MEDICAL PLURALISM:

PERCEPTIONS, PRACTICES, AND PATTERNS OF RESORT IN DANG, NEPAL

Thesis submitted to Jawaharlal Nehru University

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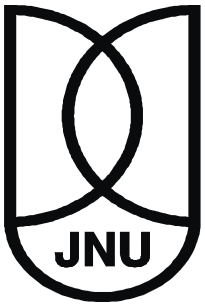
for the award of the degree of

DOCTOR OF PHILOSOPHY



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DECLARATION

I do hereby declare that the thesis entitled "**MEDICAL PLURALISM: PERCEPTIONS, PRACTICES AND PATTERNS OF RESORT IN DANG, NEPAL**", submitted by me under the supervision of Dr. Sunita Reddy to the Centre for Social Medicine and Community Health, School of Social Science, Jawaharlal Nehru University, New Delhi for the award of the degree of "**DOCTOR OF PHILOSOPHY**" embodies the result of bonafide research work carried out by me and that it has not been submitted so far in part or in full, for any degree or diploma of this university or any other university/ institution.

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Place: New Delhi

CERTIFICATE

It is hereby recommended that the thesis may be placed before the examiners for evaluation.

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I completed my Master’s degree in Anthropology in 1998 from Tribhuvan University, Kathmandu and after working for more than a decade in an NGO in Nepal, I joined integrated M.Phil/PhD program of JNU in 2011. Resuming study after such a long gap and being ready for long term commitment for M.Phil/PhD research was, indeed, a big challenge for me and my family. Last but not the least, my wife Tilotama Sharma deserves a special thank who not only encouraged me to continue my study accepting the challenge of financial hardship but also accompanied me frequently in the field which greatly helped me in building rapport with women participants. I thank, and express my love to my daughter Ila Subedi and son Bikash Subedi for their understanding, patience and love.

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ACRONYMS

AHW	Auxiliary Health Workers
AAHW	Auxiliary Ayurvedic Health Workers
ANM	Auxiliary Nurse Midwife
BAMS	Bachelor of Ayurveda, Medicine and Surgery
BHMS	Bachelor of Homeopathic Medicine and Surgery
CAM	Complementary and Alternative Medicine
CDR	Crude Death Rate
CMA	Community Medicine Assistant
CTEVT	Council for Technical Education and Vocational Training
CBS	Central Bureau of Statistics
DDC	District Development Committee
CSMCH	Center of Social Medicine and Community Health
DPHO	District Public Health Office
DoHS	Department of Health Services
FCHV	Female Community Health Volunteer
GoN	Government of Nepal
HP	Health Post
HDI	Human Development Index
ENT	Ear, Nose and Throat
HIV	Human Immunodeficiency Virus
IPD	In-patients Department
IMR	Infant Mortality Rate
JNU	Jawaharlal Nehru University
LMIC	Low and Middle Income Country
MBBS	Bachelor of Medicine and Bachelor of Surgery
MCHW	Maternal and Child Health Worker
MD	Doctor of Medicine
MoHP	Ministry of Health and Population
MMR	Maternal Mortality Ratio

NCD	Non-communicable Disease
NDC	National Dalit Commission
NEFIN	Nepal Federation of Indigenous Nationalities
NESAC	Nepal South Asia Center
NFDIN	National Foundation for Development of Indigenous Nationalities
NGO	Non- Government Organization
NPC	National Planning Commission
OPD	Out Patient Department
ORS	Oral Rehydration Solution
SAARC	South Asian Association for Regional Cooperation
SDG	Sustainable Development Goal
STI	Sexually Transmitted Infection
SLC	School Leaving Certificates
UHC	Universal Health Coverage
VDC	Village Development Committee

GLOSSARY

Achaar	Pickle
Adibasi Janajati	Indigenous nationalities
Bahun	Highest of the Hindu caste system and also known as Brahman or Brahmin
Bhut	Ghost, evil spirits, a type of laagu
Birami	Patient or ill or sick person, *Bimari*
Bimari	Illness
Bipanna	poor or lower class
Buti	An amulet made of herbs and fortified/treated with mantra,
Jantar	
Chatani	A sort of pickle which is made and served with launch and dinner (usually they grind tomatoes and spices and make a paste)
Chhetri	High caste Hindu, beneath the Brahman
Daal-bhaat	Food which is mostly taken as launch and dinner, lentil soup and boiled rice
Dhami	An indigenous shamanic healer who goes into trance during the healing session
Dal-bhat	Pulse-rice, a popular staple food
Graha dasha	Bad time of planets/ stars
Guruwa	Tharu priest or shaman
Lausari	A ritual conducted twice a year particularly to prevent childhood
Jadauri	Used cloth and footwear
Jantar	To wear an amulet made of paper and written mantra on it.
Jadibuti	Plant medicines or herbs
Janai	Sacred thread which is wore by high caste male
Jhankri	An Indigenous shamanic healer who get possessed/ tranced and uses drum
Laago	Spirit affliction, attack by dead spirit

Jhar-phuk	Traditional healing method used by a shamanic healer in which the healer brushes down the bad spirits from a patient's body with a broom while reciting the healing mantras.
Jhaskanu	Startling or alarming suddenly
Kundali	Birth-chart
Laago	Spirits attack, afflict
Mantra	A ritual formula, charm or spell
Puja	Worship ceremony and offering to Gods or ancestral spirits
Sudeni	Traditional midwife who also works as masseuse
Putreno	Painful stomach problem, navel dislocation
Rog	Disease (or illness)
Samanya	Middle class, ordinary or average
Sampanna	Well-off or upper class
Sancho-bisancho	*Wellness-illness, healthiness-unhealthiness*
Sukenas	Drying or wasting out
Tapari	A plate made of leaves of shorea robusta tree
Tarkari	Vegetables
Tarai	Plain area in southern region extended to Indo-Nepal border
Vaidya	Ayurvedic paramedics

CHAPTER I

INTRODUCTION

1. Background

Medical pluralism refers to the existence and use of different forms of medicine. Plurality in medicine and medicinal practices has been recognized as a universal phenomenon. Medical pluralism has got research attention since the early 1970s with an interest among the medical anthropologists in the plurality and diversity of medical systems. Medical pluralism was in practice in many developing societies even before the arrival and expansion of biomedicine. In fact, such diversity and plurality of medical traditions in South Asian societies worked as background for Charles Leslie (Leslie 1976, 1978, 1980), the leading figure in medical pluralism, for his deep interest and an extensive study and observation of the co-existing "Little" and "Great" traditions and the learning that "old traditions do not always decay or die"(Madan 2010, 396). Leslie wrote conclusively that "with the exception of a few small and remote primitive cultures that still lack effective contact with the civilized world, all contemporary medical systems organize diverse traditions and modes of practice in complex forms of social organization"(Leslie 1978, 65). Subsequently, many studies conducted in different parts of the world affirmed Leslie and established medical pluralism as the characteristic feature of present day "complex or state societies"(Baer 2004a, 2011). For instance, Frankel and Lewis (1988) afffirmigly states "medical pluralism is now a common pattern in all but the most isolated areas of the world" (Frankel and Lewis 1988, 1).

The study of medical pluralism also facilitated the background for global attention of the traditional medicine. By the time of Alma-Ata Conference on Primary Health Care in 1978, the use of traditional medicine and traditional medicinal practitioners got a global emphasis. Nation states made favorable policy environment for the growth and development of traditional medicine and what is known as complementary and

alternative medicine (CAM) in many developed countries. Many contries gave Traditional medicine and CAM a legitimate space in their national health care systems. The importance of traditional medicine and CAM increased with the failure of biomedicine to deal with some of the health care needs, the "holistic health and new age movement"(Baer 2003b, 233), the "re-emergence of CAM in the western world"(Cant and Sharma 1999a, 1) and national interest in promoting the traditional medicine paved the pathways for official medical pluralism (Baer 2003b).

The popularity of Traditional medicine and CAM is increasing in almost every country and the demand for traditional and CAM services and products are on the rise (Cant and Sharma 1999a; E. Ernst 2000; Gerard Bodeker and Kronenberg 2002; Coulter and Willis 2004; G. Bodeker and Burford 2007; WHO 2013b). *WHO Traditional Medicine Strategy 2014-2023* states, "More countries have gradually come to accept the contribution of traditional, complementary and alternative medicine (TCAM) to health and well-being of the people and to the comprehensiveness of their health care system" (WHO 2013b, 7). The people have been using TCAM increasingly across the world and the patients with chronic conditions often take recourse to TCAM practitioners (WHO 2013b).

1.1 The Conceptual Clarity

A difficulty exists in using the terminology to refer to the co-existing medical systems. Various terms such as allopathy, scientific, modern, western, conventional, regular, mainstream, orthodox, and cosmopolitan medicine has been used to refer to biomedicine. According to Dunn (1976), the use of terms such as ''modern", western", "scientific" medicine is misleading. Dunn and Leslie (Leslie 1976) prefer/suggest 'cosmopolitan medicine' over such misleading terms. Lock and Nguyen prefer biomedicine and they define biomedicine as "the body of knowledge and associated clinical and experimental practices grounded in the medical sciences that were gradually consolidated in Europe and North America from the 19th century on"(Lock and Nguyen 2010:365). Biomedicine is practiced in the clinical or hospital set ups and delivered through the official health care systems. There can be a possibility of geographical variation within the biomedicine and overlapping or mutual sharing between biomedicine and the co-existing medical systems. I would prefer to write biomedicine which dominates the present day writing.

Similarly traditional medicine is also invariably used as indigenous medicine, non-conventional medicine, complementary and alternative medicine. WHO, defines traditional medicine as

> "The sum total of the knowledge, skill, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness."

The term "traditional medicine" is a generic term to refer to different types of medicine other than biomedicine. In many instances, traditional medicine includes both scholarly and popular traditions. Most often the term such as "scholarly", "professional" is used as prefix to distinguish codified tradition from non-codified tradition of traditional medicine. The terms such as traditional healing practices, indigenous healing practices, faith healing, ethnomedicine, local health traditions, and folk sector has been used to refer to various traditional practices which are not codified. I would prefer traditional medicine to the medical systems which have been codified and practiced as legitimate systems and 'folk medicine' to the traditional practices which have not been codified yet but practiced largely among the rural ethno-cultural groups. The folk practitioners, which are also known as folk healers, traditional healers lack legitimate status or hold semi-legal status.

The term CAM has been gaining its popularity in recent times. (Institute of Medicine of the National Academy of Sciences 2005, 19) defines CAM as

> "A broad domain of healing resources that encompasses all health systems, modalities, and practices and their accompanying theories and beliefs, other than those intrinsic to the politically dominant health system of a particular society or culture in a given historical period. CAM includes all such practices and ideas self-defined by their users as preventing or treating illness or promoting health and well-being."

CAM has also been used as a generic term to denote medical systems and practices other than biomedicine. This includes traditional medicine and therapeutic practices such as Ayurveda, homeopathy, naturopathy, osteopathy, chiropractic, acupuncture, massage therapy. There can be both licensed and unlicensed, codified or non-codified CAM. However, the tendency and trend of using the term CAM has been to refer the codified therapeutic practices of traditional medicine which are supposed to complement biomedicine. Often traditional medicine and CAM are used synonymously and interchangeably. However, the tendency of CAM has been to hijack the traditional medicine and its marketable therapeutic practices. Another term, TCAM has been constructed include the traditional medicine into the CAM to acknowledge the separate entity of traditional medicine. According to WHO,

> "The terms "complementary medicine" or "alternative medicine" refer to a broad set of health care practices that are not part of that country's own tradition or conventional medicine and are not fully integrated into the dominant health-care system. They are used interchangeably with traditional medicine in some countries" (WHO 2013b, 15).

I would prefer to use official medicine to include both biomedicine and traditional medicine and/or CAM. Traditional healers or folk healers to the practitioners of non-codified traditional medicine or folk medicine, and practitioners or doctors to the practitioners of official medicine. Here, my intention is not to labeling particular medical system and practitioners but to help readers understand the differences which exists among them.

1.2 The South Asian Context

In South Asian context, we have biomedicine as state patronized system, which has preeminence status with its network of public and private actors from the metropolitan city to the remote village. We have wide variety of traditional systems recognized by state such as Ayurveda, Unani, Homeopathy, Tibetan System (Sowa - Rigpa), Yoga and Naturopathy. Characterized as scholarly tradition, these systems are text-based and practitioners of these systems go through the rigorous training in the formal educational systems. There is a cadre of folk healers of various capacity such as shamanic healers of various types (faith healers, astrologers, priests, spiritual or religious healer), herbal

specialists of various types (herbalist, poison healer, bone setters, tooth extractor etc.), local birth attendant or traditional midwives, massagers etc. We have also home-based practices (home remedies, of home-based care, self-care, and self-medication). In response to an illness people utilize from among these resources based on the availability and accessibility to them. They may use one system exclusively or resort to one after another or may use simultaneously combining two or more systems. The role of belief and perceptions about the illness and illness etiology, past experience, suggestions from family and friends, socio-economic conditions, education and awareness, the kind and condition of illness, the family status of patient and similar other factors can influence the selection of particular sources and treatment recourse.

People's health behavior, in today's world, which is so much complex, diverse and dynamic, is difficult to predict. Moreover, the utilization patterns vary among the different socio-economic groups. The question is how does it vary or how the medical pluralism is practiced among the different sections of the people? How do people from different caste/ethnic groups, different socio-economic status, different educational and occupational status, and different illness status resort to various healing systems at the times of illness?

The growing number of studies on medical pluralism recognize it as normal, natural and ubiquitous phenomena in most of the present day societies. Medical pluralism, the co-existence of multiple systems of medicines, reveals many things: diversity, complexities, pluralities, hierarchies, inequalities in the health care systems. The inequalities and disparities in availability, accessibility and affordability across the socio-economic groups and geographical regions has been well articulated and understood fact (Rama V. Baru et al. 2010, 50). Neither are the regions homogeneous nor the caste/ethnic groups, nor the availability and accessibility of health care services. Further, a number of studies recognize this plurality and complexity of the treatment seeking behavior. In this context, this study attempts to understand perceptions and practiced medical pluralism in a rural setting of western Tarai Nepal.

2. The Statement of the Problem

Scholars from various disciplines are now interested in questions such as how do people choose one sort of system over another? What is it that influences preference of

one form of healing over another? How does medical pluralism operate locally? They are interested in factors that affect treatment-seeking behavior. They have looked into the cost of care, the distance of the facilities, practitioners-patient relations, cultural belief and perceptions and so on. These studies, however, are not enough to explain the differential use of health care resources and the therapeutic pattern of resort (Kroeger 1983; Nichter 1978). People's behavior, which is so much diverse and stratified and constantly changing, is difficult to predict. Moreover, the pattern may vary with the wide range of variables such as class, caste, ethnicity, gender, age, education, and occupation, types of illness, etiology, perception, quality, cost, availability, and accessibility. The study result may vary from place to place or even in the same place between two points of time and sometime they may present contradictory facts.

The dynamic nature of the health care practices has encouraged scholars to reflect frequently on the popularity and persistence use of medicine. On the one side we see an importance of folk medicine and important role of traditional folk healers in providing health care to rural population and (Nichter 1978; Streefland 1985) on the other we see the dynamic nature of co-existing systems of medicine. The plea for the 'revitalization of local health tradition', 'revival of folk or indigenous medicines', 'pluralization of health care services'(D. Shankar 2007; Cant and Sharma 1999b) allude to the two things: (1) local health traditions and folk or indigenous medicines are experiencing or at least experienced in the immediate past a great loss and has not recovered yet (2) health care services, as (Baer, Singer, and Susser 2003) put, are not "pluralistic" or there is monopoly or dominance of one system over another.

Some studies state that folk or indigenous healing practices are "vanishing" or they are "at the verge of extinction" and they will "vanish slowly but surely" (Paudyal and Ghimire 2006; Bajracharya 2006; B Raut and Khanal 2011), "when modern development appears, folk system disappears"(Anyinam 1995). Some studies, on the other hand, state that the assumptions such as "biomedicine would replace the folk or indigenous healing system or traditional medical practices", "indigenous medical practices would soon die out", didn't come true (Najunda et al. 2009, 706; Lock and Nguyen 2010, 61). They did not abandon indigenous medicine, as expected by foreign scholars, rather remain pluralistic in that they always sought to use multiple systems of medicine according to situation and need ((Sujatha 2014, 237). They are always

(receptive of safe, accessible and effective medicines) open to other system as long as they provide some relief (Sujatha 2014, 243).

These studies show the strong presence of traditional and folk practitioners and they have recourse to them at times of illness. Moreover, the traditional medicines have become a national priority in the developing world after the Alma Ata conference in 1978 on primary health care, and various forms of alternative medicines are getting greater acceptance and legitimacy in the western world with the holistic health /new age movement and the emergence of CAM (Baer, Singer, and Susser 2003; Cant and Sharma 1999b; Struthers, Eschiti, and Patchell 2004).

On the one hand there are some studies that claim that the people resort to traditional or folk medicine because biomedicine is unavailable, inaccessible and unaffordable, and it is the rural, illiterate, poor, and tribal population who utilize traditional or folk medicines. On the other hand, there are studies that show high level of utilization of traditional medicine even among urban, educated and high class/caste people. These study claim that people resort to traditional systems not because of inaccessible or unaffordable general modern health services but because of the 'felt need' for services other than that of the modern system (Priya and Shweta 2010 xxiii). Educated, rich and urban turn to traditional healers when they not cured by biomedicine (Regmi 2003; Singh and Agrawal 2009).

Nonetheless, from these studies it is clear that medical pluralism is practiced. These studies also point to the dynamic nature of the coexisting systems of medicines and people's pluralistic treatment seeking behavior. There can be difference among the various sections of people in the level and extent of utilization of a particular system of medicine. But there can be no denying that people seek treatment from not only biomedicine but also from traditional medicines and herbalists, midwives, and magico-religious healers of folk system (Brodwin 1996). They may resort to the traditional practitioners of different systems of medicines for different illness conditions, because each system has its own distinct way of curing/ healing and has its own importance and limitation.

No medical system, including the biomedicine (which is generally perceived as rational, scientific and modern), is perfect. Even the biomedicine is not free from

iatrogenic effect (Illich 1976) and “can do more harm than good" (Sujatha 2012, 37). The pluralistic treatment seeking behavior reflects the inherent strengths and limitations of the various systems (Priya and Shweta 2010 xxiii).

The existence of multiple systems of medicine corroborates two things: (1) Every system has limitation and no one is a substitute for other, and (2) people resort to more than one system not only for different illness conditions but also for the treatment of a particular illness condition. The importance of traditional and complementary medicines in today’s world, according to Bode (2012:75) can be interpreted as proof of the fact, that not a single medical system can claim solutions to every form of somatic and mental suffering. According to him, the need of CAM also signifies the inefficiency of biomedicine.

Some of the scholars are critical about the kind of medical pluralism that is in existence where biomedicine has hegemonic status, state recognized scholarly-traditional medicines get nominal support and folk medicines are deprived of such support. Delineating the biomedical hegemony, Baer, Singer, and Susser (2003) state, “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 ethnomedical practices. In reality, plural medical systems may be described as dominative in that one medical system generally enjoys a preeminent status over other medical systems”(Baer, Singer, and Susser 2003, 11).

Looking at the diversity of the medical systems that are in existence in the Indian sub-continent scholars have characterized the medical pluralism by different terms with similar meanings. The medical pluralism can be characterized as "vibrant and thriving" (Sujatha and Abraham 2012) if we see the plurality of traditional systems, folk systems and biomedicines. But if looked into the level of accessibility, wide spread presence state's policy and support, then the kind of medical pluralism that we have can be characterized as "reduced and simplistic"(Pordie 2007, 2), "highly restricted" (Prasad 2007:25), “hierarchical” (Broom, Doron, and Tovey 2009; Lakshmi et al. 2014), “forced” (Sen, Iyer, and George 2007, 688), “imposed” (Albert and Porter 2015), plural but not pluralistic"(Baer, Singer, and Susser 2003, 11), “notoriously pluralistic” (Lambert, nd, Palmer 2010, 218) “illusory” (Han 2002), “exclusionary”(Attewell et al. 2012, 1) and "undemocratic"(Priya 2012, 104). Scholars are critical about the

biomedical dominance and government's negligence towards "traditional systems" of medicine. The existing unequal power relation between different medical systems, the issue of revitalization of local health traditions and inclusion of many health care alternatives, the unequal distribution of health care resources, patient satisfactions, and choice or options of health care services are some of the key issues in medical pluralism (D. Shankar 2007). With pluralism comes not only advantage but also disadvantage and the challenge is to "enhance the advantages of pluralism while correcting its disadvantages" (Leslie 1976, 357). The present concern is inclusionary pluralism with more choice and more options.

3. Rationale

On the one hand today's world is against the idea of medical monism and with medical pluralism people expect greater choice and options. On the other, growing number of studies recognize the differential access and use of health care services among the different socio-economic groups and geographical regions. The dilemma of pluralism and inequality has arisen some questions: pluralism for whom? Is pluralism always desirable and beneficial for all? Is it true that we have 'vibrant' pluralism for elites and 'highly restricted' pluralism for masses? Further, why do people follow multiple recourse patterns and who exactly among them get benefits from this? What makes people follow the longer pathways of care even for a single illness episode? Why do people follow different patterns of resort? How longer pathways or multiple recourse is related to cost of care and experience of suffering?

In this context, it is imperative to understand this labyrinth of resort patterns among the different socio-economic groups, on which so far less attention has been paid. The research attention on the patterns of resort is of contemporary need and importance. The question is what the situation of existing systems of medicine is and why do people choose one system over another or combine one system with another? What is it that motivates them to choose a given system and therapeutic service? In this context, a study of this kind is justified to better understand people's perceptions, the way they understand, interpret, identify and respond to illness, the way they choose or resort to a certain therapy systems or the way they practice medical pluralism in their ecological setting.

This study focuses on the people's perceptions of and response to an illness in a village of Dang district of mid-western Nepal. The study attempts to seek connection between perceptions and practices, ethnicity and illness, and socio-economic groups and patterns of resort. One of the reasons to study the patterns of resort among different socio-economic group is to gain insight into the people's perspective which influence their treatment seeking behavior which can be helpful to better understand the use of health care resources. The second reason is to understand the level and extent of utilization of different systems of medicines among different groups, the order of resort to they follow, the selection of healing/curing they make for an illness or disease conditions which can be an input to policy makers and planners to pay attention to the patterns of resort and plan for a better intervention strategy to improve the access to health of a particular section of people.

4. Motivation

Soon after the completion of my Master's degree in Anthropology in 1998, I joined an NGO and got an opportunity to work on the issues of community health especially among the ethnic and Dalit communities in many parts of the country, villages from plain to hill to mountains in Nepal. This gave me an opportunity to know more about the poor and their struggle for day-to-day life. I came to know that there exists a complex relationship between different sections of people and that life is harder to the people who are living in poverty ensnared by a web of exploitation and oppression. It is desirable, especially for those of us who have worked or have been working with the rural poor and want to see them moving ahead from poverty to prosperity, leading a healthier and happier life. I think to be sympathetic towards poor, Dalit, marginalized, vulnerable, exploited and oppressed is human but at the same time a possibility remains of being leveled as prejudiced and biased in social science research. Moreover, in social science research our background, our preferences of the research subjects, our way of selecting study participants, our methods, theoretical and conceptual orientation, the way we do field work and collect data, the way we analyze and interpret them, and our priority on certain themes/ topics and not others and even our perceptions, perspectives and the theoretical approach, may not seem objective, unbiased and unchallenged. Whatsoever, our concern would be to strive for balanced and unbiased approach. I

believe, there is no point of being prejudiced and biased when we accept what we are and how we did it at the outset.

I was somewhat confident that my working experience with the similar community would help me to identify with them and build a trust among the study participants in the village. I chose one of the villages (I give a pseudonym as Anjaan Gaun) of Dang district for field work which was native to me. I was inspired by the "native"[1] anthropologists who have studied their own people in their own homeland. I think it is not always desirable to follow the 19th or early 20th century western anthropological tradition of studying exotic culture and people in the far remote regions. Besides, practically it is not feasible for those of us who have no financial support conducting fieldwork in distance and unfamiliar place.

I chose the familiar area and people but when I began to do field work I realized that I was not so familiar and building trust among them was not so simple. Probably this is why extended period of fieldwork is justified for a qualitative study. Though I was aware of the advantage and disadvantage in selecting fieldwork area from one's home district. My position was that I was a male, of middle aged, of Brahmin/Chhetri caste and of Hill origin but with native connection with the study area. At the end of the field work, most of the people recognized me not only as a student researcher who asks about *sancho-bisancho* (wellness-illness) but also as an inhabitant of same district. This might have perceived differently by different socio-economic groups. I tried my best to be conscious and balanced during my field work and tried as much as I could to facilitate the interaction with the villagers, who represent different class, caste and gender.

Before beginning of the field work I used to think that my previous contact with some of the people, my working knowledge of Tharu language and my mother tongue as Nepali, which is generally spoken and understood in the area, my past experience of working with Dalits and Janajati, my training to be an empathetic listener and be non-judgmental would place me in a unique position, appropriate to do the fieldwork in the village setting. I wanted to listen to the villagers, their illness and treatment seeking

[1] Here, I use "native" only because I am from the same region and cultural background but viewing the diversity within a particular region and culture how truly one can become "native" or "insider" has always been debated. For definition and debate over "native" and "foreign" anthropologist see (Narayan 1993; Ohnuki-Tierney 1984b; Steinlien 1990).

experience. Indeed, I was motivated internally to do a good study. I went to the field, managed to stay there established a rapport and did my fieldwork. Doing field work is a different experience than the reading about how to do fieldwork. I repeatedly visited the field and the people and tried my best to document their experience. Despite my genuine efforts, possibility remains that some stories might have been missed, left unattempted or untold. I still feel that there is a lot to understand from the people and their experience.

One of the touching experiences of my M.Phil. was the *Rakku's Story* where Zurbrigg (Zurbrigg 1984) begins with a story of a woman, named Rakku. Rakku's family lives in a rural village in India. Rakku and her husband work as agricultural laborers for village landlord. Her elder son supports in cattle herding and daughter supports household chores and babysitting of her youngest sibling. The family lives in extreme poverty and hardship. The infant, which was already poorly nourished, gets less attentions when Rakku and her husband go to work for the landlord in the harvesting season. She did not get enough time for breast feeding. Ultimately the infant suffers from diarrhea. Rakku first goes to a temple with flower because she suspects of *mataji* (Goddess), and tries home remedies, and then consult a local healer, traditional midwife, and then goes to local medical clinic and to the urban hospital as the last resort. The tragedy is that even after trying so hard the infant dies. Rakku wipes her tear, takes this as Goddess's will and consoles herself. The story is very touching.

The story also presents a sort of patterns of resort moving from local healers to private practitioners and distance public hospitals which is commonly followed in similar socio-economic and illness conditions in the South Asian context. The story not only presents perception about the illnesses but also an example of multiple recourse and gives an insight into the treatment seeking efforts, the cost of care, and the suffering of the family.

The story gives us a background to reflect on many questions: What were the background reasons for an illness of the infant? How did the therapeutic journey begin and how did it end? How the decisions were made at the household levels to resort to a particular source of treatment? What would have been the resort pattern if this had happened to the landlord's family? Would it be the same? Would his family be treated in the same manner by hospital staffs? Does the perception of illness (etiology of

illness) influence the patterns of resort to care? This was an acute case of a Dalit laboring family, what would have happened if the case was of chronic and that of high caste family? The story leaves readers think over the role of an individual care seekers, fellow villagers, and health institutions and health care system to seek the answer why or because of what the infant died? The story was introduced to our M.Phil course and this was very insightful for me in shaping the theme of this study.

Another story I got was from a book by Djurfeldt and Lindberg (1975) entitled *Pills against Poverty* which presents a story of high caste family. The story also presents an example of multiple resort pattern. They present a story of a pregnant woman named Tulasi who represents middle class Brahman family. However, she is a daughter-in-law of that family. Sournammal is Tulasi's mother-in-law who plays the role of the head of the family (because her husband is a lorry driver and her eldest son or Tulasi's husband has a job in city). Sournammal plays a decisive role in the treatment seeking. In the middle of the ninth month Tulasi's feet swell and then Sournammal takes Tulasi to a clinic run by charitable organization where she was given vitamin pills and some medicines. Though they suggest institutional delivery, because of geographical and socio-cultural reasons, Tulasi with an assistance of a traditional midwife gives birth to a girl baby. The midwife uses rusty knife which develops neonatal tetanus. On fifth day Tulasi develops fever. Sournammal thinks over the past food intake, the hot-cold food and soft-solid food, and modifies the food. She starts foot massage and then calls a local healer (massager) who also brings some capsules and tablets for fever. When fever continues Sournammal sends Tulasi to an urban midwife where she gets injection and begins to recover. On seventh-day infant falls ill and on eighth day Sournammal takes the infant to the indigenous midwife because she is experienced and she gives some pills to the child. Pills don't work. She is advised to take the infant to the allopathy doctor. Not convinced Sournammal delays but when infant's condition worsens further she takes the infant to local allopathic practitioner and the practitioner advises them to go to children's hospital in the city (i.e. Chennai). The next day the infant dies in the hospital.

Another sad story. Both of these stories are of acute case and show the similar patterns of resort: use of home remedies, then traditional healer and then to hospitals which is described as "counter-acculturative patterns" in the "hierarchy of resort" (Schwartz

1969). From these stories we know that people usually try immediate resources first and based on the severity of the illness make decision to resort to the distance sources. Because of uncertainty and lack of information they may delay to take right decision or go to the facilities. And even if they approach to the right place/practitioners they may be treated with irresponsive behavior. The perceptions about illnesses, the healers, practitioners or medical systems also play a role in making decisions. The decisions cannot be right and wise always and people keep on trying different treatment sources, from the same or different systems of medicines, as long as they can afford and until the end comes. The pathway of care gets longer unless they choose right treatment and it seems that the longer the pathway larger the cost of care and extended periods of suffering.

Similar stories were documented by Ritu Priya (Mehrotra 2000a, 468–73). Priya analyzed five case studies of childhood diarrheal disease among the construction workers in Delhi (Mehrotra 2000b, 468–73). She observed an interesting correlations in the choice of therapies and the working skill of the parents, land holding, mind-sets, and level of social security and sex of the child. The relatively well-off, skilled, and those who had better land holding, who had social security had experienced treatment success while three families who had poor land holding, unskilled and lack social security had followed different resort patterns and experienced treatment failures. Even after trying multiple sources they had lost their children. One important thing the study points is that even among the same caste and for similar illness condition people resort differently and there are other determining factors which play an important role.

Dewan (2013) also observed the different resort pattern for similar illness conditions. In the study of patients suffering from chronic pain she also observed the multiple resort pattern. The patients suffering from chronic pain had followed: exclusive use of healers/priest or shrine; allopathy followed by healer; herbalists/allopathy followed by shrine; shamanic healer/priest along with herbalist/allopathy; shamanic healers followed by allopathy/herbalists along with healers. Her study also shows how patients switch back and forth between two or more systems and practitioners.

I also observed some of the cases in my M.Phil study in which people had recourse to different sources. Some were visiting the healers for the first time while others were visiting them after coming back from medical clinics and hospitals. The caste

restriction was not there in treating the patients. This was nothing new in the villages. There were local healers from all caste/ethnic groups to whom people from all caste/ethnic groups used to resort to indiscriminately[2]. My focus was on the indigenous healing practices among the Tharu, one of the ethnic communities of the area. However, I was interested to know about the similarities/differences among the co-inhabiting caste/ethnic communities. I was interested in the way different people were making use of official and unofficial treatment sources. This motivated me to go back into the field again and know more about perceptions, practices and patterns of resort among the different caste/ethnic groups.

The political events are fast moving in Nepal: The democratic movement of 1990 from which country moved from party-less *Panchyat* system with absolute monarchy to multi-party parliamentary system with constitutional monarchy, the formation of democratic governments and adoption of liberal economic policies and significant growth of private sector, decade long Maoist movement (1996- 2006), royal takeover of power (in 2005) , Second democratic movement along with Maoist party and end of monarchy, promulgation of Interim Constitution of Nepal, 2007; first constituent assembly election (in 2008) and Maoist party formed a coalition government, lack of mutual trust and consensus among the parties, second constituent assembly (in 2013) , promulgation of new constitution (in 2015), and local, provincial and national election held (in 2017) and CPN-UML won the largest number of seats and formed the coalition government with Maoist party and the integration of both parties (in 2018). Nepal has been struggling with many problems. As has been aptly termed by Shrestha and Bhattarai (2003), "Nepal is an ordinary country with an extraordinary problems." Nepal's extended period of political transition and unending political turmoil, of frequent changes in governments (almost in every one or two years), of poor economic condition, of diverse geography and culture, of poor provisioning of public services, of income inequality and rising gap between income quintile, of limited access to the public health care services, and of limited provision of traditional medicine and withered state of folk medicine have become the understood facts.

[2] It is generally seen that the size of local healers (herbalists, shaman and midwives etc.) is much higher whereas the size of medical doctors or codified medical practitioners is much lower among the Dalits in comparison to their population size. This leads me to suspect less that in a local setting Dalits as folk healers are well accepted. However, Dalit as medical practitioners, as has been shown by (Cameron 2009), may not be accepted that much or may be discriminated. The higher reliance of Dalits and Indigenous ethnic communities on folk healers can be partly associated with the size of their healers.

Though, during this period, political consciousness has increased, ethnic groups and Dalits have become more organized, empowered and assertive of their rights and their political representation has been increased and progress has been made in some of economic and health indicators (CBS 2014c; NPC and UNDP 2013, 3; UNDP 2010, 54, 2015) This period also saw an increased involvement of private sectors in education and health care services (Dolma Development Fund 2014; Sengupta et al. 2017). Though, it is questionable that the poor, Dalits and marginalized ethnic communities are benefited from the increased involvement of private sectors (Patouillard et al. 2007) There is disparity between caste/ethnic groups in terms of poverty and health indicators. The Third Nepal Living Standard Survey (2010/11) estimates 25 percent of the population lives below poverty line. However, the difference between rural (27 percent) and urban (15 percent), Dalit (42 percent) and Non-Dalit (23 percent) is much higher(CBS 2011b). Maternal mortality ratio for Dalits (273 deaths per 100,000 live births) is higher than Janajati (207) and much higher than Brahmin/ Chhetris (182) (Suvedi et al. 2009). More than one fourth (26 percent) of Brahman/Chhetri women are attended by skilled birth attendants compared with 14 percent of Janajati women and 11 percent of Dalit women and similar differences exists in the percentage of deliveries in a health facility, i.e. 24 percent for Brahman/Chhetri, 14 percent for Janajati and 9 percent for Dalit (Bennett, Dahal, and Govindaswamy 2008). Similarly, figures for infant mortality, child mortality and total fertility rate are higher among the Dalits compared to Janajati and Brahman/Chhetri.

The growing dissatisfaction among people about poor functioning of public institutions and mounting cost for private health care services have posed a problem. Moreover, they express resentment about the changes which have been taking place in their life and livelihoods, including in the field of agricultural production, food practices, and family health traditions. In this changing context, it would be important to know how the people are utilizing health care services or seeking treatment when they experience illnesses. I thought over this issue and asked myself if there is a difference among the different caste/ethnic groups in accessing health care services, whom do they resort to and why, and what is it that leads them to follow different therapeutic paths? There is no short and simple answer, as many factors can come on the fore and we need to go deep into and examine if we really want to understand the maze of medical pluralism. This is what led me to attempt this study.

5. Organization of the Study

The thesis is organized into eight chapters. Chapter I introduces the subject and gives a background of the study, rationale, motivation of research and the organization of the study. Chapter II presents an overview of medical pluralism which reviews the studies on medical pluralism, perceptions and patterns of resort. Chapter III gives an overview of theoretical models and approaches, conceptualization of the study, and research methodology. Chapter IV contains a profile of the study area and socio-economic characteristic of the people. Chapter V presents the illness and treatment seeking experiences. Chapter VI discusses on the pathways of pluralism and utilization of health care services. Chapter VII analyzes the patterns of resort among the different socio-economic groups in selected chronic conditions. Chapter VIII makes makes a discussion on the hierarchy of medical systems and attempts to examine the state's role in the making of hierarchical medical pluralism. Chapter IX presents a summary of the research findings and makes a discussion on the policy implications.

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CHAPTER II

AN OVERVIEW OF MEDICAL PLURALISM

This chapter presents an overview of medical pluralism. Beginning with a conceptual understanding of medical pluralism this chapter looks further into the classification of medical/health care systems and their strengths and limitations. Then it moves on to the topics of beliefs and perceptions related to health care, health seeking behavior, and patterns of resort. The last part presents an outline of medical pluralism in Nepal, ethnicity and access, ethnicity and health seeking, and practices of medical pluralism.

1. Conceptual Understanding of Medical Pluralism

Medical pluralism basically indicates the existence and use of two or more systems of medicine in a society. It is against the idea of medical monism and challenges the hegemony of one “dominative medical system.” It indicates to the limits and inherent inadequacy of each systems of medicine (Priya 2012). Stoner defines medical pluralism as the "existence and use of many different health care alternatives within societies" (Stoner 1986, 44). Prasad defines medical pluralism as "the coexistence of several medical systems and the relatively greater choice available for everyone" (Prasad 2007b, 3491). Now, it has been well recognized that there exists multiple systems of medicine and people use multiple sources of care throughout the world (Leslie 1980; Young 1983). Baer (2011), whose contribution in the field of medical pluralism is laudable, defines medical pluralism as “the coexistence of an array of the medical subsystems.” About the relationship between the co-existing subsystems, he states, “the medical system of a complex society consists of the totality of medical sub-systems that generally compete with one another but sometimes exhibit cooperative, collaborative, and even co-optative relationships with one another” (Baer 2011, 405).

According to Minocha, medical pluralism can be understood to mean two things: it may mean the co-existence of multiple systems of medicine, including what are called folk systems, popular systems, traditional professionalized systems which present multiple choices to individuals, and it may mean pluralism within a particular system (Minocha 1980, 217). Hyma and Ramesh (1994) give the similar definition. They define medical pluralism as “the coexistence of multiple systems of medicine (traditional, modern, folk) giving multiple choices to individuals or it can even mean 'pluralism within a particular system', allowing access to various levels and types of care" (Hyma and Ramesh 1994, 66–67). In defining medical pluralism scholars generally emphasize on greater choice and greater options. Kalpagam states that medical pluralism "refers to a context in which multiple systems of medicine coexist and in which patients of illness do have the options and make their choice between these systems and in instances even combine treatment procedures from these multiple systems "(Kalpagam 2012, 9).

In the *International Encyclopedia of Public Health* Hsu (2008) writes, “The concept of medical pluralism implies that in any one community, patients and their care givers may resort to different kinds of therapies, even where these have mutually incompatible explanations for the disorder” (Hsu 2008, 316). Hsu further states, “The study of health seeking behavior of the patient and his or her “therapy managing group” is one of the core themes of the studies on medical pluralism”(Hsu 2008, 318).

Charles Leslie was the first among others to recognize the existing reality of plurality of practitioners and pluralistic patterns of resort. Leslie conducted studies on medical pluralism in India and enlisted the wide variety of practitioners of local, regional and cosmopolitan medicine. He presented strengths of cosmopolitan and traditional medicines in a simple manner. Baer (2011) gives due credit to the contribution of Leslie by presenting him as a father of medical pluralism. Indeed, Leslie’s contribution for the coinage of the term and its application in the field has been well acknowledge (Hsu 2008; Baer 2011; Lock and Nichter 2005). Baer writes, “Charles Leslie was the first to conceptualize and apply the notion of medical pluralism in a systematic way” (Baer 2011, 406). In *Asian Medical Systems: A Comparative Study*, a well referred

book in his edition, Leslie recognized that the medical pluralism was not the new phenomena. He made a distinction of medicines between Great and Little Traditions and focused on the Great Traditions of Ayurveda, Unani and Chinese medicines while incorporating urban popular and rural folk medicine and folk healers such as shamans, herbalists, midwives, bone-setters, surgeons, snake-bite healers etc. Leslie (1976:358) observed medical system as “a pluralistic network of different kinds of physicians, dentists, clinical psychologists, chiropractors, health food experts, yoga teachers, spirit curers, druggists, Chinese herbalists, and so on.” Now, medical pluralism has been increasingly taken as real, normal and not an exceptional state of affairs (Cant and Sharma 1999b). There is an Unanimous agreement among the scholars that medical pluralism is the rule and not an exception throughout the world (Durkin-Longley 1984, 867; Stoner 1986, 44; Pigg 1995, 18; McGrath 1999, 484) and the scholars have increasingly reaffirmed that medical pluralism is not a new (or recent) phenomena (Baer 2004b, 109; Cant and Sharma 1999b, 1). And for the scholars of Indian subcontinent it was nothing new (see the works of (Madan 1969; Banerji 1974, 1973; Minocha 1980; S.M. Bhardwaj 1980). Ritu Priya also asserts the universality of pluralism, "pluralism in treatment-seeking among all sections of people is well known; among the poor and well- off sections of both 'underdeveloped' as well as the most 'developed' countries" (Priya 2012, 103).

2. Classification of Medical/ Health Care System

According to Kielmann (2005:135), “medical system is a set of premises and ideas that enable people to organize their perceptions and experiences of medical events (such as illness episodes) and to organize their interventions for affecting and controlling these events.” Dunn (Dunn 1976, 135) defines a medical system as “the patterns of social institutions and cultural traditions that evolves from deliberate behavior to enhance health”. Dunn classifies medical systems into three categories based on their geographical and cultural settings: local medical systems, regional medical systems, and cosmopolitan medical system (Dunn 1976, 139).

By local medical systems he means “folk” medicine of small-scale communities. The local medical system tends to be popular and non-scholarly. Regional medical system is

the system distributed over a relatively large area such as Ayurvedic, Unani and Chinese medicine. The regional medical system tends to be scholarly. Cosmopolitan medicine refers to the global medical system what is often referred to modern, scientific or western. He points the possibility of the regional and local variation of these systems. Dunn prefers cosmopolitan medical system over "modern", "scientific" or "western" medicine because he found these terms misleading. The local and regional medical systems are also scientific, modern and western medicine is no more western.

In his explanation of the structure of health care systems Kleinman (1978a, 86–87, 1980, 51), explains the three overlapping social sectors: popular sector, folk sector, and professional sector. The **popular sector** comprises principally the family context of sickness and care, but also includes social network and community activities. It includes a wide variety of therapies, such as special diets, herbs, exercise, rest, baths, and massage, and, in the case of industrial societies, articles like humidifiers, hot blankets, patent medicines, or over-the-counter drugs. Popular sector is the most active and widely used indigenous healing tradition. Although popular sector of health care is the largest part of any systems, it is the least studied and most poorly understood. Self-treatment by the individual and family is the first therapeutic intervention resorted to by most people across a wide range of cultures (Kleinman 1980, 51).

The popular sector can be thought of as a matrix containing several levels: individual, family, social networks, and community beliefs and activities. It is the lay, non-professional, non-specialist, popular culture sector in which illness is first defined and health care activities initiated. Most of the illness episodes are managed within the popular sector. In both Western and non- Western societies somewhere between 70 and 90 percent of sickness is managed solely within this domain. Moreover, most decisions regarding when to seek aid in other sectors, whom to consult and whether to comply, along with most lay evaluations or the efficacy of the treatment are made in this sector (Kleinman 1988, 1978b).

Folk sector consists of non- professional healing specialists which got much attention by medical anthropologists and it is overemphasized. The folk sector encompasses various healers who function informally and often on a quasi-legal or even illegal basis. These include shamans, mediums, magicians, herbalists, bonesetters, and midwives.

The **professional sector** consists of professional scientific ("Western" or "cosmopolitan") medicine and professionalized indigenous healing traditions (ex. Chinese, Ayurvedic, Unani and Chiropractic). The professional sector encompasses the practitioners and bureaucracies of both biomedicine and professionalized heterodox medical systems, such as Ayurvedic and Unani medicine in South Asia and herbal medicine and acupuncture in the People's Republic of China.

Attewell et al.(2012) classify the existing medical systems into two broad categories based on the accessibility: statist medicine and subaltern medicine. By statist medicine they mean state sanctioned medicine, which include both biomedicine and classic systems (popularly known as AYUSH[3] in India) and subaltern medicine refers to the non-elite form of therapeutics or the popular therapeutics. Statist medicine serves more to the elite and is relatively inaccessible to the masses, whereas subaltern medicine is comparatively accessible for the masses.

To extend this, based on the nature of the systems of medicines, biomedicine can be characterized as bourgeoisie medicine, scholarly traditional medicine as feudal medicine (but with professionalization and commercial thrust it is also more like bourgeoisie medicine) and folk medicine as proletariat medicine. Han (2002) opines that the traditional medicine also contains some features of capitalist mode of production because they are sold in ready for consumption or tablet forms, even though they contain the legacy of tradition which reflects pre-capitalist mode. Hsu (2008) affirms that the TCAM reproduce the bourgeois philosophy and the same capitalist principle that shape biomedicine. To substantiate, the neoliberal capitalist influence can be observed even in the folk sector.

[3] Acronym for Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy

3. Strengths and Limitation of Medical Systems

Each system has its own strengths and limitations. The Table 1 presents some of the strengths and limitations of each of the medical systems as described in the literatures (Leslie 1980; Dunn 1976; WHO 2001; Sujatha 2003; Cohen 2007; Winkelman 2009; Priya and Shweta 2010; Priya 2012).The comparison is questionable as there are arguments on the epistemic variance. Additionally, the term 'traditional medicine' refers to various systems of medicine and all types of traditional medicines cannot be treated equally and this is what makes the comparison questionable. It is also argued that some of the traditional systems are now no more traditional, regional and unscientific. They are also modern, have gone global or become cosmopolitan and follow scientific methods of observations and experiments. Similarly, there can be arguments on the strengths and limitations of folk systems as the folk system is also an umbrella term for wide range of practices. The labeling as strengths or as limitations for certain characteristic features of a medical system can also be debatable. For instance, in South Asian context herbal medicine is considered less toxic, having fewer side effects and works slowly whereas, biomedicine is considered more toxic, having side effects but works rapidly. The perceptions also vary according to time and context.

Table 1: Strengths and Limitations of Medical Systems

Types	Strengths	Limitations
Biomedicine	• Scientific and valid, based on empirical observation and measurement • Greater choice, has a global existence • Advancement of research and medical technology • Amazing success in specialist care and surgery • considered highly effective, Speedy recovery, quick effect of chemical drugs (demonstration effect)	• High cost and limited access (access depends on income) • Hospital based, physician dominated, individualist care, focus on disease • Iatrogenic, invasive technology, and killer drug • Urban centric, and high technology • Paternalist and profit motive

Traditional Medicines	• Text based and patronized systems • Culturally accepted • Equal access or economically affordable • Low-cost and simple technology • Safe/ No or less side effects • Strengths in the management of chronic illnesses • Focus on health rather than disease	• Regional or area-specific existence • Qualities varies across the regions • Less efficacious • Steady recovery • Social hierarchy between patients and provider
Folk Medicines	• Better healers- patients relationship (shared worldview, corresponds to the patients ideology) and human touch • Community based, egalitarian and family involvement • Treats cases untreatable by other systems (Curative care and chronic care) • Voluntarily, no or low cost • Greater accessibility (local and rural existence)	• Lacks scientificity (or proven safety and efficacy) • Lacks legal recognition • No uniform or standard procedure (not documented) • Culture and area specific practices • Some practices are harmful practices, blind faith

4. Perceptions and Patterns of Resort

This section reviews some of the empirical literatures on the treatment seeking behavior, perceptions and patterns of resorts. I begin with the studies conducted on the people's belief systems, etiology and treatment seeking behavior. In the patterns of resort I look into the use of self-medication, home remedy, folk healers, and professional practitioners of both traditional medicine and biomedicine.

4.1 Studies on the Belief and Perception in Nepal

After the end of the autocratic Rana rule in 1951, Nepal opened its door to the outside world and since then a number of studies conducted by the foreign scholars. The subject drew attention of the scholars on various aspects of traditional and folk medicine. A general review of the literature (Blustain 1976; Pigg 1995, 1996; Shafey 1997; Devkota 1984; Hitchcock 1967; D. Beine 2001; Stone 1976; Peters 1978; Mumford 1989; Dietrich 1996; Bista 1969); (Parker 1988) provides that the focus of most of the studies was on the classification of folk healers, healing practices, illness causation, modernity and change.

Types of Healers: most of the studies classify folk healers from three to five categories. These healers basically include:

i. ***Shamanic healers*** (described as *Dhamai, Jhankri, Bhopa, Bhagats Ojha etc.).* Some of them give a separate categories for **astrologers** *(Jyotish, Jaisi, yogi-baba etc.)* and **religious healer** *(priest, pundit, guru, pujari, lama, babaji, mataji, hafizgi, etc.).*

ii. ***Herbal healer or herbalists*** (*Baidya and baiduwa/baidiniya*). Some studies classify pulse specialists, tooth extractor, poison healers, bone setters separately.

iii. ***Midwife and massagers*** *(sudeni, sorhenya, massagers etc.*). Some studies use modern equivalent such as physiotherapists, gynecologists, masseur, masseuse etc.

Methods of Healing: The studies describe various healing methods followed in the particular community. The major methods can be classified as follows:

i. ***Use of Mantra*** and healing rituals, worshiping of God which shamanic or religious healers follow such as sweeping blowing (*Jhar-phuk*), reading pulse, writing amulet, use of *tika* (to be put on forehead as blessing of God) and *jal* (fortified water) and *prasadi* (holy food offered to God/Goddess).

ii. ***Use of Medicinal Herbs*** or herbal healing which includes the plants and mineral resources for preparation of drug. The drug can be in solid, semi-liquid, liquid and gas/smoke forms. Some study includes physical examination and pulse reading.

iii. ***Use of Massage or Body Manipulation*** techniques such as massage, fixing muscle or bone dislocation and midwifery activities.

Some of the study classify treatment method into two categories: magico-religious treatment and treatment by herbal medicine knowledgeable persons.

Belief and Perceptions: has been described as a way to understand people's health behavior, as an obstacle/barrier to introduce biomedicine and also to rationalize their treatment seeking order. Some studies show a difference in perception about the health

and illness between western doctors and indigenous healers. Perceptions and treatment seeking behavior are culturally constructed and culturally interpreted. What is illness in one community may not be regarded illness in another and what is severe in one culture may not be that much severe in another.

Types of Illness: A few studies have classified illness into major and minor, hot and cold, communicable and non-communicable and internal and external.

Etiology of Illness: Various explanations of illness causation has been explained. The causes can be classified broadly into two categories:

i. ***Natural causation:*** illness caused by germs, body weakness, climate change, wrong or excessive food. Natural causations are impersonal and resembles with biomedical theory which to include pathogens, trauma, nutrient deficiencies, and other tangibles that can befall anyone.

ii. ***Supernatural causation*****:** illness caused by unseen forces such as spoiled planet, bad karma, spirits, bewitchment, loss of soul, evil eye, possession by evil spirits, ghost intrusion, wrath of local deities. In the study of ethno medicines, scholars have placed much emphasis on supernatural (personalistic) causations than on naturalistic or empirical components (Waldstein and Adams 2006).

If the people attribute it to natural causes they may resort to naturalistic medicine and if they attribute it to supernatural causes they may resort to shamanic or faith healers. However, in South Asian context, in most cases an illness can be thought of caused by both natural and supernatural causations (Nichter 1989).

Treatment Seeking Order: Very few studies have explained treatment-seeking order as self- treatment and/or home remedies, local healers or health care providers and hospitals. As a general pattern, for many and in many cases, the first resort would be home remedies and the last resort would be to go to the hospitals based on the nature and severity of the problems. In between comes folk or indigenous healers, local medical practitioners, pharmacists and drug retailers.

Role of the folk healers as bare foot doctors, as barefoot botanists, as community psychotherapists, as specialist of psychosomatic disorder, as massagers and midwives. Some studies answer why the (shamanic) folk healing continues. The reasons are people's perception of illness and the meaning they assign to its etiology, a sense of service to the community and people's faith in the healers' skill, effective, simple, safe, inexpensive, nontoxic and time tested, best remedy for non-medical or allopathically untreatable illnesses. Shamanism persists because the shaman mediate between community and supernatural force, reconcile the dispute between households and community with the forces, and facilitate to rebuild the relationship of patient with families and communities. This may seem irrational belief in the supernatural force but can be a rational choice for many social-psychological problems.

Development and Modernity and Change: Some of the studies have paid attention on the changing perception of the people. To believe in shamanic healing (such as *dhami-jhankri*), in the present context, is equated to be backward, traditional, villagers, uncivilized and superstitious. Backward and superstitious people are considered barrier to development and modernization. An irony is that no one wants to be termed as superstitious and uncivilized but can't help resorting to the faith healers or shamans when they are suggested or feel a need.

These studies (i) provide a background of medical pluralism, the coexisting diverse traditions and their utilization by the diverse groups, (ii) reveal that people resort to varieties of healers and medical practitioners in search of cure, (iii) show the association of illness etiology, their belief and perceptions and choice of treatments, (iv) provide little information on what the different socio-economic groups do when they contact disease and experience illness, where do they go or whom do they consult, and (v) leave a scope for the study of patterns of resort among the different socio-economic groups.

4.2 Studies on Health Seeking Behavior

When a person experiences an illness what does he or she do first? Studies on health seeking behavior[4] explain that home-based practices are the first source of care. When

[4] Health seeking behavior can be understood as the process of making choice from among the available health care options.

home-based practice fails a sick person visits folkhealers and then to practitioners of official medicine. Because in many context it is not considered rational act “to consult a doctor first which might result in the waste of time and resource” (Nichter and Quintero 1996, 945). Therefore, after home remedies the person may resort to folk healers for treatment. However, the person may resort to hospitals or medical practitioners skipping the folk healers or may use both simultaneously, if the nature of illness demands. Studies have shown that the preference of village healers is high both in the earlier stage of illness, in a chronic condition and when people cannot pay for medicine (Guite 2011:101).

Reflecting upon the above the question answer might be a little different: When a person falls ill or experiences illness his or her first attempt would be to treat oneself without reporting to the family and friends (or what Janzen calls “therapy management group”(Janzen and Arkinstal 1978) Kleinman calls “popular sector”(Kleinman 1980) and Stacy calls “domestic domain”(Stacey 1988). In fact, for some of the illness episodes people would like to treat by themselves without the knowledge of family and friends. In that case people may try self-medication, self-treatment or simply wait for some time with a hope that body system automatically recovers. Many illnesses are not treated or left untreated waiting for some time body to heal on its own. Scholars (Beal 1976; Mehrotra 2000b) have documented that people with illness, in some conditions, generally wait for some time to get well. Because of the fear of stigma and discrimination associated with some of the illnesses (such as problems related to genital organs, STI, HIV, Leprosy etc.), people would not feel comfortable to disclose their illness or make their illness public in the beginning. After some time they may gather courage to overcome the fear and share their illness with family and friends, healers or practitioners. It is logical that treatment starts from patients themselves and with the experience of treatment failures moves ahead to home remedies, to healers and to hospitals.

In most cases people report to their family and friends and make the illness public and it becomes unavoidably public in the illnesses, which cannot be hidden long. So, treatment starts from private illness and once he or she shares the illness it becomes public illness and he or she enters into a sick-role behavior. The family-friend circle or those who know the illness work as “therapy managing group” which has a role to play

in the pattern of resort (Durkin-Longley 1984). The group may be required to construct a hierarchy of resort and elaborated treatment plan (Fabrega 1999, 192). In her study, Durkin-Longley (1982) found that upon recognizing an illness, a patient's family first responds to the symptoms by preparing home remedies, which are generally folk or traditional medicines. If the symptoms persist, the family then forms a "therapy managing group" and selects from a multitude of therapeutic options (Durkin-Longley 1984, 867).

The Choice of Medicine

People make choice based on the type and severity of the illness, available options, their perceived efficacy, and the cost of medical care, the time to get the service and the previous relationship with the practitioners. Previous experience of family and neighbors, relatives and professional circles on the perceived quality of care also helps to decide the system. (Surinder M. Bhardwaj and Paul 1986, 1003) observe that choice of healer of particular type is associated with the health condition or severity of patients, relative proximity of the healer, transportation facilities, cost of health care, gender of the patients, attitude of the parents toward different systems of medicine, past experience, expectancy of cure and the like. However, Minocha (1980:218) is of the view that the real bases of choices are the availability, accessibility and quality of medical care but not the people's cultural perceptions or cultural consonance of medical systems. She also adds the past experience of illness episode and patient's status in the family as bases of choice. She observes that cultural congruence or cultural acceptance is not the real base of the choice (Minocha 1980). However, Kroeger (Kroeger 1983, 147) reviews both etiological concepts and world views as well as the acceptability, accessibility, costs, as important factors in the use of health care. Samuelson also stressed on the accessibility, cost and staff attitudes as important factors for the local populations' evaluation of public health care services and social networks on the health seeking process (Samuelsen 2004). This signals to the possibility of diverse therapeutic itineraries influenced by the socio-economic factors. Treatment seeking behavior of an individual cannot be taken as independent behavior because not only the individual's personal characters such as age, sex, education, occupation and personal habits but also the social characters such as family/households, family's position in the ladder of power, prestige and property; caste and ethnicity, community and community

awareness about the service provision are equally important. Moreover, it is wrong to perceive individual's health and wellbeing has nothing to do with the political system, religious and cultural practices, economic system and overall societal structure. In other words, an individual's health can be associated with the health of the overall system because individual variables are influenced by structural variables and a subset of culture is influenced by overall health culture(Banerji 1982)

In the study of strategies of resort to curers in two villages of South India (one is close to and another was far from the Bangalore city) (Beal 1976, 184) presents wide range of practitioners including unpaid local healers, saints, religious figures, priests, drug and herb authorities, midwives, astrologers, government doctors, missionary doctors, private doctors and foreign returned doctors in both of the villages. The decision-making strategy leading to resort to one or several of these curers depends upon

i. The general concept of the nature of the things and proper strategies of life;
ii. The kind of disease and afflictions that are present
iii. The folk interpretation of these disease and their causes, cures and curers
iv. The economic and social status of the patient and his family ; and
v. The kind of advice and information available at the time a particular strategy is adopted.

People close to city or urban are more likely to have a wide choice of practitioners and treatment options (Beal 1976, 191).

The initiation of strategy of resort begins when an individual exhibits symptoms of illness. And if a patient is a valued member of the family and if the possibility of some expenditure can be contemplated, advice concerning treatment is collected from relatives, friends and neighbors. For example, severe headache may often be handled in a dramatic fashion- buying aspirin over the counter, massage from a barber and taking some home remedies simultaneously to get relief from pain or visit a local healer for recitation of some mantras (incantation) (Beal 1976, 194). Beal refers to the complex, hierarchical and pluralistic nature of 'Indian Universe', and states that "single individuals embrace a variety of explanations for illness, and different individuals differ considerably in their explanation of the nature, cause and cure of an illness" (Beal 1976, 184).

Mark Nichter (1978) also conducted a study in South India on patterns of resort in the use of therapy. He selected an area for study, which was served by a variety of traditional, eclectic, and modern medical practitioners and focused on patterns of resort in the choice of medicine for a variety of illnesses. He observed that despite the popularity of biomedicine among the people, for many types of illnesses they first visit the indigenous practitioners. He showed a need to study of availability and accessibility of different types of medical practitioners, studies on resort patterns to assess the role of indigenous medical personnel" (Nichter 1978, 29).

In a study conducted among the Asian Indian migrants in the USA, Rao (2006) finds different choices for treatment of illness, which include folk remedies, Ayurveda, homeopathy and allopathic medicine. She finds that home remedies and 'Indian medical alternatives' were the first resort in case of minor ailments while allopathic medicine was the first choice for serious and chronic illnesses. She concludes that the decision to choose from among different alternatives for treatment of illness depends on people's beliefs about the severity of illness and the effectiveness of treatment options while the hierarchy of resort depends on the kind of illness. The hierarchy of resort to treatment followed the acculturative pattern (i.e. biomedicine is the first resort) for major or chronic illnesses and counter-acculturative pattern (i.e. biomedicine is the second or the last option) for minor illnesses (Rao 2006, 153).

Studying about the multiple therapeutic use in urban Nepal, Durking- Longley (1984, 867) found two basic patterns of resort: illness specific and multiple use. She observed the difference between general attitudes and preferences or actual therapeutic choices. She finds that the "general attitudes toward and preferences for available therapies tend to show illness-specific patterns, while observations of actual therapeutic choices during illness episodes more often portray multiple use." She presents the pervasiveness of multiple therapeutic use and the disparity between attitudes and preferences of individual patients and actual strategies of resort pattern (Durkin-Longley 1984).

Axel Kroeger (1983) reviews the literature on health-seeking behavior in developing countries and observes two major trends: (1) emphasis on service factors such as

accessibility, costs, acceptability and (2) emphasis on etiological concepts and world views (Kroeger 1983, 147). He reviews the factors associated with the use and non-use of health services in developing countries and presents a framework that shows the choice of healers in relation to various possible explanatory variables. These factors include (1) Predisposing factors (age and sex, household size, social network, ethnic group and religion, education, socio-economic status and occupation); (2) Disorder and perception (chronic or acute, severe or trivial, natural or supernatural, expected benefit and consumer satisfaction); (3) Enabling factors (geographical accessibility, acceptability, quality, cost and fees) (Kroeger 1983, 148–53).

4.3 Plurality in Treatment Seeking

The studies on the existence and use of different therapeutic sources in societies across the world supports pluralistic treatment seeking and multiple patterns of resort. Janzen's study in lower Zaire also shows the multiple resort patterns: the use of biomedical practitioners, indigenous healers (of herbalist and shaman), kinship therapy, and diviners (Janzen and Arkinstal 1978). Crandon-Malamud's study in Bolivia highlights five types of medical care utilized by the people depending upon diagnosis: Ayamara home care, shamanic care, mestizo folk home care, biomedical clinical care, hospital care. She shows how medical pluralism is related to three ethno-religious groups and as well as to hierarchical class structure (Crandon-Malamud 1991). The study in Guatemala by (Cosminsky and Scrimshaw 1980, 267) reveals a pluralistic complex of multiple and simultaneous usage including home remedies, curanderos, herbalists, midwives, spiritists, shamans, injectionists, pharmacists, private physicians, public and private clinics, and hospitals. These resources include and combine aspects from Mayan, Indian, folk Ladino, spiritism and cosmopolitan medical traditions. They observe that people take short course of treatment and small quantity of injections and (antibiotic) drugs because they cannot afford full course, sometime doctor also prescribe for short period and also because they expect quick results which also leads to multiple usage (Cosminsky and Scrimshaw 1980).

In the study of medical pluralism in Japan, Ohnuki-Tierney describes the three coexisting medical systems: biomedicine, Kanpo medicine (the medicine introduced

from China) and religious healing. These systems comprise a number of practitioners who follow different diagnostic and treatment methods and healing practices. She also gives an idea about the existence of traditional folk medicine, the shamanism and massage *(anma* and *shiatsu)* practices. The study focusses on "how people in a society with plural systems of medicine choose among the options available to them" (Ohnuki-Tierney 1984a, 5).

In the use of multiple therapy systems some anthropologists have attributed these patterns to the perceived etiology (e.g. natural and supernatural), an illness, its acute or chronic nature, or the age of the afflicted or sick person. A number of studies highlight the importance of perception of illness in treatment seeking. For instance, belief in the supernatural causation of illness can lead people to follow the different path of care. Sometimes belief in supernatural causes for illness outweigh other factors such as cost and geographic distance. There are many who strongly believe that official medicine cannot work at all for spiritual illnesses. Thus, there seems to be some evidence that people use both types of medicines, official and non-official, but depending on the illness, they have a preference for which to use. However, the illness causation is one of the factors. There are other factors such as information and awareness about illness, life conditions and opportunities, past experience about which works best for what kind of illness.

The difference between treatment preferences and actual behavior are also related to enabling factors such as geographical accessibility, ability to pay for treatment and competing time demands (Nichter and Quintero 1996, 945). "A common patterns of resort in the literature entails allopathy medicine being favored for acute illness but herbal medicine for chronic illness" (Nichter and Quintero 1996, 945).

Priya (2012) finds a well-established patterns of treatment choice among the laboring Dalits in Delhi. She states, "their choices are informed by their perceptions of the knowledge base and quality of the services of the various medical systems accessible to them" (Priya 2012, 113). In the resort pattern, "Generally, a habitual line of action for common illness was followed first; if that failed, a conscious choice had to be made. That is when 'experience' with various systems and 'belief' came into play most

explicitly and there was a movement from one form of treatment to another." In the study of treatment seeking behavior, Priya identifies four factors which influence treatment related behavior patterns: 1. Nature of illness, 2. Forms of treatment that were accessible and the degree of access; 3. Individual and collective experience of treatment; and 4. belief about different treatment systems and service providers (Priya 2012, 113). The nature of illness suggested the line of action based on the perceived role of four actors: 1. Nature's power of spontaneous healing, 2. Human action (herbal/animal products, massage, vaid/hakim's/ doctors' medicine 3. Mediation of the spirit world 4. The will of God or destiny (Priya 2012, 14–14).

Dewan's study also supports the fact of resorting multiple types of healers. Her study reveals that people generally take recourse to traditional shamanic healers like *bhopa* and shrines (with or without allopathy/herbal treatment) at some point or other during the course of chronic pain. Her study also shows that people keet shifting from one kind of healer to another and sometimes they use multiple healers simultaneously. She has pointed to a number of interrelated factors such as patients' past illness experience, their response to particular treatment, (physical, economic and social) access to the services, belief about therapy systems, health care providers, expertize of healers and healer's adherence to the ethics and morality which can influence the health seeking pattern.

5. Studies on Patterns of Resort

People seek services from different health care providers at different times for a number of reasons. The manner in which people and families care for illnesses is called "patterns of resort" (Skolnik 2011). (Ryan 1998, 211) writes "patterns of resort are what people do; they are the sequences of health actions that care takers perform. In a pluralistic environment, across multiple illnesses and caretakers, there can be many patterns of resort. Some sequences are minor variations of other sequences and researchers can combine them into general patterns. How much variation there is in a community's patterns of resort is an empirical question." Kroeger (1983) terms

multiple treatment-seeking as 'healer shopping', whereby people use multiple healers for one episode of illness, without referral from the first. People switch from one medical system to another and one kind of practitioners to another and one place to another which has been termed as doctor shopping or healer shopping. People may resort to similar categories of providers from a single system following a horizontal patterns of resort or they may follow vertical patterns of resort or hierarchical care such as from more generalist to specialists.

In the study of patterns of resort probably (Schwartz 1969) comes first who identified a "hierarchy of resort" in which many people utilize self-administered folk remedies or consult folk healers before visiting a biomedical clinic or hospital for their ailments. Conversely, while this sequence is the most prevalent one, more-acculturated often rely upon biomedicine initially or first after home remedies; if these two fail, they may finally resort to folk healers. Schwartz (1969: 205) presents two sequences:

i. **Acculturative sequences**: from medical doctor to priest to local exorcist

ii. **Counter-acculturative sequences:** from local exorcist to priest to medical doctor and back to priest and local exorcist, if the condition is terminal

According to Sobo, "While the concept, as first used, related patterns of resort to acculturation issues, the phrase is often used today to mean that people try the most familiar or simplest and cheapest treatments first and seek more expensive, complex, or unfamiliar treatments later, if necessary" (Sobo 2004, 6). Here it is important to note "the treatment choice can follow a hierarchical sequence, but patterns of resort often involve many treatment modalities at once. Although for some conditions only one treatment modality will be necessary, this is not always the case. There exists a "hierarchy of resort" in which people first try one thing and then another until their condition is fixed to their satisfaction" (Sobo 2004, 6).

Where do people resort to care and under what conditions? This is the questions researchers are still struggling to answer. There are no such established patterns as the subject is complex and changing with time and context and geography and culture. In our context, generally people manage illnesses at home (which involves special diet, herbal medicine, and self- medication and home remedies) without resorting to folk sectors (which involves wide varieties of healers and healing practices). For those who move outside the home, folk sectors is the most popular first resort. On the use of home remedies, traditional medicine and biomedicine as Banerji writes, "Usually traditional healing practices and home remedies are adopted: (i) side by side with western medicine; (ii) after western medicine fail to give benefit; (iii) when western medical services are not available or accessible to them due to various reasons; and, (iv) most frequently, when the illness is of minor nature" (Banerji 1989, 1477).

A study conducted by Sato's (2012a, p. 1450) in Ghana shows that "rising income is associated with modern care use whilst decreasing income is associated with traditional care use. Raising income have a positive effect on choice of modern care as a first provider, whilst choosing it second, third or never is associated with decreasing income." The effects of income on utilization patterns of traditional care are stronger: as income rises, utilization of traditional care as a first choice decreases. The study has shown that it is predominantly the poor who use traditional care. Sato (2012) looks into a number of recourses people take for one episode of illness and finds that at first recourse, use of traditional medicines is fairly low, but once second recourses are accounted for there is a doubling and tripling of incidence of traditional medicine use for both acute and chronic diseases, respectively (Sato 2012b, 1)

Observing the people's differential preference and practice of medicines Priya (2012) distinguishes three different mindsets:

i. ***The moral rationalists:*** Those who relatively belief in nature's spontaneous healing powers, and are more critical about the supernatural causation and who prefer naturalistic remedies.

ii. ***The go-getters:*** Those who relatively believe more on human naturalistic intervention, and are critical but use supernatural forms more than the moral rationalists and also advocate the use of biomedicine.

iii. ***The fatalists***: Those who believe more on supernatural forces, and depend more on faith healers and are most uncritical of the doctor's practice.

Nevertheless, no one group resorts to only one form of healing (Priya 2012, 14–14).

Kleinman (1980, 187–89) identified three major patterns of resort:

i. **Simultaneous resort pattern,** in which people combine two or more systems at any stage of illness, especially when illness persists.

ii. **Hierarchical, exclusive type pattern,** in which people follow one system after another but do not combine two systems (for ex. Self-treatment → social network → western style or Chinese style doctor → resort to folk practitioners→ resort to any of the above).

iii. **Hierarchical, mixed type pattern,** in which people resort to another system but often continue or mix the previous one or more systems.

In almost all episodes initial recourse was self-medication and then family members, neighbors, local lay experts, pharmacists or professional or folk practitioners. The decisions regarding whom to consult are based on illness beliefs, course and type of sickness, past family experiences with health care, and other factors such as local health care ideologies.

The above studies shed light on the coexistence of varieties of health care systems and health care practitioners. These studies point to a number of factors that affect the pattern of resort. These studies also point to the role of illness etiology and perceptions in the utilization of health care services. However, these studies are not sufficient to shed light on pattern of resort among the different section of people. How the medical pluralism is practiced and how the patients of various illness conditions resort to the therapeutic resources (home, healers, health post and hospitals) still needs to be explored. The study tries to contribute in this field of treatment seeking sequence. In short, the study attempts to look into the perception of health, illness and disease and enhance our understanding in the way medical pluralism is practiced locally and among the selected socio-cultural, caste/ethnic groups.

6. An Outline of Medical Pluralism in Nepal

A number of studies have been conducted among the different caste/ethnic groups of different ecological regions. These studies overwhelmingly assert that medical pluralism has been in practice among the people since long. Before the arrival and expansion of biomedicine traditional medicine such as Ayurveda and folk medicine were the main forms of medicine practiced in the nooks and corner of the country.

We know very little about the medical history of Nepal. However, the scholars prefer to begin with an incident of Ramayana where by Hanuman (monkey god) was called to fetch *sanjeevani buti* (a kind of life saving medicinal herb) from the Himalaya to treat the wounded Laksman (younger brother of Ram) in the war between Ram and Ravan of the Hindu mythology (Dixit 2005; R. P. Shankar, Paudel, and Giri 2006). They also connect Ayurvedic tradition as ancient tradition of Nepal, a country of Indian sub-continent which is also known as "land of Gods" *(devobhumi)*, "land of meditation" *(tapobhumi),* along with its richness on medicinal herbs found in the hills and himalayas (B. Subedi 2016). The ancient sages and authors, such as Veda Vyasa (around 1500 BC), had written the Hindu religious texts such as Mahabharata, Puranas and Vedas in the land of Nepal. Dixit (2005) reminds us of the teaching of Lord Buddha (567-477 BC), who was born in Nepal, such as "to born is to suffer, to fall ill is to suffer and to die is to suffer" and his guidelines on healthy living. Indian Emperor Ashoka (304-232 BCE), who later converted into Buddhism, is also acknowledged for his contribution to health and healthy living during his visit to Nepal.

We know very little about the actual begging of public health care services as many areas of the Nepalese history are missing (Marasini 2003, 306). In the history of Nepal, Lichhivi Period (400-879 AD), Amshu Varma is described as a great king of Lichhivi dynasty who had established an *Arogyashala,* the Ayurveda hospital. In the mediaeval period (879- 1750) Pratap Malla (1641-1674), one of the King of Malla dynasty, who established Ayurvedic dispensary in Kathmandu and gave permission to establish Christian mission offices and medical clinics in Kathmandu valley. During Rana Rule (1846-1951), Prime Minister Jang Bahadur Rana's long trip to Britain and other European countries in 1850 is described as an unprecedented event in the history of

Nepal. This trip was impressive in changing an attitude toward modern medicine as he had brought some of the modern medical drugs and equipment. However, nothing much has been done for public and it was only in 1889 government established a hospital with 30 beds (known as Bir Hospital) in Kathmandu to provide health services to common people. During those days there used to be official *baidyas* attached to Rana and Shah royal palaces and military outfit. When Jang Bahadur Rana went to England, his *baidya* accompanied him to look after his health as well as the health of his entourage. In 1928, the Rajkiya Ayurveda Vidyalaya (Royal Ayurveda Institute) was started in Nardevi, Kathmandu to train *vaidyas*, the ayurvedic physicians (N. R. Shrestha and Bhattarai 2003, 155). During the Rana period Homeopathy was introduced in 1920s.

Systematic introduction of modern medicine to the Nepali masses began only after the end of Rana rule. Professional association of Nepali medical doctors, Nepal Medical Association, was formed in 1950 (N. R. Shrestha and Bhattarai 2003, 234). Before the first five year plan period (1956- 1961), there were only 33 hospitals (with 649 beds), 72 dispensary, 43 Ayurveda dispensary, 15 other health institutions across the country and of them only 23 hospitals and 16 dispensaries were located out of the Kathmandu valley (NPC 1956). As we will see in the following paragraphs the number of biomedical institutions increased tremendously following the advent of democracy in 1951 with state's emphasis on development, modernization and expansion of modern health care services. Consequently, the Ayurvedic system almost went into a coma, experiencing a period of sustained decline. Already confined to urban areas with a limited reach, the penetration of biomedicine based health care services further dampened its desirability (N. R. Shrestha and Bhattarai 2003, 155–56).

The situation of health care system changed since the democratic revolution in 1990, which had established multiparty democracy with constitutional monarchy. The 1990s was a starting period of privatization, commercialization and liberalization. Since 1990s an increased number of private hospitals, nursing homes, specialty centers, medical colleges and medical dispensaries came into existence. For instance, before 1991 there were only two private hospitals but the number of public and private hospitals grew: from 78 and 69 respectively in 1995 to 97 and 350 in 2014" (Sengupta 2011, 2).

Similarly, before 1990 there were no private medical colleges but by now 18 out of 23 medical colleges are in private sector (ibid, 2011). The traditional medicine could not get much attention from both public and private sectors. Folk systems did not get an attention but remained as traditional source among the people. The above description shows that biomedicine has a short history in Nepal in comparison to Ayurveda and other indigenous or folk medical systems. However, "almost exclusive emphasis of the government on biomedicine alienated other systems of medicine (NESAC 1998).

There is no such mention of various types folk systems and folk healers in these documents, however, their historical existence can be ascertained from Charaka Samhita, an early text of Ayurveda, which mentions the importance of learning/knowing from nomads, goat/shepherds, cowherds, hunters, and forest dwellers about the properties and usage of medicinal herbs (Priya and Shweta 2010, 169–70). In terms of mass access till now folk system is much more accessible to the masses than other systems. The co-existence of these folk systems, early Ayurvedic traditions, and now, scholarly Ayurveda and other codified systems and biomedicine has been well recognized. The study of medical pluralism across the geographical regions (from the plain Tarai to the mount Everest region) and among the various ethnic communities has been described by researchers (Shafey 1997; Callaghan 2006; Parker 1988; M. S. Subedi 2003); (Durkin-Longley 1984; J. Subedi 1992). Now, medical pluralism is a well-recognized and state legitimized phenomenon in Nepal. The following heading presents the current status of Nepal's health care system.

7. Health Care/Medical System in Nepal

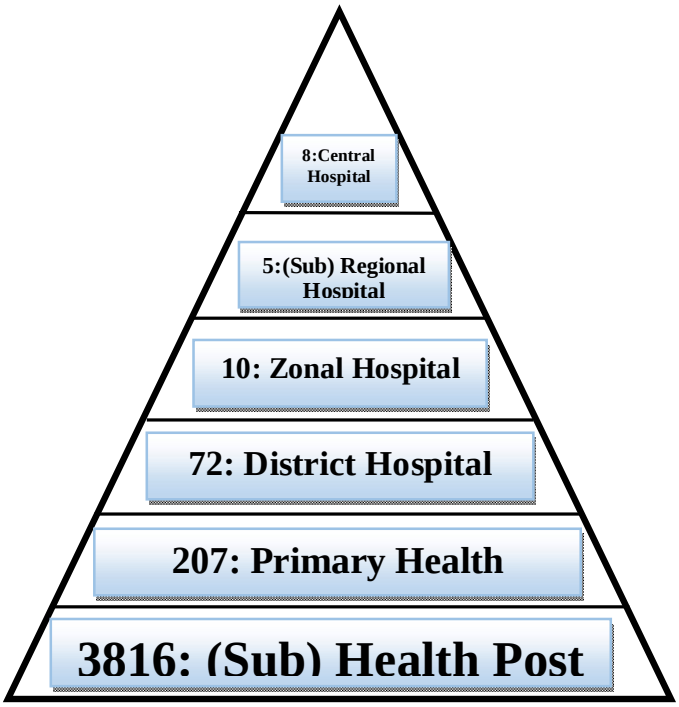
Nepal is a host to a wide array of medical systems some of which are more indigenous to the region and have longer history of practices. A variety of professional practitioners of biomedicine and professionalized indigenous medicines, folk healers

and family members at home are serving the people. Multiple health and medical systems coexist simultaneously, and sometimes uneasily, in the country (NESAC 1998, 60). Such systems, for the present purpose, can be divided into four broad categories: the home-based system, the traditional faith healing based system, the Ayurvedic, homeopathic and Unani systems, and the modern allopathic system (NESAC 1998, 60). Following the classification of Kleinman (1980), the health care system of Nepal can be described as follows:

7.1 Popular Sector

Popular sector where the greatest amount of health maintenance and restoration of health takes place. It includes self- healing and self-care, self- treatment, self-medication, healing by family members, friends, neighbors and communities. In this sector illness is first recognized and reported and experienced person, family members or mothers and grandmothers diagnose and treat with the available resources at home. Most of the healing activities take place at home without the consultation of healers or medical practitioners. The family members also learn the skills usually from their elders as a process of enculturation.

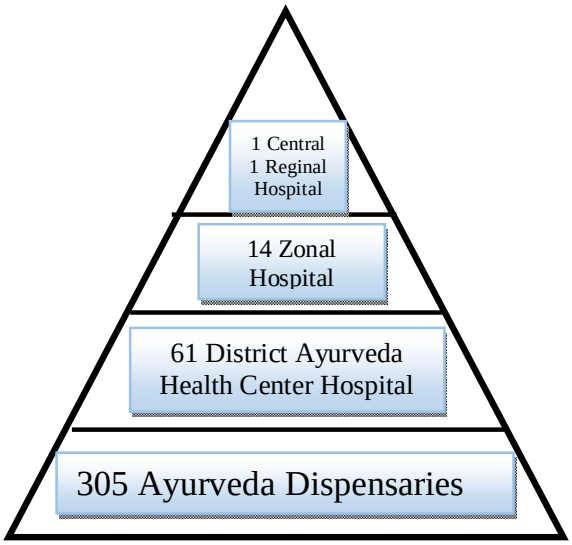
7.2 Professional Sector



Biomedicine or cosmopolitan medicine is a dominative medical system and has got the preeminent status in the national health care system. Government policies and programs are also promoting biomedicine. Though, biomedicine is still less accessible both geographically and economically in rural areas compared with the local folks systems. So in terms of wider accessibility biomedicine comes second to the folk systems. However, it has a dominant presence in the urban areas.

Currently there are eight central level hospitals, three regional hospitals, two sub-regional hospital, 10 zonal hospitals, 72 district hospitals, primary health care center/health center 207, 1689 health posts and 2127 sub-health posts in the country (DoHS 2014, 4). These government hospitals (central, regional, sub-regional, zonal, district hospital), primary health center, health posts, and sub health posts provide the health care services. There are parallel hospitals (specialty center), medical colleges, nursing homes, clinics, dispensaries and individually owned pharmacy in private sector.

Professional traditional medicine comprises organized, codified and integrated systems such as Ayurveda, Unani, Homeopathy, Naturopathy and Tibetan System of Medicine[5]. These are the systems in use not across the country but in some selected regions. Among these professionalized systems, Ayurveda has the leading status. The practitioners of these systems are trained in academic institutions of Nepal and India.



Ayurveda is the earliest known system in Nepal. It is also a national system of medicine. The formal Ayurveda education started in 1929 from Rajkiya Ayurveda Vidyala; prior to this there used to be *guru-shisya* (teacher-disciple) tradition of learning. The traditional practitioners used to be known as *vaidya* and are still known by same till now. The department of Ayurveda

[5] Some of the writers have mentioned the official acknowledgement of allopathy, Ayurveda, Homeopathy, Unani and Tibetan systems (Maskarinek 1995; Gewali 2008). The three year plan approach paper (2010/11- 2012/13) states in its working policy to "recognize the interrelationship between Ayurvedic and alternative medical systems which includes, natural treatment, Yoga, Homeopathy, Unani, Amchi and Acupuncture to ensure service in an integrated approach"(NPC 2010, 131).

was established in 1981. The formal Ayurveda BAMS (Bachelor of Ayurveda, Medicine and Surgery) course started in Tribhuwan University from 1987. The first Ayurvedic hospital was established in 1973, which is now known as Nardevi Ayurveda Hospital. The hospital has total 100 beds with daily OPD, indoor facility, Panchakarma, Acupuncture, Laboratory facilities etc. There is a regional Ayurveda hospital (in Dang with 30 bedded), 14 zonal ayurvedic dispensaries, 61 district Ayurveda health center and 214 Ayurveda dispensaries (MoHP 2012, 35). According to the website of Department of Ayurveda there are 305 dispensaries. Ayurvedic health centers and dispensaries are considered to be part of the basic health services.

The department of Ayurveda was established under the ministry of Health in 1982 which is responsible for development of Ayurveda and alternative medical systems (MoHP 2012). Simha Darbar Baidya Khana, a government owned manufacturing unit for Ayurveda medicine, produces most of the medicines. However, Nepal also imports Ayurvedic products from India. There are currently 402 Ayurveda doctors, 612 AHA (Ayurveda Health Assistants) and 1123 AAHW (Ayurvedic Assistant Health Worker) registered under Nepal Ayurveda Medical Council, which was established in 1989. There are around half a dozen Ayurveda colleges, which offer course on BAMS (Bachelor of Ayurveda, Medicine and Surgery), AHA, and AAHW. Ayurveda has an important place in Nepal's health care system. About the importance and use of Ayurveda WHO writes, "The use of medicinal herbs in Nepal's traditional medical system dates back to at least 500 AD. In Nepal, traditional medicine, although low profile, has been an integral part of the national health system. More than 75 percent of the population use traditional medicine mainly based on the Ayurvedic system" (WHO 2001, 137).

Unani has been included in the national health care system and holds a history of more than half a century. However, it's in a poor state in terms of public provision of its services. There is only one government Unani dispensary in Kathmandu valley and a few private clinics/dispensary inside and outside the valley. There are no training institutes or colleges of Unani system and those practitioners who have been practicing

in Nepal are trained in India. Nepal also imports Unani medicine from India. People resort to Unani practitioners (known as Hakim) for various types of illness conditions (Bechan Raut and Khanal 2011).

Homeopathy is one of the most popular forms of medicine in Nepal. The system has been recognized as a component of national health care system by the Government of Nepal. Introduced as early as in 1920, homeopathy in Nepal is largely a private sector initiative which encompasses approximately 500 practitioners and 100 clinics (NESAC 1998, 61). The number has increased now, as there are several private homeopathic clinics and dispensaries across the country. However, at government level, there is only one hospital named Sri Pashupati Homeopathic Hospital. Established in 1997, the hospital provides OPD and IPD services to the patients. The hospital provides its services to 200-250 patients daily and the number of patients has increased in subsequent years (Bechan Raut and Khanal 2011, 878). Currently 25 beds are allocated for indoor patients to admit for treatment along with meal free of cost (DoHS 2014, 242). A Homeopathic college named Nepal Homeopathy Medical College (established in 2002 in Biratnagar) was the first institute in the country to formally teach homeopathy medicine which offers Bachelor of Homeopathic Medicine and Surgery (BHMS)(Gewali 2008, 9).

Yoga and Naturopathy are not official system of medicine, but are well-practiced by the people. Training in yoga and naturopathy is provided by the private sector. There are private hospitals, training centers, clinics, and dispensaries in the country (Bechan Raut and Khanal 2011). Yoga activities are on the rise because of growing interest among the people towards yoga. Private institutions such as Patanjali (Baba Ramdev's) branches, Aarogya clinic and health and fitness movement have been playing as push factors. Yoga and Naturopathy is now being delivered by the private sector and government plan is to regulate it by establishing a mechanism (NPC 2007, 292) .

Tibetan system, also known as *Sowa Rigpa* (knowledge of healing), is also practiced in some selected areas of the country. The *Sowa Rigpa* practitioners are known as *Amachi* traditionally. The system is closer to Tibetan herbal tradition, which resembles the Indian Ayurvedic medical system in some respects and Chinese medical

traditions in others. This type of healing practice is existing in the upper Himalayan region of the country. This is not an official system of medicine. Himalayan Amchi Association established in 1998 in Kathmandu works for the recognition and support of the Tibetan medicines. There are two types of practitioners in this system. Some of them are institutionally trained and others follow the tradition. Lo Kunphen School situated in Lomonthang, Mustang provides academic and clinical education (1 year course) on the Traditional Tibetan Medicines (Bechan Raut and Khanal 2011, 878). Recently (in 2016) a Sowa Rigpa college has been established in Kathmandu.

Recently a new National Health Policy 2014 has been brought out which has adopted its policy "to develop Ayurvedic and other complementary systems of medicines, to manage and utilize the medicinal herbs available in the country and to formulate and implement the long term plan for the protection, development and expansion of the Homeopathy, Unani, and other complementary medical systems" (MoHP 2014b, 10)

The Thirteenth Plan's (2013/14- 2015/16) one of the stated working policy is to make services accessible to all by integrated development and expansion of Ayurveda, natural medicine, yoga and meditation, homeopathy, Unani, acupuncture and Amchi services. And it has aimed to expand the preventive and promotive health program to the community and schools and to communicate health message, and to bring effectiveness in the health services cooperation with public private non-government, community, youth, *dhami/jhankri*, pundit and civil society (National Planning Commission 2014:144–145).

7.3 Folk Sector

Between popular and professional sectors there exists a folk sector. Folk sector consists of a wide variety of non-professional healing specialists. These healers are not part of the official medical systems, and occupy an intermediate position between the popular and professional sectors (Helman 2001, 84). The main folk healers include various types of shamans, herbalists, lay midwives, massagers, poison healers, bone setters, tooth extractor, astrologers, spiritual and religious faith healers and other informal practitioners. These healers are not trained in academic institutions or have not received

formal training and education. They learn the healing knowledge skills from their elder members through oral tradition and by practicing. The local healers use both material and non-material components. The material components comprise plants, animals and mineral resources for medicine. The non-material components comprise healing mantras, incantation and rituals of magico-religious and spiritual healing (B. Subedi 2013). The folk sectors contribute greatly to meet wide range of health care needs of the people.

The folk systems mainly consist of three components:

1. **Shamanism,** which includes shamanic, magico-religious, spiritual or faith healing practices. Healers are known by various names (such as *Dhami Jhankris, Jhar Phuke, pundit, Jyotish* in Nepal) and most of them recite mantras. (Gewali 2008) classifies shamanic healers into four categories:
    a. Shamans (*dhami-jhankri*s)
    b. Sweeper and blower of spirit (*Jhar-Phuke*) who recite mantra but do not go into trance
    c. Priests (*pandits, lama, gubhaju, pujaris*)
    d. Austrologers (*jyotishi*s, *yogi-baba*)
2. **Herbalism,** which includes herbal practices. Herbalists prepare medicine from variety of herbs, plants, animal and mineral resources. Various types of healers such as traditional vaidyas, hakims, bone setters, snake-bite healers etc. practice herbalism.
3. **Midwifery and massage,** which includes the practices of assisting birth, massage and activities related to body manipulation, physiotherapy etc.

Researchers are interested in the persistence and pervasiveness of the folk sectors, even after the introduction and expansion of biomedical services. One study estimates 400000 to 800000 various categories of local healers (NESAC 1998, 60). The majority of the population living in rural areas was served and is still being served by local folk healer. (J. Subedi 1989, 413) refers to a study report, which shows that more than 75 percent of all illnesses/ diseases in Nepal are treated by the traditional health care system.

Majority of the people in rural areas have recourse to these healers first and public hospital last. The existence and omnipresence of folk healers in Nepal has been well recognized. “There is hardly a community where one cannot find a *dhami* or *jhankri*. For the vast number of people in Nepal, use of locally available herbs and a shaman is the first line of health treatment. Despite the onslaught of modern medicines, this age-old home-based medical practice remains highly popular in Nepal's local as well as national health system. In the nation's countless remote areas, it is the only system available” (N. R. Shrestha and Bhattarai 2003, 155). The MoHP annual report (MoHP 2012, 1) also begins with an affirmation of the *major* role played by the traditional indigenous healers *(Dhami/Jhankris and Baidyas)* in the health care sector of Nepal. People prefer folk or indigenous medical system because they are culturally acceptable, physically accessible and economically affordable and also because, the system "closely corresponds to the patient’s ideology, and is less paternalistic than allopathic medicine" (WHO 2001, 3).

The folk healers provide their services voluntarily. People know their healers and there exists a relationship between the healer and the patients that is long lasting and durable in comparison to other medical practitioners. People trust them because they share the same culture and the same sentiments. Thus the cultural similarity between healers and patients leaves no room for "cross cultural misunderstanding" (Winkelman 2009, 2). Winkelman (2009:184) writes, "involvement of family system, closeness and informality of healing relationship, the status of the healer in the community and shared worldview and value system are the advantages of this system.” The folk medicines are used simultaneously with or used as an alternative of other medicines. They are also largely continued when taking allopathic medicine (Priya and Shweta 2010 xxiii). People may, for instance, practice massage, as complementary or alternative, depending on whether they use it in combination with or apart from biomedical practice.

8. Determinants of Practiced Medical Plualism

The existence of multiple systems, multiple providers/practitioners, and multiple illnesses signal to the multiple use and plural patterns of resort. Here, some of the questions arise: How pluralism is practiced in a real ground? How do different sections

of people make choices to resort to particular practitioners? What are the factors, which influence the resort patterns? Does socio-economic factors really affect the practices of pluralism? What makes people use more systems and more practitioners even for a single illness episode? Who among the people move back and forth or move from one place to another and another? What is the role of caste/ethnicity in the patterns of resort? Does caste/ethnicity comes first as a determinant (in comparison with other factors such as poverty, availability, accessibility, perceptions etc.)? Though, these questions have not been answered specifically, this section reviews some studies conducted on the caste/ethnicity (or socio-economic group) and their access to health and treatment seeking behavior. Before that, a brief introduction of caste/ethnic composition of Nepal is in order.

8.1 Caste and Ethnicity in Nepal

Nepal is a country of diversity, both geographically and culturally. Nepal is composed of three physiographic regions: Tarai region, Hill region and Mountain region. To the south, lies the Tarai region which comprises plain areas and to the north, lies the Mountain region which houses some of the highest peaks of the world including the Mount Everest. And in between the Tarai and Mountain there lies Hill region, which comprises mostly hilly areas and some of the beautiful valleys. From the northern Mountains to the southern plains of the Tarai, Nepal is a home of around 26.5 million people with 125 caste and ethnic identity, speaking of 123 languages as mother tongues and following 10 types of religions (CBS 2012). As has been characterized in The Constitution of Nepal, 2015, Nepal is a multi-ethnic, multi-lingual, multi-religious and multi-cultural country and this multiplicity is imbedded in the multiplicity of medical traditions.

According the 2011 census, Chhetri is the largest caste/ethnic groups having 16.6 percent of the total population followed by Brahmin-Hill 12.2 percent, Magar 7.1 percent, Tharu 6.6 percent, Tamang 5.8 percent, Newar 5.0 percent, Kami 4.8 percent, Muslim 4.4 percent, Yadav 4.0 percent, Rai 2.3 percent, Gurung 2.0, Damai 1.8 percent. There are 123 languages spoken as mother tongue reported in census 2011. Nepali is spoken as mother tongue by 44.6 percent of the total population followed by Maithili 11.7 percent, Bhojpuri 6.0 percent, Tharu 5.8 percent, Tamang 5.1 percent,

Newar 3.2 percent, Bajjika 3.0 percent, Magar 3.0 percent, Doteli 3.0 percent, and Urdu 2.6 percent. There are ten types of religion categories reported in the census. Hinduism is followed by 81.3 percent of the population while Buddhism 9.0 percent, Islam 4.4 percent, Kirat 3.1 percent, Christianity 1.4 percent, Prakriti 0.5 percent, Bon, Jainism, Bahai and Sikhism (CBS 2012, 4). According to 2011 census, Brahmin & Chhetri constitute 28.8 percent, indigenous nationalities (comprised of 59 ethnic groups) of Nepal constitute 35.5 percent and ***Dalit*** (comprised of 21 castes) constitute 12.8 percent of the total population (i.e. 26,494,504) of Nepal (CBS 2014a, 1–3).

Muluki Ain, a national legal code proclaimed in 1854, had classified people into following categories:

1. *Tagadhari* (those castes who wear sacred thread) for eg. Brahmin, Chhetri
2. *Matawali* (those castes who consume alcohol), for eg. indigenous people
    a. non-enslavable
    b. enslavable
3. *Pani Nachalne* (Water unacceptable)
    a. *Sudra* (Impure but touchable castes)
    b. *Achhut* (Impure and untouchable castes) for eg. Kami and Damai (Bhattachan, Sunar, and Bhattachan 2003; M. Subedi 2010)

The following table by (Bennett, Dahal, and Govindaswamy 2008, 2) provides a concise information about the caste division in Nepal with geographical and religions features.

Table 2.1 Nepal Social Hierarchy, 1854

Hierarchy	Habitat	Belief/religion
A) WATER ACCEPTABLE (PURE)		
1. Wearers of the sacred thread/tagadhari		
"Upper caste" Brahmans and Chhetris (Parbatiya)	Hills	Hinduism
"Upper caste" (Madhesi)	Tarai	Hinduism
"Upper caste" (Newar)	Kathmandu Valley	Hinduism
2. Matwali Alcohol drinkers (non-enslavable)		
Gurung, Magar, Sunuwar, Thakali, Rai, Limbu	Hills	Tribal/Shamanism
Newar	Kathmandu Valley	Buddhism
3. Matawali Alcohol drinkers (enslavable)		
Bhote (including Tamang)	Mountain/Hills	Buddhism
Chepang, Gharti, Hayu	Hills	
Kumal, Tharu	Inner Tarai	Animism
B) WATER UN-ACCEPTABLE/Pani Nachalne (IMPURE)		
4. Touchable		
Dhobi, Kasai, Kusale, Kulu	Kathmandu Valley	Hinduism
Musalman	Tarai	Islam
Mlechha (foreigner)	Europe	Christianity, etc.
5. Untouchable (achut)		
Badi, Damai, Gaine, Kadara, Kami, Sarki (Parbatiya)	Hill	Hinduism
Chyame, Pode (Newar)	Kathmandu Valley	Hinduism

The following major six caste/ethnic groups, which constitute 49 percent of the total population of Nepal, 87.3 percent of the total population of Dang, 94.5 percent of the total population of Amuk Village Development Committee (pseudonym) and 100 percent of the study Anjaan Gaun (a pseudonym for study village) can be grouped into three major categories: *tagadhari,* (Khas Arya[6]), *matawali* (Janajati) *and pani nachalne* (Dalits) as follows:

Brahmin and Chhetri, classified under the *tagadhari* (sacred thread wearing groups) are at the top of caste hierarchy, of Indo-Aryan origin are found all over Nepal. Brahmins, called Bahun locally, occupy the highest status in the caste hierarchy. In the caste ladder, the position of Chhetri comes after Brahmin. The traditional role for Brahmin was priestly work and teaching-learning activities and for Chhetri it was the job of warriors and administrators. The Chhetris constitute the highest percentage of the Nepalese population[7]. Brahmin/Chhetri, along with the Thakuri and Sannyasi (Dashnami) fall into the *Khas Arya* group.

[6] Constitutionally, "*Khas Arya*" means *Kshetri*, *Brahmin*, *Thakuri*, *Sanyasi* (*Dashnami*) community.

[7] According to 2011 census, Chhetri constitute 16.56 percent, Brahmin (Hill and Tarai) 12.68 percent, Magar 7.12 percent, Tharu 5.81 percent, Kami 4.75 percent and Damai 1.78 percent of the total population of Nepal.

Magar and Tharu, classified under *matawali* (liquor drinking) groups, are the indigenous nationalities (respectively known as *Adibasi Janajati*) of Nepal. All the ethnic communities fall into Janajati group. Tharus are found throughout the Tarai region of Nepal and Magars are mostly found in the hilly region. According to the civil code, Tharus were classified as enslavable and Magars as non-enslavable castes. NEFIN has classified all the 59 indigenous nationalities into five groups: Advanced, Disadvantaged, Marginalized, Highly Marginalized and Endangered groups and Magar fall into Disadvantaged group while Tharu fall into marginalized group. According to the 2011 census, the population of Magar is 7.1 and of Tharu 5.8 percent.

Kami and Damai, classified under the *pani nachalne* (water unacceptable group), ranked as low caste Hindus, fall at the bottom of the caste hierarch. They are also found throughout Nepal with various surnames. They are also recognized as occupational castes. The Kami are blacksmiths/ goldsmiths and Damai are tailors and musicians. The traditional occupation of Kami is metal working and they usually serve other castes to make or repair agricultural equipment. The traditional occupation of Damai is tailoring and they also work as entertainers, playing musical instruments (such as the drum and flute) and dancing and singing at weddings and festivals (Cox 1994). Both of the castes are provided with certain amount of food grains in exchange for their work. Both of the castes still suffer from caste-based discrimination and untouchability. According to 2011 census, Kami and Damai constitute about half of the Dalit population.

National Dalit Commission (NDC) defines Dalit as “those communities who, by virtue of atrocities of caste based discrimination and untouchability, are most backward in social, economic, educational, political and religious fields, and are deprived of human dignity and social justice” (Bhattachan, Sunar, and Bhattachan 2003, 3).

Dalit are also known as lower caste under the hierarchical ladder of Hindu caste system and they are the ones most discriminated in both the public and the private sector. They are the ones who experience social hindrances toward health care access. Caste is recognized as an important determinant of health (Acharya 2010, 108) (Acharya 2010b, 208).

There is an Unanimous agreement that the term 'Dalit' must be used as long as caste based discrimination including untouchability continues to exist in Nepal" (Bhattachan, Sunar, and Bhattachan 2003, 3). 'Dalit' has become a preferred term even among the so called 'untouchable'. As has been put by Bharati "Dalit is not a caste, it is a constructed identity. But at the macro level analysis, when one is studying caste phenomena and the scheduled castes in general, then Dalits is an appropriate term (Bharati 2000, 4339). I would prefer to use Dalit instead of specific castes such as Kami & Damai simply because the term has become an appropriate term and also a common/unifying term for both castes. And it is similar when I use Janajati instead of Magar and Tharu and Khas Arya or Brahmin/Chhetris instead of particular clan names falling under this category as these are the unifying terms. However, I will use the name of particular caste whenever caste specific description is required.

Table 2: Socio-economic Indicators by Ethnicity

SN	Indicators	Brahmin/Chhetri	Janajati (Excluding Newar)	Dalit
1	Per capita income (PPP $)	1115	844	755
2	Life expectancy	73.99	69.86	67.19
3	Adult literacy	76.32	66.93	52.27

Source: Nepal Living Standards Survey 2011 (NPC 2014, 97).

8.2 Access to Health Care Services by Ethnicity

Our society is a hierarchical society whereby socio-economic resources are not distributed justly and the groups at the bottom of the hierarchy are deprived of the resources. This division also signifies that the health care services are neither equally available in all areas nor accessible to all socio-economic groups. Leslie (Leslie 1980, 191) writes, "access to medical care differs among rural and urban populations and members of different social strata and ethnic groups." The access varies even in the most advanced industrial nations of the world. Qadeer (2011:68) explains the inequalities of resource distribution, of access to services, of participation in decision making and of health status in the context of India which holds true in many countries across the world.

Caste/ethnicity has been recognized as one of the most important factors which impacts in access to health care services. Poverty is also recognized as one of the most important determinants of access to health care services. This may be what led Acharya (2010, 1) (Acharya 2010a, 1) write "most poor are Dalits as well as most Dalits are poor." The poor health outcome of Dalits and ethnic communities affirms the fact that these are the groups hit most by illness and diseases. Studies conducted in various region of Indian subcontinent provide astonishing data about the gravity of discrimination and exploitation of these groups (Pyakurel 2011). It is the poor and Dalits who spend more (percentage of their income) than others groups for (the treatment of both acute and chronic) illnesses and fall into a debt trap (Sujatha 2014). The Dalit women and children suffer the most from the caste-based discrimination in the health care access (Acharya 2010a).

People with poor economic conditions have poor access to the health care services. Now a known fact is that the "incidence of poverty is higher among the excluded groups of people such as Dalit, Muslim and Janajati in Nepal and schedule castes and schedule tribes in India, and ethnic minorities in the United States"(Chitra Bahadur Budhathoki 2011, 42). Good sign is that the caste relations are changing and ethnic groups and Dalits are "raising their voices for an appropriate share of positions and power in society" which, according to (Pandey 2005) is resulted in " breaking down the concentration of power through allowing the expansion of the circle of elite in society." It is evident that all Dalits are not equal, neither the Janajati nor the Brahmin/Chhetris. So, the access and use of therapeutic services can vary between and within the caste/ethnic groups. The ethnic (or Janajati) communities, though some of them are relatively in better position even compared to Chhetri, the so called upper caste, as has been noted by Hachhethu (2003), are also deprived of resources.

There is no denial that the rural communities, especially of poor and Dalit, do not have great choices in medicine. They have limited option in treatment seeking on the use of medicine. Prasad asserts that "the supposedly pluralistic medical tradition of India loses part of its plurality when one is interested to understand and explain the therapeutic itineraries of the poor. While pluralism is glorified on one corner, it is highly restricted on the other" (Prasad 2007a, 1313).

It is important in understanding the factors which influence their resort pattern. Why some group of people such as poor, Dalit and Janajatis do not utilize official medicine much? Some of the researchers appear more concerned about the resistance or non-utilization and non-compliance of biomedicine. They find problems on the people's belief and perceptions, pervasive illiteracy and ignorance. Reddy (2008, 68) asserts that "the fact behind not utilizing and noncompliance by people is not because of individual problem, ignorance or the resistance of modern medicine but because of social hierarchy and power differentials between the so-called modern doctors and indigenous population." Therefore, the reasons for non-utilization of health care services by the poorest and Dalits can be attributed to the hierarchical social structure, which has roots of discriminations, including caste based discrimination.

8.3 Treatment Seeking by Caste and Ethnicity

Studies have shown that health seeking behavior is also influenced by the people's ethnicity Budhathoki & BC list people's caste/ethnicity along with their socio-economic conditions, cultural practices, and perceived quality of the health facility (Budhathoki and BC 2008, 91). Tamang and Broom (2010, 328) also observe that caste and class background along with experience of patients as determinants of the choice of sources of treatment. According to them "the difference between castes and ethnic groups is due to their different social and cultural background." This is indicative that the choice of treatment sources is influenced by multiple factors including caste/ethnicity.

Kakar also found that the higher caste respondents were more inclined to attribute illnesses to natural causes than their lower caste counterparts. Older respondent had a stronger belief in supernatural causation. Literate respondents recognized natural causes more than their illiterate counterparts. Those respondents who were economically better-off such as those engaged in business and employed also showed a greater tendency to recognize natural causes than those who were less well-off, especially those who were in farming and agriculture labor" (Kakar 2013, 308). This shows the

differences in perception and the the role of socio-economic factor such as education and occupation in shaping the perception.

The review by (Kroeger 1983, 148–53) also shows the different pattern in the use of care in different groups, for example, most frequently elderly and children predominantly consulted traditional healers, extended family behaved more traditionally than nuclear family, educational status influenced the pattern of utilization, formal education turned villagers away from traditional healers, higher socio-economic status was positively correlated with the use of biomedicine, the well- off resorted to spiritualist's temple, chronic disease were usually treated by traditional healing methods, traditional healers treated particularly chronic conditions, severe diseases treated predominantly by modern health practitioners, people with severe disease resorted to the modern system, trivial ailments were commonly treated at home with self- medication, illness with supernatural causation were treated by folk healers, people's concept of illness etiology contributed substantially to the choice of health services, quick effect of chemical drugs was the main stimulus for resorting modern services, long distances and waiting time were major regions for not using allopathic dispensaries, lack of rapport between doctor-patients and perception of the doctor's superiority was another reason for not using allopathy, poor quality of rural health services deterred people, high cost (including travel expenses, wage lost) are found as major barrier to modern health facilities.

Conducted in South Gujarat, Prasad's (2007) study specifies that there are certain illnesses for which the rural communities depend exclusively on folk healers regardless of caste and class. He describes about the three types of folk healers -- herbalist, faith healer and faith healer cum herbalist and their multiple role. He found all social groups belonging to different castes and classes were seeking treatment from those healers for a number of illness conditions such as snake bite, jaundice, evil eye, childlessness, bone setting, and menstuation problem. In fact, such healers were those to whom people resorted first and religion or caste "purity" did not seem to be issues for the sick because upper caste patients frequently approached and received treatment from the so-called lower castes (Prasad 2007a, 1313).

For majority of the people various forms of folk medicine serves as ‘primary medicines’ because official medicine is inadequate and are largely situated in urban settings (Tamang and Broom 2010, 328). In the context of Nepal, (K. Ghimire and Bastakoti 2009, 2071–72) observe the high dependency on folk systems by elders and the poor than young and well-off families. Despite the decades of planned development effort, Nepal has not come out of poverty, illiteracy and ill health. Nothing significant changes have been made to address the general living conditions of people even after the Maoist Movement (1995-2006) (Ghimire 2009, 139) and as Adams writes, social injustice, a cause of ill health, is particularly visible among the Nepal’s rural poor (Adams 1998, 1).

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CHAPTER III
THEORETICAL APPROACHES, CONCEPTUALIZATION, AND METHODOLOGY

As the title suggests, this chapter consists of three sections. The first section reviews the theoretical models and approaches applied in the study of health seeking behavior. The second section presents conceptualization of this study, research questions and objectives. The third section is about research methodology which gives details about the study area, study population, methods of data collection and data analysis, ethical issues and the limitation of the study.

1. Theoretical Models and Approaches

There are various theoretical models and approaches which try to explain the health seeking behavior. This section presents a brief introduction of some of these models.

1.1 Social Cognitive or Social Psychological Models

1.1.1 Health Belief Model

The **health belief model,** developed by social psychologists, is probably the most used model to study, explain and predict health-related behaviors, particularly in regard to the acceptance of health services (Rosenstock, Strecher, and Becker 1988; Conner and Norman 2005). The basic premise of this model is that health seeking behavior are based on individuals' perceptions of susceptibility and severity, the barriers and benefits to enacting the behavior and the cues to action. Later, self-efficacy was incorporated into the **health belief model** and that was named **extended health belief model** , which is based on the assumption that persons will take a health-related action

if they believe that a negative health condition can be avoided, hold positive expectations that taking a recommended action will result in avoiding the condition, and believe that they can be successful in enacting the recommended action (Conner and Norman 2005).

The model considers individual differences in beliefs and attitudes. However, it does not account for other factors such as habitual behaviors (e.g., smoking), living conditions, emotional factors such as fear, love, hate, and stigma which can influence the health seeking. The poor self-confidence, poor self-esteem, and (self) stigma can also deter people from seeking health care. Health belief model holds that people decide on their own individually. The model focuses more on preventive health behavior and associates "lack of adoption of particular behavior" with "lack of awareness and education". The model focuses on a single disease episode, individual behavior, personal variable, and preventive or treatment compliance behavior.

1.1.2 Theories of Planned Behavior

Theories of planned behavior outlines the factors that determine an individual's decision to follow a particular behavior. The theory proposes that the proximal determinants of behavior are intention to engage in that behavior and perceptions of control over that behavior (Conner and Norman 2005). Intentions represent a person's motivation in the sense of his or her conscious plan or decision to exert effort to perform the behavior. Perceived behavioral control is a person's expectancy that performance of the behavior is within his/her control. Control is seen as a continuum with easily executed behaviors at one end and behavioral goals demanding resources, opportunities, and specialized skills at the other (Conner and Norman 2005).

Intention is itself determined by three sets of factors:

i. **Attitudes**, which are the overall evaluations of the behavior by the individual;

ii. **Subjective norms**, which consist of a person's beliefs about whether significant others think he/she should engage in the behavior; and

iii. **Perceived behavioral control**, which is the individual's perception of the extent to which performance of the behavior is easy or difficult.

Each of the attitude, subjective norm and perceived behavioral control components are also held to have prior determinants. Attitudes are a function of beliefs about the perceived consequences of the behavior based upon two perceptions: the likelihood of an outcome occurring as a result of performing the behavior and the evaluation of that outcome. Subjective norm is a function of normative beliefs, which represent perceptions of specific significant others' preferences about whether one should or should not engage in a behavior. This is quantified as the subjective likelihood that specific salient groups or individuals (referents) think the person should perform the behavior, multiplied by the person's motivation to comply with that referent's expectation. Judgments of perceived behavioral control are influenced by beliefs concerning whether one has access to the necessary resources and opportunities to perform the behavior successfully, weighted by the perceived power of each factor to facilitate or inhibit the execution of the behavior. These factors include both internal control factors (information, personal deficiencies, skills, abilities, emotions) and external control factors (opportunities, dependence on others, barriers)(Conner and Norman 2005, 10). In short, attitude toward behavior, subjective norms, and perceived behavioral control, together shape an individual's behavioral intentions and behaviors. The theory explains those attributes which induce certain health behavior. It is not an individual but the important others (such as boss, teacher etc.) but the significant others (such as father, mother etc.) who decide.

1.1.3 Social Cognitive Theory

Social cognitive theory talks about three types of expectancies: situation-outcome, action-outcome and perceived self-efficacy upon which human motivation and action are based.

i. **Situation outcome expectancy** represents beliefs about which consequences will occur without interfering personal action. Susceptibility to a health threat represents one such situation-outcome expectancy.

ii. **Action-outcome expectancy** is the belief that a given behavior will or will not lead to a given outcome. For example, the belief that quitting smoking will lead to a reduced risk of lung cancer would represent an action-outcome expectancy.

iii. **Self-efficacy expectancy** is the belief that a behavior is or is not within an individual's control. An individual's belief that he or she is or is not capable of performing a particular behavior, such as exercising regularly, would constitute such a self-efficacy expectancy" (Conner and Norman 2005, 9–10).

There is overlapping of constructs and with this recognition efforts were made to identify a definite sets of variable. As Conner and Norman (2005) describe 'major theorists' identified eight variables which were organized in two groups. First were those variables which they viewed as necessary and sufficient determinants of behavior. Thus, for behavior to occur an individual must have (i) a strong intention, (ii) necessary skills to perform the behavior, (iii) experience an absence of environmental constraints that could prevent behavior.

The second set of variables were seen primarily to influence intention, although some of the variables may also have a direct effect on behavior. Thus, a strong intention is likely to occur when an individual (i) perceives the advantages (or benefits) of performing the behavior to outweigh the perceived disadvantages (or costs), (ii) perceives the social (normative) pressure to perform the behavior to be greater than that not to perform the behavior, (iii) believes that the behavior is consistent with his or her self-image, (iv) anticipates the emotional reaction to performing the behavior to be more positive than negative, and (v) has high levels of self-efficacy (Conner and Norman 2005, 19).

The social cognition or social psychological models take individual as sole decision makers and health is influenced by individual behavior and individual behavior can be

changed through education and awareness. The models explain that perceived threat, potential risk or potential health benefit automatically motivates people to make right decision. These model often missed the role of cultural, socio-economic and larger socio-political forces. Social cognitive models place topmost importance to an individual for his or her health seeking behavior. These models largely take health seeking behavior as an individual behavior. Each of these models is not free from criticisms. There are overlaps of constructions of models such as outcome expectancies, perceived threat, self-efficacy etc. And even the eight point proposed by major theorists lacks some of the points such as perception of susceptibility and severity (Conner and Norman 2005, 19). The existence of various models itself reveals that no model is perfect and can explain clearly why is it that people do or do not resort to certain types of treatment sources. As patterns of resort may not be similar for diverse illnesses and among the diverse socio-economic groups, level of awareness, and motivations may vary from people to people. The role of other variables such as past experience, self-prediction, moral norms, anticipated regret and self-identity in potential predictors of health behavior (Conner and Norman 2005, 10).

1.1.4 Health care Utilization Model

The health services utilization model is an improved model which attempts to overcome the drawbacks of social psychological models. The model arranges predisposing, enabling and need factors in logical sequence to show how these factors act upon health services utilization behavior of people. The predisposing factors include demographic, health structure and health beliefs; enabling factors include personal, family and community resources; and need factor include to the health status or perceived or evaluated illness which is the most immediate and important cause of the utilization of health care services (Aday and Andersen 1974); (Andersen and Newman 2005)

1.2 Explanatory Models and Illness Narratives

Medical anthropologists have developed explanatory model (EM) to analyze the way therapeutic decisions are made during sickness episodes (Young 1982). According to Kleinman, the Explanatory Models (EMs) are "the notions about an episode of sickness and its treatment that are employed by all those engaged in the clinical process" (Kleinman 1980, 105). Latter, in the *Illness Narratives* he reframed the definition as " the notions that patients, families and practitioners have about a specific illness episode" (Kleinman 1988, 121) to include the explanation of patient and family care givers. According to this definition, there can be explanatory model of patients, their families, and practitioners or clinicians. Kleinman further writes, "The interaction between EMs of patients and practitioners is a central component of health care. The study of practitioners' EMs tells us something about how practitioners understand and treat sickness. The study of patient and family explanatory models tells us how they make sense of given episodes of illness, and how they choose and evaluate particular treatments." (Kleinman 1980, 105).

Explanatory models identify how a particular illness comes about and describe the progression of symptoms and prognosis. The explanatory model is often used for explaining choices of health care (Hsu 2008, 318). The model seeks to understand the basic element that people associate with certain illnesses. The explanatory model seeks to explain the following five things about the illness episodes (Kleinman 1980, 105): (i) etiology; (ii) time and mode of onset of symptoms; (iii) pathophysiology; (iv) course of sickness (including both degree of severity and type of sick role- acute, chronic and impaired etc.) and (v) treatment.

Explanatory model refers to "the systematic set of knowledge, beliefs and attitudes with regard to a particular illness which offers explanations of illness and treatment to guide choices among available therapies and to cast personal and social meaning on the experience of illness" (Kielmann 2005, 135). The explanatory models helps us to understand the patient's perspectives of illness experience. This is not only important for clinician to better understand the issues and concerns of the patients they are supposed to deal with them but also to the researchers who are interested in the

treatment seeking behavior. Similarly, the Illness narratives, the narratives about patients' illnesses, can provide insight into perceptions, treatment practices and the patterns of resort. Illness Narratives provides detail information not only about the patients' illness but also about their feeling, belief and perceptions, experience of treatment recourse, role and relationship, cost of care, effect on their lives.

The explanatory model and illness narratives have their limitation. As EM has also been criticized on the ground that it also takes the individual experience or the illness of the patients and/or practitioners. The role of external socio-economic forces can not be ignored in shaping an individual explanatory models of patients and practitioners.

1.3 The Concept of Health Culture

The concept of health culture, developed by Banerji, posits an alternative framework in the study of people's health seeking behavior. The basic premise of this concept is that health culture is a subset of the larger complex of culture. It is a sub-cultural complex which is formed by various factors such as cultural perceptions of the health problems, cultural meanings and cultural responses to these problems which interact intimately with one another. It is not static but dynamic and changing. Health culture also undergoes changes with change in the overall culture and any change within it has repercussions on the overall culture. Therefore, health behavior cannot be studied in isolation. Health culture is subjected to change as a result of cultural innovations, cultural diffusions and purposive interventions from outside to bring about a desired change in health culture (Banerji 1982, 2). The concept suggests linkages between inside-outside communities and a two-way relationship between local phenomenon and a macro politico-economic phenomena.

According to Banerjee

> "The health culture of a community is a component of its overall culture, which responds to a variety of social, economic, political and technological forces. Among other factors, the health culture of a community is formed by: (a) the cultural meaning of health problems; (b) cumulative health practices, derived

> from various systems of medicine, home remedies and non-professional sources, that are acquired by the community as its social inheritance; (c) diffusion of health practices from outside; (d) active efforts to acquire health practices from outside; and (e) cultural innovations by the current generation to more effectively deal with the prevailing health problems" (Banerji 1973, 2261).

The important point the concept of health culture suggests is the two way relationship between sub-culture and overall culture. In a way, the concept is closer to the perspective of political economy of health, even though it seems grounded by cultural perspective of anthropological tradition and influenced by structural-functionalism.

1.4 Critical Medical Anthropology

Medical anthropologists are interested in looking at the micro-macro linkages of medical pluralism what is now understood as critical medical anthropology (CMA) (Baer 2003a; Crandon-Malamud 1991; Singer 2004; Lock and Nichter 2005) and/or political economy of health (PEOH). This approach places emphasis on the "wider causes and determinants of human decision-making and action"(Singer 2004, 24). The approach holds a macro view and looks into the role of external forces and its influence on health and the health care systems. Unlike the social cognition models which take health related problem as a local phenomenon and at individual level and emphasize more on local belief and perceptions, CMA approach views how individual belief and perception and health behavior are patterned by the larger regional and global societies. It provides a framework for studying health behavior and social stratification, hierarchies, social inequality, social discriminations and social causes of disease. For instance, critical perspective sees medical pluralism as a phenomena of class-divided societies which shows unequal social relationships, with the patterns of hierarchy among co-existing medical systems being based upon the reigning structure of class, caste, racial, ethnic, regional, religious, or gender distinctions (Singer 2004, 24).

The basic idea of the CMA perspective is that "social inequality and power are primary determinants of health and health care" (Baer, Singer, and Susser 2003). The perspective "views health issues within the context of encompassing political and economic forces that pattern human relationships; shape social behaviors; condition collective experiences; reorder local ecologies; and situate cultural meanings, including forces of institutional, national, and global scale (Baer, Singer, and Susser 2003, 4). They go on to say that "The emergence of critical medical anthropology reflects both the turn toward political-economic approaches in anthropology in general, as well as an effort to engage and extend the political economy of health approach" (Baer, Singer, and Susser 2003, 4).

The CMA perspective places power and politics topmost to the medicine and treatment seeking. In other word, 'power' comes first then only comes 'medicine'. This perspective helps us to see the linkages of individual life conditions and opportunities to a broader socio-economic and political forces. Here it is important to note Hsu (2008), who states "when studying the patient and their itineraries, one cannot focus on the individual and its therapeutic managing group alone. Rather an illness event is entangled in the social, economic and also political dynamics at large"(Hsu 2008, 319).

In short, CMA perspective focuses on the political economy of health or on the dynamics of power and exposes the negative effects of global capitalism and class inequality on health care and health outcomes at global as well as local level (Van Hollen 2016, 74). The perspective looks into the forms of structural violence and strives to demonstrate the relationships among political economy and health disparities globally and locally (ibid, 2016).

The CMA perspective, according to Merrill Singer, "understands health issues in light of the larger political and economic forces that pattern human relationships, shape social behavior, and condition collective experience, including forces of institutional, national, and global scale"(Singer 1986, 128). This perspective attempts to understand the influence of international and national policy on the aspects of human life. The perspective is employed to study the class, caste and gender disparities and inequalities in treatment seeking and its association with medical knowledge and power. This

perspective holds that social status such as class, caste and gender is an important factor associated with the disparities in access and disparities in health outcome.

In short, socio-psychological or behavior models view health seeking behavior as an individual behavior and suggest modification of behavior through education, awareness and behavior change communication to address the illness conditions which are considered as resulted from the life styles. EMs place importance on the notions that patients, families and practitioners have about a specific illness episode for clinical process, to contribute to the clinical intervention by increased understanding of patients' EMs. Illness narratives provide insight into perceptions, treatment practices and the patterns of resort. The concept of health culture suggests that health behavior can not be studied in isolation because health culture is a subset of the larger complex of culture and and there is two-way relationship between health culture and overall culture and the local phenomenon and a macro politico-economic phenomena. CMA or PEOH looks into the micro-macro linkages. Focusses on how individual health behaviors are influenced and shaped by external forces. The first two focus on micro (individual) level but the last two focus on the macro (societal) level. The behavior model aims to change the individual behavior, EM aims to change the clinical process (doctor- patient relations), and CMA or PEOH aims to change the system.

2. Conceptualization of the study

Let's look at the meaning of the perceptions, practices and patterns of resort, the three important terms which constitute the subject of this study. By p**erceptions** we mean the way people understand and explain illness, their notion about the different therapy systems, by **practices,** the way they behave or act in response to illnesses (or their health seeking behavior), or "what people actually do when they are ill or suffer misfortune"(Pool and Geissler 2005, 51) and by **patterns of resort**, "the way in which patients move from one type of practitioners to another" (Lock and Nichter 2005, 9) or "the paths people make as they pick and choose their ways from one sector of the medical system to another, in pursuit of diagnoses, cures, and other medical services" (Young 1983, 1207). Young (Young 1983, 1207) describes two types of patterns of resort: simultaneous, when a patient consults different sectors at the same time, and sequential when the patient exhausts the resources of one sector before moving on to another. By medical sectors he means, "a segment of medical systems which is dominated by a particular medical traditions" (Young 1983, 1207). There can be many sectors such as Allopathy, Unani, Homeopathy, Ayurveda etc. in a given geographical setting.

The purpose of this study is to understand what people believe and experience, when they fall ill how do they decide to seek treatment, how do they resort to the healers or providers of the co-existing systems of medicine. In short, how do they practice medical pluralism? The possibility is that different people resort to different systems in different ways and to different degree. The study of this kind will add our understanding not only on the perspective of the different people as they understand and explain the illness but also to see the depth of the disparity in treatment seeking or the utilization of health care services. The study intends to document the perceptions about health and illness, their health/treatment seeking experience and gain insight into what is important to them in the use of therapeutic resources.

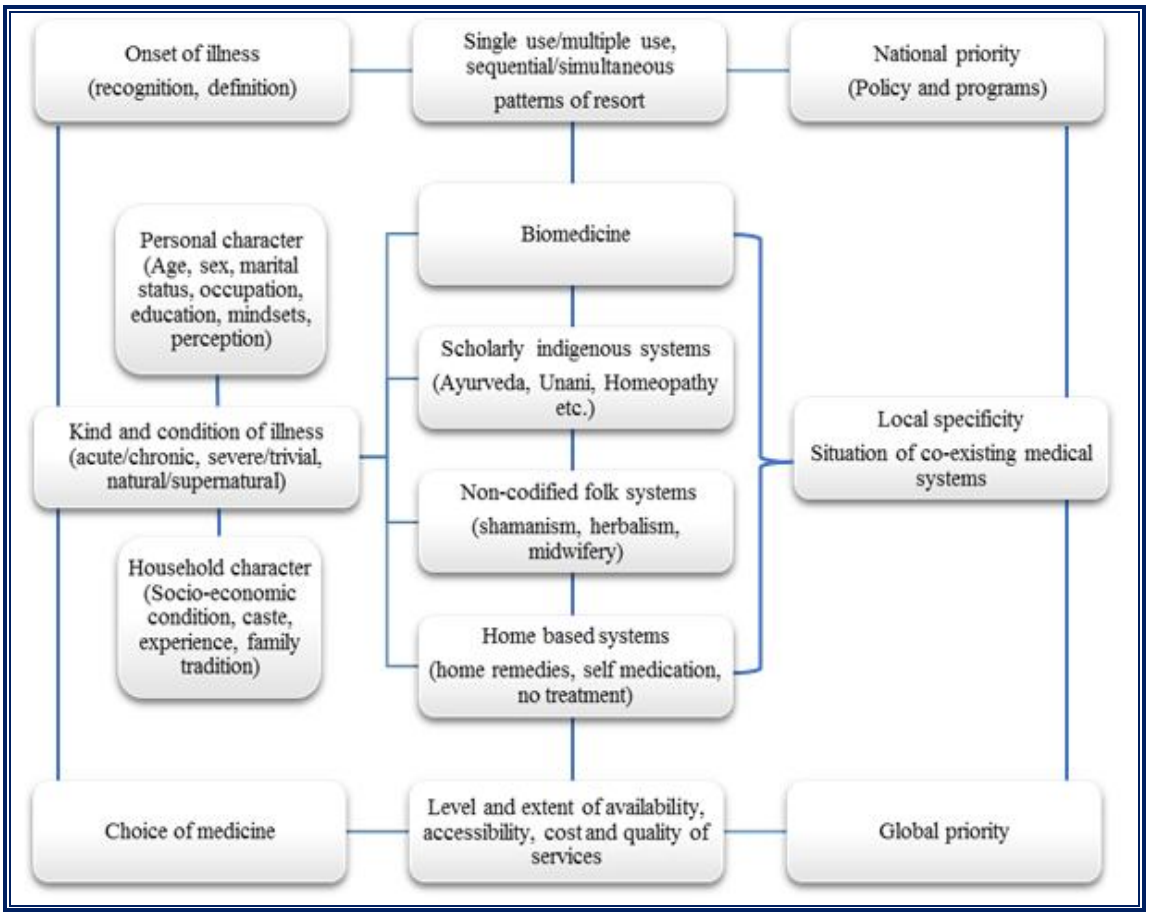
The basic assumption is that there are variations and differences in perceptions, practices and patterns of resort among the people and these variation and differences need to be understood in terms of the class, caste and gender structure of the society. The study attempts to understand these differences and its linkages with the class, caste and gender structure of the patients (and their family) and the healers (or practitioners) of the co-existing systems. The data collected from the field (i.e. from patients and their family members, key informants, community people, healers and practitioners) help to understand the extent of use of the health care resources. The use and non-use of health care resources have further connections with the state's role in formulating policy, implementing programs, allocating health care resources, promoting/demoting a particular systems and particular sections of practitioners. The national policy and programs which is a reflection of the mindsets of the people in power, the policy makers and planners, has much influence at the household and community levels. The national policy and programs also experience influence and imposition from global organization and financial institutions (for instance various program of WHO, UNICEF, World Bank/IMF). Hence, one cannot simply avoid the micro-macro connections when looking at the individual treatment seeking behavior.

People use different forms of medicine for different types of illnesses and even for a single type of illness they may use a variety of treatment options simultaneously or successively. The coexistence of different systems of medicine or medical pluralism has been rationalized that each system is in existence because it has some functions to fulfill. The factionalist approach of understanding medical pluralism, which basically holds that medical pluralism exists there because it fulfills certain functions of the society, can help us understand how the system is working. However, we also need to keep in mind that medical pluralism is related to caste and ethnicity as well as hierarchical social structure of the societies (Crandon-Malamud 1991) and it would be incomplete if we ignore that present day medical systems are the result of constant struggle over power and legitimacy. It is the socio-economic and political forces, which decide the priority, shape perceptions and influence health care practices. To be precise, it is the larger socio-economic and political framework under which individuals, families and communities act. Individual therapeutic choice and preferences are not simply individual decisions, but are also closely related to the struggle over power,

domination and hegemony (W. Ernst 2002, 4). On the study of medical pluralism, as it is being practiced, Khan (2006) opines "we must not ignore or underplay issues of power, domination and hegemony and must locate our work in a larger historical, social and political context" (Khan 2006, 2786). (Navarro 2009) also places high emphasis on power relations and unequal distribution of resources. Frankenberg pinpoints, "the societies in which medical pluralism flourishes are invariably class divided" (Frankenberg 1980, 198). This perspective suggests us to look into the class characters and go beyond functional perspective and to associate medical pluralism with conflict, hegemony and power. (Broom, Doron, and Tovey 2009, 698) conclude that "the notions of pluralism, so often espoused by global health organizations, may conceal important forms of social inequality and cultural divides."

Drawing from the idea of critical medical anthropological perspective this study, therefore, conceptualizes the role of various factors in the use of multiple therapy systems, which trigger multiple recourse among the different socio-economic groups. The provisioning, financing and resource allocations, drug and technological choice, governance and "the nature of services are determined by the socio-economic and political forces in a given society" (Rama Vaidyanathan Baru 1992, 8). The local power structure, nature of health institutions, response to illnesses of various kinds, perceptions of the various aspects of health program can influence the health care utilization (Baru 1992). This suggests that an individual or familial response to illnesses should be looked in light of national and global response. Second aspect is to throw light on the inequalities and differences among the different socio-economic groups in the utilizations of therapeutic resources and look at these inequalities and differences in the context of larger societal structures.

Figure 1: A Conceptual Framework on the Use of Medicine



Note: The idea of this figure has been adopted developed from Kroeger (1983), and Anderson and Newman (2005).

The Figure 1 presents a conceptual framework on the use medicine. The therapeutic recourse begins with an onset of illness, once illness is diagnosed and defined at the individual or family level. A choice is made to resort to the existing systems such as home-based systems, folk systems, traditional systems, and biomedicine. There can be single use (using one system exclusively) or multiple use (using two or more systems sequentially or simultaneously), horizontal resort patterns (in which people resort to similar providers from a system) or vertical resort patterns (in which people resort to

hierarchical care such as from more generalists to specialists or vice versa) according to the nature and conditions of an illness (acute/chronic, major/minor, severe/trivial, natural/supernatural). The individual characteristics such as one's position in the family, age (children, adult, old), sex (male, female), education (educated, uneducated), occupation (agriculture, non-agriculture), marital status (married, unmarried), past illness experience (success, failure) etc. and family characteristics such as family's position in the community, household size (small, large), economic condition (poor, average, well-off), caste/ethnicity (Brahmin/Chhetri, Janajati, Dalits), social resources (kinship connection, social networks and rural-urban orientation) and cultural knowledge (perception and experience, family tradition) can play an important role in the use of these systems. The service provisioning, method of delivery, technology in use, (perceived and actual) quality of the services and the incentive/disincentive to the users (direct and indirect cost, user charges, and wage loss) can influence the choice. The choice of medicine as well as patterns of resort varies with the relative access to and control over resources (including medical or therapeutic resources). Individual or familial choice or the actual patterns of resort also depends on the local situation of co-existing medical systems, national policy and programs, private sector and market forces, international policy context and global priority.

This shows that health seeking behaviors are not purely an individual behavior and they are not independent behaviors. There is connection between individual or familial health behavior and the overall policy and programs of the state. Individual behavior, understanding about the illnesses and treatment recourse, and the decisions to seek treatment from particular sources is influenced by the state interventions. The state can influence the utilization of health care services by ensuring the quality and cost of the public health care services. The state can make a difference by making health care services universal and accessible for all.

As the universal health coverage is gaining currency in the current health care debate, it is important to map the patterns of resort to understand where do people resort to in search of care? What are their preferences and choices about medicines? Why do people use traditional and folk medicine? Why the world seems ready to give more space (with recognition, inclusion and integration) to the traditional and CAM? In this

context, the study of co-existing medical systems and their usages by the people becomes even more important. The study, therefore, first documents the illness experience, analyzes the utilization of health care services and therapeutic resources and analyzes the resort patterns and then it moves into the inequalities and differences in the use of therapy systems which has its roots in the hierarchical structure of the society and then it seeks linkages with the (hierarchical) structure of the medical system and then examines state's role in the making of hierarchical medical pluralism, which has failed to benefit the poor and marginalized but has succeeded to benefit the elite and well-off sections of society because of its differential treatment and exclusionary role which favors biomedicine and serves poorly to the poor section and better to the better-off sections. Finally, the study comes up with some measure to mitigate this disparity and discrimination by making medical pluralism more inclusionary, more democratic and more just.

2.1 Research Questions, Purpose and Objectives

2.1.1 Research Questions

The research questions are as follows:

i. What are the perceptions of people about the health and illness and to what extent perceptions matter in the choice of medicines?
ii. What are the various types of medical systems, health care practices, local health traditions, and home-based practices?
iii. What is the situation of existing systems of medicines in terms of availability, accessibility, affordability, acceptability?
iv. How do people from different socio-economic groups use the co-existing systems of medicine or utilize official health care services?
v. What is the contemporary trends of self-medications and home-based practices among different groups in the present context of socio-economic, political changes?
vi. How do people take multiple recourse for a single illness episode, how the multiple recourses is viewed and how these practices are related to extra amount of time, effort, money and suffering?

vii. What is the state's role in the making of hierarchical medical pluralism by promoting biomedicine?

2.1.2 Purpose and Objectives of the Study

The main purpose of the study is to explore the medical pluralism as it is practiced in a rural setting of Nepal.

The main objectives of the study are as follows:

1. To document the illness experiences of the people.
2. To identify the belief and perceptions related to health and illness.
3. To analyze the patterns of resort among the different socio-economic groups.
4. To examine the state's role in the making of hierarchical medial pluralism.

3. Research Methodology

I conducted fieldwork in Dang district, which lies approximately 450 km south west of Kathmandu. I collected field data from a village for which I have given a pseudonym of Anjaan Gaun of one of the VDCs[8], pseudonym as Amuk VDC of Dang district. Village is called *gaun* (गाउँ) and the *Gaun Bikas Samiti*, translated as Village Development Committee (VDC), is called *Gabisa* (गाबिस) in short. I selected the Anjaan Gaun for an in-depth study. The reason to select one village was to focus on the study participants of one geographic unit having similar ecological habitation. Another reason for the selection was because the village was geographically accessible, and logistically feasible and could provide, to some extent, a familiar background with the people and culture. Moreover, the village was relatively better composed in terms of caste/ethnicity. The village also presents a changing way of life which most rural villages with an urban connections have been undergoing. The village has mainly three clusters inhabited by Brahman & Chhetri, Magar and Tharu (or Janajati), and Kami & Damai (or Dalit groups)[9].

Anjaan Gaun is located at a distance of approximately eight kilometers from Ghorahi, the nearest city and district headquarter of Dang district. The village is connected by

[8] VDC is a local political and administrative body with a government employee as office bearer and 4/5 support staff appointed locally and are paid from local resources. Each VDC is divided into nine wards and a ward consists of two or three villages similar to Anjaan Gaun. For the VDC level development activities, a VDC gets around three million rupee annually from the government and the VDC also generates some funds from land revenue and local taxes. Each VDC has roughly around 10,000 population. Within a VDC usually a health post or sub-health post and an agriculture and veterinary service center/sub center has been established to serve the VDC population. There are 3915 VDCs and 58 municipalities in Nepal. Now, with the promulgation of Constitution of Nepal 2015, administratively Nepal is divided into 7 Provinces, 77 Districts, 481 Gaun-palika (rural municipality) and 246 Municipalities, 11 sub-metropolitan cities and 6 metropolitan cities. In the new restructuration, the Amuk VDC has has been included into the Ghorahi sub-metropolitan area.

[9] Brahman & Chhetri constitute 29.3 percent, Janajati 37.2 and Dalits constitute 12.7 percent of the total population of Nepal. These three groups represent the major (but not all) categories of people of Nepal. This classification does not include the Muslims and other Tarai/Madhesi castes. (Bennett, Dahal, and Govindaswamy 2008) classify into seven groups: 1. Brahman/ Chhetri 2.Tarai/Madhesi Other Castes, 3 Dalits, 4.Newar, 5 Janajati, 6 Muslim (Madhesi and Churaute), 7. Others (Marwari, Bangali, Jain, Punjabi/Sikh, Unidentified Others. The Brahmin/Chhetri, Janajati and Dalits are further divided as Hill and Tarai/Madhesi categories. Diversity exists within each of the groups, however, it has become a standard practice of making comparison among these groups.

graveled road and jeep service is available as means of transport. There are two primary schools, one government and another private, two cooperative offices, two small rice mills, half a dozen small shops, and eight healers (faith cum herbal healers and traditional midwives) in the village. For secondary level education students either go to Ghorahi where there are government and private schools or to the next village where there is a government school and can be reached within an hour by walking. For medical facilities either they go to the private medical stores of the village or they may directly go to Ghorahi where there is a 50 bedded government hospital and many private hospitals, clinics and pharmacies. An Ayurveda Hospital is located approximately 20 kilometers west of Ghorahi, on the way to Tulsipur, another municipality of the district. The distance between Tulsipur and Ghorahi is approximately 25 kilometers and these two municipalities are well connected by blacktopped road and in between is located a Sanskrit University and an Ayurveda medical college. In Tulsipur there is a zonal hospital, an eye hospital and some private clinics and pharmacies. Most of the villagers are subsistence farmers and hold small plots of agricultural land on which they grow rice, wheat, maize, pulses and mustard. The village is surrounded by similar other villages.

I stayed in the village, interviewed people and observed the treatment seeking activities. I also used participatory methods for social map and wellbeing ranking. A semi structured interview was used to collect socio-demographic and treatment seeking information. However, some modifications were made in the course of field work. For instance, I did not ask question related to their income which they felt uneasy and there was possibility of getting incorrect or 'politically correct' answer. The wellbeing ranking provided the necessary data on the socio-economic status of the households. I came to know who is who in the village by the end of fieldwork period. The semi structured interview was conducted in their home and in their preferable time and I made every possible way to make them feel comfortable with me to share their feeling and experiences. The interview was conducted in Nepali language which is commonly spoken and understood in the village. I also attempted to explain and clarify in Tharu language whenever there was a need.

The main focus was on the belief and perceptions, the understanding of illnesses, causations, the preferred therapeutic options and actual resort patterns. The data were collected by interviewing people and observing the treatment seeking events. Sometime actual treatment seeking behavior were found different from anticipated behavior (Anwar, Green, and Norris 2012, 511). The field stay and observation of daily life helped to know more about their treatment seeking practices. Some of the health behavior cannot be understood just by asking questions because the response to the questions can be different from actual behavior. The qualitative methods such as staying in the village, observing, interviewing and interacting with people have more strengths to collect some of the important information.

3.1 Selection of the Study Participants

All the 126 households of the village were selected for field study. The households represent six major caste and ethnic groups: Brahmin & Chhetri, Magar & Tharu (Janajati), Kami & Damai (Dalits). There were 50 households from Brahman/Chhetri, 56 from Janajati and 20 from Dalits. The head of the households or the elder member of the family and patients with acute or chronic illnesses were interviewed. The illness experience of both acute illnesses such as common cold, diarrhoea, pneumonia etc. which last for a short period but sometimes can become serious and fatal, and chronic illness such as diabetes, blood pressure, arthritis, asthma, mental illness etc. which lasts for a long period of time were recorded and updated with the subsequent visits. Additional data and information were also collected from the key persons including folk healers, local leaders, medical practitioners, health workers, medical doctors, and government officials.

3.2 Methods of Data Collection

Primary data were collected from the field using interview and observation methods. The interviews were conducted with the household heads, patients, healers and practitioners. The observation of people's day-to-day activities including treatment activities and household health practices was important to know about the home-based practices and to understand what people say and what they actually do. Observation was an integral method of data collection throughout the field work period of

November 2015 to December 2016 and three subsequent short visits in 2017. During the field work period, I kept a field diary and took notes which I thought important for the study.

The household heads were briefed about the study objective and requested to participate in the study and it was really encouraging that no one disagreed to participate. The interview schedules were of semi structured types, in which there were some open-ended stem questions. The questions were designed to invite answer about the onset of illness and their response, pertaining to the belief and perceptions, their feeling and experience about the illness, the therapeutic options, preferred practices and the actual patterns of resort. Many ccomplementary questions were asked as and when necessary at the time of interview. The participants were visited repeatedly in their home and interviewed and interacted when they had free time. The repeated visits increased the familiarities and help build trust and because of this some of them also shared their private illnesses such as vaginal discharge, piles, tuberculosis, problem related to mental illness which most people do not think appropriate to share such illnesses because of stigma attached to such illnesses.

In doing field work informal interaction with the people was an important way of engaging them in the subject. An attempt was made to make a familiar environment, creating an informal setting for interview. Most of the time I began without showing them any paper, pencil or diary because using these materials in front of them often blocked a smooth interaction. The informal or unstructured interaction provided an easy way to begin with a dialogue in which people felt comfortable to share their experience. This was one of the ways of engaging with the people as normally as possible by taking off the hat of researcher and getting them talk in a free and frank manner. It is also a mutual or reciprocal way of knowing each other, and each other's concern, building a relationship and developing a ground for further interaction.

During the field work period many people were contacted in places such as tea stalls, temples, rivers, mills, market place, shops, medical clinics, hospitals. Assessing the situation the family members who accompany patients to the health facilities and who provide home-based care were asked for an update about the treatment progress. The

field data were collected by visiting all the 126 households of the village. Besides, a wellbeing ranking was also carried out and social map was made with the help of local teachers to better understand the socio-economic status of the people.

3.3 Tools and Techniques of Data Collection

A semi structured interview schedule (see the Appendix 1 for schedule) was used to collect household level primary data from the study participants. Interview schedule, which contained questions about socio-economic and demographic information, illness problems of the family members, the experiences of treatment seeking orders, activities followed over the course of an illness. There were some major (stem) questions in the schedule and complementary (branch) questions were asked according to the specificity of individual patients. The interview was conducted in Nepali language. The Tharu also understand and speak Nepali Language but whenever needed Tharu language was used.

An observation guide which contained some important points for observation was developed. This was helpful not only on what to observe but also on what to talk and what not to miss. An interview guide consisting of some important questions about the treatment seeking behavior, individual experiences, notions about the existing therapy systems and perceptions about the health and illness was developed for an interview with key informants. Besides, a field diary was maintained to take field notes, and to note down the information gathered from observations and informal interactions. Necessary tools were prepared and used for conducting well being ranking and social map.

3.4 Data Analysis and Interpretation

The interviews were recorded, transcribed/translated and reported in a narrative form. A total of 126 household head were interviewed to collect basic socio-demographic and treatment seeking date and patients with chronic illnesses were repeatedly visited and interviewed to know more about the treatment recourses they took. Besides, interviews were also conducted with half a dozen of folk healers, 2 village paramedics, 2 paramedics of Ghorahi and 2 doctors from Ayurveda hospital and 4 doctors from

biomedical hospital and a dozen of key informants such as local leaders, school teachers, female community health volunteers, village development committee and health post and hospital staffs were interviewed.

The narratives, quotations and verbatim have been used to substantiate the findings of the study. The narratives of the patients were important for understanding the individual experience of illness, their feeling about the treatment process, belief and perceptions, cost and suffering, hopes and expectations, role and relationship with family and friends. There were some socio-demographic data in quantitative form and those data were analyzed by using simple statistical methods.

3.5 Ethical Consideration

Each of the study participants were explained about the purpose and objective of the study and voluntary nature of their participation. They were asked whether they were willing to participate in the study and sought consents before starting interviews. They were assured of confidentiality, privacy and anonymity. They were clarified about their right to terminate at any time (before or in the middle of the interview) and their right not to respond to any question which they do not feel comfortable. Oral and written permissions were sought before recording and taking photographs. The name of the study participants, the village and the VDC have been changed and given pseudonym to anonymize their identity. The interview schedules, audio files and photographs were kept confidentially. The ethical clearance for this study was obtained from the Institutional Ethics Review Board, Jawaharlal Nehru University.

3.6 Limitations of the Study

More than three-fourths population of Nepal lives in rural villages. The rural areas also vary according to physiographic location. A village of Tarai region can be different from a village of hill or mountain region because of geographical and cultural diversities. The selection of villages of all geographical regions would have given a better understanding of the people of Nepal. Because of many constraints, this study was restricted to a village of Tarai region. Since the study was conducted in a particular geographical setting, collecting field data from a small village, the findings of the study

might not represent the entire country. The population characteristics, their socio-economic condition, geographic location and co-existing medical systems and the illness and treatment seeking may differ in other regions.

There was a plan to observe and interview every patients of the village who had taken recourse to different sources of treatment. However, it was not possible to meet every individual. A good number of people were absent in the village as they were working somewhere else at the time of fieldwork. Besides, few persons must have chosen not to report their illnesses especially the one attached with social stigma. Even among those who were interviewed, a possibility of underreporting of illness episodes because of various reasons. Some illnesses were not considered worth reporting and in many illness episodes, they might not be recalling every detail of illness and treatment seeking at the time of interview. The sharing additional information in the subsequent visits also affirmed this fact. There was also a possibility of missing the recourse times taken for the treatment of an episode of chronic illness, from the onset of illness to the conclusion of the treatment, therapeutic recourses taken for diagnostic and treatment services.

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CHAPTER IV

PROFILE OF THE PEOPLE AND THE PLACE

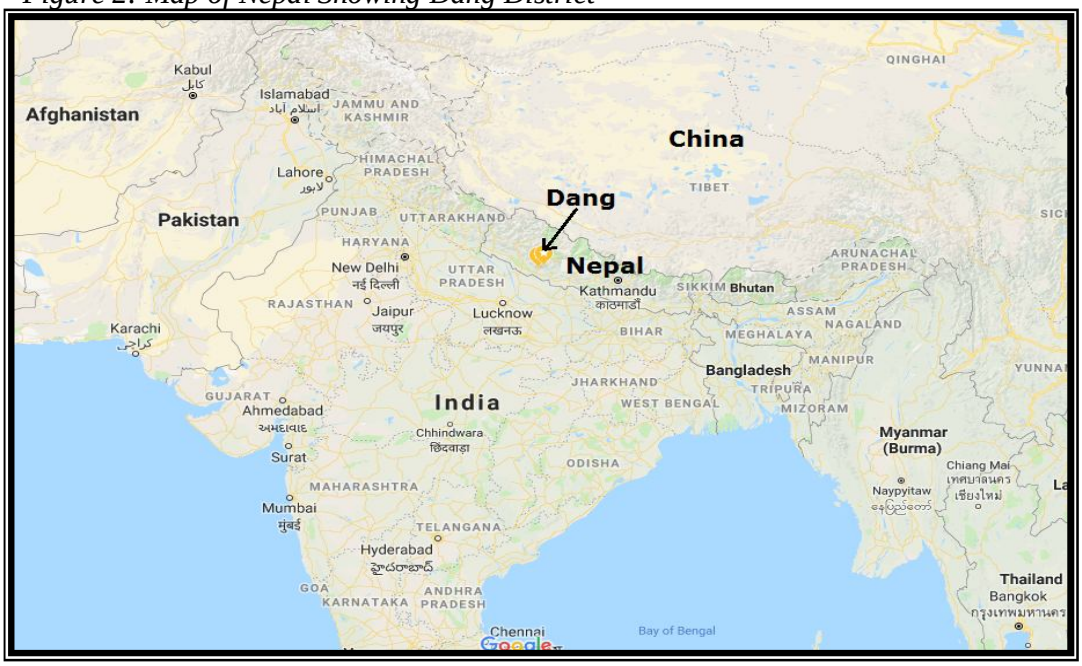
This chapter introduces the people and the place where fieldwork was conducted. This chapter provides a brief introduction of the geographical location of the field site and socio-demographic characteristics of the people. The chapter begins with an introduction of Dang district of Nepal and then moves to the field site of a village where an in-depth study was conducted. The chapter looks into the population composition, food and dressing, education and occupation, housing and settlements, household assets and possessions, ethnicity and wellbeing, availability of health facilities and the urban orientation of the village.

1. Dang District of Nepal

Nepal is a small country (with an area of 147181 sq.km.) situated in the South Asian region bordered by India to the east, west and south and China to the north. Nepal is divided into three east-west ecological regions: Himal (mountain region to the north), Pahad (hill region in the center) and Tarai (plain region to the south). Nepal is of roughly trapezoidal shape with an average width of 193 kilometers (north-south) and an average length of 885 (east-west) km. The three ecological region are vertically intersected by three major rivers: Koshi, Gandaki and Karnali which flow from north to south. Nepal is known for high Himalayas, including the Mount Everest, the highest in the world. Nepal is praised for spectacularly beautiful landscape with an abundant natural resources (with more than 40 percent forest area, running rivers originated from the Himalaya, beautiful lakes, and water falls). Nepal is also known for Lumbini, the birth place of Lord Buddha, and the world heritage sites of cultural importance such as Pashupatinath, Baudhanath, Soyambhunath, Durbar squares.

Despite the development efforts, Nepal remains as one of the least developed countries with a low human development index. The development efforts of Nepal have been constrained by the political instability, frequent changes in governments, democratic movements, Maoist armed conflict (1996–2006), prolonged transition period in the constitution making process, and promulgation of new constitution and the establishment of Nepal as federal democratic republican state.

Figure 2: Map of Nepal Showing Dang District



Source: Google Map, 2018

The study was conducted in Dang district of mid-western Nepal. The district approximately 450 km south-west of Kathmandu, the capital city of Nepal. Elevated from 90 km to 2058 meters above see level and expanded to an area of 2955 sq.km. Dang district is one of the most important district of Nepal. The district is bordered by India to the south, Rolpa and Pyuthan districts to the North, Pyuthan and Kapilvastu districts to the east and Salyan and Banke districts to the west. The district consists of two valleys: Dang and Deukhuri. Dang is extended between Mahabharata and Siwalik range and Deukhuri between Siwalik and small hill range. Dang is considered to be among the largest valley not only in Nepal but also in Asia (DDC 2014). Rapti and Babai are two large rivers running across the district. Besides, there are a number of small rivers and rivulets, ponds and lakes.

According to 2011 census, the total population of Dang district is 552583 (male 261059 and female 291524). Socio-culturally, there are 62 caste and ethnic groups in the district. The Tharus are in majority (29.5 %), followed by Chhetri (24.9%), Magar (13.6%), Brahman (10.2%), Kami (6.4%), Damai (2.7%), Sanyasi (2.3%) and Sarki, Kumal, Yadav, Thakuri and remaining 51 caste and ethnic groups have less than one percent of the population. Tharus were the early settlers and Brahmans were the second to settle in the district and until 1950s Brahman's population was the second largest in the district. The population size of Tharu and Brahman started to shrink when the population of other caste and ethnic communities expanded with the migrated population (District Development Committee 2012). According to the 2011 census, 21 types of languages are spoken in the district, two third (66.5%) speak Nepali as their mother tongue, a little less than one third (28.1%) speak Tharu, and some speak Abadhi, Magar, Kham, Hindi, Urdu etc. Religiously, the followers of Hindu (96.5%) are in majority, followed by Buddha (1.6%), Christian (1.3) and Islam (0.9%), and Bahai religions.

According to 2011 census, two-thirds of the people depend on agriculture. Most of them do agricultural work on their own land or for wages as agricultural wage laborer. They produce enough grain and vegetables for their consumption and sell the surplus. Some farmers are involved in the commercial production of vegetables, poultry farming and fish farming, bee keeping. More than one third of the population is involved in service sectors, business and foreign employments.

The district is well connected by road transport and each of the village development committees of the district are connected to Ghorahi, the district headquarter of Dang district. There are half a dozen local news papers published from the district and a dozen of FM radio stations. In the district there is one sub-regional hospital, one zonal hospital, two eye hospitals, one Ayurveda hospital, and eight private hospitals. There are branch offices of major national banks, I/NGOs, a central university and 31 colleges (of which eight provide masters level courses and others up to bachelor level) and more than 600 schools (District Development Committee 2012).

The socio-demographic data of Dang district does not contrast much with the national average. The district has made remarkable progress in the last decades, however, still falls below to the national average in terms of poverty and human development.

Table 3: Socio-demographic Indicators of Nepal and Dang District

SN	Particulars	Nepal	Dang	Remarks
1	Expectation of life at birth	66.6	66.3	
2	Infant Mortality Rate (IMR) (Per 1000 live birth)	40.50	41.04	
3	Crude death rate (CDR) (per 1000 population)	7.30	7.27	
5	Literacy Total	65.9	70.3	
	Male Literacy	75.1	78.9	
	Female Literacy	57.4	62.8	
6	Poverty (Population below poverty line) @	25.16	31.09	(Mid-Western Tarai)
7	Human Development #	.0490	.485	(NPC and UNDP 2014)

Source: CBS 2011

#(UNDP 2009), @(CBS 2011b, 6)

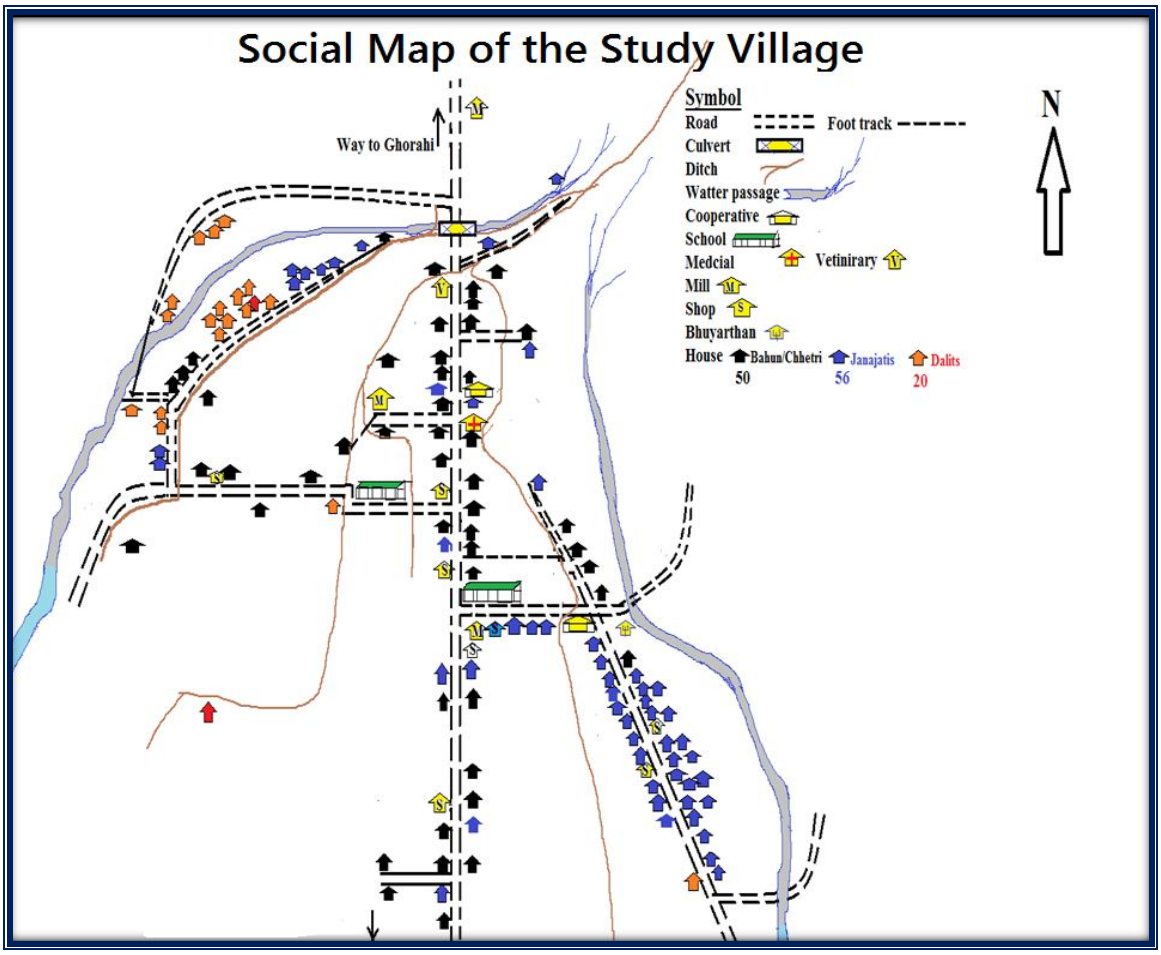
2. The Study Village

The household data about illness and treatment seeking were collected from a village Anjaan Gaun (pseudonym) of the Amuk (pseudonym) Village Development Committee (VDC)[10] of Dang district. The village is similar to many other villages. A graveled road connects the village to Ghorahi. The road is not so wide but enough to run four wheeler vehicles. The means of transport is private jeeps which run at least twice a day

[10] A Village Development Committee (VDC), locally known as *Gabisa* (abbreviated from *Gaun Bikas Samiti)* is a local level administrative and political unit. The *Gabisa* is the new name given to what was previously known as *Gaun Panchayat*. The VDC conducts village level administrative and development works by its own source generated from land revenues and other local taxes. The VDC also receives annual grant amount from the state.

between Anjaan Gaun to Ghorahi and serve villagers who go to Ghorahi in the morning and come back to village in the evening. (See the Figure 3 for social map: The black colour represents Brahmin/Chhetri, blue Janajati and red poor. I have followed similar pattern of black, blue and red to represent well-off, average and poor in most of the figures).

Figure 3: Social Map of Anjaan Gaun, the Study village



While going to Anjaan Gaun from Ghorahi people either take jeep, ride their motorcycles, cycles or simply walk on foot. One can see running jeep, motorcycles, cycles and walking pedestrian on the road. One can see the beautiful houses on both

sides of the road while walking on the way to the village. On the roadside the electricity poles stand in an order and the hanging electric wire connect to the houses. Most of the houses are of two stories, brick-walled and galvanized tin roof. Some of the recently built houses are of cement bonded brick wall, cemented pillars and cemented roof. Whether the houses are of traditional type or of recently built, a television antenna (dish home) and a solar panel can be seen as displayed on the roof top. Most of these houses are either fenced by bamboo sticks or brick wall with an iron gate. The distance from one house to another reduces at the center of a village and increases at the periphery and the expanded agricultural land separates one village from another.

After crossing half of the distance arrives a crossroad which separates Ghorahi from the VDC. While moving straight to the direction to Anjaan Gaun one sparsely built houses and open agricultural land with greenery of seasonal crops. The people plant rice and maize in the summer and wheat, lentils, mustard or oil seed in the winter season. In some of the roadside houses, people can be seen walking or gathered around small shops.

The village arrives soon after crossing a small bridge (culvert) made over excess water passage. We can feel the village with traditional houses, cowsheds, heap of rice-straws, dusts, cattle, and cow-dung, women, men and children in typical clothing. We can see some more house, fields and people at work when we keep on moving to the village. Most of the houses have small courtyards and cowsheds. In between these houses fall veterinary center, saving and credit cooperative office, medical shop, a small rice mill, a village shop (from where a secondary road goes to a privately run primary school and this road connects to the western villages), a government primary school (from where another secondary road goes to the east and then moves to the south crosses through a dense settlement and connects another village). If we keep on moving on the road we see a shop and a tea stall where people come for tea and snacks (in which momo, chowmein, samosa, pakoda are served), and then again a dozen of houses on the left and right side of the road. A little further, when the road bends nearby an irrigation ditch, the border of the village ends, from where forest hill can be seen.

On the main road mostly Brahmin/Chhetri live and on the left cluster mostly Tharus and on the right mostly Dalits and poor Janajati and Brahmin/Chhetri. There are two saving and credit cooperatives where people come for saving and get credit and in one

of the cooperative office people also come to buy seeds, manure and insecticides etc. In the left cluster, the houses are of (mud) brick wall and tinned roof, without a fence, densely built on the both side of the road. As an exception only two (out of 38) houses have been fenced with an iron gate. The road is wide enough for a vehicle. Most of these households keep cattle, pigs and chickens and have a pile of rice straw near the cow sheds. Some of them keep she-buffalos for milk and he-buffalo for ploughing and many keep goats, lambs, pigs and chickens. Approximately one fourth of these house also display television antenna (dish home) and solar panel.

A secondary road connects the left side cluster and presents a panoramic view of the agricultural land expanded up to the next village. On both side of the road there are a few houses in which new comers live. Moving a little further to the point where there is a shop a tertiary mud road leads to the north along with the bank of irrigation ditches. The area, which is a sloppy and narrow strip extended between the tertiary road and water passage, is where mostly Dalits and poor Tharu and Brahmin/Chhetri live. Unlike the Brahman/Chhetri, the Janajati and Dalits keep pig and piglets and consume pork. Most of them have wall of mud brick and thatched roof, without a fence or gate, without electricity connection, without solar panel and dish home, and without milk buffalos or heap of rice straw.

3. The Population Composition of the Village

The total population of the village is 666 (334 male and 332 female) which lives in the 126 households. Tharus are in majority (36.8%), followed by Chhetri (22.2%), Brahman (13.5%), Magar (11.1%), Damai (11.3%) and Kami (5.1%). If grouped into three categories Brahman/ Chhetris constitute 35.7 percent (50 households), Janajati (i.e.Magar and Tharu) 47.9 percent (56 households) and Dalits (i.e. Kami & Damai) 16.4 percent (20 households). According to 2011 census, Brahman/Chhetri constitute 28.8 percent, Janajati constitute 35.5 percent and Dalit constitute 12.7 percent of the total population (i.e. 26,494,504) of Nepal (CBS 2012). Brahmin are on the top in terms of socio-economic position followed by Chhetri, Magar Tharu, Kami and Damai in the village and perhaps this is the situation in the country in terms of their socio-economic backgrounds.

Table 4: Population Composition by Caste and Ethnicity

Particulars	**Total Population**	**Brahmin /Chhetri %**	**Janajati %**	**Dalit %**	**Others (**Muslim, Madhesi, Sanyasi, Dasnami etc.) **%**	**Total %**
Nepal *	26494504	28.8	35.8	13.6	21.3	100
Dang District *	552583	35.2	44.6	11.9	8.3	100
Amuk VDC *	12101	31.6	60.3	4.5	3.6	100
Anjaan Village @	666	35.7	47.9	16.4	0	100

Note: * Calculated from the 2011 Census report

@ Collected from the field study, 2016

A total 15 children born during the fieldwork period of 14 month and of them 6 were born at the homes (One among the Brahmin/Chhetri, three among the Janajatis and two among the Dalit families) with an assistance of traditional midwives. Among them, one was from well-off, one from average and four were from poor families. A total of 6 people died during the period: Four were men two were women. Among the men two were just around 70 years of age (one was suffering from asthma and one from hypertension) one from cancer (63) and one committed suicide[11] at the age of 38. Both of the women were just around 60 years of age. Among them one who was from Dalit community was, suffering from diabetes and other who was from well-off Brahmin/Chhetri family, was suffering from unknown disease and whose husband blamed the doctor's negligence for her untimely death.

[11] The man who committed suicide by hanging in a rope was from poor Brahmin/Chhetri family. He had healing disability. He was married and had a wife and two children. Previous day he was drank and was bitten by his neighbor for bad-mouthing. According to his father, he felt helpless when no one from his family spoke and took action against against the cruelty of neighbor. Rather his brother and his wife scolded him for drinking, badmouthing and quarreling with neighbor. He felt distressed and hanged himself.

4. Food and Dressing

The most common staple meal is *daal-bhaat* (lentil soup and boiled rice), *tarkari* (curried vegetables), *chatani* (usually made from fresh tomato and spices) or *achaar* (pickles). The *daal-bhaat*, which is a popular cuisine throughout the district, is taken twice a day (as lunch and as dinner). In the city restaurants momo (steamed dumpling with meat or vegetables), chowmein, samosas, chat and parathas are served as snacks. They also have seasonal fruits which include mango, guava, banana, papaya, pear, lichee, *kimbu* (Mulberry black), *jamun* (Syzgium cumini), pomegranate, *sarifa* (Custard apple), *bel* (Wood apple), *katahar* (jack fruit), *amala* (gooseberry) and the like. They also buy some fruits such as apple, grapes, oranges and bananas, *kaaphal* (Bay-berry or myrica esculenta) from the market.

All the families cook twice a day, once in the morning at around 9:00-10:00 am and once in the evening at around 6:00- 8:00 pm. They use firewood or cow dung cake for cooking in an improved stove/hearth. They eat *daal-bhaat* in the morning as morning meal and evening meal. Some eat *roti-sabji* in the evening. Many family make and drink tea in the morning, some especially those who keep buffalos drink milk tea. Children are served with left out food from the last night. At around 9:00 am they get morning's meal and in the middle of the day between 2:00 to 4:00 pm they get something as snacks. The school children eat something when they return from home. Daal-bhaat is the most common food. The Tharus also drink home brewed fermented rice as breakfast or snacks. In the day time, especially in the summer season, they drink *maad* (watery porridge).

Once, when I was walking through a village cluster in the morning. I went to the front entrance and saw an elderly male having morning meal sitting on a mat. He was in a hurry to go for work and having food so early (at 7:00 am). This was not the first time. We had met many times before. But this was the first time I got to see him having lunch so early and in haste. I sat where his wife placed a straw mat at one side of the room. He caught me glancing at his plate. He had only rice and *gundruk* (fermented and dried radish which tastes sour) soup in his plate. Jokingly he expressed, "This is our *chaurasi byanjan* (literally 84 items in a meal)." It was no more a hidden truth for me. He was having two items what most poor have. Sometimes, children are found eating

rice only after coming back from schools. And people often say that *bhok mitho ki bhojan*? (Whether hunger is tasty or the food?).This means hunger does not judge the taste of the food. If one is not hungry even the *haurasi byanjan* (84 items) do not taste good. But by using the phrase he was expressing his pain of not being able to afford a good food in a humorous way. *Chaurasi byanjan* is not what people need but on what most villagers feel comfortable is that if they have a good combination of two food items, *daal-bhaat* (rice and lentil soup) or *roti- sabji* (chapati and vegetables) supplemented by green leaves/vegetables, pickles and milk or milk products. This is what was seen in the food plate of better-off families. The *gundruk* is considered as a poor substitute to lentil, a vegetable of hard times to be used when green vegetables are not available in the kitchen garden. One can get *gundruk* free of cost from one's neighbors and relatives.

Most of the people are non-vegetarians and take meat irrespective of their caste/ethnic background. Though there are some restrictions to Brahmin/Chhetri as they do not take pork and buff and a few of them are vegetarians. There is no such cultural restrictions among other castes and ethnic communities. Tharus catch rats, collect snails and crabs or involve in fishing. As an exception, some people from Brahmin/Chhetri also accept buff or chicken momos and drink liquor when they are in restaurants even though that does not have acceptance by their caste. The drinking of alcohol, home-made *jand* and *raksi* (fermented rice and home brewed liquor) is common among Janajati and Dalits. The Tharus also make *maad* (a sort of watery porridge made of rice, wheat and gram etc.). About one third adult male, especially the working adult, from all the caste/ethnic communities smoke or chew tobacco.

The dressing among male is Nepali cap, shirt/T-shirt and pant or half pant. The aged Brahman also wear traditional Nepali dress- *daura* (a type of upper wear similar to *kurta)* and *suruwal* (a type of of trouser) and *dhaaka topi* (Nepali cap). Women wear traditional *guniyu-choli* (a sort of saree - blouse) or *lungi* and short sleeved blouse or *kurta- suruwal*. The fashion has been changed as young girls have also started to wear pants and T-shirt. There are notable differences among the ethnic communities as some of the elderly wear their traditional costume. The traditional clothing such as *guniu-choli* has been changed. Now, the dressing style has been homogenized with the availability and use of ready made sessional wear. The women wear maxi (a sort of

gaun) when they are at home but some of them wear saree-blouse. There are cloths according to the time and seasons, for example in the winter they wear woolen sweater and long sleeved blouse.

All the married women wear *pote* (the colorful glass bead necklace) *or mala* and/or golden chain around the neck. They put *sindoor* (vermilion powder) and/or *tika/bindi* on the forehead. They also wear ornament in the pierced earlobe and nose. Some men also wear gold ring on their fingers or chain around the neck. Some of them wear amulet as an ornament. The Tharu women make traditional tattoos on their legs and hands but the size and style of the tattoo has been changed. Now a days, a few youths were found having tattoos on their body parts. Traditionally, Tharus used to wear lockets made up of coins and Magars *naugedi*. Now they have also started to wear ready made modern jewelry.

5. The Alcohol and Tobacco Use

Many working people habitually drink alcohol and use tobacco[12]. More than half of the working men in the village drink alcohol and use tobacco. Among the tobacco users, the number of those who chew tobacco is large than those who smoke regularly, and among those who drink, more drink home brewed alcohol and fermented rice than the manufactured brand of alcohol. However, an increasing number of the drinkers are drinking alcohol produced from the country distilleries. The use of factory produced alcohol has increased with the expansion of markets and availability in local shops.

It is not because they are not aware about the fact that drinking alcohol and chewing tobacco is harmful to health. They know that smoking and drinking are not good for their health. Many of them also shared their unsuccessful attempt to give up such habits. They shared that they feel hard to say 'no' when their friends offer. The individual habit of tobacco and alcohol use is also associated with their working colleagues and working conditions. Among the ethnic groups, use of fermented rice or

[12] Percentage of people aged (15-49) who use any type of tobacco is 16.5 (Male 27.2 and female 5.8) in Nepal (Ministry of Health, New ERA, and ICF International 2017). The alcohol use in Nepal may be higher than this figure for similar age groups. The WHO Global Status Report on Alcohol and Health estimates that 61.7% of the population (15+) had not drunk alcohol in the past 12 months worldwide. The low income countries have smaller number of people and low level of per capita consumption of alcohol (WHO 2014). However, the percentage of people who consume unrecorded (home brewed or illegally/ informally produced) may be high compared to high income countries.

home brewed liquor is also associated with their cultural traditions. In some households, *jaand,* the fermented rice, is also used as snacks. For some, smoking and drinking can be a coping strategy to minimize a work stress and tolerate the pain. From their perspective, taking a glass of alcohol can work for short-term relief from fatigue and tiredness, even though this may affect adversely to a good health in the long run. However, it is not only the working people themselves but also their life conditions which seems responsible for shaping the habits of tobacco and alcohol use. The role of market force and the national and global policy on tobacco and alcohol control is equally important. Furthermore, the poor food items and malnutrition is not less responsible for their ill health than the tobacco and alcohol use.

Once, I was wandering in the village street in the evening. I saw a group of three people sitting on the mat placed on the foreground and there was something in the middle of them. They were quite familiar about me. I asked simply, "It seems you guys are having something?" One of them replied, "We are having *vitamin*." The use of original English word "vitamin" made me curious and dragged me to them. When I got near to them, they started to giggle and making me puzzled. They were having chicken meat and puffed rice along with local brand alcohol. Understanding the real meaning of "vitamin" I expressed, "Oh I see… This vitamin seems unique. By the way, what illness it is for?" One of them replied, "This is not for illness, this is for energy". Another added, "Energy for the night duty." The term 'night duty' had double meaning and the laughter burst. They know drinking alcohol is harmful to health but they cannot help drinking when they come back home tired from work. The cheerfulness and frankness makes it easy to proceed further. The more I got familiar with their habits the more they became open to me.

In the beginning some of them used to hide the smoking cigarate from me. Later, they did not bother to hide. Few of them rather made humorous attempt to justify the use. Once there were two young men, who were SLC and above educated, siting on the wooden bench and mixing tobacco with slake lime to make the tobacco chewable. When I saw, I asked with smile, "What is going on?" One of them replied, "We are

making *jadi-buti* (herbs). This is purely herbal. It has no *side effect* (original English)." I also attempted, "You are right, it has no *side* effect because it has *direct* effect." We started to laugh. Another person whom I had briefed about my interest in social medicine while seeking his consent, funnily added "This is our *samajik ausadhi* (social medicine)." And we all roared with laughter.

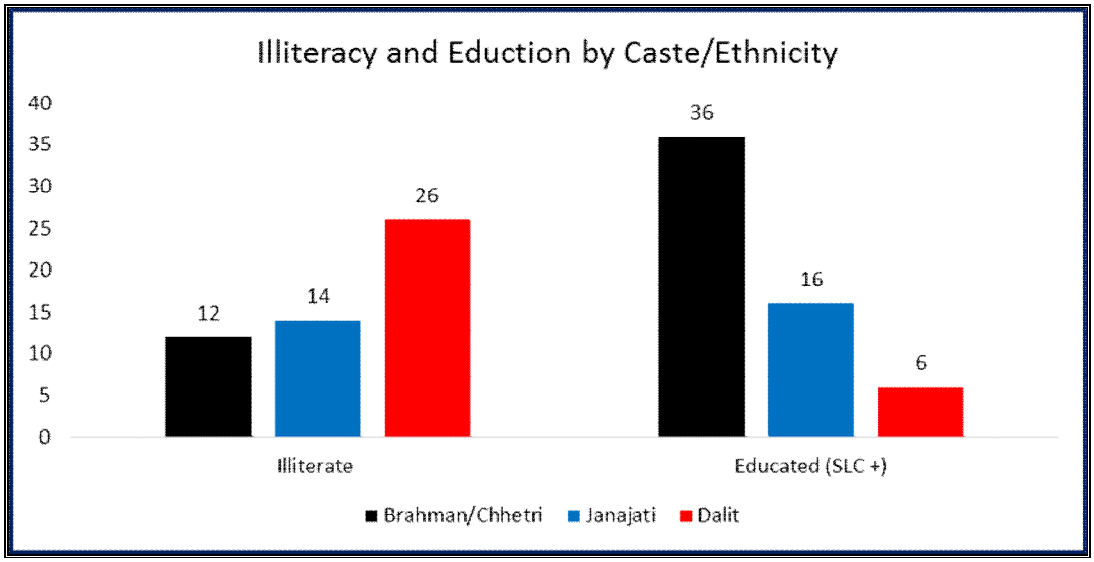
6. Education and Occupations

According to 2011 census, 5 years and above literacy rate of the Amuk VDC is 73.8 percent (Male 83.9 and Female 65.6) (CBS 2014b, 49) and approximately 10 percent of the people have education of SLC (school leaving certificate) and above. However, in Anjaan Gaun which lies in one of the wards of the Amuk VDC. Based on the household data collected in 2016, the literacy rate of the village found to be 85 percent and SLC and above education about 20 percent. This shows that the village is comparatively better in terms of literacy and education. The literacy is high in the village partly because the field study was conducted five years later than the national census and partly because of the literacy programs for adults and school enrolment campaigns launched by the governments. Besides, the people in this village do not have to send their children to the distance schools for primary education. There are two primary schools (one government and another privately run) in the village and this places the village in a better position to access primary education. School education is free in government schools whereas the private schools charge fees. People are increasingly sending their children to private schools with a hope of better education. However, most of the students in the private school are from relatively well-off families.

Of the 44 students enrolled in the two primary schools, 15 were at government school and 29 were at private school in the village. Those who are relatively well-off tend to send their children to the private schools. There were only three Brahmin/Chhetri households out of 15 who had sent their children to the government school. More number of households from Janajati and Dalit had sent their children to the government school. The contrast is more visible among the higher grade students. Some poor household also try their best to send their children to the private school but many had to

withdraw their children from private school and join government school because of an unaffordable tuition fees in private schools. There were more school drop out children among the Dalits and poor families. The illiteracy percent is low but educated (SLC and above) is high among the Brahmin/Chhetri whereas this is quite opposite among the Kami & Damai (Dalits). The literacy is high among the Brahmin/Chhetri (88%), followed by Janajati (86%) and Dalits (74%). The class and caste difference is reflected in the school enrolment, retention in the school, choice of school, and educational attainment. There is internal variation within each of the caste but the total percentage of people without any education is high among the Dalits (26 percent), followed by Janajati (14 percent) and Brahmin/Chhetri (12 percent) whereas the percentage of SLC and above education is high among the Brahmin/Chhetri (36 percent) followed by Janajati (16 percent) and Dalits (6 percent) (See Figure 4).

Figure 4: Literacy and Education by Caste Ethnicity



The village has fertile and irrigated agricultural land. Most of the families own some agricultural lands. They produce and sell their agricultural and diary production. The village represents an agricultural society with an urban influence. Agriculture along with animal husbandry is the main occupation in the village. Most of households of all caste/ethnic groups are small farmers. Only very limited number of people are employed in service sectors. Some of the youths have gone to the gulf countries for employment. When we walk through the village we can see the growing crops in the

surrounding lands, cow sheds and cattle, buffalo and goats knotted with a rope eating fodder or grazing in the fields. We see heap of rice straws to feed the domestic animals, heap of dung cake or firewood, loaded cycles with green vegetable going to sell in the market, milk-can assembled in the collection center.

The size of the plot can vary but almost all the households hold some agricultural lands and do some agricultural work on their own land or fellow villager's land for wages or for share cropping. They cultivate rice, wheat, maize, mustard, lentils and vegetables. According to the Amuk VDC source, about 74 percent of the families are getting food products from their own farm enough to feed their family for 12 months of the year and the remaining 26 percent have to depend upon other sources of income to cover the deficit food grain.

Most of the households keep domestic animals. They keep goats, sheep, pigs, poultry birds and pigeons for meat, cow and she- buffalo for milk, he-buffalo and oxen for ploughing. It is natural to see running roosters and chickens around the house, playing children on the road, farmers carrying plough on their shoulders and driving oxen from back, ploughing in the fields, women carrying vegetables basket on their head, men carrying goods on the cycle, men and women carrying milk bucket to the collection center, women cleaning dishes or washing cloths near the tube well, student in uniform going to or coming from schools, youth playing carom board close by the village shop, people chatting and having tea in the tea stall.

Most of the households hold own some agricultural lands and produce and sell their agricultural and diary product. Two third of the households produce sufficient food to feed their family throughout the year from their own agricultural land. Those who have very small land holding (or who cannot produce enough) work either as sharecroppers in the village. One third of the households work in other's land as sharecroppers. The poor households work as wage laborers in the cities within and outside of the district. They either go to the construction sites or to the agricultural fields, especially during the planting and harvesting season. Some of those who can afford the travel cost go to the Golf countries for contractual labor, some work as private employee and a few households have members who work as government employees as police, army, school teachers. Some of them work in cities as laborer, carpenter or mason worker on a seasonal basis.

7. Housing and Settlements

All the families have their own home to live. Most of the houses are connected by the main, secondary or tertiary roads and grouped in three main clusters. The settlements can be distinguished based on the caste or ethnic concentration even though there are some mix up. The village is divided into three main clusters: At the center on the side of main road (where mainly Brahman and Chhetri live), to the east (where mainly Janajati live) and to the west (where mainly Dalits live). The Magar households are scattered throughout the village.

There are mainly three types of homes: (i) RCC roof with baked brick and cement bonded wall, (ii) galvanized sheet (tin) roof with baked/unbaked brick and mud bonded wall, (iii) thatched roof or tiled roof and raised eaves with wooden pillar and bamboo-stick wall. The people who are well-off have the first or second categories of house and it is more likely that solar panel and dish home (television connection antenna) will be displayed in these houses. A motorcycle can be seen kept in front of such houses. Well-off community use biogas or cylinder gas for cooking whereas poor family use firewood and cow dung cake. When one moves around the cooking time one can see/smell the smoke of burning cow-dung-cake and firewood. If we look into the land holding and land use of these households, the well-off section hold more land and hold a government or private job. The households can be distinguished based on the observation of the household's visible assets.

8. Assets and Possessions

The possession of household assets is positively associated with the socio-economic status of the people. For example, among the bottom 33 percent households the possession of motorcycle, dish homes and biogas plant, television sets, smart phone, water pump, agricultural equipment, milk buffalos or cows are either non- existent or very few households hold only a few of these items. These households hold very small size of land (around 5 *kattha*[13]), send their children to the government school, use firewood or cow dung cake for cooking fuel. For Dalits the proportion goes further down. Not a single Dalits family is found living on the main road side, only two

[13] One kattha is equal to 338.6 square meter, 30 kattha is equal to 1 hectare is equal to 2.471 acres.

households were residing on the side of secondary roads and remaining 18 on the tertiary roads or connected to tertiary with a foot trails.

Figure 5: Household Assets by Caste/Ethnicity

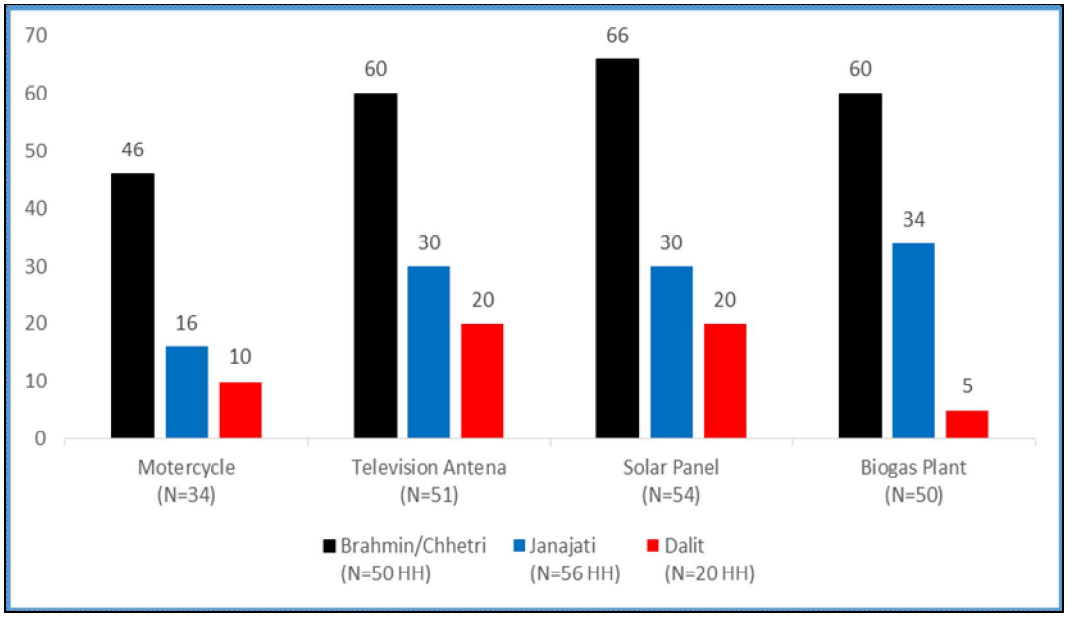
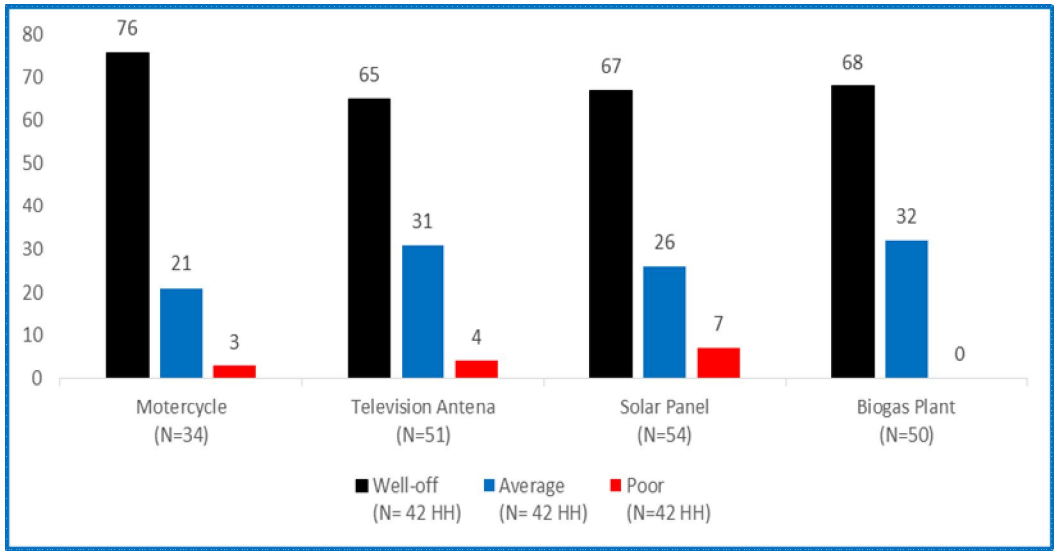


Figure 6: Household Assets by Wellbeing Status



Each of the houses own an ordinary or a flush toilet, however, very few own bathroom and water tank. Many households which are close to the main road have separately built (or unattached) toilet and bathroom and some of them have water tanks on the roof top. More than half of the households have covered well with a hand pump for

drinking water. People generally use underground water source for drinking and household use and for irrigation they use running water of a stream. Most households use firewood or dung cake for cooking. While moving around the village at the time of cooking one can see or sense the smell and smokes of burning cow dung cake and firewood. However, more than one third of the households have biogas plant or use cylinder gas. More than three-forth of the households use electricity as main source of lighting and more than one third have also installed solar panel as an alternative source of lighting or have power back ups, as power cuts is a regular phenomena in Nepal. During the field work there used to be power cuts for few hours a day.

However, there are differences in the possession of household facilities. Among the Brahmin/Chhetri 46 percent of the households have motorcycles whereas only 16 percent Janajati, and 10 percent Dalit household possess motorcycles. More number of Brahmin/Chhetri household possess television, solar panel, biogas plants then the Janajati, and Dalits.

Among the bottom 33 percent households (i.e 42 households), only four percent households have television antenna and seven percent have installed solar panel for lighting use, only three percent have motorcycle, biogas plant is non existent whereas among the top 33 percent households more than two third households possess all these assets and among the average less than one third households possess these assets This clearly shows that poverty is the main reason of not having household assets rather than the caste. (See the Figure 5 and 6).

Table 5: Land Holding by Caste Ethnicity and Wellbeing Status

Caste/ Ethnicity	**Nuber of Households**	**Average Landholding (in Kattha)**	**Wellbeing Status**	**Number of Households**	**Average Landholding (in Kattha)**
Brahmin/ Chhetri	50	22.86	Well-off	42	31.26
Janajati	56	12.12	Average	42	11.24
Dalit	20	5.6	Poor	42	3.57
Total	126	15.35		126	15.35

Figure 7: Land Holding and their Uses by Caste/Ethnicity

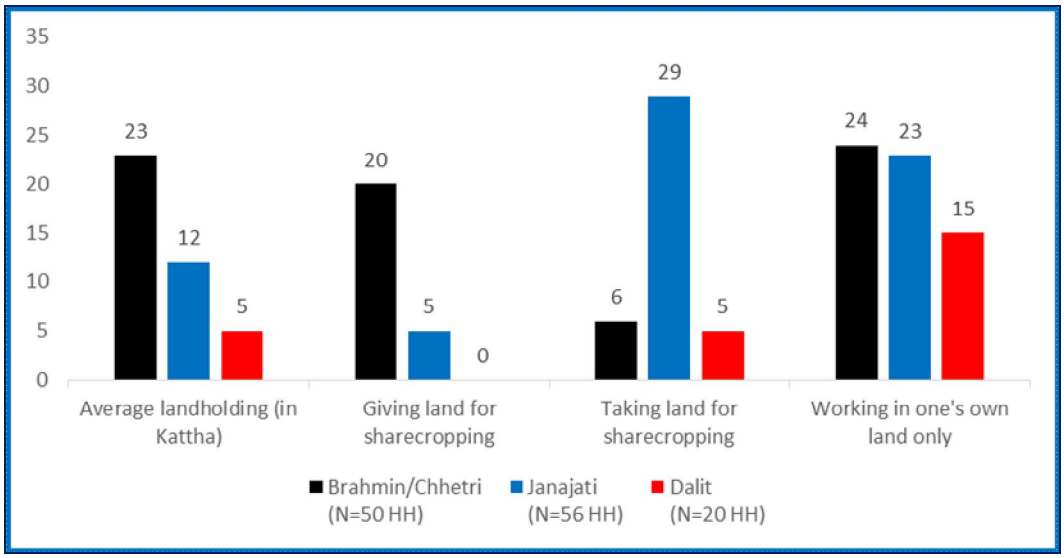
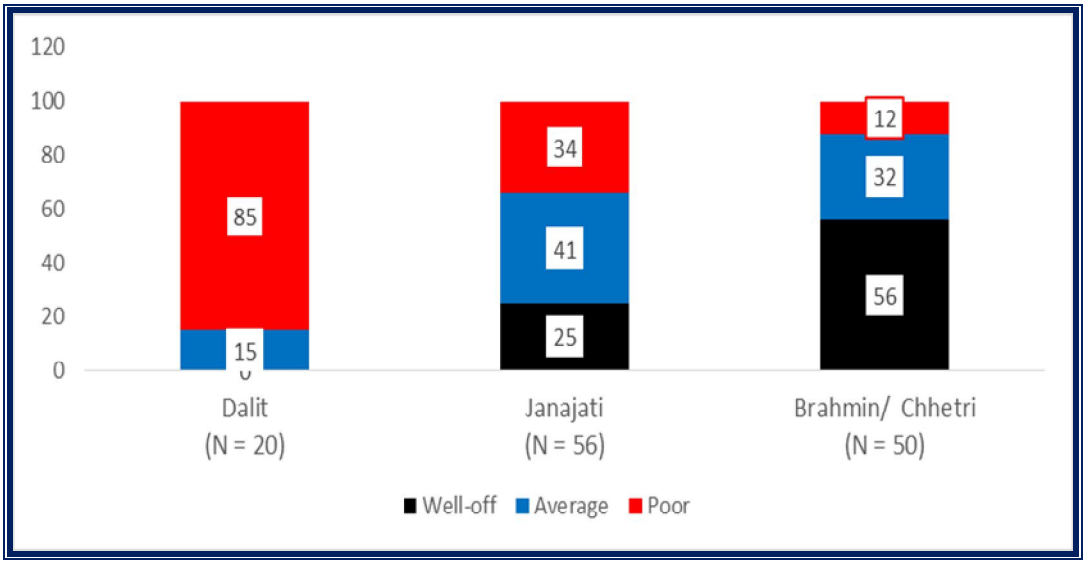


Figure 8: Wellbeing Status by Caste/Ethnicity (in Percentage)



One can distinguish the poor households from well-off by an observation of the household assets and activities. Those who produce more rice will have large heap of rice straw. Those who have heaps of rice straw likely to keep healthy buffalos, cows or

oxen. The house who keep buffalos and cattle most likely to sell milk and use biogas for cooking fuel. Those who have biogas plant have relatively clean kitchen than those who use firewood or cow dung which create smoke into the kitchen. A few well-off families have power tillers to plough their land and to plough fellow neighbors' land for rental.

In terms of socio-economic status Brahman are in a better position followed by Chhetris, Magars, Tharus, Kamis and Damai. The well-off have better education and literacy, better house type and assets such as television and motorcycle and hold large size of fertile agricultural land. The Brahmin/Chhetri hold more agricultural lands (from 2 to 70 Kattha and 22.86 Kattha in an average) than those of Janajati (from 1 to 60 Kattha and 12.12 Kattha in an average) and Dalit (from 2 to 15 kattha and 5.6 Kattha in an average) and many of them who have large land holding give their lands for share cropping. Though the sharecropper households are found in every caste/ethnic community, the number of sharecropper is by far the highest among the Tharus. The sharecropper is the one who does the agriculture and gets fifty percent of the agricultural products produced from the land. The sharecropper does everything needed to produce and the land owner provides fifty percent of the cost of seeds, insecticides and manures to the sharecropper and gets the 50 percent of the share. It is noteworthy that Brahmin/Chhetri hold more than four times than the Dalits in an average and the top 33 percent (ranked as well-off) households hold six times more land than the bottom 33 percent households (ranked as poor). As an exception only one household ranked well-off despite holding only 2 Kattha of land because he was a job holder and possessed a good house and assets, and only one household despite having 18 Kattha of land ranked as poor because of illness, illiteracy and poor living condition and low social dignity.

9. Ethnicity and Wellbeing

The differences among the people are visible and this is also ascertained by a wellbeing ranking. In a wellbeing ranking, Brahman/Chhetri are at the highest, followed by Janajati, and Dalits. Many studies have also shown that Brahmin/Chhetris are in a

better position compared to Janajatis and Janajatis are better compared to Dalits. In terms of human development Brahmin/Chhetris have the highest HDI value (0.538), followed by Janajatis (0.482) and Dalits (0.434) (UNDP 2016, 5). However, all the Brahmin/Chhetris are not equal and so are the Janajatis and Dalits. As (Hachhethu 2003) notes, some of the Dalits and Janajatis are in better position even compared to Brahman/Chhetris.

In the wellbeing ranking, 56 percent households of the Brahmin/Chhetri and 25 percent households of Janajati ranked well-off whereas not a single household ranked as well-off among the Dalits. Among the Brahmin/Chhetris Only 12 percent households ranked as poor while 34 percent Janajati and 85 percent Dalit households ranked as poor. This supports that socio-economically these three groups vary and the degree of variation is also remarkable. (See Figure 8 or Table 6).

Table 6: Wellbeing Status of Households by Caste/Ethnicity

Caste/Ethnicity	**Well-off**	**Average**	**Poor**	**Total households**
Brahmin/Chhetri	28 (56%)	16 (32%)	6 (12%)	50 (100%)
Janajati	14 (25%)	23 (41%)	19 (34%)	56 (100%)
Dalits	0	3 (15%)	17 (85%)	20 (100%)
Number of HH	42	42	42	126

The five government school teachers, who were from the same or neighbor village and represent Brahmin/Chhetri and Janajati community, participated in the wellbeing ranking. The participants were given 126 cards on which the name of household head were written. They were instructed to arrange the cards in an order based on their wellbeing status. The participants talked about the social prestige of the family, size of land holding, type of the houses, level of educational attainment, type of employment, household assets such as motorcycle, water pump and sanitation, biogas, agricultural equipment, amount of agricultural production, number and types of domestic animals, disability, disease, and healthiness of the family members while they were inserting the cards one after or before another. Later, these cards were divided into three equal numbers and characterized as *sampanna*, *samannya*, and *bipanna*.

The word *sampanna* means better-off than the average villagers. The ***sampanna*** (translated as well-off) households were those who hold relatively large plots of irrigated land, have a good house in better location usually connected to main road and electricity, who give their land for sharecropping, have a housing plot in Ghorahi, have someone in the family holding a government or private job or getting pension, have bank balance and can give loan to the villagers in need, own a mill, power tiller/tractor, motorcycles, solar panel, dish home and television sets, have water tank, good furniture, wear gold ring/chain or good watch, hold smart phones, keep she-buffalos for milk, use biogas or cylinder gas for cooking, have shares in cooperative banks or boarding schools, do not work as wage labor, hire labor for their works, send their children to distance cities for education, afford education at boarding school and private college, afford to go to Ghorahi, Lucknow and Kathmandu for treatment, posses *ijjat* (social respect), play a lead role in social work, hold a position in the local institutions such as school management committee, temple management committee, forest user committee, saving and credit cooperatives etc., are invited to resolve disputes in the village, organize social functions or family feasts and festivals and invite more number of villagers and guests.

The ***samannya*** (translated as average) households were those who hold some agricultural land and a good house, have no difficulty in two times meal and seasonal wear, are honest and hardworking, can get loan from cooperative banks or from local money lenders, can get land from landlord for sharecropping, have someone in job or has gone to Saudi Arab, Qatar, Dubai and Malaysia for a contractual labor, can produce enough for their family, send their children to schools and afford basic treatment services, can buy agricultural inputs such as seeds, fertilizers, have healthy he buffalos or oxen for ploughing or can pay for tractor or tiller charge, run small shops, sell milk or vegetables, do not worry when a few guests arrive, invite fellow villagers when they organize *pooja* (cultural ceremonies), contribute for social work, pay attention to the village level development activities.

The ***bipanna*** (translated as poor) household were characterized as holding very less land (often unregistered), have difficulty to manage two times meal, have small one story house with thatched/tinned roof and mud-brick wall, hold few household assets,

do not have good cooking utensils (like pressure cooker), lack electricity connection, television, solar panel, lack good oxen and buffalos, work as labor or do petty work or go to Indian cities to work as domestic servants or factory workers, borrow money from local money lenders frequently and live in debt, do not have bank account, cannot get credit from the bank and cooperatives, send children to public school often irregularly or drop out from school, use firewood or cow dung bar for cooking fuel, wear unclean and tattered clothes and foot ware or *jadauri* (used cloth and footwear), have less items in their daily staple food intake such as ghee, milk, vegetables, lentils and pickles (chutney); have someone disable or chronically ill in the family and cannot afford for treatment, feel difficulty to feed the guests, are not invited in social gatherings, meetings and even if they are invited they keep silent (or have little to say)

10. The Health Facilities

Dang district is divided into 39 Village Development Committees (VDCs) and two municipalities: Tulsipur and Ghorahi. Ghorahi is the district head headquarter of Dang which is connected to the east-west highway and at the center of Ghorahi there is a public sub-regional[14] hospital and a number of privately run clinics, nursing homes and small hospitals, eye and dental care centers, medical pharmacies, yoga centers, homeopathy and acupuncture clinics. In Tulsipur, which is approximately 25 km west of Ghorahi, well connected by black topped road, there is a zonal hospital and an eye hospital and a number of private clinics and pharmacies. On the way to Tulsipur, at Bijauri, there is a regional Ayurveda hospital with Ayurveda College which offers courses up to bachelor courses (BAMS, Kabiraj and Vaidya). In the district, there are four PHCs, ten health posts and 26 sub-health (which have been upgraded to health post) and three Ayurveda dispensaries. There are folk healers of various knowledge, skills and capacities and their number exceeds the number of formally trained practitioners in the district.

Many of the illnesses are treated at home or with the help of village healers. There are half a dozen of healers (herbal healers, faith healers) and two traditional midwives in the village. These healers provide shamanic or faith healing, herbal healing and

[14] The hospitals are ranked as central, regional, sub-regional, zonal, district, *ilaka* and then comes primary health care center (PHC), and health center (HC), health post (HP) at the grassroots.

midwifery and massage services and traditional midwife assist in childbirth and provide postpartum massage. People also go to surrounding villages to visit such healers which are known for the treatment of snake bites, dog bites, and navel dislocation, problems related to nose, tooth and child illness. The herbal healer keep roots, bark or parts of plant in their sacks and suggest fresh plant parts whereas faith or shamanic healers use mantras and some of them have kept images and statues of Gods and Goddess in a room of their house. Healers with repute to treat some specific illness such as jaundice are also found in the distance villages where people resort to when they need.

There are two medical stores in the village, one at the center of the village and another at the border of the village on the way to Ghorahi. These medical stores have been running by paramedics since the last four or five years. Before that people either they used to visit a clinic of next village or to go Ghorahi. The number of such private medial stores have been increased with the increase in the private training institutes which offer paramedical courses. The road transport improved, market expanded and private medical shops increased in the last few decades. There are a number of such medical stores across in the district. Usually the registered paramedic run such medical stores but in their absence their untrained/unqualified family member also take charge. Some of these paramedics also work as government employee, especially in health posts, health centers and hospitals. These medical stores keep basic drugs needed for fever, pain killer, ORS, condoms, vitamins, primary antibiotics and ayurvedic medicines and products including *chyawanprash, vicks, ashokarist, dashmularist* etc. They also provide basic physical examination often using stethoscope, thermometer, and sphygmomanometer and sell medicines with or without prescription. The paramedics also provide home service to the patients when there is an urgent need and the villagers can pay back the paramedics later, if they do not have cash at the time of treatment.

The health post lies in approximately at a distance of six kilometers from the village. The health post provides primary health care services and provides some essential medicines free of cost. The health post has seven staffs: 1 HA (health assistant), 3 AHW (auxiliary health worker), 2 ANM (auxiliary nurse midwifery), 1 Office assistant (government approved posts for Health posts) and 1 ANM and 1 Office assistant (on contract from VDC source) and 21 Female Community Health Volunteers who support

national campaigns, antenatal and immunization programs. Very few villagers go to the health post because there is no transport facility to the health post. The health post data also suggest the poor use of health post services from the people of this village. Many prefer to go to the village medical stores or Ghorahi where they can avail services from government hospital as well as private clinics and pharmacies. Ghorahi is at a distance of eight kilometers and they can take a jeep. Besides, they can avail market facilities such as buying fertilizers and seeds, getting bank services, buying household goods, paying electricity bill and the like. However, the villagers are getting maternal and child health services from monthly mobile clinics run by the health post. Besides, the people also visit female community health volunteers, of their locality in many times.

There is a sub-regional hospital in Ghorahi and zonal hospital in Tulsipur, four PHCs, and 36 health posts in the district. Besides there is a regional Ayurvedic hospital, three Ayurveda dispensaries, one eye hospital, one Leprosy and TB hospital (CBS 2005). There are half a dozen private hospitals and around 200 private medical clinics and pharmacies usually owned by paramedics. Some of them are provide acupuncture, homeopathy, and Ayurveda services. There are a few dental and eye clinics. Some of these clinics are run by paramedical person and in some clinics doctors (MD and MBBS, BAMS) who are employed in the nearby hospital provide the services, especially in the morning and evening. In the district, there are five health related training centers to provide CMA, ANM and Nursing training (District Development Committee 2012) and an Ayurvedic college which produces BAMS and mid-level course for Ayurveda.

11. Health and Sanitation

The health awareness has been improved among the villagers. They give importance to personal hygiene and sanitation to avoid illnesses. As almost all households have made toilet which was promoted by the “open defecation free area” campaign. They regularly brush their house with the mix of cow dung and red clay, sweep inside and outside of house, wash used dishes and utensils, cut their finger nails, comb their hair, take bath, wash mouth and brush teeth, use toilets and wash their hands after toilet, wash and wear clean cloths. However, this is not always the case. Some still do not mind to

defecate open, do not bother washing hands (with soap after toilet), brushing teeth, cutting finger nails, and taking bath regularly. Many women use cloth sanitary pads but feel ashamed to dry them out open in sunlight. Small children, particularly in some poor families, are seen with running noses, eating food and driving housefly moving around them, walking naked and bare foot, wearing worn out and unclean cloths, playing in dust and mud, keeping long finger nails, and eating without cleaning hands. Some of the elderly and working men and women also do not care much about the personal hygiene. Occasionally, they are also found wearing cloths soaked with sweat, emitting smell. In summer season, housefly increase and people are also seen driving housefly from their food plate. Some of them do not care much about the drinking water. Some of the cooking and vegetable cleaning style may be unhygienic such as cutting potato without washing mud and washing green leaves vigorously after cutting. Similarly, they do not bother to wash many vegetable and fruit items. They eat radish, carrot and ground fruits by cleaning the soil with wearing cloths. Some of them also keep goats, chickens inside the house at night and cattle nearby the house. The sanitary situation is comparatively poor in left cluster where mostly poor and Dalits live. The economic condition of the family also determines their sanitary condition. As the poor cannot afford separate shed for their cattle, they keep their cattle in a makeshift type of shed attached to their house. The Urban Orientation of the Village

The village is well connected to the Ghorahi. The people of this area go to Ghorahi to buy agricultural inputs and pay electricity bills, sell their agricultural products, avail postal or banking services. The villagers often report the changes that have been taking place in the village. Many such changes can be viewed as an urban influence. Most of the traditional houses made of wooden pillar, bamboo stick or mud wall and thatched roof are being replaced by brick wall, mud or cement bonded, and tinned roof. Some are making modern house with RCC pillar and cemented roof. The road has been expanded and graveled. The changes can be observed not only in physical infrastructures such as road, irrigation, schools and agricultural practices but also in dressing styles, language, livelihoods and many cultural practices. The interaction of the people across the cultures, the development of transport and communications expedited the pace of change. The changes can be observed in marriage (inter-caste and love marriage), family size (small), occupations (non-agricultural), housing (modern), dressing and ornaments (fashion) and in the ways of celebrating festivals and in food

practices and food items. More people than before watch television, ride motorcycles, and use smart (mobile) phones.

In the village level social functions all are invited regardless of their castes, even though the caste based discrimination and untouchability still exists. During the field work a better-off Dalit family organized a *puja* (worshiping ceremonies) and he invited the villagers including the Brahman and Chhetri. In that *pooja,* the women from other castes were making and distributing the food and *prasadi* (foods to be offered to Gods). When a Brahman family organizes such a *puja* Dalit women are not allowed to do the same job of making food and *prasadi*. They are assigned different tasks other than cooking and distributing food and this is mainly because of the sense of untouchability.

Next to the village, at the lap of forest hill there is a Hindu temple. All the people visit the temple irrespective of their caste/ethnicity. Like other local institutions, the temple management committee is dominated by Brahmin/Chhetri, despite the inclusion of Janajati and Dalit in the management committee. The Brahmin/Chhetri are more frequent in visiting the temple. The Brahmin /Chhetri wear *janai* (sacred thread) and some of them wear *lungi* or *dhoti*[15] and take food only after bathing in the morning. In the marriage ceremony, the service of Damai as well as Brahmin pundit is necessary. And when Tharu organize *gurrai puja* all the households irrespective of their caste make contribution. Now, the villagers are also increasingly using the catering services in such ceremonies.

12. Access to Natural Local Resources

The poor households do not have biogas plants or cooking gas and they need to collect firewood. But the nearby forest is managed by the community forest users groups which is dominated by the well-off section and those who do not need firewood as cooking fuel. The the committee announces and allows only for a few days in a year to enter into the forest to collect dried and wasting branches as firewood. The poor firewood users have faced difficulty and forced to other alternative options because of the committee' emphasis on the protection and conservation of the forest. Similarly, most of the poor and Dalits who live in unregistered land and do not have *laal purja*

[15] The traditional menswear, in which a loose piece of cloth, mostly in white, is wrapped around the waist extending to cover most of the legs. Usually, the *lungi* comes in two meter length and *dhoti* four meters, and wearing style also differs.

(land certificate) of their land in which they do agriculture depending on the rainfall. Though the water irrigation runs through the ditch nearby their lands, they are not entitled to use the irrigation water. They may be allowed when the water runs in excess, with the discretion of the *aguwa* (irrigation management leader, who happens to be someone influential and well-off. The poor used to collect fish and crab in the nearby irrigation ditches and water pass ponds. Now, on the one hand the use of chemical fertilizers and pesticides reduced their availability of fish and crabs and on the other, they are not allowed to do things (such as use of soil, and divert or store water) necessary to do fishing. However, the poor are not left out from voluntary labor contribution when there is public works. Once there was a public sweeping event, named as *sarsafai karyakram* (sanitation program) in which the poor from left cluster were also called. They brushed the main road and cleared the waste and weeds of roadsides but they did not bother to do such *karyakram* at the tertiary roads and foot paths where mostly poor and Dalits live.

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CHAPTER V

ILLNESS AND TREATMENT SEEKING

Illness is a condition of ill health experienced by a person. Illness is an individual experience of symptoms and suffering (Kleinman 1988). Everyone has a story to tell about illness and treatment seeking. Illness is inevitable. Everyone falls ill from time to time. No one is immune to illness. Illness is naturally a human experience. Time after time people experience illnesses and respond to them in their best capacities. If we just attempt to look into one's illness and treatment seeking story, we will find one's life more of a struggle over a series of illness episodes and treatment successes. In a way, life is a success story of winning over illnesses. If one succeeds, one continues to live a life, which happens most often, but if one fails to get an appropriate care and cure in time, the consequence can be fatal. Most of the illness episodes, especially those which are called minor, are treated at the first or the second attempt. But some illnesses, which turn to be severe or chronic in nature, are not treated even after the multiple attempts. The patients and family care givers experience treatment failures over and over again and struggle against or cope with and live with the illnesses. Sometimes, they do not know what to do, where to go or whom to consult and how to deal with the illnesses that they face. They move from place to place, exhaust their resources, express helplessness and experience intense suffering. Sometimes they simply do not get needed support from their family members, neighbors, medical practitioners, health facilities, and hospitals. Their life becomes sorrowful when they lose the hope. This chapter looks into the stories of the people who had experienced illnesses and sought treatments for themselves or for their family members. The illnesses vary. So are the stories. The selected stories illustrate the treatment seeking in a particular socio-economic context of the family but can be found associated with the health care context of the society at large.

1. The Types of Illness

Mainly scholars distinguish illnesses into two types: acute and chronic. Acute illness has a short and rapid onset and does not last long while chronic illness has a gradual unset and lasts long. The illnesses are considered chronic which last more than three months but some of them may be life-long lasting. There are different ways of classifying the disease and illness. There is difference between disease and illness. Disease is a condition which is medically understood and explained, which can be diagnosed based on the sign and symptoms the sick person exhibits. Illness is the experience of ill-health, a feeling of pain and discomfort, possibly because of disease. One may feel illness without having a disease or have a disease without feeling or experiencing ill-health.(Field 2001, 334). Illnesses have subjective meaning while diseases got the objective focus. Field distinguishes illnesses into four types: short term acute illness, long-term illness (stigmatized and non-stigmatized) and mental illnesses (ibid, 2001). In explaining the categories of illness (D. K. Beine 2000) in his study in Nepal distinguishes between *saano* (minor) such as cough and cold or the illnesses which can be cured easily with available medicine and *thulo* (major) or serious which may not be treated easily, *saruwa* (transmissible) and *nasaruwa* (non-transmissible), *bhitri* (inside) such as such as gastritis which are invisible and *baahiri* (outside) such as skin rashes or scabies which are visible, *sardi* (cold) and *garmi* (hot) which need hot and cold food to deal with such illnesses. In terms of illness causation and perception there can be *rog* (disease) which doctors can treat and *bimari* (caused by *laago-bhago*) which faith healers can treat.

There are 666 people living in 126 households and more than half of the people reported one or more illnesses they experienced in the last six months periods. The households were repeatedly visited during the fieldwork period of November 2015 to December 2016 to know more about the treatment seeking. The children and the aged/old had experienced illnesses more than those of young and adults. The most common illnesses were fever, cough & cold, headache, joint pain, diarrhea, gastritis, skin infection, injuries, jaundice and the illnesses of indigenous origin. The reported illnesses can be roughly grouped under three categories:

i. Common acute illnesses: such as fever, headache, loose motion, dysentery, diarrhea, pneumonia, common cold, cough, sour throat, dental problem, eye

problem, skin problem, scabies, jaundice, wounds, small injuries, bites, burn, etc.

ii. Chronic illnesses: such as chronic head ache, body/joints pain, arthritis, chronic skin infection, hypertension, thyroid, mental illness, asthma, stomach pain (gastritis), lower abdominal pain, reproductive health problem, sickle cell anemia, cancer, etc.

iii. Culturally understood illnesses: Besides they also reported many illnesses in their local terms and most of which are locally understood and explained: *Sato gayeko* (soul loss), *jhaskine* (sudden frightening), *tarsane* (sudden aback), *daraune* (fearing), *aithan parne* (frequent nightmare), *nidra nalagne* (insomnia), *gara pareko* (ill intention casted upon), *kapat pareko* (bad spirit), *chokhe lageko* (not feeling to eat), *sukenas lageko* (stunting of child), *boksi lageko* (attack by witch), *laago lageko* (attack by dead spirits), *najar lageko* (evil eye), *kamar sadkhne* (waist dislocation), *dhad dukhne* (back pain), *jiu dukhne* (body pain), *pinas bhayeko* (nasal problem), *putreno gayeko* (navel dislocation), *apach bhayeko* (indigestion problem) and the like. These illnesses can be of acute or chronic, of minor or major based on the nature and severity.

The above list represents most of the illnesses experienced and reported by the people. This presents the types of illnesses for which people had sought treatment or were in the treatment process during the fieldwork period. Most had used one or two sources of treatment while many others had used many different sources of treatments, following different patterns of resort. Many illnesses might have been underreported either because they considered minor illnesses not worth reporting (such as common cold) or because of stigma. In certain conditions people want to keep their illness private and do not want to share with others. They do not want to make their illness public. Illness and treatment seeking is a complex activity and it is hard to know, how many recourses they had taken for an episode of illness and what was the sequence. Besides, it was not possible to know about the illnesses and treatment seeking of many youths and adults who were staying outside of the village for study and work.

2. The Stories of Illness and Treatment Seeking

The following stories of illness and treatment seeking explain the kind of illnesses they experienced, the perception about illnesses and treatment sources, the number of recourse they had taken, the treatment costs and repercussion in the families, and the sufferings. These also provide a picture of therapeutic trajectories, visiting different places and practitioners, in search of treatment among the different socio-economic groups. The stories were told either by the patients themselves or by their family members. The stories are real but the name of the patients and their family members, the storytellers, have been changed and given pseudonyms instead to protect anonymity. The main question on which I focused was: '*What they did when they were sick, when they experienced illnes*ses. In my first visit, I asked about the illness they had experienced in the last six months (for a survey of illness) and the treatment they had sought. After that, I visited them regularly during the fieldwork period and updated their subsequent treatment seeking efforts. The focus was to know about the illnesses they experienced and the types of the treatments they sought. I asked many complementary questions as needed according to the situation and need (See Appendices for interview schedules). I visited some of them repeatedly and observed their treatment activities, in their home, in the village and even in the health facilities, which were located within the district.

2.1 The Story of Gita

Standing in front of the main door of a house, I shouted, *gharma ko hunuhunchha,* is anybody at home? This is the question usually people ask loudly, when they want to meet someone in the house. It was midday of May and it was hot. I was hopeful that I would meet someone because people used to take a short break after launch. I moved my eyes around the house premises. The house was of two-storied, brick-walled and tinned roof. In the nearby shed, a milk buffalo and a calf were knotted, in front of which was a heap of rice straw. On the left side were a water hand pump and a small vegetable garden along with few trees of mango and guava at the margin. On the right side was a plant of holy basil planted on the top of a tiny temple like place, around

which there were some flowers planted in a row. The physical appearance of the house was revealing that the family was relatively better-off.

A woman opened the door just in a while. After exchanging *Namaste*, the local greeting, she said, *bhitrai aaunus babu*, please come inside sir[16]. She had known something about my work and me. In the village, many had already known that I was there to ask about the *sancho bisancho*, the healthiness and unhealthiness, of their family members. I went into the front room and sat on a plastic chair where she had pointed to with polite gesture. On the one side there was a bed of wooden cot and at the corner was a television set on a table. People in the village generally use the front room as a meeting, sitting and resting room. The poor also use as dining room. On the wall there were some photographs framed and hanged in an order and a calendar published by a local cooperative office. At one side of the wall, there was a small rack in which there were a few small bottles of medicine. I was moving my eyes around the room. She asked, *pani khanu huchha,* would you like to drink water? Many households ask about water. This was a courtesy. I replied *hajur*, yes that would be very kind. She handed me a bottle of water. Now people have started to use water bottles or plastic jugs instead of traditional brass tumbler or copper/steel jugs. I held the water bottle and drank half of it. She sat on the margin of the wooden bed facing towards me.

I began by pointing to the medicine bottles, "What are the medicine for? Does someone in your family have any health problem?" She replied, *Ke garne babu… budhi bhaiyo, kehile ke hunchha, kahile ke hunchha. Bisancho bhanera tyasto bisancho pani hoina tara sancho pani chhaina. Aausadhile chhodeko chhaina. Merai aausadhi hun babu, tyaha rakheka.* (What to do sir… I became old, sometimes one thing happens and sometimes another. I am neither so sick, nor so well. The medicine has not left me yet. Those are my medicine sir, kept over there). We started to talk about the illness she experienced and the therapeutic recourses she made.

After sometime, a middle-aged woman came with a sack of grains. She was her daughter-in-law and had returned from a rice mill. People generally go to the village rice mills taking their produce for milling service of removing husk from rice, grinding wheat into flour and crushing oil seed into edible oil. She kept the sack inside the room

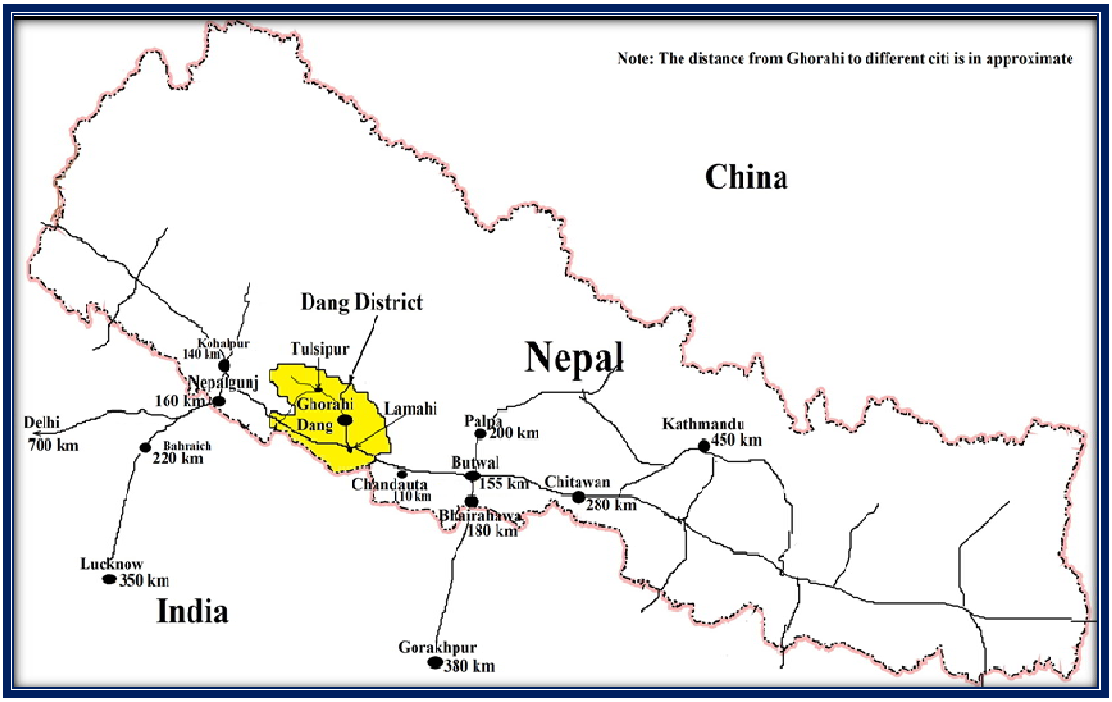
[16] Babu is often used by elderly woman to address a young and educated man out of affection. This is roughly an informal term for Sir/Mr.

and she also joined in our conversation. We talked at length about the *sancho bisancho* of all the family members. I came to know more about the illnesses they experienced and the treatment they sought in my subsequent visits.

Let me describe the illnesses Gita and her family members experienced in the last six months. Gita is a woman of 66 and she became widowed in her late fifties. She suffered from cough in January, a winter month. When she had cough, she first tried home remedies. She boiled local herbs (leaf of *holy basil*) and added some spices (carom seeds, zinger, turmeric and a little salt) and drank as tea. Her daughter-in-law explained how they made such herbal preparation. This was a common practice in the village for cough and cold. When the herbal tea did not help she reported her daughter. Her daughter is married and lives in Ghorahi city. Her daughter and son-in-law know many medical clinics and doctors and among them they know an ayurvedic practitioner since long. Her daughter explained the problem to the practitioner and she bought those medicines for cough (labeled as *kasturi bhusan* and *cough keshari*). She had not thrown out those empty bottles because when the cough repeats, she needs to show the bottles to ask someone to buy her the medicine.

Many people go to Ghorahi daily and some of their relatives have settled there. Ghorahi is a market place for the villagers and a city where there is a public hospital, medical dispensaries, pharmacies, and quite a few Ayurvedic, Homeopathic, Acupuncture, dental and eye clinics. The villagers seek treatment services either from public hospital (which they call Ghorahi hospital) or from privately run clinics and pharmacies (which they call either by the clinic's name or by the doctor's name). The number of biomedical clinic clinics is very high compared to the traditional medicine. People also go to Nepalgunj (a city near Indo-Nepal border and from where people go to Lucknow, New Delhi and other Indian cities), Butwal (another city from where people go to Chitawan, Palpa, Kathmandu, and also to Gorakhpur, a city of India).

Figure 9: Treatment Sites outside of the District with Approximate Distance



And then she had loose motion and this time she took yoghurt and powder of *bhakimlo* (rhus semialata) and that worked. And then she had short-term fever which disappeared the third day without any treatment. She said that she had thought to go to a medical facility in the village but the next day the fever fell down and disappeared. However, for fever most people either visit a female community health volunteer for paracetamol or go to the medical store in the village and buy medicine. There are two medical stores in the village, one in the middle of the village and another on the way to Ghorahi at the border of the village. These medical stores are privately run by paramedics trained as community medicine assistants (15 month training course after school leaving certificate) since the last four or five years. The villagers call them medical or clinic or the owner's name. The medicals work as clinic cum pharmacy and people consult these paramedic and buy drugs when needed.

After a few months she got back pain with fever. She thought it was because of the heavy work, lifting of grain sacks from one room to another, might have caused the back pain. She hoped that it will be alright without any intervention, like the fever she had experienced previously. When the pain persisted she consulted a village healer in the evening, thinking that whether that was caused by *laago-bhago* (evil spirit) The

healer did his *jhar-phuk* (brushing down-blowing up of the spirits by the broom stick) and suggested her to go to a hospital and the next day morning she went to Ghorahi without visiting the village medical as her son, daughter and daughter-in-law talked over phone and decided. In Ghorahi, her daughter accompanied her to visit a private clinic, which they used to visit most often. They feel comfortable to talk to the doctor whom they have been visiting. The reason to choose private clinic was to meet the doctor without waiting long, before office hour, and get a little more time to explain their problems. After physical examination the doctor asked them for x-ray, blood and urine reports. They waited for reports and then the doctor wrote some drugs and sent to a nurse for an injection.

She paid 480 rupees (approximately $ 5 as consultation fee, which she could have saved had she gone to a public hospital. The public hospital charges only 20 rupees for registration but OPD service starts only after 10:00 a.m. in the morning. The private lab charges are higher than the public hospital for diagnostic tests. She spent 5000 rupees in total. However, she expressed her satisfaction as she had got a relief from the pain then and there, after getting injection. She bought the prescribed medicine and came back home. Her condition improved with the medicine.

After that she developed a problem in her mouth. The *bimira* (a number of tiny watery bubbles) spread in her mouth. She had pain and great difficulty in eating, especially hot and spicy food. She again consulted the same healer and she also prayed her *kul devata* (the clan deity). She offered *dhaja* and *dhup*. *Dhaja* is a strip of cloth usually in red or white color and *dhup* is traditional home-made *agarbatti*, the incense. They take dry leaves or flower of *titepaati* (*mugwort or artemisia vulgaris* plant) and mix with little ghee and put into burning coal to make smokes of odor. By doing this, she asked for a blessing, *Lau parmeswar! Jaan anjaanma yedi timro sewamaa bool bhaye maafi deu, Yo dukkha darda bata paar lagau* (Oh Supreme God! Forgive me if I did wrong, knowing not knowing, in your service and rescue me from this suffering). Along with this, she also kept green leaves of holy basil into her mouth and ate soft food, drank water and milk and avoided sour and hot things for few days. That improved. She was fortunate that she did not have to seek medical help.

She also shared that last year she had a pain in the abdominal area and after consulting a *janne manche* (the person who knows) she went to Nepalgunj where her son works.

They went to a hospital and visited a doctor in his private clinic. They were referred to diagnostic center for lab test and ultrasound, which was located next to his clinic. The private diagnostic centers charged very high but did not make them wait long. After collecting the reports they again visited the doctor. The problem was diagnosed as *patthari* (gallstone) and the doctor prescribed some medicines. She came back to home and took medicine regularly, avoided oily/fatty and spicy food as suggested by the doctor and added the soup of *gahat* (black gram) and some fruits and vegetables as suggested by *janne manchhe*. She went to Nepalgunj after there months for follow up visit. Again they visited diagnostic center for ultrasound report. The doctor said that the size of the stone was reduced and no worries for surgical removal. The doctor wrote additional medicine. The pain had already gone. She believes that the changes in her diet must have contributed to the treatment.

She reported six episodes of illnesses, which she had experienced in the last one year. Such problems are not unique to her. Many people of her age had experienced various illnesses time to time. She had reported a relief of back pain but many were there who had been living with chronic low back pain, leg and hand joints pain and pain in the body. Some of them were suffering from chronic illnesses such as diabetes, hypertension, chronic headache, mental illness, stomach/gastritis problems and problems related to reproductive health. She had used home-based practices, the use of healers and private clinics in Ghorahi and for a difficult case in Nepalgunj. Her story is not unique in that many illnesses are treated at home. But many cannot afford distant private facility. The point of my interest was how they follow the treatment recourses. This case gives a rough idea about the illness and treatment recourse from home to hospital. Most of her illnesses were attempted at home and treated at first or second recourse. For the general physical problems she consults local healers or asked the persons who know, visits local medical store and for illnesses which she and her family perceives severe, consults a medical doctor in Ghorahi where her daughter lives and Nepalgunj where her son works.

The story of Gita will not be complete without understanding her family. Her family was ranked as the *sampanna* (well-off) placed at 24th out of 126 households in a wellbeing ranking carried out among a group of local teachers. Indeed, her family is socio-economically better. She is Brahmin/Chhetri by caste. There are five members in

her family: her son, daughter-in-law, a grand daughter and a grandson. Her son, aged 45, works for an organization in Nepalgunj, lives in a rented room. He occasionally comes home and his wife also goes to visit him at times. They keep a buffalo and hold approximately 20 kattha[17] agricultural land, which they have given for sharecropping. Her son has been taking medicine for hypertension from the last two years. It was not possible for me to know more about his illness experience because I could not meet him during my field work.

Her daughter-in-law (Rita) also has many problems. She said, "I have a small tumor on my left foot, I have the problems of piles, I have pain inside my right ear, I have problems of *baath* (joints pain), I have *pathegharko samasya* (problem related to uterus) let alone the seasonal cough and cold." She has been trying to seek appropriate treatment for her problems since long. Every time she visits her husband she convinces him that she is having problems. Her husband sometimes pays attention and takes her to the hospital for treatment, sometimes when he thinks the problem is not so severe and does not need an immediate treatment, he postpones for the next visit. She said that she had visited hospitals several times with her husband. In my subsequent visits I saw her leg bandaged. She reported that her tumor on foot was removed surgically the third time and because of that she had been suffering with painful walking. She said that it was due to her barefoot walking in her childhood that she got deep thorn prick into her foot. Someone in the family removed the thorn from her foot and she recovered soon. After a decade or so she started to develop a hard tumor on the very point. She says that might be because of incomplete removal of the throne. She worried for having the problem since long. She was worried because the previous surgical removals were unsuccessful. She was also having a problem of lower abdominal pain since long. Like many women, she called that *pathegharko samasya* (problem related to uterine prolapse) She visited three different hospitals and private clinics. Every time she visited, she was prescribed some medicine by the doctor. But the problem still persists. She says, "When I take medicine the problem of pain and white discharge stops and then after sometime the problem appears again."

[17] One kattha is equal to 338.63 square meter (roughly 12 kattha is equal to one acre and 30 kattha is equal to one hectare)

During this period, her two children, a daughter and a son, who read in a private school did not fall sick except the seasonal cough and cold. But the last year, her daughter had visited a dental clinic in Ghorahi for tooth ache because she had dental caries and she got it filled with cement and her son had a twist at the ankle joints which was treated by a village healer, by fixing the dislocation manually and applying the local herbal paste.

In my last visit she reported that she had a plan to go to Nepalgunj to show her ear problem to a specialist. She said, "Last time when I visited an ENT doctor, he said that there was nothing inside my ear. If there was nothing, would I have pain? It pains from inside. I hear a noise in my ear. The doctor could not diagnose my problem. My husband also believed that I was telling him a lie". With a hesitation she shared, "Once my husband slapped me close to my ear when we had argument over the issue of children's education. It started to pain since then. But my husband does not believe this." She felt shy when she was sharing this. When a quarrel between husband and wife takes place, usually wife becomes the victim. Women fear to share such an incidence because they feel shame or a sort of guilty. In the village, they take it as normal phenomena. They say *logne swasniko jhagada paralko aago* (quarrel between husband and wife is like the fire on the rice straw), vehement but soon turn off. However, this points to the fact that family relations matter in health and illness. The domestic violence is not limited to physical injuries and wounds but also related to emotional and mental health problem. There were quite a few cases of illnesses associated with husband-wife relations and family disputes. A few women who had mental health problems had bad experiences in their husband-wife relations. The tussle between husband and wife seems to be affecting the health and illness experience. Accepting the truth of violence she said, "*Uhi aagole polchha, uhi aagole sekchha* (the same fire hurts, the same fire warms up). The husbands are the ones who beat their wives and who also seek care for them." Women are dependent on their husband and male members (father or fathers-in-law) for treatment expenses. Most women need permission to step outside of the home to visit their relatives and friends. The male members give permission to visit the local healers and one of the reasons is because this costs less time and money. This does not become an issue because usually a healer happens to be someone familiar to the family. This may be one of the reasons why women visit more often the local healers than the far away healers or medical doctors. Visiting village healers also gives them a little freedom to go outside and visit someone

with whom they can share their problems. Sometimes, men do not pay attention or resist the women's request to go to the distant healers or health facilities. Women have to exhibit extra pain and suffering to convince husbands to seek treatment for them. Sometimes they need to stop food and regular work such as cooking, dishwashing and other household chores and then only husbands are convinced of the illness that they suffer really needs care. Like many patriarchal societies, the status of women has been dominated by their male counterparts in the family, in the community and at the national level.

After reading this story I have few questions, try to answer them to give analysis. For the old woman having educated children, working and staying in towns, especially a daughter takes care of her medical care is at more privileged position, than the woman (daughter- in –law) who is also in the village but suffers illness more than the old woman. She is also at the mercy of her husband only? Why? Why younger woman suffer more than older woman? Are the emotional mental health for a younger woman more than older woman? Older woman has more power and freedom than younger woman? Who does the everyday household chores? Why younger woman did not go with husband to town? Are there property issues? How much they spend in the family on health, who gets more priority? Substantiate these arguments with other readings in your analysis.

Men have a dominant status in the family power structure. In the case Gita's back pain and fever the final decision to seek treatment was made by her son. Her son, though was not at home but was reported about the seriousness of the illness. Gita's daughter-in-law (Rita) had played a role of reporting. Gita's daughter played a role to convince him. This was done because they do not bypass him in case of illnesses which they perceive serious. The next recourse would have been to the city hospital where her son has been working, had her illness persisted. There was moral or ethical obligation to seek appropriate care in time. Morality of her son and daughter-in law will be assessed based on their effort to seek appropriate care in time. The extended family such as Gita's husband's brother who live in the same village and close neighbors also make close observation and assessment of the treatment activities. Besides, Gita also holds the land certificate, transferred after the death of her husband, and exerts power over her daughter-in-law to influence in the decision making, such as reporting favorably.

The good care of mother-in-law is also associated with the issue of smooth property transfer as Rita and her husband have the obligation to please Gita and be the *budhes kaalko sahara* (help at her old-age).Her daughter is educated and lives in a city, holds a job which gives her an authority to have a say over the matters. Her daughter-in-law is not so educated and does not hold a job. Besides, Rita lives in the village to take care of her children and her mother-in-law. Rita does all the household chores, from cooking, washing, cleaning and taking care of the domestic animal. Rita has to convince her mother-in-law first to go to her husband and there must be good reason such as seeking treatment. The management of household work becomes difficult for Gita in Rita's absence. The children are growing and can help in the household chores but cannot substitute Rita. In family, the mothers-in-law have more power and authority than the daughters-in-law. The daughters-in-law also gain some power with their growing children and aging parent-in-laws.

2.2 The Story of Sita

Sita is a 32 years old woman from a *samanya* (an average) Janajati family.They depend on agriculture. She herself and her husband are literate and they are sending their three children to schools. All of her family members, she herself, her husband and their three children, had experienced one or more illnesses during the fieldwork period. Among them her elder daughter was suffering from a chronic illness. She narrated her daughter's story as follow:

> My eldest daughter used to fall sick frequently since she was born. Small children fall sick, but she was falling sick again and again. Sometimes she used to complain stomach pain, sometimes chest pain, sometimes joints pain. She had many problems. We visited village healers, medical clinics, and hospitals many times. The medicine used to work for short time. She was just 4 years old and she was admitted in Ghorahi hospital for jaundice when she was weak, pale and yellowed. She recovered from jaundice. After that she suddenly lost her consciousness. Again we admitted her in the hospital but the hospital referred to Nepalgunj hospital and from there to the children's hospital in Kathmandu. At last we went to Lucknow, she was admitted and her blood samples were also sent to Mumbai. The report

came and the doctor told that she was suffering from sickle cell anemia. We had no idea about the illness. The doctor told that it was not curable. We were so sorry when we knew that she was suffering from such an incurable illness. They said that she needs regular blood transfusion. At that time she was only five years old. Since then we have been regularly going to hospitals for her treatments. She got appropriate treatment only when she was diagnosed with sickle cell anemia. Later, we knew that we were not alone to suffer, we met the people who had such illness in Ghorahi hospital. We got a great relief when government started to provide free treatment[18] two years ago. This was a great help for us. I cannot imagine what would have happened to our family if the treatment had not been made free. Now she is 13 years old. She goes to the school and studying in class five. She has not grown up to her age. She has not progressed in education. This is because of her illness. In the beginning the doctor used to call us in every six months for blood transfusion and then in every three months and from the last two months, when she was unconscious and admitted in hospital, every two weeks.

Ours was a large family. There were my husband's parents and his two brothers with their wives and children. You know, it is easy to take care when someone is sick in joint family. There were many working hands. But my husband's brothers feared from the treatment cost and forced us to be separated from the family. They did not say anything to us openly but, surely, they thought that the treatment cost will ruin them if we remain in a joint family. They sensed *dubaune bhaye*, that we will push the family into an inescapable swamp of debt. They gave our share of the family property and made us live separate. We had to face this when we were at dire need of the family support. After being separated we faced many hardship because we had no such source of income except the agriculture. It was very hard for us to take care of sick child and care and support other children. We had to give time and make extra effort to carry on with our agriculture and care for domestic animals. We had to borrow a lot of money. We borrowed from moneylenders, from women groups and from [saving and credit] cooperative bank.

[18] Government has made an arrangement with hospitals in the patients of sickle-cell anemia get free treatments covering up to one lakh rupees.

> Our main income is from vegetable farming. But sometimes the price goes down unexpectedly. The loan amount increased when we borrowed to repair the home we got after separation. The interest amount is high but till now we have been able to pay by selling the vegetables we produce. Everyone knows that my husband is very hardworking. He has no bad habit. He never drinks *jaand-raksi* (fermented rice bear and liquor), never smokes and he never plays cards. He never gets angry and rarely scolds me. He never slaps children even when they make mistake. We also grow off-seasonal vegetables to get high price. We work throughout the day in our small field. Usually, I collect vegetable from the field in the evening while my husband goes to Ghorahi bazaar to sell the vegetable loading them on cycle every morning. I do all the cooking and send our children to school. The loan amount makes us worry, especially when the day approaches to pay the interest and installments. Sometimes we cannot sleep well, thinking about the amount we borrowed. Sometimes we fear of losing our land. I have added goats and chickens and we are trying hard to pay back the loan. First we will pay the money lenders because that was of very high interest rate (36 percent) and later we will pay the cooperative (12 percent). *Sab thok khanu tara hares nakhanu bhanchhan* (A saying which means one should never give up hope).

They were having immense hardships and sufferings. But there was a sort of satisfaction that she and her husband made commendable effort for the treatment of their daughter. She was not looking gloomy while telling her story. Her face looked bright and her voice sound lively with the satisfaction achieved out of struggle against the difficult circumstances. They were in debt because of the treatment cost but there was no regret. Despite the poverty and indebtedness, love was there, love between husband and wife, love for the children. A hope was there, a hope that they will overcome the difficulties, a hope that they will be able to pay back the loan by making an extra effort. Many families were struggling to live happily amidst poverty and indebtedness. Besides the sick daughter, she herself had a problem of abdominal pain and diagnosed with kidney stone. When she was in hospital for her daughter's treatment, she managed to consult a doctor and took the prescribed medicine. She had not gone for follow up test till the time I visited her last. She was hopeful that the stone

might have gone out of urine. She also shared that she drank plenty of water and avoided foods that were considered not good for stone, such as tomato, spinach leaves, and beet roots. Her husband and other two children had no serious illness except seasonal cold and cough, which they managed at home. Her husband had once short fever and for this he had taken a few paracetamol tablets from a neighbor who was working as a peon in a health facility.

2.3 The Story of Mina

Mina, 54 years old woman from a poor families from Dalit community, narrated the story of her husband who was suffering from mental illness:

> We were five in our family, two son and a daughter. Our elder son is separated and lives with his family. Our younger son is unmarried and has gone to Mumbai in search of work and our daughter died at the age of 20. She died all of a sudden. She had fever and she died without seeing the hospital. My husband was a handsome and a healthy guy. He used to buy he-buffalos and he-goats from the villages and sell them to a butcher in Ghorahi making some profits. We had agricultural land on which we could produce sufficient for our consumption. My husband's mental state started to worsen when our younger son was three years old and eldest was 12 years old. One day I saw him weeping at the time of harvesting wheat. He was sitting on the margin of our wheat field. He had beaten up our daughter for her minor mistake and I thought that he was remorseful for that. I thought he might have felt guilty after beating her. We came back from the field but he started to wash our house flour [which is considered women's work] without eating morning meal. That was strange. Then he started to talk strangely. He said police are coming to take him to jail. He ran here and there and then started to show unusual behavior. He did not sleep well. He did not eat regularly. He started to talk pointless and nonsense. He started to self-talk when there was nobody around him. Later, he started to go undressed. We called healers after healers, from far and near. We took him to Ghorahi many times. We also took him to Deukhuri, another part of the district, to visit a shaman. But he repeated the same unusual behavior and every treatment short lived. He used to refuse to take medicine and ask us, *malai ke bhako chha ra*

"What happened to me? I am all right and I do not need to take medicine." His condition worsened further when our daughter died and his younger brother killed [at the time of Maoist movement]. And then he started to fear and hide himself in the rooms. He repeatedly said that police are coming to catch him. He used to cry secretly without an apparent reason. He started to walk out without a purpose. He left home and wandered around the streets of Ghorahi city. When people did not offer him food he stole from a shop and was taken to police custody. He came out from custody because the police soon knew that he was *khuskeko* (out of mind). Our neighbor informed us that he was bathing in a mud water and small children were teasing him as *baula* (mentally retarded) and pelting small stones towards him. He became violent to the children, pedestrian and passers-by who teased or pelted him. He grew aggressive in the family, spoke loudly and we had to keep him knotted time to time. He used to leave home without letting us knowing and we used to bring him back again.

When my husband developed such *manasik bimari* (mental illness), everything went wrong in our family. I suffered so much during his treatment. I had to look after my home and my husband. I had to borrow money and sell our land because the loan amount was rising with high interest rates. There was cost for the setting of shamanic healing rituals (*dhami-jhankri basne*) to sacrifice a rooster or a black he-goat, to offer *bheti* (cash amount) based on the reputation of the shamans. At that time, we spent a huge amount of money in Lucknow, where he was admitted for one and half months. We spent a lot of money (around 50,000 rupees) in Gorakhpur hospital for hospital charges and for drugs. We visited repeatedly and each time spent around 15,000 rupees. The doctor used to tell us that he will be alright, keep few more weeks. But we could not afford more because there was no one to lend us more money. Many a times, he refused medicine and the improvement did not last long. The problem remained as it was then. He goes mad time and again. Sometimes he scolds me and beats me with whatever is in his hand. I do not talk to him when he is not in good mood. Sometimes I go to the neighbor's house to hide myself from him. I come back when he cools down.

I also talked to her husband. When I first met him, he had kept long hair and beard and was wearing tattered and not so clean T-shirt and half pant. He did not show any interest in me. He was reserved. I managed to talk to him in my subsequent visits. He talked with me very politely. Though, I could not understand many things, I found him very lively in his talking. At one point he accused local landlords and money lenders for grabbing his land. Once, I also saw him making a hand broom. Mina said that he was skillful in making hand broom before marrying her. Till now, he use to make brooms, when he is in mood. The neighbors buy his broom at petty amount, enough to buy a sachet of chewing tobacco. During my field period, they did not seek treatment from professional practitioners. Mina expressed helplessness about his further treatment. She was cursing her fate. She was consoling herself, *mero bhagyama yestai rahechha,* (such was the thing in my fate).

There are many such stories like those of Gita, Sita and Mina. These stories tell about how treatment is sought, what happens when the illness persists or turns to be a chronic one. The stories also give clue about how the families, who are struggling with poverty, have to make difficult choices while seeking care. Many who had minor illness episodes such as cough and cold, sore throat, headache and short fever, minor cuts and wounds, and constipation and loose motion most had recourse to either home-based remedy or consulted village healer or paramedic but for severe or chronic illnesses they had taken multiple recourses. These stories give some idea about the health and illness perceptions, the role of the families and kinship in treatment seeking, the use of home-based practices, the utilization of health care services, the consequence of health care cost, and the state of medical pluralism. Many themes can emerge from these stories of illness and treatment seeking. The following section attempts to substantiate some of them.

3. Perceptions of Health and Illness

"Sanchai chha?" is a question asked for "how are you?" (Or are you alright?). The question also works to know how one is feeling about his or her health. However, possibility is that most of the people reply affirmatively even though they are not fine or alright. Even if they are not well and have health problems. I asked *"sanchai chha"* to an elderly man. We have become very close as his house was on the main road and we used to exchange smile and say hello while going to and coming back from the next cluster of the village. One day, I was walking to the next cluster. When I saw him in front of his home, I asked with friendly smile, *sanchai chha?* Between us was an open dry drain, he coughed out and spitted into the drain and replied, *sanchai chha* (yes, I am fine). Apparently, he was not fine because he was coughing. Another elderly person also replied with *sanchai chha* while he had visible scars of abscess in his leg. This may be because they did not count those problems as worth mentioning or those problems had already been taken as normal. Despite having common cold and cough, having abscess, fleshy warts, fungal infections, or even having mild fever they may reply affirmatively to the question 'Are you alright'? Normalization of health problems shows their resilience and do not even fell them as health problem or recognize them as illness as long as they are able to carry on with their daily routine work.

Further interaction and rephrasing of questions yielded the answer about whether they had any health problems and sought any treatment. Some people are less concerned about some illnesses and do not feel to share them with others. This is not because they did not feel discomfort but because of the low priority given to such illness and a low level of illness perception. There were people who have apparent symptoms but they did not feel to seek treatment unless that turns to be painful or likely to exacerbate. When reminded of the visible symptoms, they smile and say, "Y*e, yo ta purano bhaigo*, (Oh! This has become outdated)." This means they had problems before but now they have stopped to seek care for such problem, either because they are recovering, or hopeful to be recovered or because these problems are not painful and can be lived with them, sometime with a hope that the problem will disappear in due course. From the queries about the scars of a child, I came to know that a dozen of children had chicken pox. Then they had no problems with the scars and were hopeful that the scar will disappear in due course.

The illness perception varies. What is illness to a person may not be perceived as illness by another person in the same community. Same is with the health. Different people perceive healthiness differently. A participant said that you go to the doctors healthy and the doctor will diagnose something out of you. Most people in the village hold that as long as a person eats full stomach, works as usual, sleeps well and has no 'tension', the person is healthy. The condition of a person is described as having illness or sickness when there is imbalance in the food intake, difficulty to do the regular work, poor sleeping, restlessness or mental worries. The baldness, small wounds or scars do not hamper the food intake nor the work efficiency nor causes problem in sound sleep. The family also gives less priority to such problems.

There is a debate among the youth and elderly as who is really healthy, the new generation or the old one. Most of the elderly people are of the view that they are not so healthy than their forefathers. They hold that people of the present time are not healthy and this is because of the changes in the life style, the production and consumption of new varieties of staple foods and vegetables. They are concerned with the increased use of chemical fertilizers, insecticides, pesticides and newer varieties of seeds. A retired government employee (67 years) from well-off Brahmin/Chhetri family observes the changes that has taken in the village:

> Life has become easy now. We do not go to jungle to collect firewood and fodder. We are cooking in biogas or using gas cylinder. We cut grass, which we grow in our land. We use power tillers instead of oxen to plough the field and we use thrashing machine instead of moving oxen. We use rice mills instead of *dhiki-janto* to grind wheat and to remove husk from rice. We stopped walking, we ride motorcycles or take bus to go Ghorahi. We do not carry goods on our back instead we use vehicle. Everything has become easier now. There is no hard work even to give birth a child. Today, women give birth easily with an injection and C-section. We are living comfortably but we are not living healthy.

A retired police, 52 years, who was active and energetic and belongs to well-off family of Janajati community opined that people in today's time are not so healthy:

> People of present time are neither healthy nor strong from inside. They are *rogi* (diseased) and they cannot live without medicine. Most of them take medicine daily, either for pressure or diabetes or thyroid or uric acid or asthma or depression or for something else. Healthy is a person who can live without medicine. But nowadays, it is difficult to find a person who is not taking any medicine.

The elderly hold that illness and misfortunes result not only from imbalance in the physical body but also in the imbalance of spiritual body, *man-mastiska* (heart- mind). They also give importance to the supernatural causes such as bad spirits for an illness. However, some of the educated, youth and who are employed in the urban areas or who are exposed to the outside world hold that there is no such supernatural force, which can cause a person sick. The education and awareness on many of the newer disease condition has shaped their perception that the illness results from natural causes than those of supernatural causes. This also makes them to decide to go for official health care facilities than to the faith healers. They hold that for disease conditions, it is better to go to medical practitioners than to the folk healers. However, for certain things many feel that they can rely on the local healers. People make sense of the illness and have preference in their choice of medicines. A Janajati woman when I asked, "Why did you repeatedly visit the same healer?" She replied, "*Jaha biswas chha, tyaha jane ho* (where you have faith, there you will go)." The choice of medicine also depends on how the patients and caregiver perceive about the illness. Most of them perceive that the folk healers better serve for the illnesses which are culturally understood and which have social causes. The shared worldview, the good relation with healers and the healer's tolerant behavior to listen to the problems of the patients encourages them to visit them frequently. Sometimes, those who say that they do not believe in *jhar-phuk* (a healing practice in which a healer sweeps down and blows up the bad spirit using a small hand broom and healing mantras) also found visiting the faith healer.

An educated person, aged 54 years, from Janajati family shared his experience with an urban healer. This also points to the use of faith healers and the existence of such in the urban areas as well.

> My son (4 yrs.) was seriously sick. We had admitted him in Ghorahi hospital. He was vomiting whatever we fed him, milk and medicine. I secretly visited a nearby healer without the knowledge of the doctor. He did *jhar-phuk* and chanted healing mantra to ward off the roaming spirit and then we quickly returned back to the hospital bed. The vomiting stopped and medicine started to show its effect. I do not know whether it was the effect of *jhar-phuk*. I was happy that my son recovered. When there is an emergency we cannot help trying such thing. *Marta kya nahi karta?* (A dying person does everything).

Mansari is a woman (46 years) from poor Dalit family who consulted a healer shared:

> I had stomach pain. I suspected something else when the medicine bought from village medical did not help. Then I went to a healer. The healer did the *jhar-phuk*. And he also gave me the *dhulo* (powder made of herbs) and that did help me. I do not know whether *jhar-phuk* worked or *dhulo.* Perhaps both of them worked.

Society is changing and so are the perceptions. They place importance to the *dhulo* rather than the *jhar-phuk.* However, ambivalence nature can be observed. There are some people who say that they do not believe in faith healing but if closely observed they are found seeking care from them. I visited some individual in the healer's home or at the site where healing rituals took place. When I asked an individual about the reason of being there, he replied, "*Bhai halchha ki bhanera aako* (came with a little hope of being cured)." A few have also invited *jhankri* (shaman) from the neighbor district and the *jhankri* costs relatively high because not only they have to pay a satisfying amount to him but also to pay for an accompanying person who works as porter to carry his paraphernalia.

Kumari, 26 years, a woman from Brahmin/Chhetri family shared her father's illness:

> My father was suffering from *jhaskine and daraune*, (sudden frightening and fearing). We called two *jhankris*. The first was from the next village. He

> performed healing rituals and gave him an amulet to wear but the problem persisted. Then we invited another from the distance village. He performed his healing session whole night. He came two more times to visit and performed rituals of *dhaja-dhup* to appeasing clan deity. We did not have to pay much for the first one but for the second one we gave him 3000 rupees (Approx. Rs 100 = 1$) for his service. This was the amount, which other people also give. When the problem did not appear again we gave him an extra 5000 rupees out of happiness.

This shows a commercial or market influence in the traditional healing practices. Previously the offering used to be petty and voluntary. Now, the amount has become high. The big healing ritual costs high. This is not only with shamanic healing bot also with herbal healing and specialized treatment such as bone setting and snake bite healing. Even the traditional midwife have started to demand a little more amount. The rational is that everything has become expensive and nothing is available free of costs. Even the faith healers for general *jhar-phuk* (an act of sweeping down and blowing up the bad spirit with healing mantra using a hand broom) expect little more cash as offering. However, still they are less costly compared to official medicine. One of the teachers had argued for the cost of shaman saying that the shaman spends whole night but the doctor spends even less than minutes to treat the patients. He questioned me, "Why are you worry with the amount a shaman is offered and not with the amount a doctor charges. A shaman gets just just around 3000 rupees but can you dare to visit a doctor of Lucknow with that little money? Besides, there is no guarantee of being cured even after spending thousands of rupees in Lucknow for such (mental) illnesses." He also referred the woman who had spent a lot of money but has not been cured.

Not only have the poor, Dalit and Janajati but also better-off, Brahmin/Chhetri had consulted such healers. Some medical doctors of the district also accepted the consultation of folk healers for themselves or for their family members. They had also sought help from traditional midwives for massage and postpartum care. They also have faith in medicinal herbs and express their desire for "natural products." The doctors, who were from the same district were more familiar with the folk healing practices and also shared that they asked patients about their prior visits with healers in their history taking.

4. Perceptions and Treatment Seeking

The perception of disease and treatment seeking largely depends on the etiology of the disease. The causation of disease determines the course of action. The villagers believe that a person contacts disease from various reasons such as contacting diseased person, having stale or unhygienic food, contaminated water, changes in seasons, and imbalance of hot-cold food. They also point to chemical fertilizers, insecticides and pesticide for the causes of some diseases. They also believe that dead spirits, evil eye and wrath of deity also cause illnesses.

They usually visit local herbalists or medical practitioners for disease and injuries and they visit local faith healers when they suspect of any evil spirit. They have some criteria about whom to consult for what type of problems. When they are uncertain about the causes they resort to the healer as well as medical practitioner for a single episode of an illness. A general rule is that for supernatural causation a shaman or faith healer is the first choice but for physical problems and injuries, herbal healer or medical practitioners. This partly tells when they resort to the healers or medical practitioners and what the logic behind their selection is.

They do not care much about the bearable amount of pain such as headache, common cold, sore throat, stomach pain, running nose, short fever and the like. They do not seek treatment for some time with a hope that the problem will be fine in due time. When they feel a need, they try home remedies themselves or seek help from the family members, friends and neighbors and if that does not work they visit village healers, village medicals, health post or they may decide to go to hospital or private clinic. Choice is made based on the experience of family and neighbors, the familiarity with the healers or practitioners, the type and severity of the illness, and quality and cost of care. The treatment seeking order, thus, starts from home-based practices and self-medication then moves to the local healers. They think that it is not wise to go to the distance hospital without consulting a healer. They argue, ‘What is wrong in showing

once to the healer before going to city hospital." In many cases, they visit a shaman or faith healers because they want to be assured that there is no supernatural element behind an illness. The healers also suggest the patients to go to hospitals if the illness is not likely to be treated by them. The village healers are the first point of contact for many illnesses. In most cases, general resort pattern follows home remedies to healers and/or paramedic to hospitals. Sometimes they come back from hospitals and again consult these healers and/or paramedic. For instance, when a woman (HHN 55/126, 42 F, Janajati) had headache first she drank a glass of lemon water and tied her head tightly with one part of her saree. Then she visited a healer the next day and when the pain persisted and fever increased she went to Ghorahi hospital. The pain spread from head to the shoulder, low back joints she visited the doctor again. The doctor changed the medicine. She visited another healer because the medicine did not show an effect. At last she went to Butwal hospital and diagnosed with jaundice. She started to take doctor's medicine along with herbal juice as suggested by local healer and home-based fruits and vegetables such as papaya, and cucumber and carrots which were considered good for jaundice. Similarly, a person (HHN 25, 57M, Brahman/Chhetri) get massaged with vicks, when he had headache first and then visited village medical and bought tablets (of paracetamol) when headache persisted he was suggested to visit eye clinic and he got the eyeglass and it worked for a few months. When the headache persisted, he visited a healer suspecting of *laago* (roaming spirits or unseen force) When this did not help he went to Ghorahi hospital and diagnosed with hypertension. He has been taking medicine since then. Now he goes to medical to get blood pressure measured and purchase the medicine prescribed by doctor. This shows that people resort to many different sources when illnesses are not treated because of the wrong diagnosis and wrong treatment.

5. Role of the Family in Treatment Seeking

Family plays a crucial role in the treatment decision and in taking care of the sick. Many illnesses were treated at home. The cultural traditions and perceptions of the family also influences the treatment seeking. When people experience an illness and feel a need of medical help, they begin the journey of therapeutic recourse. The

beginning happens when family makes an assessment of the illness condition and takes a decision about the therapeutic choice. The therapeutic choice may vary according to the socio-economic status of the family, also the status of the person in the family and the condition of the sick person. The role of the family member is very important to decide the path of the care. In following the treatment paths they often move from an immediate source of treatment such as home-based practices or visit the village healers or paramedic or go the clinics and hospitals first within the district and if that does not help to the outside of the district. What is found is the complexity of treatment seeking rather than a pattern when observed different illnesses. Many things come to play a role, the perception, economic condition, family condition and kinship connection in course of treatment seeking.

When a member of family falls ill relatives come to visit with fruits and foodstuffs such as *kurauni* (dessert like food made of milk), *okhte pitho* (flour food having medicinal quality) or market items such as *glucose, chawanprash, horlicks, ashokarishta, dashmularishta* etc. The relatives ask about the condition and suggest something based on their knowledge and experiences. They lend money for the treatment if needed. Such support are seen more when a person from better-off family falls ill. The socio-economically better- off seem to make best use of their kinship and social network. A participant who was from well-off Janajati family and suffering arthritic problem said, "When both of my legs swelled, I was admitted for 12 days in hospital and I stayed at my brother son's home after I was discharged from the hospital. They take good care of me till the follow up date. I came back home after I got recovered". Many families have relatives and close friends who live in cities and at times they accommodate them. However, not all family have same extent of urban connection (to have someone who studies, works and lives in cities).

Family is the main unit in making treatment seeking decisions. The family and neighbors' knowledge also plays an important role to manage the illnesses and to take decision to seek treatment. When a person experience symptoms of disease the person tries to do something by himself or herself or reports to family members to seek help. Depending on the illness and the status of the family the sick person or his or her family members make a decision either using home-based measures or consulting a local healer/medical person or consulting medical doctors. The patterns of resort can be

hierarchical, that is first they try immediate, familiar and cheapest sources and then they move to the distance, unfamiliar and expensive sources when the condition does not improve. Each time they evaluate and assess the condition and make a decision to move further, following simultaneous or sequential patterns of resort.

In many illness condition home-based practice becomes the first and last options. Most of the illness and discomfort are managed with the home-based treatment. Home-based practices are considered as effective and healthy way to treat some of the conditions. The villagers use different measures to deal with the different problems. These include using or avoiding certain food items, using varieties of plants and spices as medicine, buying medicine from the pharmacists based on prior experience and doing self-care. This also includes visiting temples, doing offerings, and praying Gods and performing rituals that are deemed to be helpful in the recovery of the sick person and bring back the health and happiness in the families. Many of the the home-based practices are culture specific and are based on the prior knowledge and experience. The family plays an important role in the home-based practices. The family members learn many such practices in the home as family tradition and culture.

A level of awareness regarding the medicinal values of some of the plants, herbs, vegetables and spices is found among all the people. Someone in the family, especially elderly and aged person, knows about the medicinal plants and the way of using them. The knowledge about medicinal plant is low among the youths as they name only a few plants and the way of using them. Though they know more about the name of widely used drugs needed for the treatment of conditions such as paracetamol for fever, oral rehydration sachets for loose motion. They know what medicine a female community health a volunteer keeps.

The family practices are the most important therapeutic option among the villagers. In most of illness conditions people do ‘something’ in their home before seeking help from local healers, medical practitioners and visiting a health facility. The ‘something’ consists of many things such as treating small cuts and wounds with herbal juice and paste. Using guava and yoghurt *or bhakimlo* (rhus semialata) or *salko karal* (gum of shorea robusta), banana guava for controlling loose motion, using *jamun* (Syzygium cumini), or decoction of *khayar* (Senegalia catechu) to control sugar, making holy basil or ginger tea for cold and taking water vapor for running nose or applying vicks

on the forehead for headache. Some of the houses also keep roots or bark of various herbs for home use.

A skinny woman, 47 years of age, from a poor family of Janajati community shared

> It was the time of *Dashain*, a Hindu festival. I could not control my temptation of eating more. I ate full stomach of *masu-bhat* (mutten meat- boiled rice). Because *Dashain* comes once in a year and there is rare chance to have *masu-bhat* for the poor like us. That was oily and spicy (hot). The next day, I got loose motion. I treated it with home remedies. My neighbor gave me powder of *bhakimlo* (rhus semialata) and yoghurt and then it stopped.

The kinship network also helps them to seek appropriate care. For example, a woman who had problem of stomach pain first tried home remedies and then went to medical and then to a vaidya. She also used the herbs suggested by her husband's brother who was a healer and made decoction advised by her friend's mother. Then she consulted a doctor but the problem persisted. Meanwhile Tihar (*Dewali*), a Hindu festival arrived and she went to her brother's home and shared her problem with the family of her brother. Her brother again shared the problem with his friends and neighbors. The problem was matched with the problem of a woman. Her brother and the woman's husband went to the same pharmacy and bought the same medicine and that medicine improved her. In her own words, "*balla rog ra aausadhiko bhet bhayo* (and then only the disease and medicine met with each other). It stopped my acidity. It solved my indigestion. It cleared my stool. It increased my appetite. It increased my work interest (*jangar laagna thalyo*)."

When the family tries hard to seek treatment for sick members this becomes a cause of satisfaction for the family. When the sick person gets cured they share their treatment seeking as they are blessed and fortunate and they appreciate that for God. Sometimes they get failure but at least family members feel that they did whatever they could. The patient also gets a reason to *chitta bujhaune* (to feel satisfied). When family members make genuine effort the patients feel that they are loved and cared by family and sometimes that becomes a reason to accept the condition as their fate and try to live with the illness as much happily as they can. A woman (HHN 89/126, 73F, Brahmin/Chhetri) who was suffering from multiple illnesses but apparent was

respiratory problem expressed, "*Ghorahi, Butwal, Kathmandu. Kaha gaiyena, ke gariyena. Mero rogai tysto chha. Daktarko dawai kati khaye kati khaye. Kehi gare bhayena, kehi gare hudaina. Aba marne bela bho, ke sancho hola* (Ghorahi, Butwal, Kathmandu…went every place, and did all the things. Such is my illness [incurable]. I took many doctors' medicine. Nothing cured, nothing will cure. My time has come. It will not be cured)". She was at her old age and the family also feels the same. But they think that it was their duty and a duty which they think God will bless them if they do. They think that the God is looking over them and knows whether they are serving *saccha manle*, with true heart-mind.

Another woman who was adult said, "Whenever there is change in season. When it is cloudy and raining or whenever I work in water I feel pain inside the joints. Mine was such type of illness. The doctors also say that it will not be cured but controlled. Whenever I fall sick, my husband does everything, cooking washing, cleaning…. He took me many places but my *rogai tyasto* (illness was such). Persisting no matter what is tried.

But there are stories that show that the less care from a responsible member of the family hurts very much. A woman whose husband had died who had been taking medicine for hypertension, wept while she shared that her husband was not taken to hospital on time. She blamed the careless nature of her son and son's wife. She was very sorry that she was not there, when her husband was short of regular medicine. She expressed deep pain of unexpected death of her husband. The husband was aged and suffering from other illnesses as well. According to the woman, he could have been saved, had they made little more effort to take him to hospital. She would have got a reason to *chitta bujhaune* (self-console), had her husband got good care. If family attempts hard even if the illness is not likely to be cured, especially the one who loves most, will be satisfied from the efforts.

6. Treatment Failures and Multiple Recourses

When a sick person does not improve, the sick or his or her family decide to resort to another source of care. The persistence of illness, the failure in diagnosis and treatment, had led people to recourse to different sources.

Gulabi, a young woman at the age of 24 years from average family of Janajati community shared:

> I visited faith healers, medical stores *kati ho kati, bhanera sadhya chhaina* (literally uncountable times). The healer's *jhar-phuk,* and medicine, cetamol and cough syrups, did not work. Weak after week the problem of cough and fever increased. In the daytime it used to be alright but at night it used to be high. When the problem got worse, I went to hospital and then only my problem was diagnosed as TB. I have been getting medicine from the hospital since then. The medicine is free but I have to go daily until, I complete six months. Now, I am not worried about the illness but the travel costs. You know, it cost a lot to go to hospital daily.

Ganesh who works in distance district as police, belongs to an average family from Brahmin/Chhetri community shared:

> I got a problem of *daad* (skin infection) in my private area. First, I applied the paste of green leaves of a kind of bean at home. This is what we do in our village for *daad*. But, that did not work for me and then I visited a village paramedic and bought a skin ointment. The ointment did not show any effect. The infection spread and itching grew. Then I went to a Vaidya and he also gave me another type of ointment and some medicine. I visited him two more times because the medicine prevented further spread and itching had went down. However, the *daad* persisted. Then I bought a *zalim lotion,* an ayurvedic drug for skin disease, on my own and applied. My friend suggested this. I also visited a doctor in his clinic while I was in Butwal and got some more ointments and medicine. That helped in the beginning but when medicine finished, the itchy rashes spread throughout my groin and thigh. At last, I went to Nepalgunj and visited a skin specialist. The specialist gave me tablets for three months and

different lotions. I have been taking medicine and applying the lotion since than. It has improved a lot and I hope this will cure.

Baburam, 78 years old from well-off family of Brahmin/Chhetri community shared:

> My diabetes diagnosed only when I went to Lucknow 18 years ago. I was weak, thin, and had lost weight drastically. I was visiting healers and medical of Ghorahi. At that time there was no such facility here in Ghorahi. A neighbor, who used to go to Lucknow for his treatment, accompanied me to go Lucknow. We visited the doctor and did the blood and urine test. The doctor read the report and said, "You have diabetes. There is no cure for diabetes. But if you take medicine regularly, you will live long." I could not remember what he said but the word "no cure" *(koi ilaaj nahin*) hit my head. I was shocked and dumbfounded. I came back with medicine. In my next visit, he assured me, "Do not worry, take medicine regularly, diabetes does not kill you, it keeps you in *discipline*." He suggested what to eat and what not to eat. The medicine was costly but I had no option. I continued his medicine. I also used local herbs in the beginning but stopped later when the doctor said that was not necessary. I went to Lucknow regularly to consult and to buy medicine. After few years the doctor managed to supply the medicine at Bahraich, (a town of India which is around 60 km south from Nepalgunj) and then at Nepalgunj and a pharmacist from Ghorahi supplied. Now, the medicine became easily available. From the last few years, I have been taking insulin. I feel a sort of sensation in my hand and leg. The doctor has suggested making hands and legs active. I move around the house. The illness cost me much. The family income was not enough and I had to sell half a hectare of my land at that time to cover the cost of medicine, travel and accommodation for accompanying persons.

7. Multiple Recourses and Cost of Care

The more the number of recourse that people take, the more the cost of care that they bear. Sometime resort to one particular source (for example folk healer) can cause unnecessary waste of time and money. In most cases each of the subsequent recourse, especially in hierarchical one or what is explained as counter acculturative resort, i.e.,

moving home to healers/practitioners to hospital people had to pay more. The above stories of illnesses such as sickle cell anemia, mental illness, diabetes and even in the case of skin infection each subsequent recourse cost them an increasing amount of money. The cost increases when they resort to the facilities located outside of the district for they need to pay hospital/clinics as well as travel and accommodation for themselves and accompanying persons. The increase in recourse time increases the cost of care.

Parvati, a woman of 38 years, of from average Janajati family shared:

> I was suffering from abdominal pain. When the pain increased, I went to a private clinic, spent 2500 rupees, and then to hospital, spent 1500 rupees, and then another clinic and spent 7000 rupees. No medicine worked for long time. And after 6 months I went to Nepalgunj and visited a famous doctor in his private clinic. I spent 10,000 rupees. His medicine also made no difference except reducing the pain till I took the medicine. Then I went to Butwal hospital and spent Rs. 12,000. *Paisako kholo bagyo, samasya ta jyun ka tyun* (The money spent like running stream, but the problem remained the same). Then I went to a *maata jee* (woman faith healer) of a faraway village. This also did nothing. I offered Rs. 50 as *bheti*. At last, I went to Chitawan and the doctor said it was because of hormone. I am taking his medicine and feeling better. I spent 20,000 for the lab, medicine and travel and accomodation.

Radha, a woman (63 years) from well-off Brahmin/Chhetri family, whose most family members are living with chronic condition shared:

> My husband got paralyzed. We visited hospital after hospital in Ghorahi, Nepalgunj and Kathmandu and at last in Lucknow. He needs help for having food, bathing, sitting on toilets and wearing cloths. He needs help to walk around, sit on chair and sleep in bed and to take each dose of medicine. I have diabetes. My son has diabetes and asthma. My grand daughter has been taken to Kathmandu for surgical treatment. We have been going to Lucknow since then. Though he gets pension and my son has job now but the income was not sufficient for the treatment, we had to sell a piece of land to cover the cost.

The multiple recourse, whether a poor or well-off person take, bear the increasing amount of costs. The poor as well as the well-off suffer from the rising cost in their subsequent recourses.

8. The Cost of Care and Consequence

The health care is not free in Nepal. Health care services are provided by both public and private sectors. The private health care is costly but people resort to the private clinics and hospitals many times not by choice but by compulsion. The health care cost has been increasing year after year as the consultancy fees, prices of drugs, diagnostic tests, and in-patient bed charges have increased significantly in the last few years. The villagers express worries about the rising cost of health care. One of the participants said that the doctors and private clinics/hospital treat patients as if they are milking cows. They milk the patients as much as possible. They leave the patients wander when they cannot milk them anymore. One's illness has become another's source income. There were many instances of borrowing money for their treatment and selling their assets. Even the patients from better-off family shared their bitter experience about the costly private services.

Lalmani, a reputed person and a retired teacher, from well-off Brahmin/Chhetri family shared:

> I have to borrow from my friend to go to Kathmandu because I had spent all of my money to the private clinics in Ghorahi. I was having stomach pain. I spent almost one year visiting medial clinics, including the ayurvedic one. When no clinics of Ghorahi left to visit, I went to Kathmandu and diagnosed that there was wound in my large intestine. The doctors do not tell you that they cannot treat you. They humbly welcome your money as Goddess Laxmi (the Hindu Goddess of wealth). They order you for various tests, prescribe medicine and ask you to visit them again. Every time you visit them they ask you to repeat the same tests. This is what they did for me. When my stomach pain did not come down from twenty to nineteen, I went to Kathmandu.

Govinda, 39 yeas, from a poor family of Dalit community shared:

> My son broke his hand and I took him to a bone-setter. I had no money to afford x-rays and things to do plaster. Without money what is the use of going hospital, let alone the private clinic. The private clinics are there for those who have money. I have gastritis and my wife complains of abdominal pain. Without money what to do? Govinda has relatively a big family with eight members. They have four small children and their eldest daughter who was married out has come with her baby daughter after a dispute with her husband. Govinda and his wife have to postpone the treatment of their problem as their problem was not pressing like the fracture of hand of their son.

Chmela, an old frail woman from the poorest Dalit family shared her difficulty:

> Last time my cough and fever did not stop no matter how much I tried at home. Then, I visited a healer. I visited the medical (of the village) and bought medicine from there. At last I went to Ghorahi hospital. I had only 500 rupees. The doctor ordered x-ray and it cost 300 rupees. The doctor checked x-ray and then wrote medicine for seven days. The pharmacist asked for 700 rupees for the medicine. I told him my problem and asked medicine for just two days. He laughed at first but he became thoughtful when he looked at me. Maybe he found me poor and helpless. He gave me the medicine for seven days and that cured.

Dilmaya, from the poorest Janajati family shared her problem of money:

> I have been suffering from over bleeding during menstruation. Sometimes I go to the medical to buy medicine (pain killer) which lowers the bleeding pain. *Paisa nabhayera aspattaal jaane himmat chhaina* (I have no courage to go to hospital for not having money).

The socio-economic condition of the family played an important role in treatment seeking. Those who were from poor socio-economic background suffered the most and faced the adverse consequences from the treatment costs. The story of those who

wanted to go to hospital shows the pain that they could not afford the cost. This also shows the difference between preferred (anticipated) and actual patterns of resort. The experience of those who had been to hospitals and clinics were not always good. The costly treatment had not brought any good result. The costly treatment and the consequences in the family shows another sort of pain and miseries.

Thaman, 34 years, from average Brahmin/Chhetri family who was seeking treatment for his wife's mental illness shared:

> I lost all the money in her [wife's] treatment. I had plan to add a room in my house but *manle taakchha mudho, bancharole taakchha ghudo* (mind aims wood-log, the axe aims knee). That was all my earning of the last two years. The money lost and her condition worsened. *Mero ta purpuroma haat raakhne bela bhayo* (Now has come the worst time for me).

Sarita, a woman of 26 years old from poor Dalit family shared:

> It was during the time of Dashain festival. My husband complained about stomach pain. We suspected about the over-eating. I made ginger tea for him adding a little salt. He started to become restless and I called a healer who lives just two house back from ours. The pain did not come down and we took him to Ghorahi hospital. Only the emergency room was open and no doctors were there (may be they were in holiday). From there we went to Nepalgunj and visited a doctor in his private clinic. After diagnosis, the doctor said that there was injury into the intestine and needs surgical treatment. I had to sell the wedding necklace to manage the cost.

Basu, a man from average Janajati family aged 62 shared:

> I did not suspect that this was jaundice. How could I suspect? I had pain in stomach and I was not yellowish. I suspected gastritis. I had sold he-goat at 9000 rupees. I went direct to a doctor in his private clinic in Ghorahi. After that, I went to Nepalgunj with my brother and visited a reputed doctor. I got relief

from pain with his medicine. I visited him five times in six months. But I was weakened and almost bed ridden. I could not walk and work. I sold my oxen at low price to cover the cost. I went to Chitawan with a friend by borrowing money from my sister. The doctor ordered various tests. He checked a pile of reports and said that there was a tiny stone in my kidney. He also wrote medicine for gastritis saying that was the main problem and suggested not to take oily, hot and spicy food. I came back with a lot of medicine. Time passed but problem did not. I was weak and most of the time used to lie on bed but without a sleep. Then one day a woman from the next village suspected black jaundice and gave medicinal herbs. I drank the juice of the herbs and felt like vomiting. Meanwhile, I remembered a neighbor who had jaundice and was treated by a vaidya. I went to the vaidya and he examined my body and urine and confirmed jaundice. The vaidya gave decoction of herbs in plastic jerricans (400 at the rate of 400 rupees per jerrican). I got better after drinking five jerricans but continued to drink two more jerricans as he suggested. At last he gave herbal powder to take for few more days. It was the vaidya who saved my life.

These narratives point to individual and family struggle of seeking care. In many cases, people are forced to take recourse to the health facilities outside of the district because the health care services are not sufficient in the district. Moreover, what is available are not accessible to the people, especially to the poor. The catastrophic health care expenditure has caused much pain and suffering in the family.

9. Illness, Pain and Suffering

The stories of illness are many, and many of them are very sad. Some had lost their money, lost their property, lost their health and even the dearest one. Listening to their stories makes the moment serious. Selling of property, having loan and living with illness is something which makes people feel sad. When they start to share something sad, their facial expression becomes dark like the cloudy sky about to rain. Feeling not

loved, weeping and wiping away the tears, showing helplessness, questioning the God, cursing the bad fate. By listening their stories I could only imagine what might have gone inside their heart and mind. When a family member falls ill the regular household activities get hampered. They fear of missing farming season, delay in plantation or harvesting. They fear of the consequences of not feeding their children on time, missing schools and regular work, caring of cattle and poultry birds. In the peak agricultural seasons, many had postponed their treatment seeking plan and there were severe consequences of it.

During my field work a total of six people died. I felt great difficulty to face the family whose member had died of illness. I felt that morally it was not good to be indifferent in such difficult time. I had spent some happy moments with them and I could not turn away from sad moments. But I had found myself in an awkward position. I was unprepared because I had not imagined that such things can happen during my stay in the village. A lot of things were going into my mind. I also felt a moral pressure to present myself in front of them to express sympathy and support. To visit in person and express condolence was really a difficult time for me.

It became very hard to me when I visited a woman after the death of her husband. Her husband had hypertension and was suffering from many complications. We had been meeting since the beginning of my fieldwork days. That was a different time. I was sad and sorry for the loss. I was wordless to express my condolence. She was alone and started to weep when she saw me. She was in grief at the loss. She expressed of her guilty of not making an extra effort from her part. She was sorry for the behavior of her son and daughter-in-law who had not taken her husband's illness seriously.

I felt similar situation with the man whose wife had died of diabetes. He used to look bold in my earlier visits. This time he was weak and could not stop shedding his tears. He wept and wiped his tears. His wife had died unexpectedly. She had been managing her diabetes with medicine and suggested dietary regimen. A few villagers guessed heart attack might be the possible cause of her death. I could only imagine how deep would be the pain of losing one's wife or husband at the later part of life. The woman whose husband was suffering from stomach pain used to tell me he was taking medicine for gastritis and then jaundice and after the death she revealed that it was cancer that had taken his life. They had also sold their land to cover the treatment cost

and had made every effort but, in her words, "*bhabiko lekha, kaslai ke thaa* (No one knows what the almighty had written on one's fate/forehead)". I feel that the death is the most saddest and unhappy moment not only for the family and fellow villagers but also to the field workers who make a kind of bond with them.

There was a woman whose whole family was suffering from illnesses. She was suffering from diabetes, her husband from severe paralysis, son from asthma and diabetes, grand daughter was undergoing a surgical treatment of intestinal wounds. And her daughter, who was married out, was also diagnosed with diabetes recently. The whole family, except her daughter-in-law and grand son, have been living on medicine. This was heartrending. Economically, the family was better-off but they also had to sell their land for the treatment. The severity of an illness is also associated with the severity of pain and sufferings in the families.

10. Life is Hard and 'This is not a Joke'

Life is hard and problems are many. People are struggling to manage their health problems. They are making every efforts to struggle with the life conditions. Despite the bitter experience of illness and treatment seeking, they never stop trying to live as happily as possible. They recover from sadness, win over unhappy moments, and attempt to bring brightness in their face. After all, people of Nepal are known for their cheerfulness and good humor. This shows the resilience of people to face any adverse situations and deal with it. People look happy and talk in a carefree manner even when they are facing hardships. They talk happily in spite of illness, pain and suffering. This may seem strange to an outsider. Sometimes they share their experience with jokes. I cannot forget some of the conversations with them which lasted with humor.

"Have you had your tea?" I asked a person who was preparing to go to agricultural field with his wife. His wife replied rather humorously, "Yes sir, we just had tea, I had hot tea and my *budha* (husband) had cold tea. I guessed what she meant by *cold tea* from her smile. The person laughed at her witty remarks and admittedly said that he had drunk a glass of alcohol instead of tea.

A person had a problem of headache. Two days later when I met him again, I asked, "How is your headache now?" He replied, "It became alright." I queried, "How did it become alright? Did you use any medicine?" He replied, "Yes, I used *gharelu ausadhi* (home-based medicine)." His friend raised his eyebrows with a bright smile and revealed, "That was not *gharelu* (home-based) that was *gharpala* (home-brewed)." He was pointing to the fermented rice liquor. He had a mischievous smile. Surprised, I expressed, "Oh! That was it? And there was laughter.

It was after lunch time. I was walking on the dusty road to a village cluster where mostly poor and Dalit live. With my repeated visits, many of them had become familiar to me and had started to say hello in a friendly way. I used to ask some short questions to know something more about their *sancho-bisancho* (healthiness-unhealthiness or wellness-illness). The most common questions would be *sanchai chha?* (Are you alright?). The intention behind asking *sanchai chha* was to get updated about their health and illness and engage into further conversation. Sometimes the simple questions such as *khana khanu bhayo* (Have you had your lunch?) works as a greeting, shows how you care, and facilitates for further dialogue.

When I saw a person whom I had interviewed earlier and who had asthma and had been using inhalers. The inhalers are shaped like *sulfa* (traditional smoking clay pipe) and the act of inhaling is compared with smoking *sulfa*. He was standing in front of the house and can be communicated from the street. When we saw each other, I asked with a smile, "*Sanchai chha*?" I realized at once that was not a good question for him as he had asthma, and I rephrased, I mean, are you smoking the *sulfa* regularly? To my surprise, he raised his right hand displaying a hidden cigarette stick pressed between his middle and index fingers, with smile he replied back, "No sir, I am smoking a cigarate instead of *sulfa*." I had not noticed that before. The double meaning of *sulfa* had disclosed the secret and that had brought out laughter. He knows smoking is injurious to health. I asked: How often do you smoke? He answered: Sometimes. He expressed shyness of not being able to quit the cigarate. He shared that he was advised not to smoke cigarettes many times, by family members and doctors. He showed his helplessness. Inhaling a last puff he dropped his cigarette on the ground and crossed it with his shoes. He exhaled, took a long breath and said, "I am inviting my death." Still there was a smile on his face with deep sense while he was saying this.

One of the participants was suffering from knee joints pain since long. When he became quite familiar with my question "*Sanchai chha?*" once replied rather strangely, "*Sancho ta aba ekai patak hune hola* (I will be alright once and forever)." He meant that he tried many things and his problem still exists and will not last unless the final day comes. The art of expressing deeper pain with smile was really a unique way of expression among the villagers. It seems they hide pain and suffering with such short lived jokes and laughers. For many this may be a strategy to cope with the difficult life conditions. Use of such jokes in their communication helps them to take the problem as lightly as possible without worrying much. Sometimes they say, "*Jo hoga dekha jayega*" (whatever comes will be faced). Sometimes, they find it difficult to hide the pain and suffering.

11. Conclusion

This chapter concludes with these narratives of illness and treatment seeking. The above narratives provide examples of multiple recourses that people take. However, these narratives are not sufficient to understand the differences between the socio-economic groups. As observed, in many instances, both the poor and the better-off, the Janajati, Dalits and Brahmin/ Chhetri, men and women, educated and uneducated had sought services from whatever was available and accessible to them. The people, regardless of their socio-economic condition (the class, caste, gender, education and occupational status), hold common idea about the illness types and treatment choices. They explain when to go to folk practitioners and when to go to the city hospitals. They explain the benevolent and malevolent spirits, role of God and Goddess, bad spirits and evil eyes, and the use of a shaman/faith healer and vaidya. Their treatment seeking behavior sometimes obscures the socio-economic differences. However, the people exhibit not only the similarities but also the differences in the use of medicine. The similarities can be observed in the commonly understood conditions with common etiological understanding. For example, the local faith healers were consulted by all the socio-economic groups for the illnesses which they sensed of spiritual causation. The differences can be observed in the extent of the use of folk healers and official medicines.

The chapter has highlighted the pluralistic treatment seeking behavior, the cost of care, hardship and suffering. This has shown how people resort to many different sources of treatment. How the cost increases with the increase in recourse times and how the families are affected from the high expenditures. Many households from poor socio-economic background had borrowed money from neighbor, local money lenders, women's group and cooperatives. They had sold their domestic birds and animals (roosters, goats, oxen, and buffalos), jewelries and their lands for the treatment expenses of the sick member of the family. The stories of the families who had member (s) with chronic illnesses (for example, who had a daughter with sickle cell anemia, who had husband with mental illness, who had jaundice, stomach and at last diagnosed with cancer, who had diabetes and had husband with severe paralysis) present the example of suffering resulted from the illnesses. The family and households are not homogeneous. The socio-economic differences exists among them. The next chapter makes a discussion on the use of medicine and the pathways of pluralism.

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CHAPTER VI

PATHWAYS OF PLURALISM

The chapter first makes a short discussion on the pathways of pluralism in general, the therapeutic journey from home to hospital, and analyzes the utilization of health care services and looks into the the structure and composition of health care staffs in the health facilities.

1. Pathways of pluralism

The people choose many paths of care when they experience illnesses. Most of the therapeutic activities, from preparing particular food or using particular herbs, doing family massage or applying ointment for pain relief, managing small cuts or wounds, praying God, doing *puja* (worshiping) or offering clan deity *dhaja-dhup* are conducted at the household level. Consulting shamans and faith healers, diviners and herbalists, massagers and midwives, and illness specific folk practitioners to visiting temples and praying Gods and performing customary preventive rituals (such as *gurrai,* a ritual performed twice a year to prevent disease and epidemic in the village) doing *puja* and having *prasadi,* visiting village medical (pharmacies) or local health post are the things which they do at the village/community level. At the district level, they visit various clinics and hospitals and sometimes when the illness persists or turns to be a severe one they go the hospitals and clinics located outside of the district. Most of the problems are solved at homes or in the village community, but for some illnesses they have to take recourse to faraway hospitals and clinics. In most illnesses, they do not have to follow long therapeutic journey, but for some, particularly for the severe ones, they have to. Sometimes they get lost in the labyrinth of pluralism and the lengthy therapeutic journey causes much pain and suffering in the family.

Some of the patients had to sell their property, fall into a debt trap of local money lenders, face family breakdown and undergo a financial hardship, poverty and misery. When a family member falls sick and needs family support, other members face the challenge of running regular works and supporting the sick. The story of a mother whose daughter had sickle cell anemia, the story of a person with mental illness, the story of a woman who had chronic joints pain, the story of the woman whose husband had died recently who had a problem of hypertension, the story of a man whose wife died of diabetes, the story of a person who had sold his property for the treatment of what he used to call *gyastik* (gastritis) and chronic stomach pain, and later jaundice and eventually, as his family revealed after his death, was diagnosed with cancer, and the household whose most family members were living with chronic conditions better explain what happens to the family when family member(s) fall sick and experience chronic illnesses. The chronic illness is not only limited to bodily pain and suffering but also related to the relationship between family members, and their emotional state and behavior.

The story and struggle of the woman whose daughter had sickle cell anemia was heart touching. She expressed how she had managed to seek treatment for her the sick daughter despite being forced to live separate from the joint family. It is easy to take care of the sick in the joint families because there are many working hands but when other family members feel the burden of cost and sense the negative consequences to joint property, the family effort breaks down. The family breakdown resulted when other family members showed unwillingness to bear the burden of treatment cost for an incurable condition of a girl child. This shows how families have to make an unpleasant and difficult decision. There was another story of a newly married woman whose relation ended up with a divorce when she had tussle over the issue of illness and treatment support with her husband. Chronic illness has many repercussions in the families. The chronic illness is not only limited to individual pain and suffering but also related to work impairment, worry about the future, family bonds and family relationship (Osterweis, Kleinman, and Mechanic 1987).

The story of a woman whose husband had mental illness had to incur the catastrophic expenditure. After years of medications, moving between shamans and psychiatrists,

they lost the hope of getting back to a normal life. They had to stop seeking care when they could not afford more and take as if it was the curse of God. The land was a source of livelihood for them. Unfortunately, they had to lose the land. When all the resources exhausted no professional treatment was sought. The person had to live with the illness and family had to take his illness as normalized. The pain of losing property exacerbated the problem in the family. The family knows better when the family's main bread winner suffers from such chronic illnesses. There were half a dozen of households who had to borrow a large amount of money, sell their cattle, jewelry and properties. Selling of sacred jewelry such as *mangalsutra* (wedding necklace) shows the seriousness of illness, the sacrifice from women's part, and the gravity of the situation. This draws attention to the human suffering and to think over the issue and understand why this is so and who suffers the most?

What is striking is the ultimate result of treatment recourse, life and death. At one extreme, a person who was diagnosed with diabetes 18 years ago has been living "a disciplined life" in his eighties on the other a person who was diagnosed with diabetes three years ago died in her sixties. The person who has been living fine was a man from well-off Brahmin/Chhetri family and the person who died was a woman from poor Dalit family. Half a dozen of patients with asthma have been living fine with medication but among them one who was from poor Brahmin/Chhetri family dies. Many people with hypertension were in regular medication and living healthy but among them a person who was from poor Janajati family died all of a sudden. The people who experienced the illnesses which were explained as *nasa sambandhi* (nerve related) or *maanasik* (mental), had experienced success or were living fine with regular medication or trying their best in search of better care but among them two families lost hope and were left with no choice. And those were also from the family with poor socio-economic background. Some people with diabetes were diagnosed because they suspected the early sign while others were diagnosed in course of seeking treatment for the symptoms without any suspect of diabetes. Similarly, some people were diagnosed with hypertension while doing normal check-ups but some were diagnosed when they were seeking care for some other problems. Those who were diagnosed early were relatively better-off, while the other who were relatively poor diagnosed late. The death came sooner to the persons who diagnosed late, experienced treatment failure, and who

were from poor socio-economic background. Among the six people who died, four were from Brahmin/Chhetri, one from Janajati and one from Dalit families. In terms of family wellbeing, one was from well-off, three from average and two from poor families. The death data of a small village in a particular fieldwork period cannot be considered representative. However, this is indicative that the poor, even from Brahmin/Chhetri families, experience treatment failures and death, sooner than those of socio-economically well-off. The same illness were experienced differently by the different socio-economic groups. The same illnesses were responded differently following different pathways of care and resulted in different treatment outcomes.

Many people with severe illnesses were found moving between therapeutic sources but some had stopped seeking medial care and relying on the home-based measures to manage the illnesses. There were many such patients who had been trying their best to seek appropriate care for their illness conditions. Some had followed the right pathway and found the right care at the right time but some had found themselves lost in the pathways of pluralism. Some had gone directly to the destination while some had no idea about the destination or left with no means to reach there. The same illness was narrated by some as success story of treatment seeking, the same illness became a story of pain and suffering. Though there were similarities in the patterns of resort in many illness conditions. For example, in some illness specific patterns of resort, no matter what their socio-economic background, they had visited local healers for certain illness conditions or visited health facilities and experienced success. However, that does not mean that they follow exactly the same pathways of care. The differences were also found and we will also look into the differences in the section that follows.

2. From Home to Hospital

The patients, their illnesses, and their therapeutic practices differ. However, most people follow a certain pattern of seeking care. First, they use home-based practices which includes wide range of activities from dietary restrictions to the use of the homemade herbal preparation. If that does not work, then they move to the therapeutic sources which are available in the village. This includes consulting local healers, female community health volunteers (FCHV) and local paramedics. The village healers

provide services for minor illness, stomach problem, sudden twist and joint dislocation, and the illnesses which are culturally understood and explained. Some of them treat snakebite, dog bite and also deal with veterinary problems. The FCHV can give something (such as paracetamol, ORS etc.) if they have in their kits and suggest something (such as home-based measure or suggest where to go and whom to consult). The village paramedics, who run the pharmacy cum clinics in the village, provide primary level care including the treatment of small wounds and injuries and sell modern drugs. They also keep a few branded ayurvedic medicine and nutrition supplements such as *chyawanprash* in their drug stores. The users of such Ayurveda products may be high. Sometimes the patients or their family members buy drugs from these medicals for minor illness and wounds to use at home. The people make a selection of these services based on the kind and condition of their illnesses. If their condition does not improve or the nature of the illness demands more than this, then they move to the hospital and clinics. Sometimes choosing a treatment source for an illness becomes a very difficult decision to make.

The illness etiology, the causes of an illness, is an important factor in determining the choice of the treatment. Medical anthropologists have developed theories about how people understand and interpret the causation for an illness. They have made a distinction between two main types of illness etiologies: natural and supernatural, naturalistic and personalistic, non-supernatural and supernatural, immediate and ultimate, internalizing and externalizing (Baer 2003b; Garro 2000; Foster 1976; Murdock 1980). The former attribute to imbalanced natural equilibrium and cause-effect relationship, while the later to the superhuman or unseen forces such as evil spirits, ancestral spirits and deities. In the illness specific patterns of resort, people use official medicine (both biomedicine and traditional medicine) and herbal healing for the former type of illness and faith based healing for the later.

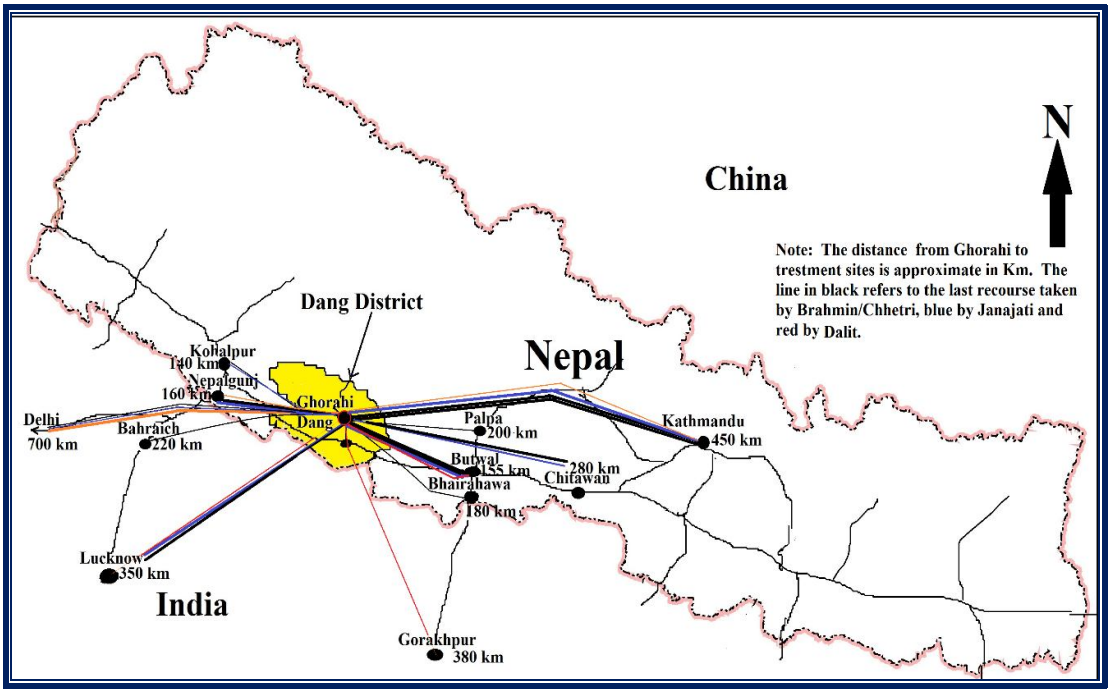
People have their perceptions about illness occurrence and they follow some understood measures to deal with the illnesses. The belief and perception strongly influence the treatment seeking behavior of the people. The belief such as illness occurs because of evil spirits leads them to follow the path of supernatural healing. The faith healers are required for this because other practitioners cannot command supernatural problems. The cultural understanding of illness and illness causation exists among

every caste and ethnic communities and every class gradients. Most participants opined that the treatment by faith healers was the most effective treatment for the illnesses caused by supernatural elements. The patient's and care givers' belief and perception about the illness and illness causation also plays an important role while assessing the illness and choosing the healers or medical practitioners.

In the illness specific patterns of resort, the distinction among the people of different class, caste, gender, educational and occupational background seems invalid as all the people are found following similar patterns of resort. However, in overall recourses, people living with poverty, with low education, women, elderly, Dalits and Janajati were found visiting folk healers more frequently. They also tend to associate many of the illnesses with the supernatural causation. Some people, particularly the young who were educated and exposed to the outside world, also found questioning the scientific basis of faith healing. They simply reject the efficacy of the faith healing and occasionally express doubt of the potency of the crude herbs which the healers give. The packaged drugs are considered more scientific, potent and powerful. A young participant who works in a tailoring shop in Ghorahi said, "The tradition of *dhami-jhankri* was the tradition of our father-grandfather… How one can depend solely on such healers in today's time? Such a large number of clinics and hospitals would not have come up had the healers were sufficed." This points to the limitation of folk healing and changing perception towards faith healing. However, herbal practices, massage and midwifery and professional folk practices such as the treatment of joints dislocation, fractures, snake bite, jaundice etc. still hold relevance among many.

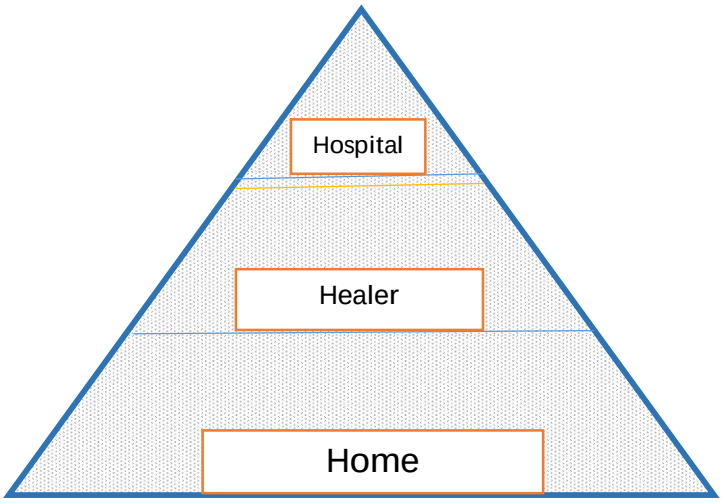
In the hierarchy of resort, the most common resource was home-based practice followed by local healers/health practitioners and hospitals or medical clinics. Some of them went to the cities outside of the district, and most of them who went outside were from socio-economically better-off groups. Though, the poor also visited the faraway city hospitals, there number was less. The major destinations were Butwal, Bhairahawa, Kohalpur, Nepalgunj, Chitwan, Kathmandu, Lucknow and other Indian cities.

Figure 10: The Destination and Distance to the Treatment Sites



The figure shows the major destination outside of the district where people had resorted in search of treatment.

Figure 11: Therapeutic Recourse from Home to Hospital



The therapeutic itineraries of many of the patients show multiple recourses, moving between the therapeutic sources of their home district and beyond. Some had taken recourse to the hospitals out of the district, sometimes even across the border in India.

Most of them had taken recourse to biomedical facilities, and few to Ayurveda and very few to homeopathy. As an exception, one or two had taken recourse to acupuncture clinic, and ceragem center.

The majority of patients and care givers reported that treatments outside of the district were expensive. Some of them complained about the exorbitant cost for diagnostic service and drugs. The cost for the travel, food and lodging for accompanying person had escalated the total cost of care. The majority of patients who had taken recourse to many different sources outside of the district had suffered from financial hardship. Despite an introduction and expansion of biomedicine in the district, patients and their family care givers continue to resort to distance hospitals, even across the border. The stories of treatment failures, increased costs and suffering also point to the inadequacy of health care services within the district[19]. The therapeutic itineraries from home to hospital, the travel from place to place, points to the need, access and use of different types of medical services. Not all people follow exactly the same itineraries, but the chronic condition makes therapeutic path lengthy, troublesome, arduous and onerous.

The therapeutic itineraries from home to hospitals can be influenced by many factors such as patient's socio-economic condition, distance to the facility, familiarity with and the reputation of doctors/hospitals and social networking such as having someone in the city (Nichter 1978). This is also observed by (Samuelsen, 2004):

> "The therapeutic itineraries are influenced by physical accessibility of health to reach a health facility. The quality of care including the interpersonal relationship with the staff is also found to be important in many different location, the availability of drugs and financial capabilities are important factors."

[19] The district is relatively privileged district in terms of health care facilities but still people suffer from inadequate health care services. Worse would be the situation of the people who live in the remote districts of Nepal.

3. Utilization of Health care Services

This section looks into the utilization patterns of health care resources among the different sections of the people and the structure of medial/health care staffs. The family and folk sector of health care constitutes an important sources of care. People take recourse to these sectors because the official systems cannot address all types of health care needs of all the people for all the time. On the one hand sometimes people find no options and on the other cost comes as barriers. They recourse to family and folk sector of health care not only because of their prior bitter experience with the health posts and hospitals or because health posts and hospitals are not equipped well, staffed and supplied adequately, and hospital might refer the patients to distance hospitals and if there is an emergency case such as snake bites, when poison spreads throughout the body no one knows what will happen to the patients while going to the distance hospitals but also because of their strengths. However, policy makers and planners often looking at the weakness rather than the strengths of family and folk sector of health care sought solution to expand official medicine with public and private sector provisioning. The better equipped, staffed and supplied health facilities will increase the access to and utilization of official medicine. This is true that when people get quality services free of costs at an accessible distance the utilization increases.

However, neither the health care services are at accessible distance nor they are free and nor there are any special provision to increase access and utilization of health care services among the poor sections. The private sector facilities charge high for the medical check ups, diagnostics, and surgical treatments. They fear that when they go to private sector they will have to sell their assets and face the consequences arising from that. Even the village medical also charge them high. A man, from poor family of Brahmin/Chhetri community, who broke his hand falling from a tree, while cutting grass for his goats, went to a bonesetter instead of hospital or clinics. On my question, "Why did you go to a bonesetter instead of hospital?" He replied, "Hospital for us is *aakaashko phal, aankha tari mar* (a saying, literal meaning is: fruit of the sky, die gazing eye)." The modern health facility for the poor is like the fruit hanging up the sky high which neither falls down to the ground nor can they catch by any means. The problem of money is not only with the private clinics and hospitals of the cities but also with the village medical stores and clinics. A father of a child from poor Dalit family

says, “The *daaktar* [local paramedic] first tells you that the condition is very serious and needs an injection, and the injection costs this much. Whether the patient is serious or not so serious but he always tells you that. I have a doubt of his intention behind telling this. Our son was sick and we had to visit him because we had no money at hand. I would have gone to Ghorahi, had I some money”.

The folk healers such as bone setter also have started more money because they see the market value of such service. However, people still find them less costly than those of official practitioners. They resort to folk healers not only because they cost them less but also because they have past experience of successful treatment. A woman from a poor family of Janajati community shared, “I had *gyastic* [gastritis]. I took medicine from village medicals. That did not help. I took medicine from Ghorahi hospitals. That did not help either. It was the crude herbal medicine given by (name) the healer (who lives in next village) which truly helped me”.

The villagers had to pay more amount of money to obtain the services from distance hospitals and were much affected by and suffered from financial hardship when they had taken recourse to distance hospital and private facilities. They did not have to worry about the high costs while resorting to folk healers, even though bone setters, snake bite healers, reputed shaman with particular therapeutic skills, traditional midwives have started to charge more than the previous time, because the traditional values are eroding by the neoliberal market values. The people and healers have also started to value the healers’ services in monetary terms, a service to be bought and sold like those in the markets. It is notable that not only the cost but also other factors such as perception, distance, service timing, mutual trusts and healer-patient behavior also play a role. Besides, many of the folk healing practices are not costly and the overall cost to folk healing are comparatively affordable.

3.1 The Health Post

A network of health posts and primary health care centers has been expanded nationwide but they function poorly because of absenteeism of medical staffs and shortages of medical supply. The health posts operates practically only before the first

half of the day. After 2:00 pm staffs begin to disappear and by the 5:00 pm, which is the official closing time, no one will be left including a peon who locks the door. The people visit health post because the services and drugs are free.

The Following table provides the information about illness and the number of patients treated by the health post located at Amuk VDC.

Table 7: Illnesses Treated by HP OPD in the year 2015/16

SN	Illness	Number of patients	Percentage (%)
1	Skin disease (Boil, abscess, fungal infection, scabies)	694	21.6
2	Injuries/Fractures + Surgical Problems	381	11.9
3	Dysentery, Diarrhea	323	10.0
4	Lower +upper respiratory tract infection	313	9.7
5	Typhoid	232	7.2
6	Gastritis (APD)	167	5.2
7	Arthritis +back pain	151	4.7
8	ENT infection (tonsillitis, Acute suppurative otitis, sore throat)	151	4.7
9	Headache	141	4.4
11	Other problems	134	4.2
13	Oral health problems (toothache, caries)	103	3.2
15	Intestinal worm, cholera	94	2.9
16	Pneumonia + Bronchitis	86	2.7
17	Hypertension	66	2.0
18	Virginal discharge +lower abdominal pain	51	1.6
19	Eye problems (conjunctivitis, sty)	44	1.4
20	Asthma	36	1.1
21	Nutrition deficiency	23	0.7
22	Burns and Scalds	16	0.5
23	Tuberculosis	9	0.3
	Total	**3215**	**100**

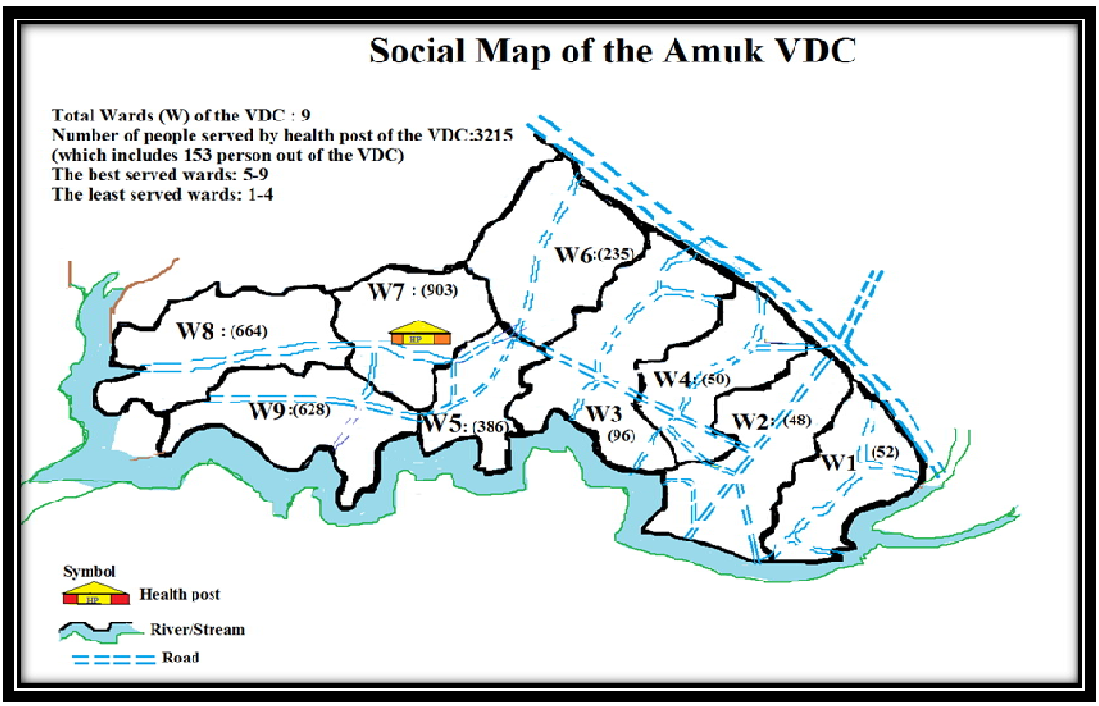
Source: Calculated from the annual report of the Amuk health post, 2015/16

One day, I contacted 16 patients when I was there. They were there for skin problems, gastritis, wounds, common cold and fever and joints pain. Eight of them had tried something at home and three of them had already consulted village healer. However, most of them from the surrounding villages of the health post and none of them were

from the study village. This may be because of the distance. The Figure 8 shows the location of wards and the people served from the health posts in the last one year's period. The health post provides primary health care services to the people of Amuk VDC. The population size of each of the 9 wards is more or less similar. However, according to health post data the people of ward no 2 which also includes the study village are the least served compared to other wards. The health post is located in ward number 7 of Amuk VDC and the study village is located at distance. The people who were close to health post were best served whereas the people from distance wards were least served. For instance from ward number 7, a total of 903 people served in the last year whereas from ward number 2 only 48 people served. This shows that the utilization of health care services are influenced by the geographical locations. The people who live close to health post utilize the health post services more than those who live far from the health post.

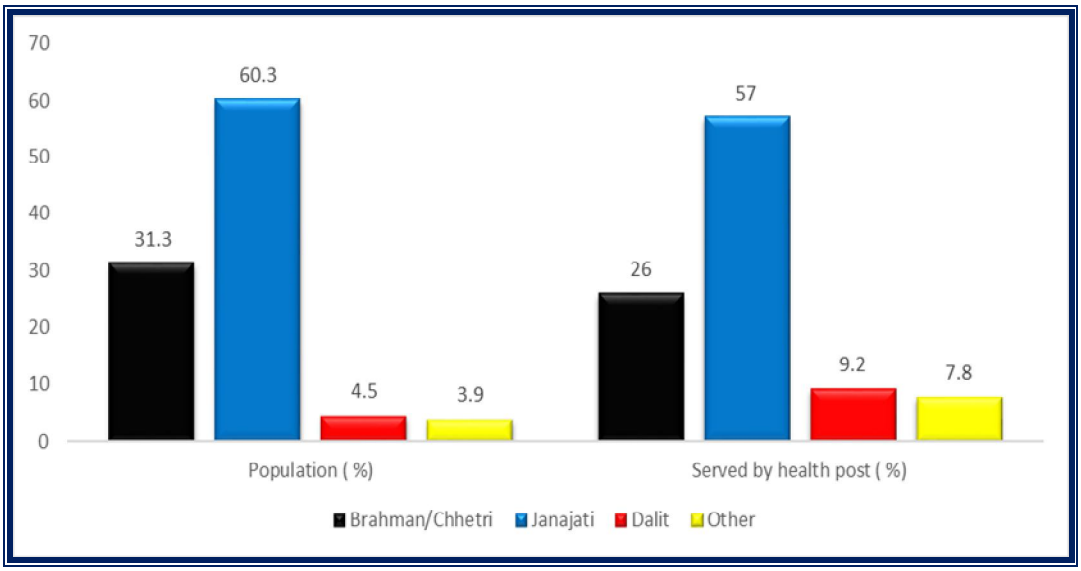
The main reasons for not going to health post from the study village were because of location and distance. The distance to go to the health post and Ghorahi is roughly equal, but the health post is not located at the suitable direction. Some of them expressed fear of coming back with bare hands losing a whole day's work because there is no certainty of medical staff and availability of prescribed medicine. Some complained about the short and unsuitable opening hour and not so welcoming and knowledgeable staff. Some doubt over health post drugs, "health post's drugs are not effective because they distribute whatever they have left over in their stock. Sometimes they do not feel the need to go to health post for the minor illness such as common cold, short headache or short term fever and if the illness is of different nature or of indigenous one.

Figure 12: Number of OPD Patients Served by Health Post by wards



Source: Health Post of the Amuk VDC 2015

Figure 13: Utilization of Health Post Services by Caste/Ethnicity



Source: Census data (CBS 2014b, 31) of the Amuk VDC and two years annual progress reports (2015/16 and 2016/17) of the health post (HP) at of Amuk VDC.

The Census data and health post data are of different period. However, since the VDC level caste/ethnic composition has not changed much since 2001 in terms of percentage of the caste/ethnicity the comparision makes sense (According to 2001 census, the population of percent Brahmin/Chhetri, 30. 7 percent, 60. 2 percent Janajati, 3.8 Dalit and 4.3 others).

Figure 13 shows the differential utilization of health post services. Dalits were found served more then the Brahmin/Chhetri. The population of the Dalits is 4.5 percent in the VDC whereas Dalit constitutes 9.2 percent of the total population served from health post. This data refutes assumption that Dalits are poorly served by the local health posts. At first, I thought of two possible reasons for this variation. The first is that this may be because less number of Brahmin/Chhetri population and high number of Dalit population living closer (which is from ward no 5 to 9) to the health post in comparison to the peripheral wards (which is from ward no 1 to 4). (See the figure 7 for ward wise map) The second reason would be the general tendency of Brahmin/Chhetri to go to Ghorahi directly or seek services from private clinics. However, going through the ward wise population data (given by Amuk VDC office) the first reason found invalid. Because of the total Brahmin/Chhetri population in the Amuk VDC 38 percent live in closer wards and 62 percent live in peripheral wards and surprisingly this is exactly similar among the Dalits, i.e. 38 percent of the total Dalit population lives in closer wards and 62 percent in peripheral wards. However, 71 percent of Janajati live in closer wards but 29 percent in peripheral wards. But there is no effect of closer living among Janajati because 57 percent served instead of 71 percent. The second reason has the possibility as the households from well-off sections including the well-off Dalits and Janajati go to the private clinics or directly to the hospital in Ghorahi. The health post had served a total of 3215 persons of which 153 were from outside of the VDC area and among the 153 person Dalit percent might be high. This does not hold a greater possibility but can be a third reason to increase Dalit percent percentage. The more frequent use of health post services by Dalits may be a fourth reason and this supports that the poor and Dalits fell ill more or not treated at the first recourse. Here, it is very important to note that the poor and Dalits seek no treatment in many times for minor illnesses, they also visit local healers more than other groups. Despite this fact they visit more to health post which possibly supports that they fall ill more than the

better-off and Brahmin/Chhetri and recourse more then other groups. The high utilization of health post services by Dalits rather than Brahmin/Chhetri may not be true for other health post. However, a study in Midwestern hill district of Nepal also shows that Dalits and Janajati had significantly more access to government health facility than the Brahmin/Chhetri and the study also points to the possibility of Dalits being sick more often than those of Brahman/Chhetri and they are less likely to use private private health facilities (Paudel, Upadhayay, and Pahari 2012). This shows that the reason of using government health facilities by poor and Dalits is because of costly private facilities. Again, there is no denying that the better-off and Brahmin/Chhetri utilize official free health care services more than the poor, Dalits and Janajati.

3.2 Ayurveda Hospital

The Ayurveda hospital (locally known as Bijauri hospital) is located in Bijauri at the premises of Sanskrit University College which is about 20 kilometers west from Ghorahi on the way to Tulsipur, another municipality of Dang district. The Ayurveda hospital remains often uncrowded because less number of people visit the hospital. The people can avail ayurvedic services in Ghorahi and Tulsipur as there are several privately run ayurvedic pharmacies and clinics. Three ayurvedic physicians (out of six sanctioned posts) were working there along with a dozen of ayurvedic paramedics and the total staff strength was 41 posts including the contracted with local resources. The patients who were contacted in the hospitals had arthritis/joints pain, stomach abdominal pain or having digestive problem, child illness (pneumonia), skin problem, typhoid fever, wound and abscess. Most of them had visited local healers or medical clinics before visiting the hospitals. Most of the patients were from surrounding VDCs but very few from distance VDCs and neighbor district. The hospital was housed in a large one story building and expanded with staff quarters, herbal plants and trees (like *amla*, Indian gooseberry). The building was old enough and staffs were complaining of water leakages from the roofs. It was a rainy day and I met only 22 people at the OPD counter. However, according to the staff, the average number of patients ranges from 40 to 50 persons per day. The hospital data shows that the hospital served 13613 patients in the last year. This is a 30 bedded hospital and also provides inpatients services.

3.3 Biomedical Hospital, Ghorahi

Ghorahi hospital is a 50-bedded sub-regional hospital which serves the people from Dang as well as from surrounding districts. The hospital is staffed by more than two dozen of MBBS and MD doctors, and over a hundred of paramedical staffs, lab technicians, nursing and support staffs. According to hospital source, in the year 2014/15 there was a total of 44962 OPD visits which means eight percent of the district population, that was two percent point increase (i.e. from 6 to 8 percent) since the last year (i.e. 2013/14). According to registration staff, around 150 patients visit the hospital daily in an average. The total admission of the patient was around six thousand for inpatient services.

More than half of the patients had come after visiting local healers or medical clinics when I asked 92 patients waiting and standing on the line one day. Some had come for follow up visits with necessary reports. Most patients who were from Ghorahi and adjoining VDCs were there for the first time (first recourse) for the illnesses they wanted to consult.

People stand on queues in front of the registration counter. The queues (separate for women and men) becomes longer at around 9:00 am and staff come for registration. At the mean time medical doctors gather in the superintendent's office, have tea and and by 10:30 start to provide services for the patients. By 1:00 p.m. the crowd disperses. Most of them go back to home with medicine but some wait for reports to show after the break and some come back the next day if the report delays.

3.4 The Structure of Medical Staff

Table 8: Hospital and Health Post Staffs by Caste/Ethnicity

Particulars	Brahmin/ Chhetri%	Janajati %	Dalits %	Others (Muslim, Madhesi etc.) %
% Population Dang district *	35.2	44.6	11.9	8.3
% of Two hospital staffs (Zonal and Sub Regional) #	65.9	25.2	1.7	7.2
Population of Amuk VDC *	31.6	60.3	4.5	3.6
% of Amuk Health post staffs#	66.6	33.3	0.0	0

Note: * Source: 2011 Census

#Source: Field study, 2016 (collected from Hospital source)

Among all categories of medical staffs in the health institutions of the district, Brahmin/Chhetri constitute the vast majority (two-thirds) followed by Janajati, Dalits and other groups. Similarly, the number of women doctor is very less compared to men, even though women have better representation as paramedical, nursing, and support staff. The Janajati and Dalits as paramedical and support staffs have better representation than as doctors. . I could not get the segregated data from the Aurveda hospital but all of doctors and most of paramedics were men and from Brahmin/Chhetri communities. Though the number of women, Janajati and Dalits paramedic and doctors have been increasing steadily with the reservation policies in education and public services positions but still their number is far less in proportion to their population size.

As of October 2016, the following health institutions had the following number of health staffs

Table 9: Caste and Gender Status of Medcial Staffs in the District

Caste Health Institution	Categories	Brahmin/ Chhetri		Janajati		Dalit		Other		Total	
		M	F	M	F	M	F	M	F	M	F
Amuk HP	Paramedic	3	1	1	1					4	2
DPHO (3 PHC and 36 HP)	Paramedic	112	66	42	23	1	3	10	1	165	93
Ghorahi Hospital	Doctor	15	3	3	1	0	0	6	0	24	4
	Paramedic	34	34	10	25	2		5	6	51	65
Tulsipur Hospital	Doctor	7	0	3	2	0	0	4	0	14	2
	Paramedic	11	27	4	5	1	1	1	1	17	34
Total		179	130	62	56	4	4	26	8	271	198

Note: M= male, F= Female. In the total Amuk health post (HP) is excluded as this was one of the 36 HPs under district public health office (DPHO). Support staffs also included into paramedic raw (In each HP and PHCC (primary health care center) there is one support staff. The number of paramedic may be in similar ratio in the hospitals. In each HP there are usually seven staffs and in each PHCC a dozen but in a few HP/PHCC there are shortfall of few staffs.

The Table 9 shows the size and strengths of medical staffs in various official health institutions. From health posts to hospitals Brahmin/Chherti men dominate. The medial profession has been dominated by well-off, upper caste and men. This table just indicates to whose hegemony has been established over the medical profession. The domination of men doctors and medical staff and the male gaze also discourages women to resort to the facility of official medicine. This is a reflection society and the representation of staff as in the society and hierarchical structure of society. Powerful positions are hold by by well-off and upper castes and few support from from poor and Dalits.

4. Conclusion

The treatment seeking data suggest that caste based differences are large and class based differentials are even larger. Data also suggest that only few percent of the Dalits went outside of the district but fewer poor went outside of the district in search of medical care. The visible difference is that a poor Dalit women sensed death and died of diabetes at the age of 63 where as a well-off male Brahman has been living "a disciplined life" at the age of 78. The poor women lost hope and lost life whereas the well-off Brahman has been upholding the hope and gaining a life. A poor had sold almost half a hector of land and a well-off had also sold same size of land for the treatment of similar illness, but the consequence was more devastating to the poor than the well-off. Because the land sold by the poor was half of the total land but the land sold by the well-off was one-tenth. The suffering and death are unequally experienced among the different groups and the poor section suffered the most.

The socio-economic differences exists among the people in the village. So is the pathways of care and patterns of resort. Seeking an answer to why people follow the different pathways of care we find many socio-economic factors that influence the perceptions, treatment seeking practices, and patterns of resort. The possibility of taking uninformed decision among the people results in lengthy pathways to care and multiple recourses. The poor and Dalits have poor access to information and likely to take many recourses. It is important to understand whose therapeutic route has many stoppage and transits and whose route leads directly to the destination. However, overall goal should be to shorten the therapeutic routes of all the patients and help them reduce the cost of care and the suffering. The challenge is that on the one hand medical pluralism, pluralistic treatment seeking, multiple recourses and different therapeutic routes are described as natural phenomena and this is justified because the patients have differential needs and they have the right to choose from the available health care options. On the other, choice of medicines and practitioners may not be right every time because of lack information, differential access to health care services, and poor functioning of health care system.

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CHAPTER VII
PATTERNS OF RESORT

The therapeutic path becomes lengthy and painful when the illness turns out to be a chronic one. The length of the path depends on the kind of illnesses. But will it be the same for same kind of illness for all? This is the question which this chapter attempts to seek answer. This chapter looks into patterns of resort in selected four chronic conditions in terms of the socio-economic background of the people. There are similarities as well as differences among the socioeconomic groups.

1. Chronic Illnesses and Patterns of Resort

In most households, one or two persons reportedly have illness of chronic natures According to Nepal Living Standard Survey (NLSS) III, the percentage of the population reporting chronic illness was 11.7 (male 9.9 and female 13.3) in Nepal and among them vast majority were from 45 years of age and above groups (CBS 2011a, 106–8). In the distribution of types of chronic illness, the highest percentage was gastrointestinal diseases, followed by rheumatism related, high/low blood pressure, asthma, heart related condition, diabetes, gynecological and others (CBS 2011a, 106–8). Among the illnesses which they experienced and most reported were the joints pain followed by hypertension, diabetes, reproductive problems, gastritis, mental disorder, thyroid, and asthma in the village. Only one or two households reported sickle cell anemia, tuberculosis, cancer, paralysis, heart condition and obesity. For such chronic illnesses most of the patients had multiple recourses. They had resorted to the clinics and hospitals within and outside of the district along with the use of folk and home-based practices. The therapeutic route is more or less similar in most cases which begins from home to local healers or health practitioners to hospitals. They kept on trying until and unless their problems diagnosed or treated appropriately. The failure of one mode of treatment pushed them to another and another. Thus, the pathway of care

got longer and longer in course of diagnosis and treatment. The path before diagnosis varies than the path after diagnosis of the problem. The differences in the patterns of resort narrows down after diagnosis with certain conditions such as hypertension, diabetes, thyroid, uric acid etc. They followed the path of routine check ups and medications following the similar patterns of resort after the diagnosis of their conditions. The patterns of resort in four chronic illnesses shows not only similarities but also differences according to illnesses and socio-economic status of the people. The following analysis is based on the field data collected from the head of the household and the adult family members.

1.1 Joints pain (Arthritis)

Joints pain, which includes various types of arthritis, is one of the major chronic conditions across the world[20]. A large number of people reported recurrent joints pain (of hands, knees and low back pain) and 42 persons from 39 households had sought treatments from various sources. There is no significant difference in terms of prevalence among the class and caste, even though poor and Dalits reported slightly less than those of better-off and Brahmin/Chhetri. However, in terms of gender, two third (27 out of 42) of them were women. See the Table 10 for the distribution of joints pain by caste/ethnicity and their wellbeing status.

[20] Studies show an increasing prevalence of joints pain (arthritis), rheumatism or musculoskeletal related conditions. A study estimates one in four adults suffer from knee joints pain (Nguyen et al. 2011). According to (Woolf and Pfleger 2003) self-reported persistent pain related to the musculoskeletal conditions such as osteoarthritis, rheumatoid arthritis, osteoporosis, low back pain affects up to 20 percent of adults. The incidence of osteoarthritis is higher among women than men among all age groups and the older age population suffers the most (Woolf and Pfleger 2003).

A study conducted in eastern Terai of Nepal reports high prevalence of chronic pain. The study reports that half of the 1730 individuals of aged 15-64 reported pain and of which 44 percent have musculoskeletal origin (such as backache, multiple joint pain, generalized body ache, shoulder pain and knee pain). The prevalence was found high among the women than those of men, among the elderly than those of younger age and among the illiterate than those of higher education. (Bhattarai et al. 2007)

Table 10: Person with Joints Pain by Caste/ethnicity and Wellbeing Status

Caste/Ethnicity	**Population (%) (N=666)**	**Patients (%) (N=42)**	**Wellbeing status**	**Household (%) (N=126)**	**Patients (%) N=42)**
Bramin/Chhetri	36	40.5	Well-off	33.3	38.1
Janajati	48	47.6	Average	33.3	33.3
Dalits	16	11.9	Poor	33.3	28.6
Total	100	100	Total	100	100

The most villagers attribute to the use of hybrid rice and vegetables for the increasing incidence of joints pain. They belief that when people eat such hybrid rice, soon after the harvest, the chances are high to develop the problems at later ages. However, many of them cannot store rice for more than a year because neither their produce is enough for more then one year nor they have enough space in their home to store for the next year. Those who produce enough also have to sell to cover the family expenses needed for round the year. The logic of using fresh hybrid rice and its association with joints pain seems not convincing when we consider the poor and the Dalits because they are the ones who can not afford to store rice for more than a year and they have to use similar type of fresh rice, but they reported less than other groups. The data indicates to the positive association between socio-economic status and joints pain. However, the opposite can be true because Dalits and poor tend to underreport the illnesses they experience. Another logic given was the living in cemented house, especially the cemented floor of the house. Some of the well-off families have cemented house or cemented floor. Most people remain barefoot inside the home because using footwear inside the house is not accepted culturally. They gave similar logic for the use of varieties of pulses and vegetables. Only further scientific studies can establish or refute their logic. However, the villagers' experience needs to be considered in the study designs to identify the root cause and to device preventive measures to joints pain, but the focus seems to be on drug-based treatment and increasing drug dependency rather than preventive measures.

The patients who had been suffering from joints pain were found trying many things as their problems persisted even after they visited different places and different practitioners. Some of them were diagnosed with different arthritic conditions and taking prescribed medicine, and some were following home-based measures. For joints pain they are following various measure at home. The most common is to use home-based massage with mustard oil treated with fenugreek, garlic and *timur* (Sichuan pepper). A few had used home-brewed alcohol from millet, used warm salted water, and warm at fire. Some have bought special oil or balms from vender healers and ointment from pharmacies. A few of them had tried meat of forest jackal and black monkey and wild birds. They also consider the turmeric and thyme seed's soup or soup of bony mutton, pigeons and local chickens cooked with spices such as garlic, ginger and cinnamon good for joints pain. Some of them have used traditional varieties of rice instead of new hybrid varieties. One-fifth of them has been doing yoga or going for a walk. Those who had severe pain had recourse to hospitals or private clinics. A few of them had recourse to homeopathy, acupuncture, Ceragim and the faraway traditional healers. All of them were following dietary rules. For example, they avoid cold foods such as *maas* (black grams), peas, yogurt, yam, and hybrid vegetables (for ex. tomatoes) which were considered not good for joints pain.

The most common way of treatment was to get massaged from family members and midwives using local mustard oil or special oil bought from vender healers, show the healers, use painkiller or ointment bought from the village medical store or pharmacies of Ghorahi. The further recourses were made to hospitals and clinics when the joints were swelled and pain became unbearable. Some had visited many places in search of better care and taken injections and medicine. A group of six had gone to homeopathy hospital in Butwal and a group of five had visited a distance traditional herbal healer reputed for such problem. There were many examples of visiting folk healers and hospitals at distance in small groups. The use of medicine and recourse varies for joints pain even among the same caste/ethnic groups.

Bimala, a woman, 47 years, from well-off Brahmin//Chhetri family shared

> I have *bath* (arthritis) and it pains from inside the joints like something is biting (*kata kata khancha)*. There is no place where I had not been for treatment. In the beginning, I used to do home massage but when it became painful, I went to

> hospital. I got some relief from the hospital's medicine. But when season changed, I could not even move my hand and leg. I went to Kathmandu Ayurveda hospital and took medicine for six months. I had no problem for almost one year after taking those ayurvedic medicine. I visited a reputed healer when it started and then to a clinic in Ghorahi, Nepalgunj and Chitawan. I used jackal meat. I exchanged my hybrid rice with the local one. Nothing seems to work. Worse is that, my daughter (aged 24) also developed similar problem.

Hom Bahadur, 68 years old man from well-off Brahmin/Chhetri family also had similar story

> I am suffering from knee joints from the last 10 years. I consulted a medical doctor here in Ghorahi and then went to Butwal homeopathy hospital with friends and then Nepalgunj and Lucknow. Last year, I got injections, three times at the rate of 2000 rupees. The injection worked. I am also using old rice. I also used black monkey's meat once. I also visited (name) a healer of next village. But *kehi gare pani hunna* (Nothing seems work long last). It repeats again and again.

Malati, a woman 43 years, from average Brahmin/Chhetri family who had initially followed horizontal resort patterns to folk medicine and then to biomedicine and at last traditional medicine shared

> I feel tingling and burning sensation in my leg joints. I usually do *tel ghasne* (massage with mustard oil) and *sekne* (to heat or warm up at fire). I visited a *baba,* (a healer) and he gave black pills made of crude herbs. I visited *mataji* and put *tika* on forehead. I bought ointments from an ayurvedic clinic. I visited Ghorahi medical and got some tablets. I went to Butwal [homeopathy hospital]. The medicines were different from there, tiny white pills and an ointment. I took all the medicine but still I feel pain time to time.

Suk Bahadur, 74 yeas old man, from poor Brahmin/Chhetri who had been suffering from knee joints pain and followed multiple recourse and at last had stopped seeking care shared:

> This (showing to the knee joints) is a very old problem. Sometimes the pains increases. I went to a pharmacy and got some medicine and then went to an acupuncture clinic who gave me many injections. I got relief for few months. Then I went to Butwal and the doctor said it was *uric acid* and I had been taking prescribed the medicine once a day for long time. The medicine helped to reduce the pain but no cure. Last year, I went to Chandrauta [a town of adjoining district] and visited a *vaidya* (herbal practitioner). He gave large quantity of decoction made of herbs but after taking that I felt burning pain in my eyes. I went Ghorahi for eye check up and used eye drops. I am tired of visiting doctors and *vaidya*. I would not visit any of them, *Paisa maatra sakine ho, hune kehi hoina* (money will be ruined up, nothing going to happen). Rather, I am avoiding pea, yam, gram, mutton and beans. I take *roti-subji* instead of *daal-bhaat*, drink holy basil tea and go for walk in the morning and evening.

The above cases show variance even among the certain caste/ethnic groups. Many patients with joints pain were found using various sources of treatment. The major patterns of resort include: (i) use of home-based practices followed by folk medicine or traditional medicine or biomedicine (counter acculturative pattern such as followed by Malati), (ii) use home-based practices along with one or more systems (hierarchical mixed type such as Bimala) (iii) use of biomedicine followed by traditional medicine, folk medicine and home-based practices (acculturative patterns such as Suk Bahadur). When patients experience no improvement in their conditions from biomedicine they take recourse to traditional medicine or folk medicine again. A study conducted in Kathmandu valley also shows that about 60 of percent the patients had visited the private health facilities of Ayurveda, Naturopathy, Homeopathy, Acupuncture and Amchi medicine only after making the first visit to biomedicine based facilities (R. Koirala et al. 2013).In the treatment of joints pain, most of them had combined two or more systems rather than exclusive use of one system. The well-off seem to use official medicine following horizontal patterns of resort in their subsequent recourses while the poor seem to use folk healers in their subsequent recourses.

1.2 Hypertension

Hypertension, also known as high blood pressure, is a chronic condition. According to WHO, globally an approximately 40 percent of adults aged 25 and above had been diagnosed with hypertension in 2008 (WHO 2013a, 10) and the prevalence of hypertension was higher in Low and Middle Income Countries(LMIC) and among men than women. According to 2017 Nepal Demographic and Health Survey (NDHS), 23 percent of men and 17 percent of women age 15 and older have hypertension in Nepal (Ministry of Health, New ERA, and ICF International 2017). A total of 33 persons from 31 households reported hypertension. The total population of the village was 666 and two-third of them were 15 years and above. Hence, this makes 7.4 percent. This is around half compared to the NDHS results. This may be because many people in the village do not know about their blood pressure status. Unlike the NDHS findings, more women than men (18 women and 15 men) had hypertension in the village. One of the causes may be because some youths and adult were working outside of the district and their status remained unknown. Majority of them were diagnosed within the last five years period and no one of them was below 30 years. The villagers call “pressure” to mean high blood pressure. Though there were a few who reported low blood pressure and one of them was admitted in hospital because of low blood pressure.

The villagers were more concerned about the complication and consequences of high blood pressure and were in routine medication. Most of them were also following home-based measures to manage the blood pressure level along with the prescribed medicine. During the field work a person who had hypertension and also suffering from other complications died. Once his wife went to her maternal home to attend a ceremony. When she returned home she found her husband bed-ridden and was short of medicine. She suspected that he must have missed to take required doses of medicine. She found her son and daughter-in-law very uncaring. On her arrival, they felt ashamed and immediately called a village paramedic. However, the paramedic suggested them to take him to Ghorahi hospital. They had a plan to take him to Ghorahi hospital the next day morning, but the person died at midnight. Among the people with hypertension eight had joints pain (arthritis), six had diabetes, three had asthma, and two had heart problems.

Table 11: Hypertension by Caste/ethnicity and Wellbeing Status

Caste/Ethnicity	Population % (N=666)	Patients % (N=33)	Wellbeing Status	Households % (N=126)	Patients % (N=33)
Brahman & Chhetri	36	54.6	Well-off	33.3	51.5
Janajati	48	33.3	Average	33.3	30.3
Dalits	16	12.1	Poor	33.3	18.2
Total	100	100	Total	100	100

The total population of Brahmin/Chhetri was 36 percent but they constitute the 54.6 percent of the people who had hypertension in the village. The Janajati and Dalit have less number of people with hypertension compared to their population size. There are comparatively few number of people with hypertension among the poor and Dalits. Dalits constitute 16 percent of the total population but only 12.1 percent of the people who had hypertension were from Dalits. Similarly, only 18.2 percent of the people who had hypertension were from the poorest 33 percent of the households whereas the figure was 51.5 percent for the top 33 percent of the households. This shows that the hypertension is positively associated with the class and caste. One of the reasons for low level of hypertension among Janajati, Dalits and poor can be because they do not go for early diagnosis and another would be low prevalence among them because they involve more in physical works more than those of the better-off and Brahmin/Chhetri.

The patterns of resort among the people with hypertension differs, especially before the diagnosis. Some had tried something in their home, some had taken recourse to the healers while others to the clinics and hospitals. In most cases, high blood pressures were diagnosed in course of treatment of some other illnesses. For example, an adult went to an eye hospital for he had problems in eyesight and he was diagnosed with high blood pressure. Some of them had headache, dizziness, and weakness and later diagnosed with high blood pressure.

Hiralal, a man of 52 years old from well-off Brahmin/Chhetri family

> I had problem in my eyesight. I went to an eye hospital (in Bhairahawa, a city near Butwal located at around 180 km west of Ghorahi). There, I knew that my blood pressure was high and later I consulted a doctor and since then I started medicine.

Sumitra, a woman of 30 years from poor Janajati family

> I was feeling weak. I also had headache. I did not know it was because of [high blood] pressure. When home measures did not work, I thought of *laago-bhago* (dead spirits). I went to the healer for *jhar-phuk*. The headache persisted because the illness was not caused by *laago-bhago*. I went to the medical bought medicine and then I went to hospital and came to know that it was because of pressure.

A few of them knew about their blood pressure level from the village medical and went to Ghorahi hospital for further diagnosis. In many cases the high blood pressure was diagnosed while seeking treatment for some other illnesses. For the treatment, most of them visited biomedical practitioners and started to take medicine regularly along with adopting behavior which are suggested or considered helpful in controlling blood pressure such as taking low amount of salt, doing yoga and exercise, and going for morning and evening walk. Only a few of them, who were from poor families, were managing their pressure level exclusively with home-based practices. These practices include taking local herbs such as neem leaves (azadirachta indica), taking specific vegetables (such as bitter guard, garlic) and tea holy basil/cinnamon tea.

Madhav, a government employee, aged 48 years old from average Brahmin/Chhetri family

> I never thought of having [high blood] pressure. Once I fainted when I was in duty. The official staff took me directly to Kathmandu hospital in our official vehicle. I was admitted there and then only I knew that it was pressure that had hit me. Since then I have been taking medicine.

Shanti, a woman, 56 years, from poor Janajati family

> I used to feel dizziness and exhausted and tired without working much. When *jhar-phuk* did not work, my son accompanied me to Ghorahi. We visited a doctor in his clinic and he told us that it was because of high blood pressure and since then I have been taking medicine for pressure.

Sharmila, a woman of 47 years, from poor Janajati family

> I went to a clinic for I had burning sensation while urinating. The doctor wrote many medicine and one of them was for pressure. I completed other medicine but have been continuing the medicine for pressure.

Sandhya, a woman, 64 years, from well-off Brahmin/Chhetri family

> I used to feel very tired. My hand and leg had no strength (*phatrakka galthe*). Once I heard from a radio that a reputed doctor was coming to Kohalpur (a town close to Nepalgunj where there is a medical college) from Lucknow. I went there with my son and son-in law. I came to know that I had high blood pressure. I took the prescribed medicine for a month and then only I felt comfortable. From the last 12 years I have been taking the medicine. Even after taking this medicine my pressure is high. In the beginning, I used to take a type of flower's leaves (catharanthus roseus), cow urine, alloevera etc. Later I stopped them when the doctor advised not to use them. I have not stopped morning walk but have lowered salt intake.

The patients had taken recourse to different healers, medical clinics and hospital before diagnosis but after diagnosis most had relied on the medicine. There is no such difference among the people who had hypertension in terms of the home-based measures and medicines taking. However, a few poor were found relying on exclusively home-based herbal medicine. In terms of recourse times, the poor had recourse more than the well-off before the diagnosis.

1.3 Diabetes

The prevalence of diabetes has been increasing across the world since the last few decades and it has increased remarkably in many developing countries like Nepal. Globally, the prevalence of diabetes has increased from 4.7 percent in 1980 to 8.5 percent in 2014 among the the adult (i.e., 18 years and older) population (WHO 2016a, 6). In Nepal, the prevalence of diabetes is estimated to be around 9.1 percent (10.5 percent men and 7.9 percent women), according to WHO diabetes profile. A study estimates pooled prevalence of type 2 diabetes in Nepal to be 8.4 percent (Gyawali et al. 2015)**.** The prevalence of diabetes is low among the rural population but rural population constitutes more than three-fourths of the total population of the country and quite a large number of people are suffering from diabetes and related complications. The times of recourse and cost of care may be high among the rural population because the rural areas are deprived of health care services and the people with diabetes likely to suffer much from the urban bias in health care facilities. The stories of the people with diabetes points to the high cost for travel and time loss to go for consultation, medicine and regular tests.

Diabetes, which is commonly known as 'sugar' among the villagers, is one of the major chronic illnesses from which a total of 13 people were suffering in the village. Table 3 and 4 show the socio-demographic characteristics and the the patterns of resort.

Table 12: Diabetes by Caste/Ethnicity and Wellbeing Status

Caste/Ethnicity	**Population %** **(N=666)**	**Patients %** **(N=13)**	**Wellbeing status**	**Households %** **(N=126)**	**Patients %** **(N=13)**
Bra/Chhe	36	61.5	Well-off	33.3	61.5
Janajati	48	15.4	Average	33.3	23.1
Dalits	16	23.1	Poor	33.3	15.4
Total	100	100		100	100

Table 13: Patterns of Resort in Diabetes by Caste/Ethnicity and Wellbeing Status

SN	Caste/ ethnicity	Wellbeing Rank	Age	Sex	SLC + Education In the family	Family Occupation	Medicine From (Yrs)	Resort patterns
1	Bra/Chhe	3	78	M	3	PJ	18	C→C→ A+D
2	Bra/Chhe	3	64	F	3	PJ	10	A→ B+D→A+D
3	Bra/Chhe	3	45	M	3	PJ	6	A→ A+D
4	Bra/Chhe	3	46	M	2	PJ	10	A→A+D
5	Bra/Chhe	3	66	F	0	Ag	13	A→C+D→B+D
6	Bra/Chhe	3	82	M	3	Ag	12	C→ A→ B+D→A+D
7	Bra/Chhe	3	56	M	3	GJ	9	A→ B+ D→ A+D
8	Bra/Chhe	2	58	M	1	Ag	6	A→ A+D
9	Janajati	3	56	F	0	PJ	5	C→A→ C+D→ A+D
10	Janajati	2	53	F	1	GJ	2	C→ A → C+D
11	Dalit	1	55	F	0	Ag	3	C→ A→ A+D
12	Dalit	2	57	M	1	GJ	4	A→C+D→A+D
13	Dalit	1	63	F	1	Ag	3	C→ A→ C+D (death)

Note: Symbol for Biomedicine (A), Traditional Medicines (B), Folk medicines (C), Home-based medicines (D). The letter A or B or C or D denotes single use if separated from comma and the arrow mark (→) denotes sequential use and a plus mark (+) for simultaneous use of two or more systems.
Wellbeing status (1 = poor, 2 = average, and 3 = well-off)
Job (PJ= Private Job, GJ= government job, Ag= Agriculture)

There were 13 diabetic patients in 12 families. Most of them were in their 50s and above, ranging from 45 to 82 years and seven of them were men. The Brahman/Chhetri constitute around one third of the village population but more than two thirds people with diabetes were from Brahmin/Chhetri families. Diabetes among Dalits is also high but very less among the Janajati compared to their population size. The low level of diabetes among the Janajati may be either because the screening is low among them because they do not go for a test unless they experience symptoms or because the prevalence of diabetes among them is actually low among them because the physical activities among them is high than those of Brahmin/Chhetri. However, if we take the wellbeing ranking of the household, two thirds of the diabetic patients were

from the top 33 percent of the households whereas only 15 percent of diabetic patients were from the bottom 33 percent households. So, wellbeing status seems associated with diabetes more than the caste and ethnicity. Even among the Dalits, the families and position of the patient in the families were slightly better. In terms of education, almost 85 percent of them had one or more family members who hold SLC and above education and two third of the households have someone in the government or private job. Only 15 percent households work as sharecroppers while two third of the household give their excess land to other households for sharecropping. In short, diabetes is positively associated with class, caste, occupational and educational status and status in the family. Better the status better the chances to have diabetes. A study conducted in Kathmandu valley by (Saito et al. 2014) also shows the association of hypertension and diabetes with economic quintile of the households.

Like in hypertension, many of them were diagnosed when they were seeking treatment for some other illness. But a few of them had gone themselves for blood sugar test. Among them SN5 had tested blood while she was accompanying her husband in Lucknow, SN 3 diagnosed while he was in the process of his parents' treatment and SN 4 also went for blood test suspecting the early sign. But even among them a reason was there for blood test. For instance, SN 3, an educated participant who teaches in a college, had problem in eyesight and an eye clinician had advised him for the blood test. He did and diagnosed. First he tried home-based measure to manage the blood sugar level and then started medicine as per the doctor's advice. Most people living with diabetes were using various types of herbs such as *sisnu* (urtica dioica or stinging nettle), *bahramase ful* (catharanthus roseus), Indian blackberry (Syzygium cumini) and the like, exclusively in the beginning and later along with the medicine. The SN13 was diagnosed in a hospital of Ghorahi when she was there for problem of weakness and fatigue. She had been following recommended diet and home-based herbal medicine to control blood sugar. She had been visiting private clinics in Ghorahi for blood tests. She had plan to go to visit doctor after agricultural season. Last time when I met her she said, "I have become very weak. I have no strength in my body. Whether this picks me up soon… What is this falling upon me? *Ma ta marchhu ki kya ho?* (Feel, I might die)." Unfortunately, she died.

It seems the thinking such as 'I am going to die' and 'I am not going to be healed 'or 'I am not going to die' and 'I am going to be healed' makes a difference. There may be background reasons for having positive or negative thinking and only positive thinking is not enough. However, the positive thinking can work as placebo effect whereas negative as nocebo effect. The SN 1 had said, 'Maybe I will live some more years' because I am following "a disciplined life". He was living fine till the end of my field work. He had been frequently visited by his relatives with gifts and goods and he has been getting good food and good care. This is not that the poor and Dalits do not have positive thinking. Off course, they have. However, they lack such source of positive thinking as well as enough time and resource needed for treatment and to engage into spiritual and religious activities like those of better-off and Brahmin/Chhetri. The walking to and fro a temple might be helping people in their physical exercise as well. Things would have been different had she belong to better-off socio-economic family. The treatment of better-off seems more regular than the poor. As the woman who died had postponed to go to the hospital for there was agricultural season. While the better-off can afford to go for regular tests and buy medicine as needed or they may avail free services because of their connection with the people in the health facilities. They can claim free health services which are meant for the poor, helpless and the needy.

The stories of two Brahmin/Chhetri woman is different. They got the chance to show their problems to the doctors while they were accompanying to their husbands to the distance city hospitals. Both of them got to know that their sugar level was high and a woman started the prescribed medicine since then along with home herbal preparation. Later, she left to take herbal preparation as the doctor advised. Another woman has been going for regularly health check ups with her husband and was able manage her sugar level with home herbal preparation and ayurvedic medicine since the last 13 years.

The cases of two Dalits women resembles. Three years ago SN 11 had a problem of weakness. She recalls:

> I was feeling weakness. Once I went to cut grass in the morning for my goats, when I came back carrying the grass on my back, I experienced a deep pain in my lower abdomen. I went to medical and bought medicine. After some time, when the medicine did not work I went to Ghorahi hospital. The pain went

down but I was weak and not feeling better. After that I saw small ants attracted to where I had urinated. People used to tell that happens when one has sugar. I went to Butwal hospital with my son. It was confirmed and since then I have been taking the medicine".

The two Janajati women (SN 10 and 11) also shared the similar experience but the recourse time varies. One of them who had been taking regular drugs (metformin tab.), was diagnosed with diabetes in Nepalgunj hospital when she was tired of moving between healers and local medical clinics. Her weakness increased and in her words, "felt thirsty and hungry but could not eat much" and started to seek treatment. Another woman did not have to go Nepalgunj. She was diagnosed in Ghorahi hospital but had been using the decoction of *khayar* (Senegalia catechu) as suggested by a healer.

These persons were at various stages of diabetic conditions and their treatment recourse also varied. Among the people living with diabetes more than one-third were diagnosed in the last five years and more than one-third 10 years ago. The difference is that the better-off youth and educated were diagnosed early without taking many recourses.

Here it is important to note that some of these persons with diabetic conditions are relatives. Number 2 is number 1's younger sister, number 9 is number 10's elder sister and number 12 is number 13's younger brother. Number 3 is number 2's son and number 4 is number 1's younger brother's son. There is also relation between diabetes and hypertension. Six out of 13 diabetic patients had also hypertension.

1.4 Mental illness

The terms such as *nasha sambandhi* (nerve related), *manasik bimari* (mental illness), *khuskeko* (loose mind), *pagal bhayeko* (gone mad) are used to the problem related to mental illnesses. Studies have shown a high prevalence of mental illness across the world[21]. However, only eight persons reportedly had sought care for such problems in the village. There was variation in the types of mental illnesses they reported. Of the eight patients, five were women and three were men, four were from Brahmin/Chhetri and two from Janajati and two were from Dalit communities representing all class but highest from the *saamanya* (average). However, there might be some more persons who did not seek treatment or who did but did not report, as many families do not feel comfortable to share about the mental illness because of stigma. The persons who are suffering from mental illness also feel shame to share their experience. The family plays an important role to seek treatment and to provide emotional support to the persons suffering from mental illness.

Table 14: Mental Illness by Caste/Ethnicity and Wellbeing Status

Caste/Ethnicity	**Population % (N=666)**	**Patients (%) (N=8)**	**Wellbeing status**	**Households % (N=126)**	**Patients % (N=8)**
Bra/Chhe	36	4 (50%)	Well-off	33	2 (25%)
Janajati	48	2 (25%)	Average	33	4 (50%)
Dalits	16	2 (25%)	Poor	33	2 (25%)
Total	100	8 (100)		100	8

[21] Steel et.al. (2014) estimate that on average 17.6 percent experienced a common mental disorder within the past 12 months and 29.2 percent across their lifetime. Women had higher pooled prevalence rates for mood and anxiety disorders compared with men but men had higher pooled prevalence rates for substance disorders compared with women (Steel et al. 2014) The prevalence estimates are less in developing countries than developed countries (Kessler et al. 2009). A study conducted in a rural village (a VDC of Baglung) of Nepal found an overall prevalence of 37.5 percent of psychiatric cases. The overall prevalence was more among the women, Dalits and aged 30 and above(Khatri et al. 2013).
Another study on anxiety and depression conducted among a representative sample of Nepalese adults aged 18–65 years (N = 2100) found 22.7 percent crude prevalence of anxiety and 11.7 percent of depression (Risal et al. 2016)

Table 15: Mental Illness and Patterns of Resort by Ethnicity and Wellbeing Status

SN	Caste	Wellbeing Status	Age	Sex	member	Occupation of Family	Patterns of Resort
1	Bra/Chhe	3	57	M	2	Gj	C→A→A
2	Bra/Chhe	3	33	F	2	Ag	C→A→C→A
3	Bra/Chhe	3	18	F	2	GJ	C→ A→A
4	Bra/Chhe	2	28	F	1	Business	C→C+D→A→C, A→A
5	Janajati	2	55	M	0	Ag	C→C→ C
6	Janajati	1	22	F	0	Ag	C→A→ A→C
7	Dalit	2	32	F	1	Ag	C→ C+A→ C
8	Dalit	1	58	M	0	Ag	C→ C+A→ C →A→A

Note: Symbol for Biomedicine (A), Traditional Medicines (B), Folk medicines (C), Home-based medicines (D). The letter A or B or C or D denotes single use if separated from comma and the arrow mark (→) denotes sequential use and a plus mark (+) for simultaneous use of two or more systems.
Wellbeing status (1 = poor, 2 = average, and 3 = well-off)
Job (PJ= Private Job, GJ= government job, Ag= Agriculture)

The Table 14 and 15 show the socio-demographic characteristic of the people with mental illness and the patterns of resort. They had followed different pathways to care. All of them had taken recourse to a shaman or faith healer first and then to medical doctors or psychiatrists. Some had moved back and forth between shamans and psychiatrists. Only one person (SN 5) had exclusively relied on faith healing following vertical patterns of resort, consulting more experienced and expensive healer in the subsequent recourses. Many had taken recourse to hospital or consulted a psychiatrist in private following hierarchical resort patterns. Half of them (SN 1, 2, 3, 6) were in regular medicine and SN 5 and 8 had not sought any further biomedical treatment.

A few villagers had reported problems of *jhaskane daraune* (startling and frightening), *nidra nalagne* (insomnia) and *darlagdo sapana dekhne* (bad dream or nightmare), *manma kura khelne* (worrying because of too much thinking on some matters) which can be counted as mental illness. These cases have not been included in the above list.

For such problems they had relied exclusively on faith healers and shamans. Similarly, there were two cases of suicide attempt which were also not included in the list. According to WHO World Mental Health Surveys up to half of all people with serious mental illnesses (mostly in anxiety and mood disorders) in developed and three fourth in the developing countries are not receiving treatment. This means in many developing countries most people might be relying on folk or informal sector.

A girl who had drunk a bottle of poison to commit suicide. Her mother suspected soon after she drank the poison and the family and neighbor first attempted to make her vomit and then rush to Ghorahi hospital and from there to Nepalgunj hospital. She survived and discharged from the hospital after eight days. But people used to say that her mental state is not in balance. The incidence took place when her father scolded and slapped her for not focusing on study and visiting boy friend without his knowledge. She was a secondary level student (class 9) and had performed poorly in the recent exam. A woman who had given birth to son two month ago also attempted to commit suicide by swallowing the poison bought for agricultural use. Similar recourses were taken: first aid at home and rushing to Ghorahi hospital and then Nepalgunj hospital. She was admitted there for six days and discharged. It was said that there was *khat-pat* (clash/dispute) between the woman and her mother-in-law and she felt abandoned when her husband did not take her side. These cases have not been included as cases of mental illness in the above list. The difference can be seen in use of medicine and patterns of resort in mental illnesses. The better-off and Brahmin/Chhetri tend to resort to biomedical doctor or psychiatrist following horizontal patterns in their subsequent recourses than the poor and Dalits. The Dalits and poor were likely to follow mixed type hierarchical patterns of resort.

Madhav, a 48 years old man from average Brahmin/Chhetri shared:

> My daughter (SN 3) was an active girl. When she failed in her exam, she was depressed. She started to *jhokraune* (lost in oneself and looked as if she was in deep thought). We did *jhar-phuk* in the village and then went to a doctor. The doctor gave few tablets and after that we went to Nepalgunj and visited a psychiatrist and he gave medicine for *depression* (original English). She took medicine for one and half months and after that we have not visited the doctor

because she seems fine now. She has started to take tuition class for the failed subjects.

A woman (33 years) from well-off Brahmin/Chhetri family who had been taking medicine for what she calls “stress” shared

> I (SN 2) was not feeling good since the morning. I was feeling tired. I found the food tasteless and ate a little. There was mild fever and headache in the evening but it increased at night. My husband called a healer. The healer examined my pulse (by hand) and read rice grain and assessed whether that was caused by any evil spirits. He said that the pulse was good and there was no evil influence. He suggested to drink some water adding a little turmeric powder and wait a couple of hours. I got little relief after drinking, but the pain did not come down. The next morning, I went to Ghorahi with my husband and visited a doctor in his private clinic. We did various test but nothing diagnosed. He gave medicine for headache and sleeping tablets. But the pain spread from head to the shoulder, backside and down to the waist. Then I visited a faith healer and he did *jhar-phuk*. I could not sleep well at night. There was tension in the family and no one was caring about my illness. I was suffering from headache and sleeplessness. After a week, again we visited the same doctor and did the thyroid test. He found no problem in the report and said this is because of ‘stress’ and changed the medicine. I have been taking the medicine and after two month I will visit him again.

Thaman, a man of 34 years from average Brahmin/Chhetri family who was seeking health care for his wife shared

> My wife started *to jhonkraune, tolaune* (lost in thought) and *nasutne* (sleeplessness) since the last year. I took her to a famous healer who lives in the next village. The healer did *jhar-phuk* and assure to be alright. As per his advice, I also offered *dhaja-dhup* to the *kul devta* (clan deity) with the help of my father. And then I took her to another healer with a rooster suspecting of bad spirits. Two or three months spent and no improvement was observed. My mother had knee joints pain and my father was taking her to a clinic in Butwal and I joined them and we all visited Dr. A in his clinic (Dr. A is a well known

physician, transferred to Butwal hospital from Ghorahi hospital). Dr. A examined my wife and told us about 'depression' and prescribed some medicine. We came back and she took all the medicines but she did not improve. She would have been cured had she have any disease. She didn't have any disease and the 'depression' was *manko kuro* (the thing of hear-mind). When my family insisted, I invited a shaman who was far from our village. He did an elaborate shamanic healing ritual (*jhankri basne*). The ritual was impressive as was explained to me before inviting him. He made an amulet for her and suggested to change the place of residence and bed location as the current place was eyed by bad spirit. We also offered the blood of black he-goat as required for his healing rituals. After that her condition improved. She was very much active and doing her household chores responsibly. Children (a son and a daughter) were getting food and dressed up in time for school. Everything was fine. I had got a great relief. I have/had doubt of shaman's healing but that was really a magic.

Unfortunately, the happiness did not last long. Again she started *jhokrauna*. Neither *bhut- pret* (attack by dead spirit) nor a *rog* (a disease), I had no clue what the hell was happening to her. I was in trouble. One day morning I listened an advertisement in an FM radio that a psychiatrist doctor was coming to Dang from Kathmandu. The FM had explained the problems exactly what my wife was suffering from. I noted down the day and the clinic venue. He was a *manasik rog bisesagya* (specialist psychiatrist). We went there. It was a big crowd. We registered name and waited till late afternoon. The doctor prescribed medicine and advised to visit him in three months time. Now, she has has been taking the medicine and she has started to sleep well and do the household chores. With medicine I hope she will alright.

However, last time he said that after that he went to Lucknow two times and told that she has been taking medicine from there. He had also revealed, "My wife thinks that I love someone else and and I bringing someone as her co- wife…I do not know why she thinks so. Not only the girls, whoever come to my shop I serve with a smile. And girls come to my shop to buy things, not to do what she thinks. *Banko bagh le hoina, manko baghle khane bhaneko jasto* (This is like being afraid of the tiger which is not in the

jungle but which is in her heart-mind)". He pointed to her suspicious nature but also accepted that the verbal spat and quarrel over on this issue with his wife. Indeed, the fear of *sauta halne* (co-wife) may have caused her *jhokraune*. This also indicates to the association of mental health with family relation.

Table 16: Use of Medicine and the Recourse Times in Chronic Conditions

Illnesses	**Choice of Medicine**				
	No of Patients	First recourse	Second recourse	Third Recourse	Fourth Recourse
Arthritis	42	12A, 9C, 21D,	18A, 3B, 8C, 9D	13A, 5B, 8C, 5D	7A, 4B, 5C, 4D
Hypertension	33	16A,11C, 6D	17A, 5AD, 4C, 3D	6AD, 3C, 1BD	3AD
Diabetes	13	7A, 6C	5A,3AD, 2CD,2BD,1C	5AD, 3CD, 2BD	2AD
Mental Illness	8	8C	5A, 3CA	4A,4C	2A, 3C

Note: Biomedicine (A), Traditional Medicines (B), Folk medicines (C), Home-based medicines (D)

The table 16 presents a summary of choice of medicine and recourses the sick person with four chronic condition had taken. This shows a recourse pattern among the people and their choices from among the different systems of medicines. In most cases, people had used home-based measures before seeking professional help and then had taken recourse to folk, traditional or biomedicine. In the table, only up to fourth recourse included but a few of them had taken more than that. In arthritis, people had switched back and forth between different systens and practitioners, in the beginning the home-based measures and folk system dominates but in the subsequent second and third recourses the use of biomedicine increases and again the use of traditional and folk medicine increases. The home-based measures seems falling in the subsequent recourse, however, many use simultaneously. In hypertension, most had taken recourse to biomedicine either in the beginning or in the two subsequent recourses. In hypertension, use of medicine varies before diagnosis but after diagnosis the use of biomedicine dominates. The folk medicine and home-based measures seems complementing. The home-based practices constitute an important source in both arthritis and hypertension in terms of combine use. In case of diabetes, before diagnosis they had taken recourse either to biomedicine or to folk medicine but after diagnosis they had recourse to biomedicine and had combined folk, traditional or home-based

sources. In case of psychological distress, the first recourse was folk medicine and later biomedicine and some had navigated between traditional healers and psychiatrists, similar pattern was observed by (Kohrt and Harper 2008)[22].

[22] In Nepal, traditional healers are the most prevalent practitioners (1 traditional healer per 650 persons, 1 physician per 5000 population, 1 psychological counsellor per 35000 population, 1 psychiatrists per 900000 population and 1 clinical psychologist per 4.5 million population in Nepal (Kohrt and Harper 2008)

2. Socio-economic Background and Patterns of Resort

The patterns of resort, the approach to treatment seeking among the people, and number of recourses to treatment sources differs according to the socio-economic background of the people, even though they share similar geography and culture. The differences exists even for similar kind of illnesses. This section looks into the patterns of resort based on their socio-economic background.

2.1 Wellbeing Status

Figure 14: Chronic illnesses by Wellbeing Status

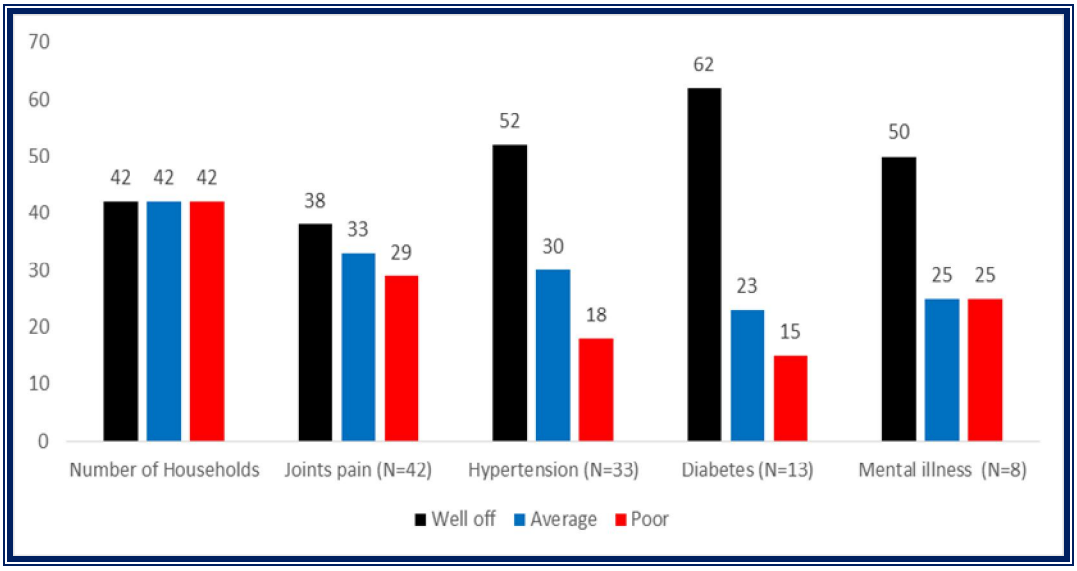


Figure 14 shows the distribution of chronic illnesses among three different classes: well-off, average and the poor. The black represents the well-off, blue average and red the poor. The figure shows that more percentage of people reported chronic illnesses from well-off households. According to wellbeing status, if other things remain the same, the patients who are from well-off socio-economic background are likely to seek treatment soon. They do not stay long without seeking treatment but the poor are more likely to stay long with no treatment. The home-based treatment were followed by all

sections of people more or less at the same level. The tendency is that the poor are likely to use home remedies exclusively in many illnesses whereas well-off use home remedies along with other systems. In terms of visiting hospitals outside of the district the poor visited less than those of well-off. The number of poor who visited facilities outside of the district (Nepalgunj, Butwal, Chitawan, Kathmandu, Lucknow and other Indian cities) was high only because of those poor who had been working there. More number of people from well-off section go to the hospital of distance cities and visit private clinics but poor do not go to the distance hospital unless there is an urgent need. It is natural that the more they seek services from distance hospitals the more they incur the expenses. However, the poor visit many practitioners for an illness episode within the district and sometimes they take risk to go to distance hospital and spend much as compared to their family income and property.

Table 17: Treatment Sites by Wellbeing Status

Types/place of treatment	**Well-off (42 HH)**	**Average (42 HH)**	**Poor (42 HH)**	**Total (126 HH)**
No treatment	1	2	6	9
Home Treatment	19	17	14	50
Use of local folk healers	19	24	20	63
Traditional (Ayurveda & Homeopathy hospitals/clinics)	5	1	4	10
Village medical store	9	11	12	32
Within the district (Ghorahi biomedical hospital/clinics)	35	29	31	95
Outside of the district	28	30	13	71
Total	116	114	100	330

Table 17 shows the last treatment site of the patients who had reported in home visits. The number of people suffering from illness was a grossly underreporting because many illnesses which were treated easily and quickly at home often get no mention. 'No treatment' were the cases, despite felt sickness problem and expression of need but

had not sought any treatment outside of home. However, a hypothetical question such as “What would you do if a doctor comes with free medicine in the village” yields many untreated illness. If there is a doctor of their type along with free diagnosis and drugs the number of people who want to visit would be high, as it happens usually in occasional health camps. This shows that a large number of people are living with untreated illness. Because people do not seek care for those illnesses which are not pressing and painful and which do not hamper their day to day work. However, even if there is a camp the poor will not go to consult because if their work and wage loss is weighed high. The figure can be taken as indicative of the trend, i.e. which group despite having problem delay or do not seek care. Similarly, the home treatment which comes before, during and even after seeking the professional may be under reported. It is often the distance, costly and professional care recalled and reported than the one which are treated without cost and at home or in the village.

In some illness conditions there are similarities but in many there are differences in the resort pattern among the social groups. There are different reasons for choosing different path of care among different people. The family plays a key role and specially the perception of the head of the family and faith in certain things matters. Sometimes money comes first, while in other the illness conditions. The decisions are made based on the assessment of illnesses, type and severity, cost for treatment, and the suggestion of neighbor and relatives, workload of the family. For example, if it is not an agricultural season they are likely to go to hospital without delay while in agriculture seasons they are likely to postpone the plan unless there is an emergency. There were some who had postponed to go to Ghorahi hospital/clinics to test sugar level, pressure, thyroid, eye check up, back pain etc. Many had reported their plan to go to hospital only after the season of plantation or harvesting of crops.

Gender too played an important role in giving priority to treatment seeking. The lack of money at hand also altered their plan, for example, a woman who wanted to go to Ghorahi for she had axed on her toe while splitting firewood, but treated using home-based measures. Sometimes, family does not give priority to the problems of women. She was sorry that she could not get the needed sympathy and support from her husband. Similarly, a woman was suffering from piles since long but she was not able to make a plan with her husband to go to hospital because he was busy in labor work

and was not paying attention to her problem. The problem was worsening. She shared that when she sits for toilet, blood drops from the warts around the anus. She was sharing her problem with great difficulty, with shame, fear and tear. The problem was painful and probably they will visit hospital soon after the agriculture season. There are many untreated problems and sometimes family members also think that they are untreatable and do not attempt unless the pain is unbearable. There are people living with many problems, treatment attempted but not completed. When treatment is attempted but there is no improvement that causes a type of pain and suffering but when they report to the family repeatedly but the family members do not respond, that causes another type of pain and suffering.

2.2 Caste and Ethnicity

There is a relationship between caste/ethnicity and treatment seeking and use of medicine. When Dalit and Janajati experience the symptom of illnesses the possibility is that they may not attempt to seek treatment or try home-based measures and then go to folk practitioners or visit medical or to health post while Brahmin/Chhetri likely to resort directly to the professional practitioners for treatment when they experience illness.

Figure 15: Chronic Illnesses by Caste/Ethnicity

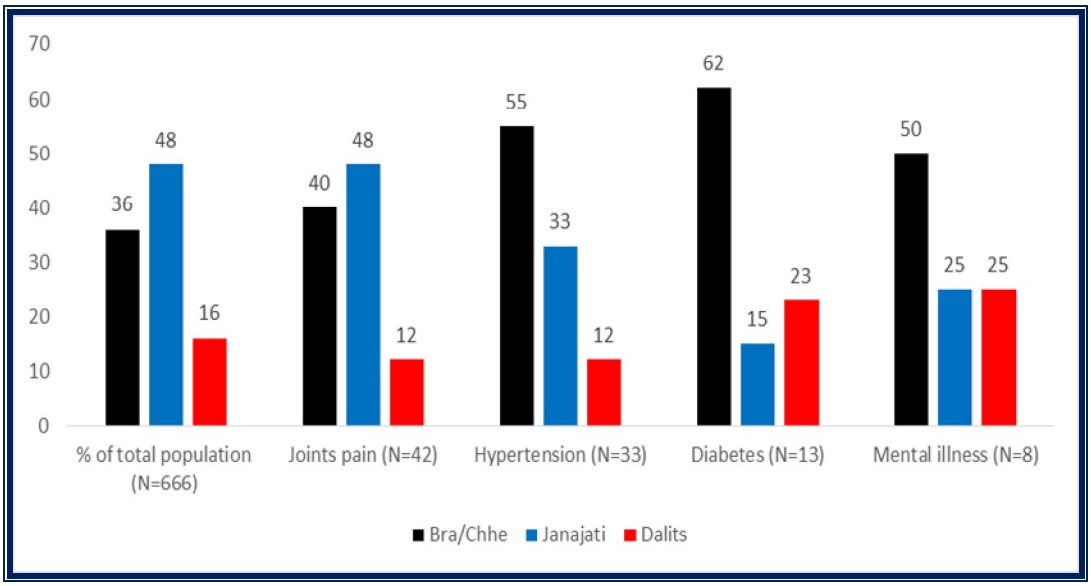


Table 18: Treatment Sites by Caste/Ethnicity

Types/place of treatment	Brahman & Chhetri (N = 238)	Janajati (N=319)	Dalits (N=109)	Total population (N=666)
No treatment	1	4	4	9
Home Treatment	20	19	11	50
Use of local folk healers	17	32	14	63
Traditional (Ayurveda & Homeopathy hospitals/clinics)	5	5	0	10
Village medical stores	9	19	4	32
Within the district (biomedical hospital/clinics)	44	37	14	95
Outside of the district	38	24	9	71
Total	134	140	56	330

The Table 18 provides reported data of treatment seeking. The number of the patients who had sought no treatment were found high among the Dalits and low among the Brahmin/Chhetri communities in terms of their population size. Home-based treatment and treatment seeking from folk healers is higher among the Dalits followed by Janajatis and Brahmin Chhetri. However, Dalits were not found using traditional medicines and other groups had also taken recourse less to the facilities of traditional medicines compared to folk medicine. Visiting clinics and hospitals in Ghorahi does not vary much among the caste/ethnic groups. However, more number of Brahmin/Chhetri had visited the hospitals and health facilities out side of the district followed by Janajatis and Dalits. If we look into the data of visiting Lucknow and other Indian cities the Dalits outnumber the other groups and this is mainly because of the reporting of some Dalits who had been working in Delhi, Haryana and Punjab and who had sought treatment in the hospitals and clinics there. If we exclude this, Brahmin/Chhetri outnumber the other groups.

2.3 Education and Occupation

In the use of medicine education and occupation of a patient and or his family makes a difference. The educated family members likely to resort to official medicine than those with no or low education level. Similarly, those whose occupation is agriculture or work as share croppers are likely to resort to folk healers or to the village medical than those who hold jobs or work as laborers in the cities. The educated and those how have jobs were likely to take less number of recourses in overall illness episodes. When we look into the education data, the well-off have more number of SLC and above educated family members. Similarly, Brahmin/Chhetri have more number of educated and job holders followed by Janajati and Dalits. In terms of education, Dalits have the highest percentage of illiterate people and lowest percentage of SLC and above educated. In terms of occupation, they are mostly wage laborers. A few households have been still doing traditional caste-based occupation such as tailoring and iron works and some have gone to India which is not a preferred destination in comparison to Korea, Malaysia and Gulf countries. Very few households keep she-buffalos and very

few households own enough land for agriculture. Their location of settlement is also at the margin (peripheral part) of the village. As an exception, only two households are at better location. And those were the families who had someone in government job since the last generation and those were the families from where the representatives from Dalits for ward committee, school management committee, guardian's committee, temple management committee, and forest users' committee are elected or nominated.

2.4 Kinship and Urban Connection

The patient and his or her family is connected with kinship and social relations. The network of kin and kinship, friends and friendship, neighbors and relatives constitute an important social capital. It was observed that the patients tend to choose the healers or medical practitioners who were connected with family bonds and social relations. The treatment seeking decision is found to be much influenced by the kinship connection. If a healer or medical practitioner is someone connected by family relations then there is chances of visiting them first. If there is someone who lives in a city, possibility will be high in the selection of a hospital located in that city. The exploration on the question why did they decide to go there, the kinship and urban connections were the main reasons. Sometimes the use of treatments sources is influenced by the kinship network. The patients and their care givers are likely to recourse to the healer or the medical practitioner who comes under their network. The first priority is given to the person with whom they have prior contact or acquainted with or belongs from similar caste/ethnicity and have local connection. For example, a medical doctor of Ghorahi who was from the next village was consulted by many because he was either relative or acquainted person to them. When some one is sick in the family and they have to go to the hospitals outside of the district, first priority would be where there is such connection. The connection was the main reason for Dalits to have services from Indian hospitals as someone from their family was working there.

The better-off have used various systems of medicines, visited many different places for treatment and have better used urban and kinship connections. The socio-economically poor lack such urban and kinship connections. Unlike the poor, the well-off get support from their relatives who live or work in the cities within and outside of

the district. And even in Lucknow or Indian cities they will have someone who knows the better hospital in terms of cost and care. They will find someone acquainted who at least knows the budget hotel (or *dharamsala)* and public or charitable hospital. The poor and Dalits lack such connection in the cities. For example, only one Dalit has gone to Kathmandu because he had someone there working. However, from among the well-off Brahmin/Chhetri, there were many in Kathmandu either working or studying. The socio-economically well-off also know where to go for what kind of illness, which hospital provides free and quality care, and where to stay to save money.

The inequality in the socio-economic status is associated with the differential treatment seeking behavior. The people with poor socio-economic background often have to compromise in their treatment choices and experience treatment failures. Because of many constrains it is not possible for them to make right decision to seek right treatment from the right practitioner at the right time. The well-off sections have relatively better chance to get right care at right time from the right practitioners. This is possible not only because they can afford for the cost but also they have better urban connection and better use the kinship social networks.

Many a time, people consult their family and friends about their problem. This includes a network of neighbors, relatives and acquaintances. This network plays an important role in the decision making to choose the type of medicine and practitioners. Sometime the local healers or medical practitioners also suggest them for further recourse. Sometimes their past experience also helps them to decide. Sometimes they assess the similar symptoms with other relatives and then go to a particular practitioner. Sometimes they go to locally renowned practitioners with a hope of good care. The perception of better services also helps them to decide to use certain facility. People have been using their networks but the network and information access differs among them. The people of all sections use their social network for the treatment seeking. If someone has a relative in urban area then there is likely that he or she may go to there for treatment. So there are many factors which come to play. When I asked doctors whom they consulted when they or their family members were sick last time. Most of them replied that they consulted whom they thought as related to the particular problem. A doctor (nephrologist) had consulted a pediatrician friend for his child's illness when his prescription did not work. An orthopedic doctor had sent his mother to

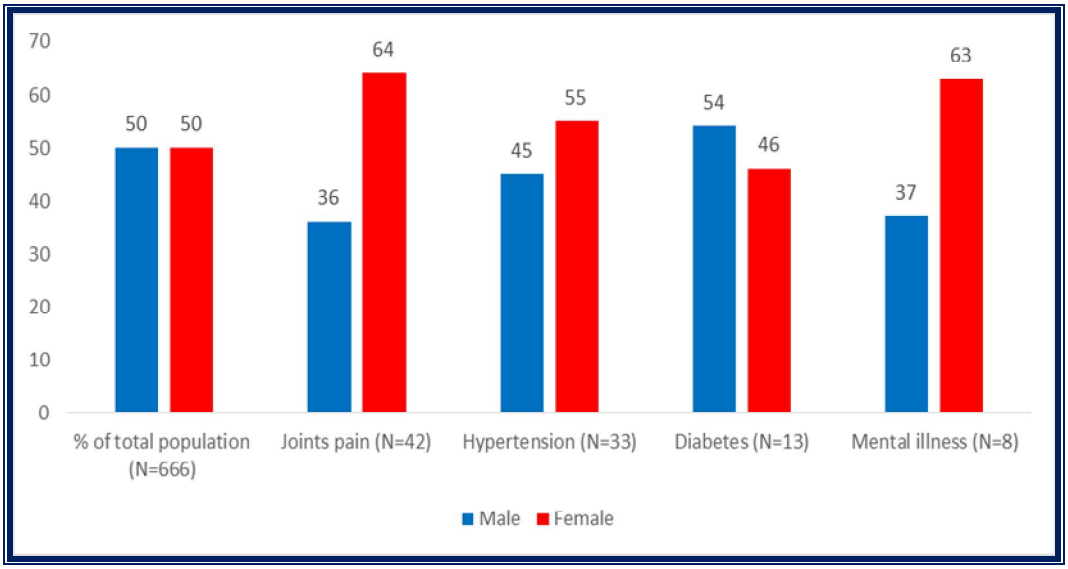
Kathmandu to a diabetologists for he suspected of diabetes. The doctors himself consulted a doctor when he was in Lucknow to attend a program. The network of doctors have better connection with the doctors and that helps them to take recourse to the source that have greater possibility of getting correct cure. This shows that the better the network the more the chance to have less recourses. Most poor and Dalits lack such network and they are likely to take many recourses.

2.5 Gender Status

Table 19 Chronic Illnesses by Gender

Gender	% of the total population (N=666)	% of people with joints pain (N=42)	% of people with hypertension (N=33)	% of people with diabetes (N=13)	% of people with mental illness (N=8)
Men	50	36	45	54	37
Women	50	64	55	46	63
Total	126	100	100	100	100

Figure 16: Chronic Illnesses by Gender Status



There are differences between men and women in the treatment seeking. The women who are elderly and uneducated are more likely to take recourse to folk healers more frequently for themselves and for their children. The women visit these healers before and after visiting the hospital. They consult faith healers, midwives, herbal healers and illness specific healers according to the need. More women than men were found suffering from many chronic illnesses. They were also found compromising in the use of therapeutic resources. Sometimes they had to take recourse to the folk treatment even when they wanted to visit hospital because of lack of money at hand. Many a times woman are not allowed to go distance facilities alone and in most cases their treatments are delayed where as men were found seeking treatment from distance facilities without delay. Women tend to use home-based measures or visit local practitioners whereas men tend visit health facilities. Women are not taken to the hospital unless they are seriously ill. Thus, the use of medicine varies according to gender and socio-economic status of individuals within the family (Abraham 2005). In some of the chronic illnesses women suffer the most than those of men. There were conditions related to uterine prolapse, lower abdominal pain and vaginal discharge from which women were suffering.

The patterns of resort, be that illness specific, varies across socio-economic groups. The poor, Dalits, women and people with no or low education and those who lack kinship and urban connection likely to take many recourses, use folk and home-based medicine more and often follow counter acculturative patterns of resort whereas the better-off Brahmin/Chherti, educated and who have jobs often follow acculturative patterns of resort, or use official medicine first followed by folk medicine and home-based practices.

3. Conclusion

There are similarities as well as variation in patterns of resort among the socioeconomic groups. The patterns of resort vary according to illness conditions as well as the socio-economic background of the people. The selected chronic conditions suggest that people are not equally suffer from similar illness conditions. The prevalence may vary among the different section of the people. Such variation exists even the village with similar geographical location and cultural setting. The patterns of resort varies and the

people with poor socio-economic background (women, poor, Dalits, people with low or no education and people who lack urban connection) are likely to take recourse to many different treatment sources per episode of illness. The people with poor socio-economic background are also likely to be diagnosed late and are not served with appropriate care timely. They are the ones served poorly by the official health care system. They are the ones who are left uninformed, get exemption from payment, if there are any provision, and experience an uneasiness with the "medical gaze".

The above stated chronic illnesses have been recognized as global public health problem. The prevalence of such conditions has been increasing. The prevalence of some of the conditions may be low in some groups but no group is unaffected. The people with diabetes and hypertension have been advised for morning walk and exercise to increase physical activity. In the village, the physical activity is high among the women, poor, Dalit and Janajati as they cannot stay long without working or they have to work for subsistence. The problem of so called "life style disease" is not solely responsible for the bodily inactiveness. The villagers concern about the changing food practices, especially the production and consumption of cereal crops and vegetables may be important factor. They point to the erosion of local health tradition and folk practices which they think were beneficial in the healthy living. The individual and family health has been affected by the changes that has been taking place in societies whereby unhealthy health tradition are promoted (for example, advertised as if packaged milk is better than the mother's milk and cold drinks and what is called energy drinks as if they are nectar or elixir (*amrit*) and "unhealthy health policies" have been adopted to suit the neo-liberal market force. The patterns of resort tells us the partial story of treatment seeking as an individual efforts. However, treatment seeking cannot be understood unless we look into the making of medical pluralism, the structure and function of health care system, the control over the health care resources. The individual treatment seeking has connection with the structure of the health care/medical systems. In the chapter that follows makes a discussion on the hierarchy of medical systems and the state's role in the making of this hierarchy.

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CHAPTER VIII

HIERARCHY OF MEDICAL SYSTEMS

"Medicine is a social science and politics is nothing else but medicine on a large scale. Medicine as a social science, as the science of human beings, has the obligation to point out problems and to attempt their theoretical solution; the politician, the practical anthropologist, must find the means for their actual solution."

(Rudolf Virchow, 1821-1902)
http://www.pathguy.com/virchow.htm

The medical system across the world is pluralistic in that diverse systems of medicine, both official and non-official, co-exist in a hierarchical order. A hierarchy of medical systems is in practice in which biomedicine comes on the top followed by traditional medicine and CAM at the bottom falls the folk medicine. This chapter makes a discussion on the hierarchy of medical systems and examines the state's role in the making of this hierarchy. The chapter makes an attempt to review the historical development of health care/medical system, the development of national health policies, and the contradiction that exists in policies and practices. Then follows a discussion on how the access and utilization of health care services are connected to hierarchical medical systems and the hierarchical structure of the society.

1. The Hierarchy

Hierarchy refers to an ordered arrangement or classification of the people or things according to superiority and inferiority. The criteria of superiority and inferiority can vary. For instance, a particular good or service can be ranked as superior or inferior based on its quality. A person can be ranked superior or inferior based on his or her social status and authority. Similarly, a medical system is ranked superior or inferior according to its status and authority. Social status is determined by the possession of prestige, power and property. The authorities are vested upon by the state rules and

regulations and the power is exercised with that authority. The prestige, power and authority varies among the medical practitioners and this is determined by their training, education, experience and expertise in particular stream of knowledge system. A medical system is ranked according to the state's treatment, which is much influenced and shaped by the dominant global perspective. In the contemporary world, biomedicine is a dominant system, which exerts global influence and remains on the top in the hierarchy of medical systems (Broom et.al. 2009:698). Today, biomedical clinic health care system has become a norm across the globe. Though, traditional medicine, and what is known as CAM in many countries, have been recognized and treated, as a part of national health care system, the status and authority of these systems is not at par with the biomedicine. There can be country specific variation in the status and authority of a particular medical system in terms of service provisioning, financing, human resources, market regulation, recognition of the knowledge system and the state policy environments. For instance, what status and authority Ayurveda enjoys in South Asian region may not be the same in other regions and within the region there can be variations. The kind of medical pluralism can vary "depending upon social-historical and ecological circumstances" (Lee 1982, 629). Leslie explains that medical systems "vary from one part of the world to another according to the family structures, religious, economic and political institutions of the regional and national societies in which they are located" (Leslie 1980:191). Shim (2018) presents three types of plural medical systems: interpenetrative pluralism in China, exclusionary pluralism in Korea and subjugatory pluralism in Japan (Shim 2018). The medical systems "differ in structural superiority (i.e. power over health affairs, prestige in the society, and wealth from the government and/or people) and in functional strength (i.e. the extent of distribution and actual utilization)" (Lee 1982, 640). "A hierarchy of systems of medicine, whether or not acknowledged, is exercised in most societies, with biomedicine at the top, certain TCAM systems next and local healing traditions last." (Lakshmi et al. 2014, 1).

1.1 Understanding Hierarchy of Medicine

The ordinary villagers tend to perceive segmental division rather than the hierarchical division among the medical systems. For the general public, it is not the superiority but the availability and accessibility that matters the most. They use whatever is available nearest and cheapest to them. They view that all the co-existing systems of medicines have importance as they serve the different health care needs. They do not know about many systems and are not concerned about the differences, though they can differentiate between practitioners based on the kind of the services they provide. In terms of utilization of medical systems, people are described as 'pragmatic users' in that they are open to all the possible options. The general public perceives that each of the therapeutic sources have their specific usages and significance. For example, they hold 'when you are struck by evil spirits, what is the use of doctors and for a disease or injury what is the use of shamans?' They hold that aurvedic herbal medicines are harmless and for some diseases and surgical treatments biomedicine is the best. The common people also compare the practitioners and the medicine they practice in the way as Leslie (1980) explains:

> The structural reasons laymen have such high regard for cosmopolitan medicine are that its practitioners: (1) have the superior status of people with formal educations: (2) in poor countries they have the power to own or use automobiles, typewriters and telephones; (3) their claims to authority are sanctioned by law and government officials; (4) their surgery and chemotherapy have impressive "demonstration effects", (5) their buildings and medical instruments are impressive. Yet laymen also consult practitioners of the "alternative therapies." They are often socially and physically more accessible to them; they understand and deal with the patient's and family's experience of illness in a comprehensible manner; their therapeutic interventions also have "demonstration effects", and many of them possess symbols of power like stethoscopes, motorbikes and wrist watches (Leslie 1980, 194).

Some of the healers and practitioners have established themselves as superior than others and this superiority was established from their long-term involvement in the

profession, sometimes more than one generation[23], and the types of the illness they deal with and the size of the patients they cater. Some of the healers, traditional practitioners and medical doctors are reputed for their specialties in certain conditions. The healers, traditional practitioners and medical doctors with different specialties cannot be compared, as they do not represent the similar category. A snake-bite healer is also equally praised in the village, same as a medical doctor who treats a difficult condition. A key informant explained this with a story of a pilot and boater[24]. By this story he meant that everyone is not the best at everything and everyone's knowledge and skill counts. A medical doctor also opined, "We know something about the medical system on which we have knowledge but we do not know about other systems on which we do not have knowledge. No doctor knows everything." However, the dominant thinking is that the knowledge of the pilot is far more superior to the boater. The saying, *kacha vaidya ko maatra, yamapuriko yaatra* (Little learned practitioners are dangerous) also acknowledges the importance of learned and skillful practitioners.

The feeling of superiority or inferiority exists across the practitioners of different medial systems and at the level of doctors, policy makers and planners than at the level of ordinary population. Because for an ordinary person, all the practitioners and their services are equally important even though some may have their own choices, preferences and reservation on certain therapy systems. Though the coexisting medical systems interact with each other and there are overlapping and interconnectedness among the systems, a hierarchy of medical systems, of different knowledge streams exists and these systems exert different level of power and influence. The medical doctors express that biomedicine is the best compared to Ayurveda and Ayurveda practitioners are the best compared to traditional/folk healers. Thus, in the structure of

[23] A traditional *vaidya* of twenty-third generation was interviewed by (Cameron 2008).

[24] Once a young pilot, who was a self-praised person for his knowledge and skills, had to cross a large river. A Bote, whose hereditary occupation was boating and fishing, boarded him on his boat to cross the river. While on boat, the pilot boasted of his knowledge and skills, "I can fly in the sky. Can you fly a plane? "The Bote replied, "No, I cannot." He said, "You poor fellow, you know nothing!" When the boat reached to the middle of the river, the river swelled with flooding water. Bote made an extra effort to move the boat fast. But a forceful current of the flood water hit the boat and the boat lost its balance and it became uncontrollable. The boat was about to turning upside down. The pilot terrified. Bote asked, "Can you swim?" The pilot replied, "No, I cannot?" The pilot realized his limit. The Bote jumped into the river and swam to the bank and saved his life. The learning of the story is that every one's knowledge is equally important and everyone should be treated with humility.

medical system traditional medicine is subordinated to biomedicine (Leslie 1988) and folk medicine by traditional medicine.

The hierarchy *of* medicine (i.e. hierarchy among the different systems of medicine) and hierarchy *in* medicine (i.e. hierarchy within the organizational and structure of particular system of medicine) has been an undeniable fact world over. Hierarchy in medicine, often termed as medical hierarchy, refers to the hierarchy, which operates in the health care system, from center to local health care settings. The wide range of medical practitioners is organized in a hierarchical structure. For instance, in a hospital administration, medical superintendent heads the team of medical doctors, paramedics and support staffs. The medical superintendent coordinates the doctors and paramedics to run the inpatient and outpatient care smoothly. There may be specialists who head the specialized departments (such as general surgery, orthopedic, skin disease, ENT, gynecology, pediatrics etc.) under whom other medical doctors and staffs work. Within the system, experienced and specialist doctors and surgeons are ranked as superior than the newly appointed ones. Doctors are socialized to respect and reproduce hierarchy from the start of medical school, where they learn not to challenge the authority (Lempp and Seale 2004).

The medical hierarchy replicates the societal structure of class, caste and gender hierarchy (Baer, Singer, and Susser 2003). Hierarchy *in* medicine is the reflection of the hierarchical structure of the society and the hierarchy *of* medicine is the reflection of larger socio-economic and political relations. The domination of biomedicine reflects the class caste and gender relationships of the domination. The dominance, as suggested by Lee (Lee 1982) includes two dimension: structural superiority (power, prestige and wealth) and functional strengths (distribution and utilization). The domination of medical profession by well-off, Brahmin/ Chhetri, and male practitioners mirrors power structure of the society. Though absolute domination has been delegated, as better-off women, Dalits and Janajatis are also stepping into the medical profession but the overall structure has remained intact. The hierarchical structure of the society has been reflected into hierarchy in medicine and hierarchy of medicine.

Hierarchical understanding exists among the practitioners of different streams. For example, an ayurvedic doctor expressed, "There is no charm in Ayurveda compared to biomedicine." He was referring to the perks and benefits and career opportunities. As the patient flow is less compared to biomedical facilities and less number of people consult ayurvedic doctors in private even though they charge competitively. The biomedical doctors also look down to the doctors of traditional medicine. One of the biomedical doctors viewed, "Those [traditional medicine] are the complementary medicine [and not the mainstream medicine]. There is no alternative to modern medicine." The tough competition for medical entrance, high cost of medical education, rigorous course contents, and better scopes are described as the basis of being superior. They also view that biomedicine is more scientific and patients are treated successfully with modern diagnostic devices and proven and potent drugs. Moreover, specialization in particular area is valued. A biomedical doctor (nephrologist) expressed his dissatisfaction with the naming of *stri-rog bisesagya* (literally women's disease specialist as translated from gynecologist in Nepali) for that was a generic term which does not indicate to any specific area of specialization such as nephrologist. This also points to the hierarchy of medical knowledge systems, the practitioners (generalist and specialists), medical products and treatment practices. To extend and affirm Leslie (Leslie 1980, 194), with impressive medical products, demonstrative results of drugs, standardized and scientific medical practices, and high class practitioners and further more, with state and market support the biomedicine enjoys the hegemony over traditional and folk medicine. The amazing success in the treatment of people with severe disease conditions and success in medical surgeries such as liver transplant and open heart surgery, involvement of institutionally trained and academically qualified doctors, and belief in the highly sophisticated medical equipment and diagnostic devices, a general public perception is being shaped that (hospital based) biomedicine is the best. One of the reasons why biomedicine is placed in a superior position to traditional and folk medicine is the claim of a superior form of knowledge and 'scientific' practices (Abraham 2005). Biomedical as well as ayurvedic practitioners also assume that biomedicine is more 'scientific', having advanced diagnostic technology, potent drugs developed from rigorous clinical trials than traditional, complementary and alternative medicines. As Abrahams posits,

> The ‘scientific’ status as well the economic and political power that each system wields, both nationally and internationally, determine their positioning in the hierarchy. Allopathy occupies the privileged and incomparable position in this regard, followed by Ayurveda and other systems. It is privileged by the ideology of science, as being the only legitimate scientific system which places it in a superior position vis-à-vis all other medical systems” (Abraham 2005, 190).

Indeed, the supremacy of science has helped to establish biomedical supremacy and sometimes used as weapon to diminish the different traditions. Lee (Lee 1982) also emphasizes the “ideology of scientism” in the development of biomedical supremacy. With the weapon of “science” biomedicine’ tends to either absorb the different traditions, which have been scientized, or disregard their existence which have not adopted the science.

It is often argued that since there is an ontological and epistemic variations the comparison between these systems makes no sense. They differ in the philosophy of knowledge about human body and human health and that all the systems have their own importance and are superior in their own terms. An ayurvedic practitioner, for instance, argued, “Ayurveda is the science of life and its focus is on healthy life. Ayurveda contributes to holistic health. It is not fair to compare only in terms of curative qualities and how many patients you get in your clinics.” Besides, the level of patient’s satisfaction is high with traditional and folk medicine. However, the power and influence what biomedicine enjoys, is not the same as traditional medicine or folk medicine. Rather, folk medicine is steadily losing its ground to the power and influence of official medicine. The question is why this is so and what is working behind the making of the medical pluralism hierarchical. The perceptions of politicians, planners and policy makers, which is shaped by dominant medical ideologies, are articulated through the national health policies and programs. The history, politics and power have shaped the medical pluralism in the present form (Lee 1982).

Last (1981) observes a hierarchy of medical systems in terms of wealth and power and in the degree of their systematization. According to him, traditional medicine is at the

bottom of the hierarchy and is so un-systematized as scarcely to constitute a system, though it flourishes nonetheless (Last 1981, 387). The patients and practitioners, according to Last (1981) 'don't know' and 'don't care' about the heterodox systems. Last questions the medical cultures and the tendency of not knowing or not caring to know. The mindsets of not caring to know about the medical culture results in an unequal access to state resources thereby creating a hierarchy of the medical systems. The de-systematization of medical system disorganizes the traditional practitioners (Last 1981, 387)).

There are "contestations over legitimacy among individual practitioners and hierarchies of authority between different medical traditions" (Lambert 2012, 1029). The practitioners of traditional medicine such as Ayurveda, Homeopathy, Unani are considered as subordinate to the biomedicine (ibid 2012) and folk medicine considered subordinate to the traditional medicine. Priya (2013) also affirms the existence of hierarchy between expert systems such as AYUSH and biomedicine and non-expert system such as folk systems and home-based system commonly known as Local Health Tradition (LHT) in India (Priya 2013, 25). According to (Baer, Singer, and Susser 2003, 11), "biomedicine enjoys a dominant status over heterodox and/or folk medical practices and exerts dominance over other medical systems with the support of social elites. The "patterns of medical pluralism" according to Baer (2003: 44), "tend to reflect hierarchical relations in the larger society. Patterns of hierarchy may be based upon class, caste, racial, ethnic, religious, and gender distinctions. Medical pluralism flourishes in all class-divided societies and tends to mirror the wider sphere of class and social relationships." Bear (Baer 2004a, 111) explains, "The dominant status of biomedicine is legitimized by laws that grant it a monopoly over certain medical practices, and limit or prohibit the practice of other types of healers. Nevertheless, biomedicine's dominance over rival medical systems has never been absolute". Singer (2004) affirms that "the national medical systems in the modern or postmodern world tend to be "plural," rather than "pluralistic," in that biomedicine enjoys a dominant status over all heterodox and ethnomedical practices" (Singer 2004, 29).

1.2 Hiding Hierarchy with Pluralism

Conceptually, medical pluralism refers to the opposite of medical monism, whereby many medical systems co-exists. "Medical pluralism" may not be an appropriate concept to characterize correctly the existing situation of medical systems because plural*ism* suggests to a state where every medical system co-exists with an equal and independent status. Contrary to this ideal condition, we find the co-existing medical systems situated in a hierarchical power pyramid and some forms of medicine have limited or restricted position. This may be one reason why many scholars prefer to use, sometimes interchangeably, "plural medicine" (W. Ernst 2002; Saks 2008), or "plural medical system" (Shim 2018) or "medical diversity" (Penkala-Gawęcka and Rajtar 2016; Parkin 2013), or "medical landscape" (Hsu 2008) or "medical tradition" over "medial pluralism". Many scholars are also skeptical about using the term medical system to refer to traditional and folk medicine. They seem to prefer CAM (sometimes TCAM to include traditional medicine) instead of traditional medicine, "medicine" or "medical tradition" instead of "system" when writing about the medical system other than biomedicine. They feel comfortable to use "folk practices", "folk tradition" or "healing systems" instead of "folk medicine" or "folk system[25]" and healers instead of practitioners to those who practice folk medicine. Indeed, a sort of dubiousness exists among the scholars as what constitute a medical tradition a system and what constitute a system a medical tradition. Sometimes it seems that the academic branding of system and non-system also contributes in perpetuating the existing hierarchy among the different streams. The western scholars, especially the scholars with medical background, prefer CAM (complementary and alternative medicine) while writing about traditional medicine or about the specific therapeutic practices of traditional medicine, which Bode terms "CAM variants" and "CAMinization" of traditional medicine (Bode 2013, 2011). The idea of CAM itself suggests that there is only one system and that is biomedicine (which is also called and understood as mainstream, conventional and orthodox medicine) and the role of other system is just complementary and/or alternative. Whatever the academic and scholarly preferences in writing, the term medical pluralism suggest that "biomedicine did not have the monopoly over health care...but was competing with a plurality of professionalized

[25] See (Press 1980) for the terminological preferences.

traditional medicinal systems" (Hsu 2008, 317). Medical pluralism was in existence before the emergence, arrival and expansion of biomedicine, "what has changed is the hierarchical relationship between the different medical traditions" (Lee 1982, 636).

In short, the term "medical pluralism" can be misleading as it does not necessarily refer to an egalitarian status or an equal standing of each and every co-existing systems, even though conceptually it sounds so. The notion of medical pluralism has been used sometimes to serve the purpose to hide the hierarchy, inequality and injustice "neglecting or underplaying the importance of political, economic, structural and power issues" (Penkala-Gawęcka and Rajtar 2016, 135). "Medical pluralism, while reflecting important richness in cultural knowledge and practice, emerged as inextricably linked to forms of social inequality and suffering" (Broom, Doron, and Tovey 2009, 700).

2. The Making of Hierarchical Medical Pluralism

The following section makes a discussion on the role of the state in the making of the hierarchical medical pluralism. This also attempts to see the linkages between the national policy development and the international contexts. The present state of medical pluralism can be seen as an outcome of the interplay of local, national and global forces to shape the medical pluralism from a non-hierarchical to a hierarchical one (Abraham 2005, 190) or what (Lakshmi et al. 2014) has termed from *de facto* to *de jure* medical pluralism, from introduction and establishment of biomedicine as official medicine and delegitimization of certain TCAM to relegitimization and inclusion of certain TCAM. In a way, the present form of health care system has resulted from the tradeoff between different levels of socio-political forces. In this section, rather than discussing further the hierarchical structure of the medical pluralism, I attempt to understand the making of medical pluralism in the historical context. I will discuss on why the present form of medical pluralism is in existence and what was it that contributed in the making of such a hierarchical medical pluralism and what could be the best way to utilize the positive aspect of medical pluralism in the context of Nepal. In the present context of pervasive neoliberalism, what is it that impacted the existing medical systems, the role of market components in traditional medicine and changing folk and family sector of health care. Despite the need and demand, why the agenda of state provision and promotion of

traditional medicine has not become a priority. Why the erosion of folk and family health tradition could not become a matter of concern? How the state power has been directed to influence the medical pluralism people practice?

2.1 Historical Development of Health Services System in Nepal

Table 19: Timeline of Historical Development of Health Care System in Nepal

Date	Major activities
Ancient Period	Hindu mythology explains the use of life saving herbs, describes Nepal as *devobhumi* (land of Gods), *tapobhumi* (land of meditation) where ancient Ayurvedic tradition originated. Lord Buddha's teaching of healthy living is also supposed to be associated with the origin of *Tibetan Amchi* system Contribution of Emperor Ashoka (304-232 BC) in the healthy living.
Lichhivi Period (400-879 AD)	Lichhivi Period described as the "Golden Age" Established an *arogyashala* (ayurvedic hospital) by Amshu Varma, a king of Lichhivi dynasty.
Mediaeval period (879-1750)	Established an ayurvedic dispensary for common people by Pratap mala (1641-1674), a king of Malla dynasty. Established government manufacturing unit of Ayurvedic medicine and herbal products named *Singha Durbar Vaidhya Khana* (1714) Christian missionaries introduced modern medicine in 17th century and by 1750s medical clinics formally established in Kathmandu.
Modern Period (1750-1951)	The tradition of using official *baidyas* for royal palace, Rana families, and military outfit. Prime Minister Jang Bahadur Rana goes to England and other European countries in 1850 and comes back impressed by modern medicine. British residency in Kathmandu (in 1802) with a provision of resident surgeon Khokana leprosy asylum for leprosy patients in 1857 Bir hospital in Kathmandu in 1889 to provide health care to the public. Nardevi Ayurvedic hospital in Kathmandu in 1917 and *Rajkiya Ayurveda*

	Vidyalaya started in 1936 for formal education, before that there used to be *gurukul* System (R. R. Koirala 2007) Department of Health Services (DoHS) established and started official health services (1933) A holy man named Ram Nath established a homeopathy hospital in Kathmandu in 1950
1950s	The end of autocratic Rana rule and Nepal opens for outside world in 1951. International organizations start to provide support in the health care development. Introduction and expansion of biomedical clinic dispensaries, (sub) health posts, and hospital outside of Kathmandu valley Formation of Medical Association of Nepal (1951) First Five Year Plan (1956-1959) starts with a focus on curative services Beginning of the decline of Ayurveda and other traditional systems
1960s	Disease centric vertical programs started: malaria in 1958, smallpox in 1962, Leprosy in 1963, and Family Planning in 1962. And several hospitals were established outside of Kathmandu
1970s	Institute of Medicine established under Tribhuvan University to train mid-level medical practitioners Long term health plan prepared and the concept of primary health care services emerged, Nepal became a signatory of Alma Ata declaration, realized the importance of primary health care (Sub) health posts were established across the districts.
1980s	Tribhuvan University Teaching Hospital established in 1983 Nepal eye hospital established in 1986. Established homeopathy hospital (1983) in Lalitpur The Female Community Health Volunteer (FCHV) program started (in 1988) to promote public health activities (focusing on immunization and maternal and child health) in the local community.
1990s	Democratic movement of 1990 established Nepal as multiparty democracy with constitutional monarchy. Beginning of privatization, commercialization and liberalization 1991 National Health Policy emphasized on biomedical clinic health facilities and provision of health facility in every village development committees. Promoted the private sector in the delivery of curative services, medical

	education and pharmaceutical production. The Ayurvedic service recognized as an integral part of health services and the policy stated to encourage Unani, Homoeopathy and Naturopathy. Formulation of the Second Long Term Health Plan, 1997-2017 to focus on improving the health status of women and children, rural poor and the marginalized population
2000s	Several medical colleges, hospitals, clinics established from private sector including a few Ayurveda, Homeopathy, Amchi etc. Interim Constitution of Nepal 2007 recognized health as fundamental right of the people.
2010s	2014 National health policy aimed to increase access of every citizens to quality health care services (adoption of Universal Health Coverage). To protect and develop Ayurveda, Homeopathy, Unani and other coexisting complementary medicine. Promulgation of Constitution of Nepal in 2015. Recognized health as fundamental right: Every citizen shall have the right to free basic health services from the State. Directive policy to ensure easy, convenient and equal access of all to quality health services and to arrange for access to medical treatment while ensuring citizen's health insurance, and to promote Ayurveda, Natural Therapy and Homeopathy system. Draft national health Policy 2017 to further the UHC and achieve SDG health goals.

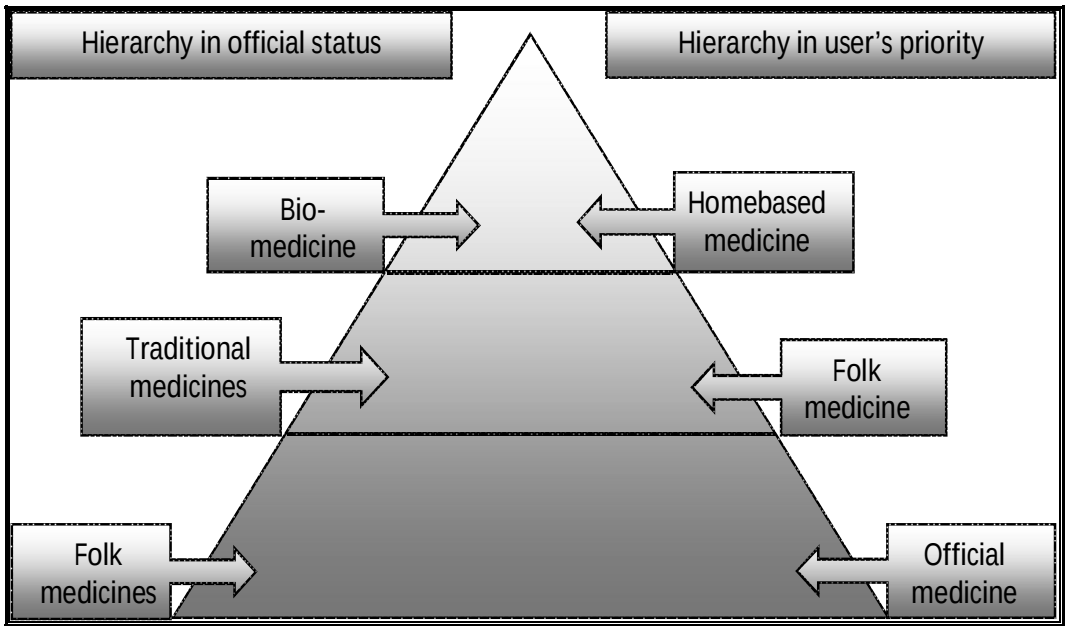
The time line gives a glimpse about how the health care/medical system evolved, developed and shaped in the present form in Nepal. The organized national health care system is a recent phenomena. The Ayurveda and folk systems fell behind with the introduction and expansion of biomedical clinic health care system. As in many developing countries, biomedicine emerged as if it is the only state sanctioned national health care system. Later, Ayurveda and homeopathy, Unani and Amchi other certain traditional medicine included as the legitimate systems. The planned development, which started from the 1950s, placed biomedicine at the top most position in the hierarchy of medical systems. The institutionally qualified practitioners were/are very less than the traditionally trained Ayurvedic and folk practitioners. A large number of

people, resort to Ayruvedic treatment "about 75 percent of the population" (Bannerman, Burton, and Wen-Chieh 1983, 238).. However, the percentage of the people resorting to official ayurvedic medicine went down because the official Ayurveda remained far behind to biomedicine, consequently less number of people served. The situation of homeopathy, naturopathy, Unani and Sowa-Rigpa (Amchi) system remained in dismal state. Since the last few decades policy documents have stated 'to protect, promote and develop Ayurveda and other alternative medicines'. In practice, these systems get support for the name sake. There has been no policy and concrete programs for the protection, promotion and development of folk medicine. Soon after the Alma Ata Conference, there used to be training programs for traditional birth attendants and traditional healers, to support the official health care system. Now, the state has shifted from these healers to the institutionally trained paramedics and created the structure of FCHV to meet the challenge of targeted programs such as reducing infant, child and maternal mortalities. The enrichment of knowledge and skills of existing traditional healers never became a priority of the sate. The unstated state policy has been to shun from folk medicine.

However, at the people's level herbal based medicines were never looked inferior. For example, a poem by Bal Krishna Sama (1902-1981), on *Ichchha*, the wish, has expressed how important was the Himalayan herbs for him. In his poem he wrote, "I wish the herbs of Nepal Himalaya be in my mouth, while I fall in bed counting my last days." The importance of medicinal herbs was recognized from the very early times. The early ayurvedic texts, Charaka Samhita mentions the importance of learning from nomads, goat/shepherds, cowherds, hunters, and forest dwellers about the properties and usage of medicinal herbs (Payyappallimana and Hariramamurthi 2012). The herbal practices also remained as family health tradition since time immemorial even though these traditions are undergoing a change because of the cultural, socio-economic and political changes in the societies.

2.2 Hierarchy of Medicine and Hierarchy of Use

Figure 17: Hierarchy of Medical Systems by Official Status and Usages



The above figure presents a hierarchical structure of medical systems in terms of official status and priority of usage. Scholars have mainly distinguished medical systems into three systems: folk systems (local, herbal, faith, symbolic, ritual or religious), traditional codified systems (Ayurveda, homeopathy, Unani, Tibetan system and acupuncture), and biomedicine (or allopathy). Biomedical facilities, drugs and products dominate the market which has been pushed further by the neoliberal globalization. Recently, Ayurveda, Chinese, Unani, Homeopathy, and CAM are increasing their shares in the global markets with the movement of products and services across the countries. But these medical systems do not have an equal position. Some systems are favored/preferred over others. Some are accessible and used than others. Some have strong hold in some geographical regions than others. The hierarchy of usage may vary according to geographical location or between rural- urban populations, and among the different socio-economic sections of the populations. When we look into the people's health care practices, home-based medicine comes first

followed by folk medicines and official medicines. The use of the home-based practices and folk medicine satisfies most of the health needs. In the wide spectrum of illness episodes, from minor to major, the official medicine, the biomedicine and traditional medicine, even though they are expanding, cater only a portion of all the health care needs of the people.

In explaining the structure of health care systems across the world Kleinman terms three overlapping health care systems: the popular sector, folk sector and professional sector. The most important observation he made is that the popular sector plays by far the most important role in health maintenance and treatment of illnesses. In his study in Taiwan, he found that almost 70-90 percent of the people were treated by the popular sector. Indeed, the popular sector which includes the health care activities carried by the family, friends, and occupational groups constitutes a major share in the management of illnesses episodes (Kleinman 1980). This constitutes a major part of what has been termed as local health tradition (LHT) in India. In terms of the use of medicine, the popular sector is the most used followed by folk sector and the professional sector.

A study "estimated that about 20 percent of all medical care in India was provided by qualified practitioners divided half and half between the state health services and private practice. Another 20 percent of all medical care was provided by "Indigenous Medical Practitioners". And the remaining 60 percent was met by folk practitioners and home remedies" (Leslie 1988). Similarly a study in Nepal estimated that "the health infrastructure treats about 20 percent of the population with facility-based primary care" (Skar and Cederroth 1997). Things may have changed a little since then. As Nepal Living Standards Survey (NLSS III) (CBS 2011a, 102) states that about 69 percent of people with an acute illness reported to have consulted with some kind of medical practitioner in Nepal: 28 percent consulted paramedic, 25 percent consulted doctor and, and 16 percent pharmacists and 2 percent traditional and other practitioners. This might be gross under reporting on the part of traditional healers, even though they are less consulted for acute illnesses. May be those 31 percent who did not consult any health practitioners, practiced something at home or consulted the traditional healers. According to the NLSS, about 63 percent visited private health institutions, the remaining to government institutions (an increase in the percentage of people with

acute and chronic illnesses, a higher rate of consultation in urban and among richer quintiles, and a higher rate of consultation with paramedics in rural areas) a decrease in the percentage of the users of traditional healers, a decline in home deliveries and deliveries attended by families, neighbors, relatives and traditional birth attendants, and an increase in institutional deliveries and deliveries attended by skilled birth attendants from NLSS (1995/96) to NLSS (2010/11)[26]. This can be taken as an indication to the changes in the extent of use of official medicine, reducing the base of hierarchical pyramid, the family and folk sector. However, notable is that the utilization of official health care has increased among the well-off than those of the poor.

The previous chapter analyzed the differences in the use of medicine within and across the social groups. The use of medicine does not solely depend on the availability of health care services but the affordability, accessibility and acceptability also play a role. The villagers do not think it wise to seek expensive services for what the traditional healers can offer at low cost. For instance, among the 11 people who had hand or leg fracture/twist, four people had resorted to bone setters and seven had resorted to public hospitals or private clinics/hospitals and among those who had resorted to the bone setters no one's family was ranked as well-off (one family as average and three as poor). Similar was the case with injuries. Most had resorted to the private or public facilities for major injuries but for minor injuries, most poor had resorted to healers or managed at home while most well-off had resorted to medial practitioners. During the field work period, two people who were bitten by snake (whose families were ranked as well-off) were treated by snakebite healer. None of them had gone to hospital. The hospitals are not equipped well and their past experience makes them believe that from snakebite healers you will be cured but when you rush towards hospital there is no guarantee and you will be referred to a distance hospital. The village study indicates that a large section of the people from remote and rural areas depend on the folk practitioners for such problems. Studies have also pointed that among those who use official medicine poor tend to use private pharmacies whereas wealthier tend to seek medical care in private clinics (Stoermer et al. 2012, 19).

[26] According to NDLS 2016, home deliveries fell down from 63 (in 2011) to 41 (in 2016) and births taken place in a health facility increased up from 35 percent (in 2011) to 57 percent (in 2016).

In terms of official status and authority, biomedicine enjoys the dominant position followed by traditional medicine and folk medicines. Biomedicine gets the largest share of state resources whereas traditional medicines get nominal amount and the folk medicines lack such support. The number of health facilities, strength of practitioners, medical colleges and training institutes, the intake capacity in medical colleges the traditional medicine falls far behind. While writing about the characteristics of medical pluralism in Nepal in my M.Phil thesis, I had chosen an analogy of a large tree, shrubs and grasses. This holds true that biomedicine has grown tremendously over the planned development periods and which can be compared with a full grown tree under which traditional medicine and folk medicine look like shrubs and herbs under grown or struggling to grow. As the size of the biomedical tree increased, with many large sized branches, the traditional and folk medicine remained under shadow, deprived of sunlight. The size of the tree and the size of the shrubs and herbs, which are growing under the tree, may vary across the regions. This variation is mainly because of the differential treatments. Sometimes people pour water into one plant and complain about the undergrowth of others. One should not make mistake that they also need water to grow, they also need sunlight, and they also need manure. The importance of shrubs and herbs cannot be underestimated especially when they have medicinal values. Sometimes the value of small herbs can be more important to the people. The state resources work as water, sunlight and manure to rejuvenate the withered shrubs and herbs. Many have already realized the importance of growing shrubs and herbs in their respective regions. Because the shrubs and herbs as traditional and folk medicine are being used as primary resource by the poor rural mass, and also better-off and urban elite as backup resource. When biomedicine fails they turn to traditional and folk medicine. Sometimes biomedicine also needs herbal balm. A balm to recover from the wounds of drug resistance, side effects, iatrogenic effect and as an alternative to “killer commodities” (Baer and Singer 2008).

The state’s role has been discriminatory in pouring the water into one system. Off course, now tree needs more water but that should not be at the cost of shrubs and herbs. However, when it comes to the folk medicines the state does not bother to pour a little into them. This also reflects why the folk medicines and folk practitioners are looked down. What is surprising is that the folk medicine exists till the day despite the

disincentive from the state. This must be because folk system has something important to offer to the people. However, without the state resource and recognition folk sector will see further erosion in the days to come.

According to Darshan Shankar, Indian medical heritage flows in two streams: *Prakrit* stream (vernacular or folk stream) which is an oral tradition carried by families, farmers, forest dwellers and folk healers, and *Sanskrit* stream (codified stream) which is based on the codified literatures and carried by learned scholars and physicians and ayurvedic doctors (STEPS Centre 2011). Both of these streams are very rich in tradition and work as two sides of the same coin. He suggest to look Ayurveda in terms of two streams because Ayurveda is a generic term for acknowledgement of life. He goes on to say that the folk stream is ecosystem specific, ethnic community specific and living tradition and the nature of Ayurveda (the knowledge of life) in this stream is empirical whereas the nature of Ayurveda or the codified tradition is specific with sophisticated pharmacology and systemic theories (Health Swaraaj 2015). He also points to the importance of folk stream and importance of knowing from farmers, forest dwellers and folk healers who use around 6500 plant species whereas all the codified traditions of AYUSH have so far documented only around 2500 plant species (Health Swaraaj 2015). According to Ritu Priya, the folk practitioners should be recognized as the 'paramedics' of AYUSH, as they are often the first contact point for patients and the messengers of the AYUSH worldview (Priya 2013, 25). This suggests the need of recognition of traditional (herbal) knowledge and knowledge holders and the need to bring folk medicine on board of national health system.

Here, it is important to note the hierarchy within the traditional and folk medicines. Though, the traditional medicines are subordinated to biomedicine, even among the traditional medicines a hierarchy exists in which Ayurveda has a leading status in terms of service provisions, drugs, and products, and the position of practitioners, policy priority and official programs followed by homeopathy, yoga and naturopathy, Tibetan system and Unani in Nepal. In the hierarchy of folk system, the states have become positive towards the herbal practices than the midwifery, faith healing or shamanic practices. However, in terms of usage, faith healing and midwifery still hold the strength.

2.3 Unequal systems, illegitimacy and unofficial pluralism

The medical systems are neither equally distributed across the regions nor accessible and utilized by all the people nor they are treated equally by the state. The present form of medical pluralism exhibits an unequal power relation between different systems of medicine, resulting unequal distribution of health care resources, limiting choice or options of health care services, limiting the medical pluralism. By definition, medical pluralism points to the greater choice and greater options for everyone. However, in the hierarchical society, choices are restricted to the people with poor socio-economic background and when the state favors one medical system over others there cannot be fair competition between medical systems and freedom of choice to the patients (Bode 2011, 17). Therefore, official pluralism becomes an illusion or myth (Han 2002) when state policy imposes a limit to medical pluralism. Moreover, the structural (social inequality, availability and accessibility) and cultural (acceptability) factors constrain the choice and options (Bode 2011, 17). The official health care services are either unavailable or if they are available, they are unaffordable. The highly trained modern practitioners are out of reach and local healers are losing their illegitimacy with new policy developments[27] (Cameron 2009). The official medicines do not provide much choice to the patients and this is one reason why folk medicine holds the relevance. Besides, folk medicines are culturally acceptable, physically accessible and economically affordable, and provide a health security to the poor section. The popularity, persistence and pervasiveness of folk medicine and in Lee's term "functional strength" (Lee 1982, 640)) is high among the rural population. The folk medicine serves as 'primary medicines' as official health care services are concentrated in urban areas (Tamang and Broom 2010).

[27] The Ayurveda Medical Council Act, 1988 prohibits to carry on ayurvedic practices by non-registered practitioners. The criteria for registration as stipulated in article 5.1.1B, "In the case of a person who is Fifty years of age, and having obtained recommendation from the concerned District Office with the certification of experiences being involved in the Ayurveda medical science since three generation, such person may carry on Ayurveda medical profession by obtaining permission under separate provisions as specified by the Council within one year from the date of commencement of this Act."(Nepal Law Commission 2045).

There is a wide variation among the traditional healers in terms of their experience, knowledge and practices. Similar is with the official traditional medicine practitioners. There is not only official but also unofficial pluralism and as Bode writes, “pluralism exists within, rather than between medical systems” (Bode 2002, 198). There is much variation in the practices, practitioners and the kind of patients they serve. Some traditional healers are consulted by family and close neighbors while some others are consulted by a large number of patients. The traditional healers treat wide range of illness condition, however, at present they are facing a lot of problems such as decreasing faith in the traditional healing, lack of interest among the new generation to learn and practice, the decline and depletion of medicinal herbs, and the lack of recognition and official legitimacy (Aryal et al. 2016). There is no formal relationship between official practitioners and the folk practitioners. The primary health care need of the patients would have been better served, had they been incentivized, enhanced and strengthened with knowledge and skills. Though folk practitioners try their best to treat the patients but due to the lack of knowledge about many conditions, sometimes they hold patients and the treatment delays. This shows the need of national policy on folk medicine to make appropriate use of the folk knowledge of health and health care. The policy and plans need to focus on folk practices and motivate and promote the folk practitioners with enhanced skills, registration, integration, scientific validation of knowledge, bioprospecting and the protection of intellectual property rights (Aryal et al. 2016).

On the one hand it is argued that to be recognized and accepted as biomedicine, traditional and folk medicines need to follow the biomedical standards of research and teaching. While on the other it is also argued that following biomedical path is neither necessary nor required and there is no need to prove the efficacy of traditional and folk medicines. These have been the time tested practices and present the experiential evidence. Following or adopting biomedical way of research and teaching would not contribute to the growth and development of these systems. Rather, the adoption of biomedical paradigm can pollute the purity and loss the essential feature of the traditional medicine and biomedialization of traditional medicine further to make the services out of reach. While on the other, there are argument for the modernization or scientization of these systems and the need to follow ‘the scientific way’ of research

and teaching/ learning. The traditional medicine follows very much the same way of research and teaching and learning to establish them as scientific as biomedicine. Many family and folk practices may be beneficial but systematic research on the effectiveness of such practices has become a need of present time to establish the evidence and be assured of valid practices.

2.4 The Contradiction and Mismatch between Policy and Practice

On the one hand, there is general acceptance of the omnipresence of traditional healers and their *significant role* on the other there has been an *insignificant support* of the state to link them with the public health system (Tamang and Broom 2011).The Ninth Plan (1996/97-2000/01) stated, “about 800,000 Dhami, Jhankri, Lama, Vaidya will be encouraged to provide health services” (NPC 1997). Time and again official reports also affirms of the *major role* played by the traditional healers in the health care sector of Nepal (MoHP 2012, 1). On the one hand, they accept that a large majority of the people depend upon traditional healers showing its importance, on the other, due official attention has not been given to their growth and development. Rather, new policy have become regressive attempting to prohibit them to practice and tend snatch their semi-legal status and making them an illegitimate practitioners or quacks.

The folk medicine, which is the most popular system throughout the country, has been deprived of a legitimate space. State’s policy is to ensure easily available and equal access to quality health care for all. However, despite the rhetoric of "increasing access to quality health care services “nothing much has been gained in terms of accessibility and quality. The issue of aaccessibility and quality is not only with biomedicine but also with other systems that people use. Similarly, while the rhetoric is of “promoting Ayurveda and other alternative system”, the focus is only on biomedicine. The new constitution also repeats “to protect and promote health systems including Ayurveda, as a traditional medical system of Nepal, natural therapy and homeopathy system” (GoN 2015) as one of the directive policies of the state. Still, the traditional medicines other than Ayurveda are not provided from the public sector outside of Kathmandu, the

capital city, even though there were plans to expand the services to other regions of the countries. The health care resources are directed to the growth and expansion of biomedical health care services. This is where the contradiction and mismatch exists between policy and actual practice.

It would be ridiculous when we pure water into one plant but complain undergrowth of another. If we expect real growth of traditional and folk medicine we need to pour some water into them. If we want to improve people's health, we need to invest in the foundation of health, the traditional and folk medicine. It is simply logical that only with strong foundation whole building stands strong. We need to enhance the community knowledge and empower the people. The communities have experienced changes in their life and they express a loss of experiential health. They are doing whatever they can do for their health and wellbeing from their part. If anything outside intervention is intended, that must not disempower them. In the health care system, a change has been experienced where "health for all" has been reduced to "health for some" and people express worries, because on the one hand the folk practices are withering, the local health facilities function poorly, urban facilities are expensive and unaffordable[28]. Indeed, changes are taking place with the expansion of official medicines and penetration of private sector pharmacies into small towns and urbanizing villages and the interaction with folk medicine. Time and again a concern of safe guarding indigenous knowledge systems is expressed. As the re-emergence and resurgence of CAM as a new avatar of traditional medicine or reinvention of traditional medicine and renewed interest in the herbal medicines on the one side and growing concerns over withered state of folk medicines on the other signals to such changes. However, in terms of state's support and provisioning of the health care services even traditional medicines have not got due share. The sceptical and ambivalence attitude toward folk medicine has been reflected in the policy and planning documents. There is a hesitation to provide due space to folk medicine in the recent health policy documents. The national health policy (MoHP 2014a) seem to

[28] Using NLSS data (Gupta and Chowdhury 2014, 238) estimate that "The average per capita out of pocket spending (OOPS) on health in Nepal increased sevenfold in nominal terms between 1995–1996 and 2010–2011. Thirteen per cent of all households were found to incur catastrophic health expenses in 2010–2011. This proportion of households incurring such expenditure rose between the two time periods most sharply in the Tarai region and among the poorest quintile."

praise the traditional healer's role in the past rather than the present. The folk medicine sees systematic avoidance and folk healers' practice remains at state's discretion even though they are the most trusted, most intimate and immediate source of health care.

A sort of mismatch can be observed between people's preferences and policy maker's priorities and also between what state commits to do in its policy documents and what actually it does. The policy has been to encourage folk practitioners and 'develop, protect and expand Ayurveda and other alternative systems'. But in practice what is being encouraged, developed, protected and expanded needs no further clarification. The policy provisions are useless unless they are implemented. Rather, the policy documents either remain silent or speak the ambivalent language in case of folk medicine. On the one hand, they cannot deny the importance of the folk practitioners on the other they seem to avoid and ignore the agenda to create an environment in which traditional healers can contribute to primary health care as envisioned in the Alma Ata Declaration. A serious reflection is needed to move ahead from this ambivalence and inaction toward a more inclusive and democratic pluralism.

2.5 International Health Policy

In explaining the levels of health care system, (Baer, Singer, and Susser 2003, 39) present four level of analysis of power relations: Macro level, intermediate level, micro level and individual level. At the macro level, the national health policy and health care systems are influenced and shaped by the international power centers through an ideology of the neoliberal globalization. These include international aid agencies and organizations, international policies, corporate and state sectors, financial institutions and the foundation and countries who fund/finance them. At the intermediate level, the health institutions/policy and the decision-making, hospital administration-health personnel interaction. At the micro level, patient-practitioners relationship and the therapy management groups, patient's response to illness and patient's personal support networks. At the individual level, the patient's response to illness or sufferer experience. Each level is influenced by and influence on other levels. There is two way relationships, the micro level is influenced by the macro level forces and micro level also holds the capacity to influence the macro level. The individual experience of illness and treatment seeking are connected with the national and international context

of policy making. The macro level policy changes have an impact to the health and illness at the micro setting and the micro level experiences can contribute to the macro level policy changes. However, it is often the macro level forces that dictates the micro level.

Many studies have highlighted the impact of international health policies and their manifestations in developing countries (See Justice, 1986; Vidnes, 2015). There are several instances and anecdotic evidences of the influence of global health policy, whether on the disease centric vertical programs or the preference of selective PHC over comprehensive PHC (Qadeer 2006), whether the replacement of maternal health by reproductive health or adoption of universal health coverage instead of universal health care (Qadeer 2013). The emphasis on the "universal health coverage" in the Nepal's National Health Policy 2014 and adoption of the term "health insurance" in new constitution of Nepal was not a mere chance. The term would not have appeared in the new constitution had there not been in the international health policy context. There is no dearth of study on how "unhealthy health policies" are imposed on the people (Castro and Singer 2004; De Vos, Dewitte, and Van der Stuyft 2004). The global health policies influence and contribute in shaping the national health policies. The national focus on the targeted MDG, and now SDG are shaped by the international policy contexts. Nepal, like many other countries, is guided by the international development agendas backed by global programs, funding and technical support. They hold the power to shape the perception of policy makers and exert influence on the policy decisions. Nepal has been a recipient of foreign aids which constitutes a major share (sometime almost half) of the health budgets and has been dependent on the INGOs for policy and program development and implementation. The international organizations have been playing a decisive role in shaping the health policies around the world (Irvine et al. 2006). Justice (1986: 46) writes, "In the realm of international health aid, donor agencies exert a strong influence over the policies of many recipient governments. Certainly their influence has been strong in Nepal." She goes on to say that "health policy and planning activities are often oriented towards donors' priorities and interests (Justice 1986:68). It is undeniable that the international community exerts influence upon the national health care systems. They have an influential role in shaping national policies, prioritizing the programs, and financing the health care

systems. Thus, we see the linkages with the international motive and drive in the making of health care system of Nepal.

The World Bank funded health sector reform in Nepal has been critically appraised (Maskey, 2002). But in spite of these oppositions, Nepal's health policy is faithfully following the path of health sector reform (Maskey 2004, 128). The contradiction and mismatch exist in the statement of the Constitution of Nepal 2015, which in its preamble expresses the commitment to create the bases of socialism by adopting the socialism-oriented economy but the state's commitment seems to further the economy in the neoliberal direction. The present practice of the state which attempts to favor private sectors by removing taxes and providing concessions likely to make health care services and medical education further expensive to the people. The perpetuation of this hierarchy signifies that rural poor do not deserve quality health care services. The state follows guided by the neoliberal forces which has negatively affected the very poorest sections of people which they aim to serve. Hence, medical pluralism is being transformed into 'hierarchies of health', mediated by existing social inequalities (Broom, Doron, and Tovey 2009, 700).

Developing countries across the globe have begun to implement universal health coverage as one of the major health goal. The policies and programs are developed with the technical and financial support of international funding agencies. The dependency on the international agencies on technical and financial support are reflected in the policy, plans, and programs. In the early 1990s, the national policy was formulated to promote private investment following the neoliberal trend of market based reforms (Foley 2008, 271). This was the period of neoliberalization which led to privatization and commercialization of public health care services which also impacted on the utilization of health care services. The neoliberal globalization has altered the medical pluralism and the differential use of the health care resources. The government hospitals started to charge fee for the services (from registration fee to diagnosis and drug and in-patient bed charges). The bad experience of user charges are documented everywhere in South Africa, Latin America and South Asian countries. The neoliberal ideology has been working in every sectors: health and education, water and sanitation, transport and communication, bank and financial institutions including those of

grassroots microfinance. The neoliberalization has been penetrated even into the grassroots level through micro finance and women's group saving (Rankin and Shakya 2007).

The role of donor agencies often termed as external development partner has been laudable and decisive in the health care development of Nepal. They have played a crucial role in globally launched disease centric programs such as tuberculosis, malaria, HIV/AIDS; strategy of financing such as user charges, health insurance, primary health care, and implementing the programs to achieve the MDG and SDG. The health insurance programs were also piloted, reviewed and national health insurance policy drafted with an assistance of external development partners.

Universal health coverage means all people receiving the health services they need. The national health policy formulated following the global goal of universal health coverage (UHC). By definition, "UHC means that all people receive the quality, essential health services they need, without being exposed to financial hardship" (WHO 2016b). As (Bode and Hariramamurthi 2014, 12–13) argue, "Making good use of folk medicine might be the best strategy for achieving UHC" so that all people can use the preventive, curative, rehabilitative and palliative services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardships. If UHC is about access, quality and affordability, people do not have access to biomedicine, public health facilities are often of inferior quality and people are facing financial hardship due medical expenditure (Bode and Hariramamurthi 2014, 12–13) With enhanced capacity, the folk healers might fill the gap by offering affordable treatments at the doorstep of villagers (Bode and Hariramamurthi 2014, 12–13).

3. The Functioning of Health Care System

In a country where unfair, unjust and corrupted system prevail, health care system cannot function fairly and efficiently. The story of treatment failure and multiple recourses which follows hierarchical patterns also indicates to the inefficient health

care system. When people start to move from home to distance hospitals in search of treatment it costs them unexpectedly. When the poor falls ill seriously and attempt to seek treatment from tertiary health facilities they are likely to fall into the trap of broker and hospital nexus. The national media also report the loot of the patients from private hospitals and their nexus which are expanded to local medical persons and down to the ambulance and taxi drives. The commissions and incentives are offered to refer patients to the private hospitals and diagnosis centers. It is understood that Dr. X prescribes particular brand of Y medicine produced by Z pharmaceutical company (Brhlikova et al. 2015). The pharmaceutical influence the prescription behavior of the Doctors (Giri and Shankar 2005). The quackery and corruption exists at all levels across the system. The medical bureaucracy competes and exercises the *source force*[29] to be posted in lucrative places and power positions. *Afno manchhe* [30](one's own men) get posted in the facilities which are considered good to earn name, fame and fortune. On the one hand the government provides tax concessions to the private medical colleges and on the other they are charging high tuition fees from medical students and making hefty profit. The expensive medical education likely to affect the affordability of health care services to the people as the future doctors will feel further pressure to recover their investment in medical education.

There are a number of public and private hospitals, clinics and nursing homes but these do not provide services at affordable price. The private health facilities make hefty profit out of patient's conditions and the public facilities have also started to charge high rates. There is no such system to provide the people with free or affordable official health care services. The rural people are deprived because the health posts which are supposed to provide them with health care services are poorly equipped and staffed. The well-off section take recourse to private or public services and when needed they can afford to go to the Kathmandu, Nepalgunj or Lucknow and other Indian cities. The political leaders and bureaucrats frequently fly abroad to New Delhi, UK, US, Singapore, Thailand as medical tourists mostly at the expense of state's coffer. The argument of the private medical establishment is that they are committed to provide

[29] A catchword among the educated Nepalese to refer to a person's access to money and power. For detail see (Weiner 1989)

30 A term which refers to a person who is connected by kinship and/or give-and-take relationship in a power hierarchy. For detail see (M. Subedi 2014)

world class health care services and attract those who otherwise go abroad to seek medical care and the private medical colleges argue that they want to stop students going abroad for medical education. The so called top colleges and hospitals are not meant for the poor but to those who can afford the costs. They argue that by doing this they are contributing to prevent the nation's money from flying abroad, reducing the dependency on foreign countries for medical care and education, and contributing the economic development of the country. The private medical colleges and big hospitals are better serving the interest of cronies of handful bureaucrats and politicians. However, the large population, especially the poor often fall into trap when they have to resort to such hospitals. Many have shared their bitter experience with the big private hospitals. Many have questioned whom the big private hospitals and medical colleges are meant for. Like many developing countries, the political parties and government in Nepal aligning with the dominant class interests within and across the countries embracing the neoliberal policies which was proposed by the global financial institutions such as the World Bank and the International Monetary Fund. The neoliberal policies contributed in widening the gap between the haves and have nots, income inequality, promoted the profit sector, privatization of public institutions, adversely affected the national health care systems and health status of the people (Navarro 2013). The economic growth has not contributed to reduce the poverty in Nepal. The people who have access to control over productive resources are becoming richer whereas those who lack such control are becoming poorer. In fact, the gap between the rich and the poor has been rising across the world. And Nepal is not an exception.

3.1 Government Expenditure on Health

Nepal spends around 4.5 percent of its GDP on health and about 55 per cent[31] of total health expenditure is made directly by private individuals/households in the form of out-of-pocket payments (MoHP 2012). Health care services are provided by both public and private sectors and the private sector. The public health care services are very inadequate in terms of both coverage and provision. The hospital based services are

[31] The per capita OOP can be higher than this

available only in Kathmandu and urban cities areas where less than one-forth people live. Most medical colleges, hospitals and medical doctors are concentrated either Kathmandu or in big cities of the country. In rural areas, there are HP and PHC which mostly focus on primary care, immunization, reproductive health, family planning, and provide ambulatory services. The HC and PHC and hospitals of remote districts suffer from the chronic shortages of medical staffs and medical supplies. The private sector basically provides curative services in urban areas. In the rural areas underqualified private practitioners run the pharmacies. The government reports also accept the availability of "limited service at lower tier health facilities and the rapid commercialization of basic health service provision" (DoHS 2017, 239). The health care is falling on the shadow in the name of public private partnership which is being resulted in "anti-poor partnership"(Qadeer and Reddy 2006, 17). On the one hand they weaken the public services and strengthen the role of the private sector. They do not see the problem in user fees which has been restricting the poor section to access to health care.

3.2 Universal Health Coverage

The private clinics charge exorbitantly and even the public hospitals have become unaffordable because of the diagnostic technology and the rising costs of medicine. The high out-of-pocket expenditure pushes poor section at risk of catastrophic expenditure and prevents them from using official health care services. The catastrophic health spending is the main reason argued for national health insurance program (NHIP). The NHIP was introduced in Nepal a decade ago as pilot Community Based Health Insurance Program (CBHIP) by both public and private sector. Recently, NHIP has been launched nation wide resonating the global goal of universal health coverage[32].

[32] The health insurance coverage would be Rs. 50,000 per year per 5 member family and Rs. 10,000 for each of the additional members of the family not exceeding the upper cap of Rs. 100000 and the premium would be of Rs. 2500 for a 5 member family per year and Rs. 425 for each of additional members of the family. The health care package include free drug and free care services. The coverage does not include cosmetic surgeries, abortion, artificial organ, reading glass not more than 500 once in a year, hearing machining, organ transformation, injuries cost due to personal warfare, accident related treatment due to alcoholic and drug use, in the case of dental treatment, modern dental implant, root canalling, etc. The PHCC and public and private hospitals are supposed to provide the service. Till now only 5 percent of the people of 15 district (out of 77 district) have been enrolled and the target is to cover cent percent by the year 2030. In the preliminary findings of the enrolment and service utilization women are behind, even though they experience illnesses more often.

Though till now the CBHIP has a very limited coverage (Stoermer et al. 2012, 33). The main logic behind the adoption of UHC is to ensure access to quality health service and protect people from financial hardship by reducing out-of-pocket expenditures. The health insurance program was initiated in April 2016 but till now the program is in its preliminary phase and has enrolled a very limited number of households some districts.

Constitutionally, everyone has the right to get free basic health care services from the state and every citizen shall have equal access to health services. The directive policy of the state, as stipulated in the constitution, is "to arrange for access to medical treatment while ensuring citizen's health insurance" and "to ensure easy, convenient and equal access of all to quality health to make people healthy by enhancing the public investment and to make private health sector investment in health service-oriented by regulating and managing such investments" (GoN 2015). Even the constitution gives emphasis on "private sector" and "health insurance" which is in line with the idea of neoliberalization. The SDG goal of universal health coverage is getting currency in the present health care services. The objective of health insurance is to provide health care services protecting people from financial hardship by reducing OOP expenditures.

3.3 The Control over Medical Resources

The Janajati and Dalits have better control over folk medicine and folk healers. However, a process has already begun to make ethnic communities resourceless, whereby neither they will have control over their indigenous resources nor they will have access to official resources. Though, Article 24 of the United Nations Declaration on the Rights of Indigenous Peoples states, "Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals" and binds nation states to respect the rights of indigenous peoples (United Nations 2008). However, the bitter truth is that neither state seems to respect the rights of indigenous people nor the indigenous people are in a position to make the state respect their right.

The number of traditional folk practitioners in Nepal is very large[33] widely available in all caste and ethnic communities and who use very large number of medicinal and aromatic plants (R. R. Koirala 2007, 15). The traditional healers have not been included in the national health care system neither there are programs to train and mobilize them. The majority of the folk healers are often poor and belong to Janajati and Dalit communities. They are not organized and lack the political support to advocate for their rights and recognition. The Alma Ata recommendations for the integration and utilization of the the traditional healers have been taken as obsolete. They are the one who are resource less and fall below the power pyramid. They are the one who lack international support and funding to be trained, organized, and integrated into the formal health care system.

In many ways, the folk medicine has been contributing to the foundation of health care services. But the very foundation has been weakened mainly because of the state policy. If the access to the official health care facilities is to be enhanced, there should be connection between traditional healers, whom the people visit first, and the health facilities. Better health services can not be ensured without the linkages between popular and professional sectors. For instance, the female community health volunteers (FCHV), which are appreciated for their role to link the community with the official health facilities, have shown the importance of local health workers. The creation of such formal structure has been for different purpose. The linkages between popular and professional sector cannot be achieved without considering a role for folk healers. At least, they have been contributing as "traditional health volunteers" and with recognition and some incentives they can contribute to "traditional meidicne" no less than FCHV to biomedicine. The traditional healers have already proved their importance and there are few studies which show a better result after the basic training and mibilization of such healers (Oswald 1983).

[33] The estimated number varies greatly. A study estimated the number of various categories of healers in Nepal to be around 400,000 to 800,000 which is widely cited (R. Shrestha and Lediard 1980; Poudyal et al. 2003). In my study in one of the VDCs in Dang, I found 102 healers of various types. There were 3915 VDCs and 58 municipalities in Nepal at that time. If we add 58 to 3915 and multiply by 102 assuming that the VDC represents an average number of healers for each VDC and municipality we get the number 405246. Hence, the number must be somewhere around 400,000 at present. However, there will be gradual decrease in the number of healers in the days to come.

The health care system of Nepal has pushed many households into poverty because of the expensive health care services. A study conducted in Kathmandu shows rising catastrophic expenditure, more than 10 percent of the income expenditure in the last 30 days survey period, due to the chronic conditions and injuries (Saito et al. 2014). The diversity of medical systems has not posed as much as the privatized and commercialized public system and profit mongering private sectors in terms of health care spending. The profit making private sectors which is characterized as "crony capitalism" has benefited to the small number of business elites who have political connection and get political protection. This section has been organized as a syndicate in medical education, corporate hospitals, and hold the power to resist any regulatory measures. They present themselves as great contributors to the nation and to the people, and lobby for state support for their institution developments. They present their institutional development as nation's development. As a result they get state favor and misappropriate the state resources. The neoliberal policies have done more harm than good to the masses. By not scrapping the profit monger and unregulating the penetrative private sector state has favored to the handful interest groups and business elites.

The differences and inequality in the wealth and income affects to access and use of health care services. The health care services, even though targeted to all sections of the people, the poor and Dalits have not and will not benefit much without enhancing their socio- economic conditions. The poor sections will remain deprived without social policies related to welfare measures to improve the livelihood condition. From the perspective of equity and justice, the poor and Dalits need especial attention. This calls for not only by providing incentives to use official health care services but also to address the issue of their socio-economic conditions. The simple logic is that what they are using must not be of poor quality, whether that is the food they eat, the environment in which they live or the the medicine they use. This must include the quality concern of folk medicine and official medicine provided by both public and private sector. The poor state of official health care system as well as folk and informal private sector contributes to the multiple recourse. The challenge is to provide quality health care services from the official service outlets and regulate the informal private sector and ensure quality care from folk sector in a way what best explains a Nepali proverb *saap*

pani maros, laathi pani nabhahiyos (literally, snake be died, stick be unbroken). Quackery must end and traditional knowledge system must not be broken. There should not be the state policy of *kasailai kaakhaa kasailai paakhaa* (literally, keeping someone on lap, someone far back), biomedical practitioners on the lap and folk practitioners far back. There should not be Brhaminization of biomedical practitioners and Dalitization of folk practitioners.

With the advancement of neoliberal ideology the rationality of equity and justice has been weakened. The line of thought is much influenced by the neoliberal idea. The out of pocket is rationalized and illness is considered as risk to be covered by medical insurance. Private profit in medical care and medical education is rationalized and everyone is treated as consumer of the market. The dominant trend has also influenced the line of though even among the people. They see health care services, medical education, agricultural inputs, transportation, communication, electricity, drinking water, drainage system every where through the commercial lenses. They do not see the state as responsible for the rising costs and commercialization and privatization of the public serves. Even the public hospitals have started to operate private clinic within the hospital premises. For example, in a hospital there are two lines one for wealthy who pay consultation fee and have direct access to the doctors without waiting long and one for poor who pay minimal amount for registration but wait long and possibly get low quality services. This is something like an Indian rail where there are berths for various classes with different price ranges. If closely looked, every hospital have differential system in terms of inpatient cabins based on classes. The people do not see problems with such type of variation as the commercialization is being deeply engrained into the thought process. The process of making hospital an academy of health sciences and giving institutional autonomy the forms of commercialization and privatization have been made invisible.

4. The Structure of the Government

The new constitution, promulgated in 2015, declared Nepal as Federal Democratic republican state having three structures: The Federation, the State, and the Local level. At the Federation level, the voters elect 275 members of the House of Representatives (lower house), of which 60 percent (i.e. 165 members, one member from each of the 165 constituencies) are elected directly through first-past-the-post system, and 40 percent (i.e. 110 members) through proportional representation system, in which whole country is considered as a single constituency. There are 59 members of National Assembly (upper house) of which 56 (8 members from each of the 7 provinces) are elected by Electoral College which consists of State Assembly members and village and municipal chairs/mayors deputy chair/mayors. The president of Nepal appoints the remaining three members.

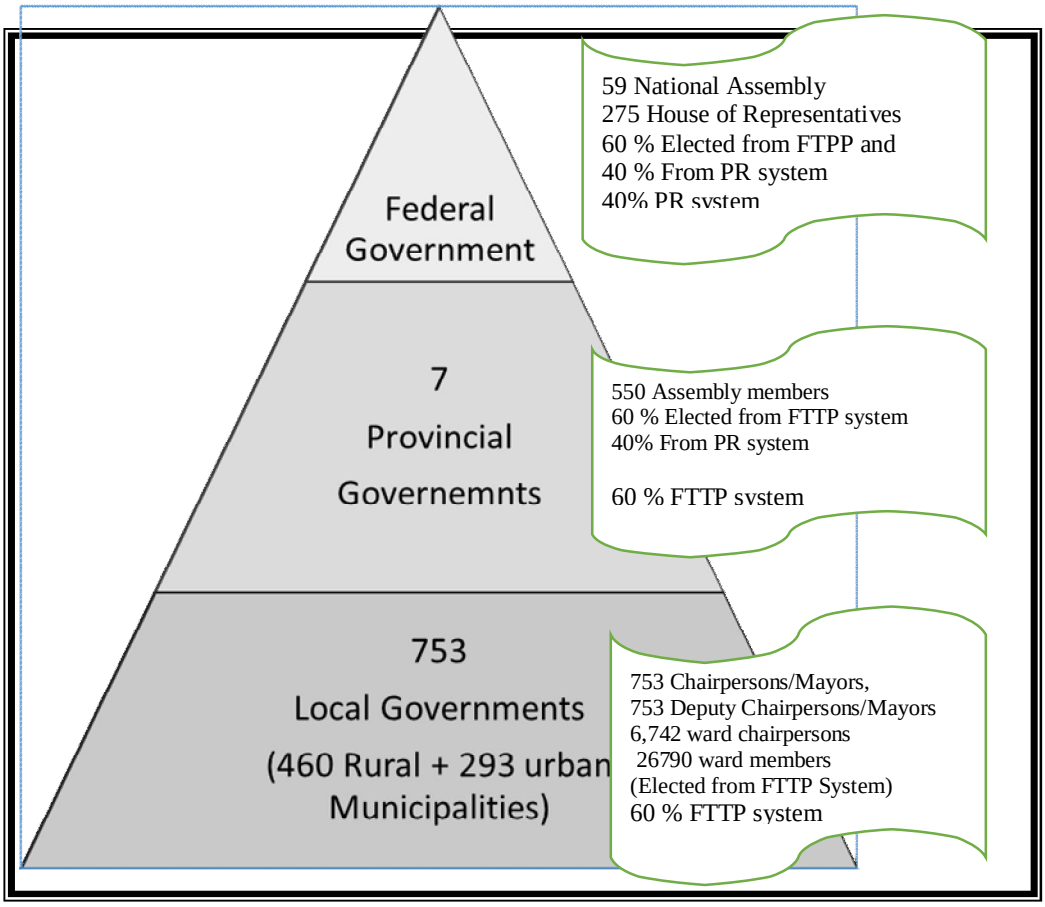
At the State level, Nepal is divided into 7 provinces and a total of 550 State Assembly members are elected of which 60 percent (i.e. 330 members) through first-past- the-post system and 40 percent (i.e. 220 members) through proportional representation system.

In all three levels: the Federation (members of the Federal Parliament), State Level (members of State Assemblies) and Local level (Chairpersons/Mayors and members of Rural/Urban Municipalities) one-third of the total seats are reserved for women. The political parties must ensure at least one third women of the total members at the Federal and State level. The political parties need to represent the Dalits, indigenous people, Khas-Arya, Madhesi, Tharu, Muslim, persons living with disabilities, and backward regions as specified according to demographic composition. The political parties are required to fulfill the required number through proportional representation system when less candidates are elected from the reserved categories in the direct election.

At the Local level, there are 753 local bodies: 460 Village municipalities and 293 urban municipalities (which include 6 metropolitan city, 11 sub metropolitan city and 276 municipality). The municipalities are further subdivided into 6742 wards and each ward

has a chairperson and four members, of which two members must be female and of which one member must be from Dalits group. The total number of municipality wards vary based on the population size of the municipalities. There are a total of 753 Chair mayors/chairpersons, 753 Deputy mayors/chairpersons, 6,742 ward chairpersons, and 26,790 ward members. Besides there are 77 district assemblies elected from the local bodies of the respective districts. There is reservation for women and minorities in the district assemblies too. Though political parties were obliged to select candidates from women either chairperson/mayor or deputy chairperson/mayors. However, in the last election, men were elected as mayors/chairpersons and women were as deputy mayors/chairpersons because women were given tickets deputy chairperson/mayors instead of chairperson/mayors. Consequently, roughly around two percent women were elected as mayor/chairperson and two percent as ward chairperson. This indicates that despite the constitutional provision, the women were not given powerful position because of patriarchal mindset. Though, women have been better represented than before in the political positions from local to national levels, men dominate the dominant section dominates the powerful positions.

Figure 18: Government Structure of Nepal



Despite the better representation of different caste/ethnic communities in all three levels of governments, the governments remained dominated by the powerful sections. The inclusion criteria has increased the participation of the constitutionally identified communities but they are still far from securing top positions. The reservation system, though aimed for equal opportunity to the deprived sections, indirectly favored the privileged section and benefited them than those of marginalized and vulnerable sections. This also disguised the differences within the groups as if they were homogeneous. For example, the Janajati group consists of a variety of ethnic communities (ranging from endangered, highly marginalized, marginalized, disadvantaged and advanced groups) and some have better representation than others and the better-off among them got the greater chance to be better represented. Similar was the situation with other groups. Similarly, the reservation systems introduced with

an amendment in Civil Service Act to increase participation of women, Janajati, Madhesi, Dalit, disabled, and the people from remote areas in civil services. So far only a small number who have better position among these groups have been been able to secure the bureaucratic positions.

Nepal witnessed political change but the mindset of the politicians, bureaucrats and businessmen have not changed. The political parties, bureaucracy and administration of Nepal have not moved away from what people explain by Nepali terms such as *naatabaad* (nepotism), *kirpabaad* (favoiritims), *chaakari* (sycophancy), *chaaplusi* (flattery), *jaal* (conspiracy), *jhel* (betrayal), *kapat* (perfidy). The people have expectation of good governance, development and prosperity with the political changes. The constitution has stipulated the fundamental rights including the right related to health and education. The health and education sector which are considered as precondition for development and prosperity have been weakened and worsened in the public sector. The public health institutions are suffering from chronic shortage of medical staffs, drugs and equipment. The physical appearance of HP, PHC and district hospitals expose their sickness with dilapidated condition. Similar is the case with education and other sectors. The people express their disappointment with such state of public sector for being week, inefficient and corrupt. The people have hope with the newly elected communist government but so far the government has not shown a willingness to change the system of governance. As long as the vested interest, red-tapism, corruption remain unchanged people's aspiration of more strong and efficient public institutions will not be fulfilled. As long as the public sector remains in dismal states, the poor sections will continue to suffer.

4.1 Democracy and Neoliberal Development

Nepal witnessed many changes in the socio-economic and political fronts since the democratic movements of 1990 which replaced the autocratic partyless Panchayet system with multiparty parliamentary system with constitutional monarchy. After the formation of democratic government, many (sub) health posts, primary health care centres, and district hospitals were expanded and expanded throughout the country and private sector's investment was encouraged in health and education with a wave of

neoliberalism and structural adjustment (Kentikelenis 2017). This period saw a remarkable increase in the number of both private and public health facilities, schools and medical colleges. During this period Nepal witnessed a greater role of INGOs and international donor agencies as development partners. The increased involvement of these agencies in the development of Nepal facilitated the "mushrooming of NGOs". The privatization and commercialization move directed by the neoliberal policies encouraged private sector growth in many sectors including health and education establishments. This period also saw internal conflict, political instability resulted from hung parliament and frequent changes in the government, almost every one or two years. Lengthy constitution making process and long period of political transition. This resulted in an unemployment, poverty, illiteracy and ill-health. As a consequence a large number of youths started to go abroad especially to the South Korea Malesia and Middle East countries as unskilled and semi-skilled labours. The solution for rising unemployment has become to push the youths into the international labour market. Now the remittance constitute at least one third of the GDP of Nepal. Agriculture which was (and still is) the main source of livelihood dwindled in this period. This period accelerated the growth of profit making private sectors in health, education, and economic sectors, at the same time economic inequality has been increased (Wagle 2010).

The Maoist insurgency began in 1996 because of the worsening condition of the country. The insurgency further worsened the political situation which facilitated the king to assume absolute power in 2005 by forming the government with his hand picked leaders. The seven ruling parties and Maoists signed a 12-point peace accord under India's facilitation in New Delhi and organized second democratic people movement against the King's direct rule which reinstated the dissolved parliament and promulgated an Interim Constitution 2007 which established Nepal as a federal democratic republican and abolished he monarchy. The constituent assembly elections were held two times to draft a new constitution. Often the political instability and unstable governments were sited as example of Nepal's failed development. Finally, a new constitution promulgated in 2015 and according to the constitutions elections were held and federal, provincial and local governments have been formed by the two communist parties which have been unified into a single largest party and people have hope of stability, development, peace and prosperity.

In 1991, with the adoption of neoliberal policies and following the market principles it was predicted that by the year 2001, Nepal will graduate from the least developed countries (Skerry, Morgan, and Calavan 1991). However, Nepal is still struggling to graduate by 2022 (NPC 2016). Nepal still falls among the least developed countries with low human development. Despite the involvement of INGOs and aid agencies in the development efforts socio-economic inequalities widened and people at the bottom continued to experience hardship, disease and death. As in many countries, the health sector in Nepal has been privatized, commercialized and left to the market. There is no dearth of study to explain how the people of developing countries are badly affected and from the marketization, commercialization and privatization national economic policies facilitated by international financial institutions (Pfeiffer and Chapman 2010) (Pfeiffer and Nichter 2008).

The Maoist movement began in 1996 when the then government did not show willingness to address the demands of the Maoist party. The Maoist movement took its height and the government could not hold the elections. The King dissolved the ruling government and gain the absolute power. The political parties along with the Maoist formed an alliance and launched second democratic movement which overthrew the monarchy and established Nepal as federal democratic republic state in 2007. The democratic movement established Nepal as federal democratic republic state. Federalism, secularism, inclusion, and proportional representation is often described as the main achievement of the people's democratic movement. Indeed, during this period political awareness raised among the people. The Constitution of Nepal adopted the principle of inclusiveness and proportional participation of women, Dalit, indigenous peoples, indigent Khas Arya, Madhesi, Tharu, Muslims and backward regions, minority communities in all organs of the state "to ensure economic equality, prosperity and social justice, by eliminating discrimination based on class, caste, region, language, religion and gender and all forms of caste-based untouchability" (GoN 2015, 6). However, the spirit of inclusiveness and proportional representations diluted because the top leaders of the major political parties allocated the election tickets mostly to their cronies and to those who have already access to power and politics.

State has been creating policy environment to invest in health care for profit making private sectors. The elites and businessmen with political connection have control over the big hospitals and medical colleges. For example, during my study period, Dr. Govind KC, one of the eminent orthopedic surgeons of the Institute of Medicine, staged hunger strikes more than a dozen times to pressurize the government to stop rampant commercialization and corruption in the medical sector. The agreements were made on many points such as formation of commission to regulate private medial college, ceiling for MBBS/MD fee and seats, and issues of affiliation to establish medical colleges but the government showed an unwillingness and he had to repeat the strike again and again. Even after the series of indefinite hunger strike, no significant changes were made because the resistance was/is strong as some of the private investors have been holding political positions, rather they continuously lobby for favorable policies. The "conflict of interest" as pointed by Kedar Bhakta Mathema, former vice chancellor of Tribhuvan University and the coordinator of the high level committee on the national medical education policy, was the main reason for the unwillingness to implement the Mathema committee's recommendations (B. Subedi 2016).

5. Conclusion

In the official hierarchy, biomedicine remains at the top and folk medicine at the bottom, and in between remains the traditional medicine. However, in the use of medicine almost reverse is the situation, folk medicine comes first followed by biomedicine and traditional medicine. The present hierarchical structure of medical pluralism does not match with the state's priority and people's choice. The hierarchy of medical system reflects the hierarchical structure of the society. The overall health indicators have been improving in Nepal[34]. However, the gap in the utilization of health

[34] For example, life expectancy has increased from 54 to 69 years, under five mortality rate declined from 162 to 38 per 1000 live births and maternal mortality ratio fall from 850 to 258 per 100000 live births from 1990 to 2014 (NPC 2016). Similarly literacy rate has increased from 39.6 percent of the 6 years and above population to 65.8 percent of the 5 years and above population from 1990 to 2011 (CBS 2014c).

health care service and health outcome is widening over the years among the different socio-economic groups[35]. Often it is argued as the right of the poor to have equal access (financially and physically) to safe, effective and quality biomedical health care serves. The logic is that biomedicine is the best and they should also have the access to the best. The state efforts are seen to be directed to this end, increasing and expanding both public and private health care facilities based on biomedicine. The kind of official health care services, in which they have some access (to be provided by the health post and primary health care services) are often inferior quality and to those facilities which provide better quality services they do not have access because of high cost. When the issue of catastrophic health expenditure surpassed other issues, the agenda of health insurance has been put forward to increase the access and coverage. This is the pathway on which the world is moving forward.

However, the insurance models are not free from problems both in terms of coverage (as many will be left uninsured) and the cost of the care (as the cost containment will be the new challenge). With national health insurance programs, certainly the government expenditure on health will increase but it remains uncertain that the poorest section will be better served than the well-off. There are evidences that the countries which are on the path of health insurance have been struggling with the cost containment. The insurance models might work as the next level of privatization (Reddy and Mary 2013; Indranil Mukhopadhyay 2013; Dao and Mulligan 2016). Besides, without strengthening the local health facilities which are supposed to provide quality health care services, the insurance program might not improve the access and equitable distribution of health care services. The poor Janajati and Dalit rely more on folk or non-codified traditional medicines compared to better-off Brahmin/Chhetri. Since the folk and traditional medicines are unofficial and likely to be uncovered by the national health insurance programs. This poses a challenge for the real financial protection of the poor section, even though folk medicine is relatively accessible. Embracing a policy of one size fits all and keeping folk medicine out of coverage challenges the very meaning of universal health coverage (UHC) making UHC an unfair health coverage. From the user's point of view, it is better to have options and choices, even from non-codified folk sector. From the state's point of view it is the regulation and provisioning of quality services

[35] For example, see (Målqvist et al. 2017) for the equity gap in utilization of antenatal care, skilled attendance at birth, and facility based delivery.

from official systems. However, without the consideration of this situation financial protection will remain unfulfilled. The best use of could be an option to the poor section which is accessible, available, acceptable to them but has been ignored and considered obsolete. The state does not see the importance of traditional healing no matter how effective are the traditional health practices in the eyes of the villagers. No matter what the possibility is with folk sector to contribute to the health care system. The only logic generally put forward is that the medical claims needs to be proved with scientific standards the way biomedicine does. The "folk conceptions tend to be treated mainly as 'subjective' beliefs and not as valid forms of knowledge" (Sujatha 2007, 169).

There are issues on the politics of unequal distribution of medical knowledge and politics of knowledge recognition. The knowledge is power and the medical knowledge has the greater power in which the dominant sections have control. The folk knowledge system in which rural communities have control to some extent and strengthening of the indigenous knowledge system would be empowering to rural communities. However, the situation is like this: neither the rural mass have strong and effective folk system, nor they have access to quality official health care. Neither they have something on which they can stand nor they have something which they can catch[36]. The folk system in which they have control and better access is crumbling and the state does not pay attention to support the crumbling folk sector to the end of better quality, the official systems which is considered better quality but they do not have access, and no matter what the political rhetoric be, state has failed so far. The hierarchy of medicine will be retained and reinforced unless the existing status quo challenged. The poor sections will continue to suffer until and unless the politicians, the practical anthropologists, look into the root causes of the problem and find the means for the actual solutions. With the changed political system, people of Nepal are desperately waiting for the time that the practical anthropologists of Nepal would be able to bring

[36] While writing this, I was recalling a person who had climbed on a large mango tree with a number of branches to pick ripe mangoes. He was standing on foot and stepping towards the bunch of mangoes, holding upper branch by one hand picking mangoes by another hand and putting them into the sack which he was carrying on his cross shoulder. While doing this, he reached to the end of a branch. Unfortunately, the branch on which the person was standing broke, the small branch which he was holding could not support his weight any more, and he fell down to the ground. People were surprised and found him lucky because he survived from serious injury. He had fallen from the tree because he found no shift on which he could stand and to which he could catch/grip at the right moment.

smile and hope in the face of the poor section of the populations. Hope is the only option that people can hold, on which they can stand and by which they can catch.

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CHAPTER IX
SUMMARY AND CONCLUSION

1. Background

This study is about medical pluralism. Medical pluralism refers to the existence and use of different forms of medicine. Plurality and diversity exists in medicine and people exhibit pluralistic treatments seeking behavior. The study focusses on how medical pluralism is practiced in a rural setting of Nepal. The main objectives of the study were to (i) document the illness experiences of the people, (ii) identify the belief and perceptions related to health and illness (iii) analyze the patterns of resort and (iv) examine the state's role in the making of hierarchical medial pluralism.

The study was conducted in Dang district of mid-western Nepal. Field data were collected from a village (anonymized as Anjaan Gaun) where 666 people with different caste and ethnic background live in 126 households (50 households from Brahmin/Chhetri, 56 from Janajati and 20 from Dalit communities), following qualitative methods. I stayed for 14 months (November 2015 to December 2016) in the village and observed closely to the treatment seeking behavior in Anjaan Gaun. A semi-structured interview was conducted with the head or the elder member of the households. I interviwed healers and village paramedics, who run medical stores in the village, health post staffs and medical doctors, medical and administrative staff of the hospital in the district. I repeatedly visited the households with chronic conditions and talked at length with patients and care givers and knew more about their subsequent treatment recourses in my subsequent home visits. I also collected information by adopting some of the participatory methods such as social map and well-being ranking. I came to know more about people, their socio-economic background, illnesses and the the treatment seeking and got an idea about their kinship and social connection. At the end of the field, I came to know who was who in the village power structure.

2. Findings

Medical pluralism has been practiced by various sections of the populations at varying level. The context of local treatment seeking is undergoing a change which is mainly influenced by the state intervention in health and health care. All sections of the people in the village have used the official health care services, which is mainly based on biomedicine and traditional medicine, along with the folk medicine and home-based practices. The folk medicine still constitute an important treatment resource among the rural populations. The practice of self-medication, buying drugs without a prescription, is increasing among all sections of the people. The folk practices are falling down while the increasing number of people have been using biomedicine and traditional medicine, especially Ayurveda and Homeopathy. The folk system has been politically marginalized whereas traditional system has got political acceptance. The traditional medicine and CAM have been gaining global acceptance and the international stance has become positive towards these systems. The recognition of Ayurveda as part of national health care system and public and private provisioning of Ayurveda and other traditional systems has encouraged people to practice medical pluralism. The use of both official (biomedicine, Ayurveda and other traditional system) and non-official medicine (folk and home-based practices) strongly affirms to the pluralistic treatment seeking behavior of the people of Nepal. The folk and home-based practices have an important place especially for the treatment of minor illnesses and culture specific conditions. The people's illness and treatment seeking experience reveals why people choose healers to hospitals or vice versa.

The analysis on the patterns of resort among the different socioeconomic groups shows the similarities as well as differences in the use of medical system in different illness conditions and explains the logics behind the use and non use of multiple systems. The local healers such as shamans/faith healers, herbal healers, bone setters, snake bite healers, and traditional midwives provide wide range of services. The shaman or faith healers handle culturally understood illnesses such as *jhaskine* (startling), *daraune* (frightening), nightmare, and attacks by unknown forces and the illnesses of emotional, spiritual, and mental conditions. For such kind of illnesses people see no better substitute to these healers. The use of herbs and herbal healers has always been an

integral part of health and treatment seeking and traditional midwife, who assist in child birth and postpartum care and massage still constitute an important source of help. These folk practitioners follow a distinct way of healing, use healing mantras, herbal medicines and massage techniques. Most often these healers are consulted first before going to the urban hospital and for some conditions people frequently visit them because of their expertise in certain conditions such as jaundice, navel dislocation, sprain, snake bites, dog bite, bone setting and the like. However, it is notable that the people have become selective in their choice which reflects the changing perceptions of the communities. They have doubt on many practices because of lack of scientific study and evidence.

In the home they use various type of herbs, food items and spices to deal with the illness conditions which are minor but constitute a major share of the number of illness episodes they encounter. In the management of illnesses such as diabetes and hypertension people also follow yoga, exercise, regular walking and dietary regimen. Based on the illness types and severity they try home-based practices and move to local healers/ medical practitioners and to the hospitals, within and outside of the district. The use of home-based practices and folk medicine is much higher than traditional medicine (Ayurveda, Homeopathy, Unani and acupuncture) and biomedicine. However, they have been increasingly using ayurvedic products. The people have also been utilizing biomedical drugs and health care services more than before. The expansion of private sector pharmacies and clinics has also contributed to the increased use of biomedicine, as the private facilities outnumber the public facilities.

The perceptions, practices and patterns of resort vary across socio-economic groups. The people from each caste/ethnic group had taken recourse to folk healers at least in some of the illness episodes. The Brahmin and Chhetri, educated and well-off more often resort to biomedicine based health care facilities than traditional healers whereas those of Dalit, Janajati, under/uneducated and poor more often resort on traditional healers. The women and elderly people resort to the traditional healers more often than the youths who are educated and exposed to the outside world or who have urban connection. Many of them are selective about the folk practices and they have their logic of being selective. The common perception is that folk healers can provide relief from some of the conditions but not all. If people perceive that an illness is caused by

an evil spirit or by a supernatural element, then the choice would be to resort to shaman or faith healers whereas for illness caused by natural factors choice would be either to herbal healers or official practitioners, both biomedicine and traditional medicine. And, if there is uncertainty, they are likely to consult both types of practitioners simultaneously or sequentially. The people's perceptions about illness play an important role in the choice of medicine. However, it is not the belief and perceptions but the socio-economic condition of the family that seems more associated with the use of folk systems. The differential use of medicine cannot be explained merely because of differential perceptions. The treatment seeking behavior shows an association not only with the use of medicine and health perceptions but also the use of medicine and their socio-economic conditions.

A patient's actual patterns resort can vary with his or her perceptions and preferences because the decision making in the family is influenced by the perceptions and preferences of decision makers, cost of care, symptoms and severity. For example, an educated youth can influence the decision making in his or her family and suggest to visit official health facilities, a woman may take her child to a faith healer, and an elder may be taken to biomedical hospital even when the elderly believes in or prefers to folk healing. The decision to choose a system can be influenced by the family's socio-economic status and the status of the patient in the family.

The home-based practices play an important role but are changing as the use of over-the-counter-drugs is replacing the home-based herbal remedies. The availability of modern drugs in the village medical clinic and strong faith on modern drugs has encouraged the self-medication practices. The self medication is not only limited to the common people but also to the medical practitioners and doctors. The consultation with folk healers are shrinking but consultation with village paramedics and pharmacists, medical practitioners and doctors is increasing. The young generation has started to look into the traditional practices through the lenses of science and superstitions. They think that many of the folk practices are unscientific and irrational.

The socio-economically poor sections likely to resort to the nearest and the cheapest sources of care in comparison to the better-off sections who can afford the expenses of distance sources. The patients from poor socio economic background and those who lack or cannot make best use of kinship connection or social network tend to recourse

multiple sources, following either a simultaneous or hierarchical (exclusive or mixed type) resort pattern, end up paying more for the treatment of an episode of illness. The patients who resort to many different places bear the increased cost. The treatment cost increases exponentially for each subsequent recourse when they follow hierarchical resort patterns. The poor are severely affected by the consequences of increased cost. At the household level, the multiple recourses are considered as a genuine effort in treatment seeking. The family care givers express a sort of satisfaction when they report their efforts of seeking care from many different places. This is expressed mostly when they experience treatment success or feel that they made each and every attempts which were worth attempting. However, behind the story of genuine effort is a pain and suffering experienced by the patients as well as by family members.

The people irrespective of their socio-economic backgrounds recourse to multiple sources for persistent illnesses. There are similarities in the patterns of resort among the socio-economic groups, especially in the culturally understood conditions but there are differences in many other conditions. The therapeutic paths chosen by the poor sections tend to be lengthy in some illness episodes. Even though their socio-economic condition limits them to seek treatment from distance and expensive sources thereby reducing the overall recourse times and costs, a single episode can cost them much when they attempt to. The well-off sections resort to better care than those of poor which reflects the hierarchical structure of the society. It is important to determine who goes where and why in search of treatment and who gets quality care. Different people follow different patterns of resort and use different systems. It is not unnatural. A uniform therapeutic pathway is neither desirable nor justifiable. Nevertheless, pluralistic therapeutic pathways cannot be justified unless people are able to make informed decision and follow a better path to better care.

The health care resources are not equally distributed among the different socio-economic groups. The study strongly affirms that the poor sections do not have equitable access to health and health care resources. The illness and treatment seeking are influenced by socio-economic inequalities within society. The differential experience of illness and treatment seeking are the outcome of the unjust socio-economic and political system, which gives advantages to some at the expense of

others. The utilization patterns reflects the class, caste and gender inequality, the inequality between well-off and poor, Brahmin/Chhetri, Janajati and Dalits, educated and iliterate, and male and female.

The health seeking behaviors are not purely individual, independent, and isolated behaviors. There is connection between individual behavior and macro socio-economic and political forces (Baer, Singer, and Susser 2003). These forces decide the policy priority, shape the perceptions and influence the treatment seeking behavior. In a way individuals, families and communities are connected to and act under the larger socio-economic and political structures. The role of larger socio-economic and political forces is crucial in health care provisioning, nature of the health care services, priority of the health programs, resource (human and financial) allocation and uses (Rama Vaidyanathan Baru 1992, 8). The individual behaviors are not only shaped by the cultural perceptions but also by the state interventions on the provision and delivery of health care services to the people of a particular geographical setting. The understanding of household level treatment seeking behavior of the people calls for an understanding of interplay of power at different levels. The inequality and difference in the use of health care resources is not only associated with the household level socio-economic differences but also with the nature of national health care system.

The official facilities such as HC and PHC function poorly and non official sources such as folk practices and local health traditions are weakening hence the rural people are being pushed towards the large cities where big hospitals are concentrated. The large crowd of patients is fueling for further expansion of hospitals.

The practices of medical pluralism have both positive and negative experience. On the one hand, the use of different systems play a complementary role for the treatment success for an illness episode. On the other, treatment failure in one system leads to another system or results in multiple recourses, which eventually costs high and increases the suffering. The simultaneous use of multiple drugs prescribed by different practitioners can have adverse effect on health thereby triggering further complications and iatrogenic effect. The common people, as well as local doctors, do not see any harm using biomedical drugs along with ayurvedic herbal medicine and supplements.

The increasing incidence of chronic illnesses has driven people to multiple recourses. The multiple recourses are not exception to the poor section. All sections, including the local doctors, had taken many recourses for the treatment of an episode of illness. However, the poor section tends to experience treatment failure than the well-off and educated because with limited access to information, education, know-how and knowledge it is not possible for them take right decision at right time to resort to the right therapy and right practitioners. The treatment failures leads people to longer pathways of care which increases the cost of care per illness episode. The failure from the first recourse leads to the second recourse and then to third, fourth and so on because they keep on trying one after another unless they leave a hope to be diagnosed, treated or improved to a level of satisfaction. The field narratives of the patients and care givers on treatment seeking experience affirm that the more they recourse to, the more they bear the cost of care, and the more intense the suffering. The multiple recourses and rising cost has caused deep pain and suffering among the poor sections. This supports the need for quality health care services, provisioning of strong and efficient public health care services and increasing accessibility, increasing access to information, and raising awareness on the therapeutic options and facilitating them for informed decisions.

The multiple recourses have profound implications to the patients and their families irrespective of their class, caste and gender status. However, the poor section suffers the most. The disparities exists mainly for two reasons: (i) the medical pluralism is exclusionary, undemocratic and unjust where biomedicine gets state's favor, traditional medicine remains deprived and folk medicine weakened (ii) the poor have poor access to the state favored medicine while the folk medicine, on which they have access, has no access to the state resources and there is no efforts to revitalize the local health traditions. The disparity will perpetuate unless (i) physical and financial access to official medicine is ensured by making services free of costs and addressing the issues related to social determinants of health, and (ii) quality services are ensured from all the co-existing systems of medicine including those of folk medicine, and (iii) medical pluralism is made more inclusionary, more democratic and more just through state intervention and affirmative policies towards the co-existing systems.

3. Policy Implication

In this section, I discuss on the policy implication of the findings. The findings reinforces the fact that there are inequalities and differences between and within socio-economic groups. The differences in the access and use of health care resources reflects the hierarchical structure of the society. The Dalits and poor have poor access to, and are served poorly by, the official health care system. The traditional healers and local medical practitioners are an important source of treatment for all the social groups in the village. However, the poor, Dalits, and ethnic groups rely more on them than those of socio-economically better-off. Sometimes they recourse to them not by choice but because of the rising cost of the formal health care services. The present health care system has served the better-off section than the poor section.

So the question is what would be the possible way to benefit the poor section. One of the official policy is to make official services affordable and accessible to the socio-economically weaker sections of the people. When the policy documents recognize and repeat this fact again and again, this affirms that the issue remains unsolved. This also means nothing concrete has been achieved so far in benefitting the rural poor. This is either because the policy did not address the real cause or because the policy remained only in papers or implemented half heartedly because of weak political will. Similarly, the policy documents repeat to encourage folk practitioners and develop, protect and expand Ayurveda and other alternative systems. But in practice what is being encouraged, developed, protected and expanded needs no further clarification. A sort of mismatch can be observed what the state commits to do in its policy documents and what actually it does. The recent policy seems more regressive when it remains silent or used ambivalent language when it comes to folk medicine.

The issue, which is often ignored, is the relationship between folk medicine and their users. The poor will be served poorly from the folk medicine and the unofficial sources on which they rely more. The unstated policy to address this issue is to decrease the dependency of the people (including the rural, poor and indigenous people) on folk system by continued neglect and avoidance. However, people did not and will not stop

using the folk medicine not only because they have poor access to official medicine but because of differential health care needs the folk system serves. The policy of avoidance and neglect has adversely affected the growth and development of folk sector, which indirectly has cost high to the people and also to the state. This will continue unless state takes an initiative to ensure the quality services from the folk sectors. There is no option to improve the quality and increase the access to health care services. The quality, access and utilization no more remains caged into biomedicine based health care. This also includes the quality, access and use of traditional and folk medicine. The unregulated informal sector poses a challenge to ensure the quality services. There is also a challenge to identify, organize and enhance the knowledge and skills and mobilize the folk practitioners to serve the national health goal. And the challenge is unavoidable.

The state's non stated policy has been to shun from the issue of folk sector. However, avoiding this issue means avoiding the concern of a large section of the rural people. Without addressing the issue of folk sector on which rural people largely depend, quality services cannot be ensured. The folk sector works as the base of the rural communities. If a strong base is desirable, a genuine effort should be made. For instance, the contribution of female community health volunteers has been laudable. Based on this experience, the folk practitioners also have the great potential to contribute to the revitalization of local health tradition and to the primary health care services. This calls for policy attention to use the folk sector as untapped resource to contribute to the formal health care system.

Another issue which often gets less attention is home-based practices or the family sector of health care. The family remains as a primary source of care which supports sick members through the practices of home remedies, home-based care and support, and self medication. The self medication is gaining an importance because it saves money and time. However, self medication can harm if the family members do not have necessary skills and knowledge. A family member can buy drugs and even some devices such as thermometer, blood pressure and glucose monitor and necessary skills can help them a lot. The family plays a major role in health maintenance and treatment seeking. In a way, the professional practitioners' role is to help families in their effort

to make sick member well. The enhanced knowledge and skills of the family helps to evaluate and assess the condition of sick person, to seek required therapeutic services in time, and to provide the better home care to the sick. The better the family sector of care the better the family can collaborate with professional practitioners. It is far more cost effective and sustainable to encourage home care than to increase the number of hospital beds and extended bed occupancy.

The sustainable use of medicinal herbs is an important issue. There should be program to promote home herbal production which are most commonly used at the household level and increase the herbal literacy among the youth. The present state of home-based practices and self medication needs an attention because these practices are associated with the treatment of acute as well as the chronic illnesses. As the responsibility of care and management of chronically ill person falls upon the family members. Hence, education and general health awareness among the family members about the home-based use of medicinal herbs can contribute to good health. The information access is very much needed than ever before. The ultimate goal of all the medical systems is to provide a medical cure for the people affected by illnesses. If the goal is same there is no point casting one system as against and not having a dialogue among the different streams of medicines. So, a mechanism should be developed for this dialogue.

The private sector has been developed greatly since the 1990 when the state adopted the neo-liberal policies. Now, private sector has become a dominant provider of curative health care services (Sengupta 2011, 2). The purpose of private sector involvement in health has been to partner the state in the improvement and development of better health care system. However, the private sector is motivated by the profit it can make investing in health care market. Private sector has been committed to develop health care as industry, a business enterprise, where the patients are served as consumers. The profit motive has pushed the service motive far away. Health as public good has been pushed into free market for private loot. The unregulated private sector has posed a challenge to the very purpose of the state to ensure the rights related to health and health care. From the villagers point, they use private health care services only because when there is an urgency *najikko satru, tadhako mitra* (close foe comes to help first than the faraway friend). The foe (private sector) cannot occupy the place of friend

(public sector) but when the friend does not come to rescue them in need, even the kindness of the foe is appreciated. The efforts should be made to strengthen the official systems and to keep health as public good.

With the rise of chronic illnesses, the use of several systems and multiple recourses has become unavoidable. The limits of biomedicine and increased utilizations of traditional medicine and CAM also suggest the strengths of different systems. The uncertainty of the illnesses, the limitation of treatment interventions and treatment failures makes multiple use and multiple recourses inevitable. The people's illness experience signals to the fact that in much of the time patient move from one source of treatment to another because of uncertainty about the treatment service required for a particular illness they face. Many a time, uncertainty exists irrespective of the socio-economic background and even among the practitioners. They first try themmselves and when they know that illness is not likely to be treated they refer to other facilities or providers. The use of different sources of treatment is justifiable when no source can provide a complete treatment for an illness. The experience of failure in the treatment and further efforts from the patients and their care givers is justifiable. However, when the patients and care givers take recourse to many sources it results in an increased cost, risk of side effects, severity of illness and suffering. With better access to information on treatment services the recourse times can be cut short. To shorten the recourse times, the patients and their care givers need support in making informed decisions about the health care options. The issue needs an attention from the policy and program's viewpoint. The focus on biomedicine based, hospital delivered curative services limits the health goal of preventive health, primary care and social determinants.

To conclude, the study finds the differential use of the co-existing systems of medicines among the different sections of the people. There is a divide between those who use more official medicine and less folk medicine and those who use more folk medicine and less official medicine. A section who is socio-economically week resort more to folk medicine and informal sector and another who enjoys better socio-economic condition resort to formal official medicine. In the use of official medicine, the poor section likely to resort to the public facilities whereas the better-off to the private facilities. Similarly, the poor section is likely to take an extra recourses per episode of

illness in many acute and chronic conditions. The better access to public health care services and efficient and quality services can reduce the recourse times of all sections and the poor section likely to benefit from the efficient, affordable and accessible public system. However, increasing quality and efficiency of public system and official medicine solves only a part of the problem, unless and until the private, informal, and folk sector taken into consideration. The differential treatment to the co-existing medical systems will not address the issues of the poor section. The differential treatment to the co-existing medial systems has resulted in the differential treatment to the different section of the people. The policy of *khaye kha, nakhaye ghich* (you take it or leave it) have left people with no choice. The people, especially the poor, Dalit and ethnic communities have been served by the same menu and they have to take that willingly or unwillingly.

The state seems clear to further expansion of biomedical health facilities and increase of biomedical doctors would ensure the accessibility and quality health care services. The state is committed to increase access to medical treatment by making private sector investment in health and by ensuring health (or medical) insurance. The state is hopeful that present effort to universal health coverage and the provision of insurance would increase the access and address the equity concerns. The universal health coverage has been presented as the panacea to the increased out-of- pocket (OOP) and catastrophic health care expenditure. Time will tell whether this would really increase the access to health care services and reduce the OOP and protect them from catastrophic expenditure. However, the experience of health insurance in many countries are not encouraging and if the UHC is supposed to yoke different section together, this would be something like making low-height athletes look tall enough by adding artificial legs and setting them in line and call out "on your marks, get set, go!" The equity and social justice would be a farce if such athletes are called out to compete the race with those who are already in privileged position. The state should ensure the quality care not only from what state wants to provide but also what the people want to avail for their good health and wellbeing. This necessitates not only to ensuring access to biomedicine but also ensuring access to traditional and folk medicine. The expansion and strengthening of local public health care facilities, integrating traditional medicine, revitalizing family health tradition is crucial from the perspective of equity and social justice. The present

government's vision is *Sukhi Nepali, Samridhha Nepal* (Happy Nepali, Prosperous Nepal). The roots of prosperity and happiness must go deep into the family and community. The strong base of family and folk sector of health, and inclusive democratic medical pluralism can contribute to this vision. What is needed is a political action for actual solution.

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APPENDICES

APPENDIX I: INTERVIEW SCHEDULE

A. Household Interview Schedule

1 Basic Information of the Household Head

Name		Education	
Age		Occupation	
Sex		Address	
Marital Status		Mobile No.	
Caste/Ethnicity		Family members	M: F:

2 Basic Information about the Family

SN	Name	Age	Sex	Relation to HH	Marital status	Education	Occupation	Remarks
1								
2								
3								
4								
5								
6								
7								
8								
9								

3 Information about Assets and Income

SN	Particulars	Ownership/Types/Quantity	Remarks
1	House		
2	Housing Plot		
3	Land holding		
4	Use of land		
5	Livestock holding		
6	Water source		
7	Cooking fuel		
8	Electricity		
9	Mobile/ Phone		
10	Motorcycle		
11	Television set/ Dish home		
12	Annual income (Rs.)		

4 Illness and Treatment Practices

Is there anyone in your household who had experienced or has been experiencing illness in the last six months? If yes, could you please provide the following information? (Talk at length about the types of illnesses, causes, onset of illness, diagnosis and treatment detail, cost of care, and their experience)

SN	Name (who had/has illness	Types of illness (problem) sign and symptom	Onset of the illness	Causes of illness (Diagnosis)	Treatment activities (where, whom and how many times)	Reason of resort to that system (why?)	Current status of illness	Cost/ Expense	Future plan
1									
2									
3									
4									
5									
6									

4.1 Use the following table to record recourse patterns

SN	Name of the member who had illness	Illness Episode	Therapeutic Recourses Where did you go and whom did you visit?					
			First	Second	Third	Fourth	Fifth	Remarks

Note: Write (A) for Biomedicine, (B) for Traditional Medicines, (C) for Folk medicines, and (D) for Home-based medicines. Write A or B or C or D for single use and add a symbol of an arrow mark (→) for sequential use and a plus mark (+) for simultaneous use.

Complementary questions: To be asked according to need and situation. (The possible question: What was the first thing you did when you fell ill? What did you do at home? Whom did you consult first, and then, and then and last time? Where did you go for treatment and why? Who helped you? Who among the family, neighbor, and relatives helped? How the decision was taken? What was the reason to visit particular facility, practitioner or healer? Why didn't you opt to other available services? How much did you spend for the services, for drug and diagnostics, for transport and accommodation? What was the time/cost needed to reach the facilities? How the treatment/ facility/ practitioner was? What about healers (herbalists, shamanic healers, midwives), medical shop, health post, hospitals, private clinic? What is your experience with HP, PHC, clinics or hospital?)

B. Interview Guide

1. General Information of the Study Area

- Demographic history, migration and trends
- Housing, sanitary condition, and drinking water
- Practices related to personal hygiene
- Major health problem of the area, major illness, seasonal illnesses
- The most common illness in the village.
- The illnesses and most affected group of people
- Health status of various sections of people (inequality and differences)
- Health institutions: Public and private (medical store, health post and hospital)
- The number, types, class, caste and gender categories of practitioners

2. Perceptions, Culture and Changes

- Perceptions of health, illness and disease
- Changes in people's perceptions and practices
- Current trends in food habits and nutritional state
- Trends in self-medications, home remedies and home-based care
- Health related community events, cultural practices, rituals, offerings and worshiping
- Doctor- patient and healer-patient relationship
- Relationship between among the healers and practitioners
- Local health traditions (preventing illness and promoting health)

3. Medical Systems and Therapeutic Choice

- Existing systems of medicines: biomedicine, traditional systems, folk systems and home-based medicine (self medication and self-care)
- Use of various medicine and health care services
- Types of illnesses and preferred therapeutic services
- Major destination of therapeutic resort
- Referral among the various practitioners
- Causes of multiple recourse and its impact on cost and health.

2. Observation Guide

2. Observation at Household Level

- House: Size and type
- Sanitation in and around the house
- Front space and kitchen garden
- Water source and usage and cleanliness
- Personal hygiene among the family members
- Cowshed and cattle
- Toilet and bathroom
- Cycle and motorcycle
- Electricity, TV antenna, and equipment

3. Observation at Community Level

- Road and footpaths
- Schools and public places
- Public spaces, temple community hall etc.
- Institutions (cooperatives, mother's group and youth clubs)
- Sanitary condition of the village
- Agricultural fields, crops and irrigation
- Forest, river and ponds
- Transport and communication
- Health post and hospitals

4. Observation at the Treatment Sites

- Home-based practices and home remedies
- Healers and healing practices
- Village medical stores and treatment
- Health facilities: hospitals, clinics, pharmacy
- Traditional medicine pharmacies and clinics

5. Observation of Socio-cultural Events

- Socio-cultural events in the villages
- Cultural practices and rituals
- Social gathering and participation
- Religious custom, rituals, offerings and worshiping
- Clothing, food habits and food practices
- Herbs at the local market
- Day-to-day activities in the village

APPENDIX II: PHOTOGRAPHS FROM THE FIELD

Photo 1: A View of Poor Village Cluster

Photo 2: A House of Relatively Well-off Family

Photo 3: A Village Medical Store

Photo 4: Buying and Selling Crude Herbs in the Local Market

Photo 5: Arrival View of Ghorahi

Photo 6: Rapti Sub-regional Hospital, Ghorahi

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