countries of Asia, Africa and Central America. Needless to say, the most affected remain women and children because of their low bargaining power within their compounds, and the poignant question has always been what to do in terms of public policy.

Health seeking behaviour is not just an outcome of existing material conditions; these conditions are structurally controlled, gendered and contextualized by powerful forces like patriarchy, caste and class. Franckel (2002) writes about the survey presented here by Aurelien Franckel, Frederic Arcens and Richard Lalou, which took place in thirty Senegalese villages where the authors interviewed 902 households with children below age 11 presenting febrile symptoms generally associated with malaria. There are large variations in health-seeking behaviour and types of care dispensed between villages, and two distinct geographic zones emerge, characterized by a very unequal risk of malaria exposure and large differences not only in health care provision but also in cultural, religious, and historical influences. While pointing out these disparities, the authors show how they interact to shape the health-seeking strategies adopted by households in the different villages. The fact that all the villages studied belong to the Serer ethnic group and have a traditional agro-pastoral economy illustrates the risk of applying an undifferentiated health care policy to the various populations concerned (Franckel 2002). Moreover, Gage and Guirlene (2006) report,

> An analysis of data from the 2000 Demographic and Health Survey shows that little use is made of antenatal and delivery-care services in rural Haiti. After adjusting for individual-level factors, poor road conditions significantly reduce the likelihood of timely receipt of antenatal care and of four or more antenatal care visits, while the availability of a health centre within 5 kilometers significantly increases the odds of each outcome. The odds of being attended at delivery by trained medical personnel and of institutional delivery are significantly reduced by mountainous terrain and

> distance from the nearest hospital, and are increased if a health worker providing antenatal care is present in the neighbourhood. Neighbourhood poverty reduces the likelihood of safe delivery care. The findings suggest that improving the use made of maternal healthcare services would require, among other things, improvement of the availability of services and road conditions, and the reduction of poverty (Gage and Guirlene 2006: 271).

Several models have been developed in medical sociology to predict treatment- seeking behaviour (Becker and Maiman 1983), but the socio-behavioural or Andersen model (Aday and Andersen 1974; Andersen and Newman 1973) is one of the most widely used frameworks. The SBM provides a framework that unifies a variety of models (Cummings *et al.* 1980) and describes health care use as a function of "predisposing," "enabling," and "need" factors. Predisposing factors are demographic and attitudinal factors that exist prior to the onset of illness that may influence health care use. Enabling factors are factors that facilitate access to health care such as the availability of services or financial resources to purchase services. Need factors reflect perceived needs of the people and the severity of the illness episode, as measured by indices such as the number of symptoms and disability days. Moreover, health-seeking behaviour is a relative condition, it varies according to the temporal and spatial context. Pool (2005) has mentioned, in Haiti, a combination of gender inequality, traditional and emerging patterns of sexual union, prevalence of STDs (and lack of access to treatment for them), inadequate response by public-health authorities, lack of culturally appropriate prevention tools and political violence all contribute to particular individuals' exposure to HIV. This example shows that personal behaviours are conditioned by sociocultural patterns and inefficiency of health service systems to respond to the disease condition further contribute to the spread of communicable diseases. Similarly, Paul Farmer (1997) tries to understand the dynamics of HIV and risk in Haiti by carrying out detailed ethnographic studies of vulnerable individuals and situating these in various layers of context: local culture, local and national political and economic conditions, and global relations. He criticizes the narrowly behavioural and individualistic conception of 'risk' that is common in epidemiology. In the context of Nepal, Beine (2001) has discussed that people of Sano Dumbre categorized their sickness by labeling them as a "*sano rogh*" (small disease) and "*thulo rogh*" (big disease) according to the treatment availability and its efficacy. In "*sano rogh*" people first sought treatment with various home remedies according to household level and if there was no improvement people considered them *'thulo rogh'* and went to the hospital.

Similarly, symptom awareness is also another factor that determines treatment strategies. Beine further mentions that new hybrid medical systems are developing in Sano Dumbre in Nepal that are similar to pluralistic tendencies prevalent in other parts of south Asia. In this kind of hybrid model, to maximize the treatment seeking options, people seek both traditional and western treatments as per their specific illness context. Moreover, as Kleinman (1988) writes, each patient brings to the practitioners a story. That story enmeshes the disease in a web of meaning that makes sense only in the context of a particular life. But to understand what creates that life and illness experience, we must relate life and illness to a cultural context. He further writes that disease or illness also varies from society to society. In some because of climatic or geographic conditions, but in larger parts because of productive activities and resources. It is not just the straightforward result of a pathogen or physiological disturbance as argued by biomedicines. It is a result of a variety of social structural conditions all of which are ultimately rooted in the capitalist world system. Thus, disease and illness can result from malnutrition, social stratification, economic insecurity, alienation in the workplace, occupational risks, industrial and motor vehicle pollution, inferior housing, poor sanitation, the stress of everyday life, and environmental degradation. Therefore, Baer *et al.* (2003) forwarded the conceptual tool which suggest understanding the nature of the relationship between micro parasitism (the tiny organisms, malfunction, and individual behaviours that are the proximate causes of such sickness) and macro parasitism (the social relations of exploitation that are the ultimate causes of much disease) and their dialectical relationships between each other. Both dynamics are influenced by power relations operating in the society that influence both local and global dynamics. Kleinman (1988:136) writes, "The difference between transcript and record, interview and writing medical notation, is the differences between illness as the patient's problem and disease as the physician's problem. The core value structure of traditional biomedicine can be seen in this transformation of a sick person into a case". As Morell (2009) argues, the ability of an individual to change his/her personal circumstances through therapy is dictated, limited, or modelled by 'social power'. Social power is external to and beyond the influence of the client. Potent factors in the manufacturing of social power on the individual include the influence of close family and friends, but are primarily the physical environment, general attitudes and prejudices, organizational allegiances and crucially the actions of those in government, those who run global corporations, and those who head up military oligarchies (cited in Kennedy and Kennedy 2010).

2.11 . On Medical pluralism

Brodwin (1996) has written on the struggles of healing in the context of religious and medical pluralism in Haiti. In his book *Medicine and Morality in Haiti*, the author explains, medical pluralism refers first of all to the social organization of healing practitioners, who often occupy different religious, ideological, "ethnic," or class positions in their communities. It also refers to the cultural organization of their practice: the coexisting and competing discourses of affliction and healing with which they legitimate their therapeutic power. The author further argues that the seemingly stable array of religions and medical traditions in rural Haiti is deceptive. There is, in fact, a continual struggle over the effectiveness, political potential, and moral meanings of healing power. This struggle both reproduces and destabilizes the conventional categories of healing practices and religious identities. The author has further examined these contests for healing power across the history of Haiti and in people's lives from a single rural community in the late 1980s. According to him, studies of the "desocialization" of suffering, in particular, have criticized biomedicine for its tendency to reify sickness. Because biomedicine reconstructs disease as a neutral, autonomous biological reality, it prevents people from interpreting bodily disorder in terms of the lived world of everyday experience, including local forms of inequality and oppression. He further writes, most villagers do not single out biomedical therapies as foreign or contrast them to a separate category of "indigenous healing." People do not generally oppose biomedicine on moral or political grounds, nor do they seek out biomedicine as a way to consciously show that they are "modernizing" or to identify with the national elite in Haitian society. Rather, villagers easily intermix biomedicine with other types of healing, without invoking the historical association of metropolitan medicine with foreign or neo-colonial domination. Like in the example of Haiti, Brodwin (1996) writes, people routinely combine elements from diverse or even contradictory medical traditions. Moreover, the practice of healers - both their actual therapies and their authoritative conceptions of health and disease - typically contain hybrid elements, borrowed from other traditions and grafted onto their own. This is the paradox of biomedicine in Jeanty, on the one hand, it is undeniably a metropolitan import, and it arrives with the full weight of foreign power and cultural cachet. On the other hand, it does not threaten to replace the work of midwives, herbalists, and religious healers with its own set of reductionist and culturally foreign interventions. Baer *et al.* (2004) write that medical pluralism flourishes in all class-divided societies and tends to mirror the wider sphere of class and social relationships. It is perhaps more accurate to say that national medical systems in the modern or postmodern world tend to be plural, rather than pluralistic,

in that biomedicine enjoys a dominant status over heterodox and ethno medical practices.

In reality, plural medical systems may be described as dominative in that one medical system generally enjoys a preeminent status vis-a`-vis other medical systems. While within the context of a dominative medical system one system attempts to exert, with the support of social elites, dominance over other medical systems. People are quite capable of the dual use of distinct medical systems. Citing Lowenberg and Davis (1994) Cant and Sharma (1999) writes, "Certainly alternative medicine seems to demedicalize personal health by encouraging the individual to be less dependent on biomedicine but paradoxically it can remedicalizes life, bringing all areas of a person's emotional and spiritual life under scrutiny." Moreover, in terms of varieties of consumers, Sharma's (1992) study has shown, Midland locality users were divided into three main types. The "earnest seekers" were those consumers who were prepared to try a variety of approaches for one condition and did not intend to carry on with alternative medicine once their immediate problem was resolved. Here, for instance, there was some evidence of users who simultaneously used herbal medicines and analgesics. "'Stable users' had a regular relationship with a particular practitioner or therapy, and in this category it is possible that such a relationship may enable the users to consult their practitioners more regularly and without always also consulting the general practitioners. "Eclectic users" were those consumers that shopped around among practitioners for a variety of conditions. Certainly in the latter two cases, the patients revealed a high degree of knowledgeability and control over their health and were able to envisage situations where they would see their doctor and when it would be more appropriate to use their practitioners. In other words, users may "use" both alternative and biomedical care but for different problems, biomedicine being regarded as particularly important for acute conditions and accidents. It also suggests that patients are not dissatisfied with the treatment *per se* but perhaps dissatisfied with the treatments for a specific ailment (Cant and Sharma 1999). Notions of medical pluralism had deep impact among the villagers in Nepal. Pigg (1995) discussed how the ways local people manoeuvre in this pluralistic medical field is determined only in part by their access to therapies and their judgments about which works best for what. She further discussed about the meaning of pluralism in local context, the way local people experience the intervention of 'modern' western healing methods and their response to healing methods as a national agenda of development.

The practice of medical pluralism is influenced by different layers of realities operating in the society. Kleinman (1980) has elucidated that both clinical and social realities affect the health seeking behaviour of any individual. According to the author, beliefs about

sickness, the behaviours exhibited by sick persons, including their treatment expectations, and the ways which sick persons are responded to by family and practitioners are all aspects of social reality. These patterns are largely shaped by distinct cultural constructions that exist in different societies and diverse social structural settings within those societies. Moreover, the author has further mentioned that the same health related aspects of social reality, especially attitude and norms concerning sickness, clinical relationships, and healing activities represent the domain of clinical reality. Social factors such as class, education, religious affiliation, ethnicity, occupation, and social network all influence the perception and use of health resources in the same locality and thereby influence the construction of distinctive clinical realities within the same health care system. Moreover, the author has agreed that it is difficult to challenge the clinical reality imposed on patients by medical professionals or to get them to view it as not the "only" or "true" one, but as one among a range of clinical realities operating in health care systems because there are range of clinical realities of the different sectors and their components differ considerably. Likewise, he has delineated the realities among popular, professional and folk cultures, and their subcultural components which shape the illness and therapeutic experiences in distinct ways. Finally, the author argues, although the popular sphere of health care is the largest part of any system, it is typically the least studied and most poorly understood. Similarly, Baer *et al* (2004) writes, it is the lay, non-professional, non-specialist, popular culture arena in which illness is first defined and healthcare activities initiated, but the power to create illness and treatment as social phenomena, to legitimate a certain construction of reality as the only clinical reality, is not equally distributed. Similarly, the inability of biomedicine to cure the somatic distress and sickness associated with the postmodern world creates a potent source for pluralism. Under such circumstances, it is common for popular health movements, folk healing systems, and heterodox medical traditions to rise up to fill the void.

2.12 On Social suffering

Kleinman *et al*. (1997) mentions that social suffering takes in the human consequences of war, famine, depression, disease, torture and the whole assemblage of human problems that result from what political, economic, and institutional power does to people, as well as human responses to social problems, as those forms of power to influence them. Technologically, war is becoming more complex and fatal than it used to be : advanced chemical weapons replaced bows and arrows, while tankers, fighter planes and Navy ships replaced horses and elephants. The transformation of war from manual to highly advanced

warfare technology is becoming increasingly fatal and perpetuating layers of lethal consequences. However, because of its devastating nature, conflict is completely a 'lose-lose' situation for conflict-affected victims. It was a very difficult task for health workers to maintain absolute neutrality in conflict affected zones. "Terror warfare is predicated on a bastardized understanding of cultural transmission that posits that maiming and murder of a few will terrify the many into political acquiescence" (Nordstrom 1997b: Nordstrom 1998 : 107). Supporting one side would upset the power relations between the warring parties and thus preclude any access to the other side. Although difficult to achieve, avoiding politics helps protect humanitarian workers and furthers their relief effort by not making them enemies of any of the warring parties (Berry 1997).

Ethnographic textualization helps to communicate the immediacy of individuals' pain and suffering. As Kleinman (1988) mentions "empathetic listening, translation, and interpretation" are the keys to unraveling suffering, which helps us to represent illness narratives in a meaningful way. Kleinman further argues that illness narratives are important because they help us to understand how cultural values and social norms shape any individual's perception about their body. Such narratives often reveal how individuals label and categorize bodily symptoms, and interpret complaints in the particular context of life situation, and the way people express distress through bodily idioms which are both peculiar to distinctive cultural worlds and constrained by their shared human condition. Moreover, Kleinman (1988) has emphasized that chronic illness and its therapy creates a symbolic bridge that connects body, self, and society. This underscores the importance of interconnection of physiological processes, meaning that relationships link our social world with our inner experience. Illness narratives educate us about how life problems are created, controlled and made meaningful. Moreover, health related beliefs and illness narratives of the people are manipulated by different forms of power relations operating in the society. Such healing powers are operating in different forms and scales all over the world. As Illich (1976:42) writes "Previously modern medicine controlled only a limited market; now this market has lost all boundaries. Un-sick people have come to depend on professional care for the sake of their future health. The result is morbid society that demands universal medicalization and a medical establishment that certifies universal morbidity." Such "universal morbidity" needs universal health care systems with welfare values as a strong response to tackle social suffering.

CHAPTER III

3. Mapping the Socio-political history of Rolpa:

Socio-political institutions are important to address the manifest and latent functions of human existence and their day-to-day necessities. Every political regime that has ruled Nepal has made 'substantive efforts' to develop and channelize public policies to uplift living conditions of the people. However, the impact of these policies on the masses have not been adequately researched. Many public institutions in Nepal are severely affected by kith and kin relationships operating in the private sphere. In such a critical condition, the role of the actors, their powerful influence on policy making process and further impact on public institutions is important to understand to make it clear that policy making process cannot be free from biases and lobbies. In the specific context of Nepal, areas like political economy of health, the nature of mal-governance and its relation with different subsystems of the state (like health, education and bureaucracy) have remained relatively under-researched. Since the country was "closed"[7] to outsiders until 1950, it became one of the crucial factors to prevent outsiders, especially researchers from foreign universities and other institutions to conduct any kind of academic research in Nepal. Despite this rule foreign scholars like Sylvia Levi, F. C Hamilton, W. Kirkpatrick, and prolific record keeper Brian Hodgson visited Nepal before 1950 and a few others who held diplomatic positions could document about Nepalese society, mostly only the historical, socio-cultural and architectural landscapes of the country. More specifically, medical doctors like H.A. Oldfield, Perceval Landon and also Brian Hodgson have noted different kinds of health problems and presence of disease in different communities and their beliefs and treatment practices. These accounts and biographies of Nepalese society help us to understand the historical and cultural dynamics of the Nepalese society.

Nepal has traversed a long journey since then in terms of social and political transformation. It is therefore necessary for us to understand the contemporary social institutions and entrenched power relationships in diachronic and critical framework. Similarly, the modern education system in Nepal had begun only after 1950. Prior to this period there had been severe institutional constraints to conducting holistic academic research by insiders due to lack of educational research institutions. Thus, this study is an attempt to

[7] Before 1950, it was difficult for visitors to freely travel in Nepal, and only visitors with special authority could visit the country.

raise the complex task of exploring and analyzing historically marginalized social facts, which have been grossly excluded and seriously under-represented in the anthropological and medico-anthropological studies in Nepal. To explore the dynamics of institutional development in the context of peril-conflict political order, this research attempts to analyze the interconnections between different sociopolitical institutions, the role of involved actors and their lived experiences historically.

Since Rolpa as a district has a recent history, its existence in the political geography of Nepal, most of the time, the same sets of political actors have been involved to initiate and facilitate the early foundation of political, administrative, educational and health service development. As Tilouine (2013) has discussed, the 'poly-centric portrayal' of 'village life' is important to understand the micro history and one should zoom the analytical lens close to the actors themselves. This chapter has followed the notion of social-political and cultural poly-centrism and their structural localism to explore the poly-history of sociopolitical development in different regions of Rolpa. More specifically, I have particularly exploring the nature of contestation among political actors in relation to local level power dynamics and conflict of interests during resource sharing and utilization process and its significant impact on institutional development in Rolpa. Ethnographically, rather than understanding the research universe as a monolithic, unilinear and isolated entity, I believe every ontological reality is heterogeneous, multilinear and explicitly connected with the larger socio-political world which have not only horizontal and vertical dimensions but also cyclical and spiral layers. One reinforces the other.

3.1 The era of subsistence economy in Rolpa

3.1.1 Rolpa in the reign of petty principalities. (Until 1950 AD)

There have been episodes of rise and fall of royal dynasties in the political history of Nepal, before it emerged as an independent nation state in 1825. The Shah Dynasty, with its rise to power in the eighteenth century, was preceded by the Malla dynasty who had ruled over the then (much smaller) territory of Nepal centered in the Kathmandu valley from the 12th to the 18th century. In addition, there had been parallel existence of another Malla kingdom in Jumla, Sen Kingdom in Palpa and conglomeration of many small states like Baiisse and Chaubisse confederations located in different regions of the present boundary of Nepal. Before Rolpa emerged as a separate administrative district, this region was largely a part of Pyuthan, which was associated with the *Baiisse* confederation. Therefore, without exploring the pre-modern history of Pyuthan, it is be difficult to understand the modern

development of Rolpa. Giri (1995) writes that in order to demonstrate their power and to acquire prestige in their locality, many Thakuri rulers of this region used to claim themselves as Rajputs and used to have family and marital relationship with Indian Rajputs. Similarly, Bhattarai (2008) writes,

> *After the annulment of the Khas state, there had been existence of different states in present mid-western region, among them Pyuthan was one of the important states. Earlier Pyuthan was one of the important political alliances, which consisted of Pyuthan, Musikot, Isma, Khungri and Bhingri. Similarly, in 1843, Pyuthan was "unified" into a larger Nepali state during the reign of Rudra Pratap Chanda. Later on Rudra Pratap Chand fled away and took shelter under the King of Tanahau.*

After the rise of King Prithivi Narayan Shah in the seventeenth century, the Gorkha Empire began its aggressive expansionist campaign in the name of national unification. Consequently many petty principalities were merged into a larger Gorkha Empire, either by violent or non-violent means. Giri (1995) writes, that Rudra Pratap Chanda, a son of Deep Pratap Chanda was the last king of Pyuthan, who fled away silently from his palace after surrendering to the Gorkha empire. Despite of being a powerful political centre, the expansionist agenda of the Gorkha Empire dissolved Pyuthan into the larger Gorkha territory and curtailed the latter's autonomous status. Similarly, Kalases used to be one of the important politico administrative loci in pre-modern history of Rolpa, which was significantly different from the ruling system under the Thakuri Kings that existed in its borderland states of Gajul or in Pyuthan, which were under Baisse alliance. Giri (1995) writes that there had been no strong evidence to prove the existence of a Magar king in the Pyuthan region; however, he claims that the domination of the Magars in Barha Magarat Chettra (Twelve regions dominated by Magar Community) is suggestive to prove the existence of a Magar king before the existence of Rudra Singh in these regions. In contrast to this argument, cultural activist Bamkumari Gharti Magar mentioned that since there was the existence of a Magar King, the life of the last Magar king Dare Jaitum and his family members from the Kalases region ended in a natural disaster in the place called *kot-alim* in Kotgaon. Kot means the name of the place and *lim* or *limnya* means drove by the big flood or water in Magar language.

Gharti Magar further states,

> *After this tragic end, in order to continue the ruling mechanism, there had been existence of a traditional ruling system called 'pancha amal pancha taluk' which was the composition of Mukhiya (Chief), Ghabudha (Senior advisor), Jimmawal (Tax collector), Gauraha (Accountant) and Tahabil (Communicator) who were supposed to run the day to day administrative mechanisms of the kingdom[8].(Interview)*

[8] Indepth Interview with Bamkumari Gharti Magar taken in Kathmandu 2014/04/21

Later on the Kalases region was integrated within the Pyuthan district during administrative reform[9] under the reign of the Ranas. In the geographical territory of the present Rolpa region, there existed dependent states[10] (petty principalities) like Khungri, Sarikot, Khungrikot and Sipakot and the Rolpa region was the buffer zone between the *Chaubisse* confederation of small kingdoms to the east and the *Baisse* confederation to the west. Adhikari (1986) writes that in the Baisse confederation there had been the presence of different small kingdoms, among them Kalagaun, Khungri and Darma. They are now integrated in the Rolpa district. Stiller (1973) indicated that, the existence of these trivial principalities was ultimately contingent upon the ability of their individual Rajas to defend the state against aggression and to control the administration of the state itself. According to oral chronicle, some of these dependent states were "unified" during the reign of King Bahadur Shah. Moreover, during the expansion process of the Gorkha Empire, smaller states were encroached upon by the bigger states of the same region. The dire condition of internal conflicts and fragile existence of different petty principalities were weaker points to fulfill the dream of territorial expansion led by the Gorkha Empire. Similarly, in Gajulkot and Khungrikot, there used to be the existence of a Thakuri king of the Sen Dynasty. The chronicle source dated 1646 AD based in Gajul has documented the existence of a king's palace located at Gajulkot. Adhikari (1986) writes,

> *Another chronicle source belonging to the King of Khungrikot mentioned, after the split among offspring of Doteli King Ritu Malla, they came to Gajul and began to rule this region. Tutha Singh was the king of Gajulkot[11] who got married to Tumbabati Mayya, a daughter of Dare Jaitum who was the king of Rukum, Sarpakot. Ajaya Singh's brother Sundar Singh got separated with his brother and established a new kingdom at Libang; however until date there had been no archival evidence found to prove the separate existence of Libang. The last king of Gajul was Gajindrapaal*

[9] During the reign of Bir Shumsher in 1895, Nepal was divided into thirty-five districts and Pyuthan was categorized as a district of third ranking. (Bhattarai 2008).

[10] "Dependent states were those states who surrendered to the Gorkha Empire during the state expansion process. (In nationalist perspective this means by unification process) These states voluntarily supported the sovereignty of Gorkha Empire and sanctioned internal autonomy among themselves, however, they were supposed to pay a certain kind of tax called 'Sirto' and even bonded to provide military support to Gorkha government as per necessity during war." (Bhattarai 2002)

[11] According to a local myth, the kingdom of Gajulkot was vacant for a long time. Officers were in search of a talented person to become their king. Meanwhile, they made some secret decision; during the time of digging a pond at Gajulkot whoever would appear there, and would put off his hat and take rest next to the nearby tree, he would be offered the position of the king. Meanwhile, a person came to that specific place and behaved accordingly. Later on, he was identified as Tuthasen, the king of Jajarkot, Jaktipur. Then after, he was made the king of Gajulkot. According to a local myth, Tuthasen was the king of Jajarkot, after his brother's death, he was forced to marry his brother's wife. This frustrated him and as a result he decided to abandon his kingdom. While going somewhere, on the way, he took rest at that particular tree as predicted by the officers. After which, the officers from Gajulkot made him the king of Gajulkot. Later on, he got married to the king's daughter from the Rukum, Darijenum. (Based on interview with Bam Kumari Budha Magar, dated 2012, Jan 12).

and the Gurkha kingdom had forcibly integrated Gajul in its larger unification process in 1843 BS (1900 AD).

It is evident that there existed different kinds of dynasties in the present Rolpa region. However, most of these kingdoms were politically fragile and faced frequent financial crisis. According to chronicle sources, since Khungri was facing a financial crisis, the king of Khungri kept Mizhing village as collateral in 1899 and took 1800 Rupees as a loan from Karna Pal Singh[12]. It had been mentioned by local respondents in Rolpa, that among these states, the King of Gajulkot fought against the Shah rulers, so his existence had been wiped out. However, the king of Khungrikot, surrendered to the Shah Dynasty so he used to get *Vhatta* (a special kind of salary). According to the *Sanad* (legal authority) of 1933, thereafter King Tika Surya Prachanda Singh and his grandson Phatte Prachanda Singh used to get 200 Nepalese rupees *Vhatta* for his lifetime from the Shah Kingdom after abolishing the small kingdoms[13].

The trend of protection in kind by the winner of territory continued until the end of the Panchayat period till 1990. The mid-western region of Nepal had been incorporated[14] into larger Gorkha kingdom in the reign of King Bahadur Shah. Adhikari (1986) writes that during the expansion process of the Gorkha Empire under the leadership of Kaji Damodar Pandey, Kaji Jagjit Pandey, Sardar Prabal Raja, and Subba Fauda Singh won the territory of Pyuthan in 1843. After that the king of Khumri pleaded for special protection in Kathmandu and agreed to become a dependent state. He further assured the Gorkha kingdom of help in the process of the latter's territorial expansion. Giri (1995) writes that when the Gorkha empire attacked Salyan, *Jhara Sainik* (a bonded military force) were sent from Pyuthan. Similarly, when Mahodaam Kirti Shah attacked the Gorkhas, Pyuthan sent military force under the leadership of Meghbarna Gharti. After getting incorporated into the larger Gorkha Empire, one of the conditions imposed on the small dependent states was that the latter must

[12] According to the local myth documented by Sales (2013), "Dharma Pal and Karma Pal two brothers were living with their sheep on the Turpha lekh, nearby Jaljala, were good pastures. As they were hunting wild boar they discovered the large plain of Thabang covered in the forest".

[13] According to the princely state eradication act of 1962, there had been existence of seventeen dependent states till the Rana period. Those dependent states were Salyan, Jajarkot, Mustang, Bajhang, Virkot, Darna, Bajura, Thalhara, Galkot, Gulmi, Hargaukot, Malneta, Dullu, Parbat, Nuwakot, Khungrikot, (Pyuthan) and Udayapur. (Bhattrai 2002)

[14] When Parbat subjected to their rule (Gorkhali rule), the Gorkhalis retracted their steps through Dhurkot on westward to Pyuthan, which they conquered a month later, on 19 Kartik 1843 B.S, or about the end of October 1786. They then marched on to Dang in the inner Terai, conquering this kingdom ten days later, they swung to the north, taking Rolpa on 2 Marg, 1843 B.S, (November 1786) four days after conquesting Dang; and by the 7 Marg they had reached the Bheri River. (Tewari 1786 cited in Stiller 1973).

provide military help whenever the Gorkha Empire announced war against their adversary. Following this obligation, it is suggestive that the local population of Rolpa had substantially contributed an army and potters during the process of territorial expansion by the Gorkha Empire, in the name of national unification. Since the larger part of Pyuthan had been dissected to form a new district of Rolpa, it would be convincing to draw the evidence that many people from the Rolpa region had contributed their labour in the expansion process of the Gorkha Empire, both voluntarily and involuntarily. Either in the name of 'volunteer support' during the 'unification' process or forcefully joining as a bonded military force, this fact is suggestive to understand how the process of "national expansion" was exploitative to many regional minorities where many of them had contributed labour with bare survival.

3.1.2 The era of Transhumance and agro-Pastoralism

In the Himalayan highland and hill setting of Nepal, to cope with climatic variations, the trend of shifting cultivation, particularly known as vertical transhumance has been widely practiced until date. Similarly, people from the Midwestern hill district of Rolpa had been practicing different kind of labour-based economic and agro-pastoral activities to make day-to-day survival possible. In the northern region of Rolpa, many people keep large herds of livestock like sheep, cows, goats and buffaloes. During summer, there has been trend of shifting herds of sheep from lowland (*Abal* or *Naam*) of southern direction to highland (*Buki* or *Shikhar*) of northern direction[15]. Again, in winter, to avoid the heavy snowfall in the upper part, they shift herds of sheep from highland *Buki* to the lowlands *Naam*. The shifting mechanism of herds of sheep has followed cooperative values and concept of shared economy on a rotational basis. Those villagers who were not keeping sheep in their household were supposed to offer the sheep herders food items like maize, millet, barley, chillies, salt etc to survive the journey of sheep rearing. This kind of moral exchange obliges *Gothala* (permanent labour) and *Vedigwala* (sheep caretakers) to reciprocate to their fellow villagers with different medicinal herbs like *Padamchal, Timmur, Chulthe, Tite,* and *Panchaunle* while returning back from highlands to lowlands. This kind of mutual reciprocity develops the sense of belongings among each other and maintains a good social tie among

[15] "Herding of sheep and goats is done in a fully trans-human pattern. Because of the cold winter climate, the animals must be taken south to the area above the Dang Valley in the Mahabharat range. The animals move through forest and pasture near the village in late October and November and the herders gradually make their way to the Mahabharat, remaining there until early March, when they begin the trip north towards summer pastures. (Molnar 1981)

the fellow villagers. Moreover, Molnar (1981 : 41) writes,

In order to obtain thick, good-quality wool, the animals are grazed in pastures several days north of the village from June to October, when the coming cold forces them down to warmer climates. Usually only men go with the flocks, although in northern villages whole families migrate as well.

In the process of vertical transhumance, males are supposed to contribute their labour[16] as a *Gwala* and *Gothala* and females are supposed to weave clothes and prepare other kinds of indigenous woolen items like *'Bala*' and '*Kambal*'. During this period, while sheep graze, *Gothala* and *Gwala* would engage themselves in collecting cotton which needed to be sufficient to weave clothes for an entire year. In addition to woolen cloth, women weave clothes from both Hemp[17] and *Puwa.* Similarly, the weaving of the indigenous dress *(Chyanga Panga)* is another gendered task specially given to females. As these tasks form an important part of socialization of women for men centered households to play the roles of ideal mothers and wives. On the one hand this kind of value system encourages females to learn certain skills before marriage. On the other hand, it becomes a process of female subjugation by imposing stereotypical gender division of labour. Gersony (2003:9) writes, 'while the men tend the sheep, the women weave blankets which are eventually sold in Kathmandu, and generating sheep herding main revenue'. In reality, such economic activity of indigenous production from Rolpa has not maintained its strong presence in the larger market of Kathmandu valley and other cities of Nepal up to the level where they can generate good profit and extra surplus. However, it used to be largely consumed in the periphery of its production regions and a significant amount used to be sold in the adjoining cities like Butwal and Nepalgunj, primarily for domestic consumption.

There existed other forms of labour-based economy in different regions of Rolpa. Alternatively, those people who were not keeping large herds of sheep used to perform different kinds of seasonal jobs like the collection of medicinal herbs, plant roots, stems and

[16] "People with only small flocks will send one or two adult males or a hired herder with the animals. Those with larger flocks take turns if there are several men in the household, otherwise the available male is a full-time herder. Villagers prefer to tend their own flocks, as the animals can easily become sick or slip on steep hillsides if improperly tended. While cattle belonging to wealthy families are often tended by a hired herder at least part of the time, sheep and goats are usually tended by a family member. In the northern villages, where sheep and goats are raised in larger numbers, unmarried women in the household may stay with the cattle in the *goth*". (Molnar 1981)

[17] "Hemp fibre yields a sturdy cloth like jute, which is used for large grain sacks, coverings, and sometimes as an extra sleeping pad. This cloth is popular throughout the Rapti zone and traders or villagers making a trip to the bazaar for supplies will take these bags to sell. Hemp is stronger and longer-lasting than jute and people will pay a higher price for the hand-made hemp bags rather than pay less for poorer quality jute bags. The raw fiber is also exchanged for salt locally or sold in nearby villages". (Molnar 1981)

knots, which are locally known as *'Naka Katne*', *'Babiyo Katne'*, *'Khar Katne'*, *'Pipla Khanne'*, *'Jara Khanne'*, and *'Geda Khanne'*. Likewise, people from Rolpa were traditionally involved in the *Khoto* (Resin) collection business. After collecting this kind of non-timber forest products they sell it to merchants and contractors from outside. Furthermore, they used to carry their commodities to Nepalgunj and other Indian border cities for potential markets in search of a higher value. The cash earned by these activities was generally used to buy salt, oil, kerosene, clothes, and other household logistics in order to survive the whole year. Likewise, the Rolpali were involved in the collection of different medicinal herbs like *Panch aunle, Yarshagumba* (Cordiseps Sinenasis) and *Padamcal*. Because of the physical hardship and geographical barriers to sell the local product, it became challenging to maintain the marketing channels and protection of indigenous skill as a means of survival. As a result it could not last long. After shifting the caravan of sheep from highland to lowland, *Vedigwala, Gothala* and other local people would take part in the celebration of a festival named *Vhumya Parba* locally called *Namka* (worshiping of land) for recreation and social gathering. Berman Budha from Thabang has mentioned,

> *Magars celebrate the Vhumi Puja before harvesting and plantation. It is necessary to worship the land. I have heard earlier there was a trend of cutting a head of the most senior person of the village. Later on the trend has been changed and people started to worship the most senior persons of the village in this Vhumi Puja. Magar people celebrate Vhumi Puja and Ranke Sankranti and Tihar, Vhumi Sankranti is widely celebrated festivals in Magar dominant area*[18].

This kind of social gathering in the name of celebrating *Vhumya Parba* has both tangible and intangible social importance. From the point of view of intangible cultural dimension, though this kind of social gathering is organized for recreation and entertainment, this event is refreshment ceremony to those people who were busy in the month long journey of shifting sheep from lowland to highland and back. However, the tangible importance of this kind of cultural performance is to take part in the trading activities of sheep, dog's puppies, handmade woolen blankets and medicinal herbs. The numbers of sheep owned by any individual symbolized the level of prosperity in the northern belt of Rolpa, which demonstrates their class status in local context. Gersony (2003:8) writes,

> *Historically, the population of the Red Zone's*[19] *northern reaches was engaged more in sheep herding than farming, and the religious faith of most is described by local*

[18] Personal Interview- 22nd May, 2013 Thabang, Rolpa

[19] Rolpa is a Major heart-land of decade long civil war (1996-2006) in Nepal. Therefore, as a region influenced by the red army, the author has symbolically conceptualize this region as a red zone in his writing.

> *residents as more animist than Hindu. Ritual sacrifice of hundreds of rams at the Jaljala Devi mountain shrine of Kaila Baraha in northeast Rolpa, are important religious events where, according to one historical account, Magars honor ancestral spirits on full moon days of the months of Jestha (May/June) and Shravan (July/August).*

There had been a trend of sacrificing sheep in the name of ancestors and also to perform rituals to celebrate their clan deities. The process of sacrifice categorically prioritized only able bodied sheep as being ritually pure, so their blood can be offered to clan deity, but those sheep with physical disability are regarded as ritually impure beings to offer. According to Molnar (1981:14), "the patterns of transhumance and trade lead to some contact between Kham Magar in different valleys, and some news is carried in this way, but the contact is not of sufficient intensity or duration to maintain cultural and linguistic homogeneity." As a district situated at the Mahabharat hill range, the difficult geographical terrains and layers of high hills separate many clusters of settlements inhabited by Magar communities from each other and seasonal pattern of vertical transhumance alone is not a sufficient condition to homogenize each other's identities.

The traditional practices of shifting sheep herds decreased drastically after the Maoist civil war (1996-2006) in this region. The escalation of civil war also hampered the regular mobility of sheep herds and policies to protect community forests have created obstacles in the migrating route of sheep herds. Consequently, these practices are on the verge of extinction. The changes in the larger political dynamics of the country have directly impacted the socio-economic conditions at the local level. As a result, many individuals who worked as a *Gwala* and/or *Gothala* as a caretaker of sheep herds joined the civil war. Similarly, natural retirement of senior generation also created severe shortage of human resources to continue this kind of traditional practices. Many youth joined civil war as a militant force and went underground. Some of them got displaced and migrated to elsewhere to earn their livelihood. The persistent insecurity among other people during civil war has discouraged the shifting process of sheep caravan from lowland to highland or vice-versa. Moreover, Rolpa shares one of the highest rates of out migration from this district. Most of the males from Rolpa are bound to follow overseas migration culture as distress migrants, which is often considered amore, a "comfortable and fashionable" trend rather than struggling to eke out a living as a sheep caretaker in the difficult hills and terrain of the district.

3.1.3 The collapse of indigenous productivity in Rolpa.

Following the ecological diversity of the Nepalese geography, different ethnic, tribal and other non-ethnic communities practiced varieties of farming practices in their respective areas of settlement. Though the practice of vertical transhumance and agro-pastoralism had been mainly confined in the northern region of Rolpa, people in Rolpa had been practicing diverse kinds of subsistence farming in different regions of this district. The substantive reflection of empirical evidences show that economic activities have been performed on the basis of mutual reciprocity and a barter system. Scholars like Bista (1971)[20], Regmi[21] (1972), Stiller[22] (1973) and Molnar[23] (1981) have mentioned that the Nepalese hill economy was dependent on salt trading with Tibet. This kind of trading system has allowed many Rolpali people to make frequent trips in order to sell their commodities and to buy salt for their regular consumption. One of the senior residents from Mizhing, Rolpa has mentioned,

> *Traditionally, people used to bring salt from Tibet carried by caravan of Chauri and sheep. We used to eat Vhote noon, Rato noon or Bire noon used as a medicine. In death rites when the use of white salt is prohibited to people were allowed to eat red salt (Bire nun). Even salt used to come from Pakistan, later on salt dependency had been shifted from the northern belt to the southern belt of Nepal. People began to devalue our own goods and overvalued imported goods. Now people have to buy "noon dekhi soon samma" (Salt to Gold)*[24].

This narrative indicates that apart from using different kinds of salt for regular consumption purpose, it has been used for medicinal purpose too. The trading pattern of salt circulation in the hill settings even articulated in the ritual practices of local people. If it becomes difficult to milk cows and buffaloes easily, local people perform the ritual process with chanting some religious hymn (*Mantr*a), which has terminology like *'cha-aur vha-mar ubjyako'*. This

---

[20] "All the other people living in the higher hills of Nepal, and a large part of those in Tibet, have to rely upon the grain coming from the middle hills area to the south of the main Himalayan range. In return, the middle hills people look to Tibet for their essential requirements in salt and to a lesser degree, goats, sheep and wool". (Bista 1971)

[21] "Border trade with Tibet has been a major factor in the economy of the hill and Himalayan regions of Nepal through centuries. Such trade enabled inhabitants of the Himalayan region to supplement their meager income from high altitude agriculture, and those of the hill region to obtain supplies of the salt in exchange for food grains and other commodities. Indeed, the salt food grain nexus was the vital element in the Himalayan border trade. Trade was essential for both sides in order to overcome the constraints of a specialized pattern of production". (Regmi 1972)

[22] "The Bhotia intermediaries bartered salt for grain in the Terai or hills, and then bartered the grain in Tibet for salt and other commodities". (Stiller 1973)

[23] "By subsistence economy, I refer to an economy in which the basic economic transaction is reciprocal local exchange and in which outside markets play a very minor role. The most important economic unit is the household and transactions are non-monetary and between households". (Molnar 1981)

[24] Interview : 20th October 2014, Kathmandu

describes about the salt brought by yaks from the Himalaya. Moreover, this evidence shows how the Nepalese trans-Himalayan salt economy has been gradually shifted from northern neighbors, China and Tibet, to southern neighbors, India and Pakistan, and further changed its dimension from a reciprocal barter economy to a one-sided dependent economy. In Rolpa, the local proverb like *'Parbat khanu gharbeti gun, madesh khanu majhi gun*' (In the hills one has to take support of landlords and in plain land one has to trust Majhi as a middleman) has been existed in the colloquial language to reflect the importance of certain actors during the trading pattern. In this proverb, the literal translation of '*Gharbeti*' means (Home owner) landlord and denotes to that particular person who is very close to one's heart and is always ready to help at the time of necessity. Similarly, this proverb shows the respect to the landlord and sheep owner from the Parbat region for their generosity shown to the sheep caretaker by providing abundant crops for the journey. Likewise, Majhi is a middleman who is supposed to maintain trade and communication while selling the indigenous items and plays a supportive role to buy utensils and household logistics during the shopping in plain land (*Terai*) area. This kind of moral economic transaction shows a social, economic and cultural interdependence which bear the relational and causal rationales of its existence to maintain mutual reciprocity at local level.

Along with the salt trading pattern, the Rolpa region has its own copper, gold and iron industry[25] that has been used to make weapons, utensils and ornaments. In the Kalachetrra region of Rolpa, there used to be a trend of using *'Kalya Pysa'* of copper coin among Kala Magars. The existence of separate copper coins was significantly important from both ritual and financial point of view as it symbolized the territorial prosperity and level of local autonomy of Kalases region. Ghartimagar (2014:92) writes, " In the place called Tamari there were copper mines, since the time of the Rana reign there had been a prohibition to extract copper from Rolpa. This kind of prohibition is a sheer example of domination and control to prove the means through which local autonomy has been curtailed in this period and people were not allowed to extract any resources without the authority of the Rana rulers. Similarly, during the time of unification, the adjoining district of Pyuthan was popular for producing blasting materials and manual guns like *Pyuthane Naal* and *Patthar Kala Banduk.*

[25] "Local residents' extracted iron from twenty manually excavated iron mines about six meters deep. Forest hardwoods, abundant a century ago, were used to produce the hot-burning charcoal needed to melt the raw iron. The small local Dalit minority fashioned the iron into axes, picks and ploughs which they sold in neighboring areas" (Gersony 2003).

These are the local brand names of manual guns produced to fight during the war and during the time of territorial expansion process led by Gorkha Empire. Sales (2013:168) writes, "Pyuthan authorities used to make villagers produce charcoal through forced labour (*Jhara).* The production of the famous *Pyuthane nal,* a type of gun, needed fuel for melting metal for the barrel and good walnut wood for the stock". In the process of making these kinds of weapons, charcoal made out of walnut wood is needed as a fuel for melting metal. Blacksmiths from the Rolpa region used to supply charcoal to melt the irons as a forced labour. In return, a few people got a piece of land as payment. (*Birta).* However, this kind of forced labour system was exploitative and not economically supportive for many people in Rolpa. It is just one of the evidences of sheer exploitation during the authoritarian Rana reign. Likewise, people of Mirul and Dhangdhung used to make bamboo pen (*Nali Kalam*) made out of a local variety of small types of bamboo (*Deu Nigalo*) which is further carried to Kathmandu and even to the border cities of India to sell among potential customers. Moreover, there has been a trend to produce local paper (*Lokta*) and ink from a special variety of tree cover. In this kind of situation, to locate the potential customers, people used to travel more than a month long journey to sell indigenous items that were especially useful for "educated" people based in city areas. The growth of the vertical market structure in the capital city and absence of the sufficient market structure to promote the indigenous productivity in their locality, local producers therefore were compelled to perform long and hectic journeys to sell the goods in reasonable amounts. This kind of labour market participation created disturbances in performing regular household functions and other social responsibilities as expected by the family members and thus promoted social separation with long term emotional and psychological consequences.

3.1.4 American's Apple Initiatives in Rolpa.

The first phase of the Rapti I project was launched in the mid-western hill districts by the United States Assistance in International Development (USAID) in 1976 as a package of fifteen-to twenty-year Rapti integrated[26] rural development project (IRDP) with the aim of improving agricultural, irrigation, employment, administrative, education, road and health facilities for the rural people. In support of His Majesty Panchayat Government's regional

[26]Gow (1980) has distinguished the concept of integration and coordination in his field report submitted to USAID. He writes, "Integration is a structural dimension and implies comprehensiveness (a multi-sectional focus) and control (direct lines of authority). Coordination, on the other hand, is a behavioral dimension represented by the sharing of both information and resources".

development program this project was the continuation of American support which began in 1950 after the first rise of the democratic government in Nepal. Specifically, the location coverage of IRDP, Phase I had been mainly confined in four hill districts of the Rapti zone like Rolpa, Salyan, Rukum, Pyuthan and plain area of Dang district. Khadka (2000:86) writes,

> *The aid policy of the United States was formulated according to existing politico-economic theories (i.e., cold war considerations and development theory). The main considerations were: a) Nepal was susceptible to a communist threat, and any communist entrenchment in Nepal could have affected the security of other South Asian countries, which were also quite vulnerable both politically and economically, particularly in the 1950s and 1960s; b) a communist menace could also be born internally through popular uprisings and dissent fomented largely by the poorer sections of the Nepalese society; c) foreign assistance if focused on some of the vital socioeconomic sectors could contribute to making visible improvement in the living standards of the poor and thereby discourage them from being political tools in the hands of radical forces; and d) if economic growth and development were achieved, countries like Nepal would attain democracy and U.S. Aid to Nepal in the Cold War Period creating political stability, which would make them favorably disposed towards the west.*

Khadka (2000) has provided a contradictory statement.[27] in terms of channelizing The United States Agency for International Development (USAID) fund in Nepal, he claimed that with the presence of the United States (US) foreign aid in Nepal, it supported Nepal in its "independent" existence and further helped it to maintain a good relationship with China and India. Khadka (2000)'s contextual understanding of 'independence' in terms of Nepalese history is not clear in his argument. As one of the oldest nation states in South Asia, Nepal already had the sovereign status of a modern nation state since 1768, approximately hundred and eighty years prior to the launch of USAID fund in 1950. Nevertheless, it is always questionable how far it was helpful to protect a sovereign country's independent status by providing a significant amount of foreign aid which was basically targeted in a few districts only. As a defender of democracy, Nepal had an autocratic system. However there was no evidence that suggests USAID has ever shown their dissatisfaction regarding the prevailing kingship system of Nepal at that time. Moreover, the Panchayat government had banned political parties and leftist forces. This must be one of the reasons that the USAID intervention in Nepal was being indirectly fulfilled by the Panchayat Government's policy of not allowing any alternative forces (especially left political parties) to rise in the political

[27] In reaction to Khadka´s (2000) statement, surprisingly one of the pioneer communist leaders Mohan Bikram Singh from Pyuthan did not share his viewpoint on IRDP, he simply mentioned that because of his political exile he did not pay much attention and did not show concern about the project. Nevertheless,

mainstream of the country. Moreover, Khadka (2000) had accepted the reality that the US government was covertly interested to prevent the communism in Nepal by overtly forwarding the development agenda in the name of poverty alleviation. Therefore, it would be plausible to mention that in the name of protecting Nepal's "independent" status, the baggage of foreign assistance was launched in Nepal to suppress the potentiality of alternative political forces which could be a threat to the US strategic interest in the long run. During an interview, Khemraj Nepal mentioned, "American interest was more concentrated to penetrate Tibet. Therefore, it does not matter whether Nepal has an autocratic system or totalitarian because if you can please one state you will get opportunity to get benefit from other big sources[28]"(Personal Interview). Interestingly, the diplomatic tie up between the US as a 'defender of democracy' and the autocratic Panchayat government in Nepal was proven reciprocal to achieve mutual benefit and fight against radical political force as a 'mutual enemy'.

Nevertheless, Khemraj Nepal who worked as a second director of this project mentions,

> *Wherever American intervention took place, there has been growth of communism. Either you see the example of college of education funded by USAID in Kathmandu or road construction projects in Dadeldhura, radical leaders like Bhimdutta[29] were borne in this region. USAID has worked in Jamaica, Indonesia, Philippines, India and Nepal, nowhere this kind of integrated development model has been resulted in a productive solution. In my state visit, jokingly one of the professors told me that USAID means "United states always interrupts development", it sounds convincing. Don't you think[30]?*

Though Mr. Nepal broadly blamed the American intervention for creating a favorable ground for the spread of communism, specifically during his tenure, according to him he had never experienced any kind of overt or covert activities which were directly responsible either to "promote" or to "suppress" the left political ideology in this region. In response to Khadka's argument, leader of CPN (Maoist) Krishna Bahadur Mahara from Rolpa mentioned that the failures of such "reformist" projects like IRDP have prepared ground to seek radical transformation of the society. This ultimately gave the message that without bringing an overall transformation of the society, the partial improvement in the reformist model could not bring substantive changes at a ground level. Though Khadka (2000) had projected the macro scale impact of the IRDP project even to protect the sovereign status of the country,

---

[28] (Interview, 14th September, 2014, Kathmandu)

[29] Bhimdutta Panta has unified the farmers and revolt against Rana System; later on he was suspiciously killed.

[30] Interview, 14th September, 2014, Kathmandu)

contrary to this statement, Subedi (2005) had documented that the net investment out of the gross foreign assistance came to only about 25 percent, about 10 percent of the total project's cost goes in terms of wages. Supplementing Subedi (2005), one of the senior politicians from Panchayat period, Bamkumari Gharti Magar mentioned,

> *I was a national Panchayat member during the implementation phase of this project. Personally, I got the opportunity to visit other countries like Thailand, Indonesia and South Korea where USAID launched similar kinds of integrated projects like in Nepal but I do not see larger level impact of this project in the context of Nepal neither my exposure visit directly brings productive solution to our community. In this context, neither policies nor plans were designed by us. Our necessity was a decentralized governance system and the IRDP had a largely central level dictation. It was not a bottom up approach. (Interview : 16th October 2014, Kathmandu)*

The frustrations expressed by Bamkumari Gharti Magar clearly reveal the fact that overall design of this project had not touched the life of ordinary people of this region. She has mentioned that there had been neither the involvement of local people to express their necessities nor there had been a productive solution to address rural needs. Since the program was a largely top down model it supplements the arguments made by Subedi which states that a large section of allocated budget used to go back in the name of consultant's salaries and wages. IRDP was imposed with the rationale of building infrastructural support and technological enhancement in rural livelihoods. Empirically, there had been no significant impact of this project in the Rolpa district.

Bam Kumari Gharti Magar further mentions,

> *In the name of power decentralization in the field of health and education they trained some midwifes and made some toilets. For example, the investment amount was so meagre that they used to give five hundred rupees for toilet building purpose and three hundred rupees for scholarship education, it was such a meagre amount which was not sufficient to address the local needs of the people. Local knowledge and necessities were not addressed. The nature of our poverty was not realized and there had been problems in the design of the project itself. Consultancies were designing the fictional plan without knowing the ground reality and data related to agricultural production were exaggerated. Once in this integrated model there had been agreement to irrigate the land between Jangkot and Kotgaon, because of difficult topography, project designers were stationed in Dang and surveyed the project without visiting the place. Later on I raised this issue in the Panchayat cabinet and there was a big debate*[31].

In this kind of situations, the top down imposition of any development project results in utter failure, because if it fails to meet the needs of local people. Gow (1980:7) has stressed, "While the transmission of innovations from above is important, the identification of needs

[31]Personal Interview : 16th October 2014, Kathmandu

at the village level should be the primary basis for resource allocation at the district and central levels". According to Ghartimagar's argument, the above statement had accepted that 'innovation' should come from 'above' rather than at a grassroots level from 'below'. As the project was more targeted to prescribe the capsule of an 'integrated model' prepared by 'people on the top' as an inevitable solution, it did not incorporate local skills, experiences and knowledge before executing ready made plans and policies in the life of local people who were living in a far different context than the planners had imagined. Mr. Nepal further mentions,

> *Rather than understanding local problems and complications lots of resources were spoiled in the name of this project. Expensive vehicles and motorbikes were replacing the traditional mode of transportation. Foreign advisers and consultants were desperately expensive and ignorantly alien to the rural structure of Nepal. One of the chief administrators of USAID has told me that whenever there used to be a publication of a vacancy for Nepal; many people applied for the posts. Nepal is a peaceful country and the living standard is low and one can save extra surplus and spend a luxurious life in Nepal with low cost*[32].

The above narratives by Subedi, Gharti Magar and Nepal point to problems with other aid driven projects implemented in Nepal. One of the criticisms of IRDP is that it recruits expensive consultants who were more interested to improve their own living standards rather than work on behalf of the poor rural people of Nepal. This is one of the evidences that shows broader structural problem of aid are linked to dependency on foreign expertise, rather than promoting local innovation.

I have discussed earlier how geographical barriers like unavailability of roads and transportations are creating challenges for indigenous producers to sell their locally produced items to large markets. However, the road constructed as a panacea to join the different regions of Rolpa and adjoining districts also could not increase indigenous productivity. Many roads which were constructed during the phase of the IRDP were not of an international standard. They were only single tracks which were sufficient to drive vehicles one way only, and were vulnerable to many road traffic accidents. In contrast, without understanding the local dynamics and socio cultural barriers, the IRDP project was launched as a trickle down development solution and brought many devastating effects in the hill region. Subedi (2005:246) writes,

> *The program of Rapti IRDP was to upgrade and improve three roads in zonal level of about 288 km which linked the administrative headquarters of Salyan, Rolpa and Pyuthan districts with the Zonal centers of Tulsipur and Ghorahi. The economic*

[32] Personal Interview : 14th September, 2014, Kathmandu

viability of these roads was not systematically investigated before the roads were economically justified for construction. On the contrary, the people were deprived of the local products as part of the production that had been diverted towards the urban area. The small farmers and poor peasants did not gain much because, first of all, there was an intrusion by the big traders and merchants who monopolized the market through bullish and bearish trading practices and secondly they lacked both financial leverage and market information on price of agricultural commodities.

One of the specific criticisms about this project was that the agricultural road that should have connected farm to market and vice versa was not constructed. Therefore, rather than creating productive solutions, there had been a lot of negative repercussions from ill planned and ill-conceived development project like this one from the IRDP. The issue of constructing roads to link cities with villages has always been a controversial issue in the arena of development discourse. On the one hand it gives the opportunity for small producers to deliver their products to the market; on the other hand direct access to village life gives more advantage to market players to encroach in rural areas to fulfill their interest of profit making. In this kind of condition, the IRDP had been criticized for not acknowledging the ecological dynamics of village life and its viability to construct from different hilly regions, which could directly or indirectly hamper rural livelihood. Very little attention was given to raise the information and awareness level of the local farmers about the potential price of the products and nature of the market where they had to deal and bargain every day to sell their products. In this context, the facility of roads only opens the door for an influx of foreign manufactured products and therefore reducing the chances for the locally produced products to receive a reasonable price.

Apart from failures to acknowledge ecological dynamics of road construction, there had been ambiguities to identify the clusters in the community to implement the project. Khemraj Nepal forwarded some of the problems of the IRDP and its trickle down approach, he says

In broader, the Rapti zone might be the appropriate region to launch the IRDP project, however specifically there had been problems in the cluster identification to address the most deprived communities. Just like Taksera in Rukum and Jinabang in Rolpa were not even considered. On the one hand there were no sufficient motor-able roads and on the other hand there had been policies to marketing the rural agricultural products. Local indigenous knowledge, skills and technology were not recognized. Just like in every home there used to be Chiuri as a cash crop. There had been vegetable farming in Rolpa and Rukum although it was not drastically productive. The Rapti region is potential for the Sal tree, but there had been no plan to promote indigenous varieties either in tree plantation, agro farming and livestock[33].

[33] Personal Interview, 14th September, 2014, Kathmandu

Subedi (2005:253) writes,

> *The increase of the constant trend of seasonal and permanent migration in Rolpa, Rukum and Salyan and Pyuthan districts shows that there has not been any particular relief in the state of employment or underemployment. In income trend as well no particular improvement was noticed when considered in terms of gross average household income. The trend of institutional services such as credits, fertilizers, improved seeds, health and education have generally remained biased favoring the rich families and the accessible areas. In face of these situations, the performance of Rapti IRDP so far cannot be considered satisfactory.*

As Subedi (2005) has clearly indicated, improvement was wee in the living standard of the rural poor, which eventually encouraged them to search alternative means of survival. Since the IRDP policies had been jointly launched in support of the Panchayat government with its official policies of taking foreign assistance. Along with failures of international agencies the performance of the Nepal government and the Nepalese politicians cannot remain untouched. Gow (1980:32) writes,

> *Under the present system, the Panchayat activities, with the notable exceptions of rural works, tend to be somewhat divorced from those of other development offices. In addition, Panchayat offices do not appear to reach much below the Village Panchayat. If the project is to have any measurable effect on local population at the grassroots level, then steps must be taken to strengthen the ward committees or similar type of local organizations.*

Gow has clearly indicated the failures of the Panchayat government to deliver adequate level of performance to the rural mass. USAID and the official policy of the IRDP has never criticized the autocratic ruling system in Nepal. However, they have softly criticized the performance level of the Panchayat system which could be a covert indication to show that Panchayat as a system is not supportive in order to promote people's participation. On the one hand there had been ad hoc policy of people's mobilization during the Panchayat system, while on the other hand, Panchayat as a system has tried its best to make "inclusiveness" even at grassroots level. Moreover, with the lack of people's participation at a broader level, any kind of imported development model that the Panchayat government had imposed with conjunctions of international support could not bring any productive result to the people of Midwestern hill districts. In contrast, the failures of this ambitious plan compelled the donor community to rethink and review the project and later on they sliced the prior integrated concepts into few components. Chew (1990:7) writes,

> *During project implementation, it became clear that the original multi-sectoral project design was too complex to be effectively managed by USAID/Nepal and the Nepalese Government. Some activities (e.g., social services) were never implemented.*

> *Based on the recommendations of the midterm evaluation in l983 and the final evaluation in l985, the project objectives were narrowed to focus only on completing road construction and developing appropriate agricultural production technologies and local institution building.*

Initially, it was the integrated concept which included many components like soil conservation, veterinary, cooperatives, cottage industry, public health, education and also a Agriculture development bank. After the funding agency reduced the scope of the project in a smaller scale, it has been explored that from the side of the Nepal government there had been no effort to mention the needs of the Nepalese people and expected outcomes to donor community. In the interview, Khemraj Nepal further mentioned that,

> *Those politicians who had political hold they used to forward their interest to locate the project in their area to please the local people to win the election. The company named first time appeared in Nepal to work on rural development activities which had only prior experiences in urban areas. The Nepal government had agreed that the infrastructure which costs was more than 50,000 NRs needed USAID approval which was wrong because for this kind of minimum budget the government should not give extra space to a foreign agency. Politicians used to have their own consultancy form and they used to force to get tender. The issue of sustainability was another ignored issue in IRDP. There has been no involvement of local people in the concept of the service center. In Tulsipur, the army captured physical infrastructure. There has been concept of a pocket service centre in Chaurjhari, Holleri, Devistan. Though conceptually it was an integrated service centre , the physical placement of every service centre has been appeared in vertical existence. Later on those service centres were captured by rebellions. Local people did not have sense of belonging , that is why it was not protected by the community*[34].

The concept of the IRDP is to mobilize the people at grassroots level to empower them about the ideas and technology which could be used to make their living standard better. In contrast to this expectation, the narrow vertical and top down model of development could not ensure mass level of people's participation even to protect the community infrastructure from getting misused. The problem with a lot of components is difficult to integrate and coordinate also. The failure of IRDP had created frustrating perceptions among the people that exogenous model of development cannot alter the dire condition of rural livelihood. Though the failures have been linked to one of the arguments which were supportive to create favourable ground of civil war. However, the consultant of Mercy Corps International Robert Gersony (2003:49) writes,

[34] Personal Interview, 14th September, 2014, Kathmandu

The war began neither because the project activities were such a failure that local residents lost hope, not even because its activities were such a success that they raised expectations which were not met. The failed apple initiative in the Red Zone was a small effort with limited participation. As described earlier, the Maoist conflict has its origins in a different set of historical events.

In reality, IRDP as a program failed utterly because there was no significant outcome of the program in this region. Gresony himself agreed the failures of the project with the use of words like: 'failed apple initiatives', a metaphor has been developed to understand the failures of overall projects launched in the name of IRDP based on its one of the programs apple plantation in Rolpa . Though it is not possible to draw the straight and causal organic link between failure of IRDP project and the civil war in Rolpa, this kind of failure is deeply embedded in local people's mind which destined them to see failures of development projects rather than celebrating any successes which eventually promoted frustration and dissatisfaction against the state. The chronic accumulation of frustrations may have exploded at a devastating scale when the region became the starting point of the civil war of Nepal.

3.1.5 Chares cultivators of Rolpa in crisis.

Chares is a black semi solid substance prepared from both wild (*Banvhango)* and domestic variety (*Ghar Vhango*) of Marijuana plants[35] and used for narcotic and medicinal purpose. Extracting hashish (Chares) is another form of traditional occupation that has been performed by many people from northern regions of Rolpa. After making a month long journey with the caravan of sheep from lowlands to highland, special varieties of Tibetan Mastiffs (*Vote Kukur*) guard the herds of sheep, and herders (*Vedigwala*) started to collect hashish (Chares). Since Chares used to be one of the important income generating activities, people from the northern belt of Rolpa who do not work as sheepherders were also involved in its business. The flow of western hippies during the age of hippies and freaks into Kathmandu in the decade of the seventies had created a high demand for hashish in Nepal. People used to bring hashish from the rural belt including Rolpa and used to sell it in the government regulated hashish shops at the Freak Street of Jhonche in Kathmandu. Sales

[35] Wild varieties grow by nature in the forest without human intervention and domestic varieties have to be cultivated in the household to extract the grain and Chares as per necessary. The stem of this plant is used to make Lokta, an indigenous raw material to make paper. "The plant′s rough bark was traditionally used for rope; rough fiber for producing carrying bags; and it´s fine thread was woven into traditional Magar clothing. The plant′s seeds were ingredients in chutney and pickling". (Gersony 2003)

(2013:167) noted, "the subsistence economy that barley provides enough food for the average farmers had to be supplemented by other sources of income: for many years after 1930, hashish provided the necessary cash to make up the annual food deficit and, increasingly, as the barter economy gave way to consumer goods, to buy salt, oil, clothes, medicines, and school materials for children." Selling Chares used to be the source of extra income for most of the Rolpali from the northern belt. People used to make extra surplus and wear a lot of golden ornaments by selling Chares. People used to say that *'ki ses ma dhan cha ki desh ma dhan cha' which means* either there is wealth abroad or in Sesh area. Bam Kumari Gharti Magar mentioned,

> *Without knowing the multipurpose value of the Chares plant, the wrong decision and bad governance of the government to blindly obey international declaration finally created hatred and frustration among the Chares cultivators. In one season, local women used to earn 70,000 to 80,000 thousands which was sufficient for them to manage their households. Even the IRDP tried to replace the traditional skills of local people with newly prescribed training however it could not bring substantive solution for the rural mass in Rolpa. As a result there has been a revenge sentiment against the state which was capitalized by radical left parties into arm led movement against the state*[36].

Many people in Rolpa had utter dissatisfaction that the government banned Chares only for its narcotic value, however, the use and importance of the Chares plant in rural livelihood had not been acknowledged. There had been argument that the Rapti integrated project had surveyed the road from Ghorahi to Libang, moreover, (though it is not officially documented) many people shared the opinion that this project had the intention to prevent the hashish business and to offer alternative work for the people of Rolpa. Gersony (2003:12) writes,

> *Thirty years ago, they said, theirs was the most prosperous area of Nepal's western Hills. They defined this prosperity as having sufficient cash to bridge the annual food deficit, to buy salt, oil and several sets of clothes each year for their families, to acquire the silver-coin necklaces and bracelets and gold jewelry which Magar women liked to wear, and being able to remain at home, rather than migrating, to acquire the cash these required.*

Though there had been substantive evidence to prove that the Nepalese hill region had extra income to manage their household and to live a prosperous life, many scholars did not notice the magnitude of production up to the level which allow them to accept the fact that people were earning enough to generate extra surplus. Citing M. C Regmi, Stiller (1973) has

[36] Personal Interview : 16th October 2014, Kathmandu

mentioned, in the Pahar zone itself, however, as distinct from the northern Himalaya regions, one study says that whatever manufacturing and commercial activities existed were related to the needs of subsistence, and hence were not generally an independent means of livelihood. He further writes that indigenous trade was practically non-existent. As Stiller argued, it would be blunt portrayal on rural productivity to develop the understanding that indigenous trade was practically non-existent. In reality, it existed in significant volume but there had been no effort to understand the significance, proportion and its magnitude from the point of view of the centralized state mechanism. Contrary to Stiller's argument, there had been trade related activities in substantial volume, which were performed to sell local commodities like Chares and other indigenous items to earn cash to buy further household items and also strategically targeted to make huge surplus amount. The existence of copper mines and coins are significant indicators of commercial trading activities in Rolpa were substantive evidence to prove the existence of indigenous trade in hilly regions of Nepal. The discovery of hashish as a cash crop has played a vital role to bring prosperity in the regular life of many Rolpali people. This formal and regular trading pattern became the issue of international drug politics and following the international declaration, the State imposed a ban against this substance. According to Sales (2013:167), "The ban imposed by the government in 1976 on the production and sales of hashish did not stop villagers from following this lucrative trade but it made their lives more vulnerable to the intervention of corrupt police force." After imposition of ban on production and sale of Chares, the sellers had to walk off alternative trails and routes to avoid potential arrest from security forces. Many sellers even started to disguise themselves as seasonal labourers to hide the amount of Chares they were carrying to sell in the market. The dream of being continuously prosperous has not lasted long for many Chares producers from Rolpa and international declarations and policies on the trade which affected them, were very alien and exogenous for many native people to understand. "Nonetheless, the police enforced the ban effectively by interdicting the trafficking and sale of hashish along established trade routes. Scores of small local dealers and traders were arrested, and the demand for hashish in the villages diminished. When ordinary farmers carried hashish to the market, for example to Nepalgunj at the Indian border to trade for salt or cooking oil, they too were arrested" (Gersony 2003:13).

The traditional economy which people used to perform legally and proudly became illegal and those people who performed this job in a covert way were being harassed and

facing legal punishment even in present days[37]. Gersony (2003:13) writes, "between 1976 and 1980, the 'standard of living' of which they had spoken of had given way to grinding poverty in which food was shared among neighbours just so they could survive. Women sold their silver necklaces and gold jewelry; men migrated in greater numbers to earn the money they needed for their families' survival. In their perception, by banning hashish, the government had literally taken the food out of their children's' mouth". Similarly, "for different purpose, Magar people were involved in the farming of hashish, until Panchayat government had banned Chares production activity. It was a good source of income, after this people started to sale Cordyseps Sinensis (*Yarsha Gumba*), there was a good market for these medicinal herbs in China and other Asian markets." Ogura (2005:74) The picture of the economic pattern that Gersony (2003) and Ogura (2005) had portrayed is partially true, but a large section of population from the Rolpa district were not involved in Chares and *Yarsha Gumba* business and even in northern belt, Chares production was not only the only income source. Nevertheless, it was significant enough that the international declaration to ban Chares as a narcotic substance further led those in the northern highlands to struggle for alternative means of survival.

3.1.6 The Journey to the Black Hills from Rolpa.

Historically, the state-led development had been centralized and the educated elites and educational activities were primarily concentrated in the capital and city areas. Before the construction of highways as a new lifeline there was no transportation facility to connect upper hilly regions with lower plains, for instance the walking distance from Rolpa to Kathmandu used to be eighteen days or more. Gersony (2003) writes, since the 1980s, Rolpa's south-eastern corner has had a few agricultural feeder roads connecting it to neighbouring districts and perhaps one track leading to Libang. Otherwise, the District has had no motor-able or all-weather roads. Likewise, Alma Ata (1978:47) writes, "Feeder roads not only connect the farmer to the market but also makes it easier for people to reach villages, bringing new ideas, together with the supplies needed for health and other sectors". However, in the absence of such two way physical connection people have had to live a life isolated from the larger world and its rapidly changing dimensions. Many people from Rolpa

[37] During my fieldwork, Local FM was frequently broadcasting news related to the arrests of Chares vendors. After a few days in Libang the police were taking two handcuffed senior women from Kham Magar community who were just arrested a few days before and brought to the district court of Rolpa in accusation for selling Chares.

had to walk to Koyalabash, Nepalgunj, and even Battaual[38] to work as a potter to earn money to manage regular household necessities. The phenomena of manual labour [39]performance as a *'Batteula vhari bokne',* means carrying loads from Butwal to different places as per requirement of the owners, had been performed by senior generations of Rolpali males extensively. Those people from Kalasesh region of Rolpa who were involved in performing labour were largely ghettoized by labeling them as a *Shesi* by people from plain areas. Ses[40] as a term actually denotes territorial prosperity where Magar people can recognize themselves with sense of origin and representation in their locality as a culturally prosperous and dignified status. However, other people from comparatively well off areas like Dang and Pyuthan, used to be stereotyped by using the word like '*Shesi*' in discriminatory sense against those who were performing manual jobs of potters and loaders. Identifying oneself as a sophisticated and characteristically different than the people from hill origin, the notion of *Shesi* is a discriminatory identity and 'sense of othering' constructed to label the marginal people who were basically from the Ses[41] region of Rolpa. Sales (2013:168) writes, "The Nepali term Ses designates precisely a high, remote place with a sense of being 'residual'. Those Magar people coming down from the hills with their sheep are called *Shesi* by lowland who cannot express more clearly their vision of this community at the periphery". Originally, *Vedigwala* are not from the Ses region, but people from Pyuthan and Dang have homogenized the identity of Ses as backward, uneducated and uncivilized. Thus, *Sesi* became the colloquial word to discriminate the people having the same kind of dress and life standard as those in the northern region of Rolpa who would descend from the highlands for trade or in search of employment. Likewise, in discriminatory sense there has been trend of labeling as a *Doke* by older inhabitants in Dang to those hill migrants who came down carrying bamboo baskets from Rolpa and adjoining hill regions.

From the mid-western and far western development region, even in present days there had been a trend of going to *Kalapahad* (Black hills) to perform labour and to earn money to manage household necessities. *Kalapaar*, means the other side of the Kali River. In different

[38] Earlier days, people used to say Battaeul to the present day popular named as Butwal.

[39] In this kind of manual labour economy, Mukhiya and Tyala were supposed to supervise the potters carrying Khayar;. Similarly, Dyar was supposed to supervise the potters carrying 'bet'(the strings are from a kind of strong wild plant used for making chairs and furniture).

[40]The Magar inhabitants of Rolpa Libang to Taksera of Rukum are known as *Se*si Magar which is basically reside in the Kalasesh region of Rolpa.

[41] "Oral account suggest that two powerful kingdoms of Jumla and Parbat fought over the states lying between them . In the absence of clear victory of either sides, the Magar population of these districts was left to decide about their own administration. Since then so the story goes, they have called *Ses Rajya* the remaining state. (Sales 2013) Politically, Ses is the remainder a state of eighteen Magarant regions.

contexts, people from Rolpa and adjoining regions used different terminologies like *Kalapaar* and *Kalapahad* only or *'Kalapahad Jane Chalan'* trend of going to *Kalapahad*. In this case, *Kalapar* and *Kalawar* has been emerged where *Kalawar* means people residing at Magarant regions and *Kalapar* means the people those have crossed the Mahakali river in order to search jobs for bare survival. The notion of *Kalapahad* or *Kalapaar* has both physical and symbolic existence of different hilly regions of India where seasonal labours have to work hard to subsist. Seasonal migrants, especially from mid and far western region of Nepal have visualized this hardship and territorial suffering as a labour performed in the hills of death (*Kal ko Pahad*), the black hills of India. Many people have perception that there is a existence of a physical place called Kalapahad (Black Mountain) in Simla, however, there is confusion as to whether physical location called Kalapahad exists or not. It could be a virtual symbol of pain and sufferings that migrant workers, especially from far western and mid-western regions of Nepal have to bear in different places of India like Himachal, Kashmir and Simla. In this journey, after completing agricultural activities in their homeland, people from Rolpa region head off to Simla and Kulu Manali to carry out religious visit and to perform different manual activities like plucking apples, planting potatoes, carrying loads and being gate keepers.

Gersony (2003:21) writes,

> *Seasonal labour opportunities in Kalapahar for Rolpa and Rukum migrants, however, produce only enough money for bare survival. Earning less than their Indian counterparts, Nepali laborers manually break stones into gravel, carry heavy loads of it to road-building sites, and work in fruit orchards and farms. Their earnings barely bridge the annual food gap to enable them to buy a bit of oil and salt and perhaps an annual change of clothes. The migration takes them far from home and family, and the rewards are meagre though essential.*

At present, the mid-western hill district Rolpa shares one of the highest levels[42] of undocumented labour migration after the hill districts of far western development regions. Along with traditional destinations like Kalapahad and other border cities of India, today the gulf countries like UAE, Saudi Arabia, Qatar, Oman and Malaysia are the popular destinations of employment for ordinary people in Rolpa. In alternative to seasonal and forced migration a few people have joined the British Army, Indian army, Nepal army, the People´s liberation army and Nepal police and other administrative services of Nepal

[42] Since this migration pattern operates from open border between Nepal and India. No government and non-government organization has documented the exact numbers of migrants.

government. The tripartite agreement between the Nepal government, (Then His Majesty Government), British government and East India government had determined that four indigenous caste groups of Nepal like Rai, Limbu, Gurung, Magar, affiliated to Gora Paltan (*Purano Gorakh Gan*) could be sent to British army (Pun and Ghartimagar 2014). Especially in the twelve Magarant regions, which have historical linkages with pre-modern war history, apart from fulfilling financial necessity, it could be the matter of social prestige that many people from Rolpa join military services as a *Lahure* to continue their marshal traditions. As Hitchcock (1961) indicates, military rank is important for one's village social structure. The recruitment of many males in the army has shifted the occupational structure and people developed higher sense of livelihood security in government institutions rather than performing hard physical labour in rural villages. However, this kind of occupational recruitment has been criticized from a nationalist perspective and the agenda of immediate cancellation of this kind of treaty by different communist parties like hard linear CPN (Maoist) which was one of the agendas among forty points demands submitted to Nepali state before officially announcing civil war in 1995. Similarly, Nepalese migrants who work as domestic security guards (*Chaukidaar*) in different cities of India are labeled with the new identity of 'Bahadur' in derogatory manner. Along with economic necessity to perform labour in a foreign land, a Nepalese word "*Bahadur*" to denote courageous became the terminology of discrimination and subordination for many affluent class Indian citizens which also hold similar kind of sense of othering like '*Sesi*' and '*doke*' in Dang and '*Pavei*[43]' in Jumla. The lack of employment opportunity compelled many people from mid-western and far western hill region to migrate from their place of origin to elsewhere. Rolpa as a district is no more isolated from this trend of outgoing migration.

3.2 The era of socio-political and civil consciousness in Rolpa (1950 - 1995).

3.2.1 The emergence of left political consciousness in Rolpa.

Before 1950, the country was totally under the rule of Rana feudal oligarchy, and rights to establish political organizations had been legally prohibited in Nepal. After the overthrow of hundred and four years of Rana reign (1846- 1950), the first rise of democracy in 1950 spread a new shared imagination about the nation state within the general people. Thus, it changed the past perception of ruling state as a non-participatory mechanism controlled by Rana family lineage. Gradually, there has been rising awareness concerning the

[43] In Jumla, well off people from district headquarters used the term *Pavei* to discriminate the people from southern areas like Chaudhabisa.

social, political and civic freedom all over the country. Empirically in Rolpa, it has been explored that the seed of class-consciousness emerged from Thabang, a predominantly Kham Magar village in northern belt of the district. Before intensification of the intra-group conflict among the chieftains in Thabang Village, there was aggression against feudal suppression in this region. According to oral chronicle, during the time period of 14th century people from Thabang chased away the Chapakote king and in the end of 17th century Lalu Shahi and Kalu Shahi were pulled down from their horse. Actually, these kings used to impose land tax on people of Thabang by offering them rice seed to plant in their wetland. Instead, *Thabangi* fried the seed before sowing into the field which prevented it to grow as a plant which would be a step of revolt for them to show silent disobedience against the imposed decision. Later on with the help of hunters from Uwa, *Thabangi* thrashed the tax collectors sent by king of Chapakot. Subsequent to this incident, *Thabangi* left paying land tax to the kings of Chapakot. This historical experience has been evidently embedded in the common psyche of *Thabangi* people that any form of feudal suppression can be overthrown if one can develop communal strength to fight collectively against such domination and control. As James Scott (2012) describes, this event was an indication of moral economic revolt which shows the spirit of spontaneous revolt against any feudal form of suppression by the peasant community without intervention of any political organization. Similarly, there had been intra-conflicts in Thabang with newly recruited local chieftain Krishna Jhankri regarding tax collection and villagers had deep grievances for his unnecessary suppression. Ogura (2005) and Sales (2013) has documented that after being chieftain in 1952, Chieftain Krishna Jhankri Magar had imposed a new rule in order to modernize the village which was supposed to control the free movements of pigs and he brutally started to punish those people who were against this rule. The arbitrary imposition of rule by new chieftain seriously conflicted with the livelihood pattern of the *Thabangi* people. In addition, he imposed the land taxation to be paid on individual basis rather than existing lineage based on a counting system. Such punishment had further intensified the aggression against feudal domination imposed by chieftain Krishna Jhankri. In this case, there had been tussle with another Chieftain Berman Budha's group and Krishna Jhankri's group. In 1954, in the month of May/June (Jestha) in his own field, Berman Budha and his group attacked another chieftain Krishna Bahadur Jhankri Magar. Again, in 1955, because of political revenge, there had been huge rows between Krishna Jhankri and Berman Budha's allies and local people were split into two factions. Berman Budha one of the village chieftains among the conflicting parties from Thabang has explained the historical situation. He says:

We used to have tussles with local Talukdar. So we formed the group to raise the voice against his domination. Initially, the group was not politicized and we were just intended to take the revenge against any unnecessary kind of suppression in the village. Meanwhile, our group had beaten the local Talukdar. In revenge, Talukdar also began to harass our group. In this way, tussles among us were gradually intensifying. Many times we faced temporary displacement and took shelter in neighbouring villages. To avoid local disputes, our friends' left the village and went to Pyuthan. Meanwhile, the administration arrested us while returning to the village. Then after, we were taken to Pyuthan Badahakim's[44] office and were blamed for performing anti-social activities and they labeled us as a communists. We paid five rupees fine for being a communist. Though this case was ended, again the opponent filed the cases against us. We also filed the case against Talukdar for grabbing our properties[45].

In this context, the act of favouring one party and negating another, the state had developed the easy solution to punish them by labeling them a 'communist' as an anti-state ideological and practical force. In the politico-historical context of the Panchayat period, where kingship has been accepted as an integral force of ruling structure, any kind of ideology that does not support the existence of monarchy could be strictly taken as an antagonistic element and could be labeled as an anti-state force. Contextually, Malešević (2010 :333) writes, "Ideology is a complex process whereby ideas and practices come together in the course of legitimizing or contesting power relations. However, the particular situation of Thabang was significantly different where one group has tried to legitimize its own ideology on other groups and challenged the existing power relations and status quo of another group. In addition, the intervention of macro level power has challenged the non-antagonistic micro level actors up to the level where they could be potentially antagonistic. As Sales (2013) writes, conflicts do not take place between the poor and rich but are better characterized by competition of power between more or less equal groups. She further writes, "Their contestation was grafted onto local patterns of resistance that have been observed in peasant societies elsewhere, but state repression initiated a different turns of events and ironically helped to launch Thabang locality onto the national stage." (Sales, 2013: 172)

Even though, this particular event was the connecting point to Berman Budha and his friends to the leftist leaders who were already in custody due to political reasons. However, this event demonstrates the coercive intervention of state over the micro level disputes

[44] According to Buch committee report published in 1952 AD, there were twenty districts in hill regions, nine districts in Terai regions and three districts in inner Terai. Among them Salyan and Pyuthan were two hill districts formed in the time of Bir Shumsher. It has been noticed that these districts were supervised by a high rank administrative officer called Badahakim or high rank Rana military officer"

[45] Personal Interview-22nd May , 2013 Thabang, Rolpa

among local actors in Thabang which transformed its local dynamics into macro level power relation as a state-anti state confrontation. Subsequently, the interventionist act of labeling one as a 'communist' by using the language of power, state actors excluded people like Berman Budha and his allies which ultimately forced them to nurture the sense of non-belongingness to the state mechanism as anti-state actors. This exposure helped Berman Budha to understand about the left political ideology with those politicians like Rum Bahadur Pandey, Nandalal Gurung and Siddhiman Singh who were in the Pyuthan jail accused of anti-state activities under the banner of the communist party. In this period, though Rolpa as a new district did exist in the administrative structure of Nepal, there was an emergence of left political activity already in the adjoining Pyuthan district in 1953 [46] under the leadership of pioneer communist leader Mohan Bikram Singh. After the rise of the democracy in 1950, with imposed conditions to accept the existence and legitimacy of monarchy as an intrinsic dynamics[47] of Nepalese power structure, bans against the communist party were released. However, the image of Communists as an anti-state has not removed from the perspectives of the government. Moreover, in 1956, the team of Mohan Bikram Singh, Rum Bahadur Pandey and Khagulal Gurung reached Thabang[48] while traveling from Jajarkot via Rukum to Pyuthan. In this context, the role of Mohan Bikram Singh[49] has been influential to germinate class-consciousness in Rolpa and particularly in Thabang which was previously influenced by Nepali Congress ideology. Pioneer communist leader Mohan Bikram Singh says,

> *Thabang has predominantly a Kham Magar dominant structure; there was contradiction among the Jimmawals and Mukhiyas. Though Berman Budha was a son of Mukhiya[50], taking care over his progressive attitude, we have decided to provide membership of Nepal communist party. We have convinced them by saying that it*

[46] More than 150 youths were gathered and a camp has been organized. For three months, Mohan Bikram had given all kind of political, theoretical and physical training in this camp. Then after, a district committee of party had been formed. In this way, the political strength of the communist party had been expanded rapidly.

[47] Because of this clause, there had been deep contradiction among Mohan Bikram and Dr. Keshar Jung Rayamajhi group.

[48] Gersony (2003) documented that "M.B. spent six months in Thabang. He helped to organize the local Communist Party cell, established a branch of the Kisan (Farmers) Organization, and helped the people to 'resist the influence' of traditional tax-collectors and other 'feudals.'" But in reality, Mohan Bikram Singh admitted that he never stayed such a long at Thabang as Gersony had written.

[49] In 1951, there was *Chiniyakaji Hatyakanda,* and Mohan Bikram who resigned from the Nepali Congress and took membership of the communist party. During time period of 1954, while doing protest against corruption, Mohan Bikram Singh, Khagulal Gurung has been arrested and kept in Palpa jail. Since 1961 , Mohan Bikram was in jail for 9 years.

[50] "When Krishna Mukhiya died of tuberculosis, Berman Budha became *Mukhiya* in 1958 (Ogura 2062). However, in comparison to previous *Mukhiyas* he started reform activities at Thabang. In contrast, Keshav Raj Shrestha who worked as a principal of high school in Thabang blamed, "Initially lands of Thabang were not under government control. Most of the lands belong to *Jaljala Guthi*. Berman Budha has taken bribe during registration process of local land and he shifted the land ownership from communal to personal".

would be better to establish peasant's organization and work on behalf of poor peasants rather than fighting to each other[51].

As a result, in 1956, on May 26th, All Nepal Peasant Organization was established in Thabang as an open front of Communist Party of Nepal that consists of founder members like Berman Budha, Purna Bahadur Rokka Magar, Mahasur Budha Magar, Umer Bahadur Gharti Magar, Bahadur Budha Magar, Dil Bahadur Budha Magar and later on extra member Dharam Bahadur Rokka Magar. Most of the members were local farmers and most of them had never gone outside the district. After the establishment of the peasant organization, Berman Budha and his group initiated reform activities like rice plantation and regulating pig-raising process. Again in 1957, under the leadership of Berman Budha, there was a clash between the people from Uwa and Thabang, as a consequence, people from Uwa ran away and the Thabangi captured their property. Mohan Bikram Singh says," We take the strong base of Thabang as a 'gift of district magistrate (*Badahakim*) [52]'. If rulers could not arrest local people like Berman Budha, it would not be possible to extend the left political organization". He further mentioned that there was a strong sense of commitment among Magar people that if they follow certain ideology they will try to maintain consistency and give continuity. Rather than indulge oneself in an intrapersonal conflict he convinced them to capitalize their energy against the domination and suppression of the state. One of the senior leaders from Thabang Santosh Budha Magar says, since communist advocates for egalitarian society, "We Magar people are traditionally egalitarian and believe in communitarian feelings, because of ideological similarities with our commune style of living we are more inclined towards left philosophy." The commonness of livelihood pattern, land ownership and village settlement are some of the features which show egalitarian values exist in the society, and these share conceptual proximity with the Utopian idealism of left philosophy. Therefore, in comparison to other ethnic and indigenous communities of Nepal, the Magar as an indigenous group have a lesser degree of class polarization. The rapid influence of left philosophy in Thabang was quickly reflected in the election of 1959. After becoming the *Mukhiya* of Thabang, Berman Budha decided to vote on their familiar communist candidate Khagulal Gurung, who was one

[51] Personal Interview- Kathmandu, 2015, 11th November

[52] "To simplify the administrative procedure and to maintain the influence of centralized ruling system at grass root level and to collect revenue and to maintain law and order administrative division of the districts were done. The powerful officers were appointed to look after these districts was one of the important feature of administrative mechanism during Rana reign. The chief officer of the district used to be *Bada hakim*, because of power, authority, role and high position; they were somehow regarded as a ' prime minister' of the district. (Bhattarai 2002)

of the members accompanying accompanied Mohan Bikram Singh to establish a peasant organization in Thabang. Sales (2013:173) writes, "The unanimity of the votes might be attributed to the political ignorance of backward peasants blindly following their chiefs, but then obviously the strong communist presence at Thabang had attracted the attention of local authorities" During the election of 1959 AD[53], though most of the votes were cast to communist party at Thabang, the Nepali Congress candidate won the election in this constituency. After the demonstration of political solidarity among the villagers, Thabang got the new identity of being a "Communist Village" which could be a potential threat to the administration and existence of monarchy. The unanimous political solidarity among the villagers in Thabang developed a sense of belongings to their own community and they acquired further confidence to mobilize the communal strength. While class exploitation is prevalent in Rolpa and other regions of Nepal, unlike other villages; Thabang had leftist political actors who acted as a social catalyst to sensitize them about the nature of class exploitation and their existence in relation to the larger domain of Nepalese society.

Since there was no existence of any schools before the formation of Rolpa as a new administrative division, a handful of local people who were interested to pursue modern education used to go to adjoining districts like Musikot and Pyuthan.[54] In Thabang, the first primary school was established in 1959 and the ex-Indian army soldier Lal Bahadur Gharti was appointed as a teacher. Afterwards, the school received government approval and Shahabir Rokka taught in the school which was functional in Berman Budha's home. Poudel (2012) writes, the Thabang School which was established in 1960, was the centre for various political activities and teachers were connected with communist ideologies and parties. It has been explored that with the rise of leftist consciousness there has been a growing trend of micro level solidarity among the villagers which simultaneously nurtured the culture of political intolerance and a culture of non-acceptance of plural political ideology. In homogeneous settlements like Thabang, the rise of certain political ideology bound community members with additional collective strength and sense of belongings. However, it was evident that the same collective strength of homogeneous groups may sometimes become intolerant of other political ideologies. Keshav Raj Shrestha, a current resident of Libang, who once served as a school principal in Thabang mentioned that because of his non-

[53] "In that election, Anirudra Sharma from Pyuthan has won the election. Then Thabang was in Pyuthan district, after restructuring of 1961, again Thabang was placed in Rolpa district."

[54] Mukti Sena had established Ratamata high school in Ratamata of Pyuthan in 1951. Congress Mukti Sena which is also known as Congress liberation Army that was the militant wing formed to overthrow the Rana reign during 1940. Later on, after announcement of democracy this Army was integrated to Nepal police.

communist background people did not like him so he could not stay in Thabang for a long time. As Malesevic (2010) writes, with the help of certain ideological glue, this kind of micro level solidarity plays a vital role to tie the diverse citizenry into quasi homogeneous entities who will be ready to support war and other coercive causes when necessary. It is not the single case that became the political victim in Thabang, many people who were supporters of another political party left Thabang, and different political atrocities occurred afterward and also during civil war.

3.2.2 The impact of the political coup in Rolpa.

The emergence of leftist political consciousness in the northern region of Thabang has been in parallel accompanied by the growth of democratic[55] political consciousness in Gajul, the southern region of Rolpa. Local resident of Gajul, Khadananda Subedi had a personal relationship with politically eminent personalities like Anirudra Sharma, Min Bahadur Sharma and Hemraj Sharma from Pyuthan, Khalanga. Among these people, Anirudra Sharma was a Member of Parliament from Pyuthan and active figure of *Jayatu Sanskritam*[56] movement which was overtly focused to educational reform and covertly focused to overthrow the authoritarian Rana reign. As a person willing for political activeness, Khadananda Subedi, was inspired by Anirudra Sharma and his political activities. This personal political connection of Mr. Subedi with Anirudra Sharma later became catalytic for him to become involved with the revolutionary party Nepali Congress. Sales (2013) writes, the first revolutionary ideas[57] circulated from the southern bazaars in the plains up to the northern hills along the transhumance routes. To supplement, Sales' 'Thabang centric' interpretation, this research has explored additional historical facts which proves that the personal political channel of Khadananda Subedi with the political leaders from Pyuthan were supportive for him to get the membership of Nepali Congress, which was the connecting point to spread Nepali Congress ideology in southern region Gajul and other regions of Rolpa. Subsequently, in the first democratic election of 1959, Khadananda Subedi as a candidate of Nepali Congress was elected from Kalases region of eighty-three number

[55] In the context of Nepal, though mainstream left parties also believe the fundamental values of democracy, however, 'democratic' has been used synonymous Nepali congress and its followers.

[56] "This organization aims to reawaken the social faith in Sanskrit scholarship, Vedic civilization, religion, culture, in order to protect, promote and propagate Aryan's values and beliefs. Jayatu Sanskritam movement took its shape making educational demand with concealed political motive on the 1947 AD. The movement gave the Rana Regime big shock and *Jayatu Sanskritam* became historical event for the democratic movement of Nepal".(www.jayatausanskritam.org)

[57] Here, she meant the influence of Nepali Congress which was supposed to be a revolutionary party around 1951.

electoral constituency.[58] He became the Member of Parliament led by Bisweshwar Prasad Koirala[59]. The first primary school was established in Gajul during the tenure of Khadanada Subedi as a Member of Parliament in 1961. During his tenure, thirteen schools in different regions like Gajul, Aresh, Sirpa, Mizhing, Phagam, Libang, Kocha, Budhagaon etc. were established. Though Khadananda Subedi won the election from Rolpa, rather than playing an active role to establish some primary schools, being a pioneer democratic leader, he could not demonstrate his political strength to expand the political organization of Nepali Congress effectively in Rolpa. As his elder son Narayan Subedi acknowledged, Khadananda Subedi was more a social leader than a political leader who took no effort to expand the political organization and to develop a new political generation. Consequently, the individual limitation of pioneer Nepali Congress leader became an organizational limitation and Nepali Congress gradually lost its grip in Rolpa. Similarly, there has been no extra effort from party level to expand and flourish organizational strength of Nepali Congress in Rolpa.

Moreover, highlighting the inherent class, caste and other social contradictions, leftist parties started to extend class-consciousness; people became gradually inclined toward leftist ideology. The first rise of democracy in 1950 had created a favourable ground to expand political consciousness all over the country, however the political coup[60] performed by King Mahendra in December 1960 brutally suppressed political organizations all over the country. Following the coup of December 1960, many political leaders from the pre-Panchayat era went underground. Some of them joined the Panchayat system and others remained politically passive. Moreover, this coup dismantled the political parties and its sister

[58] Anirudra Sharma got elected from Baish Khuwa, Pundit Purushottam Kaji from Pyuthan, Nep Bahadur Malla from Salyan and Judhha Bahadur Neupane from Rolpa area of Salyan, Tek Bahadur Gharti from Rukum, Parashuram Chaudahri from Dang , and Ganesh Kumar Sharma were also elected in this first general election. As the Nepali Congress had revolted against a hundred and four years long Rana regime there has been influence of Congress party in other parts of Nepal and Rolpa as well. All over the country Nepali congress won with two third majorities and Communist party of Nepal which was formed in 1949 could not maintain its strong presence in this first democratic election. Khadka (1995) noticed about the weakness of communist party was that the party organization was weak and the membership was small and drawn mainly from the urban population.

[59] This government basically followed the political path of democratic socialism which was passed in its national conference in 1956.

[60] In this speech, King Mahendra has mentioned, "We have to develop our own style to develop the country. People are already irritated with the copied ruling mechanism. Therefore, Panchayat system is the base of democracy, with the failure of trickle down democracy we have to strengthen our democracy from below." (p 47, Singh 2000) Since King Mahendra was desperately planning to hold the supreme power of the nation, there have been overt and covert power games were played to launch political coup. Gresony (2003) argued, "The NC Government, led by Prime Minister B.P. Koirala, abolished *birta* (royal land- grant) tenure in the Terai and the authority of remaining feudal principalities in the western Hills. These measures made the Palace and the landowners already uneasy with the democratic process and with the presence of the Communist Party in the Parliament even more concerned".

organizations, which were still in its juvenile phase all over the country. Pioneer communist leader Mohan Bikram Singh and other important leaders like Shakti Lamsal, Khiman Singh Gurung were arrested by the Panchayat government after attending party meetings in Taulihawa. As a result, grass root political workers in many districts including Rolpa became directionless and vision less after breakdown of communication chain with central level leadership. Since Mohan Bikram Singh was sentenced to jail for nearly nine years and three months, in this context Mr. Singh accepted the fact that there had a been communication gap with local level political organizations and its members. To cope with changing political scenario, pioneer leftist leader of Rolpa, Berman Budha joined the Panchayat system. Regarding his political move to join Panchayat system, Mr. Budha had agreed that it was not a strategic decision of the communist party to join Panchayat and elected as a village chief (*Pradhan Pancha*) in 1966. In reality, after the political coup, the local peasant organization lost the connection with central organization, so actually there was no option on village level apart from supporting Panchayat in order to remain politically active. The ideological inconsistency and political opportunism of Berman Budha counter the arguments by many foreign scholars including Sales (2013) who bluntly portrayed Berman as a charismatic leftist leader from Thabang. As Sales portrayed Berman Budha as neither a 'unique charismatic leader′ nor an acolyte of the state, rather he is a man for all seasons who is clever enough to understand 'pragmatism' and favourable situation in changing political dynamics. In this context, joining Panchayat could have been another advantage for Chieftain Berman Budha to maintain his social position as a Mukhiya and also supportive to enjoy position of village chief to exercise neo-institutional power of the Panchayat government. But in reality, unlike other village chiefs many local people from Thabang mentioned, he never manipulated institutional power of the Panchayat system to suppress the feelings of villagers. However, Berman Budha himself agreed that after the civil war (1996-2006) began to escalate, his position was threatened, so he stayed in Kathmandu in his daughter's home and went back to Thabang after the official ending of the civil war. Likewise, after remaining politically passive for some time, ex member of parliament representing Nepali Congress, Khadananda Subedi joined the Panchayat system and later on wrote books entitled *'Chetan Lahari'* and '*Swargadwari*', Appreciating the role of the Palace and the Panchayat system *Chetan Lahari* has a sense like *'Uthdaicha Pancha, Bikash Boki'* that means political actors of Panchayat system are rising with development. This political U-turn of Mr. Subedi again made him unpopular among other progressive leaders belonging to the Nepali Congress and

other communist parties in the context of Rolpa. Similarly, at the central level, the polarization among communist parties who respect the *sine qua non* of the Royal take over and those who opposed the King's step divided political strength into two fractions. Similarly, after the arrest of B. P. Koirala and other important leaders of the Nepali Congress, there was no probability of an active revolt to oppose the Royal take over. Being directionless, with the political surrender and changed beliefs of local pioneer leaders like Berman Budha and Khadananda Subedi who silently surrendered to Panchayat System, the new form of power exercised by King Mahendra, automatically lost the possibility of any kind of political revolt ,at least in Rolpa. After enjoying decade long democratic values, once again the Nepalese people were forced back to the rulers of the authoritarian monarchy.

3.3 The game of Power, resources and politics (1961-1995).

3.3.1 District headquarters controversy in Rolpa.

The evolutionary phase of the institutional development process in Rolpa has been embedded with the dynamics of conflicts of interests and arbitrary exercise of sociopolitical power to control resources. Even before the existence of Rolpa as a new district there is evidence that powerful lobbying inside the district headquarters was successful to centralize the physical infrastructure in its vicinity. In 1955, the Madichowr police station that had the first administrative structure was shifted from Madichowr to Libang in the name of addressing frequent complaints by police staffs relating to their day-to-day communication difficulties with Kham language speakers and cultural maladjustment with local community residing in its surroundings. Locally powerful people like Ekdev Acharya, Obilal Subedi and police officer in charge named Vhairab pundit played a role to shift the police station from Madichowr to Libang. Similarly, despite the grievances of leaders from the western belt, a post office named *Reugha hulak* has been shifted from Reugha to district headquarters Libang. Many local people have mentioned, in both of these institutional shifting processes, unanimous consensus had not been taken and it was just the demonstration of power by the powerful coterie who could make the decision to drag public institutions to their vicinity. One of the politicians shared that large section of Rolpali people were living at a low level of consciousness, and as a result many people do not understand the value of office (*adda*) and its importance to remain in accessible region for many people. In 1962, during the administrative reform process, the Panchayat government divided the political geography of Nepal into seventy-five administrative districts. Likewise, the Panchayat Constitution launched in that same year further divided administrative regions of Nepal into different

layers like *Rastriya Panchyat, Anchal Panchayat, Jilla Panchayat, Nagar Panchayat* and *Gaun Panchayat*. Prior to the formation of Rolpa as a new district in 1962, there had been only Salyan, Dang and Puythan districts in the Rapti Zone which used to be known as *Swargadwari Anchal*. The old administrative structure of Rana reign like Kalasesh Thum[61], Baish Khuwa Thum, Rolpakot Thum and Darma Thum were merged to form Rolpa district. Similarly, fifteen Panchayats of Salyan, thirty six Panchayats of Puythan and other regions like Rungha, Pacchabang, Rangkot, Ranghsi, Thabang, Holleri and half part of Talabang were sliced to make new district Rolpa. Similarly, Jungar from Salyan and Mirul from Dang were also incorporated into Rolpa.

After the formation of the new district there was a heated discussion as to whether to place district headquarters either at Baghchowr, Damachowr or at the eastern belt Libang. There had been a debate like if the name of the district is given Rolpa[62], since this place is located in the western region, it would develop strong sense of belongings to the people especially from the western region only. Similarly, the placement of physical location of district headquarters in the eastern region results in a deep emotional attachment to the people from the eastern region. There had been efforts to balance the sentiments of the people from both regions, on contrary to this attempt. People from the western region raised the arguments like if the name of the district is given Rolpa then the district headquarters should be at Rolpa. During those days, strong arguments and discussions to place the district headquarters in the vicinity of own interest were intensifying day by day, however, no consensus was developed among neither sides. Sinha (1970) writes, after the Royal takeover of the administration in 1961, for each zonal region one Panchayat officer had been provided, while for each development district there was a Panchayat supervisor appointed. Meanwhile, in order to forward the administrative mechanism of the newly formed district Rolpa, the Panchayat development officer (PDO) Chandrabhuwan Karna was assigned by the Panchayat development committee under Panchayat directorate (*Panchayt Nirdeshanalaya*) which is under His Majesty Panchayat government. Likewise, Durga Bahadur Singh, a local resident of Salyan, was appointed as an office assistant to perform day-to-day administrative process. Regarding the controversy of district headquarters, Mr. Singh has mentioned,

[61] The concept of *Thum* was the pre modern administrative terminology, which used to incorporate certain areas of geographical coverage. *Jilla, Thum Mauja* was the administrative concept developed in the Rana regime. Single *Mukhiya* used to rule *a Mauja*. In single Village there could be different *Mauja* like Dangi Gaon, Talabang Gaon, Jinabang Gaon, Oilam Gaon. Talukdar is supposed to rule every single unit of Mauja. Later on the same *Thum* concept had been developed as a district.

[62] In that period, the particular area of Oat, Jinabang, Pakhapani, Rank and half part of Talabang used to be known as Rolpa which was resided as a small territory in the western region of present Rolpa district.

It was a central level decision to place the district headquarter in Libang. We had a document that the headquarters of Rolpa district should be in Libang Gaun (Libang village). At that time, people of Libang could not understand the concept of establishing Office (adda). Therefore, it became difficult to arrange rent room to settle government office in Libang. Since most of the areas of the district had been covered with hills, rivers trench and forests. I think the Panchayat government might have identified Libang as a comparatively better place to settle the district headquarters than other regions of Rolpa.

In spite of Mr. Singh's clarification, just to take the credit there are different opinions[63] among the local actors beside placing the district headquarters in Libang and even there had been a wrong fact[64] published in Rolpa Darpan, a memoir written by a local author. After the arrival of the first PDO Chandravhuwan Karna in the district headquarters of Libang, he rented a room in Sudarshan Upadhyaya's home, and the office of district development committee had been kept in one of the rooms of the school in Libang. Thereafter, PDO Mr. Karna extended the Acharya's house up to twelve rooms and managed additional dry land to construct the District Panchayat office. No sooner the basic settlement of district headquarters had been completed, district Panchayat election had been announced in 1963. The active supporters of the Panchayat system like Khadananda Subedi, Narayan Prasad

[63] Narayan Subedi, elder son of Khadananda Subedi claimed that his father and *Badahakim* Ratna Bahadur Gurung were known to each other since 2004. *Badahakim* Gurung met his father Khadananda Subedi and proposed to establish a district headquarter in Gajul or Mizhing VDCs. However, Khadananda Subedi strongly denied Ratna Bahadur Gurung's proposal to establish a district headquarters at Gajul. According to his brother Rek Bahadur Subedi, Khadananda Subedi hadthe perception that, if district headquarters had been placed in Gajul, the presence of police and military ruined daughters and sisters. Instead, Khadananda Subedi proposed an alternative solution that Libang could be the appropriate place to develop as a district headquarters by forwarding some logics. i.e, Libang is a central place of Rolpa that covers all the regions of the district, similarly, the availability of educated Brahmin boys to perform tasks for government offices and abundant water resources in Libang. After listening to Khadanada Subedi, *Badahakim* confirmed the location of district headquarters in Libang. Showing utter disbelieve to Narayan Subedi's arguments about his father's position on district headquarters establishment process, Balaram Gharti Magar, a Senior political leader who worked long time with Khadanada Subedi mentioned that Narayan Subedi's argument was completely false and fabricated, *Badahakim* never met Khadanada Subedi.

[64] In the preface of *'Rolpa Darpan'* authored by Nagendra Guru Dr. Krishna Raj D.C writes, 'Initially *Badahakim* had gone to Kotmalpa nearby the Salyan district with the proposal to establish district headquarters. The powerful and clever elites of that region ignored *Daudha Toli* (Government team). Local elites were fearing potential awareness among the local people that may create further harm in their domination, because of this reason *Daudha toli* went to Libang. Nagendra Guru managed five Lakhs rupees to please *Dauda Toli*. He was successful to collect five Lakh rupees in one night, otherwise headquarter would have gone to other places". Opposing strongly with this fact, Chintamani Acharya argued, at that time Nagendra Guru was just only 13 years old and it was not possible to collect four lakh rupees in one night. Even we felt difficulties to collect 2,200 rupees to buy land to build district headquarters office. Furthermore, Nagendra Guru argued that, "I have deposited my land in Dang and loaned money to establish headquarters in Libang. I was very active and senior people believed me. In one night we were able to collect about six Lakhs rupees". Similarly, Ekdev Acharya, Jhakku Subedi and another senior politician Diwakar Acharya also rejected this statement written by Dr. Krishna Raj Dc's in the preface of the book written by Nagendra Guru. I have met both Nagendra Guru and Dr. Krishna Raj Dc in Dang. When I kept my query Nagendra guru lost confident and felt very uncomfortable to justify his false statement. Similarly, Dr. Dc mentioned that he has written preface on Nagendra Guru's interview, so he was not confident with the data given by Nagendra Guru.

Chand[65], Balaram Gharti Magar and Masta Bahadur Chanda were nominated as candidates for the post of district president. In the first district Panchayat election held in 1963, Narayan Prasad Chand and Balaram Gharti Magar were elected as first district president and vice president respectively. After the election, developmental activities like opening schools, establishing health posts and constructing new roads were initiated in Rolpa. One of the pioneer leaders of the Panchayat system, Balaram Gharti Magar claimed that during the establishment phase of primary schools, apart from minor interest conflicts[66] held in Jinabang and Holleri, there were no visible tensions and the question of maintaining the quality of infrastructure was not an important issue on that time. According to him, as a newly formed district, it was important to establish more schools in Rolpa to make them accessible to larger the population.

After completion of the District Panchayat election, the first district assembly was held in the district headquarters of Libang and old administrative terminology like district council (*Jilla Parishad*) was changed into district assembly (*Jilla Shava*) onwards. In this district assembly there had been a participation of executive members like Narayan Bahadur Chand, Balaram Gharti Magar, Ekdev Acharya, Chandra Lal Pun, Chintamani Gharti, Tikaman Gharti, Kabiram Gharti Magar, Ajmad Puri and Tilakram Sharma. To fulfill some vacant positions in the district assembly, Masta Bahadur Chand, Khadananda Subedi and Chinta Mani Acharya were also nominated as executive members for District assembly[67]. Similarly, as a representative of different Village Panchayat, Village chiefs (*Pradhan Pancha*) were invited to attend District Assembly. Many of them never visited the district headquarters Libang before. In addition, it took three to four days to reach Libang on foot to people from western belt. On the one hand long walking distance had intensified their grievances regarding physical location of district headquarters, on the other hand there had been a formal announcement to place the district headquarters in Libang permanently. Many leaders from western belt were severely unhappy with this kind of decision that was imposed

[65] Narayan Chanda is a son of Captain Dalbir Chanda, who worked as a bodyguard of King George fifth ofthe United Kingdom. Many people were recruited through the channel of Dalbir Chanda in British army through Narayan Prasad Chand'as kind.

[66] Balaram Gharti Magar mentioned, "During my tenure as a district president, there were fifteen primary schools in Rolpa. In the process of establishment of a high school, instead of placing the school at Jinabang, the quota had gone to Ghodagaon. Like in Holleri, there was a conflict regarding limited quota and people used to do lobby to establish this school at their comfort zone. Later on, the government has decided to reach at least one school at every Gaun Panchayat"

[67] Sinha (1970) writes, "According to the Zilla Panchayat act of 1963 AD, Zilla Panchayat consists of Zilla Sabha and Zilla Panchayat. The district assembly (Zilla Sabha) composed by elected representatives from the Gaun Panchayats as well as Nagar Panchayats".

without sufficient consensus, consequently they continued to put their disagreement and grievances in different occasions.

In 1965, after being elected as district president Khadananda Subedi had taken initiation to construct the District Panchayat office. Local resident Sudarshan Upadhaya had donated his personal land. Additionally, Lapchand Thakuri's land was bought for three hundred Nepalese rupees. Many local people from Rolpa had contributed labor, likewise, fifty one thousand rupees donation was also collected to construct the district Panchayat office. Previously, it had been decided to construct a government office at the upper part of Libang. However, Satya Narayan Jha, Chief zonal officer (*Anchaladhish*) raised the issue[68] of water scarcity on the top of the hill, so the initial plan had been changed and district Panchayat office was shifted to a lower belt of Libang. It is very suggestive in the lack of proper plan and policies. The personal decision of powerful government officer[69] had altered the previous decision to construct administrative building in upper belt. Balaram Gharti Magar had different viewpoint about this event. He says, while some level of construction had been already initiated nearby the army barrack, unfortunately, there was a fire outbreak and local people interpreted this event as a bad sign. Afterwards, the construction of district Panchayat office had been shifted to Dirga Raj Sen's land bought for twenty two hundred Nepalese rupees[70]. In 1965, no sooner the construction process of district Panchayat had begun in the newly shifted place, Narayan Prasad Chand and his allies from the western belt raised the issue of corruption in the construction process of the district Panchayat building. Furthermore, he made accusations that the headquarter establishment process in Libang was not a permanent decision and that only twelve of the Village Panchayats of Rolpa District had supported the decision to place the District headquarter in Libang. Interestingly, on frequent occasions, leaders from the western belt were repeatedly lobbying to shift the district

[68] According to Ekdev Acharya, Satyanarayan Jha scolded local people and staffs. He said; do you think this much of water is sufficient? is this for birds?? After the establishment of the office, guest would come, in this kind of top hill where there were no other homes nearby, so it would be uneasy for outsiders to spend the night here. Ekdev further stressed because he was from plain area. Most probably, he did not like the uphill parts, moreover this place was on top of the hill.

[69] In Rolpa different types of bureaucratic officers left their impression as per their personalities, memorizing the role of Sanubabu Khatri, teacher Kulchanda Acharya mentioned, he was active to control problematic activities like alcohol consumption and playing cards. Likewise, Land reform officer *(Vhumisudhar Adhikari*) Narendra Bahadur Khatri, had gone for government work somewhere in the village. Once he had arrived in the village, Shamans disturbed him a lot, in the next days he called the shamans in his office and cut off their hair, so doing cutting their powers and intuitions.

[70] In order to facilitate the infrastructure building process, Khadananda Subedi, Narayan Prasad Chand, Sudarshan Acharya, Chinta Mani Acharya has donated money to buy land of district Panchayat office. A person like Ekdev Acharya had contributed to the labour. Similarly, Gangaram Dangi from Gotibang worked as a Technician.

headquarters. Other supporting administrative structures were also built in succeeding days. Accordingly, Mukti Prasad Vhandari came as a first tax in charge in 1965. Local resident Tara Prasad Acharya donated land to construct the building of taxation office which shows the evidence of philanthropy was prevalent earlier and people were genuinely motivated to donate their land (*Jagga daan dine*) for public institution.

In 1966, Nanda Bahadur Chand became another district president of Rolpa. In 1967, after a taxation office, a District court was established. Similarly, in 1968 Bamdev Acharya from Rolpa became the first Chief district officer. In 1969, a district educational office had been established in Rolpa. Similarly, there had been sanctioned of another high school in Thabang in the tenure of Khagendra Prasad Poudel as a district educational officer. Molnar (1981) writes, , formerly school was taught to the seventh grade, but in 1979 a high school was opened. It now goes through the eighth class and in the next two years will be extended to a tenth class. She further mentioned that there had been establishment of Post office in Thabang in 1970 and that used to be very busy because it had to deliver large amount of mails sent by those males working for Indian armies to their family members. Moreover, in the succeeding years, Dilli Jung Chand, Amrit Bahadur Gharti Magar and Prithivi Prasad Rokka Magar became district presidents in 1968, 1970 and in 1972 respectively. As a new district, although public institutions were established and began to deliver the services, nevertheless, institutional development in Rolpa is still in a premature phase and fails to deliver many services as promised by the government policies and provisions. According to Molnar (1981), while constructing the high school in Thabang in 1979, the school was actually constructed with significant community labour and materials, financed by contributions collected during the annual cultural events at the Jaljala shrine. It has been further told by the villagers that Government used to donate annually 7,500 Nepalese rupees. In this kind of situation, many schools in Rolpa were facing financial challenges to continue the day to day expenses of the school.

Since two different regions of Pyuthan and Salyan had been merged to form the new district of Rolpa, there had been growing emotional distance and tussle among the powerful people from eastern belt (Pyuthan centric) and western belt (Salyan centric) for a long time. Even after many years, leaders from Iribang and Rungha used to raise the issue of shifting the district headquarters from Libang to the western region of Rolpa. Influential leaders like Narayan Prasad Chand from western part of Rolpa were strongly opposing the current location of district headquarters in Libang. Senior leaders from eastern regions claimed that

district headquarters shifting process of neighbouring district Rukum[71] had influenced the people from western belt, it could be the motivational factor to shift district headquarter from Libang to Damachaur which is nearby the Salyan district. As Beteille (1965:142) mentions ,"Political alignments and cleavages in the village have to be considered not only in relation to other features of its social structure, but also in terms of divisions and tensions in regional society". The conflicts of headquarters shifting process in adjoining district Rukum has created strong influence even in Rolpa which used to be the tensed situation to most of the district Panchayat members especially from eastern belts. Meanwhile, there has been again re-shuffling of Rolpa district, people from western region who were raising grievances to shift the headquarters were merged to new district Salyan. This reshuffling has solved the conflict of interests among the people from different regions, which tentatively solved the issue of district headquarters and its physical location.

According to the recommendation of Dr. Harka Gurung committee, which had been formed to restructure the district and *Gaun Panchayats* on Nepal in 1978 AD, twelve *Gaun Panchayat* of Rolpa Thum and Darma Thum were merged to Salyan district and seven Gaun Panchayat of Salyan was again merged to the Rolpa district. Likewise, Mashina and Ghodagaon area from Pyuthan were also merged to the Rolpa district. With this decision, the people who were raising the controversy regarding physical location of district headquarters remained silent. Though the government had frequently reshaped the geography of the district, it created emotional difficulties to develop a sense of belonging to the new locality for many people. One of the respondents from Jungar who is originally from Salyan region mentions during an interview, "We neither became *Rolpali* nor *Pyuthani*, we are *Salyanai-Dangali*. Though we are technically *Rolpali*, our heart still goes with Salyan. We have to cross more than twenty-five uphill trials to reach the district headquarters to make citizenship and passport. It's very far" (Interview 13th December, 2013, Holleri, Rolpa). This opinion is the representative voice of the people to prove that how repeated reshuffling of the district could not alter the sense of belonging of the people to their original locality. Even in present days many people from western belt perceive district headquarters in Libang as a location with physical and psychological distance.

[71] In the neighboring district, powerful people were successful to shift the district headquarter from Rukumkot to Musikot after huge tussles, even two people died in this process. Local people in Rolpa mentioned, though Rukumkot is a far more appropriate place to form a district headquarter from many points of view, however district headquarter has been shifted to Musikot by mobilizing powerful nexus.

3.3.2 The notorious Police operation in Rolpa.

After King Mahendra's political coup to impose the Panchayat system in December 1960, peasant organizations of Thabang lost their grip with the central nucleus of the community party for another six years. In between, from 1966 to 1969 Khiman Singh Gurung and Deepak K. C. reformed the cell committee of the party which was politically passive after the political coup. Both of them were political workers associated with the Communist Party of Nepal. Overtly they worked as teachers at the Thabang School, while, covertly they worked to expand their political organization in Rolpa. During 1970, there was a conflict between the ex-Village chief *(Pradhan Pancha)* Ram Kumar Budha and Berman Budha's allies. Because of close affinity with the central administration, Ramkumar Budha was gradually trying to change the political belief of *Thabangis* and make them loyal to the Panchayat reign. As a person having good connections with the Panchayat administration, he played a role in establishing a police station in Thabang, introduced alcohol from outside and tried to prevent the local alcohol manufacturing process. The domination of Ram Kumar Budha was creating deep contradiction with the traditional cultural practices of making alcohol as a part of livelihood of Magar people. This was one of the events which became the obvious reason for many *Thabangis* to revolt against such domination and control, which was imposed on them in support by state power. In reaction to the local revolt, Ram Kumar Budha began to punish the *Thabangis* for disobeying his orders. In this event Ogura (2005) noted, he blamed people like Kaman Jhankri and other local people for being communists and they were sent to jail by following social security act. Likewise, Berman Budha and his group were once again accused for being "Communists" who performed anti state activities and were arrested in the accusation for violating the social security act and were kept in jail for twenty-seven months. Later on the Thabangi strongly revolted this suppression, evacuated the police station and threatened Ram Kumar Budha's panel not to impose any kinds of rules. Political suppression performed by local agents of state like Ram Kumar Budha was one of the most important factors for growing anti-state sentiments in Thabang, those have been continuously reflected even in succeeding years. In 1975, political workers of CPN (Fourth Convention[72]) like Mohan Baidhya and Jaljala[73] were posted in Thabang to continue

[72] In 1949 April 22 on Lenin's day, there had been establishment of Nepal communist party led by Pushpalal. The first general convention of the communist party took place in 1954. Though communist parties were banned in Nepal, however, in 1956 the ban against the communist party was again released. The party had a second general convention when it was open and no ban was imposed, there was debate whether to take part in the cabinet election or to demand constituent assembly election. The party has decided to take part in parliamentary election. In third congress, party had terminated Keshar Jung Rayamaji group for supporting King Mahendra as undemocratic stand. Moreover, after splitting with its central nucleus on contradiction related to Monarchy, the

their political activities. As a result, the left movement of Rolpa was politically influenced by Mohan Baidhya aka Kiran. Similarly, Comrade Jaljala posted in Thabang to work on behalf of the communist party and played an active role to establish women's organizations which consists of members like Dilbashi Jhankri, Vhula Roka Magar, Sita Budha Magar, Barna Budha Magar and Thipari Budha Magar. Under the leadership of comrade Bidhyakumari Rokka, in 1977, all Nepal women's organizations were formed in Thabang. That same year, there had been a formation of the *Dhikure* group in the name of martyrs comrade Surya Bahadur Rokka which had revolted against the trend of playing cards and gambling in the village. In between, Berman Budha Magar again got elected as a Village President of Thabang Gaun Panchayat in 1977.

In reaction to the autocratic Panchayat system, political parties were preparing for different kinds of underground activities. Similarly, there had been a nationwide student movement against the Panchayat government and there was influence of this movement in Thabang. CPN Fourth convention had taken stand of non-participating in the election announced by the Panchayat government and actively boycotted any kind of publicity campaign of national Panchayat election in Thabang. Mohan Bikram Singh accepted that rather than high level of class consciousness, strong caste solidarity among the Magar people was supportive to create this kind of unanimous stand against the state to demonstrate the political power of the people. Magar (2011) writes, principal Udaya Bahadur Bohara led the movement against corrupt people and made them ran away from the village taking shelter in the district administration office. Moreover, in Libang, after 1979 when Krishna Bahadur Mahara returned back from Nepalgunj completing his college level education, there was rapid growth of communist ideology among students and teachers covertly. In this context, Mr. Mahara says:

> *I was initially influenced with the sister organization of the Nepali Congress, Nepalese students association and also trying to understand the left politics with friendship of Krishna Sen aka 'Icchuk'[74]. Gradually, I inclined towards left ideology; my friendship with Krishna Sen "Ichhuk" helped me to understand left political philosophy. After coming back to Rolpa, I started to teach math and science in Libang high school and I used to be a very popular teacher those days. In 1979, all*

---

fractions led by Mohan Bikram Singh and Nirmal Lama named the fraction as Communist party of Nepal (Fourth convention), after the fourth congress of party held in Banaras, India in 1974.

[73] Comrade Jaljala was the first formally appointed whole time worker on behalf of the communist party in Thabang. Jaljala who was in declared emotional relationship with comrade Mohan Bikram Singh, who died in a bus accident of New Delhi, India.

[74] Krishna Bahadur Mahara mentioned that those days he was deeply influenced by Krishna Sen "Icchuk", who later on got killed in police custody during the civil war. According to Mr. Mahara, Krishna Sen Icchuk has played an active role to expand political organizations in different villages in Rolpa.

over the country, voices were rising in search of change, students coming from long distances like Rangkot, Thabang[75], Kureli used to stay in district headquarters of Libang which was a centre place of political storm at that time. As a popular teacher it became a favourable situation to expand anti Panchayat ideology and nurture left political consciousness among the students coming from different regions of Rolpa[76].

As a popular teacher originally from Libang, Krishna Bahadur Mahara has played a significant role to spread class consciousness in Rolpa. Present days politicos like Barsha Man Pun, Netra Bikram Chanda, Nanda Bahadur Gharti, Kul Prasad K.C and Jhakku Prasad Subedi and Nepali Congress leader Krishna Gharti were students of Krishna Bahadur Mahara during those days. In Rolpa, the first, second and third district secretaries of the Communist party of Nepal were from Thabang and fourth secretary was the Krishna Mahara from Libang, which is important to notice that the political implications of Krishna Bahadur Mahara shifted the 'Thabang centric' politics of Communist party of Nepal (Fourth Convention) to 'Libang centric'. After the political activity of Krishna Bahadur Mahara limited influence of CPN (Fourth Convention) only in Thabang area expanded drastically in the district headquarters and other regions of Rolpa. I have explored that in comparison to the political workers involved with democratic parties like Nepali Congress, left political workers were more motivated to sensitize class ideology to raise the level of political consciousness in Rolpa.

The pressure of student movement[77] held all over the Nepal in 1979 compelled the new King Birendra to announce general referendum (*Janmat Sangaraha*) on May 24, 1979,

---

[75] Anthropologists August Molnar who has done extensive field work in Thabang has mentioned, formerly the school was taught to the seventh grade, but in 1979 a high school was opened. It now goes through the eighth class and in the next two years will be extended to tenth class. Now, the older students study in Pyuthan district or in Libang. (Molnar 1981).

[76] Personal Interview, 26th January, 2015, Kathmandu.

[77] "It was a few hundred students at Tribhuvan University who became the catalyst for the political drama in the country, reflecting in the process the widespread dissatisfaction of the people with the on-going politico-economic situation. The scenario developed like this. On April 6, Tribhuvan University students on their way to the Pakistan embassy in Kathmandu to lodge a protest against the execution of the former Prime Minister of Pakistan, Z. A. Bhutto, were stopped by the police. The students and police clashed, and the former took up the quarrel with the government, demanding action against the latter. On the following day, the students prepared a list of 24 demands that included, among other things, the dissolution of the RSVM (the officially sponsored student organization) and permission to open free student unions at both the campus and national levels (student unions were not permitted after the introduction of the New Education System, obviously in an effort to depoliticize the campus atmosphere). The RSVM was held responsible for fanning these incidents. At the Amrit Science campus in the capital, located very near the royal palace, several students were subjected to beatings by the police, triggering mass indignation. Prompted by the gravity of the situation, King Birendra constituted a five-member high-powered Royal Commission with a judge as its chairman. The Commission was asked to investigate the "nature, process and incidents" of the movement. It was generally believed that the movement had gathered momentum through the combination of three groups of students allegedly affiliated with the three banned political parties the Nepali Congress (NC) and both the pro-Beijing and pro-Moscow factions of the Nepal Communist Party". (Baral 1979).

which forwarded its agenda to choose between reformed Panchayat and multiparty democracy. In this general referendum a ban on political parties was released and they were allowed to make necessary publicity to gather sentiments on behalf of multiparty system. In 1980 during the general referendum, Pashupati Shumsher Jung Bahadur Rana visited Rolpa and requested all elected Village chiefs to vote for Panchayat to preserve Panchayat system as a protector of monocracy. It has been explored that, there was publicity campaign at Rolpa, Tundikhel in the presence of one of the supreme leaders of Nepali Congress, Ganesh Man Singh. During the speech, when Ganesh Man Singh appreciated Khadanada Subedi's past activities which he has performed as a MP of 1959 Nepali Congress government, he became emotional and appealed people to support multiparty (*Bahudalbadi*) in upcoming election. Again there was a campaign by Panchayat supporters (*Nirdalbadi*) after few days, Pashupati Shumsher appreciated Khadananda Subedi's past contribution as district Panchayat president, listening to his appreciation, Khadananda Subedi blindly supported Panchayat and its agenda. As a pioneer leader of the Nepali Congress Mr. Subedi once got elected from Rolpa under the umbrella of the Nepali congress, in between a political coup compelled him to support Panchayat system. In reality, as an actor believes in pragmatic politics, it must be his 'rational political action' at local level to remain politically active in every historical epoch. However, emotional judgment to swing from one block to another eventually blurred his past political image and that has been reflected in the institutional image of Nepali Congress in district level. Moreover, continuing the legacy of resistance against state and to show disregard to the appeal of powerful leader of Panchayat, it has been claimed that all voters from Thabang cast their votes for multi-party system to respect the policy of boycott announced by CPN (Fourth Convention). Theoretically, the general referendum of 1980 was not a call for radical transformation for a left party like CPN (Fourth Congress), however the party took decision to vote against Panchayat. In overall situation of Rolpa district, the political influence of pioneer leaders from Panchayat system like Amrit Bahadur Gharti, Balaram Gharti and Rek Bahadur Subedi was very strong, as a result, supporters of multiparty democracy (*Bahudal badi*), did not get sufficient votes in the General referendum as expected. This People's referendum of 1980 could be the opportunity for King Birendra to prove him a king with liberal attitude intended to do democratic reform in the state mechanism but powerful lobbies inside the palace were not interested to lose any form of power from palace to people. In contrast to popular expectation, the result of general referendum was not in favour of multiparty democracy.

Similarly, once people from Thabang had rejected to perform volunteer labour contribution for road construction activities[78] announced by Rolpa district Panchayat during the end of 1980, Panchayat Administration in Rolpa understood this event as a activity of non-cooperation to the state and this particular situation triggered another level of hostility between state actors and local people of Thabang. In between there was another incident occurred in Thabang, Ogura (2005:60) writes,

> *At that time vice Pradhan Pancha Berman Roka Magar was beaten up by local farmers during the function at Gaun Panchayat office. During tussles, the portrait of the king and queen fell down from the table. Later on Berman Rokka Magar complained that along with other villagers Berman Budha burnt the portraits of the king and queen. In this accusation, Berman Budha was filed as a case for crime against the state.*

This particular event was interpreted against the monarchy's prestige, and Berman Budha was accused for performing *Rajkaaj Muddha* (crime against the state), as a result, in 1981 he was kept in prison of Libang and Dang for another twenty seventh months. In 1981, National Panchayat election, Mohan Bikram Singh led CPN (Fourth Convention) has announced a ban on any kind of election campaign in Thabang. Boycotting the election, nobody cast single vote from Thabang and they sent empty ballet boxes to the election office at district headquarters. The absolute rejection of national the Panchayat election announced by the Panchayat government was sheer evidence to show dissatisfaction and rejection of its existence which became 'sufficient' to create a distance gap with the state mechanisms and perpetuate additional level of political hostilities against the state. Moreover, on October nineteenth 1981, the *Thabangi* chased away some police person who reached Thabang to report the situation to administration. In reaction to the boycott of the election and to punish frequent anti- establishment activities[79] shown by *Thabangi*, the state had launched a terrible

[78] "During 1981, with the help of voluntary labour, the Rolpa district Panchayat decided to construct roads in different places of Rolpa. Thabangi were given responsibility to dig roads from the border of Dang to headquarter Libang. All the villagers have unanimously rejected this call requested by the government mentioning that the working distance is very far from their place. According to Santosh Budha Magar, at that time villagers were facing extreme shortage of food and working distance was few days far from Thabang". (Ogura 2005).

[79] "Once the school of Thabang won the Birendra shield, the award had not been granted to them. Thabangi also rejected that shield. Teacher Mohan Giri has been also excluded and filed the case in charge of rejecting Birendra shield. Similarly, in one of the local feasts, people used to play lot of card games. Khadananda, Balaram and acting in charge of the police station Vhairab Prasad and CDO has decided to stop this kind of anti-social activities. After that, they directly intervened the game; many gamblers ran away, there used to be lot of money. Police and whoever became successful grabbed the money. However, people of the Northern area became furious. Later on gamblers were arrested. This kind of activities played the role to develop anti state activities". Interview with Deepak Kc.

police operation in Thabang next day on October 4th 1981. During the reign of Balaram Gharti Magar as a home minister and Sharada Prasad Dahal as a Chief district officer. Endorsing the government's rationale of launching operation in Thabang, then CDO Dahal says:

> *In Thabang, people were performing different kinds of anti-social activities frequently. Once, they physically attacked Village chief Berman Rokka Magar while he was garlanding the photo of the King and Queen for a birthday ceremony and declared that they didn't obey the rule of King Birendra. It was sufficient proof for us to take action for performing anti state activities. Later, Village chief Berman Rokka Magar came to meet me and proposed to launch police operation. This report was circulated to chief zonal officer, home secretary and also to the palace. Finally, we have decided to do police operation in Thabang with consensus of home ministry, palace and CDO. About sixty to seventy supporting policemen came from Dang and there were about 150 policemen including our district police but there was no involvement of army in that operation. We did the operation in early morning and arrested suspected people, captured some proofs, found blasting materials, weapons and some documents which had the target list of some important people in Rolpa*[80].

The narrative of the Chief District administrator clarified the fact that the police operation in Thabang has been launched to suppress the people who were basically performing "anti-state activities." Before this incident, the *Thabangis* had never seen the presence of an armed police force in that numbers in Majhgaon of Thabang. Because of its terrifying effect and magnitude of this brutal action, the perception of deep hatred against the state had been still embedded in people's psyche and many people in Thabang believe that operation has been done by Royal Nepalese army which is notorious in the name of military action of 1981 (*athtis saal ko sainnya karbahi*). Since the brutality of the security force had been intolerable and unimaginable for many local people, they developed the perception that only army with its complete militant orientation could perform that kind of operation which is beyond the strength of police as a quasi-military force. Ogura (2005) writes, at that time, police had arrested Kaman Jhankri and other eight people from Thabang. This police operation was primarily targeted to suppress the people of Thabang and make them aware for not to perform any anti state activities. Though Chief District officer (CDO) Mr. Dahal has projected the rationale and intensity of police operation in lower scale. Magar (2011) has documented the event from his point of view. He writes:

> *In 1981, October 20, in early morning there was a massive police operation in Thabang. Suddenly, about five hundred men of the police force armed with their weapons circled the village. They tore important documents related to land, pensions and households. Police looted the property of more than hundred thousands,*

[80] Personal Interview, 9th November 2014, Kathmandu

dozens of women were raped, children and senior citizens were beaten up, eight people were arrested, fifteen of them could escape, for eleven days and eleven nights people of Thabang were locked up in the village, and villagers did not get timber and water to cook food.

It is interesting to note that the suppressor intentionally decreased the intensity of brutality and victims' sides have intentionally increased the scale of brutality. In reality, impact of police operation in Thabang was far more brutal than the CDO had projected. After this state has repeatedly launched suppression activities, the identity of Thabangi became synonymous to communists and administration and police force used to discriminate them by saying "Thabangi communist thief". In 1984, Mohan Bikram Singh led CPN (Masal) became one of the founding members of revolutionary international movement (RIM)[81] an umbrella organization of Maoist parties worldwide. In 1985, after its fifth congress, there was a split[82] in Nepal Communist Party (fourth Convention) led by Mohan Bikram Singh into Mohan Baidhya led CPN (Mashal) and Mohan Bikram Singh led CPN (Masal). After the split, many people in Rolpa supported Mohan Baidhya's CPN (Mashal) fraction, only in very few places like Aresh and Pang people supported Mohan Bikram Singh's CPN (Masal). In fact, even after the police operation in Thabang, people did not favour the political stand of Mohan Bikram Singh[83] who suggested them to leave the village. However Mr. Singh never accepted this blame and mentioned that he never suggested any villagers to run away from the village to save their lives. Khadka (1995) writes, two of the groups known as "lighted torch," CPN (Masal) and CPN (Mashal), were differentiated only by their pronunciation. Interestingly enough, all the various fractions differ very little in their ideology. Moreover, despite debate to take part in local election, CPN (Masal) has decided to utilize the election of 1986. However, CPN (Mashal)[84] has rejected the election announced by King Birendra led Panchayat Government. There had been tussles among *Thapa Samuha* (Thapa camp) and

[81] After the death of comrade Mao, there had been debate regarding Maoist thoughts and the characteristics evaluation of Chinese communist party. In this regard, the Communist party of Peru, RCP (USA), and some Naxalites groups of India were reached in conclusion that there is no socialist country in this world and counter-revolution is happening in China. In this matter, the leader of Nepal Communist Party (Fourth Convention) Mohan Bikram Singh passed the agenda of counter revolution in china in Aayodhya plenum in 1982. After that one fraction of communist party of Nepal introduced itself with the world communist movement, which fraction is now related to Revolutionary international movement (RIM).

[82] There were two types of Mashal after 1985. *Moto Mashal* means having "Sha" alphabet in the middle of Mashal, and *Masino Masal* means having only "Sa" in the Masal.

[83]) In between, Mohan Bikram Singh's personality was diminishing among the party supporters because of his emotional affairs which could be seen as matter of "cultural anarchism" in the left politics.

[84] "Baburam Bhattarai was in Mohan Bikram's party until 1991. (Ogura 2005) Later on party split has created great loss to Mohan Bikram's group. He has admitted that, "Organization became weaker after the split of 1983".

Chand Samuha (Chand Camp) which many times created severe obstacles in proper implementation of development projects like district hospital, airport and roads. In the National Panchayat election of 1986, *Thabangi* voted to Bam Kumari Budha Magar, candidate of Panchayat system who is also from Magar caste. Nevertheless, this election became very controversial. It has been claimed that Bam Kumari Budha Magar from Lokendra Bahadur Chanda camp won the election but Rek Bahadur Subedi from Surya Bahadur Thapa camp threatened the district judge and forced him to claim him a winner. Magar (2011) writes, In 1989, King Birendra and Queen Aishwarya landed in Thabang by helicopter surprisingly. In this visit, King Birendra has assured to open the road from Sulichowr to Thabang in an upcoming five years plan, because of people's movement of 1990, this plan could not be implemented. Many senior leaders have interpreted that after the police operation of 1981, Thabang was in limelight, and even the palace was not isolated from 'design-blame' of the police operation. Therefore, sudden visit of Thabang by then King Birendra and Queen Aishwarya might be to observe the historically rebellious village and also to understand the common psyche of local people. In reality, the local people at Thabang could never appreciate the King's visit[85] by heart and forget the terror of the police operation.

3.3.3 The influence of the Jhapa movement in Rolpa

During 1980, another left fraction of the Communist party of Nepal (Marxist-Leninist) initiated underground political activities in western regions of Rolpa. Being influenced by the Jhapa movement, this is the first arms insurrection raised by leftist front against the feudal in the context of Nepal. As an adjoining district of West Bengal, India, the Jhapa movement was influenced by Charu Mazumdar's people's Movement in Naxalbari during 1967, which was an armed struggle against "feudal class" to liberate the rural peasantry by "annihilating the class enemies". In the beginning, an all Nepal coordination committee was formed under the mandate of June 1975 Jhapa district conference. Afterwards a New Leftist front CPN (M-L) was established in the conference of 1978. In order to penetrate the Panchayat government, many educated people who were political workers of CPN (ML) joined army, police, and Panchayat administration strategically in the name of 'using Panchayat' (*Panchayat upayog garne*) policy of the party. In Dang region, Netralal

[85] It has been explored that during the King Birendra's visits to different development regions government staffs and concerned people used to present in their respective duties punctually to district headquarters. However, when King returns to his palace, the district headquarters continue to suffer from absence of staffs in different government offices. This is the phenomena which show that how notion of *Chakari* (pleasing the power) operates in Nepalese power structure to make vertical mobility in career path as per necessary.

Avaghi was leading *Vakari Phor Andolan*, which literally means movement to smash the stored crops and politically is an anti-feudal and anti-elite activities motivated by idea of communism. Accordingly, many local elites and feudal lords were threatened by the party. Jeevan Rai aka Alok, political worker from Jhapa movement was appointed as an in charge of Salyan, Pyuthan, Rukum and Rolpa. Memorizing the sociocultural situation of Rolpa, he says,

> *During 1980, Rolpali were living in dire poverty, crops was neither sufficient to sale nor to eat sufficiently for whole year. Consumption of alcohol was one of the regular activities and people used to earn money by selling local alcohol (Chyang). People used to heavily rely on shamanistic and faith healing pattern. People were not aware to visit health institutions. In this kind of condition to raise the general awareness among masses, we have formed district contact committee in other districts and district coordination committee in Rolpa. During 1980, in this committee Man Bahadur Batha Magar, Yam Prasad Dangi, Hari Bahadur Basnet, Prem Bahadur Basnet was involved*[86].

In the leadership of Comrade Jeevan Magar aka Alok, 'money action' has been performed at Partibang ward number five in Gairigaun, Rolpa. This political action was targeted to reveal the secret of hidden wealth that might have kept by local elites and feudal overlords. Protesters had suspected that along with storage of crops like wheat and maize, local elites might have stored significant amounts of money. As an act of symbolic and physical revolt, protesters blasted some simple guns to dismantle the crops storage of local elite Ram Bahadur K. C. In this protest, political worker of CPM (M-L) Yam Prasad Dangi and other few people were arrested by Panchayat government. This protest was targeted against the local feudal to make them aware about their exploitation and mass aggression. The Police operation in Libang compelled Comrade Alok to leave Rolpa district. After this event, CPN (M-L) could not demonstrate tangible political presence either in the local election of 1981 or in other underground political activities to protest against repression of Panchayat government. Khadka (1995) writes, ,although the NCP (M-L) accepted Mao as the sole leader of the revolutionary movement, and class conflict as the basis of struggle, it agreed to continue with the guerrilla warfare, but neither an anti-landlord nor an anti-royal regime armed insurrection was launched. Instead, either in Jhapa or in Rolpa and adjoining regions like in Dang, there have been violent activities in lower intensity to threat local feudal and elites. During 1983 Netra Lal Avhagi, an influential central committee member of CPN (M-L) has taken shelter in Nuwagaon. In his underground period, he has formed the underground committee by

[86] Interview -2015 June 18th Kathmandu.

unifying local teachers like Hira Mani Batha, Ravi Bahadur Pun and Dhan Bahadur Oli. Similarly, there has the existence of underground political committee of CPN (M-L) in Holleri, Dubidanda and Dubring with the involvement of local comrades like Rudramani Subedi, Sundar Subedi, Kumar Dashaundi, and Gopal Dangi. Though CPN (M-L) formed the committee and tried to maintain political existence in the left political scenario in Rolpa, however these activities were in utter shadow in the domination of Panchayat government. In fact, there was no significant influence of CPN (M-L) in the wider context of Rolpa. Similarly, in leftist front CPN (M-L) has extended its political organization in Rolpa after 1990. Moreover, in 1991, there had been a formation of district party active committee in Nuwagaon, Rolpa. In this committee, Yangya Raj Bastola became the district secretary which consists of other members like Kumar Dashaundi, Mitra Lal Gharti, Tikaram Khadka, Hari Basnet, Bishnu Mani Acharya and Man Bahadur Batha. After the formation of this committee, party extended different village level committee in northern belt like Jinabang, Talabang, and also in western belts like Jhenam, Dubidanda, Dubring, Sakhi, Budhagaon, Nuwagaon, Sakhi, Jungar, Gairigaun and Nuwagaon which was most influential region of CPN (M-L). It has been explored that claiming oneself as an ultra-radical communist, CP Mainali led CPN (M-L) used to blame another communist party Mashal as a pseudo Marxist. In the first district convention of CPN (M-L) held in 1994, Tika Ram Khadka became the secretary and Kumar Dashaundi became the vice president. In this committee, there has been involvement of comrades like Rudramani Subedi, Hari Basnet, Mitralal Gharti, Shanta Kumar Oli, and Mansingh Oli. Later on the election of district development committee was held and Jhakku Prasad Subedi and Man Bahadur Batha became vice president representing CPN (M-L). Comrade Netralal Avhagi from CPN ML played an influential role to create significant impact in Nuwagaon who was later on found dead in a very suspicious way in remote a region of Rolpa. At present CP Mainali led CPN (M-L) is one of the political fractions among the small leftist organization which is representative in the constituent assembly (CA) after getting significant numbers of votes in the election of first and second CA election. The rise of CPN (M-L) has not brought any substantive changes in the political scenario of Rolpa, empirically, at present there has been very negligible influence of this party in the context of Rolpa.

3.4 The era of Democracy, War and Transformation (1995 -2014)

The result of general referendum eventually could not convince the multi-party supporters for the long run. There have been widespread opinions that many unfair activities

were performed by the Panchayat government[87] to gain results in its favour. In Rolpa, during the People's movement of 1990, the teachers association was active to launch the series of anti-Panchayat campaigns. After the people's referendum of 1980, when the Nepal National Teachers Association (NNTA) was formed in Rolpa, it played an active role to create mass awareness against Panchayat system and its political domination which was a united association at that particular period. Many teachers were active members of underground political parties and teaching in schools as well. For instance, being a principal of Libang high school Krishna Bahadur Mahara was an equally active member of underground party CPN (Mashal). In the same way, within the umbrella of teachers' association, teachers like Man Bahadur Batha, Padam Pun, Hiramani Batha, Dirgha Khadka, Narayan Subedi, Jhakku Subedi,[88] Krishna Gharti and Damodar Regmi were active to raise the voices against the domination of Panchayat system. It has been realized that overtly and covertly teachers have played active role to spread anti Panchayat ideology in different regions of Rolpa. Ogura (2005:67) writes,

> *Initially many teachers were involved with CPN (Masal), later on when the Mohan Baidhya fraction had been developed teachers became active in CPN (Mashal). At that time, teachers have raised the issue to increase the salary and demanded for pension. Until 1990 most of the teachers were affiliated with this national teachers' association, later on about eighty percent teachers became the supporter of united people's front.*

Since teachers were covertly mobilized against the Panchayat system, there had been a repeated episode of harassment perpetuating by the administration to the members of Nepal National Teacher's association (NNTA).[89] In the utter domination of the Panchayat system, it was not possible for Congress and the Communist Party to oppose the Panchayat system overtly. In this kind of dire situation, political mobilization of teachers association was

---

[87] In reaction to the Panchayat system and its authoritarian ruling mechanism which was forcefully homogenizing the diversity of Nepalese societies by using the slogan like 'single king, single country, single language single custom' (*eutai raja eutai desh, ekai vhasa eutai vhesh)*. In reaction to his hegemonic nationalism (*Mandale Rastrabaad*), nationwide mass aggression was escalating in cumulative effect day by day. In between, the coalition of democratic political parties has announced the movement against Panchayat system from central to district level in 1990 in the leadership of central level leaders like Ganesh Man Singh, Krishna Prasad Bhattarai, Girija Prasad Koirala and Manamohan Adhikari.

[88] Memorizing one of the benevolent activities performed by Panchayat government officer, Jhakku Subedi mentioned that, " In that period, Arjun Dev Shrestha was appointed in Rolpa as a district educational officer, who was teacher and he was in favour of teachers, he did not take any negative stand against us, instead, he supported many teachers like Krishna Bahadur Mahara, Jhakku Subedi and Ghamanda Bahadur Dangi. He did not discourage us for showing moral support, and he used to aware us for potential arrest by Panchayat government".

[89] After 1985, government split the high school teachers association and primary level teachers association into two groups. Similarly, after 1990, Nepali congress formed different Nepal teachers association.

supportive to create anti Panchayat psychology in mass level. Similarly, during 1990 representing the CPN (Mashal) Tejman Gharti was active to organize anti Panchayat activities covertly in Libang. Moreover, representing CPN (ML) political leaders like Yangya Raj Bastola and Tika Ram Khadka formed the committee in Nuwagaon and performed some basic protest activities like leaflets distribution against the Panchayat system. In comparison to CPN (ML) during the mass movement in 1990,the district level political leadership accepted that the Nepali Congress had shown some basic level of visibility in Rolpa to revolt against monarchy. After continuous protest and mass aggression[90] for many days, King Birendra was forced to address on-going protest all over the country and finally compelled to declare the end of the Panchayat system. With this declaration on April 8, 1990, a three-decade long Panchayat system officially ended in Nepal and the King's political power had been reduced to a constitutional monarch. Consequently, political parties became legally free to perform their political activities and the country had transformed into a new political era of democracy.

After the overthrow of the Panchayat system, a new democratic constitution drafting process was initiated in Nepal. Thereafter, the caretaker government led by Krishna Prasad Bhattarai announced the first general election to form a democratically elected government. After the restoration of the democracy in 1990, many political actors of old political systems (Pancha) vanished from the political scene, some of them becoming active with a new kind of political agenda. During the days of 1990 movement, there was sharp hatred against the *Panchas* and slogans like *Pancha* thieves, leave the country (*Pancha chor desh chod*)! discouraged them to become politically active like in earlier days. Many ordinary people and pro-democracy supporters had uttered believe that all *Pancha* were corrupted people, due to their image of the past, responsible to corrupt the Panchayat system by monopolizing the power. In Rolpa, leaders from Panchayat like Balaram and Rek Bahadur were underground and it was not possible for them to show their political presence in public. To get rid from their past image constructed during Panchayat system, the *Panchas* decided to continue their political activities in the name of Rastriya Prajatantra Party (RPP). Though the party was given a democratic (*Prajatantra*) name most of the political actors were powerful figures from the Panchayat regime. The newly formed RPP followed the same legacy of the

[90] The open protest on February 18th, 1990 on democracy day in Kathmandu ignites covert protesters to surface all over the country to protest openly against Panchayat. There has been frequent deaths occurring in active protest of Kathmandu and numbers of Martyrs killed by Panchayat system was rising day by day. After intensifying the democratic movement in one level, there has been a joint movement against Panchayat system all over the country.

Panchayat period which advocated and interpreted the existence of monarchy as an inevitable truth in the existing power structure of Nepal. In central level, RPP has been established in the chairpersonship of Surya Bahadur Thapa, following this development, district level committee of RPP has been established in Rolpa and Balaram Gharti Magar became a first chairperson. In between, party again split into Lokendra Bahadur Chanda and Surya Bahadur Thapa camp on the contradiction developed with Monarchy that created direct effect in local level politics. In Rolpa, Chintamani Acharya became president of *Chanda Samuha*. In the general election of 1992 though Chintamani Acharya was in favour of another senior leader Rek Bahadur Subedi to get the ticket, in contrast to his expectation, Vhup Narayan Gharti Magar, brother of Balaram Gharti Magar got the party ticket from constituency number two in Rolpa.[91] This decision could not calm the already heated tensions[92]; this rather unsatisfied group continued their grievances to central level leaders like Pashupati Shumsher Jung Bahadur Rana and Surya Bahadur Thapa. According to Chintamani Acharya, their voices were not heard instead a central level decision intensified the dissatisfaction, so finally the district level RPP leaders like Chintamani Acharya, Gangaram Dangi and Rek Bahadur Subedi decided to quit the party and joined the Nepali Congress. From Nepali Congress Surendra Hamal was contesting the first general election after 1990, likewise, representing the RPP Balaram Gharti Magar was in the battle of election. Later on, after the formation of United Liberation Front (*Sanyukta Janamorcha*) as a political open front of CPN (Unity Centre) candidates like Krishna Bahadur Mahara and Berman Budha took part in the election. Similarly, in radical left circles there had been a heated debate in Rolpa among both types of Mashal whether to take part in the first general election announced by the caretaker government or not. One of the left political fractions CPN (Masal)[93] was in favour of

[91] There were lots of controversies surrounding in the political personality of Balaram Gharti Magar , According to Madhav Acharya , district president of Nepali Congress in 1995 said, though the Balaram Gharti Magar has been not involved in corruption directly, however, he has neither geared up nor supported development activities in Rolpa. Furthermore, Narayan Subedi has blamed that, Balaram's politics is only the politics of caste diplomacy; his politics is not supportive to transform the present condition of Rolpa.

[92] Central level leaders like Surya Bahadur Thapa and Rajeswor Devkota has tried their best to console delegation team. Later on Khemraj Pundit has agreed to calm the tension between Balaram Gharti Magar and his contemporaries like Chintamani Acharya and Rek Bahadur Subedi. But Balaram's brother Vhup Narayan Gharti got the ticket, contrary to the expectation of central level rulers, Vhup Narayan Gharti loss the election. Balaram Gharti has made several efforts to organize the party considering the political loss in 1996. However, Chintamani and his allies did not support him, Instead, Chintamani joined Nepali congress party. Initially Gangaram Dangi has been supporting Thapa Samuha later on he has changed his support to Chanda Samuha. After 1990 after second rise of democracy, Gangaram Dangi joined Nepali congress. Similarly, another contemporary politician Rek Bahadur Subedi has initially joined Rastriya Prajatantra party; later on Rek Bahadur Subedi has gone to Nepali Congress.

[93] Similarly, there had been contradiction between China block and Soviet bloc in 1966 during the time of third general convention. The tussle for *naulo janabad* and national democracy brought the party on the verge of split.

constituent assembly; however, there was parliamentary election so this fraction rejected to take part in the election. Even though there has been frequent splitting and unifying activities going on central level among the left parties, many leaders from Rolpa mentioned that every time there has been no realization of sharp polarization among the district and village level leaders following the contradiction in respective parties. Meanwhile, in 1989, Pushpa Kamal Dahal aka Prachanda became the chief of Nepal communist party (Mashal) minimizing Mohan Baidhya aka Kiran after sector event[94] of 1986. Similarly, other left political fractions like CPN (Fourth Congress) and CPN (Mashal) united in 1990 and they announced the formation of new party CPN (Unity Centre) and Comrade Prachanda became the general secretary of the party. After splitting from Mohan Bikram Singh led CPN (Masal), Baburam Bhattarai joined the CPN (Unity Centre). In this election of 1992, another left alliance launched one-communist-one- place policy (*Ek bam Ek Tham niti*), which was basically the tactical alliance done among leftist parties in central level and further implemented in Rapti zonal level. Since Congress party was in height of political fame after 1990 movement, it was the secure strategy developed by left alliance to counter the overwhelming presence of Congress party all over the country. According to this policy, there has been political agreement between United Liberation Front (ULF) and CPN (M-L)[95] not to stand any candidate in Rolpa and Rukum districts against each other. UML[96] leader Kumar Dashaundi expressed that there was severe dissatisfaction at local level against this 'ML-ULF' coalition, but there were no options left for local comrades except obeying central level decision. He further expressed, such kind of coalition was fatal attempt taken by party which has been directly reflected in non-growth of new political leadership in district level for long the run. In this case, CPN (UML) leaders like Kumar Dashaundi and Gokul Gharti both of them

---

In 1971, Mohan Bikram has initiated to make another party and made a central nucleus, in his leadership there has been fourth general convention took place in India in 1974, in order to protect the identity of party, the name of the party was entitled as Nepal communist party (Fourth Convention).

[94] "Mohan Baidhya was the general secretary of CPN (Mashal). After the party has decided to boycott the election of 1986, they attacked nine police posts of Kathmandu and few police were injured. After this event many political workers of CPN (Mashal) were arrested which turned party to a very weaker organization. Later on party has decided that it was wrong policy, as a result including Mohan Baidhya party did demotion of all politbureau members. This event is known as sector event in the political history of Nepal" (Ogura 2005)

[95] Before election there was fifth national congress of CPN ML. Senior leader CP Mainali took the stand of improvised people's mandate and respected pluralism, however Madan Bhandari stood against people's neo mandate. In the alliance of Madan Bhandari's line there were comrades like Yangya Raj Bastola, Kumar Dashaundi, Tika ram Khadka, and people like Man Bahadur Batha, Mitralal Gharti, and Ratna Bahadur Basnet were in CP Mainali lie. In local Kham language male means *chiana*, according to Mr. Dashaundi since the name of party was "no" or "do not exist" in colloquial language of Kham people, this kind of lingual sense was not very supportive to realize the physical and psychological space of party to many Kham Magar voters.

[96] After unification between CPN (Marxist) and CPN (M-L), there has been formation of new political force CPN (UML).

accepted that because of the tactical political alliance CPN (ML) lost its political influence in district level which has been reflected even in present days. Similarly, in the election of 1992, Berman Budha and Krishna Bahadur Mahara were elected from one and two number constituency of Rolpa respectively.

3.4.1 Civil war, the 'Sankatkaal' in Rolpa

In the general election of 1991, ULF won both constituencies of Rolpa. However at the central level the Nepali Congress formed the government with two third majority. The country had recently transformed from feudal oligarchy and there has been much to expect in upcoming days, but leftist parties were not in psyche to follow any kind of 'wait and see' strategy. Moreover, following the political development of 1990, some of the leftist fractions like CPN (Unity Centre) and CPN (Fourth Convention) interpreted this change as an evolutionary process rather than any revolution held for radical transformation of the power structure. The founding values of social democracy adopted by Nepali Congress was diminishing day by the after party has harshly supported neoliberal agenda and structural adjustment policy imposed by the World Bank and International Monetary Fund (IMF). In this context, radical left fractions have developed the ideology that new marriage between traditional elites of Nepali Congress and hardcore neoliberal values cannot bring substantive solution in the transformation process of the country. Left front like CPN (Unity Centre) expressing their criticism against the government despite having lot of internal ideological contradiction[97] among themselves. The general referendum[98] of CPN (Unity Centre) defeated Nirmal Lama's political line,[99] and Pushpa Kamal Dahal aka Prachand'a political

[97] There had been dispute regarding policy and leadership in CPN (Fourth convention), as a result , Fourth Convention again split into other two fractions , i.e. Nirmal lama has led CPN (Fourth convention) and Mohan Bikram led CPN (Masal). There has been further split in CPN (Masal) and Mohan Baidhya became the leader of CPN (Mashal) and Mohan Bikram Singh became the leader of CPN (Masal). CPN (Mashal) led by Mohan Baidhya fraction has been developed as a CPN (Maoist). Different fractions Mohan Baidhya led like CPN (Mashal), CPN (Fourth Convention), *Sarbahara Sharmik Sanghatan* and Baburam Bhattrai's fraction split from Mohan Bikram Singh CPN (Masal) those were united in the leadership of comrade Prachanda and there has been formation of CPN (Unity centre) which mobilized its legitimate open front ULF and won nine seats in the parliamentary election of 1992.

[98] Different political lines were proposed in their general referendum, those were, 1. To declare the base areas and go for long term civil war proposed by comrade Prachanda. 2. To establish pro-people system, applying violent means by comrade Nirmal lama, 3. Without declaring base areas, directly going for long term civil war , Ruplal' line There had been internal tussle in RIM among NCP (Masal) and Prachanda group to justify more revolutionary, as a result NCP (Masal) rejected cabinet election of 1992. It blamed to Prachanda group for taking part in election, unified party with reformist lama group. In 2049, despite internal dispute, NCP (Ekata Kendra) took part in the local election. In the issue of preparation of violent struggle, there had been tussle among the Nirmal lama and Prachanda, later on lama was taken disciplinary action in and terminated from the party. From this general referendum, instead of Maoist thought, party started to use Maoism.

[99]

line[100] has been ratified by the party which was mainly a proposal to declare the base areas and go for long-term civil war against the state. In this contradiction on the nature of class struggle between the leaders, again in 1994, there had been another split of unity centre among Nirmal Lama and Prachanda led faction. In 1994 there had been third extended meeting of CPN (Unity Centre) Prachanda group, after its third plenum held in March 1995, this meeting passed the military plan of civil war and named the party as CPN (Maoist).To start rural class struggle following party line, Comrade Prachanda led CPN (Maoist) has chosen seventeen districts including Midwestern hill district Rolpa as a base region to develop as a long term civil war against the Nepalese state.

In Rolpa, during 1992 there was a huge political tussle among the political workers of Nepali Congress and the ULF (United Liberation Front) supporters. As an open front of underground party then CPN (Unity Centre) and now CPN (Maoist), according to its party line the ULF supporters have done active protest and shown black flag when then Prime Minister Girija Prasad Koirala had visited district headquarters Libang. This boycott by ULF was seriously perceived as 'anarchist' activities by Koirala government and district administration of Rolpa. It has been stated that ULF supporters blocked the road and physically attacked the people on the way who were going to attend the prime minister's program in Libang. No sooner the prime minister returned to the capital city, in reaction to the protest activities performed by ULF in Libang, district administration brutally suppressed many ULF supporters in Rolpa. One hand CPN (Maoist) was strategically planned to launch rural class struggle to overthrow the constitutional monarchy, on the other hand suppression campaign launched by Nepali Congress government against its open front ULF supporters played role to intensified already heated conflicts at local level. It has been evident that State has launched terrible suppression on different occasions[101] in Rolpa. ULF supporters were

---

[100] "After accepting Prachanda's line, overtly party was showing the activities tend to people's movement but covertly there had been preparation of civil war and party also formed young communist league, which was kept underground. Later on NCP Ekata Kendra was also divided into two fractions. In 1995 Prachanda group took action against all central committee members of Nirmal lama and Ruplal and they terminated them. After this termination, it became easier for comrade Prachanda to implement his party line without any obstruction. Main contradiction stuff was political line, stuffs are secondary. Prachanda was in favour of civil war and Nirmal lama was in support of people's protest. Lama was frequently not presenting in meeting and not in support of people's war. Majority of voters supported the agenda of civil war. Terminated fraction also became active in the name of NCP (Ekata Kendra)."

[101] Memorizing one of those events Maoist leader from Rolpa Krishna Mahara says, in 1994, in Gam VDC local festival Asoje Mela was taking place. There was a cultural program; people were using stick to perform the local dance. For local people this is the means of entertainment and exercise also, but state mechanism took this event of Gam in a serious way. Local Congress supporters complained to the state security mentioning that Maoists are doing army training. There was some disturbances arose in the program. Many ULF supporters

tortured and beaten at Dhansi Khola, Reugha and Satdobato. In contrast ULF supporters were taking revenge with local agents of state and other feudal lords. In 1994, taking the two initials name '*Si-Ja'* of two popular icons of Rolpa like Sishne mountain and Jaljala shrine, Maoists initiated cultural activities to spread class consciousness among rural mass which was basically supposed to extend political base in Rolpa and adjoining district. These activities which were performed by Maoists sympathizers at local level, were creating more annoyance to representative of state actors like Chief district officer and district police. Present principal of Gajul high school and ex worker of ULF, Narayan Subedi says during interview, "NC leader Surendra Hamal and CDO Abdul Raish Khan were active in filing a false case against the protesters. Consequently, many people faced severe harassment and displacement. If ULF supporter was not available at home, they would also beat livestock ." In Rolpa, this kind of conflict between state and ULF supporters was intensifying and hostilities were growing rapidly. Moreover to suppress the ULF protest activities, operation[102] Romeo I was launched by Congress government in the month of November in 1995. SAHFR (2000) writes, In Rolpa, one of the four worst affected districts, police terror was unleashed during Operation Romeo 1995, a year before the People's War, it was probably the most important reason responsible for many peasants, women and men, to join the Maoists. Prior to declaration of war against the state, Thabang, a northern village in Rolpa, which has legacy of demonstrating anti state activities since long time has been chosen to conduct different level of war related training in the leadership of comrade Ram Bahadur Thapa aka Badal. In 1996, civil war has been declared against Nepali state, which was theoretically interpreted as a Communist Party of Nepal (Maoist) led "People's war" against the "old feudal state. Rolpa, a historically excluded region that has been reflected in extremely low levels of living standard with no basic facilities became the fertile ground to turn people's expectation towards battle. In between, state launched additional suppression campaign in the name of Kilo Sera 2[103] which also continued with brutal legacy of

---

were beaten up by the political workers of other parties. Later on many ULF supporters were arrested from Gam and filed false allegations.

[102] "During Romeo operation "Around 1500 policemen including a specially trained commando force sent from Kathmandu have been deployed to let loose a reign of terror against the poor peasants of that rugged mountain district in western Nepal. So far about one thousand people have been arrested, of whom about three hundred were kept in police custody or sent to jails under fictitious charges while the rest have been released on bail or after torture. The people arrested range from 12 to 70 years of age and most of them have been subjected to inhuman torture in police custody "(Thapa and Sijapati 2003:72).

[103] SAHFR (2000) documented, "State has launched another suppression campaign in the name of Operation Kilo Sero -II in 1998 which became a byword for extra judicial killings disappearances, arbitrary arrests, rape and torture. Moreover, "during the period of July 2001 Maoists attacked six police posts demolished the development infrastructure like bridges, micro hydels, and telecommunications towers and drinking water

suppression, control and arbitrary detention and killings like the Romeo operation. IDMC (2008) writes, many people had been killed in Rolpa and many thousands of other people were tortured, injured, disappeared and displaced from their homeland. As a consequence some 6,000 people were displaced within Rolpa and to neighbouring districts. "In Mirul village, a day walks from Libang the district headquarters of Rolpa, there were no men to be seen when the woman team, referred to above, visited the area in 1998. To escape being picked up by the police or targeted by the Maoists as suspected police informers, the villagers had become '*farari*, melting into the surrounding jungles to join the Maoists or to swell the ranks of migrant labour in India and the Gulf" (Hutt 2004:256). Moreover, there had been killings of Maoist supporters in Mirul, Kureli, Jelbang, Gam and Thabang in number of attacks, counter attacks happened between Royal Nepal Army and People´s Liberation Army of CPN (Maoist). Moreover, many innocent people lost their life in Rolpa in false attack (*Jhuto mudhvet*) done by state security force in Rolpa. Ghimire (2011:101) writes,

> *According to the record of Informal Sector Service Centre (INSEC) in Rolpa, the total number of people killed by the state is 610 and there are four hundred 'Martyr's families'. Likewise, the numbers killed in bomb blasts stands at forty-eight, while 115 have been killed by the Maoists (Ghimire, 2009b). Meanwhile fifty-two have "disappeared", apparently abducted by Maoists and the circumstances of ten others are still unknown. It was mentioned during the interview that they have either been killed or buried by the security forces or they have been killed in the war (INSEC).*

During the civil war which is known as *Sankatkaal* from insider's point of view, Maoist had interpreted all government authorities as an "old state" and formed a parallel mechanism called "*Jana Sarakar*" (People's Government).This people's government is supposed to look at all activities of taxation, administrative, legal and crime related issues. In the district headquarter of Rolpa, important government offices such as the judiciary, Chief District Office (CDO), Local Development Officer (LDO), District Development Office (DDC), post office, agriculture office, and Telecommunication office were all circled by metal wire *(Taar baar*). There had been frequent attempts of kidnapping important political leaders during the civil war, there was a case of kidnapping political workers[104] of other left parties of Rolpa by the Maoists. Meanwhile, CPN (Masal) led by Mohan Bikram Singh launched a remonstrate

---

supply pipes. They started campaigns to demolish and burn postal and forest offices and health posts and shut down schools which became responsible to reduce ordinary citizen's faith in them (Hutt 2004:256)."

[104] In 1999 CPN UML leader Kumar Dashaundi was kidnapped by the Maoists for being instrumental against Maoist and delivering anti Maoist speech in their core place like Gam and Thabang in the cover of Nepalese army. During 2003, because of the conflict that occurred between UML district level leader Shanta Kumar Oli and pro-Maoist school Principal Kulananda Giri about the managerial case of Jungar high school, Shanta Kumar Oli was kidnapped by Maoist army. Similarly, Congress supporters like Narayan Subedi and Rek Bahadur Subedi were also kidnapped by the Maoists in accusation for doing anti Maoist activities.

program (*Vhandaphor Karyakram*) to criticize the brutal activities of Maoist done to their supporters in different districts. Criticizing the ideological position of CPN (Maoist) led civil war, CPN (Masal) mentioned, 'though subjective condition in Nepal is favourable for arms struggle against the old feudal state however, objective condition is not favourable, therefore, rather than saying the Mao's people´s war, it´s simply the Trotskyism which do not need subjective and objective condition to launch arms insurrection against the state'.

Despite civil war in different regions of Nepal, the State declared midterm election in 1996, Maoists actively boycotted this election, and therefore, Nepali Congress won both seats in Rolpa. In 1997, Mahadav Acharya became another president of the Nepali Congress party. In the local election of 1998 including the post of district president (*Zilla Shavapati*) Nepali Congress won five regional members. In comparison to other left political parties, Nepali Congress do not have a very long history of existence in the political scenario of Rolpa. Local people from Libang like Kulchandra Acharya, Madhav Prasad Acharya, and Lekhnath Acharya. Krishna Gharti, Surendra Hamal and Nurja Bahadur Khadka were active during Panchayat period. Even they were arrested in the 1990 movement and released after declaration of democracy. Many people from Rolpa have clear perceptions that except arranging a few tree plantation programs, Nepali Congress has not done any visible activities to strengthen the organizational capacity in Rolpa. After uniting between CPN-ML and CPN Marxist another left alliance Communist party of Nepal, United Marxist Leninist (CPN-UML), emerged as the largest ruling party after the election of 1998. In between CPN (UML) faced the split into two fractions and there had been influence of party split in district level. In this splitting process, vice secretary Kumar Dashaundi and Gokul Gharti continued their support to CPN (UML) and other leaders like Kumar Khadka joined CPN- ML with majority of district level leaders.

In 2000 King Gyanendra visited Rolpa during the active period of civil war and supported seventy thousand Nepalese rupees to upgrade the condition of the high school in Libang. In the crucial time when the whole country was burning in civil war. The King made a royal visit to the heartland of civil war to prove his strength and demonstrate the power that had been criticized by many political parties and civil society. Again in 2000 parliamentary elections were announced by Sher Bahadur Deuba's government which Maoist had totally boycotted, as a result, Nepali Congress won both election constituency in Rolpa. There was a split in Nepali Congress in 2002, after Sher Bahadur Deuba dissolved the parliament and announced midterm election which created directed impact in the party structure of district level in Rolpa. Following the split in central level, Madhav Acharya

remained in establishment fraction and Krishna Bahadur Gharti became president in newly developed Nepali Congress democratic fraction. However, establishment fraction has more political hold in Rolpa. Sher Bahadur Deuba has been terminated by Girija Prasad Koirala again special convention thrown away Girija Prasad Koirala, and Sher Bahadur Deuba became the president of Nepali Congress.

Before the first Constituent election in 2007, both splitting factions of Nepali Congress merged into single a party and Krishna Gharti has been nominated as a district president of Nepali Congress in Rolpa and his tenured has been renewed again in 2011. Though the history of Nepali Congress covers more than three decades, there are only three district presidents in Rolpa. The student leader of Nepali Congress and resident of Libang, Manojmani Acharya accepted the fact that Nepali congress has shape but never demonstrated any strong ideological stand either in the time of Panchayat reign or to oppose CPN (Maoist) movement emerged from Rolpa. He further mentioned during interview, "Either from the central level or from the grass root level there has been gap to develop new generation leadership in the context of Nepali Congress in Rolpa. The lesser chance of vertical growth in the political carrier kills the vibrancy of leadership. As a result many talented youths do not join the politics, which is evident in the present conditions of Nepal" (15th October, 2015, Kathmandu). The performance of Nepali congress in the context of Rolpa has not satisfied many people of Rolpa and its own district level leadership, consequently, this party has been continued to fulfill its rhetorical existence just to prove its mere presence.

3.4.2 Post conflict context in Rolpa

The peace accord signed between CPN (Maoists) and the Nepal government in 2006 declared the official ending of a decade long civil war in Nepal. After peace process has been initiated many pending development projects like road, hospital and school building process have been continued in Rolpa. During the time of Panchayat and post Panchayat era, the school development process in Rolpa was stagnated and there were only a dozen schools. Many politicians like Gokul Gharti, Jhakku Subedi, and Kulananda Giri blamed that Balaram Gharti Magar has done intentional delay to establish the school in fear of increasing 'communists' in Rolpa. Though school establishment process has gone through more than five-decade history, over all the educational standard of this district is not satisfactory. Even before 1990, there has been plan to open college, frequent upheavals in national level political system was not being supportive to establish college in Rolpa.

The Civil war that began in 1996 once again created obstacles in many local development projects for another ten years. Ironically, there were no higher secondary and other graduate campuses till 2010 in Rolpa. In the period of Jhakku Prasad Subedi as a district president, management committee has been formed to continue the college establishment mission and granted six and half Lakh Nepalese rupees (0.65 million) to run higher educational level programs. It has been blamed by the political leaders of other parties that local leader of Nepali Congress have many times created obstacles for not to open college because that could be favourable place to increase Maoists in Rolpa. However, District level Nepali Congress Surendra Hamal sharply denied this claim. After civil war, a debate regarding college establishment again continued and later on succeeded to open Jaljala College in Libang. At present Rolpa has only two campuses, Jaljala College in Libang and Nawa Nepal campus in Jungar. Since the time of establishment, higher education level has been suffering from resource shortage to improve the infrastructural condition and to pay regular salary to the educational and administrative staffs. Likewise, a multiparty delegation team has visited Jhakku Prasad Subedi and then finance minister Barshaman pun aka Ananta promised to upgrade the educational programs of Jaljala campus[105] up to master level. In the tenure of Baburam Bhattarai as a prime minister, Jaljala campus management committee has applied to develop the campus as a permanent and affiliated college with Tribhuvan University. Financial shortages, lack of sufficient political commitment are the major factors that are hindering the growth of educational institutions in the context of Rolpa.

The CPN (Maoist) campaign to boycott bourgeoisie education has compelled many youths to leave the school voluntarily or involuntarily. As a result, one generation of Rolpali youths have seriously hampered their educational growth process because of the year's long Civil war. Bam Kumari Gharti Magar said, "Maoist were just attacking the school in the name of boycotting 'bourgeoisie education' without knowing its objective reality, they were not being able to understand which is bourgeoisie and non-bourgeoisie, there was problem in orientation of their cadres also" (Interview, 16th OCT, 2014 Kathmandu). During the conflict period, various construction activities had performed under the Maoist initiation. These included the construction of public shelters; taps, roads and the model health centers and schools. Similarly, activities of destruction were performed to fulfill the spirit of slogan such

[105] Chintamani Acharya emphasized, "in order to fulfill their needs, Jhakku Prasad Subedi assured to grant ten lakh rupees. However, finance minister who is also from Rolpa could not fulfill their demand; instead, he donated five lakh rupees to construct the temple in Libang".

as “complete destruction for new construction”. Moreover, in the post conflict period, in comparison to destruction, construction process was not performed in same spirit. Furthermore, the construction of the Martyr’s highway initiated by CPN (Maoist) has been not actively continuing after the peace accord was signed in 2006. Since there has been no local election after 1997, in the lack of elected village representative village secretaries are acting head of the village, however, many Village secretaries do not stay at village development committee office, consequently it becomes difficult for many people to complete their socio-legal and administrative tasks. As legal representatives of the Nepalese state, the civil war became an extremely unfavourable condition to stay in grass root for many VDC secretaries to discharge their responsibilities from respective VDCs. Instead they started to deliver their service from district headquarters Libang. Many VDC secretaries still do not feel comfortable to return in their respective jobs. Most of them perceive that are still under the fear of Maoists cadres in post conflict situation. Many people blamed those VDC secretaries who were displaced during wartime, now living luxurious life in district headquarters Libang and showing hesitation to go back to their duty stations in remote villages. I have observed that many VDC secretaries had opened contract office in district headquarters Libang. Prior to make citizenship and passport, the mandatory to take approval from VDC office, many people are compelled to walk a long journey to district headquarters to meet secretaries from their homeland. Instead of getting services in the vicinity of their home, people from peripheral villages of Rolpa has to walk normally two days one side to reach the district headquarters. There has been problem in the airport construction in Rolpa, many people blamed that rather than constructing airport to make it accessible for many people from Rolpa, senior leaders like Balaram Gharti Magar constructed airport nearby his home, which became dysfunctional after operating airline services for some time. Gersony (2003:22) writes,

> *More than two decades earlier, in about 1980, the Government of Nepal constructed a standard small airport in Rolpa, including control tower and passenger terminal. For reasons which are unclear, the airport was constructed in Badachowr VDC in south-eastern Rolpa (Map M), instead of near the district capital, Libang. Despite the significant investment in the facility, its location was impractical. It was used only a few times just after its inauguration, and then abandoned. Some interviewees asserted that its location was chosen because it was close to Mizhing VDC, the residence of Rolpa’s most influential national Panchayat member, an individual who had served as a government minister over a period of three decades.*

Whether its airport, road or hospital and health posts every kind of physical infrastructures in Rolpa has been dysfunctional on the issue of governance and corruption. The radical force

that emerged in the mainstream political scenario after first constituent assembly has never seriously addressed the micro level concern of the people in Rolpa, instead CPN (Maoist) also faced central level ideological contradictions which become another reason not to show concern towards people's expectations at grass root level. The Constituent assembly (CA) was announced in 2008 and candidates of CPN (Maoist) like Pushpa Kamal Dahal and Jaya Puri Gharti got elected from both electoral regions of Rolpa. Within the party there had been sharp contradictions[106] raised by another senior leader like Mohan Biadhya Kiran faction for gradually alienating with "progressive" agendas of party. One of the senior leaders Santosh Budha Magar from Thabang says:

> *During war comrades have fought only with noodles, beaten rice and many times with hungry stomach, however in post conflict phase, the lavish lifestyle of senior leaders had created extreme level of frustration among many people in Rolpa. Since the second rise of democratic government, corruption has been institutionalized, special party cadres were protected so we had growing sentiment of exclusion, anger and revolt. Leaders like Baburam Bhattarai and Prachanda represent the character of comprador, feudal, and imperialist. Twelve-point agreement done in Delhi has given Indian establishment to put unnecessary pressure in terms of political management of Nepal.(Interview-14th July, 2014 Libang, Rolpa)*

Leaders and political workers in Rolpa mentioned that the sharp class polarization or detachment with its base class one of the major contradictions to create the faction in the party. They expressed the grievances that there has been no effort done to compensate the physical and emotional loss of Martyr's families in Rolpa and other base areas. After the peace process, politics became completely city-centric and there had been very less concentration to those rural areas which were used as base of decade long civil war. Though two line struggles inside the left party has been taken as a granted concept, moreover, same two line struggles became the major reason to create another split in the party. In between UCPN (Maoist) split into two factions among Chairman Prachanda led UCPN (Maoist) and Mohan Baidhya Kiran Led CPN-Maoist. From Rolpa after UCPN (Maoist) split into two factions sixteen RBM (Regional Bureau Member) joined to Mohan Biadhya led CPN-Maoist. Similarly, among eleven CCM (Central Committee Member), eight of them remained in

[106] After first CA election, in the leadership of Pushpa Kamal Dahal aka Prachanda CPN (Maoist) formed the government with support of regional parties. In between, there has been party unification among Narayan Kaji aka Prakash led CPN (Unity Centre), after unification process between these two parties, henceforth official name of CPN (Maoist) changed to the UCPN (Maoist). After some time of this unification, small fraction of Maoist led by Matrika Yadav again split from CPN (Maoist). This fraction CPN (Maoist) claimed them as 'original Maoist' and blamed establishment of UCPN (Maoist) for alienating from revolutionary agendas. Interestingly, after the UCPN (Maoist) held the power in government, unification and polarization process inside the party was running in parallel way.

UCPN (Maoist) and four of them joined Mohan Baidhya led CPN- Maoist.

In between there had been announcement of second CA election in 2013, many people from Thabang has supported Mohan Baidhya led CPN- Maoist. Since this party has denied taking part in the parliamentary election, in support of party line of rejecting second CA election, Thabang unanimously rejected the election process and once again demonstrated the solidarity to reject the state call for vote to choose their CA representative. Again Mohan Baidhya led CPN-Maoist split into another faction in 2014 that has been led by Netra Bikram Chanda aka Biplap from Iribang Rolpa. This faction also named itself a CPN (Maoist) blaming that Mohan Baidhya led CPN-Maoist could not launch any radical programs to address the dire necessity of subordinate class. After split of Chanda faction from Mohan Baidhya led CPN-Maoist, there have been three factions of Maoists in Rolpa. Former Member of Parliament and resident of Thabang, Santosh Budha Magar supported Chanda led faction CPN (Maoist), therefore majority of people from Thabang has supported new Chanda faction. Since Netra Bikram Chanda is originally from western region Iribang of Rolpa, many leaders from western belt like Santosh Budha Magar, Kul Bahadur K.C, Nanda Bahadur Budha, Kesh Bahadur Batha Magar and Sundar Oli joined the Maoist faction led by Netra Bikram Chanda, Similarly, people from Jelbang were tilt toward Mohan Baidhya faction CPN-Maoist. Leaders like Chandra Bahadur Budha Magar and Asha Bahadur Pun are active in Mohan Baidhya's faction but Amar Jhankri Magar from Fagam has supported Chanda fraction. Likewise, senior Maoist leaders like Krishna Bahadur Mahara, Barsha Man Pun, Onsari Gharti Magar, and Nanda Kishore Pun are remained with establishment party UCPN (Maoist). After UCPN (Maoist) split into many factions, because of political frustration and sense of non-belonging to the political party, many people in Rolpa kept themselves in neutral position and feeling sense of de-politicization.

The transformation of a century long Rana reign, three decade long authoritarian Panchayat system and official ending of decade long civil war could not bring substantive political stability in Nepal. Dahal, (2010:9) “Today’s rulers are very different from the Shahs, Ranas and Panchas of yesterday in the style and rhetoric: but they are rulers yet and share the same motive-personalization of power, resource and authority and distribution of patronage to families, friends and clients”. The frequent breakdown of political parties into different factions ultimately divides political strength to gear up the socio-cultural transformation process. Empirically, in Rolpa, either in the reign of authoritarian government or in the multiparty era it has been clearly evident that general livelihood of local people was never the

primary issue of any political parties apart from their ideological contradiction which has distal rather than proximate relations with day to day survival necessity of rural mass. Furthermore, same reflection of district level has been clearly visible in national political development. As political parties were more concentrated themselves in power equation rather than prioritizing to address the dire need of needy section, there has been sufficient example to prove that political parties in Nepal are literally ignoring the expectations of the population. The limitation of political actors, the reflection of immaturity in party politics and lack of responsibility towards the people needs eventually creating crisis in societal development process which is clearly evident in the socio-political development of Rolpa. Ironically, the second CA also could not draft the constitution because it failed to solve many conflicts of interest among the political parties regarding the issue of federalism and the nature of ruling systems. Moreover, at present, the failures of the second CA has been reflected in the process of political deadlock in which people seem destined to celebrate the awkward moments of uncertainty with many fractured dreams and unfulfilled expectations of change. In between, a strong earthquake that hit Nepal temporarily suspended the political agenda which became strong divergence point to begin debate of reconstruction and recovery. Along with this program of recovery the coalition government run by Nepali Congress and UML has promulgated Nepal's constitution with the support of CPN (Maoist) in September 20, 2015 which declared secularization of the country as a federal democratic republic. Last but not the least, there has been frequent supra level changes in political structure, however, the living standard of general masses has been not changed in Rolpa and the condition is similar to other districts in Nepal. The dire conditions of social sufferings induced from socio-political upheavals have compelled a large section of Nepalese people to struggle to avail health, education and other minimum facilities to live a life of ordinary humans in a rural district like Rolpa.

CHAPTER IV

4. Tragedy of health institutions in Rolpa: A politico-economic investigation

The rationale of the existence of any public institution in society is to meet the expectations of the people and to serve the necessities of the society; however in the context of Nepal, many public institutions are facing problems of institutional malformation and a history of constant degeneration. Similar to other public institutions, many health institutions in Nepal are facing diverse kinds of visible and invisible conflicts and thus are not being able to discharge their services and responsibilities effectively. Alma Ata (1978) had visualized, that every responsive health institution should be able to deliver well-designed packages of promotive, preventive, curative and rehabilitative health programs. Moreover, these programs should deliver appropriate health services and play an active role to minimize the financial burden of the service users in relation to health related expenses. Similarly, Lancet (2009), discussed about the WHO six building blocks of HSS, like service delivery, workforce, information, medical product and technologies, financing and leadership, governance and stewardship, but Rolpa´s health service system is facing trouble to make an effective health service delivery in every of those components. As Mataria et al (2009) writes, HSS has definite goals to serve the necessity of the population in relation to improving health, responding to the non-medical expectation of the population and enhancing financial risk protection. However, many ambiguities and failures embedded with Nepal's health services are not supportive to discharge its duties and responsibilities to fulfill the expectations of the people. Like Bury (2005:80) writes, "Health services are not the only sites at which the experience of illness is played out, but they are frequently important when self-care no longer suffices". Therefore, HSS is one of the important supportive agencies in human life; it has to address the issue of accessibility, affordability and availability from both service delivery and the users point of view. In order to understand the nature of degeneration within the health care institutions, I have not kept any ideal type institutions in my mind, which will guide me to find the ambiguities and drawbacks of selected institutions; in contrast this research will explore certain historical realities and malpractices, that are responsible in the performances of health institutions.

Though anthropological engagement to study policy and practices gap has contributed significant literature in the broader context of Nepal, however, in the empirical context of Rolpa, there is a severe lack of such studies to develop proper insight on institutional failures and intrinsic power relations that have micro, meso as well as macro level determinants and dynamics. In this chapter, I have kept myself in the value critical position and confined myself to explore the role of powerful actors, their very act of corrupting institutional growth process and their influence on resource allocation process in Rolpa from a diachronic perspective. According to the annual report (2012/13) of the district health office, Rolpa has one district hospital, two primary health centers, fifteen health posts, thirty four sub health posts and two Ayurvedic health institutions. Similarly, numerous private medical shops exist in district headquarters and in other villages. Until date, Rolpa district does not have an academic institution, that offers any kind of medical or paramedical courses on health related subjects. I have purposefully chosen ten health institutions in Rolpa, those having history of institutional malingering, conflict induced destruction and pre and post-conflict governance crisis. Moreover, prior to exploration of ethnographic features of selected ten health institutions of Rolpa, this chapter will briefly outline the historical development of the health service system and supporting plans and policies in the national context of Nepal.

4.1 Development of the health service system in Nepal: A historical overview

As a country having a diverse existence of populace, many indigenous and ethnic people do have an own kind of medical practices and healing systems. Before the penetration of western biomedicine in Nepal, there has been bizarre understanding related to diseases and its causalities. There are numerous examples in Nepal, where the religious symbol of god and goddess are ritually interpreted as psychological protector to seek the favor in illness condition and symbolic entity to get rid from infertility. Even in western regions like Karnali, Seti and Mahakali, in the domain of traditional healing practices, faith healers associated with *Masta*[107] traditions are powerful and they do control the health and treatment beliefs of the people. In upper Himalayan region, *Amchi* medical practices originated from Tibetan traditional medical practices has significant impact among local communities of Dolpa and Mustang. Even *Ayurveda* as a prominent medical practice derived from *Yajurveda* has significant impact among large section of *Ayurveda* practitioners and users in Nepal. In the part of prescribing medicines, each indigenous tradition has mechanism to make own

[107] *Masta* is a tradition that follows the symbol of *Maulo* derived from twelve brothers of *Masta*.

kinds of medicines extracted from natural herbs and based on homemade remedies as well and those largely follow trial and error methods rather than any rigorous evidence based practices. In Kathmandu, *Way Sya Dyo* is a god who is supposed to take care of tooth related problems. According to this concept, after toothache people can Visit *Way Sya Dyo (Deity that should be worshipped of one has toothache)* at Kilagal in Indrachowk and hook the nail to avoid the pain. Similarly, to heal loss of appetite and to avoid the ill fate induced by different forms of black magic, visiting *Ghuvaju* and *Gathey* to eat 'blown food' (*phukera khane*) is basically a trend followed for psycho-social healing, which exists in both Newar and non Newar communities. Similarly, there is a practice of drawing pictorial image to cure certain forms of illness in the Newar community. The practices to worship '*Kandeuta than'* in Kupondole are especially important for the ailment of ear. Similarly, *Sitalmai* in the Pashupatinath temple area is to seek favour to protect oneself from smallpox. Santaneswar Mahadev at Jharuwarashi and Gyaneswar Mahadev in Gyaneswar is yet another example where visitors can pray to cure for their infertility. Most of these temples were built in Malla reign, which holds symbolic importance to understand how even during those days, when modern therapeutic procedures were not introduced, there have been cultural practices to seek psychological healing by praying the entities of different gods and goddesses. Nevertheless, these religious symbols do not have any scientific causal link to minimize the rampant condition of morbidities and mortalities, A large section of Nepalese people used to lose their lives in the lack of basic minimum health care facilities.

Since the health service system is one of the significant byproduct of modern welfare states, the concept of institutionalized health care itself is a very new phenomena for Nepal. Even though as a seed of institutional health care there has been an introduction of traditional medicine from the state level in the reign of the *Lichchhavi* dynasty. Marasini (2003) writes, "Descriptions of Arogyashala can be found in the reign of the Lichchhavi Kings Narendra Dev (643-679 AD) and Man Dev (464-505 AD). *Lichchhavi* Kings issued rules and directives to be followed by the general population on safe motherhood practices. The legacy of establishing *Ayurvedic* dispensary has not drawn much attention in succeeding reigns after the *Lichchhavi* dynasty. Dixit (2014) has documented the initiation of King Pratap Malla to establish dispensary in Hanumandhoka, that is later on expanded to Singha Durbar Vaidyakhana, a government owned institution, that produces Ayurvedic medicines. After a long run there has been effort to realize the importance of Ayurvedic medical practices, as WHO (2007) writes, "the first educational institution established in Nepal was the Ayurveda Vidyalaya established in 1936...services of Ayurvedic medicine were known to have started

since 1916 and by 1950, there were 47 dispensaries through the country and one hospital in Kathmandu". In spite of establishing Ayurvedic Schools to teach philosophy and practices of Ayurveda in 1936, there has been not sufficient attention given to flourish this system of medicine in succeeding days. Meanwhile; the early phase of modern medicine in Nepal was introduced through the Christian missionaries who used to travel Tibet through the route of Kathmandu valley. Dixit (2014:5) writes:

> *One of the earliest visitors to Nepal was father Greuber, an Austrian Capuchin monk who on his return journey from China to Europe, passed through Nepal. In 1624 both he and a father Dorville met Pratap Malla at Kantipur and were allowed by the King to preach and teach plus also to run health and education services in Kathmandu. Around this period various other fathers of the religious order were expelled from Tibet and consequently they all came and congregated in Kathmandu. ... One de Recanti had received permission from King Ranjit Malla to preach, teach and convert to their religion, the people "without violence and of a free will".*

Though Christian missionaries began to provide some health related service in Kathmandu, however, these services were sporadic and not accessible to a large section of the population. Marasini (2003) writes, In Nepal also the modern or Allopathic medicine was introduced by Christian Missionaries in sixteenth century, which could not continue for long time because of religious, and to some extent political factors. According to the author, the suspicious attitude of the kings to Christian religion is one of the important factors for the non-allowance of an open western medicine practice in Kathmandu. Besides, the rise of King Prithivi Narayan Shah and his official policy of not allowing foreign visitors (*Phirangi*) to the country restricted many foreigners to visit Nepal. Following the legacy of the suspicious attitude towards foreign visitors kept by king Prithivi Narayan Shah, there has been no entry to many foreign visitors in Nepal until 1950 and the country was "closed" for visiting purposes. As Dixit (2014) mentions, during the attack of Kirtipur in 1766/67, the wound of the king's brother Swarup Ratna was cured by Michael Angelo, a Capuchin monk. However, the rise of Prithivi Narayan Shah and his suspicious attitude towards the conversion policy forced many Christian missionaries to leave Kathmandu and Bhaktapur. In addition, the chief of epidemiology and disease prevention centre, Dr. Baburam Marasini claims, there had been conflicts among British monks and Capuchin monks in Tibet, which compelled a Capuchin group to come to Nepal and they began to provide medical services and played a role to eradicate plagues in the Kathmandu valley as well.

Along with Capuchin monks, there has been presence of medical doctors from other different countries. Chaudhary (1960) writes, according to Jordan RR, the first medical

doctor who came to Nepal was Francis Buchanan as the mission first doctors' in 1802 who came with Captain W. D Knox, the East India Company's first resident. Similarly, there have been postings of other military doctors like, A. Cambess, Henry A. Oldfield, Daniel Wright, GHD Gimlette during the 18th century. Moreover Dixit (2014) writes, that Captain Knox and Dr. FB Hamilton were appointed as a resident physician and surgeon for the British residency office in Nepal. Similarly, personal physician of first Rana Prime Minister Jung Bahadur Rana, Dr. H. A. Oldfield has documented about the primary setup of a hospital, which was built by Jung Bahadur Rana nearby his residency. According to Doctor Oldfield's personal diary cited by Dixit (2014), among Nepalese citizens, it's the children of prime minister Jung Bahadur Rana who got the opportunity to get immunized with modern vaccines for the first time in 1850 during Jung Bahadur Rana's first visit to England. The presence of foreign doctors was largely confined to provide medical services to Rana´s aristocrats and their close kith and kin, whereas a large section of Nepalese people had to rely on traditional and other alternative practices of healing. Similarly, Mali (1966) writes, first health institution to be set locally by Nepali authorities was the Khokana leprosy asylum in 1857. Since there has been huge stigma and discrimination prevalent with leprosy disease in Nepalese society, the asylum based in the Southern-Western corner of Kathmandu valley was mainly established to quarantine those patients, who were infected from leprosy. Epidemiologist Dr. Baburam Marasini says,

> *Most probably foreign visitors suggested Prime Minister Bhimsen Thapa to take care of those people who may spread their diseases to other population. During the reign of Bhimsen Thapa those infected people were forcefully kept in Khokana Leprosium. Overtly, these kind of activities done by missionaries were targeted to isolate the people who were rejected by their family and to maintain quarantine from modern day public health point of view but covertly one of the reasons beside opening Leprosium is to expand Christianity in Nepal*[108].

The acceptance of the missionaries by the infected people created a positive impression in the society; as a result, it became easier to spread the notion of Christianity in those places, where these kinds of health centers were established. The first modern hospital was Prithivi Bir Hospital established in 1890, which later changed its name into Bir Hospital, now functioning as a teaching hospital of the National Academy of Medical Science (NAMS). Apart from religious reasons, the concept of special facilities, that were provided to the Rana rulers have also supported the establishment of separate health service centers. According to Dr.

[108] Interview , 2015 May 24th, Kathmandu

Gaurishankar Lal Das, "In 1935, the Tokha tuberculosis sanatorium came in operation; one of the speculations behind the establishment of the tuberculosis centre in Tokha is to find a comfortable place for Rana Prime Minister Chandra Shumsher to treat his tuberculosis, later on *Baidhya*[109] (Traditional medical practitioners) has suggested to keep him in a separate place, where he can inhale sufficient air coming from pine trees". As a place with abundant pine tree, there has been a construction of a tuberculosis hospital in Tokha. Likewise, a leprosy treatment centre in Pachali was established in 1937 AD. During the tenure of Chandra Shumsher (1902 to 1929) there has been an expansion of health care services outside the Kathmandu valley; in 1903 he has established the Chandralok hospital in Bhaktapur, the Pritihivi Chandra hospital in Palpa, Nawalparasi, Doti and Illam. Likewise, there has been an establishment of the Tribhuvan Chandra hospital in Dhankuta, Bhadrapur, Sarlahi and Rangeli. Similarly, he has established the Naradevi Ayurvedic hospital in 1918 and in 1925 the Tri Chandra military hospital in Kathmandu. After Chandra Shumsher, Prime Minister Bhim Shumsher (1929-1932) has established the Tri-Bhim hospital in Bhairahawa, Butwal and Bhadurgunj. Likewise Ramghat dispensary in Pashupati was inaugurated in 1929. Prime Minister Jhuddha Shumsher (1932-1945) established a Tri Juddha group of hospitals in 1931 in Dharan, and in 1940 it expanded to Bhimphedi, Bardiya and Kailali. In addition, there has been different health institutions affiliated with Prithivi Bir hospital extended in Birgunj, Jaleswor, Hanumannagar, Nepalgunj and Taulihawa. Apart from the expansion of health care institutions from state level initiations, there has been evidence of personal initiatives to provide health services. Singh (1998) writes, outside the valley, Jai Prithivi Bahadur Singh established *Khaga* dispensary where doctors on deputation from Calcutta Medical College used to work there. The name of the dispensary was given after Khaga Kumari, daughter of Rana Prime Minister Chandra Shumsher. In this period, most of the Nepali doctors who used to come from Calcutta were popularly known as "*Bengali doctors*" as licensed medical practitioners. After the independence of India in 1946, the first batch of Nepalese Physicians went to study to other cities of India like Patna and Trivandrum under the Colombo plan. Moreover, there has been further expansion in super specialty services in Kathmandu. Dixit (2014 :13) writes,

[109] Gartaula (2008) writes, "Ayurvedic medicines are provided by both, trained Ayurvedic medicine practitioners and by hereditary Vaishyas. The hereditary Vaishyas provide Ayurvedic medicines and services on the basis of their experiences and training acquired mostly at the family level".

> *Initially, infectious diseases unit was started in Bir hospital. Later on changed to infectious disease hospital and finally it became Sukraraj[110] tropical and Infectious diseases hospital in 1890 and shifted to present location Teku in 1950…The first Ayurvedic hospital was established in 1916 as a social organization and started inpatient services with four beds. Similarly in 1951, there has been establishment of chest clinic at Bir hospital during the reign of King Tribhuvan and Mohan Shumsher Jung Bahadur Rana as a prime minister.*

Though many health institutions and supportive agencies were expanded in different reigns of king Rana's oligarchy, most of the activities were performed as random activities and did not have any concrete vision to expand the health services to meet epidemiological needs of Nepalese societies. WHO (2007:1) writes, until the early 1950s most health care was provided by family members and several kinds of indigenous practitioners, including herbalists and spiritualists as well as those practicing homeopathy, acupuncture, Unani and Tibetan medicine. In this kind of crucial reality, the extended modern health facilities outside the Kathmandu valley were not a systematic development, which could address day-to-day health related necessities of a large section of Nepalese people. In Kathmandu, during his tenure in 1980, Chandra Shumsher has established the Shree teen Chandra military hospital and formulated the concept of national civil medical schools. These hospitals were basically focused on curative services rather than providing comprehensive health facilities to ordinary people. No sooner the political transformation of 1950; there has been initiation to plan development activities. Accordingly, there has been launched a first five year plan in 1956, which incorporated the concept of health in its strategic interests. Justice (1986:9) writes:

> *In 1956 planned development of health service began with the government's first five year plan. Between 1950 and late 1970 Nepal expanded its health services to include 70 hospitals with 15 to 300 beds each; approximately 450 doctors, of whom 25 percent located in rural areas; 350 nurses with 40 percentage in rural areas; and 550 health posts; staffed by paramedical workers and distributed throughout Nepal's 75 districts.*

This data documented by Justice (1986) is questionable in relation to that period, because in same year of 1956, there has been an initiation by WHO and the Indian mission to establish the first Medical College in Nepal and sent three young people to study abroad in three subjects like anatomy, physiology and pharmacology. Rather than producing medical graduates, the cabinet decision of Bishweshwar Prasad Koirala has decided to start the course of staff nurse and health assistants. In this kind of reality, the availability of 450 doctors and

[110] The name of the hospital has been given after Sukraraj Shastri, one of the four Martyrs killed by Rana reign. Other Martyrs were Dharmabhakta Mathema, Dashrath Chanda Thakuri and Gangalal Shrestha .

350 nurses with 25 percent of rural postings before forty-five years in Nepal is very unconvincing fact, many rural districts had to cope with the problems even at present. Following the vision of the first five-year plan, The Malaria Eradication Organization was established in 1955 and the Family Planning, Leprosy Control, Tuberculosis and the Smallpox Eradication programs were introduced in 1958, 1966 and 1968, respectively. Likewise, the first official aid came in, which came in health related cause, was malaria prevention from USAID during the years of 1956/57 and the work station was based in Hetauda. Most of these programs have followed vertical program structure and every program used to have separate kinds of resource channels and reporting mechanisms. Justice (1986:51) writes:

> *Along with the emphasis on family planning, another extremely important policy shift was occurring during the 1960s. The donor agencies recognized that their previous hospital-based approach typically delivered services only to urban areas, where only a small portion of the population lived. Such disease-specific or vertical programs, though sometimes successful, were expensive to operate and were taking longer to complete than initially planned. Moreover, they failed to address the underlying causes of poor health, such as poor nutrition, polluted water, inadequate preventive care, poor hygiene, and so on.*

The ambiguities of vertical programs were creating techno-managerial difficulties to implement the health related services effectively. Since every project has different funding agencies, there has been fragmented approach in the program implementation. Many different service providers used to talk about different treatment procedures in the same day with the same patients, which was pragmatically irrelevant for both service providers and service seekers. As an attempt to combine several vertical health programs, the integrated basic health approach was introduced in Nepal in the late 1960s and dominated health policy and planning of the 1970s. The Family Planning Program was converted into the Family Planning and Maternal Child Health Board in 1968. WHO (2007:8) writes, "In 1978 government started the integrated community health services development project, which was entrusted with the responsibility of integrating vertical programs and expanding basic health services up to the community level and providing health care at doorstep of the people". After the implementation of integrated programs, there has been a single door policy to fund the program and the problems of heavy staffing have been reduced and techno-managerial costs have been minimized. However, Dr. Badriraj Pandey, the first director of the family planning department claimed, the integrated project was too much bureaucratized and not being able to meet expected outcomes. Justice (1986:53) writes:

> *According to a pronouncement by the king, the government sought to provide at least minimum health services to the maximum possible number of people, especially the rural majority. The government formalized this commitment by creating the Division of Integrated Basic Health Services (IBHS) within the Department of Health Services in 1971.*

Moreover, in 1974 there has been an implementation of a country health plan. WHO (2007:5) writes, "In 1974 WHO regional office for south east Asia introduced country health planning to its member states including Nepal. It introduced scientific management techniques in Planning expanded health service with the emphasis on measures on prioritization and accountability by the local community". Supplement to this statement, Justice (1986:64) writes, "Country health programming was developed at WHO headquarters in Geneva and promoted in Bangladesh and Thailand as well as in Nepal by the WHO Southeast Asia Regional Office. Its purpose was to prepare recipient countries for expanding health services by introducing planning techniques based on concepts of scientific management developed by economists and organizational specialists in business schools". Since a country health plan has focused on an allocation of resources and the formulation of public health services from management perspectives rather than public health priorities, as Justice (1986) criticized, there have been no real realizations, which met the needs of Nepalese people and the program was largely designed outside the country and forcefully tried to fit in the different realities of the Nepalese context. Dr. Hemang Dixit has mentioned,

> *As from 1974 WHO introduced the Country health planning CHP concept in Nepal. The first exercise for this had nine Nepali and six foreigners as participants. The exercise was used to prepare the first long term health plan (FLTHP) for the period 1975 to 1990. Different health ministers were preserving different version of their vision, because of this situation there has been realization of concrete health plan of the country. As a result first long term health plan has been formulated in different phases of exercise*[111].

The major purpose of the first long term health plan is supposed to be implemented within the timeline of the fifth, sixth and seventh five year plans of Nepal. Though Dixit has given credit to WHO for the rationale to implement a Country health plan, it was actually Nepal's first long term health plan. In contrast to this opinion, other public health experts denied the fact, that the first long term health plan was a byproduct of the country health plan. Dr. B. D Chatuat mentioned, "There has been preparation of first long term health plan in 1972/ 73 around but it was officially launched only in 1976. WHO's country health plan has supported to make the first long term health plan in the context of Nepal, however first long term health plan was not straight by product of country health plan". Moreover, there has been

[111] Personal Interview : 2013 , February 21th, Kathmandu

involvement of mostly medical doctors and three *Baidhyas* to prepare the first long term health plan of the country. Medical doctors like Dr. Laxmi N. Prasad, Dr. Narendra B. Rana, Dr. Manindra Raj Baral, Dr. Sundar Mani Dixit and Dr. Narendra Dhoj Joshi were involved in preparing the first long term health plan of the country. Before the implementation of the first long term plan, King Birendra has rigorously monitored and followed up through *Janch Bhuj Kendra*, which is regarded as a special agency to provide sensitive and important information to the palace during the King's led Panchayat system. Justice (1986:70) writes:

> *In 1976, after several long-term health plans had been drafted for the Ministry of Health, a final and official long-term plan was produced by a special committee of the Janch Bhuj Kendra of the Palace Secretariat and presented to the king. Serving on this committee were the chief of the Health Planning Unit (established by the Ministry of Health in 1974), who was a medical doctor, along with another medical doctor and a member of the Ministry of Finance. They worked in isolation from foreign advisers, but the influence of the agencies was reflected in the fact that the committee did not consider any approaches other than integration.*

Although the Palace has closely supervised the plan, it has been mentioned that the Palace has never interrupted any plans and policies because of the domination of professional doctors, who were ruling enough[112] to make decision on behalf of them. First long term health plan has suggested integrating vertical programs, which have been continued since the failures of vertical projects have been realized. Justice (1986:17) further writes:

> *The Integrated Community Health Program was one of several programs administered by the Department of Health Services in 1978. While the other programs were single-purpose mass campaigns, ICHP was designed to deliver all types of health services like curative, preventive, and promotive. According to long-term plans, by 1985 all single-purpose or vertical programs, such as the malaria and tuberculosis programs were to be integrated into ICHP. ICHP was perceived as the support structure for primary health care, through its aid to and collaboration with the community at all levels of its operation.*

After the effective launch of the Alma Ata declaration and its vision of comprehensive primary health care, theoretically it also supported Nepal government's continuous plan of integrating vertical programs. Though recommendations of Alma Ata (1978) have aggressively advocated the concept of comprehensiveness, problems like shortage of human resources, beds and other physical facilities took time to follow the guideline, and as a result, for long time there has been a continuity of single specialty hospitals. In 1978, there has been an initiation to open a medical school under the Ministry of Education. Dr. Moin Shah was

[112] There has been evidence that once assistant Director General from Ayurveda department became acting director general of health service department just for temporary period. That same night doctors exerted pressure on King Mahendra to appoint a medical superintendent as a director general

instrumental to visualize the concept of an Institute of Medicine (IOM) in financial assistance of the Japanese government. Dr. B. D Chataut mentioned,

> *Because of rural exposure and pro people oriented health, it has been visualized that medical doctors having base as a health assistants can be more productive and efficient. There has been mandatory to train as a health assistant first, only then one can get trained as a medical doctor. According to this concept nearly ten batches of health assistants were trained. Initially there has been training of other two batches during the reign of Panchayat*[113].

In supplement to this argument, one of the senior officers of the health education and information department, Laxmiraj Joshi mentions,

> *This concept has been guided from new education policy of Nepal. After having sufficient rural exposure, those health assistants who used to become graduate medical practitioners used to accept rural posting without hesitations. Later on this has been distorted by powerful elites which eventually change the policy in long run. At present scenario, most of the medical doctors showing pro people attitude on health through public writing or policy engagement are the byproduct of health assistant program functional under institute of medicine*[114].

Likewise, to promote the alternative healing practices, Dixit (2014) writes, it was as late as 1982 that Government of Nepal started a separate department of Ayurveda in the ministry of health and population. There have been promises to respect the notion of medical pluralism in health related policy papers, but in the shadow of biomedicine, Ayurveda as a system has not achieved equal priority in comparison to allopathic medical system under the umbrella of the health service system of Nepal.

In 1990, Nepal has achieved another significant political transformation; the rise of a democratic government, after overthrowing thirty years of Panchayat government, has launched a new health policy of the country in 1991 with more promises to fulfill the gap between service delivery and people's expectations. Furthermore, as a repercussion of the local self-governance act of 1991, the implementation of the eighth five year plan in 1992 has given more priority to decentralize the health services to make them accessible to the rural poor, and also followed the principles and guidelines formulated by the national health policy of 1991. According to the eighth five year plan (1992-1997):

> *In terms of institutional development, A long-term health plan (1975-1990) has given guideline to open the health posts have up to the Ilaka (Area) level and arrangements have been made for the services of the female community health volunteers at the ward level. As a result about 24, 000 female community health*

[113] Personal Interview, 16th June , 2015, Kathmandu

[114] Personal Interview, 9th March, 2016, New Delhi

> *volunteers have been engaged at the ward level. Moreover, this five year plan has influenced to expand district public Health offices in all the 75 districts and a Regional Directorate in each of the 5 Development Regions.*

The rise of democratic governance has tried its best to expand health services up to village level to make it accessible to a large sector of marginalized people; still there were many techno-managerial problems hindering to make the services effective. Most of the targets set up for the eighth five year plan have been continued in the ninth five year plan as well. Meanwhile, Cederoth and Skarr (2003) write, the World Bank has given Nepal a soft loan of USD 26 million over the next four years (under its program for population and health) towards infrastructure developments, namely sub-health posts and health centers at constituency level. One of the significant schemes supported by the 8th five-year plan is active mobilization of female community health volunteers at a very basic level. WHO (2007:4) writes:

> *The female community health volunteer was new type of volunteer health worker started in 1988. It was seen as means to improve community participation and enhanced the outreach of health services through local women working voluntarily. Conceptually, it was designed to enhance the country's primary health network through community participation and to expand the outreach by local women working voluntarily.*

As per the vision of the 8th five-year plan, after the active mobilization of female community volunteers, it became easier to deliver many promotive and preventive programs reaching to every individual in the ward level. Alma Ata (1978:32) writes, "For many developing countries, the most realistic solution for attaining to population coverage with essential health care is to employ community health workers who can be trained in a short time to perform specific tasks". Likewise, to fulfill the global call for action offered by the 'health for all' campaign, Nepal has officially launched its first health policy 1991, which has given priority to establish sub health posts in every VDC and primary health care in every electoral constituency. The Eighth five-year plan mentions, for a qualitative development of health services, the private sector also will be encouraged. The liberal economic framework adopted by Nepali Congress government has created conducive environment for many market players to extreme commodification of health services and health education and development of human resource on health. As a result, universal access to health became a myth for ordinary citizens and out of pocket costs have been skyrocketed. The strategy of mixed economy followed by the Nepal government provided easy legal ground to open private medical colleges, hospitals and nursing homes only in city areas, which were only focusing on

curative services to accumulate profits and left promotive and preventive health services only for the government. Similarly, following the legacy of the 8th five-year plan, a second long term health plan (1997- 2017) has started with the ninth plan, which has also given priority to private players, NGO sectors and other international development partners. In this context, the ninth five-year plan states:

> *Although Nepal has adopted liberal, open and market-oriented economic policies in line with the changes in the world economy, the objective of alleviating poverty cannot be achieved unless the government, market and private sectors complement each other and work together. The liberal, open and market oriented economic policies pursued by the country will be further strengthened and their implementation will be made more effective, which will enhance competitiveness and make these policies sustainable by exploiting the opportunities created by the open policies. The capability to cope with the changes in the world economy will be increased and reforms in the existing policies and improvement in the economic management will attract foreign investment. Encouragement will be given to private sector for developing health-related high and medium level human resources.*

The second long term health plan has acknowledged the role of private sectors and also the role of international donor agencies to join hands together with the government to achieve the objective of alleviating poverty. Supporting the concept of public private partnership, Nepalese government has officially envisioned the private sector as an important player to increase the condition of health services qualitatively. Empirically, the meager presence of the private sector in few cities and its limited curative activities have very lesser impact on the overall health service development of the country; at present the governmental health service system delivers approximately ninety nine percent of regular health services through its referral chain all over the country and private sectors hardly shares below one percent. In this kind of harsh situation, Nepal government is intentionally sidelining from its duty and responsibilities from delivering quality services to its citizens and betraying the people's right to access quality health services. Similarly, in order to effectively implement different provisions related to health services, there has been promulgation of a national health finance policy, the Antibiotic Policy of 1997 and the Human Organ Transplantation Act of 1998. Second long term health plan has envisioned reducing the infant mortality rate and maternal mortality rate focusing on the contraceptive prevalence rate and increasing the rate of safe institutional delivery. However, it has not focused to improve social determinants of health in the context of Nepal, which are directly related to reduce maternal and infant mortality rates. Nepal has formulated safe motherhood policy in 1998, as a signatory of a millennium

declaration to decrease the MMR and IMR, to encourage the institutional delivery under the umbrella of primary health care.

In 2006, a decade long Civil War has ended in Nepal after a peace accord signed between the Nepalese government and then CPN (Maoist). As a byproduct of this political change, the interim constitution of Nepal, which was promulgated in 2007, has accepted health as a fundamental right of the Nepalese people. Moreover, after ULF merged to CPN (Maoist), the new government led by UCPN (Maoist) launched a free health care program with the notion of comprehensive health services at district level. Free health services cover free registration, free availability of health services and free availability of medicines at Sub Health Post, Health Post and PHC level. Since there are no formal and convincing mechanisms to categorize the patients, health workers do face difficulties to categorize poor, ultra poor and destitute people. Jones (2010:8) writes:

> *The period since the second Popular Movement that ended direct royal rule in April 2006 and has led to the establishment of a federal republic has seen the dominance of the left in Nepali politics and the implementation of a program for the health sector based on the enshrining of rights to free health care in the Constitution, further increases in public spending on health and the progressive reduction and elimination of user fees for essential health services.*

The implementation of free health programs by UCPN (Maoist), without strengthening the deplorable condition of the health service system all over the country, is facing severe crisis in performance level to fulfill the growing needs of the Nepalese population. Moreover, there has been implementation of a new health policy in 2012 with the values of providing high quality universal health care based on the concept of equity and social justice. In the context, where temporary and permanent absenteeism of medical doctors even in district hospitals is not abnormal news, one of the severe criticisms of these policies is the government-envisioned goal to reach a doctor in every Village development committee of Nepal. Likewise, the issue of surrogacy has been legalized by this policy, later on after media raised the issue; Supreme Court has given stay order and legally banned to provide any surrogacy facility in Nepal. The development of health services in Nepal has taken organized and expanded structure from grass root level to central level from its early days of establishment, however, Nepalese people still have to cope with low quality and expensive health services. In this kind of crucial social reality, endorsing health as fundamental right of every Nepalese citizen in its newly promulgated constitution launched in 2015, seems too hypothetical, which urged to fulfill the promises assured by the government with a strong political commitment.

4.2 District hospital in Coma: A case of institutional tragedy

Rolpa was established as a new district in 1962. Only after two decades of its existence in 1979-80, His Majesty's Panchayat government has sanctioned the authority to run district hospitals during the tenure of Sharada Prasad Dahal as a chief district officer. In this program, the Mid-western hill district Rolpa was chosen, including other hill districts like Khotang, Rasuwa, Dhading, Mugu, Ramechhap, Humla and Dolpa. As Justice (1986) writes, in 1978 only forty-eight of the seventy-five districts had district health offices in Nepal, and only about 50 percent of these had a health inspector at work. It shows the evidence of an asymmetrical distribution of health services across the country in its early phase of development. Molnar (1981:195) observes for Rolpa:

> *The nearest hospital is a few days' walk away for a healthy person and the trip is expensive. The district health posts do not have as extensive facilities as the hospital and often run out of medicine. Villagers are reluctant to walk two days to the district center to discover the doctor is away from the health post or to find the medicine they need is not in supply.*

Initially, there has been an establishment of a health centre in the district headquarters of Libang, as a seed organization to expand and set up as a district hospital in future. Following the vision of the first long term health plan (1975- 1990) to be implemented within the calendar of the seventh five year plan, fifteen districts including Rolpa were sanctioned to run fifteen-bed hospitals (*Pandhra Sayya Aspatal*). Thereafter, the debates regarding the physical location to establish a district hospital either in the district headquarters, Libang or Reugha, has penetrated everyday life in Rolpa. After a primary survey done by an expert committee, they recommended Thalibang, resided at district headquarters Libang, as an appropriate location to construct a district hospital. However, they rejected another proposed site at Reugha, indicating technical reasons like rocky land and the threat of potential landslides. No sooner the decision made by a technical committee has been publicized; there has been a rise of tensions and conflicts among the different interests groups and service users. On the one hand, placement of district headquarters in Libang was a matter of dissatisfaction to many people from Western regions and on the other hand, the arguments to place the district hospital in Libang intensified the grievances of political leaders and ordinary people from the Western region. Chintamani Acharya, one of the significant figures since the Panchayat system and a resident of Libang says, "Despite expert committee recommendation to construct district hospital in Libang, elected representatives like Balaram Gharti Magar and Rek Bahadur Subedi were interested to construct hospital at Reugha which could be strong

visible action to please their voters from western regions[115]" Though Mr. Acharya put the blame on the elected district President Balaram Gharti Magar for proposing Reugha as a better place to construct the district hospital, but Balaram Gharti has mentioned, he was in favor to establish a district hospital equally accessible for the people from Western regions such as Ghartigaon, Madichowr and Ghorneti. Nevertheless, in opposition to the decision of the chairperson, some powerful elites residing in the district headquarters put the blame on him for pulling down developmental activities closer to his vote bank. In this case it has been agreed, including him, Chintamani Acharya and other local resident like Ekdev Acharya, have shown their severe disagreement and lobbied[116] with the chief district officer to build the hospital inside the district headquarters of Libang, as Mr. Acharya mentioned during interview, "We had a good rapport with CDO and tried our best to keep hospital in Libang, but people from Thalibang could not understand the value of hospital and opposed the decision, instead they said, hospital would spread diseases, so it should be far from human settlement". In relation to this event, Mr. Dahal mentioned, "After listening the grievances of the people from district headquarters, I have convinced them to support the decision of placing district hospital at Reugha and convinced them about the probable expansion of concentrated market activities only in Libang area to Reugha which could be matter of larger betterment in future[117]". Finally, in spite of powerful elite's interest to construct a district hospital in the vicinity of the district headquarters, it was decided to construct the hospital at Reugha in 1979-1980, which is placed 2-3 kilometers away from the district headquarter of Libang. The coalition of powerful politicians like Amrit Bahadur Gharti Magar, Balaram Gharti Magar and Rek Bahadur Subedi has done a final decision in the district assembly to build the district hospital permanently at Reugha forwarding the logic of an the abundant availability of building materials like rock and timber nearby the construction site.

After the physical location to construct district hospital has been accepted, there had a been search for a local contractor to construct the infrastructures. Surprisingly, a younger brother of Deputy Minister of Panchayat government Rek Bahadur Subedi and a cousin (*Vhati*j) of pioneer leader Khadananda Subedi has been granted thirty six lakhs Nepalese rupees (3.6 million) to construct district hospital without any public call for tender. It has been explored

[115] Personal Interview, 2013, 22nd September, Rolpa.

[116] Interestingly, son of CDO Dahal got married to daughter of pioneer leader Khadananda Subedi as well as Chintamani Acharya got married to sister of Khadananda Subedi, because of this caste affinity and close kin relation it was comfortable for Chintamani and his allies to make sufficient lobby to make decision on their favor to the CDO Sharada Prasad Dahal.

[117] Interview, 9th November 2014, Kathmandu

that most of these contracts in those days were grabbed by Dilli Subedi by using his personal relations with Balaram Gharti Magar and Rek Bahadur Subedi. Though the family nexus favored local contractors to get the contract, however, the hospital construction process could not be initiated on time. As discussed in the earlier chapter, in the political power structure of the Panchayat period, two politically powerful groups, Chanda and Thapa Camp, were dominant in local politics and national politics respectively. The Local contractor Subedi was aligned to the powerful Thapa Camp at the central level; therefore, he could not maintain his influence in the local context. In contrast, local administrators belonged to Chanda Camp; consequently the situation was proven politically "unfavorable" to the contractor to perform his responsibility on time. On the one hand, because of local political tussles, local contractors found an uneven situation to execute responsibility of building the hospital on time, on the other hand, many people blamed him for being a morally corrupt person. Many local people in Rolpa mentioned, he had paid absolutely no attention and responsibility towards public health, rather he was more focused on making only profits from grabbing the contracts by exercising his personal political influence through his elder brother Rek Bahadur Subedi. To forward the hospital construction process, it has been decided to find an alternative way and the contract had been given to a second contractor to work jointly with first contractor, later the new contractor has been forcefully[118] excluded by the old contractor. After long delay, the old contractor has forwarded some effort in construction process of the hospital, because of the feeble structure; the hospital building could not satisfy the concerned stakeholders like local people, health professionals and management committee in Rolpa.

Nearly a decade has gone but the district hospital construction process could not appear in its expected physical presence until the end of the Panchayat regime in 1990. The eighth five year plan, which was effective during the years 1990-1995 has mentioned about the ongoing progress of the district hospital in Rolpa, but there has been no mention about the problems, which the district hospital is facing in its construction phase. The authoritarian nature of the centralized Panchayat government could not draw the sense of urgency to look after the crisis of a district hospital, which was occurring in the setting of an literally and symbolically 'remote and far" location from the capital city. In the case of Rolpa district hospital, neither there was a broader political consensus to gear up the construction process effectively, nor there was a devolution of power at the district level to gear up the district hospital to run the

[118] There was a huge physical attack in Jinabang when Dilli Subedi has gone to collect timber for district hospital construction process.

health care services. Onta et al (1997) writes, the district level is close enough to communities for problems and constraints to be understood and to undertake appropriate actions to implement primary health care. In contrast to this proposition, the long-term stagnation of the district hospital has compelled many people to seek the health services outside of Rolpa and the expectations of the people to access tertiary health care have been not met for long time.

After overthrowing the Panchayat system and the restoration of democracy in 1990, to continue the hospital construction process, multi-party delegations from Rolpa have made delegations to Health Ministers like Padma Ratna Tuladhar, Ashok Rai and Prime Ministers Manamohan Adhikari and Girija Prasad Koirala. Listening to the grievances of delegation team related to the long-term stagnation of the district hospital, a central level monitoring committee had been formed and the supervision committee has visited Rolpa. However, the continuously overlooked phenomenon since long time could not find any reasonable solution. The eighth five year plan (1990-1995), that has given priority to provide the required decentralized authority to the Regional Health Directorate and District Public Health Offices to effectively forward the administrative, management and supervisory aspects of health services in the country, but this decentralization policy could not even penetrate in the case of the district hospital in Rolpa and no political parties were independently able to take a decision at the district level. Since there has been no completion of the district hospital building, public health was functional in the building of a district development Committee (DDC) office in this period. Gresony (2003:22) writes:

> *The regional hospital, located on a two-hectare site ten minutes from the center of Libang, comprised fifteen small concrete and steel modules, including wards which could accommodate up to 45 in-patients, an operating room, laboratory, doctors and nurses quarters, and a morgue. The turnkey contract required the builder to provide the furniture, refrigeration, X-ray equipment and even surgical tools, to make the hospital immediately operational. In fact, the hospital was completed and ready for service in about 1995. The Ministry of Health had set aside an operating budget and personnel positions for three doctors and a complement of nurses and other staff. When the contractor presented his invoice for completion of the facility, the district hospital management committee inspected the work. It found a few minor and easily corrected deficiencies - a small walkway between two of the modules was not complete and an access road to the rear of the site was missing. Nonetheless, the invoice was never paid and therefore the contractor never released the work. The contractor's work crews were not paid.*

In contrast to Gresony (2003) documentation, Rolpa does not have any regional hospital and the district hospital does not have any policy obligation to supervise other hospitals as a regional hospital. Likewise, the place is nearly forty-five minutes walking distance from the

district headquarters. He has claimed, the district hospital was ready for service in 1995 and did not bother to mention fifteen years of history of stagnation, which was planned to initiate in 1980 and even the construction process was stopped during his visit. The information he has collected directly supports the contactors position and thus put one-sided blame on government. In opposition to his observation about the hospital, which had 'minor and easily corrected deficiencies', the overall construction process of the hospital was built in such a feeble way; it could fall down anytime with a minor stroke of an earthquake. In the Panchayat period, the original contract amount of this hospital was nearly 3.6 million Nepalese rupees, because of the low quality infrastructural set up of the work in comparison to the allocated amount, the new democratic administration, which changed after 1990, strongly denied accepting such a weak infrastructure. In fact, after the political change of 1990, since all powerful figures became underground to save their face, the local contractor also lost the moral and power back up to stand alone in Rolpa to complete the remaining task of the hospital. In between, the Communist party of Nepal (Maoists) declared arms insurrection against the state in 1995 and again created a severe obstacle in the construction process of the district hospital. Because of Maoist threats and issues related to labor exploitation during the construction, the previous contract had been canceled and the local contractor Subedi had been displaced from Rolpa. It was agreed by CPN (Maoist) district secretary Raktim, whom I met in 2009, that Maoists were not interested to accept the execution of any developmental activities performed by the "old state mechanism" in their influential area even though they were fighting for the "people's state", "people rights" and "people's health". The budget used to be allocated by the central government annually, but *Sankatkaal* (Civil War) proved to be an extremely adverse situation to continue the construction process of the district hospital. Though some basic level infrastructure has been already built and additional budget has been released several times to complete the hospital building; however, district hospital building could not appear in a convincing form, instead deterioration of the hospital buildings occurred. Gresony (2003:22) observes:

> *Unknown persons vandalized and looted the furnishings, equipment and tools and removed the doors and windows, exposing the interior of the buildings to the elements. A few steel roofing sheets were torn from one module. Abandoned and unmaintained for almost a decade, the buildings became a shelter for wandering livestock. Their floors and walls are caked with the excrement of cows, goats, bats, birds and occasional human visitors.*

As Gresony observed for many people from Rolpa mentioned during interview, it was very painful to watch the tragedy of public property and even they used to feel more hatred

towards the actors who were responsible to create the pathetic condition of the district hospital. Meanwhile, after a long term stagnation, the District Hospital was shifted to its own building at Reugha with the initiation of Doctor Pitambar Subedi, who was posted as a first governmental medical officer for the Rolpa district hospital. It has been explored, that Doctor Subedi was a straightforward personality and he forwarded the logic, that, if the hospital can be started in its own buildings, then it will draw further attention of the government for its necessary improvement and upgrade. After shifting from the Chihandanda health center to the DDC (District Development Committee) hall and to the British Welfare[119] building, the hospital found its own building only after 2005, which is nearly two and half decades after the decision to construct a district hospital.

At present, during my field visit I have observed that the district hospital has not been able to gear up its regular service delivery effectively, as it is expected to perform as the tertiary care center of the district. I would like to highlight some of those evidences, which I have gathered during the time of the fieldwork. During my fieldwork, it has been observed the district health office and district hospital building were running in the same building. In the hill district, though government has provisions to keep the public health office and the district hospital as an integrated system, but from the point of view of delivering public health, administrative and other medical and non-medical facilities, as well as the present infrastructures are not adequate to run in same building. Alma Ata (1978) has focused the point to be remembered is, that a large number of people will probably use the building, which should therefore have a spacious waiting area, either inside or under cover outside, with toilets. However, the building has been built in an ill-designed way and in an ill-planned manner. There had been no proper utilization of space outside and inside the wards. Ghimire (2009) writes, the District Hospital lacks a cafeteria or waiting space for visitors. Male and female patients share the same latrine whose condition can only be described as sickening. Patients suffering from nausea, vomiting, and other gastrointestinal diseases could literally not breathe inside the latrine. Additionally, during the time of a field visit, the district hospital does not have its own cafeteria and the space to run a cafeteria has been occupied by the Nepal Police[120]. Moreover, the general condition of the hospital rooms is, that they are not well equipped to run specialty services like ICU and NICU and other supporting units to be performed under the district level of tertiary care. The district hospital is not being able to run important medical service like blood bank in the time of emergency. Emergency and OPD

[119]British welfare committee is supposed to support in different major and minor programs by channelizing funds. Primarily, this office has been established to distribute pension for ex British army. This office has supported to construct school, bridge and water sanitation.

[120] Since Police station has been destroyed in war, Nepal Police has occupied hospital cafeteria to run its office.

was on the opposite site. Patients had to walk, after descending from the ambulance. Nevertheless, the lack of sufficient technologies and health related infrastructures; posted doctors are not being able to perform their skills. A medical officer working in the Rolpa district hospital says:

> *I came here under the compulsory rural service for those students who have studied in government scholarship. However, our health service system looks ideal, but it does not have outcome. Health workers do not like to stay in office, district hospital cannot supervise all offices. There is a lack of supervision in all programs. We don't have single nursing staff here in Rolpa. This is a final referral system of district, but we do not have complete set up here in this district. We are not able to perform even minor surgery. Blood bank facility is not here, it is not possible to take risk during major surgery. We do not have CAC surgery. Even we are not being able to start minor OT also*[121].

It is important for any skilled human resource to perform its duties in a technically efficient and physically sound environment. Similarly, training is one of the important components to strengthen the health service system. However, some level of training in the hospital management system and DOTS is frequently provided. Most of the staffs think, they are not getting sufficient training in their professional work. Since a tertiary level health institution of the district suffers from many techno-managerial problems, it is not possible to support its dependent institutions like other PHCs, health posts and sub health posts. In one of the incidents I have observed at the district hospital, X-ray films were very poor in quality. I was told, that a technician had demanded new chemical five months before, and he was working in a no response situation. In fact, the person who was working as a X-ray technician had been trained as Auxiliary Health Worker (AHW), just to get a job at a government hospital, he agreed to work as a X-ray technician after experiencing a month long informal work in the city of the adjoining district. The lack of different kinds of managerial, technical and logistic support eventually lost the energy among health workers to discharge own capability and maintain job satisfaction level. In one of the cases, a staff of the district hospital mentions,

> *It has been three years that account of hospital development committee has not been audited. The tender process to buy medicines became very controversial. Initially, hospital used to pay 14 Lakh rupees (14,000 USD) for medicines, now we are paying only 3 Lakhs Nepalese rupees (3,000 USD). Either it is a wrong estimation or it can be low quality drugs. I have heard that main tender supplier was the brother of regional director*[122].

[121] Personal Interview : 12th May, 2013, Reugha Rolpa

[122] Personal Interview-12th May, 2013, Reugha, Rolpa

The issue of transparency is one of the most crucial issues, especially in the context, where many layers of actors have interests over the performance level of a single institution and the level of resources deployed and consumed, in order to sustain the institution. In such condition, the lack of transparency in financial dynamics creates additional hostilities among the involved actors and the level of trust would decrease among each other. As a result, conflicts become an inevitable phenomena in public institutes, which eventually create stagnation in the effective functioning of its day to day services. At present, because of long-term governance problems, there has been no handover of the district hospital to the government. Whether the political actors of the authoritarian Panchayat period or the actors of multiparty democracy, every changing political system has failed to demonstrate strong political will in response to develop the health service system and to address health needs in Rolpa.

4.3 Thabang Health Post: Comrade-Contractor Complex

Thabang, a flat and elongated land with the local Magar language, is a VDC situated at the northern direction of Rolpa. The village has a predominantly homogeneous settlement of the Magar caste along with significant presence of other so-called untouchable caste groups like the Sunar and Nepali in scattered settlements. In 1977, the Thabang health post has been initiated in the private home of a local resident after getting permission to run the health centre. After the construction process of village development committee building, health post was shifted to VDC office temporarily. Molnar (1981:195) has documented the early picture of the Thabang health post. She writes:

> *There is now a health post in Thabang, but there is no competent staff to diagnose or treat properly. The village level health workers are young and inexperienced and have only trained for a few months. A health post was opened eight months before my departure in 1978, but as in other remote areas of Nepal, the government has been unable to find a Health Assistant willing to be posted in such an 'isolated' community. Most of the medicines lie unused and minor ailments are treated by unsupervised village health workers.*

Molnar's ethnographic observation, which was done before three decades has shown the preliminary condition of the Thabang health post and contemporary perception about the rural posting. After three decades of her observation, the condition of the Thabang health post is comparatively better than the observation she did in the early eighties. At least at present, there is availability of regular health staffs including health assistants to provide services. Unlike the observation of Molnar, at present people do not have to run the district hospital or other health centers for minor ailments. In the case of a suspected tuberculosis

case, there has been provision of collecting sputum in the Thabang health post and they send it to the district hospital for further diagnosis. Since there have been other health posts and sub posts, the Thabang health post alone does not have to cover the burden of the patients of this region. In comparison to Molnar's observation, health awareness among the local people has comparatively increased and there have been sufficient numbers of patients turned over to access health care services. As a regional health post, the Thabang health post is supposed to supervise the Mirul and the Kureli sub health posts also. Though the condition of the Thabang health post has been significantly changed in comparison to its preliminary setting, but this health post is not free from other complications and problems aroused in succeeding days after Molnar's observation.

After running its services temporarily in the rent room, the health post was shifted to the VDC office of Thabang. In between a strong hurricane destroyed the health post building, which compelled the health post to run its services in health post quarters. As we discussed in the earlier chapter, the Thabang VDC has been always used as "favorable ground" to nurture left political ideology, apart from launching occasional campaign to ban alcohol, there has been no effort done by any left or other political parties to promote public health in this village. Since Thabang was frequently boycotting the election activities, in response to this aggression and to maintain the control and domination by applying coercive state power, Royal Nepalese Army (RNA) has frequently attacked the health post during the Civil War, which was settled in the VDC building during the days of 2002. Moreover, in the accusation to provide medical services to the Maoists injured in the war, Royal Nepalese Army destroyed the health post, burnt medical records, threw away all medical and surgical equipment and used rocket launchers to destroy the health post. One of the permanent staffs of Thabang health post says:

> *In the cupboard of HP, there was amount of approximately nine thousand and five hundred Nepalese rupees, they smashed the cupboard and took that amount. Later on, I went to army camp and ask for BP set and Stethoscope. They asked me to sign on a paper and gave it to me back. As a health worker, irrespective of any ideological inclination we were supposed to deliver health care services. We had no option except delivering services for needy people; we had to go wherever Maoist used to take us. Only the tactics that could be useful during war is saving us and treating the injured in the war. Rather than understanding our complex situation as a health worker coping with dual obligations and bondages, army accused us by using words like "Maoist doctors"[123]. (20th May , 2013 Thabang, Rolpa)*

As the staff of the Thabang health post expressed, it was a very tough situation to remain

[123] Personal Interview : 20th May , 2013 Thabang, Rolpa

"neutral and safe" during the war in the hard core influential area of the Maoists like Thabang. Just to protect oneself, it was not possible to show any kind of hostility against the Nepal Army or against the Maoists. Ghimire (2009) writes, the contradictions of performing dual roles simply to stay alive in the war zone finally discouraged health workers from remaining in the war-affected region. As a result, rampant absenteeism of health workers was one of the prominent problems in many health posts during the days of the Civil War (*Sankatkaal*) in Rolpa. There are numerous cases where Nepal army and Maoists abducted health staffs. On the day of polio vaccination, Lali Rokka, a FCHV was abducted by the army and accused of providing treatment to the Maoists. An office assistant of the Thabang health post, Shital Nepali[124] , who was witness of this event, mentions:

> *On polio day, suddenly the army with big machine guns came in and started to beat me, they harassed our staffs, and took away female community health volunteer Lali Rokka, and we could not do anything. After two days we found her burnt dead body in the river bank below the village. After this event the posts of Female Community Health Volunteer and also other posts were vacant for many years in Thabang health post.*

The demonstration of brutality through killing a FCHV from Thabang has terrified the villagers and hatred against the state has been once again intensified. Such kind of brutal exposition of state power played to unite the villagers against domination and control. During the war, as Berry (1997:50) writes, "the process of combat and threats of further combat, both of which are targeted to destroy the enemy's armed forces, infrastructure, and popular support". Thabang HP appeared in the form of "enemy's infrastructure" from the perspectives of the RNA, which was providing treatment to Maoists whom they were fighting physically and politically. Though the health post was purely governments property and the RNA being a governmental security force, they had blasted the infrastructure and abducted the health staff to discourage their potential enemy from regular "mis-utilization" of governmental resources.

After the official ending of the Civil War in 2006, no sooner, extra land from a high school has been provided to reconstruct the destroyed health post building of Thabang; Contractor DBB got the original contract to build the Thabang health post from central level tender, however, on behalf of the first contractor, his younger brother KB appeared to work in the field as a second contractor. Ghimire (2009) writes, Thabang, a village regarded as a strong hold of Maoists has received little support in its attempt to build a health post. The

[124] Interestingly, during his India visit, Sanjaya Gandhi's Vasectomy campaign was operating in India; he was forcefully captured and done vasectomy.

contractors who had been hired to build the post seemed more interested in quick profit and left the community with a poorly designed, poorly built and poorly functioning facility. Moreover, I have again visited the Thabang VDC in 2013 for further exploration. At that time the CPN (Maoists) party has been already split into chairman Pushpa Kamal Dahal aka Prachanda led establishment faction and the Mohan Baidhya aka Kiran led CPN-Maoist faction. After splitting, there has been an ideological polarization among the villagers in Thabang, but the majority of the people were supporters of the Mohan Baidhya led CPN-Maoist, which claimed itself as more radical (*Krantikari*) than the establishment led by Chairman Prachanda. During my field visits, allies of one fraction were blaming supporters of another fraction for creating conditions to split the Maoist party. Following the ideological polarization in Thabang, it became a favorable situation to unravel each other's historical secrets and their illegitimate and unethical activities during the conflict and post conflict context. A man from Thabang and political worker associated with the CPN -Maoist states:

> *Health post construction process has given tender in seventy two Lakhs Nepalese rupees (70.2 thousands USD); if you see the quality of building it won't cost more than 2-3 millions. Contractor Mr. Basnet participated in volleyball match held in Thabang, helped Tournament as a referee and developed good rapport with villagers. Finally, we have seen his real face. I was confident with DBB, because we have done our schooling from same school. Instead of my friend, he has sent KB as a petty contractor who was alcoholic in nature. Our revolutionary party developed good consensus and solidarity with contractor, and then what do you expect? There was a corruption before the party split; activities like donation collection and bank looting were also not transparent during Civil War. We were also active in the party; even many times we were cheated. Corruption has been institutionalized in the party since very beginning*[125]*. (20th May , 2013 Thabang, Rolpa)*

In general observation, the overall construction process looks substandard and spent very low amount of the budget in the construction process of the Thabang health post in comparison to its total allocation. Most of the local people in Thabang have developed the perception of getting cheated by the contractor. Many people expressed their grievances, that 7.2 million Nepalese rupees have been allocated not only to construct the stainless steel (CGI sheet) roofed building standing in a base of four feeble wall structures. Even it has been explored, just to please the local people; the main contractor DBB outsourced three Lakhs Nepalese rupees to construct the compound wall to Ruju Bahadur Rokka, who was also one of the members of the management committee of the Thabang health post. The poorly built health post compound wall fell down by an earthquake, which occurred after few months from its construction**.** In the act of such negligence, neither community leaders nor the Maoist party,

[125] Personal Interview- 22nd May , 2013, Thabang, Rolpa

nobody has paid any extra attention towards the health facility construction process. The chairperson of health post management committee says:

> *We just resolved the war, we did not know that a contractor would do that kind of cheating. Main contractor has hand over the contract to sub-contractor in lower price. There has been weakness in monitoring process at local level. After being cheated, then we came to know about the tendency of contractor and his profit making greed. Nepal's system is like this, the person who is corrupted he is the favored by politicians and bureaucrats.*

The Chairperson of the health post management committee blamed the contractors and their profit making greed to create such unintended situation; however, the "innocent answer" of the chairperson, who is also an active member of the communist party, is highly paradoxical. People of Thabang have seen the condition of the district hospital since long time and many of them were aware about potential corruption that can be performed by the contractor. The lack of strong commitment on people's health has been reflected in the construction process of the Thabang health post where the construction process has been viewed merely as a technical matter rather than viewing any profit accumulating interest of the contractor. As the village consists of predominantly Magar settlement and the dominant trend of marriage is caste endogamy, in this kind of complexly woven kin network, most of the people share primary, secondary and tertiary kin relations with each other in this village. Apart from cultural nexus, politically there is a domination of a single party since the Panchayat era; as a result, there has been meager chance to raise the agenda of institutional corruption openly by any individual. In charge of the Thabang health post, a person who is not from Rolpa admits:

> *There is a bare evident that the Maoist Party has asked money from the contractor. It is worthless to say, who took and who did not, we do not have to stay more, so we want to remain safe. Previously they used to hide everything, after party split information is coming out. Since members of management committee are also involved in this case. It was not possible to take stand by health staffs alone. Since main contractor has good nexus with top-level bureaucrats and political leaders. Small people like us cannot do anything*[126].

Similar to the health post argument done by the health post in charge, many local people mentioned, the nexus of the contractor with central level political leaders and bureaucrats helped him to get the tender of the Thabang health post. To supplement his arguments, more specifically, one of the management committee members of Thabang clearly pinpointed to Maoist district level leaders like Comrade I and B for receiving undocumented five Lakhs Nepalese rupees from the contractor in the name of collecting donations for plus two building

[126] Personal Interview : 22 May , 2013, Thabang, Rolpa

of the Thabang high school. This argument is supplement by the narratives of an active member associated to the youth club in Thabang, who even claimed, that Maoist's district level in charge has taken cash from contractor during the meeting held at one of the guest houses located in the district headquarters of Libang. Likewise, the school principal has mentioned unrecorded cash, which was taken in the name of plus two buildings, which was not handed over to the school. Many stakeholders of the Thabang health post have unanimously agreed, that after the comrades took the special amount in the name of school building; contractors developed the confidence to be negligent in the construction process. The negative repercussion of receiving the special incentive by Maoist leaders reflected in the negligence in construction and contractor's sense of disobedience towards the local community. Even after doing negligence in Thabang, many people in Thabang expressed their grievances for providing contracts to same contractor DBB to construct the Jinabang health post in Rolpa and the health post buildings of Rungha and Mahat VDCs of Rukum as well. The Public Procurement Act of Nepal government (2007) clause number 63 (C) has clearly mentioned about the clauses[127] for black listing the contractor if he or she could not fulfill the quality of the construction. Since the Thabang health post building process in Rolpa was done in coordination with the Department of Urban Development and Building Construction (DUDBC) office in Rolpa, nevertheless, one of the senior staffs of DUDBC mentioned that the contractor's negligence has been noticed but his negligence has not perceived seriously up to the level, where he should be punished and being terminated from getting other contracts.

One of the Construction Engineers of DUDBC defends:

> *There is no policy or strict rules and regulation of the government that first contractor could not hand over the contract process to second and third contractors. If the contract amount is good then main contractors work themselves. But if the contract level is in lower amount, they may not work. After doing agreement in Kathmandu, Petty contractor appears in district level as a representative of main contractor. If the main contractor can earn 30 lakhs Nepalese rupees(30 thousands USD) only staying in the capital city, then this kind of business is always in profit, contractor does not have to visit remote place like Rolpa to construct the building. In district level, our office is especially responsible to ensure the quality of the health building. We have requested district hospital to provide staff to take care of the construction site, however, district hospital has not responded seriously in this matter. There is a severe malpractice that first contractor handovers to second and*

[127] Nepal Public Procurement Act 2007 clause 63 (C) mentions, "if it is proved later s/he had committed substantial defect in implementing procurement contract or had not substantially fulfilled obligation under the contract or the work carried out according to the procurement contract is not of the quality as per the said contract.

second to third petty contractor. Formally we won't come to know which level contractor is appearing to us, we think the person who comes in office might be the representative of original contractor. After construction, quality assurance will be done based on the basis of that amount which government has granted to the first contractor. In this process, CDO can monitor the construction process, if CDO office thinks it is necessary to monitor[128].

In reality, it's the matter of an open secret, that the main party does not appear to construct a health post in a rural hill district like Rolpa. DUDBC is well aware about the Thabang health post tender process, which has been handover from the main contractor to the petty contractor at the district level. In this kind of case, the argument done by DUDBC staff is a serious false about their compulsion to accept representatives as a main party. In district level, according to tender policy of the government, local contractors do not meet professional grade to apply for the government tender, similarly, central level also puts control and governs the tender process. Particularly in this event, chief district officer (CDO) and local development officer (LDO) have not actively intervened to monitor or to regulate the activities of the contractor. Instead, some staffs of DUDBC blamed the management committee of the Thabang health post for not supervising the process rigorously. In response to the blame by the DUDBC staff, one of the management committee members blames:

Rather than blaming the local management committee, the District hospital should take responsibility of negligence on health post construction. There is some kind of confusion, theoretically management committee are supposed to look after overall process and activities happening with health institution, but in reality, there is no responsibility of management committee to take care of budget transparency. Partial kind of authority given to management committee is not supportive to maintain local governance effectively[129].

According to above opinion, it is strongly suggestive to understand the fact about the limitations of the management committee to exercise rights and to operate within its area of authority (*Chetradhikar*). Since there has been no complete authority or clear guideline either to intervene or to observe the construction process, in such paradoxical situation, the expected level of supervision cannot be done at local level. Moreover, non-participation of the management committee members in a decision making process is another prominent problem in the composition of the health institution management committee. In response to the issue of mal governance, which occurred in the Thabang health post, Sandhya Chaudhary,

[128] Personal Interview- 26 May , 2013, Libang, Rolpa
[129] Personal Interview : 26th May, 2013, Libang, Rolpa

one of the female management committee members and representative from of the Dalit community says, "I do not understand *Kham* language, so I could not follow the debates about the controversy. I really do not know what happened actually" *(Interview-20th May, Thabang, Rolpa)* . It is a non-probability scenario for a person, who is the resident within the periphery of few hundred meters of the Thabang health post to easily avoid the whole mal governance process by showing the language issue. On one hand it could be her skill to keep herself neutral from controversial issues and her planned idea to remain safe from dispute, on the other hand, this kind of non-participatory and excluded feelings of representative from marginal community clearly demonstrates the failures of government's vision of mobilizing 'diverse community' in the health facility management committee. During the meeting of the health post management committee, in reality, elites and especially upper-class males dominate the choices and needs of the community as per their interest; most of the time coterie makes the decision and voices of the female representatives from marginalized communities are unheard and remain passive. In addition, as a person from a minority caste group, it would be a risk for her to indulge in this kind of issue, which is politically intervened with the interest of politically powerful actors associated to the CPN (Maoists), which is undeniably the powerful political force in the context of Thabang. Finally, there has been political intervention by the CPN (Maoists) party and taken some decision about the negligence by the contractor. One of the Maoist leaders of Thabang associated with the CPN-Maoist says:

> *Since health post construction process has proven below standard, then we reported to division office in Rolpa, then contractor's account has been closed. With the initiation of model village user's committee his deposit has been grabbed and shifted the amount to construct health post infrastructure again. We constructed additional pillars of birthing Centre with remaining amount, which was not paid to the contractor. Though the contractor was arguing for fulfilling the estimation from his side, however, we did not listen to his arguments. Staffs were not interested to shift health post to another side of the river. Since health, post building is not satisfactory; we thought that it would be worse if we do not use it, so we decided to deliver health services from newly constructed health post*[130].

To make the service delivery very effective, it was very urgent to shift the temporary placement of health post from a small building to the newly built own permanent building. Since the overall construction has proven substandard, there has been a controversy, whether to accept the health post building by the government or not. The hesitation of the government staffs to accept the newly made institution could not be long lasted. In between, the Thabang

[130] Personal Interview : 20th May, 2013, Thabang, Rolpa

village committee of the CPN (Maoists) has intervened to shift the health post services to a new building. As an institution facing different kind of upheavals since the early phase of its establishment, the repercussions of those upheavals have been reflected in the present performance level of the Thabang health post. The irregularity of the management committee meeting is another prominent problem in the performance of good stewardship of the health post in Thabang. Since members of the management committee are occupying different positions in many local committees, many members are not giving sufficient priority only to the Thabang health post. A member of the management committee, who is a representative of the educational sector, mentions:

> *Since the children of adolescence age are in school. It is important to become the management committee member of the health post. But school itself has lot of things to do, in this kind of case, appointing school principal as a management committee member of health post is not very supportive to the health post management committee. Local politicians do not care about the health institution; you can see the condition of health post. Since the local election is not happening for longtime, it is directly hampering local development agenda. For example, if there would be the elected ward chairperson, elected representative is supposed to look after the development process since there is no local election, at every level people are feeling low level of responsibility*[131].

Either to chair the health institution management committee or to supervise the medicine comes under free health service schemes there has been compulsory involvement of elected political representative from VDC level. Even the Tenth Five Year Plan writes, "All primary health centers, health posts and sub-health posts will be supplied with the necessary medicines with the involvement of local elected bodies". Ironically, the absence of the local government due to a non-held local election since 1997, is another factor behind this kind of ignorance of health institutions at the local level. In the lack of elected village representatives, the VDC secretary is supposed to represent as a chairperson the health institution management committee. Thabang as a stronghold of the CPN (Maoist) has a different political hold of the Maoist party in comparison to other villages of Rolpa. After many years of the official ending of Civil War,(even after mainstreaming of the Maoist party as a non-armed political party, which also further split into many factions) the village secretary does not present in the village showing the reason for insecurity and potential threats by the Maoists like in the active days of civil war. Moreover, apart from politico-administrative problems, there are numbers of logistic problems in this health post, which have to be addressed by health policies of the country. Auxiliary Nurse midwife (ANM)

[131] Personal Interview : 22nd May , 2013, Thabang, Rolpa

working in the Thabang health post share:

> *Though pregnant women gets 1000 Nepalese rupees (100USD) in hill district and extra four hundreds for completing ANC checkup, after visiting once, many people hesitate to visit health institution in the time of delivery. There is a concept of providing 24 hours Birthing Centre; however, here is no canteen, no logistics support and proper stay at health institution. There is no quarter for the staff. In nighttime, if delivery comes; it is difficult to manage everything. Sometimes, if it is a prolonged labor pain, then it is difficult to manage all logistics support to delivering women and her visitors. It is very difficult to find female staff that can manage it alone*[132].

Government has announced to provide twenty-four hour institutional delivery; but in reality the health centre building has not been constructed according to the service delivery point of view. At local level, in the lack of proper coordination between DUDBC and the department of the health service system, the model of a health post building has not followed the uniform model. An engineer of DUDBC clarified, "initially there was no concept of health post, now quarter concept has been also developed in latest model". The physical discomfort shown by female staffs to discharge their services effectively is one of the crucial factors to prevent safe institutional delivery as a round the clock service. In the lack of logistics facilities to be provided by health institutions, it simply discourages many patients and their visitors to visit health institution in the crucial time of delivery. The lack of quarters for the staffs, a cafeteria and a guest house for the visitors do not encourage many people to follow the notion of an institutional delivery, instead many people prefer to do the delivery at home. There has been a mandatory policy to fulfill the non-medical expectation, that is regarded as one of the major goals of health service system. Even the Eighth Five Year plan, that has been effective during 1990-1995 has acknowledged the shortage of buildings and quarters in hospitals and other health organizations. Despite acknowledging the importance of logistics facilities in Eighth plan, the lack of quarters and other logistic facilities in the health post building, which has been constructed after one and a half decade of policy level realization is the sheer example of negligence performed by the planners, that shows their utter failures to understand the practical problems operating at grass root level.

4.4 The Ghorneti Model Hospital: From Somewhere to Nowhere

During the time of the civil war (1995 -2006), the Communist party of Nepal (Maoists) has decided to produce a 'progressive' kind of political workers in the field of health and education. According to the health manifesto published by the party, the rates of

[132] Personal Interview : 19th May , 2013, Thabang, Rolpa

injured and dead have increased along with the rural class struggle. It was not an easy situation for many injured combatants to treat their wounds, cuts and bullet injuries during the Civil War. One of the PLA who have fought many wars against the Nepalese state says:

> *The medical expenses in each war could exceed Nepalese Rupees three million (30,000USD). The registered medical shop of Shulichowr used to provide the medicines to us. Beside this, some businessperson were actively engaged in supplying the medicines. Drug suppliers were highly benefited with medicines supplied for war; it could be more than 5 million Nepalese Rupees (50,000 USD) in single attempt*[133].

Though there are plenty of war profiteers who supply medicines to war-affected zones, but still it was very expensive and tough to supply medicines to the war zone in Rolpa. Likewise, in terms of monitoring government resources, the RNA used to follow rigorous security checking about the medicines[134] delivered from the district headquarters to identify whether those medicines sent for local health posts and sub posts were misused by rebellion forces or not. In the case of deep injuries and deep wounds, it was not possible for combatants of the People´s Liberation Army (PLA) to visit health institutions on normal trials, alternatively they had to rely on either locally available healing practices to treat simple ailments like diarrhea and jaundice or to take medicines from local health posts with threats or sometimes without threats. In complicated cases they had to do walk offs through difficult paths of forest and hills or through the dark crunch of the river to reach health services. On one hand this journey could take a week or more and injuries and illnesses could worsen on the way, on the other hand after reaching the health centre, if the injury has been induced by a bullet or blasting materials, the suspicion of the medical personnel would create another chance of getting arrested. To manage all those causalities and to treat injured combatants during the Civil War, the All Nepal Public Health Worker's Association (ANPHWA) was formed in 1995 as a sister organization of the mother party CPN (Maoists). The objective of this organization is to establish special kind of health workers, who can be mobilized during wartime and also in time of other emergencies. According to the ANPHWA constitution statement:

> *City centric reminisces of old state mechanism had blocked the medicines and other essential things. Many times treatment instruments and apparatus were grabbed by security forces. It was the responsibility of new Maoist state to provide the*

[133] Personal Interview : 2nd June , 2013 Oat, Rolpa

[134] "They used to have special routes like Thabang to Shulichowr, Tewang to Adeshkhola which could lead via Pyuthan to Bijuwar to supply medicines. Likewise, in Rolpa district other route for supply medicines to our base area could be Salibazaar to Jumkhola via Ghayyiabari, Kohalpur to Nepalgunj. Moreover, raincoats, warm coats, shoes, socks and electricity fuses to prepare ambushes were also profitable businesses during wartime"- Based on interview with PLA, I met in Reugha. *(12th May, 2013, Reugha, Rolpa)*

people with proper access to health and to manage the training of red and skilled health workers became utmost necessity. In this context, OMSA, (O-ordinary level, M-Medium level, S-secondary level and A-advanced level) the new model health workers having own kind of characteristics to address necessities in the "war relative" condition have been produced by four level of grading. These special kinds of health workers follow the concept of "bare foot doctors" in China and the experiences that have been collected by the decade long Civil War in Nepal. It has been proved that the conjunction of theoretical and applied knowledge is the basis for the knowledge theory and the process of applying this theory in practice and development of additional theory match with the philosophical underpinnings of the Prachandapath.

Under continuous threats by the RNA for providing treatment to Maoists during war, some mid-level health professionals like CMA (Community Medical Assistant), VHW (Village Health Worker), MCHWs (Maternal and Child Health Workers) of the Nepal government went underground and joined the Maoist movement. Some health workers who have already joined the party were thinking to expand a separate health committee; it became easier to materialize the situation after new health workers left the government job and joined the CPN (Maoist). Contextually, Rupkala Gharti aka Comrade Chunauti says, "I was working as a maternal and child health worker at Oat sub health post in Rolpa. Because of my husband's involvement in Maoist party, army frequently tortured and harassed me. Due to war and insecurity among health workers, later on, I also became underground and joined the party[135]". In the formation process of an organizational structure, government health workers having orientation in Western biomedical system in Nepalese Para-medical institutions used to occupy positions in the ANPHWA hierarchy according to their prior experiences. It has been explored that during "People's war", educated PLAs from the Nepal governmental educational system, those having the 'bourgeoisie education' were more encouraged to take training of the OMSA, which used to be three to four months long and which shows sharp contradiction with their campaign to boycott "bourgeoisie education" during the Civil War. In addition, after the formation of a separate health department of the party, as their claims to increase the awareness level of the population and to provide training related to public health, the community health worker's curriculum of two weeks has been designed by the ANPHWA. This is basically intended to sensitize OMSA workers on the concept of political health and one should believe in "revolutionary ideas" to complete transformation of the society to make them accessible and free availability of the people oriented health facilities. Principally, it has been argued, after radical transformation of the society, that people will have free and accessible health services, but no documents related to ANPHWA have ever

[135] Personal Interview : 2nd June , 2013 Oat, Rolpa

discussed and described how the vision of the party to provide free and accessible health services can be materialized operationally. In the latter phase of the Civil War, there was even OMSA training in different hospitals at Kathmandu and Pokhara through party channels. In between, the International Red Cross (ICRC) and other health professionals from other countries like India and Bangladesh were frequently involved to provide training for OMSA. Moreover, as per the CPN (Maoist) then long term vision to continue 'rural class struggle', the seed concept of the OMSA worker has been expanded by establishing the Ghorneti Model Hospital at Oat VDC of Rolpa in 2004 and inaugurated in 2006. One of the OMSA workers describes:

> *Just to construct our own kind of model hospital to treat our injured people during war, we have decided to construct a new hospital, at that time, party has managed rods, woods, rocks and foods, and most of the labor contribution has been done by local people ourselves. Since senior Maoists leaders like Barsha Man Pun aka comrade Ananta and Krishna Bahadur Mahara were present in the inauguration ceremony. I was very happy at that time*[136].

The bulletin of the ANPHWA (Revolutionary) claims, that during the Civil War, the Ghorneti Model Hospital has played many roles, such as initiating campaigns for people's health, arranging mobile medical camps and providing treatment for injured and other combatants. Though it has been argued to organize medical camps for general people during the Civil War in Rolpa, but the matter of accessibility of those medical camps for a larger mass in Rolpa was always a questionable issue and there has been no evidence found to prove the existence of such medical camps by the Maoists in the Civil War. Many ordinary people mentioned, during the Civil War (*Sankatkaal*) aerial attacks by throwing bombs (*Torabora*) by the RNA and false killing in the name of the two ways encounter (*Dohoro Vidanta*) could happen anytime anywhere. In such a terrible situation, even though Maoists would have organized medical camps, it would be a fatal idea to visit such camps when nobody knows who will die in a false encounter or in a road ambush.

During my first visit of the Ghorneti Model Hospital in 2008 for my M.Phil research, I have observed a OMSA health worker who used to deliver everyday a fifteen minutes lecture on public health for all the out patients prior to a formal checkup by the doctor. Such type of benevolent and unique activity to promote public health, I have never seen in any of the government health institutions in Nepal. Clean wards and furnished rooms, a well-built hospital with sufficient guest houses for the visitors, separate canteens, a well-managed dispensary and abundant space to take rest in such a remote region was incomparably a far

[136] Personal Interview : 2nd June , 2013 Oat, Rolpa

better facility than governmental health institutions were providing in Rolpa. Moreover, the hospital has sufficient equipment to perform basic laboratory services, x-ray and other surgical apparatus with good quarter facilities for the staff and a well-equipped library and other rooms, which are rarely available at other health institutions in this district. The painting of Marx, Lenin and Stalin in the Northern wall of the hospital was sufficient to demonstrate its "revolutionary legacy" and "progressive values" followed by the institution. During my visit, producing electricity from the river below the hospital was solving the problem of load shedding. Similarly, there have been sufficient supporting health professionals including medical doctors and other supporting paramedical staffs. Dr. Sikcha Poudel who was working as a medical officer in the Ghorneti Model Hospital expressed the reason behind her presence in such a remote region with the just different approach taken by the Maoists party to provide medical care to the rural masses. With the help of a Norwegian doctor, Hamid, the Ghorneti Hospital based in the rural region of Rolpa was able to provide acupuncture service[137],which is not commonly available in other cities of Nepal. Despite a lot of health facilities being served in the rural belt, most of the staffs were working as volunteers with a basic the level of logistic facilities. I had a deep suspicion regarding its long lasting stability and the continuation of same 'revolutionary spirit' pragmatically for the long run. One of the health workers tried to clarify my suspicion with a 'revolutionary statement' like, "Along with the liberation of the people, we will be also liberated" (*Duniya ko Mukti Sanghai Hamro pani mukti huncha*). For the time being, I was just surprised to observe this 'revolutionary spirit' operating with a high sense of volunteerism in remote Rolpa. I have again visited the Ghorneti Model Hospital for my long term PhD fieldwork which has started since 2012 December onwards. Unfortunately, during my second visit the Ghorneti Model Hospital was not functional and it has stopped its regular services already for the last three years. Those beautiful visitors guesthouses were simply looking like abandoned "Ghost houses" and the wall painting of those pioneer leaders of the World communist movement was fading away. Comrade Chunauti who was taking care of the hospital and also worked as an OMSA worker in the heydays of the Ghorneti Model Hospital says:

> *I am not feeling good after party split into two factions. Many people have sacrificed a lot during the People's war to construct this hospital. Party has also not given proper attention in management part. In wartime, there has been a voluntary*

[137] I myself took this service to treat a chest problem that had been giving me trouble since the anti-monarchical movement in Kathmandu used tear gas. By inhaling a large amount, my rib case is painful especially with low temperatures. Dr. Hamid has given three times acupuncture service to release the pain in my chest.

contribution; however after ending of war, there was no spirit of volunteer contribution, all comrade found uneasiness to continue. In post conflict period everything is monetized, nothings work out voluntarily. The people who served the war as a genuine cadres are in pathetic condition, still people from adjoining districts do visit this hospital expecting to get services like earlier. Now the hospital came in this condition, we are feeling so bad about this. We feel uneasy to show face in the village, there is a vehicle but not a driver. Even party could not realize our contributions, now we do not have any hope with anyone. Later on there was a loss in revolutionary spirit and all staffs got frustrated even party could not provide necessities like toothbrush, shoes and other simple logistic stuffs for working staffs in the hospital.[138]

The time when the Ghorneti Hospital was providing regular services, it was successful to draw the attention of many people from adjoining districts and many people were able to get reasonable alternative services, which were not available in government health posts. In this case, the breakdown of the political formation reflected in a crisis in institutional level, which is supposed to create frustration among those layers of workers, who genuinely worked as foundational pillars to form the public institution like the Ghorneti Model Hospital in such a remote zone as is Rolpa. Moreover, the breakdowns in political strength were a major factor behind this disfranchisement, empirically; some other factors are equally responsible to construct the psyche of alienation in the particular historical context. An ex-staff of the Ghorneti Hospital, whom I met in Thabang, explains:

Hospital in charge B had a government job before joining the party. Initially, he was in the People´s Liberation Army and transferred to this hospital as an in charge. After becoming in charge of this hospital, He has manipulated party funding for personal benefit to make his lover happy. Since he had first wife and daughters, he got married with local lady M who used to work in Ghorneti Hospital. Since the person become Anarchic, then what do you expect? Later on when there has been criticism about his cultural anarchy, he sent that lady to Dang in the expense of the party to learn computer. We have raised the voices; all our efforts became meaningless. Now he took the amount of army rehabilitation and rejoined his past government job. When I raised the voices, he even threatened to kill me. Another fellow Comrade C also eloped with someone else wife whose husband is in abroad. I had also government job, we thought war will finalize everything, and this war will liberate the people. Since the war has been ended in the name of peace accord, there is no solution; we are neither here nor there. People have fought for liberation. If result is unexpected than our goal, then it obviously leads to frustration, we were betrayed in the name of revolution[139]*. (Kranti ko naamma dhoka vhayo).*

The impact of an ideological division not only created a diversification in the strength of the party, it is further reflected in an emotional level among those people who had a deep sense

[138] Personal Interview : 2nd June , 2013 Oat, Rolpa

[139] Personal Interview : 22nd May , 2013 Thabang, Rolpa

of belongings with their associations. The Army integration program, which was theoretically and practically targeted to a de-militarization of the People´s Liberation Army (PLA) announced an attractive bonus amount for those combatants, who want to join the Nepal army or to go for a rehabilitation package. On one hand, the fund channelized the de-militarization of the Maoist army, but was criticized for killing the "radical spirit" of the Maoists workers by many hardcore political workers of the Maoists, on the other hand distribution of such funds to many ex combatants created both positive and negative impacts. Similarly, at an individual level, if someone makes access to this fund and others have to go home with empty hands, then it creates a sense of frustration among the coworkers, who have equally contributed to the party during the hard hit of the Civil War. In the abovementioned case, when manipulating the authority, one has used common property in personal relationship, then it becomes unethical and an abuse of power rather than interpreting this event only as an 'immoral' phenomena. Comrade Chunauti mentions:

> *After the peace process, we have tried to run the hospital with good spirit and management, but leaders did not take our demand seriously. As a local person, I do have deep attachment with this institution, so I am still taking care of this hospital hoping for some change in the future. Some people are jealous of these buildings and teasing for our destruction. If hospital will continue again, then I do not mind to leave this institution. Only few people do come these days. Many people have expectation to see hospital again in functional mode. We are repeatedly raising the voices however, things are not working. Now there is a debate to change this hospital to government sub health post. I have heard district hospital will send ANMS and other health staffs. People like us who have scarified their life for the party and to serve the people are still hoping to do service in Ghorneti hospital, however, the situation has been changed*[140].

It has been noticed that since the CPN (Maoists) party has been politically split into two fractions, there has been a managerial crisis started at the Ghorneti Hospital. Even during the tenure of the Health Minister representing the Maoist party in the government, no decisions were made about this hospital. Alma Ata (1978) has given priorities to the enrolment of the health workers in the health institutions especially from its vicinity. It writes, in many societies, it is advantageous if these health workers come from the community in which they live and are chosen by it, so that they have its support. The International declaration on primary health has given priority to mobilize local people nearer to the health institution, which could be matter of additional benefit to protect the health institutions. In this case, unknowingly following the values recommended by Alma Ata, because of her attachment to the health institutions being local; she is genuinely taking care of the dysfunctional institution

[140] Personal Interview : 2nd June , 2013 Oat, Rolpa

and hoping for some betterment in the future. After the Hospital became nonfunctional, many OMSA workers were displaced and some of them continued their skill as health workers in the private sector. Zharkevich (2013:128) writes:

> *In 2011, I met at least five former 'barefoot doctors', all of whom were engaged in the medical trade after the war, either by running medical shops or by working as health-assistants in the village, and in some cases by continuing their medical education at a higher level. However, the situation is not so bright for the former cultural or political workers. In the wake of the 2006 Comprehensive Peace Agreement, all of the former cultural and political workers were disbanded, except for the cultural team at the central level. Unlike the skills of medical workers, their skills were not easily transferable in the post-conflict context.*

Theoretically, the CPN (Maoist) has agreed a new concept of public health workers, which has been borrowed from the 'people's war" in China, and they have given credit to the 'barefoot doctors' even in their health bulletin. However, in terms of using terminology in everyday practices, mainly "OMSA workers" have been used in the context of the Nepalese Civil War. As Zharkevich labeled them as 'barefoot doctors' from her perspective, but the terminology was quite exogenous and not frequently used colloquially inside the group. In a few cases like Comrade Lal's, who once helped as an in charge of the Ghorneti Model Hospital, who played an influential role to establish the Jaljala health commune in Thabang with the help of Japanese doctor Rukyuichi Ishida, a volunteer surgeon working in Rolpa for many years. However, as Zharkevich mentioned, not all ex-OMSA members have not used their skills as a 'medical trade' in the post conflict context; in many cases I have observed people who were continuing their earlier experiences and do not have a high sense of motivation and some of them have opened local alcohol shops (*Vhatti*) in the Maoist heartland of Thabang, where once alcohol was strictly banned according to the Maoist's social reform policy. Moreover, I have observed, that comrade Ujjawal was staying idle for few years of after the official ending of the Civil War and mentioned, he has not planned anything to do in future as well. Similarly, another person from West Bengal who has contributed to the Maoists during the war, has opened a medical shop in Thabang and performs episodes of malpractices. Likewise, an OMSA worker from Dolakha, who used to work in the Ghorneti Model Hospital, started a small shop in Bhaktapur. Similarly, another comrade, Chandra Kumara Gharti aka Comrade Nishakar, who is also one of the ex OMSA workers blamed central level leaders of Maoist to bring unintended situation of party breakdown. She explains:

> *My husband died in the war, I am taking care of my old parents and small kids. If everyone is working together, some could get special benefits and some do not. Of*

course it creates frustration. I lost interest in politics after party splitting, there is no possibility to have anything. If I remember those days working in hospital, I feel really bad. Our dreams are shattered and we are left behind. Since politics is city centric, then all the base camps are put in the shadow, our achievements of war like model school and hospital everything remains in the shadow[141].

After dysfunction of the Ghorneti Model hospital, Comrade Nishakar assisted in a pathology technician course and opened a small laboratory nearby the Gairigaon sub health post. In my first visit, it was comrade Nishakar who was delivering everyday lectures on public health with spontaneous sense of volunteerism. Now after a few years, she is compelled to confine herself in the position of a junior laboratory technician who has to provide pathology service in order to make profit and to maintain her bare survival. She was unhappy with the turn out from the customers and planning to shift her laboratory from Gairigaon to Budhagaon. She has expressed her grievances as a member of a martyrs family. She did not get the promised amount of compensation from the government. Similar to comrade Nishakar, many people have developed a strong sense of frustration against the Maoist party for not responding their expectations and ignoring their contributions. The dreams and expectations of many people who have sacrificed their life again collapsed with breakdown of political force and their expectations turned to layers of frustrations and left out sentiments.

4.5 The Jinabang Health Post: The case of non-decision making

Jinabang, a village surrounded by the river Rapti, is situated in Western direction to Rolpa and is approximately two days walking distance from the district headquarters of Libang. The name of this village derives from Magar language *Ji-sna Bang*, which colloquially means the place to go to throw urine. Various caste groups like Magar, Dangi, Khatri Oli are in majority in this village with a presence of a caste minority like the Pariyar and the Biswa Karma. Immediately after the General Referendum of 1979 was held in 1980, with the aim of institutional expansion, His Majesty's Panchayat government has decided to establish a health post in the Jinabang VDC as a regional health post, which is supposed to supervise other sub health posts of adjoining VDCs like Pakhapani, Rank, Oat and Ghartigaon. No sooner as the Panchayat government has initiated to establish a health post in Jinabang, a local resident of Jinabang VDC named Yamlal Pun has donated his private land to construct the Jinabang health post in same year, but there has been no initiation to construct the building of the health post for a long time. Therefore, the health post has been

[141] Personal Interview : 3rd June , 2013 Oat, Rolpa

set up in a rent house and the land of the Agriculture Service Centre[142] (*Krishi Sewa Kendra*) has been given in rent to generate the cash to pay the rent of the health post. In addition to execute the governmental plan to establish a regional health post in Jinabang, initially land owners residing at lowland and riverside did not donate their land to build the health post building. Local resident Yamlal Pun donated land in the top of the upper hillside nearby his home. Though Mr. Pun has donated the land nearby his home, showing the geographical complications, it has been decided to construct the health post at low land nearby the river, but land donor Mr. Pun seriously insisted to construct the health post nearby his home in the upper part where he has donated land originally. Later on landowner Yamlal Pun filed a case against this decision and won the case. In this event, land donor Yamlal Pun clarifies:

> *Since my home is at the top of the uphill we are facing severe scarcity of water, after health post construction I am expecting to get water supply regularly. Apart from this, after my son returns from abroad, I expect a small job for my son. Only for these causes, I donated land for health post. Later on there was debate regarding shifting health post from here to elsewhere. Twice, I have filed the case to express my dissatisfaction. Later on government could not make any decisions against me. If health post got shifted from low land to uphill, then staffs may stay in the uphill then market activity would shift from lowland to high land, because of this reason shopkeepers from low land are jealous of me. Honestly speaking, when I donate land I did not know there would be expansion of market. If local people would have guessed this dimension they won't allow me to donate land at that time. When I donated land everybody thought only I became victim by donating the land free of cost, now some kind of advantage is coming because of my virtue, now local people and leaders are jealous of me*[143].

The motive of donating land to the Jinabang health post clearly indicates, it's not only the notion to achieve virtue (*Punya Kamauna*) which motivates people to do social work, there are clearly visible greed factors to get benefits besides donating his personal land to a public institution. Likewise, Mr. Pun's attempt to seek legal remedy to make a decision on favor of him again supports the fact of donating land to public institutions is merely for personal rather than collective benefit. There has been no consensus to build the health post for another ten years till 1990, unfortunately for a decade this health post could not draw the attention of the district or central level of the Panchayat government. Moreover, after overthrowing the Panchayat reign in 1990, even the democratic government, which is

---

[142] Dixit (2014) writes, "In all this it was envisaged that the decentralization act of 1982 would be enforced and that the concept of intersectoral collaboration brought into play. This advocated the formation of what was referred to as *Sewa Kendras* or service centre with the following services: health , education, water supply and sanitation, agricultural and postal services"

[143] Personal Interview : June 15th , 2013, Jinabang, Rolpa

supposed to address the expectations of the people ignored by the Panchayat government, could not provide sufficient attention to the Jinabang health post for another half decade. Meanwhile, the Civil War began in 1995 and became another reason for not gearing up the construction process. Due to the strong presence of CPN(Maoist) there was no possibility to perform any state led developmental activities especially in the hotspot of a warzone like Rolpa. Even after official ending of the Civil War in 2006, the construction process of the Jinabang health post has not drawn much urgency to concerned authorities. As a community stewardship to take care of the health institutions, the formation of a health institution management committee after 2006 became supportive to gear up the long pending process of the health post building. Finally, after a three decade long institutional stagnation, the construction process of the Jinabang health post has been initiated after thirty years of its approval in 2008/09 in upper side of the river, the place where donor Yamlal Pun has donated his land originally. However, people from the lowland market area were unhappy with this decision. One of the shopkeepers from the lowland expressed his dissatisfaction and says:

> *There is no water facility in upper side. It's even difficult to take motorbike, then how one can imagine taking ambulance and vehicle to such an uphill. It's difficult for sick patient to walk from downhill to uphill. We were not in favor to construct health post building in upper part that is physically twenty-five minutes far from main road, but the political leaders from 5, 7, 8, 9, wards were interested to place health post in upper side*[144].

Many people expressed their dissatisfaction against the political leaders for not paying sufficient attention to the during construction phase. On the one hand political leaders do not show any interest to gear up the construction process, which has been historically frozen, and on the other hand, when the construction process has been forwarded, there has been always intervention to make a decision in their favor, which shows the dual characteristics performed by the political leaders at local level. Comrade Adarsha affiliated to Mohan Biadhya led CPN (Maoist), and also resident of the Jinabang VDC accepted the ignorance of Maoist party for not paying any attention to the construction process of the health post and acknowledged the mistakes of the Maoist party for interpreting local governance agenda as 'simple technical stuff' and party's failures to demonstrate strong political will in terms of local public institutions.

Ironically, similar to the case of Thabang, the Jinabang health post once again faced the governance crisis in the post conflict context. The district hospital has raised queries

[144] Personal Interview- June 15th , 2013, Jinabang, Rolpa

regarding quality of construction and circulated a letter to the Jinabang health post management committee directing not to accept the health post from the contractor. I have walked to the uphill and observed the newly constructed health post in Jinabang. Outwardly, the physical appearance of health post looks convincingly rather than the physical appearance of the Thabang health post, however, health post staffs have different ideas about the construction. Office assistant of the Jinabang health post says, "Contractor has used soil mixed sand and painted the low quality color. Even rooms are also not sufficient in this health post. It does not look like the building made out of 7.8 million Nepalese Rupees". (*Interview- June 15th, 2013, Jinabang, Rolpa)* .Comparatively, the Jinabang health post building was better built than the Thabang health post, but the concerned authority has raised the quality issue and the health post was not handed over to the government. Interestingly, the same contractor who has constructed the health post of Thabang has constructed the health post building of Jinabang. It has been explored; tender of the construction has been announced at district level. Contractor DBB has applied the lowest bid proposal of 7.8 million Nepalese Rupees to construct the Jinabang health post and later on handed over this contract to his brother KB. Since the first contract has been handed over to the second contractor, sufficient profit has been minimized in the original contract amount by the first contractor. A senior staff of the Department of Urban development and Building Construction (DUDBC) defends:

> *In remote district like Rolpa, some of the construction sites are extremely difficult. There is no road connected to Jinabang construction site. From construction point of view, this site is extremely difficult; contractor has faced lot of difficulties to manage water and raw materials like bricks, iron rods and sand at this site. Similarly, there is absence of active males to work as a construction labor in the village. If government has not punished the alleged contractor and the same person is applying for lowest bid, then there is no option for him to prevent him from granting new contract*[145].

As the DUDBC staff argued, it has been observed that the location of the health post is not connected with drivable roads and constructed in a geographically odd location. But in reality, the first and second contractors are residents from the adjoining hill district of Rukum and well versed with the physical hardships and other challenges they have to face in order to construct the physical infrastructures in hill districts like Rolpa. Since they have already performed negligence in Thabang health post and continued this in the case of Jinabang, the profit making greed of the contractors is a predominantly important factor in this case rather than blaming to any geographical complications or policy level deficiencies. There has been a

[145] Personal Interview : 26th May , 2013, Libang, Rolpa

delay effort to move forward from the situation of non-decision making to run the health service from in the newly constructed building. Santosh Budha Magar, Member of Parliament from the electoral constituency number two and one of the senior leaders of the CPN (Maoist) in Rolpa says, "Bureaucracy is very much successful to create illusion and the politics of protection is creating problem in bureaucracy. Since statecraft is corrupted, same kind of person makes good connection with top level, then we also cannot do anything[146]" It's very depressing to know the defeated mentality of the 'radical leaders' like Santosh Budha Magar from Thabang, the way his surrendering perception to the nexus of profiteers and corrupt attitude of bureaucracy is not ideologically convincing for the leader representing 'radical party', which fought a decade long "arms struggle" against the state. In the process of analyzing the progress of mal governance in Rolpa, the vicious cycle of corruption exist in the institutional growth process and has typical dynamics of blaming each other among the range of actors who are overtly and covertly involved in the process of planning and implementation.

During fieldwork, I have observed that regular service of the health post was temporarily functional in the old building provided by the VDC office of Jinabang, which is located at the riverbank[147] and not primarily built to run health services. At present, delivery and counseling are functioning in the same room; the upper floor of the VDC building has been used as a meeting hall, storage room and staff quarters. Since there are limited rooms, health staffs complained about the space constraints in the time of delivery. Similarly, shortage of human resources on health is another crucial factor faced by the Rolpa health service system and the case of Jinabang is also not different from the overall phenomena of the country. In the time of my field visit, Mangala Dangi and Dhana Kumari Dangi, only two ANMs were working in the health post as a contract staffs, which is supported by UNICEF. Both contract staffs complained for not getting any up gradation trainings, however they are supposed to take care of IMCI (Integrated management of childhood illness) projects. If the co-workers are on leave, it is not possible for the limited staffs to attend workshops in the district hospital. During the field visit, in the case of Jinabang all posts were vacant except the post of the office assistant who was working as permanent staff. One of the ANMs says, "In management committee meeting we are raising the voices, however vacant positions are not

[146] Personal Interview-14th July, 2014 Libang, Rolpa

[147] Initially, the contractor closer to Maoist party has dug the road goes above the health post, later on along with the change of contractor; the site of road construction has been changed. As a result, since there are two construction sites, in rainy season, gravel and mud coming down from road construction project was flowing over the small kitchen building of Jinabang health post and also spoiling paddy field of local people.

fulfilled. Though the frequent complaints have been sent to regional director and district health office, we do not have sufficient staffs in this health post" (*Interview- June 15th, 2013, Jinabang, Rolpa).* Similarly, there has been irregular supply[148] of essential medicines; the district head quarter of Libang is (*24 kosh)* two days walking distance from the Jinabang VDC. I have observed, that causes of poor network facility of telecommunication, the ANM of Jinabang has to walk twenty-five minutes uphill to contact the district hospital staff to send essential medicines. Poor communication facilities in remote districts are another problem to establish proper communication among its stakeholders. Because of labour shortage, it is difficult to find the porters to carry essential medicines from the district hospital to Jinabang. The office assistant has to go to the nearest health post of Ghartigaon to take vaccines by walking for six hours a hilly road from Jinabang. In between the long term conflict occurring between the contractor-political party and bureaucracy in relation to the Madi Bridge building process is another obstacle to disturb the supply channel of essential medicines from Libang to Jinabang. Every year there has been released a budget to construct the bridge over the river Madi, but every year on appearance of the rainy season, flood takes away the bridge and again there is a release of another level of budget. Nowadays there is a contract to build a permanent bridge on the Madi River especially at the Madichowr location in Rolpa. However, during the time of fieldwork, this bridge is facing political-contractor problems and the construction has not been forwarded. One of the UML leaders expressed:

> *We have not shown any interest regarding any concern of Madi Bridge. Contractor is running after the power, first he used to say he is a person nearer to top level leader of Nepali Congress now he is claiming that he has good connection with central level leaders of Maoists. So, I have not spent any time to understand this issue. We are not protecting him, his activity is against UML. I do not know why people labeled him as a UML cadre[149].*

Many people from Rolpa have mentioned, since the contractor has financially supported the election campaign of Maoist central level leaders, it gave him confidence to do the negligence in the bridge construction and non-obedience to bureaucracy and its orders. The political blame game among the leaders of different parties has not created a supportive environment to initiate the bridge construction process on river Madi. The divergence of political interest and collective strength creates an adverse impact like non-completion of the infrastructure and encourages the trend of disobedience by the contractor. Moreover, lack of effective supervision is another problem in all health programs and the free health program is

[148] Interview- June 15th, 2013, Jinabang, Rolpa

[149] Personal Interview- June 15th , 2013, Jinabang, Rolpa

much affected in this case. There has been no local election held after 1997 and the vacant local government has to be represented by the VDC secretaries. The temporary and permanent absence of the VDC secretaries in their workstations directly affects the monitoring part of the free health program. Since medicines sent to respective health posts should be supervised by the VDC secretaries, the absenteeism of a village secretary is creating adverse impact in the supervision process of a free health program in the context of Jinabang.

4.6 Holleri PHC: The vicious cycle of blaming

No sooner His Majesty's Panchayat government sanctioned to run the Sakhi health centre at the Sakhi VDC, it began to deliver regular health services from a rent room hired in ward number two of this village. Nearer to the Sakhi VDC, Holleri is the midpoint for other VDCs like Masihna, Sakhi, Dubring and Dubidanda. As a gateway from Southern region of Dang to Rolpa, many people used to travel via Holleri to neighboring hill districts like Rukum, so the original location of the Sakhi health centre was geographically excluded from the central route. In 1961 the health centre has been shifted from Sakhi VDC to Holleri claiming that it would be geographically better accessible for the people of four VDCs like Dubidanda, Sakhi, Jhenam and Dubring. Even though a resident of the Sakhi VDC has donated land to build the health centre, however the donated land has been not accepted and further it has been decided to construct the health centre in Holleri. In this case, the management committee chairperson of Holleri PHC and resident of Sakhi VDC expressed his dissatisfaction and mentioned:

> *Since the health centre has been shifted, people of Sakhi VDC are excluded. At present, there is no sub health post in Sakhi VDC and people have to visit Holleri PHC even for minor ailments. This is contradictory to the policy of Nepal government promises to reach sub health post in every village development committee of the country*[150].

After shifting the health centre from Sakhi to Holleri, representatives of four VDCs like Krishna Bahadur Chand from Dubidanda, Gopal Dangi from Sakhi, Purna Bahadur Basnet from Jhenam and Krishna Bahadur Chanda of Dubring initiated a process to buy land in Holleri to construct the health centre building. In 1990, his Majesty's Panchayat Government Ministry of Health has supported to construct the building of the Holleri health post in

[150] Personal Interview- June 25th , 2013, Holleri, Rolpa

collaboration with an international agency. According to the government's regular plan to upgrade the health institution, in 1997 the Holleri health post has been upgraded to primary health care level, ironically it's been more than seventeen years as the PHC is running in the health post building with physical constraints. Even Health Secretary Dr. Sudha Tripathi has visited Holleri in 1999 and stakeholders have forwarded the issue, but there was no effort to construct the PHC building of Holleri. In 2001, after the CPN (Maoists) attacked the Holleri police station and killed six police, the intimidating condition of the Civil War became another complication to construct the primary health care building. Even after eight years from the official ending of the Civil War, though additional land has been bought to construct the PHC building, no initiation took place. One of the members of the management committee says:

> *Health post has been theoretically up graded in paper only. In practice, there is stagnation. Our political leaders are not being able to raise powerful voice to build the PHC building that's why we are being victimized. We had cast vote to chairman Prachanda, he got too much votes and became popular but he also became 'Kalbete'. He knew how to win the election but did not know to make us happy. At village level UML is stronger, elected Maoist leaders do not take care of this area where they have no political hold. We are raising demands even in district level; our voices are not being heard. We have realized political pressure is not sufficient to build the PHC. There is low level of commitment among political leaders. Sometimes they make oral commitments, but such commitments have not been reflecting in action level. In southern belt of Rolpa, leaders are not being able to make powerful voice to pressurize the state to hear the local necessity. Until date tender has not been granted to construct the PHC. District hospital is not giving proper attention and just giving oral assurance*[151].

The management committee member even blamed Maoist Chairperson Prachanda using a typical Nepali word like *Kalbete* in the sense of expressing frustration, which means, if a banana tree gives fruit once then it won't give fruit on a same tree second time. Similarly, the notion of *Kalbete* has been used to label personality traits of the UCPN (Maoist) chairperson Prachanda and his onetime "victory" to lead the Civil War. The UCPN (Maoists) Chairperson Pushpa Kamal Dahal aka Prachanda was elected from this region which falls under Rolpa constituency number one. In this context, as an elected Member of Parliament from certain electoral constituency and concurrently holds a position of being a central level top leader, he does have double responsibility to deal the national political issues and deal with issues related to their respective constituency as well. In reality, including Maoist's

[151] Personal Interview- June 26th , 2013, Jinabang, Rolpa

chairperson Prachanda, many top leaders were not allocating time to grass root level. It would be "rational action" to blame political parties by local people, which are in power, but the CPN (Maoists) have ignored the construction process of other health institutions in Rolpa where they have strong political influence like in Thabang, Gajul and Jinabang.

Apart from low sense of political commitment among political leaders to gear up local development agenda, there has been a gap in government policy and practices at the local level. A Three-year interim plan of the government effective from 2007/08 to 2009/2010 mentions, operation and management committees of the health institution will be given orientation training to fulfill their roles. In contrast to the policy guidelines of interim plans, I have experienced a management committee member himself, who is ignorant about the condition of the Holleri health post. Likewise, the health post management committee member representing the Nepali Congress Party has mentioned, "I really do not know why building has not constructed yet. If they invite me, I attend the meeting. I was thinking health services have been delivered from PHC building; I have never asked why building is not constructed[152]" During the time of the research interview, when I posed this question, surprisingly the representative of the Nepali Congress came to know about the status of the Holleri health post. Obviously, if a management committee member is not aware whether the PHC building has been constructed or not, it reflects the bare fact about the regularity of the management committee's meetings and the issue of the PHC building being raised as a matter of primal concern. It has been further noticed that similar to other health institutions in Rolpa, management committee members of the Holleri PHC are involved in other management committees of local institutions which distract them to make concentrated effort to think only about health institutions and their betterment. Likewise, in terms of the policy of involving local elected bodies in the physical and financial management of the health institutions, acknowledging the recommendations made by the Public Expenditure Review commission, the tenth five-year plan writes, the health posts and primary health centers will be transferred to the local elected bodies in the Tenth Plan. The government vision of transferring health institutions to local bodies seems too idealistic in the context where there is no local elected body at local level which accepts to steward a local health institution as a politically legitimate role. The chairperson of the Holleri health post management committee mentions:

> *In the lack of elected representative, Village secretary is supposed to supervise the free health care program but he has burden of taking care of other administrative tasks of more than one VDCs. One hand secretary has more tasks to*

[152] Personal Interview- June 27th , 2013, Holleri, Rolpa

> *do, on the other hand secretary do not stay in the village. In this kind of vacuum, if someone speaks, it would be like single individual is speaking rather than the voice of political representative. Once, I was a chairperson of Sakhi VDC, as an elected member, I was more confident and I used to feel high sense of responsibility. Now we all are working in Ad hoc basis, we do not have legitimacy to make our voice louder*[153].

During the context of the Civil War, showing no possibility of conducting a local election, there has been no local election after 1997, after the peace accord has been signed since the issue of federalism has been raised to demark the new political boundary according to federal structure; again the issue of local elections has been ignored. Similar to the cases of other health institutions in Rolpa, the absence of an elected local body is creating problems like even the monitoring and supervision of the packages of free medicines delivered under the free health care program. Interim plan 2007/08 to 2009/2010 writes, free and basic health services, and other health provisions will be brought into practice and in every health institution, a citizens' charter will be placed in a distinctly visible manner. In the case of the Holleri PHC, since the VDC secretary does not stay in the village regularly; there has been problems in the supervising part of the free health care program. Moreover, along with this case, many health institutions in Rolpa do not have clearly visible citizen's charters kept in the compound of the health institutions. One of the management committee members shares:

> *The monitoring part is very weak, even I do not know what kinds of medicines are coming. If health post staffs invite me to attend a meeting, I go there, if not, then I feel hesitation to make unnecessary query. We are expected to fulfill responsibility towards the health institution. In contrast, if management committee raised the questions regarding the irregularities, then district public health office does not encourage us to intervene in their day-to-day stuffs.*

There is sufficient evidence to prove that the health institution management committee in Holleri functions on ad hoc basis; similar to other health institutions in Rolpa, the paradoxical situation for the health management committee is reflected in the case of Holleri as well. On the one hand they are expected to perform a lot of responsibilities, on the other hand they lack decision power to intervene in any serious matter. Moreover, Collins (2006:908) writes, "Absenteeism is another big problem among health staffs working for the government service in rural areas", which is barely evident in the context of Rolpa. Similar to the Jinabang and Nehrpa health centers, the Holleri PHC is also facing the shortage of human resources on health. There were postings of a health assistant (H.A) and a staff nurse but those posts have been vacant for eight years. After getting the appointment through the public service

[153] Personal Interview- June 27th , 2013, Holleri, Rolpa

commission, the staff nurse and as well as the health assistant rejected the rural placement and did not appear in the workstation. Yogendra Rijal, a staff with temporary transfer (*Kaaj Karmachari*) working in the Holleri PHC has mentioned, "In remote setting, staffs do not stay long term in same station and they perceive health institution as a temporary career. Staffs are continuously searching opportunity to get transfer from remote to urban place, which becomes drawback for health institutions[154]." Moreover, the forceful placement policy of the government has forced medical graduates to stay in the rural side. Staying a year in the rural area and other one year in the city area before getting (Bachelor in Medicine, Bachelor of Surgery) MBBS certificates is compulsory for those candidates who have studied in government scholarships. Since district hospitals lack human resources and the turnover of patients is high, many times these doctors have to leave their duty station and move to the district hospital. One of the management committee members has mentioned, "In the name of *Kaaj*, doctors are being transferred to district hospital from Holleri PHC. If we complain, doctors reply they have to obey district hospital's order. There is no value whether we raise our voice or not. "[155] There has been a shortage of medical doctors especially for rural postings in the district like Rolpa. In the process of contesting for the human resource on health, district hospitals as a powerful authority to exercise the power within the district to mobilize the resources. However, peripheral zones of a remote district like Holleri has to face double layers of victimization for being 'remote' and 'peripheral' within the remote district like Rolpa. Alma Ata (1978:18) states:

> *In order to ensure that primary health care is an integral part of community and national development and does not develop as an isolated peripheral action, promotion, coordination, and support of the administration are required, not only at the local but also at the intermediate and central levels.*

Though Alma Ata has visualized proper coordination and promotional support should be done by intermediate and central level, the process of non-decision making of the PHC building and frequent pulling of medical officers to the district level shows, that as a health institution residing in the peripheral level, it has to face situations of relative powerlessness in comparison to the district hospital. The long-term pending of the PHC building construction process is creating problems in day to day activities to provide health services effectively. During fieldwork, I have observed that the Holleri PHC was facing different kinds of physical, technical and logistical problems. There was a space constraint in the emergency

[154] Personal Interview- June 27th , 2013, Holleri, Rolpa
[155] Personal Interview- June 28th , 2013, Holleri, Rolpa

room and only one room has been allotted for dressing and dispensary. Similarly, OPD and administrative tasks were functioning in same room, and the DOTS and pharmacy services were also functioning in a single room. It has been observed, that there was no waiting room for patient visitors, even staff quarters were not sufficient for all staffs and their families. At nighttime, there are difficulties for visitors to wait for the patients. The lack of a canteen in the area of the Holleri PHC has been forcing patients and visitors to visit nearby markets even to drink a single cup of tea. There is no proper lead protected room to do X ray in PHC and load shedding is another prominent problem, so as the drainage coming from the laboratory in the forefront of health post building was looking insanitary. The Holleri PHC does not have an ambulance to refer patients to other regional hospitals. Though a post mortem building has been built, it was not functional during the field visit. Duty medical officer Dr. Sandesh from the Holleri PHC has accepted the fact, that there is a lack of sufficient space to keep patients for temporary observation in complicated cases and it's difficult to maintain the privacy of the patients. Similarly, during the time of the fieldwork, the pathology laboratory assistant has gone to attend a long-term training. Likewise, I have observed a laboratory assistant, who was working on a contract basis, was using the Sahli method (old method) to measure hemoglobin in the laboratory. Though the pathology laboratory has a colorimeter, however, the laboratory staff was not using that colorimeter cause of lack of Drabkin solution. Assistant lab technician, appointed by the National Planning commission has mentioned, "I am a contract staff, other reagents are coming, Drabkin solution has not been brought. Since my tenure is going to over after two months, so I thought not to raise any issue of reagents shortage [156]" This kind of low sense of responsibility among health staffs hampers the people's health and such kind of intentional negligence in the technical level remains covert, even rural people could not make a simple guess how their expectations are being betrayed by the system and its pathetic services. The ninth five-year plan has noticed, "The problems of health institutions that still exist are the lack of medicines and equipment, lack of maintenance of hospital buildings, quarters and equipment", even after one and half decade past from the ninth five year plan and its realization, rural health in Nepal is suffering from same kind of technical and physical vulnerabilities. Furthermore, if any staffs have to visit the district hospital for advanced training, it becomes impossible to reach the district hospital of Libang the same day, because there is no bridge on the river Madi, because of this reason either one has to take the round from Ghorai, Valubhang to Libang which unnecessary

[156] Personal Interview- June 27th , 2013, Holleri, Rolpa

increases time on the way. In the winter season it may take two days to reach the district hospital and in the rainy season, there is no bridge on the river and roadblocks on the way due to landslides are creating another problematic condition. Since the bridge construction process on the river Madi is facing the "contractor problem", it is creating direct hamper to supply medicines to the periphery of the district hospital and also creating obstacles to make frequent mobility either as a referral to patients or for health post staffs to attend any trainings. The recommendation of Alma Ata (1978) has given high priority to infrastructure like roads, bridges or transportation, that should be in well managed conditions to make proper accessibility of health services, contrary to this recommendations, there have been serious shortcomings in 'contract driven approach' to develop supporting infrastructure in Rolpa, which are supposed to be functional as important social determinants of health.

4.7 The Nehrpa Health Post: The pattern of cyclical blaming.

The Nehrpa regional health post situated in the Jungar VDC is located in Western direction to Rolpa. Unlike Thabang, the Jungar VDC has a heterogeneous composition, where different caste groups exist like the Dangi, Rana, Gharti Magar, K.C, Oli, Biswakarma and Pariyar. As a regional health post, it is supposed to take care of the patients from four VDCs like Gairigaon, Jungar, Nuwagaon and Budhagaon. A local resident of the Jungar VDC, Khimlal Khatri has bought land and mentioned, that he donated it to the health center in order to earn virtue (*Punya Kamauna*). The new health post building has been constructed only in 1998 but it faced controversy while building the birthing centre nearby the health post. There was a sculpture of the Hindu god *Hanuman* at the proposed construction site; however there has been a debate whether to deconstruct the sculpture of *Hanuman* or to shift the birthing centre construction to another location. Finally, debates have been solved and in coordination with the district hospital, the birthing center has been constructed by DUDBC for the Nehrpa health post in a frosty location and there was no electricity at birthing centre either. In the time of delivery, it is even difficult to manage hot water to wash the newborn. During the time of my field visit, because of controversies regarding low quality construction materials used; the birthing centre handover process to the district hospital has not been done. In this case, one of the management committee members and representative of UML says:

> *Once, the health post gate had been demolished after the construction. Likewise, contractor has not used proper sand in birthing centre and did not provide sufficient water after the construction process. The plaster done in the building of birthing center is so weak even you can pick out with bare hand. It does not include sufficient materials; however, contractor has blamed us for creating unnecessary disturbances.*

> *Bhawan office has requested us to formulate the caretaker committee (Rekhdekh Samiti)) to supervise the construction process of health post, unfortunately we could not form such committee. It is solely the negligence of contractor. Though two contractors were UML supporters and another one is the Maoist supporter. But I do not see political intervention in this case*[157].

After well aware about the contractor's negligence during the process of construction, there has been no positive intervention from the political level. The representative of UML has blamed the contractors, but he has acknowledged, that even they could not form the caretaker committee as per direction of DUDBC. This kind of contradictory attitude has traced many times in the process of health related infrastructural development in Rolpa, where one feels free to blame another and does not care about its own responsibility. Being a representative from the UML party in the management committee of the Nehrpa health post, it could be his 'political faith' for not to perceiving any political nepotism by his party to the contractor. Instead, he further blamed the district health office for not showing sufficient attention during the construction process and further claimed, "incharge has displayed the estimation in very transparent way since he is a gentle guy it is easy to put blame on him". Similarly, a local resident and the coordinator of Civic Watch Group (*Nagarik Nigarani Samuha*) of the Jungar VDC expressed dissatisfaction for not acknowledging their feedback and further said, that profit nexus between the contractor and technical staffs of the *Bhawan Nirman Bhiwagh* (DUDBC) as well as health post staffs became a crucial element to appear for the birthing center as a low quality infrastructure. The coordinator of the Civic Watch Group mentions:

> *To resolve the conflict, there has been a monitoring visit from district level civic network (Nagarik Sanjal Jilla Samiti). We did press conference and organized a public hearing, however, health post staffs tried to prove they are right and we are wrong. Political parties are directly involved in corruption, they are protecting and nurturing the culture of corruption. So, political party is the main source of corruption. Unless the post sharing system among political parties is not removed and contractor has been protected by politician, things will not move in the right track*[158].

Apart from the nexus of bureaucracy and the health post staffs, he has directly blamed political actors to provide sufficient protectionism to the contractor. In this case, regarding his potential nexus to the contractor and the health post management committee member also denied the nexus of health post in charge and the contractor. However, one of the Staffs of Nehrpa health post says, "If the contractor and the health post in charge nexus is working, then no one can pressurize the situation, I think health post in charge should be responsible

[157] Personal Interview- July 2nd , 2013, Jungar, Rolpa
[158] Personal Interview- July 2nd , 2013, Jungar, Rolpa

for this kind of negligence"[159] It can be traced from the case study of the Nehrpa health post, that the trend of blaming to each other has been operating in a complicated way. It has been explored, if some party has to recruit the staffs for the health post, and then there will be strong political influence. If the person is nearer to a dominant political party, there can be oral appointments also. A village level political worker of the UCPN (Maoists) explains:

> *We know, there shouldn't be politics in the matter of development, but in Jungar there is politics everywhere. Either you see the construction process of health post gate or in the birthing centre construction process, in both of the cases there has been serious negligence. The Health post mechanism has been influenced and captured by the leaders of congress party.*

As Beteille (1965) writes, villagers often used the english word 'politics' to refer to factions and cliques among themselves; in this sense the term has a somewhat derogatory connotation. The situation is similar in the context of Rolpa, where many people use the word 'politics' to interpret mal-governance and illegitimate roles performed by political actors. It is interesting to notice the effort by the actors of different orientations to interpret the event as per the alleged person's inclination towards political ideology. In response to the blame by the Maoist political worker, the village level leader from the Nepali Congress says, "It's merely a blame, that we have to maintain influence in the Nehrpa health post. We have recruited poor Dalit women to work as an office assistant, how you can say that Congress has intervened in the function of the health post mechanism. Regarding the construction, it's the duty and responsibility of village secretary to maintain transparency of the allocated budget for construction process [160]" Leaders of other parties like the UML and the UCPN (Maoists) have blamed the Nepali Congress (NC) for creating unnecessary influence in the Nehrpa health post. Moreover, NC leader blamed bureaucracy for not maintaining transparency in the allocated budget. There have been cyclical blaming patterns, which existed about the negligence being done during the birthing centre construction process of the Nehrpa health post. The case of the Nehrpa birthing centre is also no longer different from other health institutions in Rolpa where blaming others and non-acknowledgement of mistakes is common characteristics, which exists in every selected institution. Apart from the governance crisis, the Nehrpa health post is facing different kinds of day-to-day managerial problems like for example the shortage of human resource on health. The acting in charge of Nehrpa health post elucidates:

[159] Personal Interview- July 3rd , 2013, Holleri, Rolpa
[160] Personal Interview- July 3rd , 2013, Jungar, Rolpa

> *There should be urgent up gradation of Nehrpa health post to primary health care centre. Staffs are not sufficient in proportionate to volume of the patients. There are four immunization centers in the village in different places like Jagarbot, Rizhuijha, Kaulabot and Nehrpa, when staffs are not in the station and gone outside, at that time it becomes difficult to run outreach clinics. Because of huge numbers of patients in rainy season, then it is not possible to do proper counseling*[161].

Lack of sufficient human resources on health is one of the crucial phenomena in the rural health system of Rolpa. In addition, the staffs that are dedicating their time also have different kinds of frustrations that may directly hamper everyday performances. Likewise, the acting in charge has studied three years a HA (Health Assistant) course and works in the post of a CMA (Community medical assistants) that only requires a one year study course at the Nehrpa health post. She has expressed her frustration regarding undervaluation of her qualification, she said , "Though I have higher degree , still I am working in junior position , therefore I do not like to continue this job for long run, If I passed the entrance examination to study MBBS I will quickly quit this place[162]" In this district, I have observed many cases[163] where staffs are working in junior positions than they actually deserve. Apart from issue of de-professionalization, the Nehrpa health post is facing the issue of non-professionalism among the staffs. There has been a conflict between local staffs and staffs from outside and one of the staffs has filed an anonymous application to the management committee describing the uneasiness in day-to-day work. A close tie between relatives working in health post was creating problems with other staffs, later o then district hospital intervened in the internal conflict and one of the staffs has been transferred to the district hospital. The particular staff who has been transferred from Nehrpa health post to the district hospital has serious dissatisfaction with this decision, she says:

> *Though I am local from that region, I am compelled to come here at district hospital. Outsiders are working there. I do not have any problem with anyone; I went there to provide health service, I was not there to do any politics*[164].

Many times, personal orientation of any individual creates problems while demonstrating collective performances in public institution, the way she labeled co-workers with the word

---

[161] Personal Interview- July 3rd , 2013, Jungar, Rolpa

[162] Personal Interview- July 2nd , 2013, Jungar, Rolpa.

[163] This case is similar to the case of medical technologists in district hospital working as a Pathology laboratory technician. After doing Bachelor in medical technology, one deserves a post of medical technologist; however in this case, particular staff has to compromise with the position which is equivalent to those people who have studied only proficiency certificate level in medical laboratory course.

[164] Personal Interview- July 2nd , 2013, Jungar, Rolpa

like "outsiders" gives the glance of the inherited conflict within the institution. After becoming staff of the Nepal government, theoretically, it does not matter which society, or class or caste that particular individual is coming from, not acknowledging the equal presence of another fellow worker is simple the notion of exclusion and a 'sense of othering' expressed by so-called "local people" in this case.

According to the health management committee guideline developed in 1996, there should be the representation of minority groups like women, ethnic, caste minority and representatives of political parties in the health post management committee. However, similar to other health institution like in Thabang, it is evident that in many cases, the members from ethnic, Dalit and women's category are not being able to put their voice effectively and decisions of few male members are dominating the management committee. Similar to other selected institutions, in terms of sharing power, there is an unclear margin between the health post management committee and the district level authority. Management committee is expected to manage, supervise and channelize health related resources in the community; on the other hand the same management committee has to confine itself into the demarcation created by district level authority. During the time of the field visit, the health institution does not have proper bathroom and even the water supply was insufficient. There was no extra room for visitors of the delivery women to wait comfortably at the health post. Even staffs were renting a room outside. There has been urgent need of an ambulance; villagers are compelled to pay expensive fares to the transportation called from the adjoining Dang district. Moreover, like other selected health institutions, the Nehrpa health post is facing similar issues like multiple engagements of management committee members to other local institutions, moreover, irregularity of the VDC secretary as a local representative and a low level of supervision to operate the free health care program is another identical phenomena operating in the Nehrpa health post like other selected institutions. Thus, different kind of physical and heath related human resource limitations discouraged motivation of staffs to work in the rural belt and even discourage patients to visit health centers in the time of emergency.

4.8 Gairigaun Sub Health Post: Felt needs versus imposed needs

In the year of 1990, there has been approval to start a sub health post at Gairigaun[165]; nevertheless only in 1993 the Gairigaun VDC managed to rent a room to run the sub health post. During the hard-hit of the Civil War, there was no possibility to construct the building because the CPN (Maoists) had strictly prevented to implement any government budget at local level. In order to run the health service program from the sub health post, the old house of a local resident was hired and renovated by collecting donations per person of two rupees Nepalese currency. This collection can be interpreted as a symbolic satire to those policy makers and planners where many health institutions are facing corruption of million rupees and on the other hand local people are collecting two rupees just to sustain the health post at Gairigaun in Rolpa. Unfortunately, because of a decade long Civil War and post conflict political instability, the health post building has not been constructed for nearly another two decades. Showing the reasons like the politically unfavorable situation, the district hospital in Rolpa has not done any effort to collect a budget to construct the Gairigaun sub health post building. The process has been stagnated for another six years even after peace accord has been signed in 2006. In this issue, the Gairigaun sub health post in charge mentions:

> *After establishing camps of People Liberation army in Tila, suddenly land became very expensive. Local people were not interested to donate land for the sub health post building. Finally, politicians have decided to utilize the government (Ailani) land. VDC has bought the land in the name of school. Required amount of payments have been given to the school, but name-shifting process has been not taken place. If sub health post wants to pass the land as its own property, there should be the decision from the cabinet. Representatives of health post and school management committee have visited Kathmandu; because of central level political lingering, our work has not been done. Kathmandu is so far, it's not possible to do frequent ups and down*[166].

I have observed, that within five hundred meters vicinity of the Gairigaun sub health post, there has been a temporary camp of people liberation army (PLA). During my field visit, the people´s liberation army rehabilitation program was already over and there was only presence of the physical infrastructure. Since huge numbers of PLA were residing in the Tila barrack, there has been rise of economic activities in the village. As a result, notion of consumerism has embedded the psyche of local people and price of land got suddenly hiked up. The growing monetary value of land has directly reflected in non-cooperative attitude to construct

[165] Before implementation of Nepal government's plan to establish sub health post in every VDC, Gairigaun sub health post was functioning under Nehrpa Health post. Local people of this VDC have to visit regional health post of Nehrpa, approximately three to four hours walking distance far from Gairigaun.

[166] Personal Interview- July 12th , 2013, Gairigaun, Rolpa

public institutions like the sub health post. In order to continue the process, common consensus among local stakeholders was built to use government land, which was originally property of the local school, but it faced bureaucratic lingering to authorize the rights of land ownership from the school to the health post. Contextually, a three year interim plan writes:

Decentralization policy will be focused toward enabling local bodies to perform the role of total development management and also toward forming such a local self-government that is capable to fight against the challenges of the 21st century, and is strong, empowered and responsible to the needs of the people.

In contradiction to the government's statement of enabling and empowering local bodies up to the level where they can manage and take care their local needs independently, the evidence of awaiting a cabinet decision to shift the land ownership of the school in the name of the sub health post clearly shows the gap between principles and practices of decentralization. It were quite contradictory activities to the vision of government of the eighth five year plan that mentions, "In the programs related to management and services of health institutions, local bodies will be involved and made accountable", instead it created hyper dependency from the central level ruling mechanism to fulfill minor tasks like an ownership shifting process from the school to the sub health post. Such dependency and non-accomplishment of people's aspirations ultimately foster a deep level of exclusion and marginalization. Apart from the land related controversy, there has been a debate related to the construction of the birthing centre of the Gairigaun sub health post, which has not started during the time of the fieldwork. Similarly, another staff of the Gairigaun sub health post mentions:

> *Sub health post building has been constructed in frosty place; it's difficult to get sunlight. Politicians were not interested to shift it from present location. Land that has been allocated to construct birthing centre is also frosty because there is natural water source near by the building. We do not have extra land to construct birthing centre. Since the construction process has not started yet, it may take another eight to ten years or may construct within one to two years, nobody knows. Outwardly, people speak about the necessity of birthing centre but nobody is taking it seriously. It's challenging to collect seven to eight Lakhs Nepalese rupees (7-8 thousands USD) at local level. I think central level policy should take care of these complications*[167].

Just to gear up the institutional growth process, the selection of land in a frosty location shows the level of vision among the stakeholders and their sensibility towards public health. In a hill region like Rolpa, especially in winter days, it becomes literally not possible to perform any delivery in such a cold place where the expectation of a room heating system would be a totally 'extreme demand' at least in the present situation. Dixit (2014) writes, in

[167] Personal Interview- July 12th , 2013, Gairigaun, Rolpa

1988 only 242 of health post had their own premises whilst the other 433 were in rented premises. One opinion voiced at the community health resources and priorities (CHRP) meeting was that if health institutions were to be in appropriate sites, and then the land of constructing the building must be purchased. Despite recommendations for purchasing land to build a health centre in an appropriate place, the act of accepting donated land has compelled the health institution to stand in a frosty place, because of the hypothermic physical environment of the hill district; in winter both patients and staffs have to face uneasiness to stay longer inside their duty rooms. In comparison to other selected health institutions in Rolpa, in the case of the Gairigaun sub health post, the management committee itself is highly paralyzed and almost all non-functional. Sub health post staffs have mentioned, that one of the female management committee members is not in contact since one year. The irregularity of meetings and continuous absence of many members in the management committee is creating problems to gear up many managerial issues about the health institution. The VDC secretary who is supposed to take care of the overall administrative and legal mechanisms in the absence of a local government is a chronic alcoholic and does not show any interest in his duty and responsibilities, so that his negligence is hampered to supervise the essential medicines coming from the free health program.

Likewise, the eighth five-year plan writes, "for the development of health services, a policy of promoting participation of national international NGOs, private enterprises and foreign investors will be adopted". According to the government's vision of collaboration, in 2011/2012 the government and a donor agency joined their hands to build the Gairigaun sub health post with the financial and technical support of an international non-governmental organization called Medical Emergency Relief International (Merlin Nepal)[168]. With this decision, the construction of a long awaited sub health post building has been moved forward, despite involvement of the donor agency, the construction process faces a lot of controversies at local level. The in charge of the Gairigaun health post elucidates:

> *Merlin has own kind of estimation. In the process of construction, they did not make good coordination with us. There are not sufficient rooms as per the necessity of sub health post. They have already estimated and we were just supposed to follow what they have brought to us. It would be easy for the patients if there has been attached latrine and bathroom, but they did not listen to us. Rather than not having building, it is better to have something, but they were so strict regarding their agenda. Many*

[168] Merlin is UK based charitable organization , that works to supply health workers during complex emergency.

times they threatened us, if we could not provide them land ownership paper; then health post construction project may shift from here to elsewhere[169].

I have observed, that in the latest building like Gairigaun, there is no attached latrine nor canteen inside the sub health post constructed by the donors[170] or even staff quarters. The lack of a separate drug store or private room to check up patients as per requirement of the sub health post is creating uncomfortable situations to both staffs and patients. Staff are not being able to maintain privacy of the patients especially for females during peri-natal checkups. In summer, the sub health post has to face severe space constraints to manage the increased patient load. The high school gave a separate small home resided in an extremely frosty place, which is not appropriate to run a birthing centre and it was not in use. There was a controversy about the transparency of budget during the construction process, SHP staffs have mentioned, that even Merlin did not show the contract paper done with government, due to this reason they could not understand the nature of contract done between government and external development partner (EDP). For that reason, local people and the management committee have raised suspicion whether cement, wood or sand brought to construct health post building has been as required per the contract budget or not. Health post staffs expressed their dissatisfaction at the District Health Office, but it did not make any timely effort to intervene in the sub health post building process, but after construction the DHO expressed its dissatisfaction about the structure of the sub health post building. Alma Ata (1978) declaration on primary health care mentioned about the active role of community representatives in local governments, which can ensure that community interests are properly taken into account in the planning and implementation of development programs, contrary to this value, none of the political parties at village level has made any effort to supervise the construction process. The ninth five-year plan has realized the lack of coordination among NGOs and INGOs, private sector and local communities in the development of health institutions, which has affected the coordination between NGOs and local authorities, consumer groups and government offices. However, this realization has not been articulated Health Volunteer and one of the management committee members of the Gairigaon sub health post said, **"**I am working as a management committee member since the formation of first management committee, I do not know too much about the construction process. Seniors were taking care of that (" In this case her avoidance to share the information about

[169] Personal Interview- July 12th , 2013, Gairigaun, Rolpa

[170] The highlight of donor's names used on the plastic mug kept in the latrines show their inherent interest for donors and their desire to publicize their work.

negligence in the health institutions reveals the fact, that further in the construction process of health institutions like Gairigaun, which should be done under collaboration of the donor agency, local people and health workers. A Female Community there has been a low level of active participation among females in terms of the decision-making process. Moreover, in this case, if she knows the feeling of psychological insecurity, then it is the byproduct of female subordination to male members where patriarchal gaze forcefully suppressed female's voices both in the public and private sphere. Moreover, while going once from Gairigaun to Thabang, I have shortly taken rest in Kureli and observed the situation of sub health post building, which has been also constructed by Merlin Nepal. Though I have not chosen this sub health post in my study, still it would be relevant for me to take some comparative reference. The in charge of the Kureli sub health post expressed severe dissatisfaction regarding the work of Merlin Nepal. According to him:

> *There has been coordination with district health office, local politicians and management committee, but construction process has not been supervised. Merlin only followed the design to build the building. However, in fact building is so fragile, all the floors are rugged and rooms are not sufficient. It is difficult to adjust patient's visitors in nighttime; there is no sufficient space to keep fresh delivered women in observation. You can see the sand is mixed with soil, and less cement has been used to construct the wall. You can simply take out the plastered from the wall. It does not look like health service institution. We love office like our home. District hospital representative has attended in the handover process; they have also seen this problem. Merlin Nepal neither listened to district health office nor listened to local management committee or sub health post staffs*[171].

It's not only the case of the Gairigaun sub health post, staffs of the Kureli sub health post are highly unsatisfied with the work of Merlin Nepal. There has been serious blame raised towards the donor agency from both institutions, because they did not listen to local needs. Justice (1986 :73) writes:

> *Planning exercises in Nepal have typically produced planning documents that may not be considered useful by government officers but that satisfy the sponsoring agency's needs. All too often the contents of the plans have been either too complex for the Nepali infrastructure to carry out or simply unrealistic in view of local conditions.*

Nearly three decades past of Justice's observation on the policy and practice gap, which exist in the Nepalese health service system. It's again another paradox to observe the same kind of problems in Rolpa, where government policy and practical realities are not meeting each

[171] Personal Interview- July 14th , 2013, Gairigaun, Rolpa

other to bring productive solutions. A Sub health post is a fundamental unit to deliver health service at grass root level. In this kind of important primary level institution, DHO and DDC, both of the important mechanisms at district level have not shown serious concern about the construction process. This kind of non-responsiveness of the higher-level mechanism is evident to prove the failure of government's commitment to deliver quality health services to the rural poor in accordance with the donor agency. Though the government had argued to increase the health service indicators in collaboration with other agencies, it is again another tragedy that even donor's intervention in the institutional development process could not realize the felt needs of the local level stakeholders, who are supposed to utilize the infrastructural facilities on every day basis. As Justice (1986:68) writes: "Health planning activities are often oriented toward donors' priorities and interests, especially their desire to make sure that the increasing amounts of aid they are providing to countries such as Nepal are being effectively spent". The way the donor has imposed the plan without consulting local level stakeholders in the case of Gairigaun sub health post shows that, one sided intention of donor just to spend the fund allocated in the name of "development" rather than showing true motivation to address the health related concern of the people in Rolpa.

4.9 The Oat sub-health post: The case of chronic exclusion and malformation

In the case of Rolpa, during the Civil War, public institutions like health posts and their staff were kept in rigorous surveillance by the state security force. The pathetic days of this sub health post began after the devastating effect of the Civil War created threatening conditions to rural livelihood; as a result, some of the staff went underground and some of them just vanished and promoted the "culture of absenteeism". The fear of potential death in two way attacks during the war and a very complicated position to maintain neutrality among the Royal Nepalese army and people of the liberation army, many health workers just left and searched alternative means of survival. Similar to other health post, the Oat sub-health post is also facing the history of institutional malformation and chronic stage of stagnation. Though the Oat sub-health posts shares the similar history of long-term institutional stagnation since 1996 like the cases of the district hospital, the Jinabang health post and the Holleri PHC in Rolpa, however, some of the dynamics of institutional malformation are atypical in the case of the Oat sub-health post. It's been sixteen years, since the Oat sub-health post has been functional in the Oat VDC Office without having its own building and the sub health post management committee was dysfunctional for a long time. One of the management committee members mentions:

> *During Sankatkaal, health post used to be closed for long time. Anytime there could be war, therefore, it was not possible to run health post. Health post was turned to cowshed and public latrine. Maoists also used this place as a shelter, army used to come and search them. Since health post and post office is in same building that's why this building is still in form, otherwise in Sankatkaal, army would have already blast this building*[172].

Despite the ongoing threats of Civil War, there has been at least a continuation of health services in the case of other health institutions in Rolpa, but in the case of the Oat sub health post, it was almost non-functional for a long time. As I have mentioned earlier in the section of the Ghorneti Model Hospital, among those staffs, Comrade Chunauti became an underground and began to work as an OMSA worker under the umbrella of the Maoist health organization. There has been a debate to construct the building of the health post after official ending of the Civil War. During the time of my fieldwork it's been already six years passed but there has been no initiation to construct the health post building. The Oat sub health post in charge says:

> *There were frequent attempts to build health post building but we could not manage land. In fact, nobody has donated the land. People feel happy to contribute labor; however, but feel uneasy to donate money. We are hearing the excuses like sometimes due to the conflict and sometimes lack of budget, construction process is not being able to move forward. It's difficult to get government land in the name of health post. Now land has been bought but we have problems to build the building. If there is proper plan and good leadership, we are ready to contribute labor. Our voices are not being heard in upper level. Leaders are just convincing and consoling us, but there is no initiation to construct the sub health post building*[173].

In the context of the Oat sub health post, since the monetary value of land increased, it has become difficult to acquire land. One of the residents drinking tea nearby the teashop of the Oat sub health post mentioned, "Who will donate their private land to health post in this kind of expensive time? Rather than donation land to construct any public institutions, people think it is a profitable option to sell the land and go abroad." The notion of expensive time (*mahangi ko jamana*) has deeply embedded in the public psyche, which has promoted the non- cooperative attitude in the work of communal benefit. After long time, the Oat sub health post management committee became able to manage land to construct the sub health

[172] Personal Interview- July 24th , 2013, Oat, Rolpa
[173] Personal Interview- July 25th , 2013, Oat, Rolpa.

post building, but again there is no sign of moving forward. Shortage of acquired amount of funding is another crucial issue in the context of the Nepalese health system. Especially for the country, which has suffered a long-term Civil War, the allocation of only 5.9 percent investment in the health sector is not supportive to response many health related expectations visualized in the governmental plan. In this kind of condition, since government priorities do not reflect in equal basis, remote and peripheral regions of the country have to suffer even more than city areas with the lack of proper decentralization of the resources. A Three-year interim plan that has been launched since 2007/08 to 2009 / 2010 states:

> *Reconstruction of damaged buildings, routine repair and maintenance of health equipment of various health institutions at the district levels, will be carried out effectively by improving the management of the district-based institutions. New construction, and repair and maintenance of staff quarters in the remote areas will be done on a priority basis. All such works will be carried out on the basis of an inventory of the physical infrastructure.*

Nepalese Government's three-year interim plan (2007/08 - 2009/2010) which has been formulated after the peace accord has clearly mentioned the reconstruction, repair and maintenance process of the health institutions of remote areas. It further writes, "Sub-health posts will be upgraded gradually to health posts as per need on the basis of population density and geographical remoteness". Many promises made by the government plan were not fulfilled in the context where there has been much urgency to upgrade the status of health institutions, in this case the Oat sub health post, the institution, which was even not functional for a long run, could not draw the attention of policy makers for its necessary up gradation and institutional strengthening. Similarly, the personal attitude and behavior of important service providers affects the institutional productivity, which has direct relationship in terms of people's health. It has been told that, since some of the staffs were alcoholic in nature and because of their personal attitude, regular functions of heath service delivery used to be interrupted even in the post conflict period. A management committee member explains:

> *There are posts like VHW, MCHW and office in charge. ANM have been appointed as a contract staff of VDC. However, staffs are not staying for long time. Last time staff M stayed for nine to ten years, if she does not take alcohol she used to open health post and used to give good service; however if she gets drunk then situation used to be worse and health post used to be always closed. Again, government sent same kind of alcoholic staff; he also used to be irregular. One of the staffs has been absence since long time because of his alcoholic habit. His post has been terminated by district the hospital.*[174]

[174] Personal Interview- July 25th , 2013, Oat, Rolpa

The Oat VDC is located at the top of the hill with very few surrounding houses. There is no environment for duty staff to get involved in some extra work apart from doing day-to-day regular services. The isolated and very premature condition of rural livelihood may create frustration among the health workers. Moreover, the moderate temperature in the hill area is always ecologically suitable to drink alcohol to maintain the acquired amount of warmth in their body. Since drinking alcohol (*Rakshi Piune*) is one of the widespread culturally accepted trends in the Magar community where they consumed alcohol by following the notion like 'caste has allowed and hands have supported' (*Jaatle payeko haatle Khayeko*). In this kind of 'culturally acceptable' and 'environmentally favorable' condition, after regular duty, if there is nothing alternative to perform, alcohol becomes a 'refresher' and means of social gathering in the local pub (*Vhatti*). Since most of the staffs have to stay without their family members, just to avoid loneliness and homesickness, staffs visit the local pub for socialization and the pattern of daily consumption leads to addiction. Ironically, the same health post staffs, if they have to treat the patients and do counseling for their better health in day time are also the same persons getting drunk in the vicinity of the health post, so it becomes an ethically complicated situation, that decreased the trust and respect towards the health workers. After defaming the social image or fear of getting worse day-by-day staffs do not stay in such an isolated remote place and find some alternative ways to get transferred from this kind of situation. A management committee members complained, "If any staff comes, they do not like to stay in this sub health post for long time. After they get transfer, it becomes difficult to fill the vacant position". In the case when some health workers do not take alcohol because of their religious faith or public health conscious attitude, it becomes again another awkward situation to continue the work in that environment where one's fellow worker is creating continuous problems because of alcohol addiction.

During my field visit, there were no permanent staffs and the condition of the Oat sub health post was very pathetic, it looked like a multipurpose supermarket. The Post office and health post services were running in same old wretched building of the Oat VDC. There was no sufficient space for the post office because the building has been originally not constructed to run health post facilities. Administrative work, storeroom, drug store, patient checkup, dispensary and post office activities were running in same room and staff are hiring a room nearby the health posts for their residential purpose. Likewise, I have observed other physical hazards like low lighting condition and very brittle condition of the building structure, which may fell down from a minor stroke of an earthquake. Working ANM has mentioned about the severe irregularity in medicines supply because of the geographical setting of Rolpa and lack

of labour force to carry essential medicines. Since this district shares one of the highest rates of migrants, at present it's difficult to find people who could work as a regular labour in the village. It's not that only staff do not have alterative things to do after or before the duty, the day to day working condition inside the duty station also is one of the important factors that determines job satisfaction among the staff. After the CPN (Maoists) constructed the Ghorneti Model hospital in same VDC, it is one of the factors, that there is low presence of patients in the health institutions, which eventually reflected in non-improvement of its regular services. Another management committee member says:

> *Since 1997, we are not getting any resources. District health office is not giving us proper attention. Again, they are planning to construct birthing centre and health post separately. We are demanding, at first there should be assurance to build birthing centre and sub health post building jointly. We are raising the voices however, president is not listening*[175].

Inside the management committee, there are plenty of grievances for not hearing plural voices properly. The phenomena of not acknowledging has both horizontal and vertical dimension where every person at the local level has grievances of being ignored from the above level power hierarchy. Either it could be the chairperson of management committee or it could be the district level authority, in many occasions these entities are blamed for not being heard from their supporting agencies. In this context the tenth plan states, "The physical and management aspects of the sub-health posts operated at the rural level will be entrusted to the local elected bodies". Interestingly, there has been no articulation of government's promises on a practical level to entrust a local body to function the sub health post to be operated with local autonomy. Drawing the analogy from the case study of the Oat sub health post, it can be argued, that rural health institutions of Rolpa are facing a strange kind of a paradoxical situation where people are expecting something to happen and the government has promised to fulfill those expectations, but in reality, expectations and promises are never met.

4.10 The Gajul health post; Clashes of interests

During the tenure of Khadananda Subedi in 1960, the first democratic government of Nepal formed after the 1959 election has sanctioned authority to establish a health post at the Gajul VDC. Previously the Gajul region of Rolpa was under Baiishkhuwa, which was basically a part of the Pyuthan district and the name of the health post used to be

[175] Personal Interview- July 24th , 2013, Oat, Rolpa

Baiishkhuwa Gajul health post. Since the time of its establishment, people from the upper region of Gajul were interested to shift the health center to the upper part away from its present location; one of the striking reasons behind their grievances is the geographical difficulty to visit the health post. A dissatisfied group from the upper region has forwarded the logic, that a regional health post should incorporate all geographical range of its catchment area. The conflict that has been emerged nearly before fifty-five years has not yet been solved; even at present people from northern belt of the Gajul VDC frequently raise their interest to shift the health post from present location to the Northern region of this VDC. Similarly, even during the tenure of Khadananda Subedi in 1965, there has been a debate to shift the Gajul Baiishkhuwa health post from Gajul to the district headquarter of Libang. Khadananda Subedi, the elected district president did not support this idea, instead he proposed to establish a new health post in Libang. Similarly, it has been further mentioned, by using a powerful political channel, that Khadananda Subedi was successful to shift the authority of the Ayurvedic centre sanctioned for the Pyuthan district to Vingri. One of the local residents from Pyuthan mentioned, "We did not know about the authority to run Ayurvedic hospital sanctioned to Pyuthan, since many people were illiterate at that time, people were not aware to make any query about gains and loss, that time was different[176]". This is very typical case in the context of a society like Rolpa where a large section of people even do not come to know what provisions are made for them on the policy level and how those provisions are already being grabbed by the "informed class" (*Jannesunne barga*) without noticing the "unaware class" (*Siddha Sadha Macnheharu*) of the society.

The both, pre conflict and post conflict scenario are significantly responsible for not executing the new building of the Gajul health post. As a result, despite the problems of space constraints in the day-to-day service delivery process, this health institution was functional in its original building for more than five decades. After the health post got its first building in 1961, there has been frequent attempt to construct a new building. There has been neither any effort taken from the three decades long Panchayat government, nor any process moved forward for another two decades after the second rise of democracy in 1990. In between, a decade long Civil War became one of the active reasons to ignore the probability of a new construction in the Maoist heartland like Rolpa. Moreover, it has been decided to construct health post after the official ending of the Civil War in 2006 and a tender process has been announced by DUDBC, but this health post again faced similar kind of governance problems

[176] Personal Interview- June 27th , 2013, Holleri, Rolpa

like other health institutions which were selected for this study. One of the staffs from the district hospital revealed the secret: “The amount of original contract was 8.6 Million Nepalese rupees, first contractor handover to second contractor in 5.6 million Nepalese rupees and second to third contractor even in lesser amount. So, there has been naked corruption." During fieldwork it has been explored that first contractor handover original contract to petty contractors and health post building appeared in substandard form because of profit making interests of the contractors and due to the irresponsibility of community stewardship. In the case of Gajul, I was connected to the petty contractor through a local journalist. During the interview, the petty contractor who built the health post building as a third party said, "I took third contract in 3.6 millions, actually I became the victim, I did not know how much the original amount was." Nearly five million Nepalese rupees, which should have been invested to maintain the quality of the health post building, were already minimized by the contractors before the construction process of the Gajul health post building even started. In this case, a local Maoist leader and resident of the nearby Gajul health post mentions:

> *We have heard that total budget is 8.6 million, but they sent petty contractor to construct health post with lower amount. We have assertively raised the issues in VDC level to make a query whether construction has been done according to estimation or not. Later on engineer of Bhawan Bivagh (DUDBC) has rectified that performance is done according to the estimation. Contractor has a good link in bureaucracy, so we could not do anything. It is conflict between policy and people's expectation*[177].

Similar to other health institutions, those which are facing the problems of the governance crisis, the context of Gajul is no longer different from the pattern of cyclical blaming existing among the important stakeholders like politicians, bureaucrats and management committee members who are theoretically and practically responsible to take care of the health institutions. The local level Maoist leader has blamed bureaucracy for creating governance problems, since he further interpreted the nature of clashes is basically the crisis of people's expectation and the loophole in the state policy, but he did not mention how far the non-participation of the CPN (Maoists) is responsible to ignore the construction process of health institutions which has a direct relationship with people's health. Similarly, staff from the technical department of the District Development Committee (DDC), has mentioned, the health post building has been constructed according to the design recommended by the DUDBC, nevertheless, I have observed there is no quarter and other supportive logistical

[177] Personal Interview- August 7th , 2013, Gajul, Rolpa

support to run 24 hours delivery services, even there is no canteen and no waiting room not even in the newly constructed building. An ANM working as acting in charge has mentioned, "I am working here since ten years, prior to construct health post building, they did not ask us once". The dynamics of "not asking" is a similar version of narratives like 'not listening' during the process of the health post construction. The notion of either not asking or not listening both shows the lack of mutual discussion to identify mutual needs to gain the mutual benefits in planning and the implementation process. Moreover, in terms of the formation process of the management committee, this health post is facing severe problems on the decision making level. Acting in charge of the Gajul health post shares:

> *In Gajul VDC, before war other parties used to possess domination. After Civil War Maoists became influential. Initially, management committee has been dominated by Maoist group. When Maoist party split, there have been factions in our management committee. Since political conflict is affecting management committee, it's not active since two years. Even the present management committee was not formed according to the guideline. These days management committee members do not visit health institutions to attend meeting. Actually, nobody came to observe and supervise the construction process of new health post building*[178].

The fissures in the political class has divided the strength of the management committee. The chronic stage of dysfunction of the management committee has eventually reflected in the non-supervision of the process of the health post building. The tenth five-year plan states, "Health services will be gradually decentralized according to the Local Self-governance Act, 1998 and the office-bearers of Local Health Administration and Management Committees will be involved in orientation programs to enhance their working capability". In contrast, the national policy has envisioned the effective implementation of the decentralization policy, but there has been a significantly different context operating at grass root level. In the lack of a proper orientation program, the management committee has even left visiting the health institution and discontinued to hold the meeting of the management committee. Furthermore, after the split of the Maoist party, there is a lack of solidarity among political co-workers. During the time of my field visit, the Gajul health Post has two groups of management committees, which is a very unusual case in comparison to other health institutions in Rolpa. One is the official committee; in which the village secretary is a chairperson and it is the coalition of the village secretary, veterinary doctor and the health post in charge but in the Gajul VDC, the village secretary does not stay in the village, however this committee exercised the power to control and allocate the resources and budget the facilitation process.

[178] Personal Interview- August 7th , 2013, Gajul, Rolpa

The other is the present management committee, which has been formed without following the guideline. Since the Maoist party was blamed to create unnecessary influence in the health post running mechanisms, a local Maoist leader mentions:

> *We know that there should be cooperative approach between politicians, health post staffs, local people and state. But if parties are intentionally paralyzed and bureaucrats are holding the political power then it would obviously create problem. Regarding the matter of management committee, one hand there has been curtailed in the authority and other hand responsibility is expected that's why our friends got frustrated. Despite elected political representative, government staffs were ruling everywhere. After Sarbadaliya (Multiparty mechanisms) has been cancelled, village secretary became more powerful, and you see it's a non-political phenomenon. Lack of local election is preventing development agenda to reach in people's access*[179].

In spite of realizing the necessity of a cooperative approach among the stakeholders to gear up a local development agenda, simultaneously the local Maoist leader expressed his grievances for not getting full-fledged authority to control the mechanism of the health post. If one theoretically believes in consensus and cooperative values, then there is no point to make grievances for getting frustrated in the lack of authority, which literally means power in this context. In reality, after analyzing many different contexts, every political party was desperately interested to make political hold in order to control the local health institution as an important public resource. Similarly, as permanent government staffs, medical staffs also do active power exercise in day-to-day mechanisms of the health institutions, in this kind of contesting realities, the idea of cooperative and consensus would implement practically if the contesting parties interests were not contradictory to each other. During the days of the Civil War, Gajul is one of the most affected VDC in Rolpa where many attacks, killings and abductions of people took place. Consequently, following the fearful environment of the Civil War, absence of the VDC secretary is one of the crucial factors even in the Gajul VDC. There has been a visit of a delegation team to the district administrative office and even the Maoists threatened the VDC secretary to be regularly present in the VDC office, but there has been no change at all. Likewise, the Gajul health post is no more excluded from the severe shortage of human resources on health issues. I have observed, that there was a vacant post for a HA since long time. In the last ten years, a HA has joined the health post just in the last year only. Auxiliary Nurses Midwife (ANMs) and office assistants are working as contract staff appointed by the district hospital. Apart from staff shortage, there was a breakdown of the team spirit among the staff. Once there has been a severe conflict between acting the in charge and a local resident and past the in charge of the health post who came from outside.

[179] Personal Interview- August 7th , 2013, Gajul, Rolpa

In this case, the acting in charge says:

> *Initially, the one in charge was interested to make his resident nearby the delivery room. I said, 'it would be irrelevant and unethical for male staff to manage his personal room nearby the delivery room'. Our conflict was started at this point. Later on, he has mentioned he was not interested to work there. Actually, he wanted to work in remote places of Rolpa to get a higher-level course in government scholarship program. Again he tried to show his presence in daily attendance, though he was out of the station, at that time, I prevented him to perform such kind of illegal act. Because of this kind of misunderstanding attitude , we had minor problems*[180].

The conflict between local staff and staff from "outside" is significantly important to understand how these conflicts are nurturing the role of locally powerful actors in the decision making process. Many local people mentioned, though staff from "outside" are skilled and experienced, local staff do not tolerate them because once they are present in the duty station, it breaks the monopoly of local staff in the health post resources. Supplementing this observation, one of the senior leaders of the Panchayat reign and resident nearby of the Gajul health post Rek Bahadur Subedi blames:

> *If senior staff from elsewhere comes to work in the organization, then it may create problems to local staff, that's why if local staff is junior they do not tolerate senior staff in the health post. Senior AHW has to leave the village after anonymous message posted in his rent room's door which was like, 'if you do not run to leave Gajul we will kill you'. This kind of message has been complained to district health office; however district health officer protected the local staff*[181].

Staff are the pillars of any public institution. In contrast, if there has been ego and conflicts on the basis of locality or carrier or for some minor beneficial, then it would create hampers in health service mechanisms like in the case of Gajul health post. This case study shows how local health institutions are used as a space to contest political ideologies where patients and their health related expectations are kept in low priority and the contestation to fulfill the agenda of the powerful class becomes high priority.

4.11 The Libang Ayurved Hospital: Common consensus in development

After the second rise of democracy in 1990, the Libang Ayurved Aushadhalaya was initiated in Rolpa. Since 1990 to 2005; the Ayurvedic Aushadhalaya was not functional in its own building. Initially, the Ayurvedic hospital was shifted from the Libang VDC to a home

[180] Personal Interview- August 7th , 2013, Gajul, Rolpa
[181] Personal Interview- August 8th , 2013, Gajul, Rolpa

of local residents, Chunamani Acharya and Madhav Acharya. Meanwhile in 2005, the Libang Ayurvedic Aushadhalaya was upgraded to a District Ayurved Hospital, subsequently, this decision has created supportive environment to move forward to build up the District Ayurved Hospital. Many people in Rolpa do have deep grievances about the placement of the Mizhing Ayurvedic Aushadhalaya in vicinity of the powerful political leader of the Panchayat government Balaram Gharti Magar's house. Later on the democratic government decided to establish a district Ayurvedic Aushadhalaya in the district headquarters of Libang, but this decision supported to concentrate Ayurvedic institutions only in the Eastern region of Rolpa. This research has documented plenty of evidences of contestations to shift the allopathic health institutions from its original location to another location in the case of the health service system development in Rolpa, since both Ayurvedic institutions are in the eastern region of Rolpa, except minor debates, many people of the Western region do not have much grievances regarding centralization of the Ayurved institution only in the Eastern region. I assume either people do not expect a lot from the Ayurved system of medicines or the Civil War has diverted the attention of a large section of the people during the time of the decision. Libang Ayurved district hospital has been constructed during the extreme days of the Civil War in Rolpa. The involvement of local actors, their sense of commitment to accomplish the task of construction, despite hard-hit of the Civil War has significant implications from local governance point of view. One of the members of the Ayurved hospital development committee has mentions:

> *When government used to release budget for Ayurved Aushadhalaya, we used to have tension whether to buy land or to build the building. In district headquarters one hand land is shortage on the other hand because of growing monetary value, nobody donates the land for public institution like in earlier days. There had been frequent proposal to construct building for Ayurvedic Aushadhalaya. However, we were suggested to manage land at local level. Then after DDC has accepted to provide 470 sq. meter land to construct the building of Ayurvedic Aushadhalaya, however, because of sudden rise of civil war, we were in confusion whether to gear up construction process or not*[182]*. (Interview- August 17th , 2013, Libang, Rolpa)*

According to the provision of the government for the building of any health institution, it should have its own land. Since many people were displaced from remote villages of Rolpa, they began to live temporarily and permanently in the area of district headquarters of Libang. As a result, the price of land has been drastically increased and the growing population has

[182] Personal Interview- August 18th , 2013, Libang, Rolpa

occupied most of the land in the district headquarters. Similar to other selected institutions, in the initial phase, the Ayurvedic Aushadhalaya has also faced crisis to stand on its own location. The Chairperson of Ayurved Bikas Samiti states:

> *During Civil War, it was very challenging to transport rods and cements for building construction. Frequent army checking on the way used to hamper the transportation of building materials. During construction, we had to face different kinds of upheavals, contractor ran away after performing some level of work. Again, there has been new step forwarded to renewal the project with supplementary budget. This building was built in total cost of 2.2 million Nepalese Rupees (22 thousands USD). Contractor might have taken genuine profit but could not corrupt the process in grand scale. During the phase of construction with Ayurved in charge has taken initiative. In the time of necessity, we used to conduct meeting any time. At that time, we have developed common minimum agreement not to show any political intervention that may ruin development activity. Though we were from different ideological background, we took local development agenda as a common necessity.*

Despite the hard hit of the Civil War, the building of the Libang Ayurved hospital has been constructed without visible and noted financial corruption. I have observed outwardly and inwardly, that the building has been satisfactorily built and justifiable according to the allocated amount of budget. The Ayurved development committee has given proper attention in the leadership of the Libang Ayurved hospital. During the days of the Civil War, there used to be very few development activities in the local level, as a result, rather than staying idle, it would be convincing for the contractor to perform the work with a low profit margin. I have interviewed many local people in Libang, nobody has any serious complaints regarding the final outcome of the Ayurved building in comparison to the allocated budget. Since the development committee has conceptually agreed to join hands together in the case of the local development initiatives and done rigorous monitoring, it was not possible for the contractor to perform any kind of negligence. In comparison to other health institutions in Rolpa, despite having diverse ideological backgrounds, the common consensus developed among the stakeholders worked as a collective strength to execute the building process in a convincing manner. Similar to other allopathic institutions, this Ayurved health institution is facing different kinds of techno-managerial problems like other health institutions in Rolpa. In charge of Libang Ayurvedic hospital says:

> *There has been delay in tender process; essential medicines are not coming since last six to seven months. We do not have sufficient staff. The post of Ayurvedic doctor has not been fulfilled yet. If some staff takes leaves for exam, we will have problem in service delivery. It would be better if we have also laboratory facility. Moreover, if we can also mobilize FCHV like allopathic system it would be better. Just like in*

Allopathic health post, they have ANMs and VHW; we do not have that kind of posts here in Ayurvedic orientation. We are not getting any up gradation training since seven years. In the age of information it would be better if we can use computer, fax and photo copies. It would be easier to work if we can computerize our manual work[183].

The eight five-year plan (1992-97) writes, health institutions will be helped to become financially self-reliant as far as possible. In the adoption of this policy due consideration will be given to the principle of social justice as well. There have been concerns to make the local health institutions self-reliant; in reality the government assurance of 'self-reliant' in its policy document sounds like the jargon operates only on Crusoe's island, where the district level health institution has to face difficulties even to buy simple logistics like computers and fax machines. According to the tender policy of the government, district level health institutions have to rely on the central level department. Moreover, the centralization of the Ayurved health institutions in the same region has even ignored the notion of social justice. The forceful centralization of the Ayurved service only in the Eastern region is excluding a large section of people from peripheral regions of Rolpa, consequently, people from the Western region have to walk difficult hill trials for two to three days, if they want to access services from the Ayurved health institutions. According to the National Ayurved Health Policy of 1995, there will be thirty bedded regional Ayurvedic hospitals in the Western and the Far-Western regions in the coming three years. Initiatives will be taken to establish thirty Ayurvedic dispensaries every year. Even a decade or more years have passed; nevertheless there is no existence of such Ayurvedic hospital either in the far Western region or the Mid-Western region. Similarly, the lack of local elections is creating a problem in the Ayurvedic Aushadhalaya as well. The composition of representatives like Chintamani Acharya, Hari Prasad Acharya, Rana Bahadur Sen, Madhav Prasad Acharya, Dwarika Shah and acting Local Development Officer are the members of Ayurved Bikas Samiti, that is supposed to take care for the Libang Ayurvedic Aushadhalaya, since the local election has not been held. As a result, the process of a new management committee formation has been inactive.

At present, the Ayurved system of medicine is going through an identity crisis in its implementation. The theoretical acknowledgement of medical pluralism in the Nepalese government system of health is not a sufficient endeavor to protect the practices of Ayurved on the pragmatic level. As medical practices based on indigenous values and systems,

[183] Personal Interview- August 19th , 2013, Libang, Rolpa

Ayurved is facing lot of philosophical and pragmatic crisis in its practices. One of the staffs of the Libang Ayurved Aushadhalaya mentioned:

> *Ayurved is highly neglected; government has not shown any attention for its overall betterment. After being victimized in allopathic system, finally patients come to us in chronic stage. In the case of Gastritis and gout, people trust us more. Even patients with the problem of diarrhea, fever, typhoid, Jaundice and other minor injuries do come here. It would be easier to diagnose the problems, if we can use pathological, radiological or other diagnostic support to identify the symptoms of any diseases. If we do not use supporting technologies then it would be like looking down and hunting a flying bird*[184].

Traditionally, the Ayurved system has is facing a severe identity crisis to maintain its originality and simultaneously following the burden followed symptomatic treatment and there have been practices to understand the symptom of any disease in the malformation of *kapha* (Sputum), *bata* (Phlegm) and *pitta* (Bile). The Ayurvedic system of treatment of maintaining evidence based practice like the allopathic medicine. If any Ayurved practitioners seek allopathic diagnostic technologies to diagnose any diseases then it is a sheer case of bio-medicalization and it would be difficult for Ayurved medicines to protect its originality and to serve the growing expectations of the patients. Citing Cant and Sharma (1999) Baer (2016 : 156) writes: "Consequently, there is a sense in which alternative medicines, besides liberating and empowering, actually "remedicalizing' many areas of life, and it is not difficult to see that there is a consistency between certain capitalist values and the values inherent in many new health practices." In the growing competition with the modern medical market, there has been a rapid bio-medicalization of Ayurveda, and many prescriptions and alternative therapies are one way or another of supporting the profit making greed of the market oriented consumerism, which is evident in the context of Rolpa as well.

[184] Personal Interview- August 19th , 2013, Libang, Rolpa

CHAPTER V

5. Social sufferings in Rolpa: The cost of political traumatization.

Even though there has been a plethora of efforts to emancipate human being from its suffering condition, many people from various regions of the world are coping with different nature of social sufferings. In such condition, sufferers' experiences is important to understand how socio-political institutions shapes the experiences of human being's pain and sufferings in a particular socio-historical context and creates sociosomatic[185]effects. Moreover, this chapter is mainly focused on exploring the dynamics on deplorable conditions of social deprivations from the silent stage of ill health and vice versa, and countless numbers of unreported cold deaths which are a by-product of institutional coercions and systemic partialities. As Nguyen and Peschard (2003) write in the edited volume by Singer and Erickson (2014 :165), "Mistrust and powerlessness are not diseases, but human beings are sensitive to power relations". In fact, the condition of mistrust and powerlessness that supports to create physical and psychological alienation leads to diseased generating conditions in many cases. As Kleinman *et al*. (1997:) writes,

> *Social suffering takes in the human consequences of war, famine, depression, disease, torture-and the whole assemblage of human problems that result from what political, economic, and institutional power does to people, as well as human responses to social problems, as those forms of power influence them.*

Either it's a hegemonic form of political power or exploitative forms of economic power, social sufferings as a humanist dimension try to understand how these forms of institutional power systematically marginalized the voices of voiceless and perpetuating unintended tragedies in the society. Moreover, it further seeks to understand the collective and organized effort to counter such type of structural violence imposed in the name of "social order" and "institutional harmony". As Pool (2005:22) writes, "Being present and directly observing a social phenomenon gives us a better understanding and more insight than simply asking about it, but having actually experienced it directly adds a whole new empathic dimension to that understanding". Therefore, in this chapter an attempt has been made to understand everyday experiences of sufferers in relation to complex socio-political dynamism of social sufferings. Likewise, it will explore the relationship between culture, health beliefs and

[185] Social effects on individual physiological responses, known as socio-somatic effects, where social relations affect the interaction between mind and body. (Winkleman 2008)

practices and social conditions that generate such kind of sociosomatic effects. Maskarinc (1998: 243-244) writes,

> *Everyone has a story to tell, a purpose for telling it, and various objectives to accomplish through the telling. Realizing that much of the social reality is constructed through narrative and that such narrative are context bound, we need to pay careful attention to each version of 'history', without necessarily endorsing any as having privileged and unproblematic authority.*

Sufferers may develop a higher degree of trust to healers and researchers rather than with their family members, or they may not develop any trust to the "outsiders". As Kleinman (1980:52) writes, "An individual is a "sick family member" in one setting, a "patient" in another, and a "client" in yet another context (cf. Fox 1968; Siegar and Osmond 1973; Twaddle 1972) in each setting, his illness is perceived, labeled and interpreted, and a special form of care is applied." This special form of care could be both contextual and conditional to many people because of changing identities where chances of the same illness experiences can be perceived in different perspectives in different context. Therefore, illness narrative that has been expressed to a researcher could be different from the narrative that has been articulated to family members or healers. In such situation, the psychic reality which people share to articulate his /her pain, and perpetual reality that researchers have to document in the process of ethnographic textualization, may distort the actual experiences of sufferers. As Pool (2005:33) observes, "illness stories told to a doctor differ from those told to friends in the home, and both differ from those told to a researcher". The situation of divergence realities where the same illness narratives of the same individual varies according to time, space, and location, consequently, the collective picture may be hidden and censored reality may not portray the sufferer's actual picture in totality.

As I outlined in the previous chapter, since the civil war, the health service system in Rolpa is not fulfilling the expectations of the people. The concept of the 4As (Availability, Accessibility, Affordability, Attainability) and 3Ds (Delay in seeking care, Delay in reaching care and Delay in getting care) model developed by Collins (2006) in health seeking behavior has been operationalized to understand the pattern of health seeking behaviors in relation to broader conceptualization forwarded by Alma Ata declaration. In terms of accessibility, Alma Ata (1978:59) describes,

> *Geographical accessibility means that the distance, travel time and means of transportation are acceptable to the people. Financial accessibility means that whatever the methods of payment used, the services can be afforded by the community and the country. Cultural accessibility means that the technical and managerial*

> *methods used are in keeping with the cultural patterns of the community. Functional accessibility means that the right kind of care is available on a continuing basis to those who need it, whenever they need it, and that it is provided by the health team required for its proper delivery.*

Since Alma Ata has further described the notion of accessibility in terms of geographical, financial, cultural and functional accessibility, every aspect of these accessibilities is crucial importance to shape the health seeking behaviours and illness experiences in Rolpa. Kleinman (1988:185) writes, "We must inquire into the structure of illness meaning: the manner in which illness is made meaningful, the process of creating meaning, and the social situations and psychological reactions that determine and are determined by the meaning". Following this notion, I have purposefully interpreted those narratives and events which are supportive to construct new dynamics of social sufferings in Rolpa. Therefore, to understand the dynamics of structural violence, the lens of 'events' and 'people's narratives' has been used to objectify the social facts, where every event has a socio historical context and significantly represents the dynamics of social sufferings as a by-product of political traumatization. As described in the operational definition, the concept of social sufferings defined by Kleinman, Das and Lock (1997) has been followed to develop the contextual understanding of pain, illness, and other kinds of social tragedies. In this chapter, it has been attempted to explore the agent-structural relationship in relation to existing power relationships, therefore, contextually social sufferings is a more appropriate terminology rather than specific term like pain, illness or grief.

5.1 Bamboo basket in Rolpa hills

Most of the regions of Rolpa are not connected with roads. Wherever roads exist, lack of transportation services prevail even in district headquarters and some of the peripheral areas adjoining to Pyuthan, Salyan, and Dang. Regarding Rolpa, due to limited options for transportation the distance and time varies to reach health centers. It can range from two hours to three days long, therefore many people have to use bamboo baskets (*Bansh ko Doko*) as a medium for a 'indigenous ambulance' to transport patients. Especially in Rolpa's peripheral areas, where people have to walk normally two to three days to even see the vehicles parked in district headquarters, there is no other option to transport patients and physically disabled people to health care institutions. Justice (1986:84) has also observed the same in the past, "In this hilly area, some patients walked five hours to reach the post. Those who could not walk were carried in back-baskets or on stretchers". However even after the

three decades of Justice's observation, the usage of bamboo back-baskets is equally significant in the life of Rolpali people to reach health institutions in any kind of biophysical complications. In substitution of bamboo baskets, people may use carriers (stretchers). However the stretchers can also carry a single person; bamboo baskets are used frequently to transport patients because of their better manoeuvrability. One of the patients I met in Mirul, was taking rest on the way to the district hospital mentioned,

> *Please do not ask how it feels, it feels guilty to ride in the back of another human. You can see, it's really uncomfortable to sit in Doko in constricted position like this. In narrow trials, it's too scary if carriers legs would skid, both of us could fall in the river. We do not have motor roads (batoghato) here in the hills, since there is no better option, rather than dying, we have to give trouble to our family members in the time of necessity....I really don't know when there will be vehicles to carry us to the hospital . The sorrow of the hill life (Pahadi Jeevan ko dukkha) is not expressible*[186].

In this case, a sick woman of sixty has been carried to the district hospital for her check-up which is not easily accessible from geographical point of view for most of the people in Rolpa. Since her son was in Gulf country, she has requested one of her neighbours to take her to the district hospital and she paid two thousands Nepalese rupees. In this case, the hardship of the patient gets even worse during the rainy season as the patient's family and visitors have to cross many narrow and slippery trails. It's not only non-accessibility of health institutions, the lack of good roads and social support also adds to the vulnerability and suffering. Especially at a time (of illness) where many people suppress their illness experiences as an unavoidable circumstances generated by structural vulnerability. Similarly, I met another person in Kureli, who was carrying his old mother in bamboo basket to take her to district headquarters in Libang to solve a legal dispute with his elder brother. It was about the sharing of the inherited property among the brothers; therefore, the physical presence of their mother was sought legally at the revenue office located at district headquarters. The elderly woman was crammed in the bamboo basket as her son carried her to Libang, which is literally one day active walking distance from the location where we met. The elderly woman reached there through many hindrances just to satisfy the legal procedure prescribed by bureaucratic authority. The power dynamics has created a powerless situation for the son and his mother in order to follow the ruling which further led them to do a long journey to district headquarters to solve the legal problems.

[186] Personal Interview-05 August, 2013, Mirul, Rolpa

I have observed significant numbers of patients in the district hospital during my fieldwork who were admitted due to accidental cases like fall down from vertical cliff while collecting grass for livestock and other fractured cases related to topographical vulnerability of the district. At Grahamjhim I observed, an elderly man carrying a woman in a bamboo basket accompanied by two other people. The woman from Thabang went to buy oranges in the upper part of Iribang, which is one day active walking distance from their home. On her way back home, she got unbalanced and fell down on the rocky trail. After sometime her leg became swollen, since the nearest health post is four hours from the place of the accident, they took shelter at a stranger's house for 2-3 days for a local bone setter's primary healing, however her injury was not cured. Later, they offered two thousands rupees for two local persons to carry her and the oranges in the baskets to her home. In reality, the amount of money she spent for carriers is more than she would make from selling one bamboo basket of oranges in a rural setting like Rolpa. In this case, the injury as a primary factor got intensified to secondary level and pushed her to additional financial loss. WHO (2009) reports on health inequity mentions, acute and chronic ill health have different social and economic consequences for different social strata, e.g. catastrophic illness can cause or exacerbate household poverty among disadvantaged groups where there is no social protection. In this case, a lady from rural village has to bear additional financial loss created by topographical vulnerability of the trek in Rolpa. Often the minor technical dimension of injury expanded into additional economic and emotional complications if there are a lack of minimum facilities like road, transportation to get on time basic health care that responds to the needy.

In another incident at the district hospital, a drunken old person is attempting to keep his wife in bamboo basket, some health workers were stopping him, when I asked him about his grievances, he was repeatedly saying "I am very satisfied with this hospital, but I don't want to keep my wife here. Now I want to take my wife to my home. Now, I do not need anything except taking away my wife from here[187] ". Since there was no improvement, he got frustrated and was not interested to wait for even his sons and daughters. His wife needed blood transfusion for which this hospital was not equipped to. After few days in hospital; he realized that her health was not improving and mentioned that rather than spending time here in trauma she could die peacefully at home. Later on, the hospital staff stopped him forcefully, however after a few hours of his constant pressure, the hospital discharged his

[187] Personal Interview 2008 December, 12th , Reugha, Rolpa

wife. The hospital staff informed me that the woman had died next day after getting discharged from the hospital. The patient needed blood transfusion and since there was no facility and the visitor was also a "non-cooperative fellow" (*Kichkiche Manche*) finally they discharged her from the hospital. This is a serious nature of institutional failure perpetuated by government health institution in Rolpa. Likewise the way hospital staffs blamed the attendant as a non-cooperative fellow (i.e. Patient's husband) for forcefully taking his wife back home, is the example of intentional attempt to hide institutional inefficiency. Moreover, many innocent people cannot relate the causes of suffering to the failures of the dominant institutions and it becomes unpredictable to understand certain forms of professional power which are manipulating their ill fate. Moreover, I have observed how simple inefficiency in HSS can create unimaginable social sufferings and perpetuate pain in an ordinary human being, a patient from Hawama mentioned,

> *I had a problem of swelling. I relied upon shamans and faith healers very much. But they could not heal me. I spent more than one Lakh on shamans and faith healers. I was admitted in the hospital for ten days in Kathmandu. Doctors have suggested me to change a valve of my heart. Until date, I have spent more than one lakh fifty thousand rupees. I have managed this amount of cost by eating simple food and saving money. I have requested my elder brother not to spend this much of amount for my treatment, but he did not listen. Now again, I have to arrange another 17,000 for a single valve. My husband is working in Saudi Arabia. I have three kids. Now I have to take an injection every three weeks. I have to leave my children in the village. I like to meet my kids as soon as possible. I have not met them for the last thirty-three days. I cannot sleep properly. I am staying in the district headquarters with my cousin*[188].

In this case, the district hospital report shows, the lady has been diagnosed with rheumatoid heart diseases with atrial filtration and chest infection. As per suggestion of medical prescription, she has to take injectable Benzathine G 1.2 million units in every three weeks. Prior to this injection, it is necessary to check allergy with this medicine. The health worker in sub health post denied giving this injection, because he was not confident to check allergic reaction. Apart from inefficiency to deliver technological support in the time of care, the expenses which she spent a great deal of money to treat her problem is leading to out of pocket expenditure to avail public health facilities which has even created financial burden to her family members. Since the problems are not treatable at primary and secondary level, the forced journey to seek tertiary care centres to avail better health care increase medical loan and financial burden similar to many abovementioned cases. This kind of financial burden

[188] Personal Interview 2008 December, 12th , Reugha, Rolpa

penetrates at very personal level and creates social distress and emotional sufferings. On one hand because of poverty and conflict induced forced migration, she has to live a separated life from her husband, and on the other hand, because of inefficiency of health workers, again she is living separated life with her family and small kids. "In the experience of illness, and effectively silenced the patient's experience, by subjecting it to the categorize and control of medical thought" (Frank 1995: 7 cited in Bury 2005). In this case, the patients illness has been powerfully controlled by medical regimen where she has to obey medical thought in order to get "cured". Like in the case of this patient, the dynamics to understand the pain of separation is not within the understanding of dominant medical thought which is even operating in psychological and emotional level. At present, because of 'medical control' to take Benzathine penicillin injection for rheumatoid heart disease in every three weeks she has to live separate life from her family. Likewise, the ill functioned mechanism of Sub Health Post (SHP) and Health Post (HP) directly creating the situation of overburden in the district hospital. This highlights the plight of women, when husband migrate and suffering caused due to the illness and caring for children. The case is an indicator to understand the dynamics of institutional inefficiency on health and its malevolent role to fuel the social suffering of the people. Likewise, a woman I met in district hospital from Rangshi VDC mentioned,

> *I had a stomach pain, I had taken an injection but it was not cured. I came to this hospital with three children, my husband is working in Saudi Arabia. We have spent one night on the way, and I had to spent money to feed my children during the journey. It takes more than one day to reach my home from here. Today we were in a hurry to catch up with the doctors on time. So me and my kids have not eaten proper food the whole day*[189].

If health service is not well equipped and non-responsive to minor ailments, consequently, it's the people from marginal area who have to suffer from institutional failures. The situation compels them to opt for long journeys from their home which directly increases their medical expenses. Like in this case, if patients have to undertake long journeys to reach a district hospital on many occasions it affects the life of their siblings and family members also. In this event, most of the important staffs of district hospital including chief medical officer were attending the programs organized by NGO in district headquarters. I have observed, after waiting for long hours, women were able to see a doctor in emergency. Staffs of district hospital supplemented my observation, "If there is a program from NGOs and INGOs, our

[189] Personal Interview-2008 December, 12th , Reugha, Rolpa

doctors do not care about the patients, because they give good amount of attendance money (*Kham bandi*) in envelope" *(Interview*-2008 December, 12th , Reugha, Rolpa) . It was a crucial situation to observe even there was no medical, para-medical staff to provide any emergency care to the patients at that time. According to the institutional framework of the Department of Health System and Ministry of Health in Nepal, this referral hierarchy has been designed to ensure that the majority of population receives public health and minor treatment in places accessible to them and at a price, they can afford. Moreover, the inefficiency of SHP and HP has pushed her to reach district hospital with many difficulties trekking the forest terrain. In such kind of situation, walking through narrow trails with three small children and spending the night on the way is an extremely severe form of social suffering that a patient has to bear because of the malfunctioning of Rolpa HSS. In the time of financial hardships, where day-to-day life is entangled with different forms of burdens to be performed in order to manage daily subsistence possible, for most of the people ignoring their own health becomes a preferable option. As a result, people visit a health service system only in chronic stage and seeks immediately available treatment like randomly available painkillers to suppress the pain. Illness narrative of above case shows similar kind of health seeking behavior and response towards the pain suppressing pattern that Molnar (1981:196) has observed three decades before in the context of Rolpa. As she observed,

> *Villagers have been exposed to the use of injections to cure tuberculosis and other major disorders and have the belief that injections contain stronger and 'better' medicine than tablets or capsules. The use of injections to kill the pain is misuse of power which mal-practitioners of biomedicine inflicted over people´s body´s for monetary benefit. They want, therefore, to be given an injection in place of a series of pills, and they feel that the health workers are refusing them injections simply because they contain more expensive medicine.*

The situation that Molnar has observed nearly before three decades has been continued in Rolpa even at present days; I have encountered many instances where people prefer to take painkiller injections just to suppress pain and to continue their work in Rolpa. In Rolpa, rampant trend of suppressing pain by taking painkiller injections has purely a market derived phenomena where local medical shop owner (*aushadhi Pasale*) makes easy profit by prescribing injections and patients also feel instant relief which help them to continue their work for some time. Paudel *et al.* (2015) has explored the incident occurred in Budhagaon. According to them,

> *A respondent from Budagaon 7 told us that his wife died because she received the wrong treatment at a nearby private clinic in Budagaon. A health worker had referred her to the district hospital but she chose to go to the private clinic because the district*

hospital was three hours away and too expensive to get to. She took the medicine and pain relief prescribed by the clinic but one night she died, vomiting blood. The post-mortem showed she had been taking the wrong medicines prescribed by the clinic for her condition for a long time.

In this case they further mentioned that it was too late for her husband to know that he can sue the medical shop owner. The construction of psyche to use painkiller injections directly gives financial benefits to those quacks and other private practitioners and also console patients temporarily to avoid bodily pain as physically and emotionally disturbing phenomena. The medicalization of pain has altered the values that in many cases people take pain killers at medical shops as easier option as compare to visiting government health institutions and following lengthy treatment procedures. In many instances, it's not only due to low level of health awareness that play role to avail health service lately, the geographical accessibility of health centers also forced people to delay in seeking care. Similarly, one of the patients, I have interviewed in Sulichowr PHC mentioned,

Yesterday evening I was going home from my wetland, it was already dusk and I was in a hurry to go home. Suddenly, some guys were shouting and suggesting to me to be careful because a stone was falling down from the hill. I thought, I can escape that stone. I tried to walk quickly, unfortunately that stone hit me. I could not protect myself and got seriously injured. Someone on the way conveyed this message to my home. With great difficulties my wife took me home. The whole night through I was having severe pain but it was not possible to visit a health post that night. Because we could not arrange anyone in night time to carry me in Doko. With the help of my brother, I could manage to come today[190].

Because of the geographical barrier, the unavailability of primary care in the vicinity of the place of accident and the home area of this patient is an important factor which contributed in the delay in seeking care. The case was occurred at a distance of six hours from Sulichowr PHC, because of narrow trails and lack of people to carry him to health centre, patient has spent whole night at home without any basic treatment. Apart from this, social support network and primary counseling of the family members are also the factor which hinder to reach to health care and get timely treatment. Pool (2005:102) writes, "Social relations do not only guarantee protection and support to the patient, but also serve as a means of gaining access to a symbolic token of healing". It is evident that in this particular case, his family members have rescued him from the place of the accident, and brought him home and the next day supported him to reach the health post. Many times if able bodied males are

[190] Personal Interview- 2013 August, 16th Sulichowr, Rolpa

unavailable and women are reluctant to carry patient in night time then it would be another layers of suffering, what a particular individual has to face during the time of illness. The repercussion of female subordinations appears as non-mobilization of female members to carry patients in night time becomes pragmatically "normal" where every spheres of public life has been dominated by males and one cannot expect prompt mobilization of females in the time of urgency only. Due to the distress migration, the reality of Rolpa has been drastically changed these days, in many household the absence of able bodied males has been altering the gender roles but not in that level where prompt mobilization of women can be expected in any kind of societal complications. Similarly, the difficult geography of Rolpa is not supportive to deliver paramedical support to the patients like in the case of testing sputum to diagnose tuberculosis. In the case of DOTS[191] (Direct Observation treatment short-course), there are many techno-managerial problems such as in SHP and HP level, there is no facility of sputum tests, but the health workers are not getting the reports of sent samples on time. Acting in-charge of Thabang health post mentioned,

> *We are not being able to meet targets. It becomes difficult to send patients to other health institutions. There is a problem with sputum check-ups. If we suspect the case, we have to send the patient in person. Once we have tried to send a slide to Sulichowr PHC, it was getting late. It is even difficult to send only a few slides. We have to collect more slides, but by that time patients will have tremendous problems. Rather than sending slides, we send patients themselves. Patients also feel more confident that they finally get good treatment in a big hospital*[192].

This narrative is significant to understand how government programs are more focused to achieve "targets" rather than to improve the qualitative indicators of health. The active walking distance from Thabang health post to the nearest Sulichowr PHC or district hospital is completely one day active walking for a normal human, which literally means someone has to start the journey early in the morning to reach destination in the evening. The unavailability of appropriate technology, and delay in diagnosis, in charge of Thabang health post has admitted that health workers has to start DOTS without having evidence of tuberculosis. After a few days when sputum result arrive at health post level, if the laboratory report diagnosed the false negative for sputum test, patients do not continue medicine afterward. The lack of accessible quality services at institutional level creates confusion to follow treatment regimen for many patients. The relapse or failures cases in DOTS has

[191] DOTS are the strategy for the TB treatment. In Rolpa, all the VDCs are covered by the DOTS and there are 4 microscopic centres where diagnosis by microscopic facility is available.(DHR 2013/14)

[192] Personal Interview : 20th May, 2013 Thabang, Rolpa.

directly relation to the failures of public health system to response the health needs of the population rather than blaming the victims for not seeking for proper treatment. Since difficult geography, low level of health awareness and hardships of rural livelihood prevents many people to visit health centres regularly, in reality the choice of the patients and their sense of urgency are determined by the accessibility of the institutions which should be both attainable and affordable. People from Eastern part of Rolpa like Gajul and Phagam visit Sulichowr and also from northern region like Thabang, Uwa, and Gam VDC visit Sulichowr to get medical services and district hospital becomes an odd location for many people especially from northern and western regions. If problems are not getting cured within the district, people visit different health service centres of adjoining districts like Dang, Chitwan, Kathmandu and hospitals in Indian borders and even to Delhi in search of better health care facilities. The decision to visit tertiary care centres beyond the locality is largely affected by social and economic status of the people they possess in the society. In reality, for a large section of deprived population in Rolpa, the expensive tertiary care facilities becomes unattainable from both logistics and financial point of view, which eventually forced them to cope with either locally available best possible options or accept silent sufferings with more deviation from health.

5.2 Targeting the bodies in civil war.

A decade long civil war in Rolpa has created institutional stagnation and human sufferings. During war there was no existence of the state administration, police stations, post offices and other government agencies outside the district headquarters during the active days of civil war in Rolpa. Since CPN (Maoist) has escalated violent activities against "old feudal states," in reaction to suppress the arms insurrection, the Nepalese state launched various counter-insurgency military operations mobilizing Royal Nepal Army (RNA) and other paramilitary forces like Armed-police force (APF). SAFHR (2000) writes, "Military operation like Kilo Sierra 2 in 1998 had resulted in extra judicial killings, disappearances, arbitrary arrests, rape and torture". Unlike Romeo operation that was targeted to suppress the supporters of ULF especially in Rolpa and Rukum, Kilo Sierra 2 was arbitrarily targeted in most of the Maoist influenced districts of the country. Supporting this argument, Thapa and Sijapati (2003) write killing of Maoist supporters and other civilians escalated to unprecedented heights in 1998. Kilo Sierra II performed in this period was spread out across all the "Maoist affected" regions of the country, while operation Romeo had concentrated on a particular area in the western hills. Frequent army operations during a decade long civil war in Rolpa have resulted in unprecedented level of tragedies and loss in rural life. It was not

only the civilians, but causalities among Maoist fighters and RNA used to be very high and conflict has induced the suffering beyond the human's imagination in Rolpa. Aryal (2005) writes, suddenly some dogs in village started to behave as mad and rabies infected. They started to bite local people and livestock. Villagers killed those dogs. Later on, it was identified, when there was an attack in Ratamata tower in Salyan, many corpses were left out. Local dogs have eaten big amount of human flesh, then after, they started to show that kind of symptoms. The trauma of civil war in Rolpa has reflected in pathetic stage where animal beings were also affected to the extent; ruthlessly they induced additional complications in people's life. One of the local residents from Badachowr mentioned, "In Sankatkaal many people from Ranghsi, Rank, Jinabang, Mirul, Thabang, Jelbang, Uwa, Gam and Hadjan lost their lives during an army operation. In Gumchal Village development Committee, 68 people were killed in single place including pregnant women and common passersby on the way. Singer *et al.* (2014:228) writes, "Inflicting pain, injury, and death not only on combatants, but increasingly on civilian populations who may be targeted as a form of terror and control". Many local people from those areas which were targeted to suppress the rebellion activities became more hostile and many of them joined CPN (Maoist) just to save their own lives or to take revenge of killings of their kith and kin murdered during army operations and fake encounters. As Nordstrom (1998) writes, if political will is a dynamic attribute of one's self and identity, killing a "body" will not necessarily kill the dynamic font of political will. During Rolpa, the act of targeting bodies has not suppressed the political will of people; instead there has been aggravation of aggression even in larger scale. From both sides, as Berry (1997 :4) writes, "Civilians are targeted because they sustain the warring parties and how they align themselves determines a war's outcome". Maoist political workers and leaders were for sure targeted and if army knew their potential home of hiding, they risked having their homes destroyed. Many people from Rolpa expressed, the psychological terror of the army operation used to be extremely terrible, they used to create psychological terror in the village for many days. Since there have been episodes of war fought against state for a long time, many ex combatants are still living with injured, handicapped and other physical and psychological impacts created by war-induced sufferings. Even Maoists fighters especially women faced different levels of sufferings during war. A lady working as an on the job training staff in district hospital mentioned, "My cousin had joined Maoist movement; she was pregnant those days, later on, I have heard she died because of self-carried bomb in her

back which suddenly got blast during cross fire[193] " The compulsion of joining Maoist movement and carrying bombs despite the pregnant status within the "revolutionary sphere" portrays the complexities of civil war and dire condition to continue fighting despite psycho-physical conditions of the fighters. Moreover, everyday national television and radio used to broadcast News related to two way encounter (*Dohoro Vidanta*) between the "Maoist rebels" and the RNA and disclosing certain numbers of deaths, in reality most of these encounters are one sided fake encounters (*Jhuto Mudvet*) operated by state security force to kill the bodies that may be antagonistic and hostile. Though Media reports the total numbers of body killed in war, moreover, deaths, tragedies and ill health produced by violence and conflict has larger emotional magnitude than quantifying the numbers of dead bodies. Since Thabang village has projected its "revolutionary image," as a village to give birth to communist since Panchayat regime, it was one of the most targeted villages during Sankatkaal in Rolpa. One of the local residents from Thabang mentioned,

> *There used to be frequent army operations, we used to leave our homes for many days. During these operations, the army used to forcefully enter our homes, used to slaughter our pigs, chickens and grab expensive ornaments. Since villagers had to leave their homes for longer times, many women from our village gave birth to their babies in forests and caves. Once, after killing a deaf person in Thabang, media has broadcasted the news that the Nepal army succeeded to kill the local commander of Maoist in Thabang*[194].

Particularly, in this case, for a person with a hearing impairment with learning difficulty it was not possible for him to understand the political reason of Army mobilization in the village and follow the collective decision to avoid the state suppression. When all villagers decided to leave the village, he alone was roaming during the army patrolling, as a result he was shot dead in army operation. Not only in the case of Thabang, there have been other evidences where disabled and deaf people, who could not leave the village were directly targeted and some of them were killed. Pettigrew (2003:13) writes, "One day shortly after that a *lato* (deaf mute man with a learning difficulty) was shot dead by the army as he ran away when he saw them. They killed him because they thought that he was a Maoist". As Pettigrew writes, numbers of physically challenged people lost their lives in civil war. Many times people lost their lives just because of their mere presence in the conflict zone, would be also regarded as potential threats from the state security point of view. However, such kind of murder of innocent people becomes an additional reason to generate hostility against the state

[193] Personal Interview-2013th , 9th August, Libang.

[194] Personal Interview-20th May , 2013 Thabang, Rolpa

for many people in Rolpa. Citing the argument done by physician Jerome Marmorstein (2001), Singer *et al.* (2014: 227) writes, "No matter how war begins, it always ends up to be a devastating form of traumatic disease. Because it kills, injures and disables more people in shorter periods of time than any other known disease, war should be recognized as a true disease epidemic." Consequently, frequent army operations and a long-term tensed wartime situation was a sufficient condition to create mental morbidities in those places, where many army operations had been done in Rolpa. A medical officer in the district hospital mentioned many people of remote villages have complained of symptoms such as anxiety and loud expressions by shouting in the night, arrhythmia and palpitations, PTSD (Post Torture Stress Disorder), ADHD (Attention deficit hyperactivity disorder), erectile dysfunction (ED), hypochondriacs, mild and severe depression and psychosomatic problems with multiple complains in Rolpa. Supporting this fact, one of the health workers working in Rolpa district hospital mentioned,

> *In the initial days of civil war, my father was also involved in the Maoist party, later on some kind of conflict aroused between my father and other party people. Thereafter, they started to torture him. Because of the tension, my father could not sleep during night time. He had hypertension. At that time his mental condition was so disturbed that he was not able to identify a baked bread from an unbaked one. I also started to feel heart vibrations after that incident occurred to my father*[195].

The above narrative is very suggestive to understand how forceful tortures given to any individual during war or other intimidating conditions even create cumulative effects to their family. Moreover, because of her father's case she is also victimized as a witness of violence. Likewise, I have observed a girl who suddenly fell down on the way to go home from school. Her friends mentioned she has seen firing from a helicopter during *Sankatkaal*, if she hears the same kind of sound or images, she gets panic even these days. The occurrence of violent events has frequently turmoil the life of many individuals in Rolpa. As (IRIN 2005) mentions, the physical and psycho-social effects on families, children and women who have witnessed or been subject to violations and attacks will reverberate for years to come. One of the ex-fighters of civil war whom I have met in Thabang has mentioned,

> *I was involved in the Maoist party since 1995. I have participated in many wars. Though I had removed four to five splinters from my arms, some splinters remained in my hip. In summer, I can feel burning in those areas where I have bullets and in winter because of the cold, I feel pain. Once, a mine was blasted close to me, as a*

[195] Personal Interview-16th December, 2008

result, my penis got dysfunctional for three months, after massaging it for a long time, it started to work again[196].

Many physical complications of conflict remain for longer period and this particular individual has to face long term suffering. Even after a few years of the official ending of civil war, this person has to live a life with the pain of splinters remaining in his body. The powerlessness of individual Maoist cadre to remove the splinters even after few years of of civil war has shown how same person is projected as collectively powerful in order to fulfill the mission of political agency; however at the present after political mission is over same cadre is individually powerless to get rid from personal problems. Likewise, it has been observed that conflict induced mental burdens have deep roots and its effects remain for long lasting. Local resident from Thabang has mentioned,

One day after duty I was going back to my home. Unexpectedly, I heard the firing from a helicopter. I managed to reach my home with big difficulties but no-one was there. I could not understand where my wife and daughters had gone. All of a sudden, a bomb blasted nearby, a hundred meters close. The firing was continuing for a long time, while the army did this operation. They took home utensils and destroyed a lot of things at my home. I was wearing a combat dress like the army, because of this cloth I feared that the army could label me as a Maoist. After the firing was over, I searched for my wife and daughters. I found them hiding in the jungle. They took our hens, cocks, alcohols, and looted our old clothes. After that incident, I still feel deep fear, if windows and doors get locked up with a little bit louder sound, I still remember this incident[197].

Either it's a physical reminisces of bullets in people's body or mental reminisces of violence in people's mind, in both cases physical disturbances affects psychological health and vice versa. In this case, the place like Thabang used to be paralyzed for a long time and there was no possibility to run regular schools or health post during the time of army operations. It's not only the many adults having different political ideology were also targeted by Maoists, such as Nepali Congress (NC), United Marxist Leninist (UML) and United Liberation, Front (ULF) and CPN (Masal). One of the political workers of Nepali Congress party mentioned,

I was elected chairperson of VDC. I had caste vote in the 2054 B.S. (1997) election, Maoists had broken my leg in that cause because they were boycotting the election. After that, I went to a teaching hospital. I spent two Lakh ninety thousands rupees for my leg. I had to sell my Khet (wetland) for treatment. Now I can perform minor kind of work[198].

---

196 Personal Interview-20th May , 2013 Thabang, Rolpa

197 Personal Interview-20th May, 2013 Thabang, Rolpa.

198 Personal Interview-2013th , 9th August, Libang.

This narrative shows that how political biases especially during war inflicted psychosocial sufferings in individual level if someone has different kind of ideological stand. The trends of doing ideological interpretation and labeling[199] opponents as certain category like class enemy "*Bargha Shatru"* and spy *"Jashoosh"* used to be frequent trend among the Maoists. Hutt (2004) writes, "The term *hattya* is never used to denote actions undertaken by Maoists squad: they are labeled as *khattam*, which somehow has the neutral value of 'putting an end to' or as *Saphaya*, which may be understood in military practical sense ("cleaning up") or in a moral sense ("purifying")". If someone is demonstrating active hostilities against Maoist, he or she could be dead in the process of *Saphaya*, which means physically killing the opponents in war. Many innocent people were killed by Maoists in Rolpa just under the suspicion of providing information to the state security force; simultaneously RNA also tortured many people in suspicion for having connection to Maoist. The active enrolment in civil war has resulted in physical, mental and social separation of many people in the present days. A lady I have met in a commune hotel in Thabang mentioned, "Army killed my daughter in the war. My husband was already expired. Now I am adjusting myself in commune family[200]". In conflict-affected area like Thabang, many families who lost their husband, wife and children in war have developed new commune family to recover the tragedy induced by war. District secretary of CPN (Maoist) mentioned,

> *In 2056 B.S, (1999 AD) the army had raped 14 women including underage girls. Women who delivered recently and women who went to collect fodder for livestock were tortured, raped and killed during army operations by the RNA. Displaced women and girls were even forced to compromise with different jobs like sex related trade, domestic work and low paid factory labour[201].*

Supplementary to this narrative, Martinez (2003) writes, the high-intensity (more than 1,000 deaths per year) conflict between the CPN (Maoist) army and the government Army has affected the health, education, and other rights of the most vulnerable members of society, especially women and children. Similarly, Hutt (2004) writes, war and direct violence have obviously done great damage to women in Rural Nepal, individually and collectively. During

---

[199] Hutt(2004) writes, investigations of the semantic structures of Nepali Maoists discourse may shed more light on concepts such as 'people's enemy ' ("*dushman*") , and on the distinction between *khatam* (annihilation), and *saphaya* ("cleansing") on the one hand and *hatya* (murder) on the other.

[200] During my fieldwork in 2008, I have also stayed with a Jaljala commune family where many war victims were staying as a joint family. They were running small hotels and kept mules to transfer logistics from Phuliban to Thabang. Though necessity of war brought many victims together, however, by the time of 2012 many families were leaving the commune and began a life of their own.

[201] Personal Interview-2008 , 9th December, Libang.

my fieldwork many people from Rolpa has shared the unethical activities performed by RNA during civil war. During conflict time, it was not possible for police and Army to travel frequently through the way and government helicopters used to drop them. Many Police and Army had taken rent rooms in district headquarters Libang. At that time, many innocent girls were victimized and abused. There is a case of girl in Libang district who was arrested for an illegal abortion after having a relationship with a Royal army man. I met her in Libang district custody, she mentioned,

> *That day I was alone at home. After a while delivery pain began... I felt severe pain and I could not control myself.... to release the pain, I tried to pull the baby out, unknowingly I caught strongly in its neck, so it was not alive..... I knew about safe abortion also..... I was always hoping to meet him and get married, but he got a transfer to another district. I have heard that, now he is married, I am facing this kind of punishment because of him. If I would have to kill the baby, I would have not waited for nine months*[202].

The girl was arrested because villagers found the dead body of the foetus in her landlord's garden. At this crucial situation, the judiciary was not strong enough to punish the member of the Royal Nepal Army. He was brought to the district court and taken for clarification, instead he blamed the lady for not informing him about her pregnant status. Since court cannot accuse him legally, that lady has to bear social, cultural, emotional, and legal punishment. Villagers had mentioned even many other native girls who had relationships with Royal army men were left out in villages and were displaced from their homeland. This case is supplemented by the report published by IDMC (2008), it writes, direct causes of displacement include among others: murder of a family member, threats, violations of human rights, forced recruitment into Maoists forces, taxes, arrests and harassment by security forces. A woman from Tila, who had long-term involvement in civil war said,

> *Villagers have contributed a lot, first they used to protect comrades and protect themselves in war. My husband died in Ratamata tower attack. Now I have to take care of my son and parents in laws. As a member of martyrs' family we were assured to be provided with jobs and get ten lakhs rupees as a consolation amount. However, I got only three lakhs rupees until date. Since the party got split, everybody became frustrated. I am not interested in getting married again. Though my laws expect me to get married, I will not marry again, now that my son has grown up*[203].

To sustain the war, along with "organized revolutionary force" many volunteers have genuinely contributed in civil war. Many ordinary villagers from Rolpa had contributed to carry injured combatants, bullets, and bombs and fighting materials during war. Likewise, in

[202] Personal Interview-16th December,Libang 2008

[203] Personal Interview- July 12th , 2013, Gairigaun, Rolpa

order to feed huge numbers of combatants many people from Thabang and other villages have worked as volunteers and many houses were used for residential purpose. Many people have perception that such kind of genuine labour contributions done during civil war were not acknowledged by any CPN (Maoist). Those people who have contributed labour to sustain war are feeling deep level of frustration because they have spent productive age of their life in order to realize societal transformation. Moreover, in the hill district like Rolpa, as an emerging point of decade long Nepal's civil war, armed conflict has worsened the general living condition and exacerbated the distress migration from Rolpa to different districts of Nepal, India, Gulf and also to other foreign countries as an asylum seekers following different kinds of risky and unethical procedures.

5.3 Sankatkaal and Struggle for health in Rolpa.

During *Sankatkaal*, frequent security checking by both sides, blockade programs by Maoists, and risk of being caught in the crossfire were some of the factors that had discouraged people to visit health centers in Rolpa. Likewise, frequent security checking had increased the duration of time to reach health centers; a woman from Korchabang mentioned,

> *It was necessary to ask permission to travel from one place to another. If Maoist announced a blockade program, at the same time government used to launch suppression campaign. In Sankatkaal, I did not visit health centers because of fear of mines and ambushes on the way. The sub health post was three hours far from my home and it was not possible for me to go there and check whether health workers were staying there or not. In Sankatkaal, if people have some kind of injury, army used to make unnecessary query and give torture. Once they deployed in the village. It was normal for them to damage people's lives. Since there was no easy solution for war injured combatants, I have heard even Maoists threw away the injured person in the river*[204].

It has been observed during fieldwork, the long term absenteeism of health workers in their duty stations has distracted many people to visit government health centers. During Sankatkaal, the surgical problems of villagers used to get more attention from the RNA than medical problems, because the army used to suspect that they might have happened during attacks. Local resident from Libang shared, in one of the incidents, a student was shot by a bullet in the cross fire (*Dohoro Vidanta*) at Chihandanda, nearby district headquarters. It was very difficult to get permission from the army barracks and manage vehicles to take patients outside the district. The process of making unnecessary query deeply harasses the normal psyche of local people that eventually flourish hostility against the security mechanism of

[204] Personal Interview-2013th , 10th August, Libang.

state. While his parents were taking him to the hospital, he unfortunately died on the way. A regular curfew after 7 pm in the district headquarters Libang was another strong reason that people were helpless during the time of emergency. DFID (2003) writes,

> *If medical emergency happened at night, people were afraid to seek treatment and the health workers were afraid to provide it. Although technically it was allowed to transport people requiring emergency medical care during curfew hours, in reality, it was very difficult to take risk. Health workers reported that some attempts to take the risk ,during curfew,had resulted in the unnecessary deaths of patients under their care.*

As DFID (2003) observes, the provision of 'technically allowing patients' to carry to the hospital were rigorously checked by Nepal army to identify whether the cause related to medical emergency, if it was war induced or related to something else. Specially, in those cases fallen from vertical tiff, it would be more complicated to get permission thinking that patient would have involved in war and got fractured while escaping during attacks. In case of big injury and deep wounds, it was not possible for Maoists to visit health institutions on normal trails. They had to explore alternatives paths through forest and hills or the dark trench of the river. District secretary of Maoists comrade Raktim mentioned,

> *Suddenly, police opened fire on the way. I got a bullet in my eye. I fell down from the hill. After that, I woke up and started to walk. Reaching Baglung after one week with a damaged eye. Initially, I had gone to Bhairahawa, but they could not treat my eye because it was related to the retina. I reached Pokhara with great difficulties and got treatment at the Eye hospital in Pokhara*[205].

In comparison to other ordinary people, the situation could be much worse to Maoists combatants because if security force arrests them they may be severely harassed and killed. DFID (2003) writes, people with traumatic injuries (Such as multiple injuries caused by falls from trees and cliffs), or people with large cuts and wounds are often afraid to seek care because they fear that they may be reported to the security forces as suspected Maoists. However, there is a provision that treatment should be provided irrespective of their nature of involvement in war. Article 3(1) of Geneva Convention[206] related to the prisoners of war writes,

> *Persons taking no active part in the hostilities, including members of armed forces who have laid down their arms and those placed hors de combat by sickness, wounds, detention, or any other cause, shall in all circumstances be treated humanely, without any adverse distinction founded on race, color, religion or faith, sex, birth or wealth, or any other similar criteria. (Geneva Convention, article 3 (1))*

[205] Personal Interview-2008 , 9th December, Libang.

[206] Geneva Convention related to the treatment of prisoners of war of August 12, 1949 (Geneva Convention III).

Though ideally Geneva Convention has assured the treatment irrespective of any categories, nevertheless, during the hostile environment of civil war, it was not possible for Maoists cadres to get easy treatment from governments health institutions. DFID (2003) further writes, 'the ministry of Health had issued directives requiring health institutions to record details of all trauma patients. In December 2001, a specific directive from the minister instructed all health professionals to seek permission from the ministry of health prior to treating patients with trauma related injuries. Being a signatory country of Geneva Convention, imposing these kinds of directives by Nepal government was contradictory to its commitment towards international human rights principle. Such kind of coercive attempt which was strategically targeted to identify Maoists network highly discouraged even ordinary people to visit health centers because according to this provision, any kind of injury could be the effect of war and people may get arrested without any fault. Taking consideration of situation, there has been establishment of separate health department under the umbrella of CPN (Maoist), OMSA bulletin writes,

> *Whole timers*[207] *were mobilized and mobile medical Camps were set up in different places. There were mobile people's model hospitals in war time. In mobile camps, OMSA were supposed to perform activities such as Limb Amputation, Haemothorax, Aspiration, Pneumothorax, big wound management, skin grafting and fracture, removing skeletal traction and general plastering. It could be done with the help of headlights, candles and even torch lights. (OMSA Bulletin, ANPHWU(R).*

As I have discussed in earlier chapter, there has been sporadic existence of Maoist's medical camp during war. Shah (2007) writes, army is somehow conducting consolation activities in those areas highly affected by civil war, which is running mobile health camp and helping those injured who are victim between Maoists and police. Many local people mentioned, medical camp organized by Nepal army was targeted to understand the network of Maoist and Maoist medical camps were very occasional and not accommodative for large section of the people. During the dire context of war, the issue of maintaining protocols of 'good clinical practices' is always a challenging task, as a result, medical missions organized from both sides were strategically deployed to explore each other secrets among fighting opponents rather than genuinely contributed to improve people's health.

During the civil war, plethora of evidences suggests health workers had to bear torture from both sides. DFID *et al.* (2003) writes, there was evidence that health workers were being beaten, arrested and abducted by both the security forces and Maoists. Health workers

[207] Whole timers are those political workers who are supposed to work for party on full time basis taking a certain amount of salary.

had to face unlawful pressure to perform tasks for which they were not qualified. Similarly, Aryal (2005) writes, more than 32 health workers were suspected and they had to show their presence at the post of security force in provided date. During my field visit, health workers I have met in Kureli mentioned ,Village Health Worker of Kureli was tortured and beaten up by the RNA; as a result, he has suffered psychological problems. After beaten up by the army, he is mentally unfit, and kept himself in long-term leave. There is no mental health department in any of the health centers in Rolpa. DFID (2003) further writes, the government of Nepal's provision of mental health service is limited and only available in a few urban locations... most health workers reported that most people do not seek treatment for mental health problem because they do not know that assistance can be obtained for symptoms caused by psychological distress Mentally disturbed people are discouraged to visit health centers because of stigma attached to it. Most of the people perceive mental disorder as a symptom connected to psychosis. Sartorius and Schulze (2005:3) writes, "Stigmatization may lead to negative discrimination which in turn leads to numerous disadvantages in terms of access to care, poor health service, frequent setbacks that can damage self-esteem, and additional stress that might worsen the conditions of consumer (patient)". Similarly, as I have mentioned in the previous chapter, the Thabang health post peon was severely beaten up by RNA and the health post was blasted using a rocket launcher. Army has abducted FCHV, they kept her in camps for few days, and later on her burnt body was found in the river beach below the village. In addition, VHW of Jaya Maa Kachala was severely tortured in police custody. In Serum, the peon of a sub health post Dhana Bahadur Rokka was kidnapped and killed by the RNA. Human rights activist and Station manager of Radio Rolpa states,

> *A peon of Ranghsi was accused for providing treatment for Maoists. At that time, there was a big army operation going on. The army reached Serum via Pang and Gam VDC. The army had asked him to carry heavy loads, and then they shot him nearby the river*[208].

There was compulsion for many grass root health workers to provide medicines to Maoist in order to remain safe in Maoist heartland. In contrast, same activities could be interpreted as a highly hostile task from the point of view of state security force. Berry (2005) writes, people shoot enemies not friends at least in politics. Here, government security force perceived serious enmity against government health workers and physically challenged up to the level

[208] Personal Interview-2013th , 10th August, Libang.

where their deaths were counted as a victory over the opponents. According to the principle of ICRC, there is the obligation to respect and protect medical and religious personnel, medical units and means of transport (Berry 1997). In contrary to this obligation, in Rolpa health workers were tortured, killed and displaced from their regular jobs. DFID (2003) writes,

> *In conflict affected areas, health workers face harassment, intimidations or interference when carrying out their duties. There were numerous examples of interference by the security forces with health workers facing harassment, arrest under the Terrorist and Destructive Activities Act 2002(TADA)[209], or searches and seizure all of which have created anxiety and concern".*

Only some low-level health workers were able to develop proper ideological and emotional solidarity with the RNA and PLA decided to stay in the village. As Berry (1997) writes, failures to support one's group as well as loyalty to another group can bring death. It could be fatal for health workers to incline any of the sides and equally difficult for health workers to maintain absolute neutrality during active days of war in Rolpa. Government health professionals in their catchments area had a compulsion to support the Maoist army; it could be with or without their will. One of the health workers from Thabang mentioned, "In Sankatkaal, army had tortured me a lot. They accused me for providing treatment for Maoists. They arrested and asked me to walk wherever they go; I had a very painful experience[210]"

As discussed in earlier chapter, on one hand rural health service in Nepal has to face severe crisis of shortage in essential medicines, on the other hand the forceful utilization of essential medicines and other surgical items have significantly excluded local people to get required amounts of medical resources in the vicinity of their home. In addition, promotive and preventive services like vaccine delivery; vitamin A distribution and organization of vasectomy camp were seriously hampered. Health workers, those I have met in Bhabang and Kureli VDCs accepted the fact that, there were an enormous number of maternal and child deaths that had happened during conflict period and successive years which were even not reported officially. Singh *et al.* (2006:948) explain, "In rural Nepal more than 90 percent of

[209] A terrorist and destructive crime is defined in section 3 of the Act as any activity against the sovereignty, integrity, peace and security of Nepal through intentional disturbance or damage to poverty, lies or health using weapons, bombs, or explosive substances or poisons" (DFID at al 2003). Health workers were at risk because of the incorrect and inappropriate interpretation of this Act by the security forces may harm their personal life and career.

[210] Personal Interview-20th May, 2013 Thabang, Rolpa.

birth deliveries are at home. Women face a one in 24 risk of dying during pregnancy and childbirth, and current levels of insecurity are increasing this risk further, as the conflict is hindering pregnant women from reaching hospitals for delivery". On the one hand, the unsafe deliveries without support of Traditional birth Attendants and Skilled birth attendants were very risky and on the other hand, many women felt insecure to visit government institutions during the time of delivery. Especially in the conflict period, neither were there skilled birth attendants (SBAs) to support delivery in time nor could the frequent mobility by FCHVs and other needy patients be facilitated because of the war. Even in the post conflict period, many times vaccine supply was not regular. A patient came to check up in the district hospital mentioned, "In conflict period, "Doctors[211]" were not available at the health post; we had to rely on faith healers and shamans[212]". Since there used to be absenteeism of health workers in conflict zone, it would be plausible to argue, as one of the active districts to host decade long civil war, there have been countless of visible and invisible damages occurred in both health service provisioning and accessing dynamics that has affected health seeking behaviour among general masses in Rolpa.

5.4 Shamanism induced suffering in Rolpa

Developing health workforce according to the felt needs of the community is one of the crucial tasks of health service system. Apart from formal existence of health related workforce and medical practices, informally various forms of healing practices exist among different communities and regions of Nepal. Official health policy of the country has acknowledged the notion of medical pluralism; however there is a large gap among the different varieties of practitioners and their professional status. Even though under the domain of institutionalized care, there have been large differences among biomedical practitioners in terms of exercising authority and power as a health practitioners. Alma Ata (1978 : 61/62) writes,

> *The types of health worker will vary by country and community according to needs and the resources available for satisfying them. Thus, they may include in different societies people with limited education who have been given elementary training in health care, "barefoot doctors", medical assistants, practical and professionally trained nurses, feldschers, and general medical practitioners, as well as traditional practitioners.*

[211] Colloquially, there is a trend of saying doctor to every medical person in rural village, even people say doctor to peon of health institution.
[212] Personal Interview-2013th , 10th August, Reugha, Rolpa.

Though variation of health workers have been realized in Alma Ata (1978), however it has not mentions on knowledge level that is required to health workers to treat the patients. Likewise, power relations and unhealthy contestations among different kinds of health workers to control the resources have created confusing situations for many people to select appropriate treatment. Since there has been both formal and informal knowledge system is available in Rolpa to response the health related needs of the people, this section will explore the patient´s experiences to access traditional practices in different patho-physical and psychosomatic problems. Accessing health service facility as an institutional support is completely an exogenous culture for many people who were basically relying on traditional healing practices in Rolpa. The existence of shamanism (*Jhankri*) and faith healing (*Dhami*) is one of the structurally rooted traditional practices in Rolpa region which are colloquially known as *'Jhankri bashalne', 'Dhami lagaune', 'Janni dekhaune','Jharphuk garne'* etc. In traditional healing practices to identify evil power that creates harm on the people, *Dhami* and *Jhankri* have different kind of ritual traditions and follow separate types of signs and symptoms to identify supernatural causalities like *bokshi, vhut, maraha, baan, mashan* and *deuta*. As Molnar (1981:17) has observed,

> *Most illnesses are treated by the local shamans (Jhankri's), or by the local astrologers (Jaishis) (Nepali Jyotishis). People seldom take a sick family member to the hospital as the trip is long and strenuous and villagers are afraid of dying along the way far from their kinsmen.*

Similar to the observation done by Molnar (1981) three decades ago, even in present times' in Rolpa many people do not visit health post as a first priority. At first people visit faith healers, shamans and finally visit health centers. At present, in comparison to Molnar's observation there has been presence of allopathic medical practitioners and health related awareness have increased drastically in Rolpa, however the factors like non accessibility of health institutions, financial hardship and geographical and cultural barriers are hindering people to access timely treatment. In the context of Rolpa, though there has been parallel existence of healing systems, in many cases traditional healing practices are predominantly shaping and controlling the choices of people in terms of health seeking behavior. Molnar (1981:195) writes,

> *Villagers are aware of the existence of western medical care, but until the health post opened in Thabang were afraid to travel several days to a health post believing a child could not survive the trip. Many children grow anemic due to a variety of worms which sap their strength. Mothers know that the western remedies for worms are effective and will use this medicine if it is available. For serious illness, however,*

mothers will rely mainly upon the Jhankri and occasionally supplement his cures with medicine if it is available.

Despite knowing the alternative treatment procedures which could be more effective rather than locally available means, many times people's decisions and their choices to explore better health care services are hindered by many empirical factors. Justice (1986:95) writes, "For most illnesses patients reported that they 'waited in the house to get well'. Herbal remedies and dietary regimes were widely used. If illnesses persisted, the next resort was traditional healers-*Jhankris*, *Jharnes*, and *Fuknes*. Health posts and district hospitals were the last resort, usually sought only for serious and persistent illnesses". Since basic configuration of the society has been not drastically altered, and supra level political changes has not penetrated the ordinary life. The pattern of health seeking behavior is not significantly different in Rolpa than what Justice (1986) has observed in her study. In one of the cases, a medical officer from Holleri PHC mentioned, in the injury due to the fall, patients have followed faith healers and perceived that black magic has made him to fall from trees. He had a problem of elbow dislocation and there was a severe swelling in his hand when he came to PHC after a few days. Since shamanistic or faith healers tradition have been culturally embedded in people's mind, I have tried to explore the genesis of these knowledge traditions and its further role in term of shaping health behaviour. A shaman from Jinabang has mentioned,

Both Jhankri and Dhami are from different clans. Jhankri follow the Tantrik tradition and Dhami comes from non-tantric traditions they follow Chokhala. Dhami is rooted from Masta's family like Daremasta and Sidha masta, they follow Dhudhe Masta. I acquired Jhankri knowledge with my Guru, after god touched me then Guru blessed me with his knowledge. Once we feel the vibration, then one can realize the god has entered in our body. We have to call all gods in the time of vibration. We have to respect twelve Mandali Barahas, eighty-four Shiddas, eighteen Vhai Mastas and twenty-two Bahini boju[213].

The genesis of traditional healing practices is rooted from oral tradition of knowledge transfer circulated from generation to generation. The notion of *Kharani Phukne* 'blowing ashes' is a procedural attempt to create placebo effect in patient's psyche which shows mystical power of healers and their ceremonial procedures to avoid evil factors possessing the body of a sick person. Levi-Strauss argued that the transformations of healing involve a symbolic mapping of bodily experience onto a metaphoric space represented in myth and ritual (Strauss 1967

[213] Personal Interview- June 12th, 2013, Jinabang, Rolpa

cited in Kirmayer 2004). Such metaphoric space and symbol mapping of the bodies are interpreted in terms of 'lived cultural experiences' of the healers from where they derived symbolic analogy to demonstrate mystical power in the process of healing. In fact, such kind of random associations of shamanistic knowledge derived from mystical power may not be necessarily helpful to understand the bizarre level of psychosomatic and other biophysical abnormalities of the people. However, in many cases, good practices of shamanism is helpful to heal psycho-social problems associated with people's health, but bizarre kind of mythical and symbolic associations followed in shamanistic healing practices do not have very strong causal association to make a healthy body. In contrast such kind of bizarre process perpetuates additional level of sufferings in many cases and further affects the prognosis because of non-identification of disease causality on time. A female shaman from Rolpa Gairigaun has mentioned,

> *God blessed me with this knowledge in a dream. I only know to blow the ashes. If I wish to vibrate I cannot, if drums starts to beat then automatically my body trembles . After my father in law died, God touched me and I started to vibrate. I cannot avoid God to come in my body. If patients come to me, I will follow what God suggests me to do in the time of vibration. I follow the direction of Baraha, Chokhala Baraha, Daremasta, Dudhe Masta and Siddha*[214].

Nevertheless, the dubious use of 'knowledge' that is learnt in a dream from the supernatural entity like *Masta*[215] to cure the concrete state of deformities and also used to identify the causality of any illness with chanting mantras has many layers of ambiguities. According to shaman, from Jinabang, "Witches have nine sisters. The pain and symptoms of witches are the same. Ghosts and Masan have some different kind of symptoms[216]" The claims of shamans to identify the causality of disease in the stage of vibration during the journey of 'magical flight' are objectively disjointed from the biophysical condition of patient's body. In fact, the very primeval kinds of shamanistic knowledge which has miasmatic viewpoint to categorize illness conditions according to the symptoms has been proven 'irrational' and irrelevant in the age of evidence based practices. With the advancement of medical and paramedical sciences, one can show specific causality of the diseases and its pathophysiology along with social determinants which create condition to occur such kind of diseased condition. Pool (2005:102) writes, "From a public health perspective, one problem of

[214] Personal Interview- July 12th , 2013, Gairigaon, Rolpa.

[215] Maskarinec(1998) writes, "The eldest brother is *Dhadhar Masta*, since that is where *Masta* himself was born, next eldest is *Tharpa Masta*. Third eldest is *Kauwa Masta*. (who is also known as *Bijuli Masta*), then *Budu Masta, Sundargau Masta, Kalo Masta, Silo Masta, Babiro Masta, Dhudhesilo Masta*, and others...all known as twelve brothers *Masta.*"

[216] Personal Interview- June 12th, 2013, Jinabang, Rolpa

indigenization is that medicines, absorbed into local context and disconnected from the doctor–patient relationship, are often used in unintended ways, for example overdosing and under dosing, taking too many different medicines, or too short courses of drugs". Many forms of indigenous practices of medicines basically operates in hit and trial method, and there has been no formal mechanism to develop common understanding between the bizarre form of healing practices. A shaman from Jinabang said,

> *We have not claimed only God will cure the disease, after making clan deity happy, people can visit the hospital. There are different varieties of diseases and treatment systems. If we visit a hospital, we are not sure that a single doctor will cure us. In a same sort of way, there are different kinds of gods. Even we do not know which god can cure which diseases. Just like, we have to stimulate twelve Bhairabs to wake up single Veer Masan. We have to call all gods. God may say anything, because it is not within our control. There is no guarantee a single shaman can cure the patient. There might be the problem with one god, however, shamans may call more than one god to treat patients.* [217]

The narrative shared by the shaman is suggestive to understand how different methods are applied in hit and trial basis and it's the sick people who have to suffer from such vagueness and ambiguities, because shamanistic knowledge system cannot accurately demonstrate the disease causality and its further prognosis. Consequently, since one system cannot properly address the problems, the situation forced many sick people to follow different kind of treatment resort in order to get cured from illness. One of the admitted patients in the district hospital from Uwa VDC mentioned,

> *In the time of illness, it takes three days to reach a district hospital. I have spent 3,000 Nepali rupees for a Doko carrier to reach Sulichowr. Initially, I had spent money and offered chickens for the shamans. They said that "I was caught by evil spirit¨. My pain was increasing. So I had visited a private medical shop, run by a peon of a health post nearby my home. He said I had a typhoid . I had to pay his bill before going back to my home. Since my pain had not reduced, I came to the district hospital, where I came to know I had pneumonia*[218].

Selling drug without having drug license and certified training is another prominent problem in Rolpa. Similarly, following the pattern of self-medication, many people directly visit to local medical shop and buy medicines just telling symptoms to a person available in the shop. In this case, at first the patient was diagnosed as "caught by evil spirit (*lagu le samateko*) from the point of view of shamanistic knowledge," again; he was falsely labeled as a

[217] Personal Interview-2008 , 8th December, Libang.
[218] Personal Interview-2008 , 9th December, Libang.

"typhoid case" by an office assistant of health post who was running private medical shop and finally, in district hospital his problem has been diagnosed as a pneumonia case. Actually, as a quack, local practitioners assumed complains of pain in the epigastric region of the body with presence of fever must be the symptoms of typhoid. The layers of malpractices has compelled patient to seek alternative treatment resort in this case. Since adherence to one system of healing practices cannot solved the problems, similar to this case, many people follow alternative procedure if they feel the lesser efficacy of treatment regimen, the notions of 'medicine did not touch' (*okhatile le choyena*), 'not cured' (*Niko Vhayena*) leads to the stage of 'if not this then that may work out,' (*yeshle nochoye teshle chuncha ki*) which are confusing stages to any patients that compels to seeks multiple treatment resorts. One of the patients, I have interviewed in Gairigaon mentioned,

> *The first time I was ill was three years ago, I am 36 years old now. I do not remember how many shamans I have followed. I even went to Nawalpur to meet a popular shaman of that area. Different shamans were saying different things. Someone said 'lagu' and someone said 'bikar pareko', someone even said, I would die after six months. I do not know how many times I slaughtered goats, chickens and every time there used to be expenses of 2, 3 thousand rupees. Again I went to Nepalgunj and spent a lot of money. I also sold my ornaments . Some people said, it is a nerve problem, some others said it could be an ulcer or gastritis. People suggested to me to follow the Ayurvedic treatment system. I took a lot of Ayurvedic medicines thinking it had no side effects, but it also did not work out. I had an endoscopy, but it still was not cured. Later on the stomach pain was less. But then I started to feel some kind of shock in my hand. Again I went to check up at the PLA barrack and they gave me medicines and injections. I also did a ct scan there. They found out that there was a scar in my head. My mother had died in my childhood so I grew up with my stepmother, though I do not remember, I might have got punished in childhood. Since my condition was not improving, I was feeling burn, irritation, and anxiety. Finally, I went to do acupuncture in Nepalgunj, they gave me electric shocks for four-five months. I spent a lot of money, till date I have spent four to five lakhs, not counting the initial expenses to different shamans. The interest rate of my loan is increasing day by day. Actually, I do not see any difference between shamans and doctors. In total I have spent four to five lakhs. I care too much about myself (manma kura khelcha) and I am in stress related to my health condition. I do not keep any papers or medical bills, if my condition is not improving, I will throw away all papers and go to a new hospital. I have visited different places like Butwal, Dang Chitwan and Nepalgunj*[219].

Colloquially, the notion of *'manma kura khelne'* is a form of monologue, that is basically a psychological condition emerging in one's mind but people express that sentiments as feelings that emerge in an emotional heart (*Maan*) . Similarly '*lagu*' is caught by evil spirits

[219] Personal Interview- July 12th , 2013, Gairigaun, Rolpa.

and '*bikar*' is existence of bad things that create problems in the stomach. In terms of expression, if someone says '*kura khelne'* it´s the symptom where one is psychologically disturbed for the reason like expenses she has spent for her illness and not being able to get cured has both financial and emotional burden for herself and for family as well. Like in this case, health workers with limited health education has damaged many innocent people's health and limitations of traditionally acquired knowledge is another cause that has been victimizing the people with its trial and error methods. This case has complex psychosomatic conditions whereas Kleinman (1988:97) writes, "attention to either bodily or personal pain alone distorts psychosomatic integrity of the problem". Listening to her narratives, none of the practitioners have tried to understand her problem in totality and there has been constant attempt to prescribe medical solutions to earn profit from sufferer's volatile conditions. Ember and Ember (2004:28) writes, "Underlying the medicalization of contemporary life is the broader phenomenon of medical hegemony, the process by which capitalist assumptions, concepts, and values come to permeate medical diagnosis and treatment". The lack of trust with a single healer or to conform the pattern of treatment compliance form both 'traditional' and 'modern healers,' it promotes the trend of parallel healing that is evident in the context of Rolpa. In this case, following the insufficient orientation of biomedicine, episodes of malpractices have committed by private practitioners by prescribing pain killer injections or constantly recommending electric shocks for few months just to "cure" her diseases. In this case both domains of healing systems have done multiple experiments on patient's illness conditions and none of them were successful to provide rational solution. As Sobo (2004:92) writes, "People try the most familiar or simplest and cheapest treatments first and seek more expensive, complex, or unfamiliar treatments later, if necessary". As allopathic practitioners were testing different kinds of diagnostic patterns to identify probable cause in this case, traditional practitioners have also followed multiple interpretations and invited multiple gods to identify the cause of certain diseases. The journey she has begun from experiencing unknown prescription of a local shaman led to experience unfamiliar treatment like electric shock prescribed by unskilled and semi-skilled practitioners of modern medicine. The journey of her sufferings shows; at one level ambiguities and uncertainties are operating in both domain of knowledge system that eventually victimizing the patients in the name of treatment. Likewise, as patients have experienced the regimen of Ayurvedic medicines as a 'side effect free medicines', in reality it hinders the timely treatment and many times irrational consumption of herbal medicines delay the process to seek treatment and further problem occurs and disease crosses the phase from acute to chronic. As this patient

mentioned she does not see any differences between modern medical practitioners and shamans in terms of treatment regimen, this narrative strongly contest the claims of modern medicine for its so-called objectivity and rationality and its failures to understand the subjectivities of the people who are compelled to consume on everyday basis without knowing its forceful propagations.

5.5 Medical shops and malpractices in Rolpa

In the era of 'fast food culture' which promotes instant noodles for 'instant consumption', in a similar way, many people follow the instant consumption of medicines directly from private medical shops without knowing the nature of disease and its causalities in Rolpa. During the time of illness, many people do visit private medical shops for instant self-medication and easy availability of a medical person. In one of the medical shops in Libang, the owner of a medical shop had gone to visit Kathmandu. His daughter who has not studied any kind of medical course was selling medicines like vegetables in his medical shop. Moreover, like in the case of the Uwa office assistant running a private medical shop, many government staffs, that belong to HSS are running private medical shops in different villages. I have observed, in Thabang, that some of the grocery stores (*Kirana Pasal*) were selling pesticides, cosmetics, and other household items including medicines. Gartaula (2008) writes,

> *Kirana - Shopkeepers (Grocers) are those who hold shops of daily uses (rice, pulse, oil, soaps, etc.) besides the other materials or goods, they sell certain types of medicines such as paracetamol, analgesic, synalgia, metronidazole, eye and ear drops and certain types of antibiotics in the capsule from etc. People contact them and buy those medicines for prompt reaction or recovery. The people are acquainted with them directly or through their neighbours whom the shopkeepers oblige on the basis of demand.*

It has been observed in Rolpa that many people feel easier to visit a private medical shop rather than visiting a hospital and a health post. In medical shop one can easily mention their problem and get medicine easily. Such kind of unethical medical practices is creating conducive environment to manipulate low level of public health awareness of the people in Rolpa. Apart from private medical shop, medical malpractices is equally rampant within the government health care system also, CMA working at Ghartigaon sub health post has mentioned," We do not have x-ray and laboratory services. Without having these kinds of supporting tools for diagnosis, we have to diagnose the diseases blindly. It is very difficult to diagnose the disease"[220]. New Para medical support is another most important dimension to

[220] Personal Interview- 1st June, 2013, Ghartigaon, Rolpa.

diagnose the diseases objectively. It helps health workers to practice evidence-based practices. In one of the cases I have observed in the district hospital, a patient had clinical feature of Haematuria (presence of blood in urine). The trainee laboratory assistant was not aware about the process of centrifuging urine before looking into the microscope, as a result Red Blood cells (RBC) could not gather in urine deposit. He reported that there was no presence of blood in urine microscopically. This kind of procedural error does not play supportive role to diagnose the problem accurately; as a result it's the patients who have to suffer for long run. Those medical shops resided in district headquarters invite medical doctors once in a week and they follow advertisement of doctors through local FM radios which is regarded as unethical activities according to the advertisement policy of Nepal. Moreover, the person in charge of Gairigaon sub health post is running his private medical shop nearby the sub health post. In his signboard, it states that 24 hours services are available. The person who is working in charge of Gairigaon sub health post has to perform eight hours of compulsory duty, in this kind of context it becomes literally impossible for him to present in two duties simultaneously. Unethical activities being performed by government staffs manifest their unethical act of balancing same person as a government staff and same person as a private practioners. In the governance structure of Nepal, the notion of '*milayera garne'* to manage in doable way is one of the corrupted activities which has same genesis like *'milayera khane'* that means to grasp or gulp any kind of public resources unethically. Such kind of irrational conjunction '*milivhaga*t' operates in the health service system has corrupted institutional efficiency and also hindering to maintain good governance in Rolpa.

Until date because of extremely poor roads and exclusion from the mainstream market, the influence of medical representatives is very less; Shopkeepers have to visit adjoining cities to buy medicines in order to sell in Rolpa. Likewise, profit seekers have frequently performed activities that show the evidence of aggressive market penetration even in remote regions of Rolpa. In Jinabang; I have met a couple of sales representatives who were selling different kinds of herbal medicines without knowing the side effects and other further complexities that may occur. Similarly there have been frequent attempts by pharmaceutical company to sponsor vehicles to attend their regional promotional program while launching new drug. On one occasion, I have found evidence of medical corruption which was recommended by the state and appeared in the form of a Genvac B administration process in Rolpa, which was basically a spurious vaccine against Hepatitis B. However, instead of administering the certified (Genevac B) anti hepatitis vaccine, the alleged agency had been planning to administer counterfeit medicines (Genvac B) which had been brought to the mid-western hill

district of Rolpa via a covert route of illegal markets. After exploration of the unethical activities performed by alleged NGO, with the active solidarity of the local people, civil society and the media, public health awareness against such spurious substances was raised and later on succeeded to prevent the fake vaccine to be administered to innocent public bodies on a large scale, but significant dosages were already forcefully administered in Khungri. Such kind of forceful market penetration ultimately creates situation to follow unnecessary diagnostics that adds unnecessary burden of medical expenses to rural people. In Rolpa, there is rampant malpractice of doing advertising medical doctors and it is common that prices of medicines are different, owners are free to charge as per their will. I have listened that local FM was broadcasting the name of Japanese volunteer doctor as a visiting consultant. Actually, Japanese doctor Ishida has been doing a volunteer job in Rolpa region with his own expenses. However, one of the local medical centers in Kureli has been broadcasting his name in local media advertisement as a visiting consultant. They have misused his benevolence. Likewise, the inefficiencies of primary and secondary care centers directly create additional burdens of patients care in tertiary care centers. Those marginalized region where primary health care is under functional; it becomes the source of pushing additional patient burden to tertiary care centers. I met a patient nearby Ghorneti Model Hospital, she has expressed,

> *I had a severe stomach ache since I was in class nine. I thought during menstrual period that it was normal. After facing pain for six, seven months, I visited different places. Somewhere they said it was gastroenteritis and somewhere kidney stones. Later on, I came to know that there was a formation of additional mass (gano) in my lower womb. During my final exams of class eleven, I felt extreme pain and took a pain relief injection. Whenever there is more pain I used to go to the medical shop and take more pain relieving injections. Again I went to Kathmandu for further checkup and stayed at brick kiln owner's home in Kathmandu. Everybody used to say there is an unusual mass in my stomach, but nobody had a suggestion what to do next. They were referring me from one place to another. I went to a maternity hospital at Thapathali, Kanti children hospital, and in every hospital I had to do a blood check-up, video x-ray and CT- scan. I had already spent one and half lakhs. Finally, I was operated at Patan hospital. But there was negligence when they did the operation. Thinking that the mass was outside the uterus. Later on they said, that the mass was not outside but it was inside. Again they kept me in the hospital for another operation to remove that mass. I had to stay 21 days in the hospital. I cried a lot. After getting discharged, I came to my home. Now, I have to take injections but I could not find those injections anywhere in Kathmandu. Later on I went to Norvic hospital, for an earlier doctor said it would cost three thousands rupees, later on I was told that these were Indian injections with a cost of eighteen thousand rupees*[221].

[221] Personal Interview- 3rd June , 2013 Oat, Rolpa

One hand tertiary health care system does not have ideal service provisioning those free from malpractices and on the other hand many people have to be victimized with blunt treatment practices of biomedicine from sub health post to advanced tertiary care system. This case is suggestive to understand the inefficiency of tertiary health care system to respond to the needs of the people; as a result, most of the people are pushed to explore more expensive private health centers. Kleinman (1988) writes, most practitioners can be misled about the subject peripheral to their area of competence, They, too, may harbour a mix of common sense (which is often scientifically inaccurate and commercially manipulated) and just plain information. The non-diagnosis of specific problem is one of the typical features which show the inefficiency of the health care system. The multiple kinds of speculative diagnosis like kidney stones, gastritis and additional mass has been done within the sphere of biomedicine and also performed surgery without exactly locating the abnormal region. The medical negligence has unnecessarily kept patients under financial and emotional burden and perpetuated social sufferings. In the powerful realm of biomedicine dominated by organized professionals, it becomes impossible to claim for any legal compensation. A lady from rural Rolpa challenging their hegemony and misguided authority to operate patients without precise medico-surgical knowledge. Medical malpractice occurs not only in the organized tertiary care centers, the presence of quacks to accumulate profits in the name of medical service are also equally responsible to induce sufferings. I met an old woman walking on the way with swollen cheek-bone. Her left cheekbone was swollen more than an inch in comparison to her right cheekbone. Even her pronunciation was not fluent because of the injury she started to lament when I made the query. According to her, she woke up to go to the toilet in midnight but she knocked down to the edge of the bed, though she was feeling extreme pain in night time she could not do anything and remained asleep, when she woke up early next morning she came to know that her knocked part had already turned bluish and swollen. Later on she went to the person from her village who is running a medical shop in the adjoining district Dang. The person has operated her after she went to his medical shop; but after the operation, because of negligence, her problem became more complicated and she could not speak. Health post staffs of Gairigaun sub health post has mentioned, the person who was involved in this kind of malpractice is a quack. Having strong political back up and despite frequent action by the administration he is continuing his mal practices. She has said that after unsuccessful attempt, again she has gone to complain to that person, but that person has reacted like he cares only for money and nothing else. Major part of rural Nepal is still under process of electrification. In rural area like Rolpa, many people do not have sufficient

lighting system at their home; this is one of the hazardous conditions to cause household related injury in rural life. Similarly, once victim has claimed for compensation, but lack of power to fight against such malpractice, her loss has not been compensated. In such cases, either inside the shamanistic domain or in the domain of 'modern' biomedicine there has been parallel existence of blind diagnosis which eventually forced many patients to bear unnecessary medical cost, physical and emotional complications. From the patient point of view, patients were victimized from the malpractices of both traditions. There is no distinction between two different traditions if they come with the same results through different means. In the case where 'modern' medical knowledge is also not panacea for different forms of suffering. With the help of a health worker of the Nehrpa health post, I interviewed a Leprosy patient in Jungar. He mentioned,

> *I have this problem since I was twenty five years of old. Initially, there was some kind of wound in my hands and legs. Different shamans were prescribing different kinds of solutions for my problem. Last time, I had medication for thirteen months, even these medicines were not effective. After taking these medicines, it looks dry and cured. If I discontinue there is a pus formation and it looks disgusting. If my problem is cured then I like to follow the advice of what medical persons are suggesting. If nothing has worked out, then I do not believe anyone anymore. Even I know about three types of Leprosy, one affects the skin, another the bone and the final one affects the nerve. If it is getting cured after taking medicines then I feel comfortable, but since the medicines are not being effective, then why should I take medicines? I even had medicines from India. I also have medicines from Nepal. I know everything about Leprosy. I do not care what villagers' gossip about me for even they said, I ran away from Ghorai hospital*[222].

In this case, the health worker of the Nehrpa health post has mentioned; Just to control the reluctant behaviour of the patient, to force him to take regular doses of medicines, they took a support of police to forcefully complete the regimen of leprosy. District health report writes, "One case of Disability grade two is observed in Fiscal Year of 2012-13. Prevalence rate of leprosy is still under the elimination limit. From the above table it can be concluded that Leprosy is not the a public health problem in Rolpa". In contrast to district public health office statement, this research has committed to interpret any 'event' as a powerful mirror to understand how particular individual response towards his/her 'diseased body' and further response to access to the health service system. Moreover, even his son has taken him to India and he took medicines, since the problem has not been cured he came back to Nepal. In this case the efficacy and failures of biomedicine has been not questioned; instead there has

[222] Personal Interview- July 2nd , 2013, Jungar, Rolpa.

been application of police force to control the patient to follow the treatment regimen. If prescribed treatment regimen has been failed to cure the disease, it further creates frustrating and depressive sentiments to the person who has to bear its failures practically. Especially more in the stigmatized disease like leprosy. Kleinman (1988:160) writes, "In stigmatized disorders, the stigma can begin with the societal reaction to the condition, that is to say, a person so label is shunned, derided, disconfirmed, and degraded by those around him; though usually not mind by immediate family." Since the person has not followed treatment compliance regularly, heath workers have labeled him as "disobedience" and "irresponsible" patients but the specific nature of his problems, allergic reactions[223] of the medicines and inefficiency of drugs itself have been not questioned. The nature of frequent recurrence of his problems have been not identified rather a patient has been blamed and threatened for showing non-adherence and noncompliant attitude towards the treatment regimen and power of biomedicine has been brutally applied to the patient in conjunction with the state authority. Moreover, the forceful application of coercive power to follow adherence towards treatment resort clearly shown the demonstration of institutional power over the human body.

5.6 The intersection of contraception, pregnancy and abortion in Rolpa.

Early marriage (14-18 years) is one of the prominent social problems that is promoting school dropout rate and an increase of teenage parenthood. Annual report (2012/13) published by the district health office Rolpa shows all the caste groups based in Rolpa practice early marriages and it has further acknowledged the difficulties to increase awareness to reduce early childbearing practices. Though the district health office report abruptly mentioned all caste groups, however, this practice is comparatively higher in ethnic Magar and so called untouchables in comparison to Brahmin and Chettri caste groups. In the context of Rolpa, existence of social values such as : getting a daughter in law quickly *(phalani le ta katti chandai bhuhari kamai saki)* is supporting to get early marriages solemnized which further reproduce the social values like getting daughter in law means acquiring higher 'social status '. Acquiring a new family member to perform household work by quickly bonding her into marriage relationships are some the reasons that contributes the

[223] Following the notion of critical ethnography, I have kept myself in dialogical position and forwarded my query to health worker who were with us during conversation. My query was what if the patient has any kind of allergic reactions? Listening to my question the health worker just said, 'we do not know about that'. I have taken photographs of his hands, after returning from fieldwork, I have further investigated and his condition was looking like exfoliative dermatitis. According to John Hopkins Medicine web portal writes, this is a severe inflammation of the entire skin surface due to a reaction to certain drugs, a pre-existing skin condition and sometimes cancer. Moreover, I have called back to the health worker and forwarded the message.

early marriages in Rolpa. Moreover, in the lack of proper birth plan, the random decision of giving birth to a baby immediately after marriage is creating more burden on females rather than males. The presence of large numbers of young mothers especially on vaccination day with their newborns gives suggestive picture how early marriages are widespread practiced in the context of Rolpa. One of the health workers from Jinabang health post mentioned,

> *These days there are numbers of mobile shops in Rolpa. Overtly these shops are supposed to repair and sell cell-phones and upload new songs, however covertly these shops are playing a vital role to circulate porn movies by using code words like BF (Blue film), 'English film' or 'garib ko film*[224]*' (Poor's film). Since most of the mobile centers are selling these kind of bad things to the village children, premature sexual relationship is increasing. By nature Magar women are so open and innocent (sojho) if they like someone by heart, they quickly get ready for sex and they become pregnant. You know, they do everything without using any condom and our kids are copying them. As a result, lots of unintended pregnancies are happening in the village. Moreover, because of this kind of business local medical shops are getting patients for abortion and earning good money*[225]*.*

As argued by the local health workers, it's difficult to draw the casual link to prove the widespread circulation of pornographic materials and increasing rate of teenage pregnancies. Moreover, reproductive health education provided by schools and low level of public health awareness are some of the other factors which are responsible to promote any kind of maladaptive behaviour among teenagers. District health report (2012-13) shows that 41% people used condoms, followed by Depot Provera (36.3 %), Implant (11.4%) and oral pills (10.4%), but this rate shows under consumption and not officially targeted to provide service to unmarried teenagers. Since geographical factors hinder easy accessibility to health institutions, those for contraception, which are mainly distributed and service provided by state health institutions are not regularly available even to married couples.

Likewise, inefficiency of health institutions to provide sufficient awareness on promotive health, low level of awareness on contraceptive usages, narrow social support network are some of the reasons that hinders married couples to make rational decisions in terms of using contraception and to make rationale birth plan. Molnar (1981) writes, there was a locally-recruited family planning officer who works in the Panchayat distributing information and contraceptives. Under vertical program structure those officers were supposed to distribute temporary contraception like pills and condoms and provide

[224] Local health worker further interpreted that the notion of poor's film (garib ko film) for pornographic films has been used because artists do not wear clothes like poor people in those sex-scene performed in different positions.

[225] Personal Interview- June 26th , 2013, Jinabang, Rolpa

counseling services to perform permanent contraception. At present, people in Rolpa receive temporary contraception from Female Community Health Volunteers, a display box in health institutions as well as from local medical shops. Similarly, different forms of permanent contraception are available in primary and secondary chains of government health institutions. Despite widespread trend of using contraception in Rolpa, there has been lot of dubious perceptions in terms of using contraception. One of the health workers from Holleri PHC mentioned,

> *Initially many people used to think doing vasectomy means removal of penis from the body; gradually this false notion has been changed. Now, people do have the perception that the surgical cut during vasectomy operation may cause cancer. Some males think after performing vasectomy, it may lead to backache, lethargy and that there will be low sexual pleasure that leads to under performance during sex. Similarly, many males feel hesitation to do permanent method of contraception thinking they may get weaker and energy to perform physical labour may decrease and that it will become uncomfortable to plough the field*[226].

Contraception as a means to control the numbers of new birth has created different kinds of suspicious attitude among the users in the context of Rolpa. The psychological perception of fear among Rolpali about the potential side effects that may arise in the stage of post-vasectomy operation is creating direct impact on women's health. On one hand males are highly reluctant to perform vasectomy operation; on the other hand, in many cases women are also not encouraging males, thinking males will lose the acquired energy to perform household work. A health worker from the Nehrpa health post mentioned, "There has been multi-channel advertisement done through fieldworkers, FCHVs and local FMs and also through pamphlets, still we are not getting expected numbers of males to perform vasectomy operations". (Interview- June 27th , 2013, Nehrpa, Rolpa) The active mobilization of FCHV all over the country has created significant impact on promotive and preventive health awareness. But double burden of FCHVs to take care of their family and deliver service regarding their daily work is hindering to achieve many expected outcomes especially in hill districts like Rolpa. One of the ANMs from Holleri PHC mentioned, "since outreach clinics are not very successful; people have low level of health awareness, in the case where FCHV themselves have more than two children they cannot motivate other women for not to have many children". Likewise, the advertisement broadcasted in local FM radios to notify people about the vasectomy camps is not highly productive in Rolpa because both national and

[226] Personal Interview - Interview- July 2nd , 2013, Jungar, Rolpa

local FM radio is not audible in every corner of the district and in hill structure, even mobilization of FCHVs cannot disseminate information from door to the door. In some cases, the failures of vasectomy operation among few males discourage people not to follow announcement of the government. Similarly, in patriarchal values, the concept of castration[227] (*Khasi banaune*) denotes the condition of inferior masculinity which further prevents males to perform vasectomy in order to maintain 'masculine' status which many males directly links with performance level during physical relationships. A deep level of psychological weakness perceived by many Rolpali males is not supporting to maintain sound health of their family. However, despite high level of avoidance many males are opposing unscientific values and performing vasectomy services offered by government health institutions. A local shopkeeper from Gairigaon has mentioned, "I have already done vasectomy after two kids, I forcefully took my neighbour to perform vasectomy after four kids, initially he was denying but now he is very happy, because he does not have to use condom for sex these days[228] " Personal Interview- July 12th , 2013, Gairigaon, Rolpa. The changing perception of Rolpali males is similar to the event documented by Pomelas (2013) which mentions about growing alternative techno sociality in the context of Costa Rica where many Costa Rican males are accepting vasectomy despite lots of anti-technological notions related to masculinity. In reality, during the time of fieldwork the same level of acceptance about the permanent contraception has been not observed as dominant trend in the context of Rolpa. Apart from hesitations of males to accept permanent contraception, many females do have different kinds of perception regarding use of different kind of contraception in Rolpa. Acting incharge from Gajul health post mentioned,

> *After using contraception, some women may face the problem of bleeding and some feel headache. Other side effects of contraception like headache, dizziness, and heavy bleeding and stomach pain are complaints of many females. Many females do have perception like Pills, Depo-Provera and Implants that leads to hormonal change that may cause disfigurement of the women's body. Though Implants may cause heavy bleeding, still many women like to use Implants. Mini-lab service are supposed to be provided by doctors and nursing staffs, but we do not have nursing staffs and blood bank facility here in Rolpa, and doctors are not very trained enough to perform mini-lab services. Only in the time of mobile camp organized by the district health office a mini-lab service can be performed*[229].

---

227 This process is basically done for he-goat (*Boko*) to avoid its masculine sting and make him infertile.

228 (Personal Interview- July 12th , 2013, Gairigaon, Rolpa)

229 Personal Interview August 7th , 2013 Gajul Rolpa.

During my fieldwork in Rolpa, Minilaparotomy service was not available even in the district hospital. The use of hormonal contraception like Depo Provera is for short-term purpose however, women are compelled to use it for long time. Though Alma Ata (1978) writes, "Appropriate" means that besides being scientifically sound the technology is also acceptable to those who apply it and to those for whom it is used. The reluctance of males to undergo permanent vasectomy operation has forced many females to use different types of hormonal contraception voluntarily and involuntarily. Such kind of imposition has created forceful situation for many women to use the contraception forcefully without acceptance. Consequently, many women have to bear triple layers of burden like keep oneself under unacceptable contraception, give birth to numbers of babies and perform regular household works. This kind of practices manifest how the patriarchal power becomes dominating in order to suppress woman's body. ANM of Thabang health post has mentioned,

> *Women are encouraged to visit health centers and using IUD these days. Some males do not encourage their wives to use contraception and may suspect in their absence wives may have illicit relationships with other people. Women are worried for the potential gossiping by the villagers like 'if your husband is outside then why do you have to use contraception'? Once, there was a case that, a woman was beaten by her husband when he came to know about her usage of contraception. Later on she came to the health post and asked for pseudo removal of contraception, as per her request we kept Betadine liquid and gauge to make a proof of removal*[230].

The lack of autonomy of women over their life is forcefully accepting patriarchal subordination and adding vulnerability in their life. Singer *et al.(*2014:297) writes, "Women's continuing inequality undermined efforts to introduce birth control as mothers who might have welcomed contraceptive methods for the purposes of spacing their children and taking control of their own fertility had little power over family planning". The abovementioned case, it shows women do not have any rights over their body and husband's regulation in contraceptive choices shows that "decision less" situation and many times women cannot take independent decisions. This kind of patriarchal restrictions has affected women's reproductive health in Rolpa. Similarly, private medical centers are earning substantial amounts of money by performing secret abortion services. Many respondents have shared one of the clinics is run by a person who is nearer to UML and is performing a lot of malpractices in Libang. I have observed a women in the district hospital, who had a postoperative infection after doing abortion in that alleged clinic in Libang, she expressed,

> *My husband came home only for Dashain and Tihar festival and then again went back to Malaysia. I had a suspicion that I got pregnant. I was not interested to keep that*

[230] Personal Interview-20th May , 2013 Thabang, Rolpa

> *baby, because I have already three grown up kids. I went to the private clinic in Libang. He pasted some liquids in my stomach and shown some unclear image in TV. Later on he said, in my womb I had a baby with multiple heads. Then he operated me the same day. He took five thousand rupees and asked me to visit again after fifteen days. Again he operated me a second time and I paid an extra five thousands. He did not show me what he picked out from my stomach...after some time, my wound got worse and I came to the district hospital*[231].

In the context of this district, migrants' males working in India and other Gulf countries do come home mostly in Dashain and Tihar festivals. No sooner Tihar festival is over most of the males leave the village and district public health announces the vasectomy camp after completion of government holidays. The hide and seek between migrant male populations and sterilization policy of health institution are not supportive to each other to increase active participation for permanent contraception. The unethical use of inappropriate and limited biomedical knowledge has victimized this particular lady which has even violated her rights to know about the treatment compliance. Though local media has frequently reported about unregistered status of this alleged clinic, lack of political will among local leaders and power nexus of private practitioners to bureaucracy is not allowing district administration to take an action against this kind of illegitimate activities. In addition, many local people, civil society members and health related human resource are quite aware about the illegal act being performed by this clinic, however no action has taken place. Instead the wrong procedural attempt for this particular quack is inducing social sufferings to many innocent people. A medical doctor working in Holleri PHC has shared they have encountered plethora of evidences for performing unethically by untrained quacks without having proper medical requirements and knowledge, after complexities many patients forced to visit government health institutions in Rolpa. A medical doctor from district hospital mentioned,

> *Once I got a call from a nearby village in the night, we reached there with big difficulties. After arriving there, we came to know the patient had tried to perform an incomplete abortion but bleeding had not stopped. Her husband was abroad. It was a very complicated situation. We could not do anything at her home. We took her to the health post. Her hemoglobin level was not more than 4-5 gm/dl. We did a primary management and referred her to district hospital next day*[232].

As mentioned in this case, if the health workers get the emergency call in night-time, health workers have to face difficult situations either to reach the destination or to bring patients to

[231] Personal Interview, 2008 December 09 Libang, Rolpa
[232] Personal Interview, 2008 December 09 Libang, Rolpa

nearby health institutions. A medical officer from the district hospital mentioned her husband is abroad and the patient was involved in an extramarital affair. In the process of hiding the unwanted pregnancy she had attempted the self-abortion. Worrying for her complicated condition, her family informed the district hospital. The one sided advertisement of government policy does not necessarily encourage every person to access services in the time of need, there are many factors that hinders to access safe abortion services. This kind of unfair social patterns forced many people to hide their pregnant status as a "moral guilt" within a private sphere and eventually follow irrational procedures to abort the foetus. Regarding safe abortion service, one of the health workers from Sulichowr PHC has mentioned,

> *To promote awareness on safe abortion we have mobilized FCHV in grass root level, still very few people come from legal channels. Even in legal marital relationships, many people are still reluctant to access safe abortion practices. Early marriage leads to early pregnancy, then if the female do not want to keep the baby, then it would create complications. At first, the couple did not use contraception, later on complications may harm their life. Many times women come without a husband, If we do not perform as a government health worker, anyone does it in the medical shop and earns money. We depend on history, we do not have ultrasound here. If total time of delivery is 14 months instead of 12 months, then a medical person would be at great risk. If some complications arise, then it would put this medical person at unnecessary risk*[233].

Though the government has legalized safe abortion service since 2002, because of cultural stigma and lack of awareness, the program is not functioning as expected. Health workers in district hospital shared that many women in Rolpa still follow irrational practices of abortion just to hide the cause of pregnancy which may create societal complications. Those women, I have met while going to Ghartigaon from Jungar mentioned that before availability of modern technology, women used to keep itching herbs or hot sand in their vagina, and also insert rod or hard substance to kill the foetus. To release the foetus from womb they ate different kinds of medicinal herbs to abort a foetus. Nevertheless, health workers working in Holleri health post accepted that the trend of using irrational substances to abort the foetus has been drastically decreased in comparison to earlier days. They further blamed local medical shops for providing abortion related medicines without following proper medical combination and regimen. A medical officer from Holleri PHC has mentioned,

[233] Personal Interview, 2008 December 10th Sulichowr, Rolpa

One of the ladies from Mashina VDC has gone for a pregnancy check-up, the local medical shopkeeper (aushadhi pashale) made an unnecessary query about her pregnancy and identified that her husband is in abroad. Listening to his query, the alleged lady mentioned that she was having some kind of extra marital affair and menstrual bleeding has stopped since few days. After listening to her, medical shopkeeper asked her to bring urine and took it inside. After some time, he confirmed positive status of pregnancy in that woman. She has expressed her interest to abort a foetus, later on he gave two types of medicines and she went away. No sooner she reached in her house she had menstrual bleeding, she came to know that shopkeeper has diagnosed wrongly. She did not mention this whole process to anyone and remained silent. After sometime, her neighbour shared the suspicion of unintended babies, later on she gave those two types of medicines to her neighbour which she has brought for her cause. Her neighbour took those medicines and shown it to her husband who was teacher by profession. He has identified that local medical shopkeeper has given her paracetamol and albendajol tablets instead of any other drug related to abortion. This issue became the village level scandal and committee has been formed to punish that shopkeeper. Just to seek legal treatment of this malpractice, a delegation team visited the district police office. Listening to this problem, district police office recommended delegation team to visit district health office mentioning that without medical proof they cannot take any legal action. Again delegation team went to district health office Rolpa and got the response like since medical shopkeeper has given simple albendajol and paracetamol in non-pregnant status then they said it's not a crime, if villagers think that it is a a criminal case, then the police has to take care of this case. At last, delegation team returned to village without any solution and finally the case was dismissed[234].

Most of the medical shops are guided by open interest of earning profit rather than providing health services in Rolpa. According to the rules and regulation circulated by Department of Drug Administration (DDA), selling medicines without having drugs orientation certificate is considered as an illegal act all over the Nepal, however there has been rampant selling of the medicines without having basic medical knowledge in Rolpa. Similarly, there is no proper monitoring mechanism and strict regulation for different drugs that are not supposed to be sold without the presence of registered medical practitioners. Moreover, long-term economic migration and conflict-induced displacement are some of the reasons many males are temporarily and long term absent in their family. Perceiving her as an "immoral" being just because she has voluntarily extra marital relationship with someone else shows the abusive male gaze manifested by the medical shopkeeper. Moreover, he intervened her private sphere for having extra marital relationship, his unethical attempt to financial manipulation shows that oppressors in patriarchy operate in every spheres of public life to subjugate women's freedom and curtail her personal choices. In this case, the conjunction of patriarchal attitude

[234] Personal Interview- June 27th , 2013, Holleri, Rolpa

and application of quasi knowledge from the domain of biomedicine has been confounded to victimize a lady seeking benefit from her personal conditions. Either exploiting resources from individual by performing medical malpractices or performing corrupted activities to gulp public resources, both kind of unethical activities eventually support social sufferings and it's the poorest of the poor that have to suffer a lot. Likewise, the non-definition of departmental designation (*Chettra-adhikar*) is one of the crucial problems in Nepalese bureaucratic structure which is even reflected in this case in Rolpa. If there is a complain about any problem rather than taking responsibility many times it will get shifted into some other's head which has been evident in many events in this research.

5.7 The maltreated children of Rolpa

Civil war in Nepal has directly and indirectly victimized many children and hampered their regular growth process. During civil war, frequent security-checking, unnecessary interrogation by the army, fear of attacks and ambushes on road-discouraged children to attend their school regularly. One of the women from Nehrpa said,

> *It was normal for us to feed them frequently, it did not matter whether our children were eating or hungry, but we could never say no to Maoist Guerrillas who appeared suddenly in the evening with guns and bullets. The whole night they used to write something by candle light. I used to feel tension and could not sleep thinking that fire could burn my house. They were even forcing my elder son to go with them, I cried a lot when they left my home*[235].

During civil war, many children had lost their parents and there used to be severe food shortage in their home. Many people were displaced and rural livelihood in Rolpa was dismantled due to war. It was not possible to work in the dryland (Bari) and wetland (Khet) without fear and supply of food from district headquarters. To many peripheral villages was another hurdle due to fear of ambushes and potential crossfire that may happen anytime. Many times there was compulsion to feed Maoist combatants despite lack of financial capacity to feed in rural households. During my field visit, the children (whose fathers were killed in combats), studying in Model School of Maoists in Thabang were under nourished and in seek of extra care. This kind of low nutrition hampers further growth process of the children. Marmot and Wilkinson (1999) writes, "Malnutrition adversely affects not only bodily growth, but also cognitive development and educational attainment". Moreover, many studying children were forced to quit their regular education in the name of

[235] Personal Interview- July 2nd , 2013, Jungar, Rolpa.

boycotting "bourgeois education" and Maoists had forced many children to join as child soldiers. A person from Rangshi, I have interviewed him in Libang mentioned,

> *At that time, Maoists forced our children to quit school in the name of boycotting bourgeois education. Even my elder son left school in class nine. If my son would have continued education, perhaps he would have been like you doing PhD. Leaders forced our children to quit school, but they kept their kids in a safer place and did not destroy their future. Even leaders who have bourgeoisie degree are in top positions of the party. Now after the civil war, leaders have given good positions to their kids, but many people like my son are in Gulf, digging hot sand. War has destroyed us completely*[236].

In the process of "bourgeoisie education" boycotting campaign, many students discontinued their education and joined the "people's war". Furthermore, those children who were not interested to join civil war were displaced from their homeland and being forced to perform difficult manual jobs are some of the factors that are extremely detrimental for personality development in children. Many times war related social determinants directly play a detrimental role leading to family breakdown and it's the differently abled children who have to suffer a lot. While taking evening tea with some of my friends in Libang, I have seen a girl whose legs were paralyzed and was not being able to walk properly. In this case, her mother who is running a small tea shop in Libang shared,

> *Because of civil war, we were in India. When my daughter was born she was not well and doctors had told me to take her to surgical OPD for some kind of operation, but when I came home afterwards, my husband also vanished and has not contacted me since twelve-thirteen years, as a lonely woman what can I do without the support of a male*[237]*?*

After making query, she has shown some old documents given in hospital; a girl child was diagnosed as a cerebral palsy case in an Indian hospital and recommended her to surgical OPD. However, it's been already thirteen years she was not taken to any hospital. Later on the child was operated in HRDC[238] hospital in Kavre, Banepa, though her paralyzed legs are comparatively better after the operation, the doctors mentioned that she came too late to visit the hospital. This is a typical case where delay in seeking care, delay in reaching care and delay in getting care as Collins (2006) has described was intertwined into single case and the girl has to cope with lifelong sufferings with disability status because of her weak social

---

236 Personal Interview, 2008 December 08 Libang, Rolpa

237 Personal Interview-2013th , 11th August, Libang, Rolpa.

238 In support of her mother we have taken her to HRDC hospital in Kavre, Banepa which is famous for its care on pediatric surgery and even won prestigious international award for its care. Later on she was operated and her paralyzed and curved legs were slightly stretched and at present she can stand alone and feels comfortable to walk than earlier.

support. Though her mother has directly linked it to the absent of her husband for not being able to go for further medical treatment in this case, many times health workers in Rolpa overtly blamed local people for not showing enough care to their children. Once medical doctor in district hospital shared,

> *I feel really awkward the way people behave to their children here. Once a kid died in our hospital and I was so tensed, but her mother was saying, 'I will have another baby next year, as if she wants to challenge death with her capacity to give numbers of births every year'. You can see the undernourished stage of children, if they cannot treat them well, why do they have to give birth to unnecessary numbers of children?*[239]

In this case, child was dead because he was brought to the hospital with a very chronic case of haemolytic jaundice. According to medical doctor, for long time he was kept at home under false guidance of shamans and eating locally available herbs. Moreover the approach of health professionals, blaming the victims are not structurally convincing in these cases, where many people have to live with layers of structural deprivation resulting in low level of awareness and reproducing vicious cycle of poverty generation to generation. Once again a medical doctor from district hospital mentioned,

> *People do not have fear of death, we have seen in many cases. Patients have low priority to resolve their problems. Children are sick but mothers feel more hurry to take care of their cattle rather than their sick children. Many times I have seen, after a child's death people do not show emotional response*[240].

Nevertheless, the conditions which are responsible for not to express emotions in tragedy are structurally constructed rather than matter of being emotionally not responsive in the context of Rolpa. In contrary to established values of mother child relationship as an emotionally powerful bond, in many episodes like this narrative mentioned by medical doctors people are forced to give more priority to their livestock rather than their children. In response to this statement one of the women in Jungar mentioned,

> *In hill life, our children grow up easily playing with mud and dust. They are not like city children that keep carrying on and get feed by packed milk. Here, people have to perform their work in fields and take care of livestock as well. At least children can cry if they feel hungry, livestock cannot say anything. So you cannot expect hill people to care for children from the city, where they do not have lands and livestock*[241].

This narrative has shown additional dynamics why rural life is comparatively engaged with different kinds of manual jobs in order to maintain survival and many people do not find

[239] Personal Interview-2013th , 13th August, Reugha, Rolpa.
[240] Personal Interview- July 2nd , 2013, Jungar, Rolpa.
[241] Personal Interview- July 2nd , 2013, Jungar, Rolpa.

sufficient time to take care of their children. The way she compared rural versus city children is not emotionally supportive to many children in Rolpa and many children are compromising with substandard facilities. As discussed in earlier section, since many males show hesitation to follow permanent contraception and numbers of new-born every year risking the women reproductive health in Rolpa. In relation to childbirth, there are different social values like '*santanle danda kanda dhakun'* offspring may expand to the hills and forests promote many people to have more numbers of children. Likewise, the notion of son preferences forced many people to have more children and lack of proper child spacing it's the women who has to bear many fatal consequences that occurs during delivery. I have observed in one of the families at Jungar where I spent night during fieldwork, that they were planning to have another child (preferably son) with an assumption that their son would be needing a friend. Grandfather of alleged grandson has mentioned, 'I need a pair of grandson like pair of ox'. (*ek hal nati ta chayio kyare*). It's the same person who said some of the children is needed for land itself (*adha udhi ta vhumi lai pani chayincha*). Analyzing the subtext of this saying, it is suggestive to draw the analogy that people expect to have a pair of children like a pair of oxen to plough in the field. Since the status of children has been compared with animals, in many contexts the more numbers of children becomes additional social burden for many families in Rolpa. In same home, there were other two daughters apart from single a son, the younger daughter was having problem in listening since last year, but her father mentioned that he is not being able to manage time to think about her problem. Coincidently, I had to spent the night in the same guest house (*baash bashne thau*) with two local agents in Dui Kholi who were gone to take children from Rolpa to work in brick kiln in Kathmandu. One of them said, "There is poverty in village life, if our children can work to guard the mules (*khacchad dhapaune kaam*) and carry bricks, they can support their family[242]" Rather than performing other hard labors in village life and also to avoid "day to day burden" of walking long distance to the school, many children silently accept to work in brick kiln, which was more rampant event during the days of civil war. After 1983, the construction of Prithivi Highway linked Kathmandu valley and mid-western hill regions. Then after, 1985 /1986 onwards people from Rolpa began to visit Kathmandu to work in those kilns and to perform other manual work as seasonal labourors. Since Narayanghat-Muglin road has been not constructed, Rolpali had to reach first Butwal and extremely wavy way of Pokhara to reach Kathmandu. I have met a group of kids and their agents in Butwal while coming back to

[242] Personal Interview- July 3rd , 2013, Jungar, Rolpa

Kathmandu from Rolpa, most of the students were going for the first time to the capital city and did not know about the work nature they were going to perform in Kathmandu. The middleman (*Naike*) and women (*Naikini*) are overtly and covertly active to take children to work in different brick factories and also for other domestic work in Kathmandu and other cities. As a result, school dropout is one of the major trends in Rolpa; those children symbolically compared to a pair of oxen in rural village of Rolpa were compelled to take care of mules in brick kiln, transportation sectors and also as a domestic helper in cities where they have to perform hazardous manual work. Many international conventions related to child rights signed by government as a signatory country has been empirically challenged by presence of large numbers of child labours and their deplorable conditions in many informal sectors in Nepal.

5.8 Giving birth is like calling death in Rolpa.

A natural task of giving birth is a challenging event for many women in Rolpa. District population profile of (2012) shows that female literacy rate is just 21% in Rolpa which is also one of the factors that is responsible to enhance their vulnerability in terms of sexual and reproductive health. Though government health institutions have round the clock service provisioning to assist the institutional delivery, however, district health report (2012-13) shows that only 34 per cent of deliveries happen within health institutions. According to millennium development goals which were targeted to be fulfilled by 2015, sixty percentage deliveries should be done under supervision of skilled birth attendants. In contrast to this target, low performance of institutional delivery shows that many empirical factors prevent women's access to health services in the time of delivery. Similarly, the infant health will depend on the mother's social and economic circumstances and level of family support, as well as her health related knowledge and psycho-social support of family members. Apart from low level of education among Rolpali females, some of the social factors like excessive manual labour, early marriage, low levels of nutrition supplements and low awareness on health are responsible for unintended maternal and infant mortality in Rolpa. Giving birth is basically a natural phenomenon for any woman; however, significant numbers of delivery encounters different kinds of medical complications all over the world. Geographical barrier, substandard institutional set up, lack of sufficient medical technology and shortage of health related human resources in the time of complex emergency are some of the factors that creates fatal situation to many Rolpali females during the time of delivery. Acting incharge of Nehrpa health post mentioned,

Though the management committee has managed few carriers, for few wards, this is not a sufficient factor to increase the rate of institutional delivery in rural belt. Many women get delivery on the way, so women feel hesitation and psychologically insecure to visit health centers. We do not have ambulance facility, it is expensive to refer a patient from Nehrpa to Dang, district hospital is in an odd location people from the western region feel comfortable to visit Dang. There is no bridge over the river Madi, so it becomes easier for people of Jungar to visit the zonal hospital of Dang rather than the district hospital in Libang. In the complicated bleeding cases, if district hospitals cannot solve the problems, it will be additional tension for the patients to visit other nearest health centers that could be 7 to 8 hours far[243].

Rolpa has very few motorable roads except the major road that links district headquarters Libang to the east west highway. Therefore, non-availability of transportation facility is another crucial issue in Rolpa, if the patients have to visit outside the Rolpa district for different complicated cases; the fare of ambulance seems unaffordable for many middle income and low-income population[244]. Since the district hospital as a tertiary care system is inefficient to meet the felt needs of population; the people have to bear extra medical and non-medical expenses. It is contradictory to the one of the goals of health service system, which is supposed to 'enhance the financial risk protection' of the population. Moreover, long term non-completion of bridge over river Madi, because of the post-conflict governance crisis, is another obstacle that is hampering easy mobility to supply essential medicines and to take emergency cases to district hospital especially from the western region of Rolpa. One of the pioneer leftist leaders Mohan Bikram Singh has written in 1955 like the issue of industry, transportation and factory is very far; people are losing their life while crossing the rivers like Madi and Dharmabati which are in the main road. Ironically, social sufferings induced by lack of infrastructural support like bridge over the river Madi is similar even at present what Mr. Singh has observed before five decades. Since there has been no bridge to run the vehicle from Libang to other adjoining areas, in rainy seasons it becomes extremely fatal if people have to cross this river. In the lack of supporting infrastructure to cross the flooded rivers, in rainy season many people were already gulped by river Madi and that is continuing in the case of other rivers as well.

The lack of supporting infrastructure hinders people to reach health institutions easily, in the same way other socio cultural factors are also equally responsible to create many women to face complicated situations in Rolpa. In one of the delivery cases, I have

[243] Personal Interview- July 2nd , 2013, Jungar, Rolpa

[244] As rates vary, there are different rates for ambulance to take patients from Rolpa to other health centers of Dang, Butwal and Nepalgunj. For instance, notice kept in district hospital displays to take patient from district hospital to Nepalgunj, people have to pay around 8,000 Nepalese Rupees, Similarly, for Kathmandu people are compelled to pay 13,464 Nepalese rupees; this amount is more than normal for any ordinary people in Rolpa.

observed in Nehrpa VDC, a patient that was brought from Pachabaang, she was having complications of post-partum bleeding. I have observed a patient in emergency room of Nehrpa health post whose placenta had been broken into pieces and having severe bleeding. There have been different excuses given by the patient´s father and mother like night time uneasiness, season to collect fodder (*khar katne mausham*) labour unavailability, and fear of being caught by an evil force to fresh delivered women and her child. Actually, twice she has visited for ANC check-up, after three hours of delivery pain she has given birth to a male child around five o'clock. When delivery pain began, patient's mother did not convey the message to her father thinking that there won't be any complications, so the decision to bring her to the hospital has been taken very lately. Patient's husband was in gulf, in this case, the patient's mother was not supportive, since she had given birth to six children without any institutional support, and because of her confidence she had not encouraged her daughter to go to a health post during the time of delivery. Consequently, the patient had to face severe complications of postpartum bleeding. They were saying that even the baby's umbilical cord cut down by using grass cutting sickle. In this case, the patient was not brought to the health post on time showing different kinds of obstacles. Many mothers feel psychologically uncomfortable and geographically challenging to visit health centers during the time of delivery. Lack of proper information, shyness to get exposed, non-cooperative attitude of household members and perception that home delivery is better than hospital delivery are some of the reasons that women had to face extra complexities during delivery. In this case, her in-laws were also not supportive and absence of her husband had created a complicated situation to tackle the pain of delivery alone. High level of male migration in Rolpa has directly affected women's health during time of delivery. Many women do not get support of their males during the time of necessity which has challenged the delivery as a collaborative process between husband and wife .Wayte *et al*. (2008:84) writes,

> *Culture and tradition remain important influences on the decision to seek care during pregnancy, birth and postpartum, and there is a low level of skilled attendance at births, with most women delivering at home. Access to care is further limited by poor road conditions, dispersed rural population and low levels of income and employment.*

In the context of Rolpa, access to health service is determined by economic capacity and cultural practices of the society. Local people have mentioned, there has been a trend of using randomly available shaving blade to cut the umbilical cord and pasting cow dung as a locally available "antiseptic" to cure the wound. In this case, the authoritative use of power by

patient's mother to follow her past experiences has been forcefully applied and use of grass cutting sickle to cut umbilical cord is yet another indicator that shows low awareness of health in Rolpa. Health workers from Nehrpa health post expressed their grievances, during counseling many women agreed to visit health post during delivery, nevertheless, many times women visits health post, if they encounter complications related to delivery and post-delivery causes. Incharge of Gajul health post has mentioned,

> *When labour pain begins, women get scared for delivery on the way. There are places with 5, 6 hours walking distance far from the health centre. Women think that there won't be a fire in the health post to keep baby warm. In addition, if one has to manage food and other logistics, the amount of 1000 Nepalese rupees as a post-delivery reward is not highly supportive. Though after getting pregnant they come for ANC check-up, however, in this kind of hill regions, fresh delivered mothers cannot come with their babies to check-up three times after delivery*[245].

It has been explored that many often women give birth on the way and they feel comfortable to return home rather than coming to health post. Lack of a supportive environment at health institutions also discourages many women to visit them during time of delivery. WHO (2009) writes, socioeconomic and other physical barriers like form of distance and availability of transport prevents many mothers, especially poorer women to access provided health related services. Contextually, Nepal Government has announced free and round the clock institutional delivery service; in addition after getting delivered at government health institutions women do get 1000 Nepalese rupees as an incentive. In reality the burden of additional cost to pay for bamboo basket carriers and extra logistic cost discourage many people to visit health institutions in Rolpa. Ghimire (2009:145) writes, "The practice of carrying patients in "*Doko*' (a bamboo basket) from home to health centers continues. The cost of this service varies according to distance from home to hospital, running from two to three thousand Nepalese rupees (30 to 40 USD). However, the government has announced plans to provide around one thousand Nepalese rupees (approximately 12.7 USD) as an incentive to support safe motherhood for hill districts". In addition, apart from financial burden, since most of regions do not have transportation facility, people who can afford it, also feel uncomfortable to walk to health institution carrying their newborn babies. Despite accessibility and affordability some other factors hinder women to access timely treatment during the time of delivery, in the complex transverse lie case occurred in Thabang, health worker from Thabang health post has mentioned,

[245] Personal Interview August 7th , 2013 Gajul Rolpa.

She was visiting the health post regularly for ANC check-up. Last time when she came here, I had told her to come in time. Even a few days before her delivery, she had gone to graze cattle. I came to know she was working a lot. I heard that her husband used to shout a lot and she used to do hard labour without caring of her condition. One day suddenly that women and her husband came in the health post by walking on foot, and complaining about severe difficulties in her body. No sooner they reached here, the women complained that the baby's hand was already out. I quickly took her inside to the labour room. I did a check-up, however, I could not find the baby's head, and since one hand of the baby was already coming out I came to know it was a complicated case. They told me that the whole night they stayed in the house thinking the baby would come out easily. The woman was so overconfident, though the baby's hand was already out, she walked to the health post. Then, we had decided to take her to community hospital. The local police also helped us to carry her from the health post to the new community hospital where the Japanese doctor Ishida was working. I returned to my duty and after sometime I again went to the community health centre to understand her situation, I just stood up nearby the door and watching inside. Health workers were trying to save the mother, they were trying to cut the baby into pieces, however the bleeding was not controlled. Despite the pain she was speaking a lot. She was saying she would die and had no hope to survive. When people were trying to take her to Phuliban, she herself was scared that she may die on the way. At first her husband was not ready to take her somewhere else and she was insisting not to take her to any other health centre. There was severe shortage of time. However, in this case, money was not the reason, we had also given our word to help her husband. Since there was no communication and transportation and nobody had any clue how to contact a helicopter. We were talking outside meanwhile staffs of community health centre said she is no more….. I told her husband, since they had sufficient children, why they did not go for permanent contraception? He was cursing his fate for not changing his mind-set[246].

Collins (2006) has identified causes of maternal mortality i.e. three D´s—delay in seeking care, delay in reaching care, delay in receiving care". All three factors have played role to bring death of the mother and child in this case. As health worker from Thabang health post mentioned, she had a burden of taking care of her household work rather than giving attention to her expected delivery date. Despite enormous pressure by the villagers, her husband was not convinced to take her to district hospital. Instead he said, "I do not have money, cow also die, goat also die, if she has death in her fate, then I cannot do anything. Rather I would sign any kind of paper, I won't blame anyone, and I will console myself that my fate is like this[247]". Dr. Ishida mentioned,

I did an ultrasound and came to know the baby was in transverse lie position. We were seeking for options, after sometime there was a swelling and the baby turned to bluish. On the day of Vumya Puja, it became difficult to manage extra deliveries. There were only two options, either there should arrive an air ambulance or the baby

[246] Personal Interview-20th May , 2013 Thabang, Rolpa.
[247] Personal Interview-20th May , 2013 Thabang, Rolpa.

should be chopped out and release it from the mother´s body. Finally, when it was too late, they agreed to take her to the hospital. She had uterus rupture, initially she had gone to a government health post, and they referred to us. We have tried our best; unfortunately she just passed away with her baby. I have never encountered such a tragic incident in my life. I really felt uncomfortable[248].

Many health workers have mentioned the sensitivity of death is very low in Rolpa which is even evident in this case. But there are other abnormal factors which are responsible to construct the psyche which accept death as normal phenomena. In terms of complex medical emergency, inefficiency of tackling the problem and substandard level of health service system are some of the crucial factors behind untimely death of particular women from Thabang. This particular technical inefficiency of local level health institution in Rolpa is largely connected to inefficiency of overall health service system in Nepal which is playing an adverse role on people´s health both knowingly and unknowingly. I have met the husband after a few months of this event, he has expressed,

I was expecting at least the mother to survive; I did not care about the baby. If it were a first baby, then we would have been more worried, since that was our sixth child we were not too much worried. In between, they said my wife had passed away. I do not blame any doctors or any other person, if a person is dying then nobody can save that life.. That day, her death was in her fate that is why nobody could stop her death. On that day, there was Vhumipuja, everybody was enjoying mela, and it was difficult to arrange labour during the day. I said I would give per person 3-5 thousand rupees to have taken her to Phuliban, and then eight people were needed. On the day of Vhumipuja, we could not arrange people to carry her to Phuliban. We took her dead body and came home. I have five children, now I have to take care of these kids. I have three sons, the fourth is a daughter and the youngest one is just four years. I could not use my mind, and you can understand sometimes it happens[249].

In this case the random decision to have a sixth baby directly kept the woman's health in risk. After one month of this tragic incident, I have met other children of this family most of them were undernourished, fifth child is two and half years and did not know his mother is passed away. Many females mentioned that in rural region like Rolpa, if patient is female, many people hesitate to take her outside the district while considering it as additional financial burden. Particularly in this case, apart from class and gender factors those are intertwined to victimize a woman to force to have six children and maximizing risk, the structural factors like non-availability of health services and appropriate technology are also equally responsible to bring death. Annual report published by regional directorate of mid-western regions shows that in Mugu, Pyuthan and Rolpa, there has been no single caesarean case

[248] Personal Interview-2nd October , 2013 Kathmandu.
[249] Personal Interview-20th May , 2013 Thabang, Rolpa

performed and in the time of obstetric complications in past four years since 2010. . This caesarean section is possible where there is a medical doctor especially at district hospital, peripheral region of remote districts are always in more vulnerable conditions where presence of even low level health workers in duty station is irregular in many cases like in Rolpa. Bury (2005) writes, "Relative lack of control and inequalities experienced by women in many spheres of life (economic, public and domestic) underlie much of the gender patterning of illness. In reality, the death of the woman and her husband's acceptance as an inevitable phenomenon is a by-product of both micro and macro level structural construction as well. In the lack of road facility to run a vehicle from Thabang to Phuliban it's not possible to take her to hospital easily. If one plans to go via Kureli, Mirul and Hawama then it takes active one day and extra few more hours to reach district hospital. The road from Phuliban to Thabang which is on the phase of construction has been many times created obstacles because of civil war and post conflict stagnation. Nevertheless long term governance problem of Airport[250], there has been no airlines[251] facilities connected from Rolpa to the capital city and to other districts. The act of fulfilling personal interest resulted in confinement of physical infrastructure within the comfort zone of powerful actors, ultimately sidelined people's expectation[252] and there is no option to use airlines facility until date in Rolpa, (if one think that it could be plausible option) in the time of any medical emergency.

5.9 Alcoholism; a catalyst of suffering in Rolpa

Consumption of local alcohol (*Rakshi piune chalan*) is one of the culturally sanctioned trends mainly in Magar community in the most of the regions of Rolpa. Since use of alcohol is a ritually demanded feature in many occasions of *rites de passage*, the celebration of different festivals like *Dashain, Tihar* and *Maghe Sankranti,* has been featured

[250] Many people from Rolpa do have grievances that misusing the political authority as a minister from Rolpa, Balaram Gharti Magar has played a vital role to build an airport nearby his home at Badachowr which is three to four hours far even from district headquarters. Once civil aviation facility has already functional in Rolpa but the service has been stopped since long time. There is no road connection in every area of Rolpa; as a result, it becomes uneasy for most of the Rolpali to reach the airport.

[251] Many time people of Thabang have seen a helicopter landing in Thabang, either it's a surprise visit of king Birendra in 1989 or during the civil war or during the visit of Maoists leaders in post war phase. Even in one of the cases, His school Teacher Kulchandra Neupane has memorized one interesting event before establishing the health centers in Rolpa which was occurred in 1977, after having diarrhea, peace corp volunteer was rescued by the helicopter.

[252] Mrs. Vhim Kumari Budha Magar from Rolpa has been working as an assistant minister for ministry of tourism and civil aviation during the tenure of Sher Bahadur Deuba as a prime minister, even though, continuity of airport service is not a preferable agenda.

with the trend[253] of drinking alcohol especially in Magar, Gurung and Dalit community in Rolpa. Either in the process of *Shahimasha,* the cultural practice followed before fixing the bride and performing *Vhumipuja* in Thabang or celebrating *Lhosar* among Gurung community, alcohol is most important auspicious stuff (*Sagun*) to precede any kind of cultural function throughout the year. Though Helman (2007: 5) suggests, "In understanding health and illness it is important to avoid," victim blaming' that, seeing the poor health of a population as the sole result of its culture, instead of looking also at their particular economic and social situation" However, in spite of being one of the embedded parts of individual life and social functions, irrational consumption of alcohol is responsible to induce different kinds of alcohol related morbidities and mortalities in Rolpa. Moreover, the culturally supportive environment to consume high levels of alcohol and its impact on micro level household economy is closely interlinked and influencing each other in the context of Rolpa. In conflict time, though the CPN (Maoist) has banned alcohol in Thabang and other villages where they have strong hold, however culturally it is not possible to avoid alcohol from the everyday lifestyle of ethnic people like Magars and Gurungs. As Maoist banned selling and buying of alcohol, but inwardly there were many options to fulfill one's desire of drinking alcohol even during the time of *Sankatkaal*. Sharma and Prasain in Hutt (2004:156) edited volume writes,

> *Although violence against women is rooted in the asymmetrical power relations that exist between men and women in society, the Maoists anti-alcohol movement has appealed strongly to women in village Nepal, especially as they see that it is directly linked to the possibility of ending domestic violence. The majority of village women have experienced some kind of violence in their family or community.*

Production of country liquor is one of the important activities of village women in Thabang and not every episode of drinking habits is directly connected to the source of domestic violence. Low level of awareness among many males that confounds with fatal situation induced by alcohol drinking pattern becomes supportive to create violence against women. Asymmetrical power relations operating in patriarchy are responsible to oppress the women, irrational drinking habit of alcohol gives false perception and pseudo power to many males which further results in different kinds of violence against women. In hill setting, the high burden of physical labour expected to perform within household is another cause to induce sufferings among women that further cause the condition like uterus prolapse, menstrual

[253] Apart from Magar and Gurung, caste groups like Chettri and Brahmin consume lesser amounts of alcohol or because of strict restriction from religion point of view in many cases there could be absolute 'no consumption' of alcohol in Brahmin community, however, the level of alcohol consumption has been increasing in young generation Brahmins

excessive bleeding and chronic back pain etc. In one of the occasions, even I have observed on the way that a woman was carrying heavy loads and had also a child in her back. However her alcoholic husband was carrying his shoes in his hand. In response to my query he said, "My neighbour offered me alcohol at Libang and requesting to pass the lands and building in his son's name offering me meagre amount. However, my wife got angry, and we left from there". Since alcohol alters the normal psychological condition, many times people commit wrong decision which creates additional suffering to their family members. In Rolpa, while travelling from one health centers to another, it is very normal to see many men and women on the way in the hangover of alcohol. Health workers from Gairigaon sub health post mentioned,

> *Patient's husband has gone to Qatar as a migrant worker. The woman was having labour pain, however, both mother and father in law accepted the fact that they started to drink alcohol to celebrate the birth of a new child and did not notice that the mother was bleeding after delivery. However the women's placenta did not come out while she was bleeding, and although the woman repeatedly asked to take her to the health post, instead, they went to find faith healers. After having severe bleeding for the whole night she passed away in the morning, but the baby is still alive*[254].

In above mentioned case, though drinking alcohol and not caring for the newly delivered women seems to appear as an immediate reason behind this death . Nevertheless, structurally generated low level of awareness is responsible to create unintended death of women specifically in this case. Similarly, I have observed that in Kureli, a husband is running a medical shop from one door and the wife is running an alcohol shop from another door. Likewise, in district headquarters, significant numbers of local people are arrested under anti-alcohol checking (*Ma pa se jaanch*) process also suggests the trend of irrational consumption of alcohol in Rolpa. There is no promotive health related program run by the district public health office, in contrast Nepal police has strictly followed anti-alcohol campaign after announcement of incentive to duty police, this is the example how role of state can act as a coercive tools to control their citizens rather than playing supportive role to aware its citizens on promotive health issues. Another case of alcohol shared by a person from Gajul whom I have met in Ananda Bihar bus station in Delhi has mentioned,

> *Once a person from Rolpa was going to work in India with his newly married wife, he asked his wife to stay inside a bus. Then he started to drink alcohol at local shop at Banbasa bus stop in Uttarakhanda. After sometime, the bus moved to Delhi. Since her husband was not in bus, I do not know why his wife did not shout? Later on when he*

[254] Personal Interview- July 12th , 2013, Gairigaon, Rolpa.

came out with an alcohol hangover he was crying and searching for his wife. Looking at his situation, Indian bus drivers made some queries with their co-workers. However he could not find out the whereabouts of his wife. Then bus drivers gave him some money, later on he left for Delhi to search his wife, I do not know whether he met his wife or not. Since a new lady from the village reached Delhi without support, I do not know how she managed afterward[255].

The exposure of one's self outside from the community gives sense of extra freedom and occasional habit of drinking alcohol get reflected in regular habit if a particular person is staying alone for a long time. In this case, false sense of enjoying freedom, low sense of responsibility and personal addiction of alcohol has reflected in separation of newly married couples who were going to work in Delhi. Winkleman (2008) mentions, problem drinking is not an individual problem but a manifestation of a class problem produced by macro-level circumstances. In this case, as a person was heading to search manual class job in Delhi but his habit of drinking alcohol alter his mental stage temporarily and resulted in unexpected emotional and social consequences to get separated from his wife. Many migrants from mid-western and far western regions have to pay an extra amount of money to release their goods to enter Nepal and it's normal to face border harassment by Indian police and Nepal police in Indo Nepal border. After getting permission to enter Nepal, people feel psychologically safe and the unrestricted alcohol selling trend in Nepal create supportive environment to bring many unintended tragedies. I was told about one of the incidents by my fellow traveller on the way to Thabang, which had occurred nearby the district headquarters Libang. According to him,

Once a person was returning home after staying many years abroad, he had invited his son to district headquarters to support him to carry his suitcases. No sooner he reached district headquarters Libang, he began to drink alcohol, and he left for his house without anyone's support. While walking on the narrow trial of Hawama, he fell down and his body trapped to narrow trench. After sometime local passers-by noticed a dead body trapped in the difficult trench, local people were gathered and just discussing what to do with that dead body, in between his son who was supposed to receive him at district headquarters reached in the place where his father dead body lies, tragically he was compelled to see the dead face of his home returned father after many years in his own district[256].

In the post conflict scenario, the scenario of alcohol production and consumption has been changed. In contrast to the popular campaign forwarded by Maoists in its initial phase to gain political mileage, at present including VDCs like Thabang consumption of alcohol is one of

[255] Personal Interview 2014 , 16th January, Ananda Bihar Bus station, New Delhi

[256] Personal Interview-19th May , 2013 Rangshi, Rolpa.

the widespread trends in Rolpa. It has been observed that people who were active during war and worked in health department of Maoist party as an "progressive health worker" is now running an alcohol shop in the heart of Thabang. He expressed his frustration and said,

> *I was revolutionary before, now I am revolutionary but independent. I do not have qualification. Prachanda asked us to raise the weapons, we did it for Prachanda. During war, many people died, after split of the party, Baidhya (colloquial name for another fraction of Maoists) is also coming with the same agenda, why should I help them? Now they have to give us an answer why a single head became two heads? That's why these days I do not run after anyone. I run my own hotel, do small kind of labours and feed my family, rather than saluting anyone, I am very happy now*[257].

As discussed in the earlier chapter, the breakdown of political party has created many layers of frustration and tragedies to those people who have genuinely supported Maoist party to sustain it as a "revolutionary force" that represents people's expectations. In this case, though he was expressing his " happiness", however I have noticed that he has some level of guilt to pen alchohol shop in Thabang. After being ideologically sensitized, eventually a person opened an alcohol shop at the heartland of Maoist as an ultimate solution to join hands and mouth shows that how people have to compromise with their life even they are not fully satisfied with their means of survival. In post conflict scenario, there had been growing polarization between Maoist leaders and ordinary supporters. Most of the senior leaders were focused on central level agenda and not fulfilling basic necessities at the grass root level. This has resulted in sharp rise in frustration. Since party has already left the regular orientation session like in a war period, the continuous exclusion has developed serious detachment with local development issue and activities of central level leadership. Such state of marginalization eventually forced "progressive worker" of Maoists party to sell alcohol openly in Thabang where once they banned and not allowed to consume publicly.

5.10 Rolpa in the age of coffin economy

Agriculture is one of the important occupations in Rolpa, however the production of barley, millet, rice and maize are insufficient for many households throughout the year. Since most part of Rolpa is covered with hills and rivers, many households do not own adequate fertile land to produce sufficient amounts of food up to the level of generating surplus. Therefore, many people have to find alternative means of survival outside the district as seasonal and permanent labour migrants. As a district resided in mid-western region,

[257] Personal Interview-20th May , 2013 Thabang, Rolpa

because of the geographical proximity with India, there has been a trend of going to India as seasonal and permanent labours. Similarly, joining the job of Nepal Army, Indian army and British army is one of the established trends[258] in mid-western hill district regions including Rolpa. After eradication of malaria in Terai region, many people from Rolpa began to migrate from hill region to plain regions (*Terai*) like Dang . *Doke* is a colloquial terminology given to those hill migrants basically come down from Rolpa and adjoining hills. The tiny section of opportunistic elite class from Rolpa are able to maintain shifting settlement[259] in plain region in order to enjoy dual profit. In reality, large section of Rolpali people are struggling to manage basic level of livelihood even in present days. The conflict had also fuelled migration on a grand scale that has been continued even after the official ending of the civil war in 2005. The destination of migration from Rolpa is Kalapahad, (India), Saudi Arabia, Qatar, Malaysia, UAE and other Gulf countries. In many cases, long gap among the couples has been ultimately results in breakdown of the relationship. Under informal matrimonial practices if husband who has gone abroad does not return to village, if the woman eloped with (*Poyela Jane*) second person permanently, the second husband is supposed to pay a certain amount of money to the first husband after his arrival, this practice is called *Jari tirne,* it means paying certain amount of money to first husband by second one as a compensation for taking away his wife. *Jari tirne* is cultural practice that gets formal approval of divorce from first husband after paying certain amount of money by second one. This kind of bargaining determines the economic status and bargaining power of first husband that he deserves in the society. Moreover, as an adverse impact of male migration, growing vulnerability of HIV is another problem in Rolpa. Gazi et al (2008:1) writes, "Mobile population groups are at high risk for contracting HIV infection". The organization of HIV infected people in Libang which was formed to advocate the rights of HIV infected people from Rolpa itself is an evidence that shows the significant presence of people living with HIV and AIDS in this district. One of the health workers from Holleri PHC has mentioned,

[258]Cultural Activist Bam Kumari Budha Magar mentioned, "Similarly, there was tripartite agreement between Nepal government, Indian government and British government to encourage Rolpali males to join British and Indian army but this agreement has never played any role to encourage people from Rolpa region. Prithivi Narayan Shah has developed the concept of Kalapaltan and Gorapaltan. After visiting London, Jung Bahadur Rana turned Kalapaltan to Kali Bahadur Gan". Later on Tul Bahadur Pun won the Victoria Cross then after people from Gulmi, Parbat, Myagdi, Thabang, and Rukum Taksera was encouraged to join the British Army".

[259] After being economically well off, people do migrate from Rolpa to adjoining plain land like Dang and Butawal. In winter, those people who have their agricultural land in Dang district, it becomes easier to mobilize Tharu (marginalized ethnic community) as agricultural laborers and gives prospects to enjoy warmness of plain land. In summer season, when threat of potential malaria outbreak realizes, it becomes easier to shift oneself with family in upper hill land.

> *Rolpa has a high level of outgoing migrant community, however, VCT centers have not been authorized, and there might be the presence of more HIV cases in Rolpa. Because of the migration, on one hand, remittance is increasing in Rolpa; nevertheless low levels of health awareness is resulting in the introduction of different communicable diseases such as HIV, HBsag, Trichomonas and VDRL. These kinds of STDs (Sexually transmitted diseases) especially found in home returned migrants and their spouses, after spending some years especially in India and Gulf countries. However, the major trend is a concentrated epidemic among migrant labourers working in India*[260].

Information provided by health workers, the activities of Rolpa plus, and records of district and community hospital suggest the incidents of communicable diseases in Rolpa. Report of District health office 2012/13 shows, there are 45 HIV infected people in Rolpa and among them 80 percent are from 25-49 age groups. Likewise, Ghorneti people's model hospital pathological record also shows the presence of Hepatitis B cases in home return migrants in Rolpa. Bhatt (2006:101) writes, "In conflict there is also large scale mobility. Military personnel and outsiders come in this region while refugees move out from here. The frequent movement of people also creates condition conducive to the spread of AIDS". In the context of Nepalese Civil war, its outgoing trend from district as a temporarily and permanently displaced population is more responsible to bring HIV virus from elsewhere when they return home. Retrospective narratives collected in this research has supported to show the closer link between civil war and displaced people's exposure with HIV infection. One of the HIV infected women, I met in Libang has mentioned,

> *During Sankatkaal, my husband has gone to work in India, first he got infected in India and he infected me also. Though he did not tell me directly, I came to know through his friends, every week he used to visit brothels in Bombay. Since he is my husband it is not possible to ask him to wear a condom before sleeping together. We respect a husband like a god, but you see our god gave us this gift of Aids. Initially, I used to feel hesitation to disclose my status. Later on, I got the opportunity to meet with same people like me. Now I am thinking that we have to work for each other and keep hope to live a long life. There are around 40 identified HIV positive cases in Rolpa; among them three of them are already died. A part of the VCT infected are taking ARVs and the rests of them are taking ARVs from DHO. Similarly, there are five infected children, transmitted from their mothers*[261].

If a particular person has low awareness on health, sexual frustration among the migrant population increase the vulnerability of communicable diseases. In the absence of a permanent female partner and in order to fulfill the bodily desire, in this case her husband had

[260] Personal Interview- June 27th , 2013, Holleri, Rolpa.
[261] Personal Interview-2013, 11th August, Libang, Rolpa.

performed risk behaviour and had become infected with a sexually transmitted disease like AIDS. In this case, since she could not exercise bargaining power prior to intercourse with her husband when he returned home after long period. Bury (2005:48) writes, "While men had led more hazardous and risky lives, women have experienced more health problems as the result of oppressive gender roles". Such oppressive gender roles constructed by patriarchal values that constructed the position of husband in a "supreme power position" discourage many females even to ask to perform laboratory check-up or compulsory use of contraceptives before intercourse. If one dares, also women have to bear extra stigmatization and discrimination of being immoral and disloyal towards their husbands. Likewise, in this case, the limited bargaining power of many women for not being able to ask their home returned partners to compulsory use contraception prior to intercourse directly harms the life of women if the partner is already infected. Similarly, because of the same patriarchal structures, women cannot reveal their past involvement in sex-related trade (if they had any) in the cities. Moreover, the long term social separation creates emotional gap in personal relationship affects physical and mental health of the people, a women from Chorpani has mentioned,

> *I do not have any seniors at home. My husband is in Gulf (Khadi). I do not like to stay at home and I am not interested to change the clothes. It feels that something is sucking my blood. I feel vibration in my body, even I lost my eyesight. Then, I called a Shaman to show my problem, he said a witch had attacked me. After that I started to have fear of everything. The shaman said that I had to slaughter a rooster (Vale) in the name of god. I have shown my problems to other shamans and faith healers, some of them mentioned, I will die with this cause, some others are saying it will get better, after taking an amulet (buti). In the absence of strong support of family members, you know I cannot do anything. When my husband came home, at the time he was interested to take me to the hospital, I was convinced that I may die in hospital, so I did not follow him. After my husband went back to Gulf, my situation became worse (betha le chapyo) and I went to the hospital, where they gave an me injection, it was too painful. I spent a lot of money but it was not cured (niko vhayena). In Luckhnow, they gave me electric shock, it worked for some time but again my condition is the same. I do not know whether that hospital was good or bad. Since I do not know anything, I had to rely on others. The person who has a medical shop in Nepalgunj has suggested me to go Luckhnow*[262].

Long term social separation, especially for females, those who cannot cope with their problems have been reflecting in different kinds of psychosomatic complications in Rolpa. The absence of family members perpetuate loneliness and further it affects the psychological

[262] Personal Interview- July 12th , 2013, Gairigaon, Rolpa.

health which could appear in mild and severe levels of depression. In this case, patient has experienced many different types of treatment resort including electric shocks without identifying original causality of the problem. The stress of spending unnecessary money to follow multiple experiments suggested by bizarre kinds of therapeutic procedures are stimulating additional complexities to her health. In her case, the non-identification of her problems have been victimized by usage of pain killer injections and electrical therapy which are mainly the unethical practices blindly derived from biomedicine to suppress the psychosomatic symptoms of the patients which after all put extra financial burden. Many people have mentioned that once they reach border cities of Nepal, private medical shop keepers encourage them to visit bigger hospitals in India. In this case, medical shopkeepers are working as a medical agents to recommend patients to bigger hospital from where they can make extra profits as a 'informal referral system'. Though the remittance is increasing, once the family member gets ill, because of worse condition of health service system and crisis of primary health care, people are forced to spend a lot of money to access health services outside the district. The worse condition of public health system is supporting chronic stage of medical dependency to other tertiary and private care centers. Moreover, conflict induced migration has further led to family members living with additional mental tension given the huge loans that were to be taken to send family members abroad. As IDMC (2008) writes, "In this context, economic migration and conflict-induced displacement are often closely interlinked". A pattern of loan and interest rate taken to go abroad is also a fatal syndrome to create psychological pressure among migrant families. While going to fieldwork, I have met a person from Rolpa at Ananda Bihar bus station in Delhi who works as a driver for one of the Hotels in Delhi mentioned,

> *There is no employment in the village; many Rolpali do not have any option rather than going abroad. To arrange the loan to go abroad, if we lend the money we have to pay thirty-six percent interest rate per thousand hundred rupees. In addition sometimes it may be necessary to offer extra bonus like chicken or goat. Like earlier, these days people do not come here in India too much, during Sankatkaal many people took shelter in India, but these days people started to see big amount. If people cannot manage minimum amount to go abroad they come here in India. It's so easy to enter India, you can carry bag and move on. After managing some amount, people prefer to go Gulf. It's the nature of human, searching for more benefit is normal. Now Jana Yuddha (People's war) is over and we have joined new Dhana Yuddha (War to collect wealth)*[263].

[263] Personal Interview-2014, 16th January , Ananda Bihar Bus station, New Delhi.

According to his narrative, 36 percent interest rate per 1,00000 Nepali rupees means every year thirty-six thousands rupees get increased in original amount. Therefore, loan taken to go abroad creates pressure to earn more to many migrants. In such condition, higher valuation of currencies in Gulf in comparison to Indian currency has been shifting the process of outgoing migration in Rolpa. At present, there has been shifting pattern of migrant labourers from India to Gulf countries like, Qatar, UAE and Saudi Arabia and other countries like Malaysia and Korea from Rolpa has been increased drastically. After coming back from abroad, large scale of remittance has been spent primarily for consumerist activities and many people are forced to spend money to treat their family members as well. As he suggested because of higher amount (*Thulo dhan*), the destination of work has been changing, as a result, both positive and negative consequences reflecting in individual level. In comparison to those people who are working in India, people from Gulf (*Khadi*) come home only once in festival time or may not come for long time, however because of geographical proximity there can be frequent ups and down from India to home. Many people can give time to their household work and also manage time to do additional work in India for surplus. In one of the cases, with deep pain in her eyes, a woman from Oat VDC has shared,

> *My husband is abroad since 14 years, and did not sent any money since seven years. Actually, these days I do not feel any necessity of a husband. I am happy with my grown children. Occasionally, he gives me a call and mentions that he wants to die in Gulf, I have also replied to him it is better to die in Gulf. Since husband and wife could not stay together in heyday of life (Jawani) than why he has to come back in old age (Budeshkaalma)?*[264]

She further mentioned she does not have any hope with her husband since she has raised her children without him. This case shows that long term social separation ultimately compelled many people to cope the challenges of life without the support of life partner and matter of suppressing or expressing biophysical desires becomes her personal choice though it is largely conditioned by structural vulnerabilities. In this context, respecting the ethical dimension of research it becomes unethical for a male researcher to intervene her private life and make additional query whether her frustration towards her husband has been released in the form of extra marital affair or not. Moreover, the experience of migrant economy in Indian cities and Gulf has been drastically different for many Rolpali males. The unsuitability of extremely hot weather for hill people, long term loneliness and homesickness, culturally different hard working conditions in gulf countries have been resulting in the return of coffin boxes with dead bodies into Rolpa hills. It´s been a daily trend to receive three to four coffin

[264] Personal Interview- 3rd June , 2013 Oat, Rolpa.

boxes (*Laash ko Bakash*) from the Gulf region back to Nepal, including Rolpa mid-western hill region shares significant numbers of dead bodies that Nepal is receiving every day. It's not only the remittances Nepal earns, the increasing numbers of coffin boxes show that Nepal has been moved towards the era of coffin economy and there has been no effort to understand the silent sufferings of those people under the shadow of on-going war to earn a "bigger wealth" (*Dhana Yuddha*) .

5.11 Doctor after death in Rolpa

Many unintended episodes of deaths which have resulted due to structural vulnerabilities are major concern of the section rather than interpreting death as a natural phenomenon of human life. In many cases, I have observed unintended morbidities are directly related to institutional inefficiency and structural deprivation which further playing a role to develop low sense of sensitivity and contributing to process of "normalization" of death in Rolpa. One of the patients from Shaikha I have met him in Holleri health post has mentioned,

> *I am thirty-two years old. It is seven month now that I am not well, I am having a severe back problem. The first time, I was not well in Jestha and came to the hospital after one month in Ashadh. Initially, I took medicines for four months. It was not getting cured, so I stopped taking the medicines. Again I followed up the shamans and they said witches had caught me. I offered roosters to shamans and also followed faith healers but my problem is still not cured. There was presence of blood in my sputum, so, I came to the hospital after four hours of active walking. Even in my house I am alone and having problems to have sufficient nutritious food. In poor houses, you can understand the condition. My wife died last year because of an unknown disease. I took her to many places, she used to have fever and stomach pain, and I could not save her. I have three small kids, two daughters and a son. My youngest son is just three years. His mother left him when he was only one and half years old. My elder daughter is eight years old ,so at daytime, my elder daughter takes care of him, but in night time it's difficult to make him asleep. I have to work as a construction labourer or some random work I get anywhere in the road. I have to take care of three children. I have already fifty thousand loans in my head. Even my situation is getting worse, if something happens to me I am worried who will take care of my children...sometimes I feel too tensed and think like, 'I will throw away my kids into the river and I will also jump into it', but then I see the faces of my innocent kids and control myself*[265].

In this case, it is suggestive that, the condition of chronic disease and not being able to get cured has developed depressive sentiments leading to suicidal tendency. Encyclopaedia of medical anthropology (2004:27) writes, "Importantly, the term syndemic refers not only to the temporal or locational co-occurrence of two or more diseases or health problems, but also

[265] Personal Interview- June 27th , 2013, Holleri, Rolpa

to the health consequences of the biological interactions among co-present diseases." In addition, since the person is not being able to get rid from his diseased condition and bearing additional responsibility of small children to rear them, the dire stage of poverty has created such a deplorable situation even he could imagine to throw away his children to the river as a final plausible solution. In this case because of sickness condition of their parents, children are suffering and father himself has to live a undiagnosed condition of his problem. District health report (2012/13) shows, among ten leading morbidities, unknown and unspecified causes of morbidity is in highest ranking that is followed by gastritis and acute upper respiratory infections. The construction of "*Agyat rog*" (unknown disease) which professionally means "unknown and unspecified causes" by Nepalese media and health professionals is a typical symptom existing in many epidemiological patterns in rural districts including in Rolpa. Lack of human resources is one of the key factors acknowledged by district health office report; however there are other factors like low sense of responsibility and no political commitment towards health also reflects on unknown mortalities due to unknown morbidities. In this case the person has shared his wife has died because of an unknown disease (*Agyat rog*), the dire condition to create this kind of sufferings to rural poor is a sheer example of structural violence that is perpetuating in everyday life in Rolpa. Kleinman (1988) writes,

> *Our economic and social system places pressures on all of us, but for the powerless the local system does not deflect the impact or reduce the effect of those pressures on the person. Unemployment, Underemployment, and defeating work situations contribute to vicious cycles in which those with the least access to local resources are exposed to ever greater financial pressures, as well as to oppressively unjust relationship about which they can do little.*

There are different layers of structural power relationship which operates as societal antagonistic forces to victimize the individual. Larger level social determinants like persistent nature of rural poverty chronic stage of unemployment and non-functional local institutions are equally perpetuating to induce social sufferings in this case in Rolpa. Similarly, non-avoidance of long term sufferings because of chronic disease also develop suicidal tendency. One of the epileptic patients I have interviewed at Gajul expressed,

> *I was not well since my youngest daughter was three years old, now she is already twenty six years old. Once a horse had eaten our paddy then after, I began to feel uneasy. When the problem starts (Bethale chyapepacchi) I lose sense, my eyes ring and I vomit. Then I followed a shaman´s advice and took an amulet, I was alright for a few months. Then again after five months, my hands got burnt in the fire. You see, four times my hands have been already broken, I fell down from the upper floor, now you can see I have problems in my thigh. One of my hands was burnt 15, 16 years*

ago. But now both of my hands are giving a problem. Last time I was in Bardali, when I suddenly started to feel unwell, I fell down from Bardali, and now I have a problem in my back. My daughter in law offered me honey and ghee to eat, but still I am not cured (Niko vhayena). Despite my condition, I used to take care of my children. When I became unwell, my husband damned me and he searched another wife. My children were too small. Now who would care for them? Now, my husband is dead. I am fifty three years old. I do not have any tension, my son and daughter both have children. I neither can sit or stand properly. In this kind of condition, I am unable to die, I cannot understand what is happening. Sometimes, I go outside in the cold hoping that I will freeze to death, but I am not dying. If you can help me, give me medicines to die, so I can die easily[266].

In this case, the primary condition of epileptic disease was not treated and it's further created stage of disability which is responsible to create additional social sufferings. As Kleinman (1988:181) writes, "Social movement for the chronically ill is back and forth through rituals of separation, transition and reincorporation, as exacerbation leads to remission and then circles back to worsening, and so on." In this case also, it is suggestive that she has been separated, excluded and her sufferings have been reproduced up to the level where she is compelled to think that death is better than her present life. Though she asked me to give her medicines to die , she is still hoping to eat medicines to get cured; her aspiration to live a life has not literally dead in fact, when a local health worker has assured to bring medicines, then she talked with little bit of hope. In reality, the woman was coping with silent sufferings within hundred meters of Gajul health post and it's another exclusion done by local health post to treat her problem. In many cases high degree of stigma leads to commit suicide, if depression cannot be tackled at psychological level it reaches up to the biological level where neurochemical gets altered. The chronicity of altered neuron chemicals finally results in suicide if patients do not get timely treatment.

Working papers of the district police office shows the increasing incidents of suicide in Rolpa in the post conflict scenario. In fact, there has been low reporting of suicidal cases in war period and many of them were tackled by the Maoist people´s court (*Jana Adalat*). During active days of conflict, the absence of government authority, strongholds by the Maoists and secret functioning of people's court (*Jana Adalat*) were some of the reasons that incidents were not reported. Incharge from District police office mentioned,

I have worked in many hill districts. Everywhere the story is same, I think in hill districts suicide is normal. In Rolpa, poverty, depression and loneliness is influencing people to commit suicide. Similarly, in advance age, people do feel alienation. Most of the active ages people go to seasonal job ,advance age people do not have any

[266] Personal Interview August 7th , 2013 Gajul Rolpa.

option to kill their time. Just to forget their loneliness, alcohol becomes the final means and finally in long term it leads to depression and people commit suicide[267].

The psyche of perceiving suicide as a "normal activity" even to such important government officer has given the impression that suicides committed by many people in hill districts are no more sensitive for many powerful people who does not have to bear the consequences of such tragedies. District police office report shows some other factors such as indebtedness, incapability of managing costs for health services, alcoholism, chronic illness and conflict-induced depressions are the prominent factors to commit suicide in Rolpa. In addition, there are many incidences of suicides by hanging and swallowing poison. Similarly, extramarital affair is another social dynamics that overtly and covertly perpetuates suicidal incidents. A health worker from Sulichowr PHC mentioned, "We have dealt many poisonous cases; root cause is infidelity and extramarital affairs. Those women whose husbands are outside commit suicide to escape from unintended complexities". Moreover, I was told during the interview, the failures of not being able to hide their "illicit relationships" have also reflected in suicide by many women. One of the local politicians from Holleri has blamed newly expanded technology for creating suicidal condition, he said

> *Because of mobile, male and females are coming together. Our young people are falling in love at a young age, watching porn movies (Bulu philim) and practicing unsafe relationships. If one becomes pregnant and is not being able to hide illicit relationship, this kind of social phenomena is contributing to the trend of suicide. Whenever there is a problem in a relationship, easy availability of pesticides is another factor that supports people to implement the decision taken in hurry*[268].

As pointed out in this narrative, the easy blame that has been put on newly developed technology undermines many other structural factors those are playing overtly and covertly to take decision to end the life. Local culture like '*chorrito basne*[269]*'* among Magar community is another event that gives many boys and girls the possibility to find the public exposure which is accompanied by singing, dancing and drinking alcohol. A cell phone may play a role to make personal relationship more communicative. Particularly in ethnic Magar and Gurung dominated areas, such public exposure create situation where young boys and girls can utilize public space to come together and understand each other, however, lack of other educational and life skills to tackle the complications those arouse in relationship is leading to commit suicide. Moreover, the open selling of pesticide create supportive environment to articulate

[267] Personal Interview-2013th , 11th August, Libang, Rolpa.

[268] Personal Interview- June 27th , 2013, Holleri, Rolpa

[269] Because of civil war and rampant level of labour migration, this kind of culture is in diminishing trend in Rolpa.

immature decision taken in the time of unstable mood, however, rather than blaming the pesticides as a cause for suicide, the repressive societal condition which are responsible to take such fatal decisions should be acknowledged in this context. District police report shows in comparison to other reasons there are very few cases of suicide, those were committed because of failed relationship in personal affairs. Apart from this, domestic violence, social abuse, alcoholism and growing medical loan are some of other factors to support the rate of suicide in Rolpa. Many people that died because of hanging, falling down related causes and local, have to bear additional legal tension after occurrences of unintended deaths in Rolpa. One of the senior persons from Thalibang mentions, "once there was a suicide case in the village, local police said there cannot be post death rites without doing post mortem, there was no district hospital and doctors available at that time. It took three days to take a stinky dead body to Dang and another three days to return with the same dead body[270]". According to rules and regulation only certified medical doctors can do post mortem, in this case the dead body and its relatives has to suffer nearly for a week just to get legal clarification of that particular death as a non-criminal event. Even in present days, people have to carry dead bodies from peripheral regions to district hospitals which could be one sided a day or longer. The deplorable system of public health is even giving torture to death ones who might have never seen doctors in their lifetime, which literally means not only the alive one, even the dead body has to suffer (*laasle pani Sukkha napaune*) from institutional policy at present condition of Rolpa, the scenario is even similar in most of the rural life of Nepal.

[270] Personal Interview-2013th , 11th August, Libang, Rolpa.

CHAPTER VI

6. Health crisis in Rolpa: Interplay of power, people and politics

After conducting long term fieldwork in Rolpa, a new realization emerged in my mind, that has thoroughly transcended my prior understanding of ethnography as a methodological tool to conduct anthropological study of any society. I have developed significant differences between studying ethnography in a textual world and empirically experiencing everyday sufferings in a complex world as an ethnographer. The agony, pain, frustration and ethical dilemma, those experienced during the process of exploring particular events through the process of 'retrospective narrativization[271]' are far complex than researcher's theoretical understandings of ethnography in the textual world. In the process of ethnographic textualization, social sufferings and dynamics of structural vulnerabilities embedded with every events have literally created the frustrations, because every 'painful body' of any individual is the conglomeration of social, cultural and political factors in a particular landscape and by that have deeply affected my emotional psyche which was beyond the theoretical interpretations. Furthermore, with the use of "manipulative form of academic power" hold by an ethnographer, in this research, dynamics of social sufferings are theoretically interpreted, and however in the process of justifying ontological realities from the chosen epistemological framework may lose the real essence of the sufferers' narratives and their life experiences. In the process of reflective understandings, I have explored that the dynamics of sufferings are beyond the level of academic interpretations where one has to explore the layers of abstractions, that transcend the limitations of theoretical tools and methodological prescriptions. As Kleinman (1988) mentions, the ethnographer's interpretation commonly challenges common-sense understandings. In this context, my own "common sense" understanding on rural health institutions and the nature of sufferings have been challenged drastically which compelled me to develop additional layers of interpretations that go beyond the lay understanding on people's health beliefs, practices and

[271]"Retrospective narrativization is also frequent in situations where an illness had a catastrophic end, or when such an end has narrowly been avoided. In these instances, narrative may hold a moral purpose; it acts something like the recitation of myth in the ritual that reaffirms core cultural values under siege and reintegrates social relations whose structural tensions have been intensified". (Kleinman 1988)

institutional response in the context of Rolpa. Keeping oneself in dialogical mode, the notion of critical ethnography has been followed to understand the dynamics of the personal, socio-cultural and structural power relationship with health institutions and raised critical queries on those conditions which are overtly and covertly responsible to produce such vulnerabilities. Following the notion of expanded conceptualization, every illness narratives are as personal as social and as cultural as political. Thus the unraveling one dimension supports to explore other dimensions as an integrated whole. Moreover, ethnographic exploration has been epistemologically interpreted from the perspectives of the Critical Medical Anthropology (CMA) as a major theoretical framework with conjunction of biopolitics and critical realism as a supportive framework. As I have outlined in the introductory chapter, Critical Medical Anthropology suggests any disease an etiology conditioned by a larger level of sociopolitical, environmental and historical forces which are directly and indirectly playing a role in terms of shaping health related behavior and people's responses to their illness conditions. Here, to develop the broader understandings, the WHO (1949) conceptualization of health has been borrowed to explain people's health as a complete state of physical, mental and social well-being and not only the absence of disease or deformities. As Baer *et al*. (2004:4) describes, CMA understands "health issues within the context of encompassing political and economic forces - including forces of institutional, national and global scale - that pattern human relationships, shape social behaviors, condition collective experiences, reorder local ecologies and situate cultural meanings". The everyday sufferings of the people are the byproduct of different forms of institutional power emerged as 'ills of the modernity' where lay understandings are not sufficient to understand the different form of social, cultural and structural factors, which are increasingly shaping their choices and their life expectations. The conceptual application of the CMA to understand the social origins of sufferings in order to provide powerful alternatives to mainstream the notion of health is one of the epistemological callings of this study. Moreover, as an emancipatory philosophy, critical realism further suggests to diagnose the social sufferings as 'ills of modernity' and raises powerful critique against the existing structure, which are responsible to create such inhuman conditions. As Winkleman (2008) writes, an advocacy approach is necessary to counter the existing imbalance of power and accordingly to substantiate this argument, the critical, political and economic approach provides intellectual queries to judge the production of pseudo-legitimacy of socio-historical forces and their intrinsic power relationship and further propose counter ideological proposition to reinforce equality and justice in the society. Similarly, Morsy (1996) notes, that the critical approach to health in

medical anthropology is distinctive not simply because of its scope and concern with the macro level, but more importantly by its commitment to embedding culture in historically delineated political–economic contexts. The goal is not to dismiss the contributions of micro analyzes of illness and healing but rather to extend the realization of the relevance of culture to issues of power, control, resistance and defiance associated with health, illness and healing (Morsy, 1996). Specifically, rather than understanding cultural dynamics as a regular phenomenon of the society, the CMA suggests to understand existing culture and its counterproductive role to create illness and sickness from the political and economic perspectives with dialogical intervention. Such dialogical intervention is ultimately guided to bring transformation in the society where every marginalized population of the country could equally enjoy the notion of justice and equity in terms of health related resource distribution.

6.1 MACRO-SOCIAL

Empirical data on socio-political history, crisis in selected public health institutions and the persistent level of human suffering in Rolpa shows the complex layers of contestations between people's expectation and priority of the state in terms of resource and power distribution. In this kind of contestations, people expect the state to address the aspiration of the people whereas state mechanism is insufficient to respond to those 'felt needs' and expectations. In the context of Nepal, there had been an underperformance of the 'authoritarian state' to response the felt needs during the period of the Rana oligarchy and the Panchayat government as well as also in the post Panchayat era. The 'authoritarian state' had been frequently challenged by the people by the global rise of democratic values and aspirations to see emancipatory changes in their life-world. Among different changes, the invention of antibiotics in 1950 have assertively penetrated many exotic regions of the world including Nepal. As a country, geopolitically connected with India and China, many European visitors used to visit China and India via transit through Nepal. The socio-historic origin of Western medicine in the context of Nepal was directly connected to the presence of Capuchin monks and Christian missionaries and in succeeding days British doctors, Bengali doctors and mission workers from other European countries. As Pool (2005:68) writes, "Power, according to Foucault is no commodity or attribute of status, but a strategic relationship". This strategic relationship is significantly important in relation to the expansion of bio medicine with expansion of medical capitalism that has strategically reproduced a new 'biomedical class' in Nepal. The hegemonic presence of Western bio medicine has challenged native healing practices and labeled both, good and bad practices of native healing

as an ‘alternative’, ‘non-scientific’ and ‘traditional’. With the aggressive market penetration, the good practices of indigenous healing like psycho-social and spiritual dynamics have been challenged and the ‘power of bio medicine’ has been assertively expanded through the policies of the state. The hegemonic ‘power of biomedicine’ and its claims of ‘being scientific and rationale’ have been reproduced and nurtured by state health care system of Nepal and provided unrestricted access to get expanded in every sphere of public life in Nepal. The early introduction of Western bio medicine by missionaries and monks in contemporary Nepal appeared as an ultimate “curative solution”, which were neither critically challenged nor raised the questioned against its imposed rationality.

As outlined in Chapter II, during the “national unification” process, the way Capuchin monks were involved to treat soldiers and combatants who were injured during the war, suggests, that a different form of Western bio medicine has been introduced to Nepal. Likewise, the act of recruiting British doctors as personal physicians for the Rana prime ministers or by expanding modern hospitals in different regions of country for personal benefits, Rana prime ministers have played a significant role to expand the Western bio medicine within the political territory of Nepal. However, such kind of institutional services of health care initiated in the Rana period were sporadic and not sufficient to cover the health related necessity of the country. Doyal and Pennell (1976) have mentioned that nature of health, disease and medical response to these problems in the Third World is directly related to the capitalist development on a global scale. In this context, the interest to accumulate profit has been supported by market friendly policies on health adopted by the Nepalese state post 1990. As Singer and Erickson (2011:97) writes,

> *Policies can also have good intentions but unintended and foreseen consequences. Whether it is by reinforcing structural violence or as the result of the inability to anticipate results, policy can cause harm. It is policy that put people at risk creates disparities, creates built environment that undermined healthy living, allows harmful product to enter the market.*

In supplement to this argument, the adoption of the “liberal policy” after 1990 in Nepal supported the rise of unregulated medical markets all over the country, which has provided legal and “ethical” environment to those medical entrepreneurs to legally manipulate the sufferings of people under the legal umbrella of the state. Arguably, rather than seeking any alternatives of bio medicines and its nosology, the state has adopted Western bio medicine as an inevitable gift of modernity. At present, the usage of bio medicine has been formally accepted, philosophically “rationalized” and institutionally expanded through the wider

network of the health service system all over the country in Nepal. The negation of a modern educational system before 1950 as a conscious political act by the Rana rulers has negated even the chances to flourish the potentialities in the native healing systems. Instead, the situation compelled to adopt and implement Western bio medicine as a "scientific", "rationale" and "modern" alternatives. Since early phase, most of the health policies in Nepal were developed by medical doctors that deliberately promoted bio medicine and its curative dimension as an inevitable solution to improve people's health. By now and then there has been a severe shortage of critical thinkers on the policy level and also in academics to raise alternative voices against such domination of allopathic practitioners at the level of the policy formulation process which could challenge the forceful propositions of biomedicine and its claims. At present, as an ills of modernity, bio medicine and its "hyper rationality" has created a false 'regime of truth' and a large section of Nepalese consumers accepted it as a "normal" and "inevitable solution" of modernity.

During Cold War, the ideological polarization between US led capitalist countries and the Soviet led socialist countries has influenced countries all over the world including Nepal. No sooner there has been a rise of democracy in 1950 as there has been an introduction of US supported foreign aid in the name of an integrated development in Nepal. The US government had a fear of an increasing Russian influence in South Asia. Therefore, in order to maintain its geopolitical influence as to suppress any kind of radical political development; USAID has been strategically channelized in Nepal. This support is intrinsically loaded with vested interests of powerful aid founders to control the influence of communism among the rural population. Theoretically, the concept of an integrated rural development project has given priority to identify the local needs at village level, however, there has been already a 'design crisis' in the program prior to prescribe it as panacea for rural poverty. After overthrowing the century long Rana reign in 1951, the presence of political representatives from all over the country through the election process of 1959 has developed an equal sense of participation to the political structure of Nepal. However, there has been no participation of the people in any plan or policy which was supposed to bring changes in the ordinary living standard. Such kind of non-participation has reflected even in donor driven projects like the IRDA. In contrast to the promises of delivering required services to the rural poor, most of the funding which were allocated to projects used to go back in the name of expert's salary, international technical consultants and meager amount used to articulate at the village level. It has been further noticed that, though overtly IRDP project are more focused to

improve the living standard of the rural people with use of advanced technology and knowledge in their life, however, authors like Khadka (2000) and Poudel (2012) have mentioned, that one issue of the the covert strategy to launch the IRDP in the mid-western hill region is to prevent 'poor people from being political tools in the hands of radical forces'. In reference to the IRDP, Poudel (2012) has argued, that launching any kind of development activities may not suppress critical consciousness but instead it destabilizes the current pattern of society with growing anger against false promises shared in the name of development. In this sense, Poudel[272] (2012) further argued, failures to address the rural concern and articulation of false promises has ultimately created a situation to raise a decade long Civil War in Nepal. Likewise, Subedi[273] (2005) has critically argued, that the channelizing of development aid is expected to empower the socially and economically disadvantaged groups and lead to self-reliance, in contrast to this development, aid has created more powerlessness and dependency. Similarly, by following the international declaration, the ban imposed on Chares (Hashish) collection activities directly hampered the income generating activities of people from the Northern region of Rolpa. Such legal prohibition was a sheer example, where the government blindly followed the international declaration without critically rethinking the multidimensional value of marijuana plants beyond extracting Chares. In contrast to the expectations of the program designers of IRDA, the "development program" initiated by the international agency could not alter the rural livelihood; on the other hand legal prohibition to collect Chares has seriously suppressed the income generating activities and hampered social well-being of many people in Rolpa. Even at present days, many Chares producers were arrested for performing "illegal activities" and the state has brutally exercised its bio power to punish many innocent bodies in the name of performing illegal acts, which has ultimately intensified the hostility and aggression against

[272] Poudel (2012)writes, "Developmental empowerment cannot eliminate the possibility of critical consciousness and revolutionary subjectivities. It must destabilize the social structures of the present to legitimize certain ideas and trajectories as universal with false promises about the future. The promises have to be false because development cannot be a desiring idea without reproducing the relations of subalternity. It makes the subjects feel inadequate and puts them in a state of becoming in order to generate their desire to become full beings. But these moments of destabilization, along with politically proactive re-articulation of such false promises by organic intellectuals, can generate the possibility of a new politics and a common sense of radical transformation. The emergence of the Maoist movement in the Rapti region of Nepal was one of the culminating moments of the history of the continuous articulation of change occurring at multiple levels".

[273] Subedi (2005) writes, "By examining the overall economic condition of the country in general, and Rapti-IRDP in particular, it can be stated that foreign aid has been unable to alleviate poverty and underdevelopment in Nepal. The practice and concept of IRDP strategy in Nepal has failed to improve the quality of rural poor. On the contrary, foreign aid has rather created dualism, widened the gulf between rural and urban population within a region and created inequalities among regions".

the state. On the long run, the dire situation of joblessness and aggression against the state for banning their regular income generating work has been articulated in the form of radical political strength, which is one of the causes to join the "people's war led by the CPN (Maoist) by many local Chares producers in Rolpa. Not only in the case of suppressing Chares production, the forceful assertions of international funding agencies to implement plans and policies conceptually prepared in different setting and physically to be grounded in our setting had lots of drawbacks. For instance, as explored in second chapter, the WHO initiation to design a country health program in 1974 has been criticized for being a top down approach for not being able to understand the local dynamics and felt needs of the people. As Banerji (1985) writes, health service development should thus be considered as purposive interventions in the health culture of a community. Such interventions should involve a careful analysis of the pre-existing situation and formulation of an intervention strategy, which is both perceived and felt by the persons concerned to be an improvement on the pre-existing situation. According to Banerji, health service system can work as a "progressive engine" to eliminate the regressive health culture of the society, where rational intervention of the public health system can bring many changes in the health outcome of the population. In the context of Rolpa, the non-construction of the district hospital for more than two decades, which is regarded as tertiary care of the district has affected the referral system to deliver its responsibilities in an effective way. Such kind of non-completion has promoted the trend of non-intervention to the regressive health culture of the community, where patients are compelled to seek different forms of alternative healing practices. Moreover, the three year interim plan of 2007/08 to 2009 / 2010 writes:

> *Policy will be made clear and effective in order to enable the government, NGOs, private and cooperative sectors to establish, manage and operate health institutions. Further, to provide quality health services through such institutions, human resources, financial and physical resources will be adjusted and managed in an effective way. Regulatory mechanism will be developed and adopted to make service delivery and management effective.*

Following this notion the Gairigaon health post in Rolpa has been constructed with support of an international donor agency. During the process of construction, rather than addressing locally 'felt needs', the Gairigaon and Kureli health posts have faced severe controversies for neglecting expectations of concerned stakeholders like local people, health posts staffs, the health facility management committee and district health office. In Gairigaon, there has been no assessment of pre-existing conditions which have resulted in lack of private rooms to

check up female patients, insufficient space to both working staffs and also for the patients. Moreover, contrary to the values of Alma Ata declaration, which mentioned that community interests should be properly taken into account, however no political parties have expressed their benevolent political interest and articulate their responsibility while constructing the Gairigaon sub health post building. Similarly, the ninth plan has acknowledged the gap between lack of proper coordination between NGO, INGO local government and community interest, however there has been no articulation of such realization to develop collaboration between concerned stakeholders to construct the Gairigaon sub health post in Rolpa. The manifestation of non-responsive attitudes to supervise the construction process by the district health office or above the level supervisory chain shows, that there has been a manifestation of intentional negligence in the health bureaucracy, which ultimately victimized the local level health staffs and concerned facility users. Ironically, either it's a country health plan developed by the WHO in 1974 or imposing structural adjustment policies in support of the World Bank and the IMF in the post 1990 era, which continued one sided imposition of agenda to construct the Gairigaon sub health post. It shows the trend of domination by internationally powerful actors in terms of developing health policies that continue even in the present context. As Justice (1986) observed, three decades before, this research has explored similar kinds of one-sided imposition by international agencies as per their interest ignoring the local expectations and necessities. This example shows that such kind of a trickle down model of development is not producing fruitful results in terms of local development and to address the felt needs of local people.

Following the notion of virtue (*Punya Kamauna*) different local donors have donated land (*Daan dinu*) with minimal expectations in the case of the Nehrpa health post, the Jinabang health post, the district Panchayat office and the taxation office in Rolpa. However, the difficulties to manage free land for the Gairigaon sub health post, the Oat health post and the Libang Ayurvedic Aushadhalaya shows the growing trend of self-centrism and individualism in Rolpa. As outlined in second chapter, the frequent demonstrations of power to pull public institutions in the vicinity of own benefit and not donating land to construct public institutions because of the increasing monetary value of land has created a paradoxical situation, where people are manifesting lower interest to sustain public institutions and instead seeking more benefits from them. Evidently, in terms of satisfying personal wants by taking benefits from public institutions, the episodes of corruptions have occurred in different institutions like the Rolpa District Hospital and also in the health posts like Thabang, Gajul,

Jinabang and the Ghorneti Model Hospital. In these cases, the corrupted attitude of involved actors is basically guided by consumerist notion and has played a crucial role to create counterproductive solutions in the process of the health infrastructure development process in Rolpa. As outlined in third chapter, the mushrooming of unregulated medical shops all over Rolpa are adverse impact of the failures of the public health system of the state. Evidently, most of the medical shops performing unethical prescriptions in Rolpa are operating as a local agent of larger medical market which are basically focused on profit accumulation in the name of responding medical expectations of the people. The rampant presence of quacks and their profit oriented medical shops from the district headquarters Libang to many villages in Rolpa is one of the highly unregulated and unmonitored phenomena that has been playing an adverse role in terms of people's health in Rolpa. The non-use of power to regulate such activities by the state actors is further supportive to create conducive environment to perform medical malpractices in Rolpa. In many instances, the political protection in case of the private clinic in Libang and Dang or a person attempting to administer spurious vaccines in Rolpa, the power relations of market players with politically powerful actors have developed a web of exploitations, that has victimized many powerless people in Rolpa. As Qadeer (1985) writes, "the capitalist system thus produced the commodity, 'health services' which had an exchange value but not necessarily a use value, since it does not always produce good health but only suppress the symptoms of ill-health". In the broader context of Nepal and the specific context of Rolpa, where the public health system is not being able to satisfy people's basic health care needs, many people have to suppress ill health in many conditions and finally one has to become a 'docile' of an expensive medical market.

As outlines in third chapter, during the Civil War, Maoists have substantially utilized government medicines channelized through the health service network of the district. Simultaneously, it was necessary for them to buy medicines from different contractors by paying higher cost than the contemporary market cost. The challenging and risky journey performed by war profiteers during the Civil War to sell medicines in war zones like Rolpa shows, that war is a profitable business where few people maximize personal wealth on account of the cost of lives of many war victims. Likewise, the Maoist new health workers of the OMSA's claim, that organizing sufficient numbers of mobile medical camps targeting the health related necessity of the rural mass in Rolpa were conceptually not different from the health care services that have been provided by both state and non-state actors in the context of Rolpa. On the one hand the CPN (Maoist) claims of organizing medical camps during the

ongoing political violence in *Sankatkaal* is highly dubious. This situation is more or less similar to the Farmer (2006) observation[274] in the context of Haiti where he said, 'one can patch of the bleeding wounds but it is not possible to do any kind of public health in the middle of political violence'. In the post conflict scenario, OMSA has shown a limited focus on the public health approach by developing a trend of delivering daily orientation classes to the patients coming for a visit at the OPD, however this practice has been discontinued after moral and political crisis affected the Maoist model hospital in Rolpa. The ethnographic data shows that, either it's a Nepal government's mixed economic model on the health service system or the "socialistic medicine" forwarded by the Maoists by producing OMSA workers in Rolpa, both of them have predominantly curative orientation rather than promoting the values of public health. The flow of biomedical health workers from the government health service system to join the Maoist people´s war and the composition of the ANPHW(R) with the same set of people under the banner of CPN (Maoist) shows, that the Maoist new health workers developed under the umbrella of the "progressive red flag" is by and large similar to Nepal government's orientation on health and medicine. As Kleinman (1980:32) writes, "The bias of many health professionals in developing societies is to restructure health care delivery in their countries by imitating an idealized model of professional care in technologically advanced societies." In the context of Nepal, the governmental health care system subscribes the idea and designs basically produced in developed societies. Similarly, the involvement of government health workers in the Maoist party to develop separate health ANPHW (R) has also followed same concept of health that directly and indirectly promote bio medicine as an inevitable solution in terms of patient´s care in Rolpa. Empirically, there have been many instances where a hegemonic form of market penetration has manifested in Rolpa. For instance, activities like offering free vehicles to health workers of Rolpa to attend an antibiotic promotional program and substantial numbers of medical shops which perform malpractices are directly reproducing the profit making agenda of bio medicine in the cost of people's sufferings in Rolpa. The unethical prescriptions of electrical therapy, pain killer injections, antibiotics, vitamin capsules or performing blind surgery without diagnosis are some of the empirical evidences explored in Rolpa. In these cases, local agents of larger medical market have inappropriately subscribed biomedical knowledge and applied

[274] "You know, you can do your best to patch up wounds, and, you know, you make sure that someone who's bleeding gets sewn up and transfused, but you really can't do any good public health in the middle of political violence. It's just not possible". During Interview given by Dr. Paul Farmer to National Public Radio, entitled Haiti violence disrupts health care services.

unethically into people's bodies to fulfill their profit making greed. The advertisement broadcast through one of the FM Radios based in the district headquarters related with a Japanese[275] volunteer doctor as a visiting consultant is an additional evidence to show how profit accumulating values of the local medical shopkeeper has manipulated the notion of volunteerism and benevolence shown by a Japanese doctor serving the rural poor in Rolpa on his personal expense. This kind of trend is contradictory to Alma Ata (1978) which has visualized the role of mass media as a "supportive educational role by providing valid information on health and ways of attaining it". Moreover, the part time job being done by same government health workers by running a medical shop to make extra profit is mainly benefiting those medical staffs rather than playing any significant contributions in terms of people's health in Rolpa.

In the post 1990 scenario, Nepal actively followed structural adjustment policy especially during the reign of the Nepali Congress and the CPN (UML) government. Afterwards many private medical colleges, nursing homes and curative based hospitals were mushroomed all over the country especially in city areas. The adoption of hyper market policy in the name of economic liberalization and imposition of a structural adjustment program all over the country are some of the features that state has overtly legitimized the corporate involvement in the health care services. It has ignored the welfare responsibilities of the state, which is even contradictory to health as a basic fundamental right guaranteed in the constitution of Nepal. There has been lack of critical orientation to seek radical alternatives in the present context of a deplorable health service system in Nepal and the domination of bio medicine has not been challenged sufficiently in both the political and the academic arena. However, at the level of the agency, no organized counter hegemonic movement specifically targeted against bio medicine has been emerged, the situation is even similar to the broader context of the country. Exceptionally, the spontaneous rejection to administer spurious Hepatitis B vaccine in Rolpa has shown some level of informally unorganized activity to reject the profit making interest of profit seekers of biomedicine, which has been appeared to response to a potential hepatitis risk in Rolpa. AS outlined in third chapter, borrowing the concept of barefoot doctors from China to treat the injured combatants during the war, the CPN (Maoist) has attempted to develop "progressive health

[275] Dr. Ryuki Ishida has been working as a volunteer teacher by establishing rural health research institute in Rolpa because of his family background related to Mao's people war in China. According to him, his father was arrested by Mao's red army in China and left him alive, then after he developed the perception that Maoists are supportive to people.

workers" in the name of the OMSA workers. These workers were theoretically inclined to socialistic medicine and it has been mainly proposed as an alternative to the state owned health service system in Rolpa. Moreover, the agenda of their mother party the CPN (Maoist), the ANPHW(R) was also focused on overthrowing the national political system but never interpreted contradictions of a national health care system and its inherent contradiction and limitations. Such kind of ideological immaturity of the CPN (Maoist) has not brought significant changes in terms of developing "progressive culture" on health as they have mentioned in their political manifesto. Though the CPN (Maoist) has claimed that the OMSA will have a different orientation on health and also assumed to deliver socialist patterns of health services, however, the CPN (Maoist) neither could criticize the contradiction of the capitalist heath care system nor could understand the problems inherited in the national health care system. In such cases, according to Scheper-Hughes (1990) there must be an "anthropology of affliction," with an orientation to practices that resists the hegemony of bio medicine, where such hegemony can be challenged and altered drastically as critical realistic interpretation to bring 'transformative and emancipatory consciousness' in the society.

6.2 INTERMEDIATE LEVEL.

On the intermediate level, the CMA suggests to understand the interaction between the service seeking individual and the health institutions of the society. In the context of Nepal, such interaction between individual and health institutions have been historically shaped and politically manipulated. Therefore, without understanding the politico-historical construction of such interaction, it is not possible to understand the current pattern of conflicting relationships between service providers and service seekers. As an important sub system of the state, there has been substantial effort to develop and expand health institutions at different reigns in the political history of Nepal. In the era of territorial expansion, the potential expansion and constriction of Nepal's political frontiers used to be shaped and reshaped on factors based on military strength. Even after the modern nation state building process has begun, Nepalese economy was affected and driven by war led economy for another half century. Consequently, since the time of its modern formation in 1825 AD, prosperity and stability of a premature nation state like Nepal has been always a complicated process. The pre-modern history of Nepal is mainly confined in war related activities to expand political territory rather than showing any health related concern to address everyday sufferings of its citizens. However, the description of Arogyashala during the reign of Lichchhavi Kings Narendra Dev (643 – 679 AD) and Man Dev (464-505 AD) shows that

there has been a germination of institutional care before rise of Nepal as a modern nation state in 1825 AD. Such kind of institutional care is not sufficient to address the contemporary necessity of the Nepali people, as a result, a large section of people were relying on traditional healing patterns controlled by Shamans, Vaishyas and faith healers. In such scenario, countless numbers of people have lost their lives due to the biophysical complications emerged beyond the treatment experiences and knowledge available within the domain of traditional healing practices in Nepal. As outlined in chapter third, the act of expanding hospitals by different Rana prime ministers for their personal benefits or to address the health related necessity of the society, in early phases many health institutions were developed as random activities without following any strategic plan in Nepal.

The development of social determinants of health like the political system and educational institutions are preconditioning factors in every society to develop a matured and responsive health service system. The period of the 1960s was politically significant to rise political thoughts and movements all over the world; as a result, there has been influence of a global political momentum in South Asia and Nepal. The Rana government who were in Power for one hundred and four years has not promoted a modern educational system. Consequently, most of the sociopolitical actors involved to develop at the early phase of sociopolitical, health and educational institutions in Rolpa were mobilized voluntarily to become politically active and many of them did not even have basic education and exposure to understand day to day concern of the local people. As critical realists suggest, there should be the role of an actor to change the structure of the society in order to bring emancipatory transformation. As outlined in chapter second, the exposure of Berman Budha and his friends to the political workers affiliated with Mohan Bikram Singh[276] led communist party at Pyuthan Prison and personal connections of the pioneer democratic leader Khadananda Subedi to the activist of the *Jayatu Sanskritam* movement has played a role to penetrate political consciousness in Rolpa. There has been involvement of returnee migrants and also the role of left political workers appointed as a teacher from Pyuthan to teach local children in Thabang. Similarly, Maoist senior leader Krishna Bahadur Mahara based in Libang has done sufficient effort to sensitize his students with left political ideology. Similar kind of

[276]Mr. Singh who is regarded as a pioneer communist leader from mid-western hill district Pyuthan has claimed that his personal interest to study the progressive literatures available in Kathmandu has attracted him towards political literatures and he was reluctant to give credit to anyone for his exposure to left ideology. These "progressive books" were strategically channelized and made freely available with the support of Moscow based *Pragati Prakashan* to spread idea of communism in Nepal.

activities performed by teachers related to the UML and the Nepali congress are suggestive facts, that the teachers are important social actors and have played a productive role to nurture political ideology in the context of Rolpa. However, the political coup imposed by king Mahendra in the name of the Panchayat system in 1961 has dismantled local level political organizations and brutally suppressed juvenile state of democracy. Consequently, local leaders became politically directionless and such state of ideological disorientation has compelled pioneer local leaders like Khadananda Subedi and Berman Buda to accept a new form of political power in the name of doing "pragmatic politics". As a newly developed district emerged after the Royal political coup performed by King Mahendra in 1961, there has been a gradual introduction of new administrative institutions in the context of Rolpa. In terms of placement of the district headquarters, unhealthy demonstration of socio-political power by local actors to place the public institutions in their vicinity has been manifested as an example of human greed and controlling resources to satisfy personal wants in Rolpa. Here, interest conflict created by few powerful people to locate the physical placement of district headquarters is one of the most prominent conflicts that has ultimately marginalized the large section of the people that ultimately constructed a sense of alienation among the people from peripheral regions of Rolpa. The repeated reshuffling of adjoining districts like Salyan and Pyuthan to develop a new district in Rolpa has developed a low sense of belongings towards the frequently changing administrative structure, that has created physical and psychological distance towards the public institutions in Rolpa. As demonstrated in the second chapter, the health service system in Rolpa is suffering to fulfill different components like workforce management, information dissemination, rational use of medical products and technologies.

Likewise, in terms of day to day health service delivery, there has been a challenge to effectively implement the financing and leadership, and to maintain efficiency on management of governance and stewardship in the Rolpa health service system. The contestation of placing the Jinabang health post to fulfill the interest of the donor at the upper belt and the lobby of local shopkeepers to place the health institution in lower belt shows how interest of 'few people' becomes overtly powerful rather than locating health institutions to serve the mass necessity in Rolpa. Moreover, the contestations to shift district headquarters, district hospitals, the Ayurved Aushadhalaya of Pyuthan, the Reugha post office and the Sakhi health post to Holleri shows that 'informed and heard' (*Janne sunne Manche*) powerful local actors have actively demonstrated their socio-political power to position the health

institutions in order to gain overt and covert benefits in Rolpa. Evidently, powerful actors at the local level have shifted health post of Sakhi VDC to Holleri to make it more accessible, however, at present there is no sub health post at the Sakhi VDC even to access health institutions for basic primary care. Likewise, even after five decades of functioning of the Gajul health post in Gajul, people from the Northern belt of Gajul are still contesting to shift the Gajul health post from the present location to the Northern region. It has been observed, that in many contexts, political decisions and geographical placement of the health institution has a powerful correlation, therefore apart from financial and socio-cultural values, politics is one of the major factors behind shaping the access of the people to avail health care facilitates in Rolpa. As Frost and Reich (2008) mentioned, access involves social values, economic interests, and political processes, in every illness episodes, access to health care systems has been affected by the above mentioned factors in Rolpa.

The change of the political system from authoritarian monarchy to democracy after post 1990 could not bring stark changes in the living standard of the Rolpali people. The persistent frustration among the rural mass for not addressing basic needs have been capitalized by radical political force like the CPN (Maoist) during the decade long Civil War, which had been fought to bring radical social transformation, that has actively hampered the health service development and delivery process in Rolpa. Banerji (1985) writes,. health service development is not merely a managerial and technological process with epidemiological and sociological perspectives, but it is also the political process which is shaped by the modes of production and production relations. As outlined in second chapter, either during Panchayat or in Post Panchayat context, elites and actors with vested interest only to manipulate profit have overtly created obstacles to develop health service system in Rolpa. The dynamics like local political tussles, that had been substantially backed up by national political figures, it had taken more than twenty five years to complete the infrastructure of the district hospital, that is the main health service delivery at the district level in Rolpa. Ghimire (2009) writes, "The difficulties of the health care system in Rolpa did not originate with the Civil War. Rolpa has faced a long history of exclusion, characterized by a shortsighted government, a dysfunctional bureaucracy, and low levels of awareness by the population". The development of interests groups and their power conflicts in terms of resource allocation and consumption during the Panchayat period in the name of the Thapa Camp and the Chanda camp has actively hampered the construction process of the Rolpa district hospital. The episode of institutional malformation continued since prewar context has been intensified during Civil War. Likewise, the rise of the CPN (Maoist) has

created a completely adverse scenario to complete the construction process because the Maoists were not interested to accept any "developmental activities" performed under the banner of the "old state". CPN (Maoist) agenda of 'complete destruction for new construction' became one of the active causes for not allowing to execute the government's plan to forward the local development agenda. The non-continuation of constructing health related infrastructures substantial years after the official ending of Civil War shows that actors from so-called democratic era are also equally responsible for delaying the construction of different health institutions in Rolpa. The present condition of low grade infrastructure, limited space in the hospital, lack of non-medical facilities like a cafeteria and waiting rooms for visitors, a substandard latrine, insufficient lighting and deplorable stages of the hospital wards are some of the repercussions which are directly resulted due to the decade long institutional malformation in Rolpa. The three year interim plan (2007-2010) has given stress to construct new quarters in rural health institutions. In contrast to the policy recommendation, the promises made by the government were not fulfilled and even policy makers have not realized the sense of urgency to address the demands of both health workers and the local population. Similarly, because of the growing monetary value, it was difficult to manage land to build the Oat sub health post building where administrative work of the VDC, postal service and medical services were compelled to adjust in the same wretched building. After the peace accord in 2006, the health facility management committee was able to manage land, however, the government has not allocated the required amount of budget to construct the Oat sub health post building, which shows the government's low priority to invest on rural health infrastructure. Likewise, there has been no construction of the Gairigaun sub health post building nearly for two decades which is the manifestation of low preference and mismanagement of health related resources of the government. Collection of two rupees per person to sustain the rent of the Gairigaun sub health post in same district where other health institutions are facing millions of corruption is the policy paradox which shows the mal-distribution of the resources, that has explored in the context of health service development in Rolpa. Moreover, after the peace accord signed in 2006, the rehabilitation of the PLA at Tila at the Gairigaun VDC has suddenly hiked up the monetary value of land. As a result, it became difficult to get free land to build the Gairigaun sub health post. Finally the health facility management committee has decided to construct the Gairigaun sub health post and birthing centre building in a frosty place nearby a natural water source. This case, has shown how stakeholders of health institutions are more interested to grasp the international support rather than acknowledging the importance of those institutions to be built in a

physically suitable place from the public health point of view. Moreover, the corruption case of Madi Bridge or lingering of Martyr's highway or not constructing the road to link Thabang from Phuliban shows the problems in local governance which were specifically stimulated by the the Civil War.

There has been evidence where local actors have developed active political consensus to gear up the institutional development process and decided to buy public land to construct the Holleri health centre building, the Gairigaun sub health post and the Libang Ayurvedic Aushadhalaya. The construction of the Ghorneti Model Hospital in such a rural zone of Rolpa with medical and non-medical facilities offering extra services like acupuncture is an articulation of strong political will of the CPN (Maoist) demonstrated during war and post war period in Rolpa. These evidently shows, that common political consensus to execute a certain kinds of developmental activities brings productive outcome, however political misunderstanding hampers to achieve common goals in the community. The split of the CPN (Maoist) and its impact on the local health facility management committee into two factions has affected the the Gajul health post construction and supervision process. Likewise, political breakdown of the CPN (Maoist) has resulted in the cessation of the Ghorneti Model hospital. The decades long stagnation of the construction process of the health posts of Jinabang, Oat, Gairigaun, Gajul and the district hospital during the Panchayat and post Panchayat era, shows the non-responsive attitude of the central level government to the people. It has been explored that if the institutional development process has been frozen like in the cases of the Holleri, Oat or Jinabang health post, politicians do not demonstrate much effort to gear up the process. However, when construction process starts then there is a demonstration of an active political intervention either to take extra benefits from such a construction process or to recruit the staffs or management committee members who support their political line. Similarly, a common consensus developed by political workers of the "progressive party" to accept undocumented amounts from the contractor shows, that political domination of any party without presence of an active political opponent could be detrimental like in the case of the Thabang health post. The government has announced to upgrade the Holleri health post to the Holleri PHC in 1997. Even after one and a half decade there has been no initiation to construct the primary health care building. The repercussion of not constructing the upgraded PHC building in Holleri to address the growing demands has reflected in limited facilities for working staffs, limited space for cafeteria and waiting space,

etc. Since there is a lack of sufficient space[277] in the emergency room, there is a compulsion to use same room for dressing and dispensary. The unawareness of the management committee members representing the Nepal congress regarding the current status of the building has manifested sense of non-belongings to strengthen the local health institution. As a one of the important players in the peace process between Nepal governments, the CPN (Maoist) chairperson comrade Prachanda was more focused on country level political issues rather than showing interest on the district level development agenda. From the perspectives of the people who have cast him votes, the analogy of Kalbete[278] (one time success) to lead the "people's war" has not been reproduced to address the local agenda like the construction of the Holleri PHC building situated in his constituency. Instead, he was blamed for not hearing people's voices from the "upper level" as expected by local voters. Such a kind of gap between political commitment and people's expectations have created frustrations among the voters towards the political leadership and develop a sense of powerlessness and political deprivation. The trend of non-articulation of the political promises has been continued even during the period when the CPN (Maoist) as a "revolutionary force" was elected from Rolpa and also in the government as an elected political power. As a result, the stage of ignorance has been reflected in poorly designed and poorly built health post buildings which have been constructed by minimizing a huge amount of profit from the first contractor to petty contractors. After facing controversy in case of the Thabang HP, same contractors got contracts to build the health post building which also appeared in substandard form. Rather than punishing the repeated negligence of bureaucracy, it has defended the contractor by mentioning the complexity of construction site. Similarly, the way local Maoist leaders have shown a defeated mentality by saying that they could not understand the nexus between bureaucracy and contractors is yet another level of excuses which have manifested the sense of political immaturity and irresponsibility in terms of people's health. The evidence like the Gairigaun SHP where international donor organizations have not realized felt needs of the staffs, or the long term stagnation of the Jinabang HP or non-construction of the Oat SHP building. Holleri PHC are some of the solidly visible situations where health professionals have to deliver their services in a physically constrained[279] environment to sick people in the

[277] Likewise, OPD services, administrative task, including DOTS and pharmacy services were also functional in same room. In addition, Holleri PHC does not have ambulance service, no room to keep patient for observation and non-functional condition of post mortem building etc.

[278] This analogy has been described in chapter third, Kalbete means like banana tree which does not give fruit for a second time.

[279] At Oat sub health post, everyday working staffs have to compromise with different problems like room

literally sick institutions in Rolpa. The paradox of the Oat sub health post is, that local people are expecting to something to happen what a new government has promised to address their expectations. In reality, expectations and promises are never met and people have to compromise with a situation of powerlessness and sense of exclusion. The WHO (2009) writes, poor rural health infrastructure, both in terms of quantity and quality, may adversely affect the perception of health services in rural areas, thereby reducing demand. The evidence like non-construction of health infrastructures like the district hospital, Jinabang, Oat and Holleri even in the conflict and post conflict scenario are historically producing frustrations towards the government health service system, which eventually forced people to find other alternatives in the name of accessing quality health care. These kind of institutional malpractices show, that rather than operating politics as a 'panacea of human happiness' (*Sukkha dine*) in contrast the failures of health institutions to address human expectations reflecting as a 'causality of pain' (*dukkha dine*) in the context of Rolpa.

The low political priority on financing the rural health service system and the lack of effective supervision to monitor allocated amounts of the government budget in the construction process of the district hospital, Jinabang, Thabang and Gajul health post in Rolpa. Alma Ata (1978:30) writes,

> *The Government should express its political will to attain health for all by making a continuing commitment to implement primary health care as an integral part of the national health system within overall socioeconomic development, with the involvement of all sectors concerned; to adopt enabling legislation where necessary; and to stimulate, mobilize, and sustain public interest and participation in the development of primary health care.*

In contrast to the recommendation of Alma Ata´s declaration, the government has not articulated adequate political will in the process of health service development in Rolpa. The construction process of the Gajul and Jinabang health posts faced similar kinds of corruption processes of shifting contracts from the first to other petty contractors. Since the government contract policy demands national level contractors to apply for the tender, those contractors who are based in the capital city having an "A-grade" construction company are eligible to apply. After getting the contract, the first contractor handovers such a contract to the petty contractors minimizing drastically the amount of profit has directly created a policy loophole to support the chain of corruption. Specifically, the cases like granting the contract of district

---

insufficiency to run OPD services, lack of quarter facilities to staffs and also lack of store rooms and administrative work.

hospital to own relatives or drastically minimizing the original contract amount in the construction process of the Gajul and Thabang health posts are policy level negligence performed in the context of Rolpa. In these cases, the conjunction of the political and bureaucratic power nexus has been operated to accumulate excessive profit by particular individuals hampering the collective benefits. Rather than actively pinpointing the negligence of the contractor, the DUDBC blamed local actors for failing in provision of active stewardship in terms of the health post construction shows, that power can be brutally operated even to blame the victims. Similarly, there has been a cyclical pattern of a blame game, that exists between politicians, health staffs, contractors and members of the local civic watch committee in the case of the Nehrpa health post and its birthing centre construction process. This shows that trend of blaming others and simultaneously not performing own responsibilities. Likewise, the unclear area to use authority (*Chetradhikar*) is one of the crucial problems in the Rolpa health service system, which is evidently reflected in blurred conditions of supervision during the infrastructural development process in Rolpa. The way district level actors blamed local level actors and vice versa for not having full rights to raise the question related to budget transparency shows the visible level of power conflicts between the district level actors and the local level actors. Even in this case concerned stakeholders were avoiding to perform own responsibilities, instead blaming each other for negligence. Moreover, the conflicting dimension of the Holleri and Jinabang health posts has created a vicious cycle of blaming where one can notice the contestations among health staffs, politicians and local people blaming each other harshly on the basis of their ideological biases. Likewise, there have been stark conflicts between the medico-administrative power manifested by the conjunction of the health post in-charge and the VDC secretary in the case of the Gajul health post and sociopolitical power demonstrated by powerful actors of political parties. In such kind of power conflicts, there has been irregularity of the management committee meetings and non-supervision of the construction process during the construction of the Gajul health post, which allow the contractor to do monopoly in terms of construction. Dahal (2012) mentions, the relation-based rather than rule-based equation has distorted the boundary between the private and the public sphere. Either in the case of the district hospital or in the case of other health institutions like Jinabang, Thabang and Gajul, the series of relation based contract agreements performed were basically derived from unethical nexus between political actors and private players ignoring mass interest of the people in Rolpa.

The CMA has claimed, that the issue of health is highly a matter of political concern and there should be political attempt to address the expectations of the people. People's health related expectations are politically shaped and socially constructed in Rolpa, where along with geographical and psycho-social barriers, political decisions to locate the health institutions has also affected the accessibility to those health institutions. The declaration of Alma Ata (1978:58) writes:

> *Accessibility implies the continuing and organized supply of care that is geographically, financially, culturally and functionally within easy reach of the whole community. The care has to be appropriate and adequate in content and in amount to satisfy the essential health needs of the people, and it has to be provided by methods acceptable to them.*

In contrast to Alma Ata (1978) envisioned the notion of "geographically accessible", "financially affordable" and "culturally suitable" health care with "methodologically acceptable" contradicts with many instances in the empirical condition of Rolpa. Moreover, in the cases like performing surgery without diagnosis or discharging patients without transfuse her blood, private and the government health system both have imposed methodologically unwanted prescriptions. The construction of unknown disease *(Agyat rog*) is one of the failures of the Rolpa health service system where many people lost their life because of undiagnosed cases. The lack of a sputum testing facility in the Thabang health post and the way patients are forced to make a long journey just to test the sputum in a “big hospital” shows that in the lack of diagnostic technology, many patients have to begin late medication and compelled to bear unnecessary social sufferings. Effective technological support is a crucial component in the domain of health where rational use of technology directly affects the quality of health care. In the case of Jinabang, staffs have to walk half an hour uphill to contact the district hospital to pressurize to send essential medicines. Similarly, a person, who had to meet his home returning father’s dead body on the way because he could not timely contact his father due to poor communication network. In both cases, lack of effective telecommunications network has hampered both institutional performances and also created tragedies at the individual level. Similarly, in the complex transverse lie case of Thabang, where a woman has to die along with her baby, there was no availability of appropriate medical technology to rescue her from her complex condition. According to the institutional guideline, though the health post level is not supposed to perform such kind of complex delivery problems, however, apart from technological availability, in this case the layers of problems like unavailability of a transportation facility, the non-construction of

roads for a decade, a weak social support network and low importance expressed toward female's health are some of the factors, that play an important role in terms of availing timely care. Contextually, Banerji (1985) also writes, it is the responsibility of political leadership to articulate the people's aspiration in the form of political commitment (the so-called political will) and political action. Political action includes allocation of priorities for health and health services, mobilization of resources and policy formulation and initiation of the required administrative process. In order to initiate the 'required administrative process', formation of a health facility management committee after 1997 is one of the important indicators of decentralization, that has ensured the people's participation in terms of local stewardship on health institutions. However, the multiple engagements of the health management committee members in the case of Thabang, Holleri, Nehrpa or Gairigaun is one of the crucial indicators of a non-functional health management committee at the local level. Since same actors are involved in different management committees like schools, irrigation and community forestry, multiple engagements promote irregularity of the management committee members, which directly and indirectly affect the supervisory mechanisms of health institutions. Similarly, the management committee is expected to perform duties but the rights are not clearly mentioned and there have been different forms of visible and invisible power conflicts between the in charge of health institutions and the management committee chairperson in terms of intervening any crucial issues like in the cases of the Nehrpa, Gajul and the Thabang HP. Moreover, it has been explored, that except in the case of building the Ayurvedic hospital in Libang, in the case of other health institutions selected for this study, neither the rights have been adequately perceived by many management committee members nor their respective duties have been performed effectively to supervise local health institutions. On the one hand the HFMC is expected to perform its responsibilities, on the other hand many biomedically oriented staffs of health posts and the in charges of district health staffs do not encourage the management committee to actively intervene in their day to day performances. Such kind of expectation-performance gap is largely visible in the context of selected health institutions, which is even similar to other health institutions of Rolpa. There has not been held any local election after 1997, therefore, after termination of the elected power in 2002, local political leaders have developed a sense of powerlessness to represent local issues and feeling a low sense of commitment to make their voice politically louder. Rather than maintaining political influence even the CPN (Maoist) have not demonstrated strong political will to gear up the stagnated condition of health institutions in those VDCs, where they have a strong political hold like Gajul,

Thabang and Jinabang. The cancellation of the multiparty mechanism has given more authority to the VDC secretaries to make decisions in terms of local problems, at present, the VDC secretaries are supposed to hold the chairpersonship of the HFMC as a government representative to make the committee functional. However, it has been observed in the case of Rolpa, that such kind of ad hoc representation of the village secretary in the absence of local elected bodies does not oblige him/her to discharge the political commitment equivalent to locally elected representatives. Moreover, the lack of political will to supervise free health programs has been reflected in the Rolpa health service delivery where in many instances the temporary and permanent absenteeism of the village secretary has created obstacles to effectively supervise the health institution construction process and created obstacles to supervise free medicines delivered under government's free health care program. The stage of non-supervision of essential medicines and non-participation in the decision making process of health institutions is a gross violation of one's authority at the local level. This shows the incompetency of the political and bureaucratic actors in terms of showing concern for people's health related needs. In this context, the 8th five year plan further mentions:

> *The main thrust of decentralization is to upgrade the working capacity of local bodies under the leadership of local representatives. If the local bodies can develop a greater sense of responsibility through training of their members, the trust of the people and their participation can increase.*

In contrast to this policy recommendation, the lack of elected local representatives after 2002 has paralyzed the supervisory aspects of local health institutions and 'the great sense of responsibility' expected to be performed by concerned stakeholders are not fulfilled. Similarly, the completion of tenure of elected political representatives has created an obstacle to form a new caretaker committee even in the Ayurvedic district hospital of Libang. There has been a low manifestation of effective decentralization that has seized the effective function of local health institutions. Onta et al (1997) writes, "it is therefore, not surprising that the national health policy document itself has identified as 'lacking in the concept of decentralization' to tackle the country's "core problems" confronting health sector". The lack of basic minimum facilities like fax, computer and irregular supply of essential Ayurvedic medicines and insufficient staffs shows that there has been a serious gap in terms of making local health institutions self-reliant and effective enough to tackle minor techno-managerial problems at the local level. Similarly, in the case of the Gairigaon SHP, the long term stagnation to shift the land authority from the school to the HP only to get approved from cabinet decision has questioned the decentralization authority given to local health

institutions. In contrast to the equitable distribution of health related resources in the community, the centralization of Ayurvedic institutions in the same region has seriously ignored the issue of social justice and matters of equitable distribution of the health institutions to increase accessibility in terms of health service utilization. The reluctance of the district supervisor to reject the presence of a fake vaccination program or lack of an effective voice to demand resources to build the HPs of Oat VDC or Holleri, every evidence shows, that there has been lesser autonomy in the district hospital which alone cannot make any crucial decision in terms of health related plans and policies. Either in the case of announcing a tender to construct health post buildings or recommendations to administer mass vaccination without knowing its efficacy, the district hospital does not have autonomy to accept or reject the imposed decisions by the central level. Contextually, Alma Ata (1978:52) writes:

> *The importance of decentralization to intermediate levels, such as provincial or district levels now has to be stressed. These levels are near enough to communities to respond sensitively to their practical problems and needs; they are equally near to the central administrative level to translate government policies into practice.*

One of the crucial policy gaps noticed in the context of Nepal is, after much has been realized on the policy level, there is no articulation of such realizations on the implementation level for the long run. The tenth five-year plan effective since (2002-2007) writes, "The health indicators are comparatively weaker in the Mid-Western and Far Western Regions. In this context, special services will be made available easily and universally in the areas where health indicators show weak condition during the plan period". Since there has been realization of weaker state of health indicators in the Mid-Western region and commitment to improve such indicators with "special services" has been articulated, however, such realization manifested in policy papers do not get reflected practically to fulfill its commitment. In this context, the system world represented by the government becomes sarcastically dominating the life world of the people where the government has demonstrated its power to keep itself in the "non-decision making" mode by not responding to the health related expectations of the people. Moreover, Alma Ata (1978:3) writes, "the people have the right and duty to participate individually and collectively in the planning and implementation of their health care". In this case, "people" means in a collective sense the composition of those individuals who are organized under the umbrella of the local health management committee and representatives of different political parties, the high school and the female community health volunteers holding the individual/collective legitimacy of their respective

organizations. However, there are many episodes where political, social and patriarchal power has affected the notion of equal and inclusive participation among the management committee members. For example, in the case of the Thabang health post, the female representative in the HFMC from a marginalized community expressed her hesitation to keep her independent voice on the issue of corruption held during the construction process. Particularly, the strong domination of a single political party like the CPN (Maoist) and the silence of the female management committee member representing the so-called lower caste shows, that in the public sphere, females from a particular caste and class are subjugated with layers of power relations developed in conjunction of political power, patriarchal power and the cultural power deserved by so-called upper caste people. The exclusionary sentiments expressed by the female management committee members of Thabang, Gairigaun and the Nehrpa health post provides some insightful evidence how the notion of gender equality has been reduced in the mere appointment of a female member and their silent acceptance of male's decision eventually reflecting the process of ad hoc or pseudo participation of the women in the public sphere in the name of following the ideals of gender equality. Here, Molnar (1981:168) writes:

> *Political power is defined here as the ability to exert control within the community, i.e. extra-familial sphere. This power can be either legitimated, i.e. a socially recognized right to make decisions regarding others; or it can be informal power that stems from women's control of and access to knowledge needed to make political decisions.*

Here, the nature of power exercised by male members of the management committee in the extra familial sphere as "socially recognized rights" to make a decision on behalf of many people is basically derived from the patriarchal male chauvinism, that made a decision by ignoring the voices of others in the community. Singer (1995) writes, as the CMA defines power as a most important variable in the health related policy, planning and programming. Evidently in different conditions actors of the health care system, demonstrated sociopolitical and cultural power in the empirical scenario of Rolpa. As an important component of the health service system that has to get delivered at the intermediate level, personal attitude of the health workforce plays crucial role in terms of fulfilling health related expectations of the people. The act of managing ethical corruption has manifested in the case of Gairigaun where the acting in charge has kept the display board in his private medical shop which displays his twenty four hours availability. This particular phenomenon is a manifestation of a culture which shows the notion of '*milayera garne'* to manage in a

double way and *'milayera khane'*, grasping or gulping any public resources with unethical conjunction (*Milivhagat*) among the people with the same interests. This notion of '*Milivhagat'* operating in the politico-bureaucratic sphere of the Nepalese power structure has hampered timely completion of many rural infrastructures in Rolpa like the airport, the Madi bridge, the Martyrs highway, health posts and the district hospital. The way political favour has been taken from the contractor by the political party; there has been disobedience by the contractor to complete the bridge which is regarded as an important social determinant of health. The political nexus between contractors and comrades of the radical left party became an adverse condition to complete the Madi Bridge in its expected time schedule. In contrast to the Alma Ata recommendations to give high priority for social determinants of health, the non-construction of the Madi river bridge has highly affected the mobility of health workers and refers patients to the district hospitals. Since there has been an ambulance service in the district hospital, the lack of bridge on Madi River is not possible to provide this service to those people who live on the other side of the Madi River like the region of Ghartigaon, Jinabang, and Korchabang etc. Similarly, this process of the non-construction of the Madi bridge for a long time has affected the easy supply of essential medicines to many peripheral health institutions of Northern Rolpa like Jinabang, Rank and Pachabaang. Likewise, in the case of Jinabang, an office assistant who was active supporter of the CPN (Maoist) has disobeyed to newly appointed contract staffs to carry essential medicines from the Ghartigaun sub health post demonstrating his local political nexus to the political party. The lack of a bridge at the Madi river and shortage of active males at the village has hampered to carry essential medicines in the peripheral health institutions like the Jinabang health post.

The notion of "*aphno manche*[280]"had reflected in the day to day working attitude of the health staffs like in the case of the Jinabang health post, the Nehrpa health post and the Ghorneti Model Hospital that creates another level of institutional tension to perform effectively day to day services. Moreover, there has been an equal effort done by many OMSA workers to make the Ghorneti Hospital functional, however, among the working staffs if someone's personal interest has been protected and nurtured by ignoring public interest, then it destroys the feelings of collectivization. In the specific case of the Ghorneti Model Hospital, promoting the culture of *"aphno manche"* senior staff has created a favourable context to provide extra financial benefits because of emotional ties between two

[280]"The health sector is no exception to this policy. Each party has a network of "loyal workers" who are recruited individually through the *"aphno manche",* or *"chakary"* approach, namely taking care only of those who are loyal to you in return" Justice (1986)

fellow workers, what has created dissatisfaction among other fellow workers. Likewise, the sense of othering and internal conflicts occurred in Gajul and the Nehrpa health post by creating a duality between outsiders and locals among the health post staffs has eventually hampered the performance level of the health institutions. The presence of senior staffs from outside has directly challenged the monopoly of junior staffs (insiders) in the case of the Gajul health post. In this kind of context many local people manifest their power by using the term "local", which gives them psychologically powerful notion to feel superior among "outsiders". Moreover, it is not only the personal superiority complex of local staffs that hampers the service delivery, but for instance uncontrolled behavioral problems also directly hamper the performance of health service delivery. The irrational pattern of alcohol drinking habits has seriously affected the day to day performance of the Oat sub health post which has reflected in short term and long term dysfunction of health services. In addition, the regular absence of the VDC secretary and his alcoholic habit is another crucial problem to run the management committee meetings and supervise free health programs effectively in the case of the Gairigaon sub health post.

Similarly, lack of sufficient human resources on health is another crucial problem that has been encountered in every selected institution of this study. The non-presence of recruited nursing staff at the Holleri health post showing the reason of Civil War or irregularity of staffs at the Oat sub health post, or temporary or permanent absenteeism of health workers either due to alcohol induced causes or because of other personal causes directly victimizes the people's expectations who travel a long day journey to access health services. The non-responsiveness of the sub health post level has pushed a woman to the district hospital which is a day and more walking distance far. However, the way the district hospital staffs spending time in the NGO's program for getting additional incentives shows the conflict between professional power of the system world and continuous crisis of people's expectations in the life world in Rolpa. Districts like Rolpa where absenteeism is rampant, in this kind of conditions, when staffs have to attend frequent different health related training at the district hospital; it has hampered the health delivery services at primary health institutions in Rolpa. Likewise, pulling medical doctors from primary health care institutions of Holleri to the district hospital in deputation (*Kaaj)* or not timely channeling essential medicines to regional health posts and sub health posts shows in every episode how the concept of power operates on different layers where every level of the system is exploited by comparatively powerful systems. Therefore, as written in Higgs and Jones and edited by Scambler (2013), the authors

write, "Power cannot just be seen as embedded in the state or in institutions, it is constituted in social relations and governance, therefore is the regulation of society not by the state but by its own structures". Similarly, the failures of the system world in the case of women who are separated from her family just to take million units of Benzathine G 1.2 injection every three weeks suggests, that institutional power plays a role to perpetuate individual sufferings. Likewise, in the case of epileptic women, the inefficiency of health institutions and its non-responsiveness has been brutally demonstrated in the case of the patient who lives in a few hundred meters vicinity from the Gajul health post. As outlined in chapter third, the sense of deprofessionalization expressed by the acting in charge of Nehrpa for compromising a junior position lower than her educational qualification, the assistant laboratory technician working for the Holleri PHC or a health worker working as a x-ray technician in the district hospital, are the conditions where low motivation among health workers directly hampers the efficiency of the health service delivery. As Baer *et al.* (2004 : 42) writes, "The ironic twist of this development is that the health workers with the lowest status and least power are those persons who come into the most continuous and intimate contact with patients in hospital settings". The sense of powerlessness and lack of sufficient knowledge and skills to handle complex cases like transverse lie occurred in Thabang, the submissive condition of frontline workers has directly affected the affectivity of health care services in Rolpa.

The notion of "free" health has been even forwarded by the CPN (Maoist) before starting the arms led insurrection against the Nepali state. Principally, the OMSA documents developed by the health wing of Maoists party ANPHW (R) mentioned about "free and accessible health services", that would be provided when the CPN (Maoist) emerged as a ruling power. No sooner as the rise of a "progressive government" after the election of 2008, the CPN (Maoist) has launched a free health care scheme[281] as a comprehensive health care program up to the the district level all over the country. Moreover, the provision of providing numbers of listed drugs in sub health posts, health posts and primary health care has

[281]Before political unification with UCPN (Maoists) another left fraction of the United Liberation Front (ULF) has developed concept of free health scheme which has acknowledged the value of universal health package up to the district level. Though free health program is a brain child of ULF, because of ideological compatibility, UCPN (Maoists) has continued the concept developed by ULF as an issue of "progressive health agenda". At national level, one hand free health program has been launched by UCPN (Maoists) and most of the opinion makers were ideologically opposite to this program which could not gather unanimous support, on the other hand lack of effective monitoring of the free health care program and the stagnation of health service development process in many regions has created hindrance to effectively function the free health program in Rolpa. Since there has been no analysis of pre-existing situation and other generic problems of rural health service system, free health program could not show that level of intervention to the health culture of the community up to the level where every individual perceives the necessity of this program as a health related felt needs that is a concern of utmost necessity to the society.

narrowed down the concept of the “free health program” as a provision, that distributes numbers of free essential drugs, which come under the free health scheme, if those would be available regularly at the health institutions. One hand the concept of free health has been reduced to free distribution of the medicines on the other hand same 'free medicines' were also not sufficiently available in the health institutions. The act of not providing free medicines from the state owned health institutions and enforcing patients to buy the same medicines at private medical shops mainly owned by government staffs in Rolpa has substantially supported the market friendly policies of the country and exploited the powerlessness of local people. Either the unavailability created by techno-managerial limitations or pseudo unavailability created by health staffs , this kind of trend is compelling many people to pay an extra amount to those listed drugs, which are supposed to be freely available under the provision of the free health program in Rolpa. More specifically, a low level of awareness among general people about the free health program, non-scientific criteria to identify poor, needy and marginalized people, chronic nature of absenteeism among rural health workers, irregular supply of medicines and profit motive of both private and state health workers are other factors that have created obstacles to effectively function a free health care program in Rolpa.

It's not only the socio-economical and geographical factors, that hinder the easy accessibility to health institutions, as wells as regressive and irrational socio-cultural values among the people, which also play a crucial role to make the access to health institutions easily. In the case of Rolpa, in terms of promoting institutional delivery, the government has expected more than sixty percent of deliveries to perform under institutional support to fulfill one of the targets set by the Millennium Development Goal, which has been targeted to be achieved by 2015. Empirical factors like low awareness on reproductive and maternal health, non-accessibility of health institutions, a very low availability of transportation facilities has also affected to visit health institutions in Rolpa. Likewise, a sense of health institutions as an impure and polluted place and non-attraction towards health institutions are some of the reasons, that have been hindering to increase safe institutional delivery and to meet the MDG target in the context of Rolpa. Moreover, the lack of proper roads and transportation facilities in many regions of geographically complicated districts like Rolpa have reflected in layers of burdens to rural livelihood, where one has to rely on bamboo baskets and has to spent a substantial amount of expenses to the person who provides support as basket carrier. Contextually, Winkleman (2008) writes, that economic resources are general mechanisms

through which social conditions produce the distribution of diseases and health disparities. In many cases, it has been noted, that the health related expenses that people have to spend at health institutions either for logistic management or to pay for bamboo basket carriers is much higher than the motivational incentive, that the government has been providing to the mothers after giving birth to every child at government health institutions. Particularly, where transportation facilities are available in Rolpa, expensive ambulance services to take patients to other institutions also hinder many people to visit health institutions during the delivery. Moreover, the non-accessibility of health institutions in the vicinity and lack of able bodied males to carry injured patient at night time is a reflection of the fragile social support network where patient have to wait the whole night at home despite their emergency condition. The persistent level of distress migration has directly affected male participation in delivery and also in terms of perinatal care. The severe absence of males due to patterns of distress migration in most of the households has affected the process of safe institutional delivery and it resulted as a non-collaborative process between husband and wife. In the case of a woman, who was prevented to visit a health post by her mother- in-law only because her mother –in- law has given successful birth to six children at home. In such cases the patient's husband was abroad and the lack of strong social support prevents many women to make an easy access to health institutions. The government's policy to perform twenty four hours institutional delivery to promote safe motherhood is bluntly putting blame on the victims for not visiting health institution on the time of delivery. For many marginalized communities in Rolpa. health institutions are geographically inaccessible and financially non affordable. Moreover, in the complex transverse lie case which occurred in Thabang, both structural and individual factors are responsible to occur in maternal and neonatal deaths. An irrational birth plan, non-performance of permanent male contraception like vasectomy operations and failures of the public health system to aware people on healthy and happy family are responsible factors, that compelled particular women to give birth to the sixth child, which has maximized the risk up to her death. The non-construction of the Phuliban-Thabang road for more than a decade, the lack of accessible roads and transportation facilities to reach health institutions or the unavailability of air transportation -though once it was functional- are some of the reasons responsible for the occurrence of maternal and neonatal deaths in Thabang. In this particular case, since the patient's husband has been working in Gulf and they were in a situation to afford the financial cost. However, structural conditions encountered beyond personal capacity have resulted in such a tragedy in Thabang. The individual possibility to afford health care facilities has been defeated by structural

powerlessness which is basically the outcome of historical, political and technological ambiguities, which are severely responsible to affect the life choice of a particular class of the society. In most of the illness narrative, it has been expressed, that after trying series of treatment regimen in the vicinity of private spheres, many patients from Rolpa have begun an expensive journey to other cities like Butwal, Dang Nepalgunj, Chitwan, Kathmandu, Luckhnow, Delhi and other border lands of India to avail advanced tertiary care systems. Here, the case of a lady, who has gone to Nepalgunj and to Luckhnow for electric therapy or the case of a girl from Ghorneti whose mass has been wrongly operated, in every case, patients have suffered from malpractices performed at the tertiary health care institutions. These cases of irrational diagnosis are the representative cases that manifest how tertiary care institutions have perpetuated an additional level of sufferings and manufacturing additional risks which become the matter of an emotional and financial burden to many service seeking individuals from peripheral regions of Nepal like Rolpa. Alma Ata (1978:3) writes,

> *Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individual and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.*

In the context of Rolpa, the inefficiency of the primary health care system serves the interest of other private practitioners and patients have to begin expensive journeys of "forced medical tourism" to other destinations. Since the district hospital is geographically inaccessible to a large section of Rolpali people who are from peripheral regions of this district, people are forced to visit other hospitals of the adjoining districts like Dang, Nepalgunj and Bhairahawa (Butawal). Even in many cases people are forced to do long journeys to Kathmandu, the Indian border cities and also to Delhi to access medical services. Eventually, such inaccessibility put additional burden on the people from the peripheral area who have to sacrifice their life despite their capacity to access the medical services. The burden of walking two or three days to the district hospital or carrying dead bodies to seek legal clarification for the post mortem has also increased unnecessary expenses in terms of accessing medical services in Rolpa. Moreover, those people who are already in the condition of relative poverty, the rise of medical costs pushed them down to absolute poverty where one has to sell their properties like land, ornaments and livestock just to access medical services from the expensive medical market. However, if one cannot afford to access expensive medical services, those people are compelled to rely on alternative healing

processes or to cope with silent sufferings. As singer (1995) has outlined, interpretation of class is one of the fundamental factors in critical medical anthropology to be discussed to understand the level of expenditure in health care and their financial capacity to access health care facilities in the time of urgency. Since the nature of the health care system has been shaped according to state policies, it reproduces the class relations according to their capability to afford the services available on the market. The relative deprivation of overall health system of Nepal in comparison to highly funded health service system of other middle income and high income countries further deprives its regional layers like rural health system of Rolpa by not delivering quality services and ignoring many commitments done in different policy documents. Though there is no sharp class dichotomy as conceptualized in the sense of the classical Marxist notion of "haves" and "haves not" in Rolpa. However, the unequal pattern of resource distribution in the society has created an affluent class which has hold in resources and political power and generates a large majority of deprived people who have to compromise with many kinds of socioeconomic conditions to manage their day to day necessities in Rolpa.

6.3 MICRO-SOCIAL

The micro level dynamics of critical medical anthropology refer to the interpersonal dynamics related to the physician and patient relationship. In the context of Nepal, either it's a forceful adoption of health care policy formulated at the global level or acceptance of medical and philosophical practice recommended from the state to local level, in both cases the micro level is powerfully controlled by the hegemonic proposition of global and state level forces. In the domain of claimed "ethical practices" happening inside the institutional service and unethical practices operating in the private medical shops, in both arenas the physician-patient relationship is a strategic power relationship between accessing quality services and physicians claiming the maintenance of ethical issues where both forms of power operate to control each other. Contextually, Winkleman (2008:296) writes, "Political and economic conditions also affect clinical interactions between providers and clients and the nature and quality of care". In clinical interactions, doctors intentionally sidelined the social causes of patients' problems which directly or indirectly put the blame on patients for their physiological conditions instead of recognizing the origin of maladies in broader social conditions. Aitkin (1983:28) has mentioned that, "Medicalization transforms problems at the level of social structure—such as stressful work demands, unsafe working conditions, and poverty—into individual-level problems subject to medical control." In the act of producing

such kind of intentional blame, the vested interest of prescribing curative solutions provides additional financial benefits to profit seekers of bio medicine that affects the notion of good clinical practices. In the context of Rolpa, there are both presence of skilled and unskilled medical practitioners, apart from power relations, that operate in organized model of care, micro level analysis of the CMA is focused on a power relationship, which exist between healers and patients operating in alternative healing patterns like shamanistic healing traditions. Following the notion of expanded conceptualization, the contesting power relationship between different kinds of health workers, it is important to understand how societal conditions affect the clinical encounter and patient care. Singer (1986) writes:

> *Local context factors, including the particular configuration of class, gender, and ethnic relationships, the availability of resources and technology, demographic and ecological factors, and historic and cultural patterns, contribute to the short- and long-term effects of capitalist penetration of health care, as well as to any micro population's ability to resist the agents, agencies, and agendas of bio medicine.*

The structural dynamics of caste, class and gender stratification operating at the intermediate-social level play a crucial role to produce and reproduce hegemonic propositions imposed by global forces up to the micro level. In the context of Rolpa, the historical stage of marginalization has constructed a low level of consciousness especially on ethnic caste groups like the Magar and also among the so-called untouchables. As a repercussion of the low level consciousness on health confounded with ethnic and caste based subjugation, the trend of using irrational painkillers or injections to suppress any form of bodily pain is a powerful indicator where different forms of structural vulnerabilities are inflicted upon the individual's body where many individuals in Rolpa directly support the sustain of the agenda of capitalist accumulation. Moreover, the construction of a hierarchical structure among the OMSA workers on the basis of prewar experiences of those health workers achieved in government's health service system shows that a "revolutionary party" has reproduced the same set of the power relation operating in an "old state" mechanism of state structure. Furthermore, while the formation of the OMSA workers and the silent acceptance of 'modern medical degrees' provided by the Nepalese state, is another contradictory notion manifested by the CPN (Maoist), where they were actively boycotting 'bourgeoisie education' in Rolpa and also in other districts during the Civil War. It has been observed that such kind of boycotting has directly supported the school dropout rate during the war and many children have ruined their life either involving in the Civil War or were displaced from their homeland. Moreover, many people still believe in traditional practices like faith healing,

which was randomly available in the vicinity of their home area. As a modern medical system connotes a "new" and "modern" to many local people, many people believe still in shamanistic healing practices as a continuation of their cultural traditions. There are bizarre kinds of health workers providing health related services in both professional and personal basis in Rolpa. Alma Ata (1978:35) writes:

> *Primary Health Care is likely to be most effective if it employs means that are understood and accepted by the community and applied by community health workers at a cost the community and the country can afford. These community health workers, including traditional practitioners where applicable, with function best if they reside in the community they serve and are properly trained socially and technically to respond to its expressed health needs.*

The Alma Ata declaration has recognized the importance of traditional practitioners as community health workers, however, there are different varieties of traditional practitioners and natures of services they provide also vary in the context of Rolpa. Following the notion of the Alma Ata declaration, though state policy has accepted plural kinds of healing practices and the existence of different kinds of health workers in the context of Nepal. In reality, the professional power exercised by biomedical practitioners is incomparable to other practitioners. It has been explored in Rolpa that other practitioners have to feel an inferiority complex because of the variation in training and nature of health education required before enrolling in the professional world. [282]Continuing the legacy of unchallenged professional power, since the state has strategically supported the bio medicine as a sole rescuer of human health, there has been layers of power relations existing between formally protected and informally developed health care service providers. It has been evident in Rolpa, that failures of bio medicine have compelled many people to follow shamanistic healing and also rely on alternative medical practices and vice versa. As outlined in chapter four, in the empirical condition of Rolpa, it has been evident that similar kinds of malpractices exist under the domain of shamanism and biomedical practitioners functioning under the governmental health system and also among the informal quacks. Illness narratives explored in Rolpa clearly revealed the fact, that they do not see any differences between biomedical practitioners who demand unnecessary diagnostic technologies to rule out the disease causality or the shamans who also demand specific items to interpret disease with supernatural causality. In both cases hit and trial methods followed by both biomedical

[282]It has been reviewed in my first chapter, the influence of medical doctors in developing health policy is very significant in the context of Nepal even during the Panchayat reign, doctors were so dominant that they could influence the special committee (Janch bhuj Kendra) headed by the king which shows that physicians have exercised higher professional power than ruling political power of the country.

practitioners and shamanistic healing practices create a situation of powerlessness and intentional subjugation to many individuals. The way the state has legitimized the biomedicine and its rationale usage of prescriptions in the name of evidence based practices has given extra ordinary "delegated power" to the practitioners of biomedicine, which gives them power to demonstrate themselves as "superior" and "ethical" in everyday power relations. Kleinman (1988:135) writes, "Physical complaints are authorized, but psychological and social ones are not. The diagnosis is, in fact, a systematic distortion of the interview: only facts that relate to disease and its treatment are sought, allowed to emerge, and heard. The human suffering that is so much a part of this chronic illness is met with silence and seemingly denied." Rather than understanding the holistic dimension of human sufferings, episodes of malpractices have been operated like onion layers, where every step patients have been victimized either by 'modern' medical practitioners or by traditional healers. The inefficiency of practitioners or malpractices in both therapeutic procedures has ultimately victimized the people and decreases the level of trust in healing systems.

The medical cultural hegemony is that much powerful, that in many episodes, practices and beliefs of medical practitioners have been shaped by profit making greed of biomedical practitioners and its different layers of agents in Rolpa. In the case of the lady who has gone to Nepalgunj, multiple exposure with the different models of treatments, that a patient has to undergo is not helping her to maintain her sound health and investing a substantial amount to cure her problems is contradictory to one of the important goals of the HSS, that is supposed to enhance the 'financial risk protection" of the people. The forceful imposition of vaccine marketing in five districts of the Mid-Western region including Rolpa has a different dynamics, that shows the role of political actors and their collaboration with bureaucracy, which can play another fatal attempt in terms of people's health. Either it's a forceful imposition of spurious vaccine to administer onto people's bodies or taking medical shop owners to the drug orientation program organized by pharmaceutical companies or advertisement of volunteer doctors as a visiting consultants, the hegemonic form of bio medicine has shown its faces in different episodes in Rolpa. These every action is inherently targeted to accumulate profits from those rural mass, who are living the life of mass deprivation. The episodes of malpractices have been performed in different cases such as one of a quack running a clinic in Libang and his unethical prescription to abort a women falsely claiming, that she has a multiple headed baby in her womb. Likewise, performing a surgical procedure on an old women who has a swelling in her chick bone or prescribing medicines to

abort a fetus even. In a pregnancy negative case; in every of those episode of malpractices the inefficiency of quacks and their unethical presence on the unregulated private market to fulfill the profit making greed have reproduced the social sufferings of patients in Rolpa. The way patients develop the perception, that injections are better than tablets shows that malpractices of bio medicine has brutally reified the thinking process of the patients. Rather than seeking appropriate care and follow the process of diagnosis, many patients have developed the perception, that it is comfortable to take injections and suppress the pain which could be the primary reason for a long term social suffering. Kleinman (1988) writes, "Somatization[283] is the communication of personal and interpersonal problems, in physical idioms of distress and a pattern of behavior, that emphasize the search of medical help. In many cases, the prescription of high dosages of painkillers to those individuals, who express multiple complains has victimized many treatment seeking individuals in Rolpa. Medical shops available randomly in every region of the district are promoting instant consumption of medicines, which are mostly run by government health workers, untrained quacks and their family members just to provide random and haphazard medical services for fulfilling their profit making greed. In the case of a lady, manipulating her personal–emotional relationship, she has been given albendazole and paracetamol as a medicine to abort her fetus despite her negative pregnancy status, which shows the conjunction of male gaze and profit making interest, what has manifested jointly in fulfilling profit accumulation. Rolpa as a district is no more isolated from such rampant growth of unregulated and unsupervised private medical practitioners exploiting the people with their half-baked and quasi orientation of biomedical knowledge. The unnecessary prescriptions of pain killer injections, applying electrical therapy or performing irrational kinds of diagnostic tests shows, that there has been a heavy domination of capitalistic values in terms of the doctor and patients relationship, which operates in Rolpa. The malpractice of bio medicine is very often strongly backed up by local politicians and powerful elites in Rolpa. The powerlessness of a woman who was victimized by the quack in Dang or a similar situation of helplessness of a lady who has been double operated shows, that unethical power is that much dominating the powerless individuals up

[283] Somatization is a socio-physical continuum of experience: at one end are cases in which patients complain of bodily ailments in the absence of any pathological bodily process- either as a conscious act or as an unconscious expression of life problems; at the other end are cases in which patients who are experiencing the disordered physiology of medical and psychiatric disease amplify beyond explainable levels their symptoms and the impairment in functioning those symptoms create , usually without being aware of their exaggeration". (Kleinman 1988)

to the level, that the victimized people are not being able to express their rights to seek legal compensation on such kinds of malpractices. Low level of legal awareness, economic constraints and ideological strength to fight against the system are some of the factors that prevent people from demanding legal compensations on such kind of intentional medical malpractices.

Similarly, as Winkleman (2008:315) writes, "Physicians are also agents of the ideology of the ruling classes". Following the orientation of bio medicine as an inevitable solution, the intermediate level and micro level actors of bio medicine operate to produce and reproduce scientific claims of bio medicine as an inevitable solution in patient care. Exploring plethora of chronic cases in Rolpa shows, that both systems of medicine have powerfully penetrated the life world of many chronic patients in order to "cure" them as per their respective orientation. The evidence generated during the process of retrospective narrativization of the respondents in micro-social level has evidently contested the claims of bio medicine as 'scientific', 'modern' and 'effective' and questioned the illegitimate propositions of its creators operating in the macro–social arena. Cant and Sharma (1999) writes, that the modern state supports the expertise of various professions to exercise surveillance and control of populations, and it has developed alliance with bio medicine. The case of the leprosy patient from Jungar whose 'non-adherence' attitude toward medication has been suppressed by use of police-power to make him adhere under medical control, which shows the brutal exercise of medical power in conjunction with the state's security force. Moreover, Winkleman (2008:315) writes, medical control transforms social conditions into physical individualized and privatized circumstances. When individual struggle to access the services available in the healthcare domain many individuals have to accept the hegemonic form of biomedicine; however only few of them could challenge the hegemony of bio medicine knowingly unknowingly. Rather than following constant and effective counseling, in the case of leprosy such a forceful attempt has been applied to prove the efficacy of bio medicine by controlling the patient's choice and labeled him as an "undisciplined" (*naterne manche*) to follow the treatment regimen. Cant and Sharma (1999:14) write, "Taking medical power seriously without taking it for granted means that we will avoid the assumption that bio medicine and alternative medicine are involved in some kind of zero sum power contest; we can see both of them as embedded in a wider field of power relations." Such power relations have affected the notion of medical pluralism that is supposed to respect the notion of equality in terms of implementing health provisioning.

Though Nepal's health policy has officially accepted Ayurveda as an integral component of the health service system, however in reality, apart from bio medicine and its curative components, Ayurveda and other indigenous systems of medicine are not equally supported by the state. Instead, there has been rapid bio medicalization of the Ayurvedic system; the way Ayurvedic health workers of Rolpa have demanded pathological and radiological facilities to diagnose the disease causality is contradictory to the philosophical practice of Ayurveda.

Likewise, physicians and patients' interaction cannot be understood without analyzing the role of health institutions and influence of other powerful actors who are operating in different layers to shape the choices of both physicians and patients. Kleinman (1988:54) writes, "The commoditization of the healer-sick person relationship as an economic transaction cannot quantify this aspect of the relationship, which, as a shared virtue, is not captured by a cost/ benefit equation or financial bottom line. It is rather the healer's gift as well as that of the patient." In contrast to the ideal 'give and take relationship' viewed by Kleinman, the rapid commoditization of healer–sick relationship has degraded the humanistic side of medicine and nurtured the consumerist approach in Rolpa where neither patients nor healers can transcend the power relationship where many services are given and taken primarily for monetary benefit. Here, Singer (2011:29) mentions:

> *Doctor–patient interactions also constitute an arena of hegemonic interaction. Studies of these interactions show that they commonly reinforce non-egalitarian hierarchical structures in the larger society by (1) stressing the need for the patient to comply with a social superior's or expert's judgment, and (2) directing patient attention to the immediate causes of illness (e.g., pathogens, diet, exercise, smoking) and away from structural factors (over which physicians feel they have little control).*

According to this proposition, the misdiagnosed case of typhoid from Uwa or the complicated transverse lie case from Thabang or the stone strike case admitted in the Sulichowr PHC show, that the patterns of delay in seeking care eventually maximized the disease complication in patients. In many instances, it becomes challenging to many individuals to question the justification of treatment prescribed for them. Either the process of defining the sick role by the physicians or isolating social determinants and reducing the social distress into the reductionist model; in both of these cases, it supports the inherent interest of bio medicine to create a 'morbid society', where patients are kept under control of the medical regimen in the name of practicing "evidence based medicine" and "good clinical practices". Alma Ata (1978) writes:

> *Indeed, the improvement of health is being equated with the provision of medical care dispensed by growing numbers of specialists, using narrow medical technologies for the benefit of the privileged few. People have become cases without personalities, and contact has been lost between those providing medical care and those receiving it.*

Analyzing episodes of illness narratives from Rolpa, it shows that most of the healer patients interactions are predominantly based on profit accumulation rather than truly operating to heal the sufferings of the people. The overvaluation of the curative dimension, state supported market friendly policy and inherent interest of bio medicine to maximize its profits making interests are some of the factors which are increasingly shaping the life choices of people in Rolpa. Kleinman (1988:28) writes: "Instead, the modern medical bureaucracy and helping professions that work within it, as we have seen, are oriented to treat suffering as a problem of mechanical breakdown requiring a technical fix. They arrange for therapeutic manipulation of disease problems in place of meaningful moral (or spiritual) response to illness problems." The unethical application of biomedical technology and inappropriate prescriptions of other diagnostic technologies on many individual bodies in Rolpa suggest, that there has been a growing trend of Cartesian duality rather than the following of the Aristotelian concept of health, where psyche (emotions) and soma (body) of the people should be acknowledged as an integral part of holistic health. Finally, in the everyday domain of the healer and patient interaction, the doctor as a profession to serve the people is diminishing, gradually it is becoming the mere conglomeration of radiologist, pathologist, ultrasonologist and pharmacologist.

6.4 INDIVIDUAL LEVEL

On the Individual level, the CMA suggests to understand the patient´s response to sickness and sufferers' experiences to access the health service system. In the context of Rolpa, present experiences of individual sufferings have been generated due to malformation of sociocultural and political institutions which are historically produced and reproduced by the sociopolitical actors and their intrinsic power relations. It has been observed, that, historically many different factors have played a role to generate the continuous stage of crises in rural lifestyle which has affected the social well-being of the Rolpali people. Many scholars have argued, that indigenous trade in the mid-western hill regions have been affluent to earn extra surplus, however, shifting patterns from salt transaction from the Northern to Southern region has shifted the reciprocal barter economy to a one sided dependent economy. The restriction to extract copper by Rana rulers, the burden of traveling long distances to sell

the indigenous pen (nail kalam) and paper (lokta) were not creating favorable conditions to uplift local productivity in Rolpa. In lack of a policy level support, people from Rolpa were gradually losing their traditional production activities in competition with the aggressive expansion of mass method of production. Similarly, the presence of iron, copper and gold mines, the existence of separate a coin called *Kalya Pysa* in this reason and production of necessary weapons to sustain war were significant facts, that show the existence of rural prosperity in Rolpa. It has been documented, that apart from grazing big herds of sheep, weaving indigenous clothes like *Chyanga Panga* and collecting Chares as a cash crop is some of the important activities during the pattern of vertical transhumance. Moreover, in the process of vertical transhumance, activities like Chares collection and selling big numbers of sheep or woolen blankets made out of those sheep wool could be important for sheep herders to generate extra surplus to fulfill basic necessities of rural households. Despite many possibilities to scaling up rural productivity, many people found and the labour based economy and agro pastoral activities, which were traditionally performed in villages, were insufficient to meet the changing demands of the people constructed by the growing consumerist psychology in rural livelihood. Either it's a job of selling resin or bamboo pen (nali kalam) many local producers had to face challenges of transportation and communication skills to reach the outside world from their locality. Similarly, the existing condition of crisis has been escalated by the Civil War and gradual decline in rural productivity forced people to seek other alternatives outside the locality. Furthermore, the agricultural activities in the hill land of Rolpa are not affluent activities to maintain survival for a whole year. In such cases, food insufficiency of rural households is one of the chronic symptoms of rural poverty, that forced many people to find alternative mechanisms to join their hands to mouth. In such a process, the socio-biological burden of females to rear their children, patriarchal values, that basically restrict females within domestic spheres and the continuity of the traditional gender role, which perceives males as bread winner of the family, are some of the reasons, why males are more involved in seasonal and permanent migration. Similarly, along with the above mentioned pre-war related causes, the decade long Civil War has fueled a high level of distress migration in Rolpa. Like Bury (2005:101) mentions, "Periods of economic decline, political upheaval and war can cut across the health of individuals and public in any society." Such kind of distress migration resulted in social separation, family breakdown, introduction of different communicable diseases like HIV, Hbsag, Trichomonas and VDRL as "ills of modernity" in the rural villages as defined by the critical realist school of thought. In addition, Sinha (1997:59) writes: "When displaced people

are unemployed, face xenophobia, physical assault, harassment, distrust, suspicion, nostalgia, increasing psychological and physical hardship. They face hazardous conditions and artificial nature of life". Such kind of alienated psycho-social conditions and emotional fluctuations become a conducive environment for many males to perform risky behavior in order to fulfill their biophysical needs. In the context of Rolpa, the way male from Libang have transmitted HIV as a "gift of God" to their wives, is one powerful evidence of risky behavior performed by migrant males, that has ultimately victimized their family.

Prior to the development of Rolpa as a separate administrative district, historically this region has witnessed the culture of violence either in the process of supporting the "unification" process as a bonded soldier or opposing the "unification" movement led by the Gorkha empire. In the process of unification, petty principalities like Pyuthan or powerful like the Baisse or Chaubisse alliance of the present Rolpa region were merged into a larger Gorkha kingdom demonstrating military strength. Since most of the petty principalities were facing financial crisis, it was not difficult for the Shah rulers to defeat the fragile states of the Rolpa region with their expansionist agenda of "national unification". As a result, the king of Khungrikot surrenders to the Shah king and agreed to accept cash in kind from the Shah rulers which was even continued till the end of the Panchayat system. During the war fought for the unification process, the evidence of sending bonded armies in the leadership of Meghbarna Gharti from Pyuthan to support the Gorkha Empire in its expansionist process is suggestive to analyze, that many people from Rolpa have substantially contributed their labor to sustain the war, which has been even manifested during the Civil War, which occurred in modern Nepal. Since there had been intra states conflicts among the petty principalities, small scale warfare, contestations for territories, and application of violence to overcome the power has been historically rooted in the Rolpa region. Such kind of ritually sanctioned culture of violence used to be manifested in fighting with bow and arrow and slaughtering sheep and pigs at local festival like Vhumya Puja, which is an evidence that shows the ritualization and normalization of violence in the culture and lifestyle of Rolpali people. Likewise, after forty years of establishing the first communist organization, Thabang has been used as a base of the Civil War by the CPN (Maoist). This historical gap is significantly important to understand, how long term constant exclusion constructs a revolt psyche against the central ruling mechanism. Either it is a domination imposed by the Chapakote king or episodes of brutal suppression done by the Panchayat government, in every episode people from Thabang have experienced the brutal form of the state's power,

that has gradually supported to develop counter hegemonic ideologies and to raise organized revolt against such domination and control. In Thabang, the local dynamics of micro scale violence generated by intra-conflicts between local chieftains has been capitalized by exogenous actors to convert such local conflicts into political conflicts. The state has shown its power to control the local conflicts and played role to construct the "communism" as an anti-state force by arresting Berman Budha and his followers. This kind of state activity manifests brutal demonstration of state's bio power to suppress those groups of people, who are ideologically opponent to the ruling power. The way one of the local chieftains attempted to control local alcohol manufacturing process in Thabang is the manifestation of state power at the local level to suppress the people who are ideologically non supportive to the state. Such kind of political suppression is one of the strong factors, that is responsible to create anti state psychology in Rolpa and specifically in Thabang. The influence of left political leaders in Rolpa from Mohan Bikram Singh to the UCPN (Maoist) chairperson Prachanda shows, that the role of political actors is important to sensitize political ideology to understand the dynamics of society and existing power relationships. Some of the counter hegemonic activities such as the formation of all Nepal women's organization in Thabang, or formation of the Dhikure group or boycotting the election announced by the Panchayat government are some of the activities which were uniting the Thabangi people against the suppression of the state. Moreover, the Panchayat government has brutally launched police operations and applied state power to suppress the activities of the local people in Thabang. The demonstration of militarized power in the form of police operation in Thabang has deeply perpetuated the hatred psychology against the state. Analyzing different episodes of counter hegemonic activities performed in the context of Rolpa, it has been noticed that there could be both, individual and organized form of revolt occur, where in many instances change oriented individuals can also demonstrate their powerful voice against any form of suppression and subordination. The revolt against the Chapakote king by people from Thabang or mass solidarity expressed during the event to reject the fake vaccination process in Rolpa, these particular events have shown the evidence, that without any political support also, that there has been a tendency of revolting political power even at agency level, which is similar to the example of moral economic revolt as discussed by Scott (2012). Since the domination of the radical left party has been continued in this village and in frequent occasions political unity has been expressed, apart from banning alcohol there has been no collective effort or counter hegemonic activities performed to increase public health awareness in Rolpa. Moreover, in the case of a man who was willing to take his wife back to

home without getting permission from the district hospital staffs clearly reveals the fact, that individuals can revolt against the system. In this case, the life world of an old couple has brutally victimized by institutional power and its inefficiency to prescribe her required medical solution. Instead, hospital staffs labeled him as a "non-cooperative fellow", what (*Kich kiche manche*) shows the domination of a social power upon individuals, which can intentionally hide its negligence and blame the victim, who is already in a powerless situation. Moreover, the hegemonic form of institutional power over individual bodies is assertively dominating in the case of a leprosy patient, where health post staffs took the help of the state security force in order to create forceful adherence to leprosy medicines on the patient who has rejected to take the medicines, because the prescribed medicines were not improving his condition and this particular individual has followed the notion of non-adherence[284] to the prescribed dosages of medicine. Moreover, the formation of a separate medical department to treat injured combatants during the war shows the evidence, that if the system world is forcefully denied to treat the people by demonstrating its social-political power, there could be formation of other alternative systems to respond to the life world of the people. Therefore, analyzing the above mentioned findings, one can say that both agency and organized forms of power can revolt the system and seek plausible option to counter any form of hegemonic power and domination.

The individual's level of awareness and their particular class position in the society also play a crucial role in terms of shaping sufferers' experiences and their response to the sickness. In the case of a person whose wife has died and taking care of his small kids despite his personal illness condition, the class position of a patient and his low income capacity has created additional levels of suffering. The structural dimension of rural poverty has additionally intensified the micro level problems where a particular person is compelled to imagine, that his problems are beyond his capacity to solve and thinking to commit suicide along with his daughters. The symptom awareness of any individual on his or her bodily discomfort, bodily response to particular kinds of distress and the decision to follow the nature of treatment compliance are crucial factors where every individual has to make a

[284]"The idea of 'non-adherence' equates a temporary constellation of power relationships (between doctors and patients) with the medical system more generally, ignoring more universal forms of obtaining care: self-management. That is, the popular sector is primary and what is normal behavior in that sector becomes labeled as non-adherent once the patient's actions are reinterpreted in the context of the professional sector ."(Trostle 1988).

rational decision in terms of responding available treatment options. As Kleinman (1988:185) writes, "Culture and ethnic differences, social class and economic constraints, and host of other factors will manifest themselves in this work of making illness a part of family construction of reality." Similarly, the process of accessing health care in a rural district like Rolpa has been shaped by a conglomeration of low quality modern education; layers of socio-cultural values and sense of 'distance health care' shaped by geographical barriers where economic power of any family play a vital role in terms of perceiving the importance of illness and its further prognosis. Similarly, in Rolpa in many cases, there has been a manifestation of duality such as the people's voting to the "radical left party" seeking "progressive transformation" and also simultaneously following irrational practices of shamanism and faith healing in terms of accessing health care. Such kind of ideological cultural lag has been manifested on different occasions in Rolpa where people follow the practices of modernity and do not like to give up irrational practices as well. For example, there has been frequent expressions of community solidarity in Thabang to oppose the political suppression of the state. However, the same kind of community spirit has not been manifested in the death case due to the transverse lie held on the day of Vhumya Puja in Thabang. Though the local cultural festival has both tangible and intangible dimension to maintain mutual reciprocity and recreation, however the lack of helping hands to carry the transverse lie case from Thabang to Phuliban shows the fractured sense of collectivization among the people living in homogenous settlement. Moreover, similar to the transverse lie case occurred in Thabang, other severe bleeding cases I have observed at the Nehrpa health post, which also reflected the same kind of experiences in terms of accessing institutional delivery services in Rolpa, where the process of delivery has not been taken as an collaborative process between family members and no collective effort has been shown by the local community.

Apart from different structural vulnerabilities, cultural practices like early marriage is one of the crucial social problems in Rolpa. Early marriage leads to early child birth and thus limits the educational and career opportunity of a female risking the life of a woman with numbers of children in early age. In the case of early marriage, the Rolpali society also provokes to perform marriage of daughters in a "pure" and " virgin" stage where delay in getting married mean, they may perform any "illicit" activities before getting married, which may further ruin the prestige of the family. Similarly, the low level of knowledge on reproductive health is promoting a low contraceptive prevalence rate in Rolpa. As a result,

females have to face additional layers of burdens which force them to go through risky abortion procedures performed unethically by the quacks. Because of cultural stigma and other socio-cultural barriers like cases of getting pregnant due to extra marital affairs, it has been explored, that many pregnant women do not feel safe to access abortion services at government institutions, though it has been declared legal. Similarly, rather than associating oneself with the objective condition of pathogenesis, illness experiences have been linked to life events like in the case of an epileptic women who relate her sickness to the cause, that a horse has eaten her paddy. Similarly, different shaman's interpretation of disease condition to unknown causality is also a similar condition where shamanistic knowledge also negates the presence of objective pathogens. In such interpretations, both, the shamanistic healing system and lay knowledge cannot identify, that sickness has been primarily induced from a presence of objective pathogens which further creates dysfunctionality. Though primarily disease condition have been generated from the presence of pathogens or other kind of dysfunctionality in the body, however, illness experience cannot be reduced only to the existence of pathogens in the body. As Eisenberg and Kleinman (1981) writes: "Patient hood is a social state and not simply a biological one". Similarly, Merrill Singer in Ember and Ember (2003) write:

> *Disease is not just the straightforward result of a pathogen or physiological disturbance. Instead, a variety of social problems such as malnutrition, economic insecurity, occupational risks, industrial pollution, substandard housing, and political powerlessness contribute to susceptibility to disease (Baer, Singer, & Johnson, 1986). In short, disease is as much social as it is biological.*

The woman with an epileptic condition from Gajul and her family's inattention to get proper treatment or a girl child from Libang with cerebral palsy and her mother's non effort to take her to hospital for thirteen years show, that the biological conditions of the disease and disability have induced layers of chronicity. As Kleinman (1988:180) writes, "Chronicity is not simply a direct result of pathology, acting in an isolated person. It is the outcome of the lives lived under constraining circumstances with particular relationship to other people". Here, a particular relation of the patient to her parents has been intentionally subordinated and suppressed by not providing the required level of attention and care to her disability condition. This condition of ill health should be addressed by the existing public health system of the Rolpa as a part of the responsive health system, however a non-responsive attitude of the health system, which is more concentrated on curative aspects, is unsuccessful to explore the social sufferings of those, who are hidden in the society.

As an important variant of the CMA, this research work has been conceptualized to borrow the Focauldian notion of body politics in terms of understanding the experiential condition of ill health and social sufferings. Nancy Scheper-Hughes, one of the provocative contributors in the Focauldian camp has described the concept of the political body and according to her, everybody is not belonging to 'free standing minds of personalities' but as 'personalities within specific bodies'. Moreover, these specific bodies are continuously shaped by different socio–political and cultural forces of the society. In the empirical context of Rolpa, either it is a shaman contesting the sick person's body to rule out certain supernatural causalities or a medical shop owner expressing vested interest to inject or prescribe irrational dosages of medicines, painkillers and injections, but in every of those cases heterogeneous forms of power have unethically contested into people's bodies in order to control the bodies of the people. Since everybody is not only a biological existence as entrepreneurs of bio medicine perceived, the body is more than a 'political body', it's the conglomeration of socio-cultural, historical and the representative figures of a shared life experience under certain conditions. Cited from Merrill Singer, the Ember and Ember (2003:27) writes:

> *Lock and Scheper-Hughes delineate three relevant "bodies" in health: the individual body, the social body, and the body politic. An individual's image of his/her body, whether in a state of health and well-being or in a state of distress or disease, is mediated by particular meanings of being human as defined by the local cultural system. The body also serves individuals in society as a cognitive map of their conceptions of natural, supernatural, socio-cultural, and spatial relations. Further, individual and social bodies express power relations in both a specific society or in the world system.*

Here, both the individual body and the social body have a dialectical power relationship, where performance of the individual body affects the social body and vice versa. As explored in the chapter four, many narrative of sufferings are intrinsically linked with their local cultural system and the way they express their pain ultimately reveals the cognitive image of particular society which further construct their individual body as a representational 'social body'. The level of malpractices performed by different individuals for example as a medical shop owner or as a local shaman or as a governmental health worker, in this context the individual body of a particular person represents the social image of its professional associations. Baer et. al. (2004:44) writes: "The critical approach to the individual level begins with the recognition that sufferer experience is constructed and reconstructed in the action arena between socially constituted categories of meaning and the political-economic forces that shape the context of daily life". The expression of narratives by many individuals

in the name of *lagu, bokhsi lagne, jhumma bananune* or any other linkages with evil force, that has caught him or her and the bodily response of the disease, in every episodes it manifest the relation of existing health beliefs and cultural constructions in Rolpa. It's not only the cultural construction, cultural events also delayed the process of seeking appropriate health care on time. For example celebrating different kinds of cultural festivals like Dashain, Tihar, Maghesankranti, Losar and Vhumya Puja have been other features which give opportunity of recreation and refreshment, but it intentionally makes delays to seek timely treatment in complicated cases as well. In many cases people postponed the visiting times to health institutions just to celebrate festivals which has been even reflected in the difficult transverse lie case which occurred in Thabang, where it was difficult to arrange people to carry patients because of a local cultural festival. Similarly, in terms of cultural construction of bodily malfunction, healers also follow different metaphoric spaces and do symbolic mapping of the body to interpret the disease causality relying on bizarre interpretations related to mythological, religious or supernatural forces. Within the domain of shamanistic healing, though there are some good practices like creating the placebo effect in different psychosomatic conditions, however, many interpretations done by shamans and the way they perform magical flights or vibration to understand the disease causality remain dubious, bizarre and objectively disjointed from the patient's physical condition, which instead playing a role to induce additional social sufferings in Rolpa. Moreover, in the case of a person from Uwa whose problem has been earlier misdiagnosed as a typhoid case at the local medical shop and later on diagnosed as pneumonia by the district hospital, it has been evident, that similar to shamanistic healing practices within the domain of so-called modern medical practitioners, also there has been misdiagnosing and misjudging of the disease's cause.

Likewise, in terms of power relations between the powerful and powerless, it is an obvious fact, that powerless people suffer more because of their subordinate position in the society. The Civil War has strictly restricted the mobility of service users to avail the health services and affected the mobility of both patients and health workers in Rolpa. Both fighting parties have claimed, that they have organized medical camps to "serve" the health related necessity of the rural poor, rather than addressing the actual necessity of the people, both claims were contested to win people's psyche during the war in order to reveal the secret of fighting opponents. On one hand the state security force prevented many essential medicines or surgical items to get delivered in peripheral health institutions like Rolpa, on the other

hand a limited amount of essential medicines and surgical items was also taken forcefully by the CPN (Maoist). This shows the dire situation of powerlessness of the local people, when two powerful entities are fighting each other. The compulsion to take prior approval from the state security force before taking patients from Rolpa to elsewhere or unnecessary query done by the security force regarding the nature of the illness were harassing situations for both patients and visitors. Narratives explored in relations to the Civil War shows, that many ordinary civilians were discouraged to visit health institutions if they have problems related with cuts, burns or damages. Respecting the agreement of the Geneva convention, concerned authorities were no more supposed to make any queries behind any fatal injuries or damages, however the directives forwarded by the Minister of health to its line agencies ordered to seek approval before treating any injured patients. During Sankatkaal, either it's the restrictions during curfew or fear of mines and ambushes on the way or sudden encounter that may happen anytime, the Civil War has seriously affected people's expectations to access health care services in Rolpa. Moreover, during the Civil War, the life world of the people and the system world of the government has been contested brutally and both political and nonpolitical bodies were killed, injured, victimized, suppressed and harassed by coercive forms of state power. Because from both sides many international conventions were not followed and the state has violently manifested its bio power to suppress the individual bodies in Rolpa. It's not only from the side of the state, that fighting opponents have also killed and injured many people who were supporters of other political parties labeling them as a class enemy (*Barga Satru)* and performed killing in the in the name of class enemy annihilation *(Safaya).* Such act of labeling is similar to the act of the state which has also strategically legitimized many innocent killings in the name of different state manufactured terminologies like "two way encounters" (*Dohoro Vidanta*) or "fake encounters" (*Jhuto Mudvhet*) to justify the demonstration of its bio power to target, harass and kill the individual body, which may appear as a potential threat against the state. Such demonstration of bio power to suppress individual bodies has created war related tragedies in Rolpa. In the process of demonstrating violence during the Civil War, many people were mobilized, killed and specifically '*Rolpali*' or '*Thabangi*' as a social identity has been perceived as an anti-national, antagonistic or anti-social element that could be a potential threat to the state. The act of targeting "Rolpali' during the Civil War in Rolpa demonstrated the hegemonic form of military strength demonstrated by the state, because the connotation of 'Rolpali' represents those people living in the landscape of the war zone. Such killings have not always resulted in quantitative loss of human bodies as a dominant trend of media reporting showing all over

the world; moreover death and decay of human life has created socio-economic, cultural and emotional losses of their dependents, that is beyond the quantification of death numbers only. Likewise, opening a local pub by a CPN (Maoist) political worker, who once worked as an OMSA worker in the health department of the Maoist party is one of the powerful indicators, that manifest the regression of the Maoist political ideology and shattered dreams in Rolpa. Except a few OMSA workers who have continued their medical skills acquired as OMSA worker in the health related field, there have been frustrations among many other OMSA workers after the Ghorneti model hospital has closed and remain idol. Civil War in Nepal has given opportunity to accumulate wealth to a few who used to supply medicines, weapons or other logistics items during the war or said in another way, the war became profitable in specific cases like the in charge of the Ghorneti Model Hospital, who took a bonus amount of army integration. In contrast, the larger majority of rural mass who joined the Maoist organization expecting to get rid from the existing condition of poverty and exclusion, the rise and fall of the Maoist movement could not address the basic necessities of a large section of the rural mass in Rolpa. Here, Subedi (2005:252) writes the following: "Aid operated projects may help to curb short term human suffering but may be a factor in a long term for unfair distribution of benefits and even it may be a factor for future human suffering". The frustration created by failures of aid projects and the lack of holistic development became fertile ground to capitalize rural sentiments in the name of the people's war. At present, many people who done genuine contribution to sustain the the war has expressed frustrations because their contribution has been resulted in meaningless condition. Many sacrifices were not acknowledged and genuine political workers were forced to displace from the country and choose blue color jobs in different cities of India, the Gulf region and also forced to live a life of illegal migrants in European cities. Supplementary to Subedi's argument, in many cases it has been noticed that many people of the mid-western hill districts including Rolpa are coping with additional sufferings induced by the Civil War.

Bury (2005:21) writes: "Disorders do not occur randomly in populations. They are, in significant ways, socially patterned". Here, disorders experienced by many people in Rolpa are socially patterned and conflict induced. The way state security killed a physically disabled person labeling him a "Maoist "in Thabang, it is evident that there has been an extreme degree of brutality manifested by the state against the individuals in places like Thabang, which has been compelled to express anti-state psychology in different political events. During Sankatkaal, the state has launched episodes of army operations to suppress and target

the bodies of many people in Rolpa. Such kind of brutality has crossed the level of human imagination where village dogs have eaten human flesh left out at war and shown abnormal behaviors like mad dogs and bit local villagers. Even the "revolutionary will" of the combatants was expressed up to the level where despite pregnant status, a fighter lost the life because a self-carried bomb got blasted. Here, as Bury (2005) mentions, "relative powerlessness" of the Maoist combatants to overcome the situation has resulted in psychological and physical harm to even suicide. Apart from this cases, there are many other impacts like the case of a young girl, who was not taken to a surgical OPD even for thirteen years because her father has been displaced and vanished due to the a Civil War related cause or the case of a lady who was compelled to abort a child and legally punished because of the non-responsive behavior shown by her soldier boyfriend. This are demonstrations of bio power by the state which has brutally hampered the life world of many individuals in Rolpa. Likewise, it's not only ordinary civilians, in Rolpa the security force has brutally articulated state power in killing, abducting, harassing and torturing the government health workers to the extent where many health workers were displaced from their regular jobs and some of them were seriously beaten. The act of labeling "Maoist doctors" to the state health workers by the RNA and killing and murder of health workers in Rolpa suggests, that state has targeted health workers of Rolpa on the basis of their potential involvement to treat 'anti state forces' like Maoists. The one sided approach of the state security force homogenized the people as an enemy of the state that has eventually reflected in the blurred situation to identify who is Maoist and who is a non-Maoist in Thabang. For instance, the government security force has frequently attacked the Thabang health posts, harassed and abducted health staff, grabbed medical equipment and created no possibility to run other public health programs like immunization, vasectomy operation and DOTS related activities. As Winkleman (2008:321) writes: "The classification of medicines as substances with a potential for abuse is done in political terms and through political processes, rather than in terms of medically defined criteria regarding harm". In supplement to this point, Aryal (2005) writes: "VDCs like Jinabang, Rank, Iribang, Ramkot, Jangkot, Vhabang, Korcabang, were prohibited to send medicines. Excluding those place if there was demand of medicines from other places, it was necessary to take recommendation from District police office". Moreover, it has been explored, that in the district police office, there was a team of medical persons; it used to provide suggestions to the police force about the control of medicines which may be useful for Maoists. The continuous domination and control by the state security force during Sankatkaal in order to prevent "misutilization" of government resources has compelled many

local health staffs to show their double face just to remain neutral and safe. Only those village level health workers who could show ideological solidarity with both state security forces and the CPN (Maoist) were remained safe in the village otherwise there had been a severe absenteeism in every health institution during Sankatkaal in Rolpa. The temporary or permanent absenteeism of health workers in duty station during the Civil War has drastically discouraged many people to visit health institutions, which is even continued in the post war context.

The existence of social values like '*santan le danda kanda dhakun'* (May offsprings get expanded all over the hills) or '*ek hal nati ta chayio'* (Need pair of grandsons like ox) or inferior masculinity perception like *Khasi banaune (*Castration*)* developed by many males in Rolpa regarding vasectomy operations are some of the factors that are directly supportive to have numbers of children in Rolpa. Since males are reluctant to perform permanent contraception, as a result females are compelled to use different form of temporary contraceptives with a perceived level of side effects, that increases the layers of burdens into female bodies where they have to perform the household job and also apply different forms of contraceptives. The way males imposed restriction on women to use temporary form of contraception have violated their rights to choose contraception as per her bodily comfort. In terms of her decision over her own body Ian Ree Jones mentions in Scambler (2013:68) "Health care decision making is not and cannot ever be value free. By its very nature it is a product of and acts upon powerful interests". The non-willingness of many Rolpali males to perform a vasectomy operation or the lack of a timely decision by her husband to take a patient to an advanced health care institution in the transverse lie case, here, powerlessness of women to decide upon her bodily context has ultimately compelled her to lose her life. Likewise, relative powerlessness of her husband also has played a role to occur such kind of unintended maternal and neonatal death in Rolpa. It has been observed, that the persistent stage of rural poverty has created layers of burdens in rural livelihood where many parents are forced to care more to their livestock rather than giving proper attention to their children which resulted in malnutrition and undernourished children. As a result, the lack of proper rearing at home creates empty spaces where exploitative forms of market penetration have been manipulating such emptiness with the use of local agents and middleman (Naike/Naikini), that eventually forced many children to perform risky and manual jobs at brick factories or other manual jobs in cities. Similarly, decline in the pattern of vertical transhumance, state suppression to collect Chares and a state of mass deprivation attracted

many youth to join the "people's war." The bourgeoisie education boycott campaign launched by the CPN (Maoist) has forced many students to discontinue their school even at higher education, which ultimately fulfilled the interests of the CPN (Maoist) to increase the expected numbers of child soldiers getting recruited in the party. However, in many cases state security force has harassed and tortured them suspecting their involvement in the Maoist party.

The decline of a traditional labor based economy and agro-pastoral activities due to the Civil War has created situations of economic insecurity and food insufficiency forcing many males to follow the pattern of distress migration. As Kleinman (1988:12) writes, "Body symbolizes landscape and landscape body", the construction of new identities as a "*Seshi*", "*Bahadur*"or "*Doke*" after achieving migrant status reflect the state of political powerlessness. Such kind of discriminatory labeling gives low sense of motivation and alienation among the people. In present days, there has been a gradual shift of distress migration from India to the Gulf region countries to earn big amounts (Thulo Dhan), however newly developed patterns of labor migration have promoted an emotional and psychological gap with their family members. It has been observed, that such gaps have been attempted to being fulfilled in terms of extra marital affairs creating medico-moral complications like unintended pregnancies. Though a high level of distress of male migration has substantially contributed the remittance in Rolpa, the rural livelihood does not create many opportunities to reproduce the surplus at the local level. Instead, the situation to spend a high out of pocket expenditures for health compelled many people to decrease their surplus earned through the means of distress migration. Once the family member gets ill the lack of a responsive public health system is directly contributing to grow unexpected amounts of medical loans in Rolpa in order to avail better health care services. The high interest rate taken to go abroad is an additional dimension, that creates regular stress and forces to accept hard working conditions which results in numbers of unintended deaths in the Gulf region countries and contributing to the growing numbers of coffin boxes shipped back to Nepal. In addition, it's not only the exogenous social actors, that exploit rural livelihood at a one-sided basis, there are layers of local actors which are equally playing a detrimental role in the people's health in Rolpa. The case is evident, when opening a medical shop at a top floor by a husband and running a pub in the ground floor by his wife manifests the role of locally powerful actors manipulating the rural poor by selling alcohol and medicine to accumulate profits. Moreover, the asymmetrical power relation and the persistent level of gender subordination have been additionally

perpetuated by alcohol drinking habits which gives pseudo power to many alcoholic males to find a reason for quarrels with their wives stimulating gender based violence and promotes stages of psychopathologies. The irrational drinking of alcohol has created different kinds of social tragedies like in one case, that has occurred at the Indian border of Banbasha, where an alcoholic man has left his newly married bride at a bus stop or in the case of a person who fell down from a narrow trial nearby Libang. In such cases, alcohol became a catalyst to stimulate the existing psychosocial frustration, that has induced from a low level of consciousness. Similarly, the situation of a lady who was feeling guilty to ride over another human's back; an old woman who was constricted to a bamboo basket and taking it to the district headquarters to sort out legal disputes between her sons; an orange seller lady whose leg got fractured on the way and compelled to spent more than her expected earnings, in every case, social power is dominating the life world of the people where the individual has to bear additional sufferings because of socio-structural vulnerabilities of the rural life. The presence of syndemic conditions like the conjunction of poverty and chronic disease among many individuals creates that much of frustrating conditions where many individuals cannot get rid from this vicious cycle and ultimately choose suicide as an ultimate solution. The "normalization" of death in Rolpa is structurally rooted and socially reproduced where many people are dying every day because of structural vulnerabilities of the rural life in Rolpa. The recurrence of deaths as an episodic event eventually normalizes the individual's psyche for accepting it as a 'normal' trend rather than seeking alternatives to get rid from the vulnerabilities. In empirical cases of Rolpa, social sufferings are historically produced, reproduced and neglected one after another, the layers of violence, suppression and isolation have compelled people to accept death as an inevitable phenomena. In suicide or other death related causes, the compulsion of carrying dead bodies for post mortem is another structural burden for many people in Rolpa, where many dead bodies are compelled to be 'seen' and 'touched' by doctors who have never seen their doctor before in their lifetime.

Last but not least, the CMA as an theoretical foundation suggests an emancipatory concept which is closer to a critical realistic interpretation of the transcendental philosophy. According to this recommendation, understanding any kinds of phenomena itself is not a sufficient task, however one should have commitment to change the existing culturally oppressive and discriminatory policies and practices in relation to health in the society. The domination of an existing class interest in the process of the equitable distribution of health can be addressed only through a radical transformation of the existing economic and political

condition. This could promote the alternative values in terms of health care . In this context, as Winkleman (2008:315) writes:

> *Recognition of the role of power in the provision of care empowers an activist engagement with a community-oriented medicine designed to challenge the power relations of bio medicine by addressing the health inequalities produced by class relations and economic disparity..... This transformation is manifested in the demand for universal health coverage and public health services. This requires a reversal of health expenditures from the predominant focus on bio medicine's treatment of disease conditions and, instead, directing resources to public health prevention of the social conditions that increase susceptibility to diseases.*

The pattern of health care, the existing crisis in the rural health system and unfair distribution of health related resources in Rolpa can be radically altered, if there is rise of a political power with strong political will. Berry (1997:57) writes: "while humanitarian action helps meet basic needs and alleviates suffering, it cannot cure the root causes of suffering. No crisis can be solved without political action". In reality, in the context of Rolpa, access to health services is an outcome of constructed social values, shaped economic interests and failed political commitment. In order to transform those anomalies (*bethiti*), there should be radical transformation in the phenomena which is centralized in coterie rather than collective decision, personality rather than ideology and domination of individual leaders rather than guiding policies in both, the political system and also in the healthcare system. As Illich (1976) states: sickness is symptom of political corruption and will be eliminated when the government is cleaned up. Such kind of "cleanliness" can bring dynamism in every political system and also in the domain of the health care system which further affects the health related needs of every marginalized population of Nepal like the one of Rolpa.

SUMMARY AND CONCLUSION

Reviewing the literature from war affected countries, it reflects that war has created worst consequences like deterioration in human's health and social well-being. In every kind of complex emergencies, literatures from war related context has shown that there is always a sharp rise of both communicable and non-communicable diseases. Likewise, attacks and disturbances in the health service system have prevented people in war-affected places to make use of the health care services due to elusive accessibility. Thus, it has been explored that displacement, mental morbidities, social separation, frustration and wide scale unemployment are other negative consequences of war that directly hampers human's health in war affected zones. Though reasons of conflict may vary in different temporal-spatial condition, the level of sufferings induced by conflicting behaviours are more or less the same in all parts of the world.

Literatures reviewed from Nepal show similar findings like other war-affected places in the world. It gives evidence that armed conflict destroys the health and life of individuals, damages health service systems, prevents health care delivery and outreach programs, and leads to violations of medical neutrality. In the Nepal's civil war, disturbances in health delivery services, threats and killings of health workers, displacement of medical and paramedical workers, discouragement in accessing services, and violation of international humanitarian principles are similar to other war affected countries of the world. Thus, this suggests that armed conflict wherever, brings a similar kind of devastation that affects the physical, mental and social well-being of both individual as on population level.

The presence of international visitors like Capuchin monks, Christian missionaries, British doctors and Bengali doctors have played an influential role to expand the early usages of biomedicines in Nepal. The rise of Rana oligarchy has formally implemented the biomedicines as an inevitable solution which has been institutionalized by recruiting medical doctors or expanding hospitals in different regions of the country. Such kind of early intervention has gradually sidelined indigenous forms of medicines and hegemonic presence of biomedicines, they were neither critically challenged nor there has been any effort to seek any alternatives in Nepal.

Before the rise of Nepal as a modern nation state in the reign of Lichchhavi dynasty there has been establishment of Ayurvedic Arogyashala. In succeeding days the Rana government also has expanded the Ayurvedic health institution, which are the evidence of early emergent of health institution in the context of Nepal. In these periods, overall activity of state has been guided by war led economy. Such kind of sporadic services on people's health were not sufficient to the contemporary health related necessity of the people and a large section of the people were forced to rely on different kinds of alternative healing practices like shamanism and other varieties of faith based healings in Nepal.

After the overthrowing of the Rana regime in 1950, the global rise of political thought has been influencing south Asia which has also penetrated the local region like Rolpa. Though pioneers leaders from Rolpa were operational to flourish new political thought, the rise of autocratic monarchy has once again curtailed the political freedom of the people. As a repercussion of political coup there has been restriction of people's participation and largely minimized the chances of flourishing local institutions in a participatory and inclusive pattern that has affected every sector of the society including politics, health and educational institutions in Rolpa. The diachronic analysis of political changes occur in national level and its further impact on district level shows that political development has capitalized the sentiments of the people, but sense of responsibility to fulfill the expectations of local people have been not addressed.

The rise of new biomedical class in Nepal has ultimately created favourable ground to implement agenda of global medical capitalism to expand the usage of biomedicine as an inevitable solution in Nepal. The implementation of so-called liberalization policy after 1990 has given legal environment to reproduce the agenda of global capitalism in the guise of 'open', 'liberal' and hyper market friendly policy. The government with political instability, corrupted bureaucracy, powerful private players and mushrooming of non-governmental organizations after post 1990 are other fatal factors which become supportive, to blindly adapt the pro market friendly policy recommended by international agency basically in third world countries like Nepal. As a result, the mushrooming of private hospitals, nursing homes, research centers and medical colleges have acquired unrestricted agenda to reproduce the interests of global medical capitalism to accumulate profit in the name of people's health.

The failures of IRDP have given a strong message to local communities in Rolpa, that development programs which are a trickle down and ill designed, cannot radically transform

the stagnated social structure instead it creates favourable ground to seek radical political transformation. Moreover, the imposition of the door driven agenda in the name of ‘ created needs’ has not understood the ‘felt needs’ of the people which has been further reflected in non-productive situations and dissatisfaction among the community. Evidently, the imposition of one sided plans made either by donor agencies or state actors, such kind of top down approach has been resulted in failures to address the genuine concern of grass roots which has been evident in different programs launched in Rolpa and also in the context of Nepal.

The obedience of international ‘power-decision’ by the Nepali government in the name of following international declaration to restrict on Chares production and selling has directly hampered the livelihood and income generating activities of local people in Rolpa. Such kind of imposition has created severe frustration among rural mass and many people directly lost their income generating activities which became one of the reasons to join the civil war. The present day harassment to Chares producers have been continuously suppressing the local people which has created a sense of exclusion towards the ruling state.

The way people were motivated to donate personal land to public institutions in the early phase of institutional development in Rolpa shows the notion of philanthropic attitude untouched from sense of consumerism and personal benefits. However, in latter days growing monetary value of land and trend of selling land to go abroad has been reflected in the process of non-availability of land to construct health institutions in Rolpa. The Paradigm shift of donating land (*Daan dinu*) to health institutions in order to earn prestige *(samman)* and virtue *(punya kamauna*). Nowadays there is a trend of non-donating and constructing health institutions on frosty and wastage land shows the repercussion of consumerism and individualism that has penetrated the rural society like Rolpa.

Either the medical malpractices performed by quacks or by certified medical practioners the hegemonic articulation of biomedicine has been manifesting its power to alter, inject, dissect or intervene the people’s body to fulfill its inherent quest of profit maximization in Rolpa. Similarly, the offering of free vehicles to attend the drug orientation session for health workers, advertising volunteer motive of medical doctors as a commercial interest or performing malpractices to earn extra profit by government staffs and by other quacks in their private medical shop have been performed to accumulate profits in Rolpa. Likewise, the launching of mass scale vaccination with support of government agencies to earn profits has

overtly supported capitalistic interest of profit maximization by nurturing the 'fear entrepreneurship' to exploit the rural poor in Rolpa.

As a local agent of profit oriented medicine, the presence of large numbers of private medical practioners running medical shops for the profit making purpose are manipulating the expectations of the patients with their quasi orientation on biomedicine. The lack of regulation by the state and unrestricted condition to demonstrate exploitative form of biomedical power on to people´s bodies have been supported by hypermarket friendly policy of the state, which is creating favourable ground to exploit people's sufferings in the name of providing alternative marketing options in Rolpa. The legitimacy to exploit people´s sufferings in their own cost of lives have been sanctioned by the government to the market players which is a serious policy paradox that contradicts the constitutional guarantee of health as a fundamental rights of people in Nepal.

During Civil war in Rolpa, war profiteers have accumulated the profit by supplying medicines and war related logistics to the Maoists which suggest that profit making greed can take every kind of risk to fulfill its profit maximizing interest. Though post conflict scenario CPN (Maoist) has shown public health orientation within its progressive formation of new health workers subscribing the philosophical notion of Chinese Barefoot doctors. However, rather than mobilizing health workers to bring "progressive transformation" in the existing system, Maoist new concept of health and formation of new progressive health workers is by and large similar to government health worker which has largely subscribed biomedical orientation of the existing health systems of the country. In reality, Maoist progressive orientation on health has neither challenged capitalistic infliction to existing health care system of Nepal nor strongly argued to establish socialistic pattern of health care.

The pre-existing factors before the rise of civil war were continued during and also in post war context have strongly hampered to flourish the health institutions in Rolpa. The issues of mal-governance supported by Panchayat government, rejecting state led development activities by CPN (Maoist) and non-discharge of responsibility by so-called democratic political parties after the second rise of democracy has continuously curtailed people's rights to avail health services within the periphery of their locality. Similarly, the demonstration of power by social and political actors in terms of locating public institutions has created additional geographical barriers along with political barrier and promoted inequitable

distribution of health related resources that have been evident in the case of District headquarters, district hospital, Ayurvedic institutions and other health institutions in Rolpa.

In the intermediate level, many different factors like, non-supervision of corruption during the health infrastructure development process, lingering of other supportive infrastructures like, airport and bridge construction, cessation of Ghorneti model hospital after the political breakdown, non-preference to build a new building in the case of Holleri has hampered people's expectations to easier access to health services in Rolpa. Phenomena like non-donation of land to build health institutions, prevention of CPN (Maoist) to implement state led development activities during civil war and profit nexus among the contractors and politicians have been resulted in poor and fragile infrastructures, ill designed set up and insufficient space for both service providers and users in Rolpa. In many cases, relation based rather than rule based contract agreement between politicians and profit makers have been resulted in the poor quality of infrastructures that have affected the expectations of both health workers and service seeking population in Rolpa.

In many cases, politicians fight to recruit their own people (aphno Manche) in the public institutions, rather than bringing good people (*ramro manche*). Therefore, it has been explored that rather than working as a politics as panacea of human happiness (*sukkha dine*), in many episodes it has been proved that politics became the causality of pain (*dukkha dine*) in the context of Rolpa. Political powerlessness in this context has been accompanied by low level of education and health awareness among the population in Rolpa. In contrast to Alma Ata´s recommendation to acknowledge the community interest by the active political stewardship, in the process of infrastructural development political parties and government have not given proper attention to the construction process of health facility. As a result the substandard appearance of health facility has been appeared in the donor driven project like Gairigaun sub health post building in Rolpa.

There has been policy level loopholes in the tender process of the government that allow original contractors to 'sale' project to other petty contractors reducing huge amounts of budget in its original volume has affected the quality of health post infrastructures in the cases of Gajul, Thabang and Jinabang. Moreover, the way the governing body of the state defended the negligence of the contractors by showing the hardship of construction site has manifested the attitude of bureaucratic and private actors which can develop such kind of nexus where expectations of the people are being violated continuously. Similarly, the power

nexus of contractors and bureaucracy appears in powerful tie where once being blacklisted also the way bureaucracy defended the contractor manifested the nexus of bureaucracy and contractor in Rolpa.

In every episodes of the corruption held in Rolpa, district level actors have blamed local level actors; politicians have blamed bureaucracy and vice versa. The unclear area of authority (*Chetradhikar*) is one of the problems in Rolpa health system where in many cases there has been no department to acknowledge the negligence and corruptions. Moreover, not acknowledging the mistakes and shifting the responsibility from owns head to another is a crucial phenomenon in the health-politico-bureaucratic structure of Rolpa where every individual has pointed finger to another individual. The power conflict between sociopolitical power of HFOMC and medical power hold by health workers also affects many decisions to timely gear up the services like in the cases of Gajul Nehrpa and Thabang health posts in Rolpa.

The slow pace of rural villages, poor psychosocial support and limited refreshment options has created frustrations to health workers in Rolpa. However, crossing the limit of drinking alcohol as an "ecologically suitable" and "culturally acceptable" substance has been reflected in temporary and permanent absenteeism of health workers and hampered the expectations of the people to access regular health services in Rolpa. The opening of local pub (*Vhatti Pasal*) by OMSA worker of Maoist party in the heartland of Maoist movement like Thabang where once alcohol has been banned by CPN (Maoist) is very significant to understand how Maoist's political movement has not fundamentally altered the regressive cultural practices which were intended to change with the means of radical left politics.

The breakdown of political strength has further created impact on the volunteerism spirit of working staffs to work for model hospital established in war context in Rolpa. Similarly, the personal behaviour of the actors working for such kinds of grass root health institutions has created internal conflicts among the fellow workers which in long run became the matter of generating extreme frustrations. The abuse of authority by these powerful individuals who were supposed to lead the institution has created sense of alienation among other supporting staffs who were comparatively powerless to challenge such authoritarian decisions.

Either it's a "progressive government" or a 'democratic government" or a coalition government .The political will of the government has been inadequately demonstrated to

strengthen the health service system of the remote district like Rolpa. The culture of unethical conjunction *(Milivhagat*) and sense of favouritism as a "*aphno manche*" has hampered many different infrastructural development processes in Rolpa. The lack of elected political representatives after 2002 and absence of a village secretary, even after many years of peace accord has directly affected the supervision of health infrastructure development process in Rolpa ,which has shown the bare facts that there has been a stark gap between political commitment and health related expectations of the people in Rolpa. The delay of the construction of important social determinants of health like bridges, an airport and roads has hampered the delivery process of essential medicines and also affected the ambulance services in Rolpa .

The official ending of tenure of elected local representatives after 2002 has created lots of drawbacks either to supervise local health infrastructural development process or actively represent the meeting of HFOMC. In the absence of politically elected representatives ad hoc representation done by VDC secretary has not discharged the political commitment as expected by the people. Likewise, multiple engagements of HFOMC members to different local level organizations have drastically hampered the regular meeting process of the health institutions. Likewise, HFOMC members are not aware about the rights and duties, on one hand they are expected to perform and on the other than they are restricted to intervene, which is a blur kind of power conflict evident in many health institutions in Rolpa.

Low level of decentralization has been observed in different cases of health institutions in Rolpa which has created situations of low autonomy, as a result, it has hampered local institutions to become self-reliant, which has been promoted dependency towards central level institutions. Moreover, the issues like not being able to shift the legal authority of land (*Jagga namsari*) or revitalization of the Ghorneti model hospital, that has been stopped after the political breakdown, shows that Alma Ata´s recommendation of self-reliance and self-determination are pragmatically not reflected in Rolpa. Though Alma Ata has mentioned that people have rights to participate both individually and collectively, such kinds of participation is still not inclusive. Where different forms of political and patriarchal power affect the decision regarding the construction and shifting of health facilities from one place to another. Similarly, the observation from HFOMC meetings has shown that socio political and patriarchal power dominates the public sphere which is maintaining its domination by suppressing the voices of powerless in different public domains in Rolpa.

The way health staffs have contested to prove superiority to each other shows how public institutions have space for contesting each other‘s interests, where many different conflicting interests are hampering in regular performances of health institutions in Rolpa. Similarly, irrational consumption of alcohol by health workers has promoted both temporary and permanent forms of absenteeism which has further victimized people’s expectations to access health care services in Rolpa. Similarly, due to temporary form of absenteeism or non presence of health workers because of training related causes or deputation (*Kaaj*), the non responsiveness of primary health institutions ultimately forced people to make a long and expensive journey towards secondary and tertiary healthcare centers, which has been evident in many different cases in Rolpa.

The reduction of a free health program to a "free medicine distribution program" (if available) has not fulfilled the welfare values of this concept, that has been launched by CPN (Maoist) government after 2008. Different techno managerial limitations like nonscientific criteria to identify the category of the patients, irregular and insufficient availability of essential drugs at health institutions, temporary and permanent form of absenteeism of health workers, and the low level of awareness on free health program have directly hampered the free health program to actively function in Rolpa.

Along with geographical factors in Rolpa, specific problems like non availability of males to carry patients, due to distress migration, expensive costs to pay for the bamboo basket carriers, lack of ambulance facilities, due to unavailability of roads and the fearful sense of health institutions as a polluted place, has also affected the service seeking process in the time of delivery. Though the government has announced a 24 hours delivery, in those health institutions where birthing centers are available. In comparison to the government incentives people are compelled to spend higher amounts of expenses to reach the health institutions in Rolpa. Likewise, logistic limitations under non-medical expectations like lack of transportation, no guest house and cafeteria for both visitors and delivering women is not creating a supportive environment to encourage institutional delivery in Rolpa. Similarly, irrational birth planning and unavailability of required assisting technology and skilled birth attendants (SBA) have also been factors to contribute unintended maternal and child deaths in Rolpa.

The inefficiency of primary health care centers have compelled to perform “forced medical tourism” from Rolpa to different cities of Nepal and India, which is largely playing a role to

decrease the surplus which were earned by following the pattern of distress migration from Rolpa. The failures of the public health system in Rolpa has produced new marginalized and deprived class that is stimulating the existing conditions of the people from relative to absolute poverty. The volume of remittances earned from affluent cities again extract the surplus from Rolpa shows the chain of exploitation where people are just merely involved in the vicious cycle of reproduction, rather than possibility of transforming their class status by earning remittances.

The usage of power and its legitimate and illegitimate exercises in terms of resource allocation process and vested interest among the political and other social actors, those who are playing overt and covert games are crucial factors to make a decisive role to shape the performance level of any social institution in Rolpa. Moreover, most of the health institutions in Rolpa are suffering with premature stage of governance crisis which is specifically reflected in substandard infrastructures, low quality health services and low self-esteem among the health workforce. The placement of medical doctors in district hospitals is somehow beneficial for local people. However, in remote VDCs people still do feel severe shortage of health care professionals. The lack of sufficient medical doctors is not being able to provide the services as per necessity of rural population. Beside medical doctors, for overall improvement of public health indicators, there is a necessity of different kinds of health workers. However, the government has not given any priority for overall development of HSS in Rolpa.

Since there has been severe interest conflicts among the people who are resided inside the district headquarters in relation to locate district hospital or police station in their vicinity, the influential decision of powerful local actors have been powered back up by the Panchayat government. They have manipulated the institutional development process in Rolpa. Rather than making decisions by developing broader public consensus, the handover of contract to construct a district hospital has been done to fulfill vested interests of different involved political actors of that time. Similarly, at a national level, authoritarian power was exercised by the monarchy in the name of the Panchayat system, an unstable government in the post-Panchayat era and a decade long civil war are some of the further reasons that the local governance has been continuously hampered in Rolpa.

The benevolent interests behind the social, political and bureaucratic actors have directly affecting the collective aspirations of the people and their expectations, however malevolent

interests have created long-term obstacles and hindrances in the process of institutional development. Inherent biases like 'who will execute' the project and 'where to execute' and to 'please whom' are highly contested value laden questions among involved actors, which has evidently blurred the dichotomy of private and public sphere in terms of existing power relationships in Rolpa. Therefore, existence of any institution as a sociocultural production is finally an outcome of continuous negotiations, intentionally contested and pragmatically compromised phenomena among the involved actors in particular historical context. Either the actors with their benevolent interest to serve the mass or few actors operating only for profit, both kinds of interests has shaped the conditions of the health service development process in Rolpa.

Prior to conflict, the overall performance of the health service system was malfunctioning and struggling to provide basic health care delivery in Rolpa. The juvenile stage of the health service system has been directly and indirectly affected and disrupted during war in Rolpa. The act of severely damaging and attacking health service centers during the conflict period has excluded accessing the regular services in Rolpa. Moreover, long-term ignorance, capital centric political activities, headquarters centric development programs, low investment on health, rampant corruption on health governance, shortage of human resources on health, low incomes and lack of strong political will to strengthen the HSS are some of the reasons that most of the people faced difficulties to access regular health services in Rolpa.

The political actors of the authoritarian period or the actors of multi-party democracy, all have failed to provide a rational solution to people's aspiration to utilize quality health service in Rolpa. The health service system is the part of the political system. Likewise, political systems should be an integral part of the health system. Contrary to this, local political tussle, national level power conflicts, long-term civil war, and crises in the bureaucracy have led to the continuous ignorance of people's health issues in Rolpa. Moreover, conflict induced reasons such as long-term absenteeism, low level of physical infrastructures and health facilities, non-functioning monitoring mechanisms, and vacant posts are some of the reasons that, the government health systems have not been able to attract patients in great numbers in Rolpa.

In the everyday interaction of doctor and patient relationship, the macro level hegemonic propositions forcefully play role to channelize the micro level and those actors who are predominantly oriented in biomedical knowledge undermines the social origin of diseases

and medicalised the conditions under medical control. In the specific context of Rolpa, health workers of the government and quacks present in medical shops are medicalizing many non-medical cases and medicalization of pain to fulfill their vested interest of accumulating profits in Rolpa.

Similar to the characteristics of Nepali state, as an important sub system health service system of Nepal do not bear any compulsory responsibilities to discharge welfare facilities to the people. Such kind of irresponsibility have been reflected among the actors of system´s world and their day to day responsibilities in terms of caring for people's health. Consequently, such kinds of non compulsory welfare values have been reflected in low motivation to conduct promotive and preventive programs have been reflecting in prescribing curative solutions as an ultimate solutions in Rolpa.

Following the notion of Alma Ata´s declaration the state has accepted the varieties of community health workers to be involved in the health care practices. However, among the both formally and informally developed health workers, professional power deserved by the health workers who have predominantly orientation in biomedicine are strategically nurtured by the state where other varieties of health workers like Ayurvedic and other forms of alternative healers have to feel an inferiority complex which after all shows the asymmetrical power relationship between different varieties of health workers in Nepal. Though the state has theoretically acknowledged medical pluralism in its policy development, such kind of pluralism has not effectively reflected in Rolpa´s health care system.

Analysis of illness narrative show that either in the domain of traditional healing systems or in the so-called modern treatment system, episodes of malpractices occur like layers of the onion overlapping each other. Since both forms of treatment systems practice hit and trial methods on the cost of people's sufferings, then from the point of view of sufferers there is notion of isomorphism and inseparability between traditional forms of medicines which are largely manipulated by self-developed practitioners and so-called domain of the biomedical system, which is intentionally nurtured by state as a "modern and scientific system".

While doing narrative analysis, it has been explored that there has been paradox between the diagnosis of diseases in Rolpa, on one hand quasi orientations of biomedicines, forceful medicalization of every illness conditions which has social origin of maladies and on the other hand malpractices of shamanism treating patients without diagnosing the pathogenesis

of the diseases. In both domain of diagnosis patients have to be victimized because there is no evidence based practices. The unethical performance of malpractitioner are manifested by forcefully applying medical solutions to non-medical cases to accumulate the profit by quacks, who are running medical shops in Rolpa.

Lack of effective regulation by the state to control such malpractices and political nexus of medical shops and private clinics to powerful political parties are ultimately reproducing the social sufferings of powerless people in additional level. Similarly, inefficiency of government health system are also pushing many people to rely on such kinds of quackery and persistent stage of powerlessness among the local population. It restricts many people to find legal solutions in the case of intentional victimization. The medicalization of pain and rampant trend of prescribing pain killer injections in Rolpa demonstrated the abuse and misuse of biomedical power owned by different varieties of quacks providing their services through profit oriented medical shops, operating as a local agent of medical capitalism in Rolpa.

Analyzing narrative in a different context shows that many often people reject to avail the services offered by health workers and seek for alternative means of survival. Likewise, the application of police force in order to make adherence to leprosy patients is a sheer example of state level suppression on conjunction with biomedical power that has systematically suppressed individual's dignity in Rolpa. In the era of profit making, medicine analysis of many illness narratives from Rolpa shows that healers and patients relationships have been commoditized and sense of service has been diminishing, which largely decreasing the humanistic side of medicines.

Episodes of illness narratives explored in Rolpa show that rather than respecting the people's health as a an complete whole there has been growing trend of following Cartesian duality where psyche (emotion) and soma (body) are separated in terms of providing treatment. Since healers and patients interaction has been largely shaped by monetary relationship, as a repercussion there has been unethical application of biomedical technology, unnecessary prescriptions and inaccurate diagnostic hampering to people´s health ,which has been evident in many contexts in Rolpa.

The crisis of primary health care has led many people to make long distance travelling to access better health care. An inefficiency of government health centers to provide reasonable

solutions eventually forces people to visit other expensive health centers in Kathmandu or different cities in India. Thus, people from remote districts like Rolpa are forced to spend huge amounts of money for tertiary health centers in different cities of Nepal and India.

Since agro pastoral and other indigenous sources of productivity were gradually declined in Rolpa, many people have been forced to follow the pattern of distress migration in order to manage their livelihood. Moreover, insufficiency of food to survive for a whole year, hard-hit of rural lifestyles and minimum chances to reproduce the surplus in rural livelihood has ultimately forced many people to do forced migration which has been escalated during civil war. The pattern of distress migration from Rolpa has been resulted in different form of social, psychological and pathological impacts like social separation, family break down and presence of communicable diseases.

Civil war in Nepal has not qualitatively transformed the rural livelihood, as a result large sections of rural mass has continued the pattern of distress migration to India and other Gulf countries. The political breakdown of the party has created much frustration, even those set of political workers who have contributed during war, had realized that the contribution resulted in a meaningless condition. Displacement, depression, social separation and large-scale unemployment are other negative consequences of war that directly hampered human health in Rolpa.

The demonstration of bio power by the state security force and negation of other form of ideological existence by "progressive force" has brutally suppressed many different individuals in Rolpa where power demonstration of both sides have been manifested in different degree of brutalities creating war induced physical and psychological harm among the individuals. The coercive form of state power has been operated in such a manner that in many cases it was difficult to take patients with minor illness like cuts and burns to Rolpa. Violating the international convention rules show that the state has brutally applied the bio power to suppress the individual bodies in Rolpa.

The history of the ups and downs in power relationship and chronic condition of political instability in the national level political development of Nepal has been always playing an adverse role to fulfill the basic demands of the people in grassroots level like Rolpa. Like in pre conflict power relationship, emergent of neo form of power in post conflict context and superficial changes in political structure could not bring any substantive changes in the life of

ordinary people in a remote district like Rolpa. Similarly, structural factors like institutional inefficiencies, hierarchal power relations and persistent socioeconomic disparities are reproducing different dynamics of social sufferings and diseases among the individuals in Rolpa. Conflict has created more vulnerable situations for women and children. Such kind of power hierarchies eventually exploits its subordinates and fosters stage of mass deprivation[285] where a hard hit of aggressive market penetration and unequal distribution of health related resources create more pressure on poorest of the poor.

Ethnic Magar people have symbolic violent activities in different cultural festivals which shows that historically this region has witnessed the culture of violence which has even supported the process of ritualization and normalization of violence in Rolpa. Though the Rolpa region has been frequently demonstrating anti state activities in order to bring progressive transformation to the society, there has been launched a different form of suppression against such activities. The different form of political domination and control have created counterhegemonic ideologies in Thabang which became an organized effort to launch arms insurrection against the state in Rolpa. The local level of actors have manipulated the state power even to suppress other people. It has been reflected in Rolpa where such kind of political suppression has created alienation among the people of Rolpa.

The factors like poverty in rural dynamics have played a crucial role where in many cases individuals think that his or her problems are beyond their capacity and different form, overt and covert power relationship affects their choices to live a normal and healthy life in Rolpa. This kind of constraint structural dimension of rural poverty has affected the micro level of choices of the people up to the extent ,where they have to even sacrifice their life in order to get rid of the problems which have been resulting in suicide cases in Rolpa. Since the health service of Rolpa works as a non-responsive in different illness conditions, apart from the existing stage of poverty, structural inequality and socio cultural vulnerabilities, individual powerlessness caused by the structural factors also increase the susceptibility of the disease.

In Rolpa different form of cultural lag like voting radical parties and practicing irrational forms of shamanism shows stark difference between their political ideology and cultural

[285] According to WHO 2009 "At one extreme are the poorest countries where large parts of the population are deprived of care, even among the better off: only a small minority enjoys reasonable access to a reasonable range of health benefits, creating a pattern of mass deprivation. At the other extreme are countries where a large part of the population enjoys a wide range of benefits but a minority is excluded: a pattern of marginal exclusion".

beliefs among the individuals. It has been explored that it´s not only the factors like political-economic or geographical barriers, cultural construction like celebrating festivals also affects people to seek health care in delay which has been evident in many different occasions in Rolpa. Similarly though sense of collectivization has been revealed in different cultural episodes the same degree of collectivization has not been revealed to save the life of mother and child in Thabang which shows the fractured sense of collectivization in Rolpa.

In the empirical condition of Rolpa, the presence of a political system, health service system and other bureaucratic endeavour represent the part of a 'system world' where power lies literally, in contrast of everyday life experience of people, their perceptions towards the system, own kinds of subjectivities in terms of accessing resources and their response constitutes the part of 'life world' which is representing actual powerlessness. Moreover, the conflicting relationship between different forms of healing systems eventually do not give sense of satisfaction to service users where existence of both Ayurvedic institutions in same political constituency in Rolpa has excluded large majority of service seeking people from another political constituency which is sheer evidence of exclusion from the systems world and its decision.

During civil war in Rolpa both sides have intentionally applied its power to kill the people. Either it's the Maoists who have interpreted their antagonistic as a class enemy annihilation or the demonstration of state's bio power to kill the potential opponents in the name of two way encounter by the state, both forms of biopower have been brutally expressed to prove its domination. In the act of killing bodies in Rolpa, the identity of Rolpali and Thabangi has synonymously developed its image as an anti-state element, where this kind of territorial labeling has created terror among the specific individuals living in the particular community.

Though both fighting parties have claimed that they have organized medical camps to win the people´s trust, such kinds of medical camps were not sufficient enough to address the medical problems of the people in fact both fighting opponents have tried their best to win the psyche of the people. In fact, Maoists have taken necessary amounts of medicines from the health posts, and health workers were also forcefully mobilized during war, which has created dire situations of powerlessness to local health workers and also to ordinary people. Even during Civil war, it was difficult for many villagers and health workers to stay safe, without showing 'pseudo loyalty' and 'double standard behaviour'.

The sense of controlling virginity of the females further forced many girls to get married in early age which further risked their lives by giving births to numbers of children in Rolpa. Different forms of cultural practices like early marriage directly forced many women to give birth of the child in low age which is directly hampering their health in Rolpa. Likewise, low level of awareness has developed low confidence among many individuals for the lack of abortion friendly environments. So after all they were forced to rely on malpractitioners and profit seekers in the case of unintended pregnancies in Rolpa.

The reluctance of males to perform a vasectomy operation in Rolpa has created layers of additional burden to the females. On one hand there have been values that support the expansion of numbers of children, on the other hand there has been inferior masculinity perception among males which has directly supported to have numbers of children in Rolpa. In many cases, women are restricted to choose the nature of contraception showing the domination of patriarchal power even in the matter of choosing contraception that has suppressed woman´s rights to decide on their own body.

The hard hit of rural lifestyles in agro pastoral settings like Rolpa has not given sufficient condition for many parents to take care of their numbers of children. The underperformance of public health system to promote rationale birth plans have been reflected in growing numbers of unintended children, which eventually become the matter of financial and economic burden, specifically to the low income households in Rolpa. As a result, agents of the profit market have manipulated the sentiments of those children who were not enough cared by the parents, as a result, small kids were forced to drop the school and joined the blue color job of the cities particularly in tea shops, transportation sector and brick factories. During civil war many kids have joined as a child militia and combatants in Rolpa.

The pattern of distress migration has been labeled with different identity like *'Seshi,' ,'Bahadur'* and *'Doke'* showing that new migrants have been labeled as per their work and according to their representative landscape. The pattern of distress migration has been gradually shifting from India to the Gulf regions to earn '*Thulo Dhan*' and has created physical and psychological gap with their family members even on the long run. On one hand the high flow of distress migration has created situations to increase remittance in Rolpa, on the other hand lack of a public health system has again compelled many people to take medical loan in high interest rate to access health care services. Similarly, the return of numbers of coffin boxes everyday back to Nepal from Gulf suggest that how the hard hit of

distress migration to gulf ultimately results in death and decay of human lives particularly from remote districts like Rolpa.

In many cases irrational consumption of alcohol as an catalyst has stimulated explosive disparities and psychosocial frustrations which is reflected in social separation, violence against women and occurrences of death and diseases in Rolpa. The hard hit of rural life in Rolpa has created dire situation of powerlessness, where individuals commit suicide as an ultimate solution to get rid of structural vulnerabilities. Even after committing suicide, the long journey to get clarification forms from the post mortem process has also created an additional burden to many people in Rolpa. Similarly, the unnecessary journey to perform post mortem services also has been creating unnecessary hassle to many people for peripheral regions of Rolpa which are largely playing role to reduce surplus in Rolpa.

The normalization of death in Rolpa is to the extent that while doing an interview local people have expressed that death is the ultimate solution that cures the present stage of maladies and social pathologies. The degree of suffering has different magnitude across the different caste, class and ethnic categories. Analysis of different narratives based on different socio historical time frame in Rolpa has shown that more the deprived population, more the vulnerability of sufferings is higher and factors constructing to create diseases, conditions are more proximate in the stage of mass deprivation and structural exclusion.

The involvement of many Rolpali males in the manual jobs of Indian cities like Delhi and Bombay is the condition where one can perform risk behavior to fulfill own biophysical needs. The oppressive gender roles and limited bargaining power have prevented many women to ask their husband to use contraception prior to physical relationship which could be a matter of expressing 'disloyalty' or 'characterless' attitude toward their husbands. In the stage of such powerlessness, the husbands loyalty could not be questioned ,which ultimately victimized many women by unsafe and risky habits performed by their husbands as a 'gift of god' mentioned by HIV positive women from Rolpa .

During the conflict period in Rolpa, both fighting opponents contested HSS as state resources. The trend of regular donation, forceful involvement in war as a medical rescue groups due to Maoist pressure was some of the reasons that health workers were facing uneven situation in war-affected areas in Rolpa. The act of destroying and damaging health centers and stopping the regular development process of health infrastructure finally

contributed to increase ill health in the general population in Rolpa. Frequent security checking, fear of ambushes and landmines, potential cross fire and fake encounters discouraged people to make frequent mobility and access to health care in Rolpa.

During the time of conflict, unavailability of female health volunteers and other trained birth attendants had forced many women in Rolpa to die an untimely death because of delivery related complications. Likewise, conflict had discouraged many mothers to take their child to health centers. Many health workers in Rolpa believed that conflict has contributed both maternal and infant mortality rates which has been under reported. However, there has been no effort from government institutions or any other community institutions to spread a massive awareness on public health during conflict or post conflict context in Rolpa.

The absence of VDC secretaries due to long term conflict is directly hampering the monitoring process of free health program in Rolpa. Free incentive provision to encourage institutional delivery is not supporting the poorest of the poor where people have to carry patients in bamboo baskets and should pay more money than incentives. In addition, the malfunctioning of the health service system and unavailability of trained birth attendants are some of the reasons that delivery incentive program is not effective in Rolpa. Other factors like lack of good roads and transportation are hampering to easy access on safe institutional delivery in Rolpa.

Many people are forced to spend huge amounts of money to avail tertiary health centers in different cities of Nepal and India. On one hand primary and secondary level health institutions are not being able to provide scientifically sound and socially acceptable methods to the service seeking individuals in Rolpa. On the other hand tertiary care centres located in cities are also not demonstrating their best in order to diagnose the problems and providing rationale solutions. In many cases non-affordability of such services for large section of deprived majority has reproduced new marginalized classes basically from rural areas, who were compelled to push themselves either to compromise with low quality government health services or rely on other traditional practices or to accept silent sufferings without any treatment. Consequently, such kind of inefficiencies has adversely affected the people's health and pushing many people from relative to absolute poverty.

In a post conflict context, decade long civil war has once again directly and indirectly slowed down the regular process of health service development, which had been historically degenerated in Rolpa. Shortage of staffs, under equipped health infrastructures, availability of medicines, space constraints, lack of supportive infrastructures and skilled health workers are some of the reasons that the performance of health service system is below standard. The destructive legacy of civil war has resulted in social separation, physical loss of human beings and population suffering with many kinds of physical and mental morbidities in Rolpa. Likewise, in the post conflict context, lengthy political transition, growing profit oriented medical markets, poverty and conflict induced migration, imbalanced gender relations, stratified class and caste relationships, faith healing and bad practices of shamanism are other heterogeneous factors responsible for perpetuating sufferings and social separation among the general population in Rolpa.

Public health is one of the important subsystems of Nepali state that has been continuously overlooked and neglected since the period of its early development. Thus, the present condition of an inadequately functioning public health delivery system is primarily a result of political blunders by different political actors following different political trajectories. Strong political government can bring radical changes in the public health system in Nepal avoiding present stage of anomalies (*bethiti*) and promoting policies and practices that address the present health needs of the country. Hence, in Rolpa, resources are distributed unequally, power is concentrated vertically and needy section of the people are marginalized and suppressed. Thus, transition in Nepalese politics and the state of health service development could not bring substantive changes in grass root level, still many people are living a life without minimum basic health facilities in Rolpa.

Ill health generating structural crisis has solution in its structural transformation, and that transformation should affect political sub systems where a large section of the population find a space to maintain healthy lives. This could be in terms of accessibility and rational distribution of basic facilities like health, education, sanitation, food, housing and employment. The cost of armed led conflict has resulted in low levels of awareness, poor living standards, no availability of basic facilities and a continuous level of dissatisfaction at the micro level. The supra level changes in political structure has to move parallel with the changes of living standard of general masses, however, Nepalese people has to still struggle a lot to bring changes in their living standard with easy access to health education and other

minimum facilities to live as a normal and happy human. Hence, as long as societal unjust remains where state becomes the advantage for powerful and exploitative device for many powerless, in this kind of dichotomized reality, the production and reproduction of sufferings is inevitable in any unjust society like in Rolpa.

REFERENCES

Abbas, A. M.(2008)'Patients' opinion on the barriers to diabetes control in areas of conflicts: The Iraqi example', *Conflict and Health* 2008, 2:7 doi:10.1186/1752-1505-2-7

Aday, L. & Andersen, R. (1974). A framework for the study of access to medical care. Health Services Research, 9, 208-220.

Adhikari, S (1986) , **Baisse Rajyako Itihaash** Vhunipuran Prakashan, Baghbazzar , KTM.

Aitkin (1983) in Ember, Carol R. Ember, Melvin(eds.)(2004) , ' Critical medical Anthropology', Encyclopaedia of Medical Anthropology Volume I and II : New York : Kluwer Academic/Plenum Publishers

Andersen, R. M. & Newman, J. F. (1973). Societal and individual determinants of medical care utilization in the United States. Milbank Memorial Fund Quarterly, 51(1), 95-124.

Archar, M.(1995), Realist Social Theory, The Morphogenic approach, Cambridge university press, Cambridge.

Aryal, K. (2005), 'Aushadhiko Avhavma Mardaichan Rolpaliharu', in Gautam, B., Bhattarai, A.(eds) Swashthya, Samaj ra Rajniti, Kathmandu: Martin Chautari.

All Nepal Public health Worker's Association,(2005), Constitution prepared by first national conference, Central Commitee. All Nepal Public Health Workers Union.

Annual Report of District Health office Rolpa (2012/13), Ministry of population and health. Department of health services. Mid-Western Region Health Directorate. Nepal Government

Asia Child Rights, (2006), *Nepal: Focus on malnourishment and conflict*. Newsletter, Vol. 5, No.22

Amnesty International (2004), *Nepal: Human Rights Abuses Rise as Conflict Continues.* Amnesty International, Kathmandu.

Analysis of Disrupted Health sectors manual (2009) , Department of recovery and transition programmes, Health action in crisis, World health Organization, Geneva , Switzerland.

Baburam, Marasini (2003), Health and Hospital Development in Nepal, Vol. 42. pp. 306 - 311, *Journal of Nepal Medical Association.* Kathmandu, Nepal.

Baer , H.A, Singer , M, Susser, I. (2004), **Medical Anthropology and the world system.** Second edition, Praeger books, California, USA.

Baer, H. A (2016) , Complementary Medicine in Australia and New Zealand: Its Popularisation, Legitimation and Dilemmas. Routledge, Taylor and Francis Group, London and New york.

Banerji, D. (1985), **Health and Family planning Services in India. An epidemiological socio cultural, political analysis and a perspective.** Lok Prakashan , New Delhi.

Banerji (1986) , **Social Science and health Service development in India**. Lok Prakashan, 1986, New Delhi.

Baral, L. R (1979) , "Political System in Crisis', *Asian Survey*, Vol. 20, No. 2, A Survey of Asia in 1979: Part II (Feb., 1980), pp. 197-205 , Published by: University of California Press

Baru, Rama V. (2003) 'Privatization of Health Services: A South Asian Perspective' Economic and Political Weekly, October 18, 2003.

Baru, Rama V. (2015) (Ed) , ' Medical insurance schemes for the poor, who benefits, Academic Foundation, New Delhi. India.

Beine, David. 2001. Saano Dumre Revisited: Changing Model of Illness in a Village of Central Nepal. Contributions to the Nepalese Studies 28(2): 155–185.

Beine, D (2006), "The Cost of Conflict: The Impact of the Maoist Insurgency Upon the Spread of HIV/AIDS in Nepal. " Paper presented at the meeting of the Society for Applied Anthropology and the Society for Medical Anthropology, Vancouver, BC, Canada. March 30, 2006.

Berry, Nicholas O. (1997), **War and the Red Cross: The Unspoken Mission**. McMillan Press: London.

Bettille , A. (1965) , **Caste Class and Power: Changing Patterns of Stratification in a Tanjore Village**. Pp. 238. Berkeley and Los Angeles: University of California Press.

Bhaskar, R (1989), **Reclaiming Reality** ; **A Critical Introduction to Contemporary Philosophy**, Verso, London

Bhaskar, R (1998), **A Realist Theory of Science**, Routledge Publication, London and New York.

Bhaskar, R. (1989), **The possibility of Naturalism**, 2nd edition, Harvester, Bringhton.

Bhatt, Shafquat M. (2006) *Conflict in Jammu in Kashmir and its implications for health: An exploratory study*, Unpublished M. Phil Thesis. Jawaharlal Nehru University

Bhattarai(2002). Rana kal ma Bada Hakim Haruko vhumika.

Bhattarai, Ghanashyam (2008) Cited from An account of the kingdom of Nepal, Edinghburgh 1893, P 268-269.

Bhattrai , Ghanayashayam,(2008), Nepal ko sthaniya prashashan ko ithihaash, (1726-1951), Adroit publishers. New Delhi, India.

Bista, D. B, '*The Political Innovators of Upper Kali-Gandaki'* **.** *Man*, New Series, Vol. 6, No. 1. (Mar., 1971), pp. 52-60.

Browdin, P.(1996), **Medicine and Morality in Haiti : The contest for healing power.** Cambrdige University press, New york.

Bury, Michael (2005), **Health and Illness, Short Introductions**; UK: Polity press.

Cant, S. and Sharma, U. (1999), A New Medical Pluralism: Alternative medicines, doctors, patients and state. Taylor and Francis Group. United Kingdom

Cederoth, S. C and Skarr , H. O (2003), **Development Aid to Nepal, Issues and Options in Energy, Health, Education, Democracy and Human Rights**, Routledge, 2003

Chew,S. T (1990) , Natural Resource Management : AID'S Experience in Nepal. US agency for international development. USA.

Collins, S. (2006), 'Assessing the health implications of Nepal's ceasefire', *The Lancet*. Vol: 368 September 9

Cummings, K.M., Becker, M.H. and Maile, M.C. (1980) Bringing the models together: an empirical approach to combining variables used to explain health actions. Journal of Behavioural Medicine, 3, 123–145.

Declaration of Alma-Ata. in International Conference on Primary Health Care. (1978). Alma-Ata, USSR: World Health Organization.

Detels Roger, Mcewen James, Beangle Hole and Heizo Tanka (2004),Oxford Textbook of Public health. Fourth edition: Oxford University Press.

District Health Report of Rolpa (2013/14) , *Annual Report*, Government of Nepal, Ministry of Health and Population. Kathmandu.

District Population Profile Rolpa (2012). Department of health services Ministry of population and health.. Mid-western region health directorate . Nepal government

Department of health service (2006/07) *Annual Report*, Government of Nepal, Ministry of Health and Population. Kathmandu.

Department for International Development, Swiss Development Cooperation, German technical Organization (2003), *Conflict and health in Nepal. Action for peace building.* 6th March , 2003 , DFID/DHSP, SDC/RHDP, GTZ/HSSP .Country Office, Nepal.

Department for International Development (2004), Service delivery in difficult environments: the case of Nepal, Asia Policy Division Nepal country office Jeremy Armon, Chris Berry, Debi Duncan with Rebecca Calder, Susan Clapham, Mark Harvey

Demographic profile of Nepal. (2013/ 2014) VDC and municipality, population household and population by sex ward level. , Mega publication and research centre Kathmandu, Nepal.

Dixit, H . (2014) , **Nepal's Quest for Health;** Educational Publishing House. Kathmandu, Nepal.

Doyal, L and Pennell, I. (1976), '*Health, Medicine and Underdevelopment*,' *Economic and Political Weekly*, Vol. 11, No. 31/33,

Duffield M. (1998), 'Aid Policy and Post-Modern Conflict. A Critical Policy Review'.Public Policy Discussion Paper No. 19, University of Birmingham.

Dunham HW (1965). Community and schizophrenia: An epidemiological analysis. Wayne State U. Press; Oxford, England

Faris RE, Dunham HW,(1939). Mental disorders in urban areas: An ecological study of schizophrenia and other psychoses. Univ. Chicago Press; Oxford, England

Editorial (2008), Round Up, Conflict and Crisis Settings: *Reproductive Health Matters*, 2008;16(31):220

Ember, Carol R.Ember, Melvin(eds.)(2004) , ' Theoretical and Applied Issues in Cross-Cultural Health Research , Key Concepts and Controversies', Health and Illness

in the World's Cultures, Encyclopedia of Medical Anthropology Volume I and II : New York : Kluwer Academic/Plenum Publishers

Ember, Carol R.Ember, Melvin(eds.)(2004), 'Critical medical Anthropology', Encyclopaedia of Medical Anthropology Volume I and II : New York : Kluwer Academic/Plenum Publishers

Farmer P (1997) Ethnography, social analysis, and the prevention of sexually transmitted HIV infection among poor women in Haiti, in Inhorn M and Brown P (eds) *The Anthropology of Infectious Disease*. Amsterdam: Gordon & Breach.

Farmer, P. (2006) , Haiti Violence disrupts heath care services , Interview given by Dr. Paul farmer to National Public Radio, www.npr.org/templates/story/story.php?storyId=5193542

Ford, L.B (2007), 'Civil Conflict and sleeping sickness in Africa in general and Uganda in particular', *Conflict and Health* 2007, 1:6 doi:10.1186/1752-1505

Franckel,A. Arcens,F Lalou,R. Kneipp,R. (2008), Village Context and Health-Seeking Behaviour in the Fatick Region of Senegal, *Population* (English Edition, 2002-), Vol. 63, No. 3, pp. 469-490

Frost, L.J. and Reich, M.R. (2008) Access: How Do Good Health Technologies Get to Poor People in Poor Countries? Cambridge, MA: Harvard Center for Population and Development Studies, distributed by Harvard University Press.

Gage, A J. and Calixte, M.J. (2006) Effects of the Physical Accessibility of Maternal Health Services on Their Use in Rural Haiti . *Population Studies*, Vol. 60, No. 3, pp. 271-288

Gartaula, RP (**2008**): **Textbook of Medical Sociology and Medical Anthropology**;. RECID/Nepal. Kathmandu, Nepal.

Gass,N .(1997) 'An Analytical Model for Conflict Dynamics', The Journal of the Operational Research Society, Vol. 48, No. 10, pp. 978- 987

Gazi Rukhsana, Alec Mercer, Tanyaporn Wansom, Humayun Kabir, Nirod Chandra Saha1 and Tasnim Azim, (2008) , Conflict and Health Research Open Access : An assessment of vulnerability to HIV infection of boatmen in Teknaf, Bangladesh : *Conflict and Health*, 2:5 doi:10.1186/1752-1505-2-5

Gersony, R . (2003), Sowing the Wind : History and Dynamics of Maoist Revolt in Nepal's Rapti Hills. Mercy Corps international.

Geneva Convention (III) (1949), *Relative to the treatment of prisoners of war*,Signed at Geneva, 12 August , Switzerland.

Ghartimagar. B. M (2014), in Pun, Yam Bahadur and Ghartimagar, J. (2014) Magar Jaati: Aitihashik, Sanskritik ra Rajneetik Sandarbha , Magar Academic Group, Kathmandu.

Ghimire, S. (2009) , ' The intersection between Arm Conflict and the health service system in Rolpa district of Nepal : An ethnographic Description. Social Medicine, Vol. 4 , Number 3, pp.130-147, USA

Ghimire, S. (2008), 'HIV and AIDS in Broadsheet Dailies', *Media Addhyan*, Journal. Vol. 3, pp. 99-129,

Ghimire, L. V. Pun, M. (2006), 'Health effects of Maoist insurgency in Nepal,' *The Lancet*, Vol 368, Issue 9546, page 1494, 28 Oct.

Giacaman, R. Khatib, R., Shabaneh,L. Ramlawi, A., Sabri, Sabatinelli,G. Khawaja, M. Laurance.T (2009) Health status and health services in the occupied Palestinian territory *The Lancet*, Volume 373, Issue 9666, Pages 837–84.

Giri, G (1995) . **Pyuthan Rajyako Itihaash** Jhalak, District Development Commitee, Pyuthan

Gleditsch, N. P. Wallensteen, P. Eriksson, M. Sollenberg, M. Strand, H. (2002). Armed Conflict 1946-2001: A New Dataset: Source: Journal of Peace Research, Vol. 39, No. 5 (Sep., 2002), pp. 615-637

Good , Byron J. (1994) **Medicine , rationality and Experience : An anthropological perspective,** Cambridge University Press, UK.

Gow, D. D (1980), An information System for the rural Area Development, Development Alternative , INC. Washington, USA.

Han, G and Ballis, H (2007),' Ethnomedicine and dominant medicine in multicultural Australia : A critical realist reflection on the case of Korean–Australian immigrants in Sydney. Journal of *Ethnobiology and Ethnomedicine 3* , Biomed Central

Hahn, R. A (1995) **Sickness and healing : An anthropological perspectives**, p72, Yale University press. USA

Harre, R. (1970) **The principles of scientific thinking**, Macmillan, London. United Kingdom

Harre, R. (1994) **Physical being**, Blackwell Publishers, Oxford, United Kingdom.

Helle,V.(2003) 'Commemorative Tales: Archaeological Responses to Modern Myth, Politics, and War': *World Archaeology*, Vol. 35, No. 1, The Social Commemoration of Warfare , pp. 126-144

Helman G, Cecil (2007), **Culture, Health and Illness,** London, UK: Hodder Arnold Group.

Henttonen, M. Watts, C. Roberts, B. Kaducu, F. Borcherte, M. (2008),'Health Services for Survivors of Gender-Based Violence in Northern Uganda: A Qualitative Study', Reproductive Health Matters; 16(31):122–13

Hitchcock, John T. (1961). A Nepalese Hill Village and Indian Employment. Asian Survey 1,9:15-20

Hoffer,C. R (1943). 'Impact of War on American Communities': Review of Educational Research, Vol. 13, No. 1:The War, Education, and Society (Feb., 1943), pp. 5-12

Hollingshead AB, Redlich FC (1958). Methodological Procedures. In Social class and mental illness: Community study. John Wiley & Sons Inc.; Hoboken, NJ, US:. pp. 18–44.

Hutt, M. (ed) (2004) *Himalayan People´s war, Nepal's Maoist rebellion*. First edition. United Kingdom. C.Hurst and Company London.

Human Rights Watch (2007), *Children in the Ranks, The Maoists' Use of Child Soldiers in Nepal* ,New York Volume 19, No. 2(C)

IRIN, (2005), *Between Two Stones Nepal's decade of conflict*, IRIN Web Special, December, 2005, Available online at www.irinnews.org

Internal Displacement Monitoring Centre (2008) *Nepal :Sustainability of IDP returns undermined by lack of assistance ,A profile of the internal displacement situation*, Norway : Norwegian Refugee Council

Illich, I. (1976), **Limits to Medicine; Medical Nemesis, The expropriation of health**, Penguin books. Great Britain.

Jones, S. (2010), Policy making during political transition of Nepal, Oxford policy Management, Working Paper, Oxford University, UK.

Jordans, Mark J. & S. Keen Annalise & Pradhan Hima &. Tol, Wietse A (2007) Psychosocial Counseling in Nepal: Perspectives of Counsellors and Beneficiaries, Published online: 9 February 2007, Springer Science + Business Media, LLC 2007

Jong, K. de, Kam, S. Van der , Ford, N. Hargreaves, S. Oosten, R. van, Cunningham, D. Boots, G., Andrault, E. and Kleber, R (2007), The trauma of ongoing conflict and displacement in Chechnya: quantitative assessment of living conditions, and psychosocial and general health status among war displaced in Chechnya and Ingushetia , *Conflict and Health* 2007, **1**:4 doi:10.1186/1752-1505-1-4

Justice, J. (1986) , Policies, Plans, and People: Foreign Aid and Health Development, University of California Press. USA.

Kirmayer; L. J (2004) The cultural diversity of healing: meaning, metaphor and mechanism : *British Medical Bulletin*;69

Kowalewski, M. Jahn, A. Kimatta S, S.(2000) , Why Do At-Risk Mothers Fail to Reach Referral Level? Barriers beyond Distance and Cost , African Journal of Reproductive Health / La Revue Africaine de la SantéReproductive, Vol. 4, No. 1, pp. 100-109

Keen, David, **'The Benefits of Famine: A Political Economy of Famine and Relief in Southwestern Sudan, 1983-1989'** ,Princeton, NJ: Princeton University Press 1994.

Kennedy, P. and Kenndy. C.A, (2010), **Using Theory and to Explore Health, Medicine and Society.** The Polciy Press. University of Bristol UK.

Khadka, N. (2000) "*U. S. Aid to Nepal in the Cold War Period: Lessons for the Future*", Vol. 73, No. 1 Spring , University of British Columbia , Canada.

Kohrt BA, Worthman CM. 2010. Posttraumatic Stress Disorder in Nepal: A Biocultural Model of Aggression. The 109th Annual Meeting of the American Anthropological Association. New Orleans, Louisiana, November 19.

Kleinman, A. (1981), **Patients and healers in the context of culture; An exploration of borderland between Anthropology, Medicine and Psychiatry**, University of California Press, London , USA. **Kleinman, A. (1988), The Illness Narratives: Suffering, Healing, and the Human Condition, Basic Book, USA.**

Kleinman, A. Das,V. Lock, M. (eds), (1997), **Social Suffering** : New Delhi. Oxford University Press.

Lee, R. (2008), 'Delivering maternal health care services in an internal conflict setting in Maguindanao, Philippines.' *Reproductive Health matters*, 2008;16(31):65–74

Lancet (2009), Medical emergency in Sri Lanka, Editorial ,Lancet: Vol. 373.

Lowenberg JS and Davis F (1994) Beyond medicalisation–demedicalisation: The case of holistic health. Sociology of Health and Illness 16(5): 579–599

McHoul, A and Grace, W. **A Foucault Primer, Discourse, power and the subject**. Routledge , Taylor and Francis Group. Melbourne University Press, 1993.

Macklin, A (2008), 'Legal Aspects of Conflict-Induced Migration by Women', Reproductive Health Matters; 16(31):22–32

Magar, P.B Rokka (2011), **Krantikari Ithihash Bokeko Thabang**. Ganga Jamuna Press, Kathmandu, Nepal.

Mckinlay, John B. (1984 ed), Political Economy of Health Care*'*, Tavistock Publications New York . USA

Mack, R.W. and Snyder, R.C. (1957). "The Analysis of Social Conflict – Toward an Overview and Synthesis", Journal of Conflict Resolution, 1: 212-248.

Malesevic, S (2011) in Dowding, Keith (eds). *The Encyclopaedia of Power.* Sage Publications Pvt. Ltd. New Delhi, India.

Mali (1996), cited in Dixit, H . (2014) , **Nepal's Quest for Health;** Educational Publishing House. Kathmandu, Nepal.

Martinez, E. (2003), *Never too late to learn: Capturing lessons from re-establishing health systems in countries emerging from conflict , Impact of the Armed Conflict on Primary Health Care Services in Nepal: A Case Study* Discussion Paper: Little Bay Conference Centre, Sydney, Australia , 22-23 September

Mataria et al (2009) , 'Health in the occupied Palestinian territory 5, The health care system: an assessment and reform agenda,' *Lancet* 2009; 373: 1207 -17

Marmot, M. Wilkinson, Richard G.(ed.) (1999) , *Social Determinants of health,* Edited Volume, London: Oxford University Press.

Maskarinec , Gregory G.(1998) A Chronicle of Saru, Jajarkot / Saru, Jajarkot ko Itihas, Page 239-310 Studies in Nepali History and Society (SINHAS): Vol.3, No.2 December

Minkler, M., Wallace, S.P., &Mcdonald, M. (1995) . The Political Economy of Health: A useful theoritical tool for health education practice. International Quarterly of Community Health Education. 15 (2) 11-125.

Morell, P. (2009) ' The trouble with Therapy', Therapy Today. www. theraphytoday.net/article/show/14/.

Molnar , A. (1981) , Kham Magar Women of Thabang, The status of Women in Nepal, Volume II , Part 2. A report Conducted by Centre for Economic Development and Administration, Tribhuvan University, Kathmandu, Nepal.

Morsy (1996) in Ember, Carol R. Ember, Melvin(eds.) (2004), 'Critical medical Anthropology', Encyclopaedia of Medical Anthropology Volume I and II : New York : Kluwer Academic/Plenum Publishers

Murshed, S. M.(2002), 'Conflict, Civil War and Underdevelopment: An Introduction' : *Journal of Peace Research*, Vol. 39, No. 4, Special Issue on Civil War in Developing Countries, pp. 387-393

Mullany, L. C. Lee, Paw, C. I, Palae S. O, Maung, E. K. C.(2008), Delivering Maternal Health Services among Internally Displaced Populations in Eastern Burma, *Reproductive Health Matters*;16(31):44–56

Nagai, M. Abhram, S. Miyoko O. Etsuko K. Atsuko, A (2007), Reconstruction of health service system in Post Conflict Northern province in Sri Lanka, *Health Policy*, Vol. 83 issue 1st. September

Navaroo V. (1976), **Medicine Under Capitalism**, CROOM HELM Ltd, UK and Neale Waston academic publications. Inc, USA.

Ngom,P. Debpuur, C. Akweongo, P . Adongo,P. Binka ,F.N(2003) , Gate-Keeping and Women's Health Seeking Behaviour in Navrongo, Northern Ghana *African Journal of Reproductive Health / La Revue Africaine de la Santé Reproductive*, Vol. 7, No. 1, pp. 17-26.

Nordstrom, C. (1998),'Terror Warfare and the Medicine of Peace, The Embodiment of Violence', Source: *Medical Anthropology Quarterly*, New Series, Vol. 12, No. 1, pp. 103-121

Nguyen, V.M. and Peschard, K. (2003) Anthropology, inequality, and disease: a review, Annual Review of Anthropology, 32, 447–74

Ogura,K. (2005), Rolpa ra Rukum bata dekhiyeka maobadi, Janta ra Rajya. Rupantaran, Samaj addhyan, Purnanka 2, Chapter in (ed), Purna basnet, dinehs prashain, Shekhar parajuli, Anil Bhattrai. Martin Chautari, Thapathali, Ktm.

OMSA (2006), Bulletin: Year II, Vol. 2:All Nepal Public health worker's organization, central publication committee, CPN (Maoist) Nepal.

Oskar N. T. and Rons, J.(2007) Public health, conflict and human rights: toward a collaborative research agenda , *Conflict and Health* 2007, 1:11 doi:10.1186/1752-1505-1-11

Ommeren , M.V. Sharma, B. Thapa , S. Makaju, R. Prasian, D. Bhattarai, R. Jong. J. D.(1999) , "Preparing instruments for Transcultural Research: use of the translation monitoring form with Nepali-seeking Bhutanese refugees: *Transcultural Psychaitry.* , VOl 36, (3) : 285-301 . September.

Onta,S. Baral, K. Dr. Singh, L.M (1997), Health in Nepal, Realities and Challenges, Report published by Resource centre for primary health care (RECPHEC), 1997, Baghbazar. KTM. Nepal.

Paudel. S. B, Upreti , B. R. Acharya . G. Tandukar, A. and Harvey P. (2015), Researching Livelihood and service affected by conflict. Health services and user perceptions in Rolpa Nepal. Working paper 36,. Nepal Centre of Contemporary Research . KTM

Payne, A. (2006), **Key Debates in New political economy**, Routledge , UK.

Petchesky, R.P (2008),'Conflict and Crisis Settings: Promoting Sexual and Reproductive Rights', *Reproductive Health Matters*;16 (31):4–9

Pettigrew, J. (2003) "Living Between the Maoists and the Army in Rural Nepal," *Himalaya, the Journal of the Association for Nepal and Himalayan Studies*: Vol. 23: No. 1, Article 6.

Pigg, Stacy Leigh. 1995. **Social Symbols of Healing in Nepal**. Ethnology 34(1): 17–36.

Last (1981) in Pool, R and Geissler. W (2005), **Medical Anthropology : Understanding Public Health**. Open University Press, United Kingdom

Pool, R and Geissler. W (2005), **Medical Anthropology : Understanding public health**. Open University Press, United Kingdom

Policy Papers on health Nepal (2007) , World Health Organization , WHO Country Office, Nepal.

Potter, Katherine .J (2007), *Mitigating the Maoists conflict: The impact of civil war on health promotion Ngos in Nepal.* Unpublished Master thesis. University of Washington.

Pomales, Tony. O (2013), Men's narratives of Vasectomy: Rearticulating Masculinity and Contraceptive Responsibility in San Jose, Costa Rica, Medical Anthropology Quartely, Vol. 27. issue 1. p.p 23-42, ISSN, 0745-5194, online ISSN 1548-1387, American Anthropological association

Powell, Elwin H (1970), **The Design Discord**. USA: Oxford University Press.

Poudel, D. (2012) The Double Life of Development: Peasants, Agrarian Livelihoods, and the Prehistory of Nepal's Maoist Revolution, Unpublished Phd Thesis submitted to University of Minnesota , 2012.

Pun, Yam Bahadur and Ghartimagar, J. (2014) Magar Jaati: Aitihashik, Sanskritik ra Rajneetik Sandarbha , Magar Academic Group, Kathmandu.

Qadeer, I. (1985),'Development of health service system in India: An expression of socio-economic inequalities', Social Action, July-Sept. Vol .35.pp 199-221.

Qadeer. I (2006), Women's Health in Goa, A holistic approach,. Edited Shaila Desouza. Concept Publishing Company, New Delhi.

Rao, M. (ed) (1999),Disinvesting the health, The World bank's prescription for health. New Delhi: Sage Publication.

Rao, M. and Sexton, S. (ed) 2010, *Markets and Malthus : Population, Gender, and Health in Neoliberal Times*. Sage Publications , New Delhi .

Rai, Shiba K. Rai , G. Hira, K. Ayako, A and Yoshimi (2001)'The Health System in Nepal, An Introduction': *Environmental Health and Preventive Medicine* 6, pp. 1–8

Regmi, M. C, (1972), A study in Nepal economic history 1768-1846, Adroit publishers, New Delhi.

Ross, Marc H. (Sep. 1986) 'A Cross-Cultural Theory of Political Conflict and Violence' Political Psychology, Vol. 7, No. 3, pp. 427-469: International Society of Political Psychology.

Roy, A. (2009), Why is Binayek Sen in Prision ? Newsletter, Available online at Countercurrents. org , Accessed in 15th July, 2009.

Sales, A. D (2013) chapter in the edited volume by Tilouine, M. L (2013), **Revolution in Nepal ; An anthropological and historical approach to the people's war**. Oxford University Press, UK.

Sartorius, N. Schulze, H (2005) , **Reducing the Stigma of Mental Illness: A Report from a Global Association,** Cambridge University Press , New York.

Scambler, G. (ed) 2001, Habermas, Critical theory and Health . Routledge Publication , London and Newyork.

Scott, J. (2012) , The Moral Economy of Peasant : Rebellion and Subsistence in Southeast Asia, Yale University Press, USA.

Scheper-Hughes (1990) in Good , Byron J. (1994) **Medicine, rationality and Experience : An anthropological perspective,** Cambridge University Press, UK.

Sharma, U. (1992) Complementary Medicine Today: Practitioners and Patients, London, Routledge

Simunovic, V.J (2007),'Health care in Bosnia and Herzegovina before, during, and after 1992–1995 war: a personal testimony', *Conflict and Health* 2007, **1**:7 doi:10.1186/1752-1505-1-7

Singer, M (Mar, 1995), Beyond the Ivory Tower: Critical Praxis in Medical Anthropology: *Medical Anthropology Quarterly*, New Series, Vol. 9, No. 1, pp. 80-106

Singer and Hans (1995), Introducing medical anthropology : A discipline in action. Amityville, New york : Baywood. USA

Shivakumar, A.K. (1999), The formation of India's Health policy, A note on equity', Rao, M. (ed) (1999),Disinvesting the health, The World bank's prescription for health. New Delhi: Sage Publication

Singer, M (1986) **Developing a Critical Perspective in Medical Anthropology** *Medical Anthropology Quarterly*, Vol. 17, No. 5. (Nov., 1986), pp. 128-129.

Singer, M. (2004), Critical medical Anthropology, Ember, Carol R.Ember, Melvin(eds.) (2004), Encyclopaedia of Medical Anthropology Volume I and II : New York : Kluwer Academic/Plenum Publishers

Shah , R (2007) Maobadi bidroha, Sasatra Sangharsha ko Awadhi....(ed) : Gautam, Vhaskar, Basnet, Purna Manandhar, C, Martin Chautar, Thapathali KTM.

Sharma, M and Prasain , D. (2004) in Hutt, M (ed), Hutt, *Himalayan People war, Nepal's Maoist rebellion*. First edition. United Kingdom. C.Hurst and Company London.

Singer, M. (2014) (ed) .Pamela I ,Erickson A Companion to Medical Anthropology, Willy Publishers, New Jersy, USA

Singh, P. B (1998). Humanism and Jai Prithivi Bahadur Singh.. Padma B The Kathmandu Post, 23rd August.

Singh, (2005), 'Nepal's war and conflict sensitive development. Available online at Plus Med 2(1) : e29.doi 137/ journal .pmed 0020029

Singh, S. Bohler,E .Dahal,K . Mills, (2006), 'The State of Child Health and Human Rights in Nepal' , July 2006 :Volume 3 , Issue 7 , e203, Available online at www.plosmedicine.org

Singh, S. Sharma, S.P. Mills, E. Poudel, K. C. and Jimba, M.(2007) 'Conflict induced internal displacement in Nepal', *Medicine, Conflict and Survival*, 23:2, 103 - 110

Sinha, U. N (1965) , **Development of Panchayat in Nepal ,** P. C Dwadash Shreni and Company (Pvt.) Ltd. Allahabad, Patna.

Sinha, R. (1997) *Violence and health: An exploratory study*. Unpublished M.Phil. Thesis, Jawaharlal Nehru University.

Sobo Elisa J. (2004)., 'Theoretical and Applied Issues in Cross-Cultural Health Research , Key Concepts and Controversies', in Ember, Carol R.Ember, Melvin(eds.) Health

and Illness in the World's Cultures, Encyclopaedia of Medical Anthropology Volume I and II : New York : Kluwer Academic/Plenum Publishers

South Asia Forum for Human Rights (2000), People's War in Nepal, Vol 1, issue 3, July, Lalitpur, SAFHR Office.

Stevenson, P.(2002): 'High-risk medical care in war-torn Nepal'. *The Lancet*; 359:1495

Stiller, Ludwig F. (1973). **The Rise of the House of Gorkha: A Study in the Unification of Nepal, 1768-1816.** New Delhi: Manjusri Publishing House. Reprinted in 1975. Patna: The Patna Jesuit Society.

Subedi, M. S. (2005), "Foreign Aid, Sustainable Development and Rapti IRDP". *Occasional Papers in Sociology and Anthropology*, 9, 231-57

Subedi, M.S (2005) , Foreign Aid, Sustainable development and Rapti IRDP,

Sugden, F (2011) 'Mapping the Trajectory and Dynamics of Nepal's 'Transition'. New Angle. pp 1-Nepal policy research Network, 16, Kathmandu , Nepal.

Sunder Rajan, K. (2006), **Biocapital, The constitution of post Genomic life**. Duke University Press. USA.

Thapa, D. and Sijapati, B.(2003), **A Kingdom Under Siege, Nepal's Maoist insurgency**, **1996-2003**. Kathmandu: The Print house.

Thoms, O. NT and Ron , J (2007) , " Public health, conflict and human rights : Toward a collaborative research agenda , *Conflict and health 1: 11*, Biomed Central, Open Acess publisher. US National Library of Medicine, National Institute of health.

Tilouine, M. L (2013) (ed.), **Revolution in Nepal ; An anthropological and historical approach to the people's war**. Oxford University Press, UK.

Tool M.J and Waldman R. J (1997), " The public helath aspects of complex emergencies and refugee situations'. *Pub med Journal, Annual review of Public health*. 18.1.283. US National Library of Medicine, National Institute of health.

Wayte, K. Zwi, A. B. Belton, S. Martins, J. (2008) 'Conflict and Development: Challenges in Responding to Sexual and Reproductive Health Needs in Timor-Leste', *Reproductive Health Matters*;16(31):83–92

Weber , M. (2011) **Class, Status and Power,** Centrum Press, New Delhi. India.

Winkelman, M. (2008), **Culture and Health : Applying Medical anthropology. Josse-Bass Willy, USA**

World Health Organization, (2009) *Health Action in Crisis Analysing Disrupted health sectors-manual*. Available online at www.who.int/hac/techguidance/tools/disruptedsectors.who(Accessed:10,July 2009)

World Health Organization (2009) Health Inequities in South Asia, Selected Countries Case Studies, World health organization, Regional Office for South East Asia,

World Bank, (2005) *An Assessment of Impact of Conflict on Health Service delivery system for the rural population of Nepal***,** Source: Health, Nutrition and Population (HNP), Nepal Country Office

World Psychiatric Association (2005), reducing *the stigma of mental illness*. Sartorius N. and Schulz, H (eds.), UK, Report from the Global Program Cambridge University Press.

Zharkevich, I., 2013. Learning in a Guerrilla Community of Practice: Literacy Practice, Situated Learning, and Youth in Nepal's Maoist Movement (1996–2006). *Digital Himalaya*, *42*(1), pp.104-132.

PHOTOGRAPHS

PHOTO 1

Photo: Sachin Ghimire

Bamboo basket *(Doko) is used to carry* patient to reach District Hospital

PHOTO 2

Photo: Sachin Ghimire

Woman came to district hospital from remote village with her three children.

PHOTO 3

Photo: Sachin Ghimire

District hospital does not have wheelchair for patients.

PHOTO 4

Photo: Sachin Ghimire

In district hospital, drying surgical apparatus in sunlight.

PHOTO 5

Photo: Sachin Ghimire

Unhygienic condition of Mizhing Auyervedic health Centre.

PHOTO 6

Photo: Sachin Ghimire

Health worker with her small baby at Mirul Sub health post.

PHOTO 7

Photo: Sachin Ghimire

Ghorneti Model Hospital, constructed during war time.(1995-2006)

PHOTO 8

Photo: Sachin Ghimire

Students singing "revolutonary" anthem in People's Model School, Thawang.

PHOTO 9

Photo: Sachin Ghimire

Women carrying heay load and baby in her back. Her alcoholic husband is shouting.

PHOTO 10

Photo: Ratna Mahara (Vaccinator)

Researcher, collecting memory after crossing Ghanjyang Manjhyang.