Chapter IV

Mode of Treatment - Medical Pluralism

This chapter documents the modes of treatment, the medical pluralism, followed by the people in the study area. Medical pluralism refers to the coexistence and variation in treatment patterns and people's health seeking behaviour with respect to income, education, culture and location. Medical pluralism may be located into three sectors: Popular sector, Folk sector and Professional sector. The Popular sector refers to treatment by the ill themselves, their families, relatives and close social networks. It encompasses a wide variety of therapies, such as special diets, herbs, exercise and prescribed rest. This is part of health heritage of a community, built and practiced over generations based on their lived experiences. The Folk sector includes various kinds of healers, with some training in the trade, who work informally and often illegally without any professional license. The Professional sector includes practitioners of both biomedicine and medical professions. An individual has the option of seeking either Ayurvedic or Allopathic treatment. Similarly, treatment may be sought in hospitals, private clinics, and medical shops or in health posts.

Medical pluralism is also apparent in people's perception of disease and illness, their preference for treatment of a particular mode and their responses to other medical traditions. The sectors may overlap each other as people combine them for quick relief from ailments. At times, people may use the services of all these sectors at the same time.

In Nepal, treatment patterns vary even within modern Allopathic medicine. In rural Nepal, in addition to medical doctors, all health workers, assistants, as well as medical shopkeepers are generally perceived as "doctors". As these practitioners have (healers) varying levels of training/apprenticeship their competence is very difficult to judge. Many such "doctors" probably have no formal medical training at all. They charge relatively low fees or examine the sick for free and might not even ask for fees prior to recovery. Such business tactics and the vested interests of self proclaimed practitioners in medical shops in Banigama might actually have prompted the mushrooming of medicine shops (during the time of this survey, there were nine medical shops in Banigama). Field visits and interviews also brought to light widespread and strong beliefs in various traditional healers, varied rules of behaviour in relation to treatments by faith healers (rituals), manifold superstitious beliefs and widespread unhygienic practices. It was also clear that poor sanitary conditions cause major health problems in Banigama.

Health seeking Behaviour among Banigama People by Caste /Ethnicity

Health seeking behaviour in Banigama is clearly largely determined by caste/ethnicity. In Banigama VDC, caste/ethnicity can be categorized as Brahmin/Chhetris, Tharu, Untouchables, Terai dwellers and Others. Brahmin/Chhetris are considered to be high caste as they are better off in terms of social and economic conditions, and education compared to other groups. Tharu and Terai dwellers come in second position. Although Tharus are economically capable due to large landholdings, they have not been able to progress in other sectors such as income and education. The Untouchables are very much dominated by other castes/ethnic groups and have not been able to make progress in any field. Other castes and ethnic groups shun them socially and, as a result, they are stigmatized and reluctant to make their voices heard. These people are economically and educationally backward. The lack of education means that they cannot do the works that would have boosted their life chances and earned them recognition and honour in life.

The various caste and ethnic groups have varying understanding of and preferences for medical treatment. Traditional understanding of health issues also induces variation in health seeking behaviour. This would be clear from an analysis of the quantitative information we have collected.

Table 4.1 presents the health seeking (treatment pattern against sickness) behaviour of households. This health-seeking behaviour is their first attempt/contact with a health facility. Data reveal that following home remedies, 50.57 per cent of Banigama residents at the first stage of their illness go to medical shops, explain their problem and purchase medicine from there. The second largest group, consisting of 23.56 per cent of the respondents, consults the traditional/faith healers first. The third group (15.52%) goes to health-posts first. This trend of health seeking behavior is also seen from the table, which particularly highlights the Tharu health seeking behavioural plurality. The health seeking behaviour found among the Brahman/Chhetris was significantly different. While 55 per cent of this group consults medical shops first, 9 per cent goes to health post straight away. The largest group of respondents (46.15 per cent) among the Untouchables consults medical shops for treatment when they get sick. The second largest group, consisting of 23.08 per cent of the Untouchable households, seeks treatment in health posts first. Likewise, 15.38 per cent of these households contact health workers when they get sick. Among the Terai dwellers, 36.36 per cent, 31.82 per cent and 18.18 per cent of the respondents consult traditional/faith healers, medical shops and health posts respectively for treatment.

Table 4.1: Household Health-Seeking Behaviour

Behaviour	Caste/Ethnicity											
	Brahmin/ Chhetri		Tharu		Untouchable		Terai Dwellers		Others		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
No response	3	11.11	1	0.88	-	-	-	-	-	-	4	2.25
Traditional/ faith healer	-	-	32	28.32	1	7.69	8	36.36	-	-	41	23.56
Grocery	-	-	1	0.88	-	-	-	-	-	-	1	0.57
Medical shop	12	50.00	62	54.87	6	46.15	7	31.82	1	50.00	88	50.57
Knowledgeable person	-	-	2	1.77	-	-	-	-	-	-	2	1.15
Quacks	-	-	-	-	-	-	-	-	-	-	-	-
Health worker	2	8.33	3	2.65	2	15.38	1	4.55	-	-	8	4.60
Health post	10	41.67	10	8.85	3	23.08	4	18.18	-	-	27	15.52
Hospital	-	-	-	-	-	-	1	4.55	-	-	1	0.57
Private qualified Practitioner			3	2.65	1	7.69	1	4.55	1	50.00	6	3.45
Total	24	100.00	113	100.00	13	100.00	22	100.00	2	100.00	174	100.00

The Others (Tibeto-Burman speaking group) sought initial treatment equally from both medical shops and private practitioners. One household from this group, a Newar businessman, is economically in a relatively better position in the village, and this household could afford consultations with private practitioners.

A signboard in a medical shop serves to highlight the role of such shops as the initial place of consultation - "We treat all kinds of illness and problems such as female infertility, ear, eye problems, medicine that will bring good luck, and medicine to improve memory power". Needless to say, such advertisements offer hope to village folk and are comparatively cheaper compared to visiting a qualified medical practitioner. Because of these factors, Banigama dwellers tend to lean towards visiting the medical shop first for treatment. They also do not have wait in long queues to attend such 'doctors' attending a medicine shop.

According to the data, none of the Brahmin/Chhetri households consult traditional faith healers. This could however, be the made out answers of respondents, to pose as 'modern'. While it is good sign that a large number of Brahmin/Chhetris (41.67%) have faith in the health post, research and informal interviews indicate that there were people from this group who consulted traditional faith healers.

Variation in Health –Seeking Behaviour by Land Holding

Land holding is seen to influence health seeking behaviour greatly. In Banigama VDC, the size of the holding is also a factor that symbolizes status and well-being of people. People can grow different types of vegetables and cereals according to the size of their holding. They can

also earn money from the surplus land. Socio-economically, the size of the holding also indicates the capacity to take advantage of various treatments from individuals or organizations. The landlords, traditionally known as '*Jamindar*', have both the resources and the means to afford any kind of treatment. During the field visit, it was apparent that many people in the study area went to local *Jamindars* to borrow money not just for treatment, but also to meet other needs.

Table 4.2 presents the health-conscious behavior of households in Banigama VDC according to their land holding. As in earlier cases, medical shops appear to be the first place visited by all households irrespective of land holding. The shopkeeper listens to the symptoms recounted and prescribes medicine. It was also noticed that the locals generally incorporate the visit to medicine shops for medication into their routine visits to the Bazaar.

Table 4.2: Household Health-Seeking Behaviour According to Land Holding

Behaviour	Land holdings													
	Landless		Below 0.50 ha		0.50 to 1.0 ha		1.0 to 3.0 ha		3.0 to 5.0 ha		Above 5.0 ha		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
No response	1	2.50	2	5.41	1	2.78	-	-	-	-	-	-	4	2.25
Traditional/ faith healer	14	35.90	9	25.71	5	14.29	8	16.67	4	33.33	1	20.00	41	23.56
Grocery	-	-	1	2.86	-	-	-	-	-	-	-	-	1	0.57
Medical shop	17	43.59	17	48.57	22	62.86	23	47.92	7	58.33	2	40.00	88	50.57
Knoledgable person	-	-	1	2.86	-	-	1	2.08	-	-	-	-	2	1.15
Quacks	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Health worker	3	7.69	-	-	2	5.71	3	6.25	-	-	-	-	8	4.60
Health post	4	10.26	6	17.14	3	8.57	12	25.00	1	8.33	1	20.00	27	15.52
Hospital							1	2.08					1	0.57
Private qualified Practitioner	1	2.56	1	2.86	3	8.57	-	-	-		1	20.00	6	3.45
Total	39	100.00	35	100.00	35	100.00	48	100.00	12	100.00	5	100.00	174	100.00

The landless, as data in the table would suggest, appear to have a comparatively higher belief in traditional faith healers. This might be because of low incomes, minimal exposure and interactions with the educated people and the world outside. It might also be the cause of cultural influence and economic limitations.

Those (20 per cent), with more than 5.0 hector of land, show an inclination to consulting qualified private practitioners for treatment. This might be because of their greater health awareness and capability to afford such expensive treatment. In Nepal there is a

concept that medical practitioners offer better services and care at private clinics. This is clearly seen among the Banigama residents possessing more than 5 hector of land.

The influence of land holding in the treatment pattern could be further illustrated with the help of the following case study.

Case No. 1 (Household No. 138)

Madan Tharu, aged 30, a resident of Banigama VDC- 7, owns 3 hector of land and four buffaloes. By profession he is a milkman and has to go to market twice a day in order to sell milk. He is suffering from severe stomach pain and although he has been taking medicine regularly for two years, has been unable to get rid of his problem completely. When he feels extreme pain, he takes the painkiller prescribed by the local medical shopkeeper. Asked about the level of his health awareness, he replied, "I always have to go market twice a day so, I always buy medicine from the medical shop as it is easily available in the market." About the professional capabilities of the shopkeeper, he said, "He doesn't have any formal training but has huge experience in this field. I have a very close relationship with him and so I prefer to buy medicine from there."

It is clear that Madan gives preference to the medical shop for two reasons. Firstly, he always goes to the market anyway, so it is convenient. Secondly, he has a close relationship with the shopkeeper and is therefore comfortable with the medical shopkeeper. This case study corroborates the view that the health seeking behaviour differs in terms of the size of holding, convenience of the sick person, and his relationship with the service provider.

Income and Health Seeking Behaviour

Income is one of the major factors that determine the mode of treatment adopted. Those with high incomes are able to initiate other income generating measures to boost their economic status and with solid economic background they can afford even modern expensive treatments. The economically well off can afford treatment, whether Allopathic or Ayurvedic, within the country or abroad. Those with more money can afford to pay private qualified practitioners on home visits but the poor cannot. In Banigama VDC, Brahmin/Chhetris generally have higher income; the comparative advantage of this group is combined in better educational status, relatively large land holdings and wide exposure. Improvement in economic condition thus can influence education, people's awareness and health behaviour.

Table 4.3 below presents the variation in the mode of treatment among the different income groups in Banigama VDC. The data clearly indicate that some households with high incomes consult private qualified health practitioners. Some 30.77 per cent of the households in the high income group (> 25 000) have stated that they consult private qualified practitioners at the onset of their illness. All the other income groups, with the exception of Tharu households, first seek the advice of medical shopkeepers. The majority of Tharus, even from NRs10000-15 000 income group first consult their traditional/faith healer. However, the NRs5000-10 000 Tharu income group households also seek help (57.89 per cent) initially in medical shops. This can be attributed to the easy accessibility of medical shops and the fact that cost wise, it may be cheaper than traditional/faith healers. Even though immediate cash-down may not be required while undergoing treatment with traditional/faith healers, the cost of goods like rice, goat, pigeon, chicken, duck etc. when converted into monetary terms exceeds the price of medicine given by the medical shopkeeper. This finding is based on the researcher's observation and informal discussions in medical shops and with the locals during the course of fieldwork.

Table 4.3: Household Health Seeking Behavior According to Income Level

Behaviour	5 to 10 thousand		10 to 15 thousand		15 to 20 thousand		20-25 thousand		> 25 thousand		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
No Response	-	-	1	3.70	1	4.17	-	-	-	-	2	1.14
Traditional/ Faith Healer	27	28.42	13	48.15	4	16.67	2	11.76	2	15.38	48	27.27
Grocery	3	3.16	1	3.70	1	4.17	-	-	-	-	5	2.84
Medical Shop	55	57.89	10	37.04	12	50.00	10	58.82	5	38.46	93	52.84
Knowledgeable Person	-	-	1	3.70	1	4.17	-	-	-	-	2	1.14
Quacks	3	3.16	1	3.70	1	4.17	-	-	-	-	5	2.84
Helath Worker	2	2.1	-	-	-	-	-	-	1	7.69	3	1.70
Helath Post	4	4.21	1	3.70	2	8.34	4	23.53	1	7.69	10	5.68
Hospital	1	1.05	-	-	1	4.17	-	-	-	-	2	1.68
Private Qualified Practitioner	-	-	-	-	1	4.17	1	5.88	4	30.77	6	3.41
Total	95	100.00	27	100.00	24	100.00	17	100.00	13	100.00	176	100.00

The case study below illustrates the variation in health seeking behaviour according to the income level.

Case No. 2 (Household No. 132)

Jagat Bahadur Subedi Chhetri, 55, of Banigama VDC-9, is a retired Army man. He has been suffering from back pain for the past six months and is undergoing fortnightly treatments in one of the private clinics in the district headquarters. He is entitled to free treatment in the Birendra Sainik Hospital, Kathmandu but, due to the distance, is unable to take advantage of the provision.

When questioned about why he has opted for treatment in a private clinic he responded by saying: "There aren't sufficient medicines and equipments at the health post. I don't believe in traditional healers. In private clinics, however, the health practitioner scrupulously conducts the check ups and offers better treatment. After all, Health is Wealth." Jagat Bahadur Subedi, thus, seems very much aware of the importance of good health in life. This can be attributed to his education and wide exposure while serving the Army. Besides this, his income exceeds NRs 25000 annually and so he can afford the physician's charges and can buy the medicine and other clinical services as needed.

Preferred Treatment Patterns

There is an assortment of duality or pluralism in medical science. While individuals may resort to any home remedies, traditional faith healers, grocery, medical shop, community advisors, quacks, health workers, health posts, hospitals or private qualified practitioners for treatment, these treatment pattern can all be categorized overall into two broad clusters: modern treatments and traditional treatment patterns. The modern pattern of treatment includes medical shops, health workers, health posts, hospitals and private qualified practitioners. Traditional treatments include home remedies, traditional faith healers, quacks etc.

The mode of treatment preferred is largely influenced by socio-economic factors, culture, income, size of land holding and education. Individual perceptions also shape differences in the mode of treatment. Although people may be literate, it is not always necessary that they follow modern treatment patterns. The case study below would illustrate this point.

Case No. 3 (Household No. 76)

Ram Bilas Chaudhary, aged 62 and a resident of Banigama VDC-4, is a reputed traditional faith healer. He states that his 'Bidhaya' (knowledge of magic spell) was handed down to him by his grand father. He is locally known as '*Dhami Ba*'.

In between his busy schedule, **'Dhami Ba'** recounted his career, saying that he had entered his profession at the age of 14 and had healed innumerable people since then. He narrated the general mode of treatment in Banigama as thus: "When somebody is physically injured, they go to medical shops; for serious cases like fractures and operations they go to health post or hospital because this sort of treatment is not possible in medical shop." Elaborating the mode further he said: "When villagers contract illnesses like '*Pahelo Rog*' (Jundice), they consult an *Ayurvedic Baidhya*, but problems like stomach pain, fever and headaches are taken to traditional faith healers. I also advise patients to go to the appropriate places for treatment if it is beyond my repertoire."

Table 4.4 below presents the respondents' preference for specific treatment patterns.

Table 4.4: Household Preference for specific Treatment Patterns

Caste/Ethnic Group	Tradition		Modern		Total	
	Number	%	Number	%	Number	%
Brahmin/Chhetri	2	7.41	25	92.59	**27**	**100.00**
Tharu	13	11.40	101	88.60	**114**	**100.00**
Untouchable	1	7.69	12	92.31	**13**	**100.00**
Terai Dwellers	6	27.27	16	72.73	**22**	**100.00**
Others	-	-	2	100.00	**2**	**100.00**
Total	**22**	**12.36**	**156**	**87.64**	**178**	**100.00**

Even though a large majority (87.64 per cent) of the households covering all castes/ethnic groups preferred modern treatments, some could clearly not afford it. This was reflected in the varying treatment awareness among Banigama residents. Their understanding regarding modern treatment was, however, limited to consulting or buying medicine in medical shops, and does not necessarily include consulting the auxiliary health workers and paramedics. In contrast, Table 4.4 indicates that 12.36 per cent of Banigama dwellers believe exclusively in and prefer traditional treatment patterns.

The findings of this study also suggest that the length of a medical consultation may depends on class, income and caste/ethnicity. The only difference is that medical consultations in Banigama take place in medical shops as they are cheaper compared to

qualified practitioners. This is consistent with the hypothesis that the economy (substructure) is the dominant factor affecting everything else. It is good sign that the people of Banigama are inching towards the modern pattern of treatment, but their understanding of modern medicine and their predominant dependence on the medical stores and unqualified "doctors" smacks of the possibility of the growth of a scientifically based modern health culture.

The continuation of the traditional beliefs also deeply impairs the people's movement to modern health culture. We have illustration of this point in the following case study.

Case No. 4 (Household No. 63)

Ramchandra Tharu, aged 43, a resident of Banigama VDC-3, has passed class four from the local school and has been working in a Jamindar's house for the past five years. Ramchandra Tharu had a persistent eye problem and was undergoing treatment of a traditional healer.

He explained his preference for the traditional healer thus: "Traditional healers have been treating my family's health problems very well since as long, as far as I can remember. I have full faith in them and believe that they will cure my eye problem."

When questioned about his treatment pattern, he revealed that the medicines used are local herbs such as Harro, Clove, leaves of Citrus plants (Lime and Tamarind). There is a special bushy plant, locally called '*Bhardhana*', which yields a milky liquid from its stem and is used for eye treatment. This liquid is applied on the affected eye. Another popular method of eye treatment is that people warm lemon leaves together with ghee and apply the mixture on the eyelid to warm it and alleviate the problem. We can see here how much Ramchandra Tharu is influenced by the traditional patterns of treatment.

Interestingly, Ramchandra Tharu's brother, Rajan Tharu, aged 39, was treated in the district hospital. Being asked on this Ramchandra revealed that his brother had to be treated in secrecy in the district hospital for alcoholism. Rajan Tharu used to work in Kathmandu and earned good money. He started drinking local liquor (Raksi). When he went back to village he was already heavily addicted to alcohol. Raksi was easily available in his own house and neighborhood so without any misgivings from family members, he continued drinking heavily. An addict, he was taken to the hospital for treatment. Investigations at the hospitals revealed that his liver and lungs were already damaged.

Rajan's health seeking behaviour differed from that of his brother in two ways. Firstly, he was educated and had a wide exposure while working in Kathmandu. Secondly, he was an alcoholic and accepted that his illness was due to alcohol. Raksi is accepted in Tharu

culture and is ritualized in many occasions. Almost all adult Tharu men drink excessive alcohol, which impairs their economic well being. Alcoholism can be considered an illness in Banigama without a doubt, because, especially among the Tharus, it is a threat to physical and mental wellbeing. The average Tharu people do not see any harm in excessive consumption of alcohol and urgently need to be educated about this, as well as the value of being hard working and thrifty. From such findings, it is also possible to infer that 'ethnicity' might have a role in people's susceptibility to specific type of illnesses. In Banigama, the Tharu ethnic group clearly exemplifies poor health awareness. The sick are taken to the '*Guruwa*' (traditional/faith healer/ and '*Badghar*' (opinion leader) and not to relevant medical practitioners.

Awareness of Female Community Health Volunteer (FCHV) and Traditional Birth Attendant (TBA) services

Female Community Health Volunteer (FCHV) and Traditional Birth Attendant (TBA) are two volunteer groups within the government's peripheral health services that are active in the study area. FCHV and TBA have differing goals and objectives; while FCHV is focused on the female population in general and include programs such as immunization, health awareness programs and other social works, TBA is designed to support just the delivery of babies.

Table 4.5: Households Awareness of FCHV*, TBA Services.**

Caste/ethnicity	Yes		No		Total	
	Number	%	Number	%	Number	%
Brahmin/Chhetri	26	96.30	1	3.70	27	100.00
Tharu	107	93.86	7	6.14	114	100.00
Untouchable	12	92.31	1	7.69	13	100.00
Terai Dwellers	16	72.73	6	27.27	22	100.00
Others	2	100.00	-	-	2	100.00
Total	**163**	**91.57**	**15**	**8.43**	**178**	**100.00**

*FCHV: Female Community Health Volunteer
** TBA: Traditional Birth Attendant

The data in Table 4.5 suggest that there is widespread awareness among the people of Banigama VDC of the system of FCHV and TBA. However, the awareness varies according to caste/ethnicity. High caste/ethnic groups appear to have a better understanding of FCHV and TBA. The table indicates high degree of awareness in the group belonging to lower castes as well. This might be because of a samall number of respondents or because of their

active participation in the community. Nonetheless, this has to be considered as an exceptional case.

Case No. 5 (Household No. 44)

Manti Yadav, 38, resident of Banigama-2, is a mother of four. She gave birth to her children at home. Her major duty at home is to look after her children and do the household chores. In her free time, she works as a waged labourer in the village.

She is basically illiterate and does not like to leave the house except for paid work as a field labourer. She seemed to be aware of the importance of health as she is giving a good environment to her four children. But she seemed ignorant of FCHV and TBA services. She says, "I gave birth to my four children at home without any difficulty. There was no one to help except my mother-in-law and a neighbour." She further says, "There may be FCHV and TBA services but I don't like to leave home."

This case study above indicates that FCHV and TBA services are still not accessible to all Banigama residents. Those with regular exposure out of their houses may have taken advantage of this facility but those like Manti Yadav have not.

Assessment of Sub-Health Post Services

The sub-health post is the only governmental health facility that provides nearly free of cost services to the villagers. But the mere provision of services does not ensure that local needs are met. A close interaction between the service providers and recipients is needed to be able to assess both the level of need and the service provided. The more the local population becomes aware of the services available, the better they can mobilize them. Service assessment largely depends on education, understanding and the treatment sought. Besides, people view organizations on the basis of their active participation/involvement and service provided. When organizations provide good services, they are evaluated separately and held in esteem. This principle is also the same for places offering inadequate treatment and making a negative impact.

The table below (Table 4.6) presents an assessment of sub-health post services in Banigama.

Table 4.6: Household Assessment of the Sub-Health Post Services

Reason	Assessment									
	Very Good		Good		Fair		Poor		Total	
	No.of HH	%	No.of HH	%	No.of HH	%	No.of HH	%	No.of HH	%
Treatment	1	3.57	4	16.67	14	37.84	27	20.00	**46**	**20.54**
Availability of Medicine	1	3.57	3	12.50	4	10.81	78	57.78	**86**	**38.39**
Service of Health Worker	3	10.72	15	62.50	17	45.95	28	20.74	**63**	**28.12**
Registration Including the Cost	23	82.14	2	8.33	2	5.40	2	1.48	**29**	**12.95**
Total	**28**	**100.00**	**24**	**100.00**	**37**	**100.00**	**135**	**100.00**	**224**	**100.00**

Note: Because of multiple responses the total exceeds.

A component of the HMG/N peripheral health service plan, the sub-health post at the VDC level has one health assistant, one mother-child health worker, one village health worker and a peon. The health post receives medicine worth NRs 25,000/- annually and is managed by the VDC. The data in Table 4.6 reveal that 37.84 pr cent of the respondents rank the treatment at their sub-health post as fair, while 20 per cent of the respondents rate health post treatment as poor. Likewise, only 10.81 per cent responded favorably about the availability of medicine in the sub-health post while nearly 58 per cent complained of poor availability of medicine. The respondents were also not too happy with the kind of services they receive from the health worker. From such findings, it can be inferred that a lot of improvement is needed in health delivery services which are at a peripheral level in Nepal. The medicines available at the sub-health post in general are limited to paracetamol and de-worming tablets. To make matters worse, even these medicines have a limited shelf life of only two-three months when they arrive at the SHP as they tend to be close to the expiry date.

The scarcity of appropriate medication means that villagers often had to return home empty handed. This has understandably resulted in projecting a negative image of the SHP among locals.

One could thus assess the condition of the Banigama health post as glaringly inadequate. This is partly due to the government's inability to provide timely and sufficient medication for the health post. Secondly, the Banigama population depends largely on medical shops and traditional faith healers so that the health post management committee does not find it prudent to pressurize the government to improve the sub health post services. Thirdly, the hospital management is not responsive and efficient enough to meet the health

requirements of the people; inefficiency and corruption on the part of the hospital officials and absence of motivation to serve the people often cripple the public health system in realizing its objectives.

Case No. 6 (Household No. 26)

Rajani Kami (a Blacksmith), aged 22, unmarried and a resident of Banigama VDC-1, has been suffering from menstruation related problems for the past 6 months. She belongs to the Blacksmith, Untouchable group.

Her responses to questions about the health post services sounded like a tale from a century ago. She said, "I went for a check up in the health post, but the in-charge didn't want to listen to me as I am from the Untouchable group. However, after repeated requests, I was called into the room for a check up. When I told about the menstruation problem and that I had been bleeding excessively for 3 days, he ran from the room scolding me for making him polluted. Thereafter I have never been to the health post again."

It is a general system in Nepali society that women do not touch males during the first four days of menstruation. Women are said to be polluted up to the fourth day and only after taking the purifying bath on the fourth morning they are eligible to carry on normal everyday activities. While it is understandable that this is more prevalent in rural areas such as Banigama, it does not go with the modern medical norms to discriminate service seekers on the basis of unsociability and pollution.

"Pollution" as a Bottleneck to Health Services

Nepal is the only Hindu kingdom in the world. Like every culture, Hinduism has its own cultural rituals and superstitions. Any death or childbirth in the family automatically "pollutes" household members for a certain period. Likewise ladies are considered to be polluted at the time of menstruation. When someone loses parents, the sons have to observe '*Kiriya*' (mourning for 13 days). During this time, nobody can touch them. If in case they are touched, the *Kiriya* should be repeated from the very beginning. If in case the sons (who are in *Kiriya*) get sick, they are in trouble as nobody can touch them. In this case, family members go to show '*Chino*' (birth chart) to a Brahmin priest. Following their suggestions the family members perform religious rituals to speed up the mourner's recovery. In this condition neither the traditional healers nor doctors are called because the patient cannot be touched for 13 days. The family members wait till 13 days but if the case is very critical, the

family members themselves go to either medical shop and explain the symptom of sickness or go to traditional faith healers and bring some medicine from them.

The situation is a bit different with the lady Rajani Kami, as she was having extended menstruation. Menstruating females can not be touched for four days as they are considered polluted. So, when such females get sick they do not go to traditional faith healers whom they are familiar with as there is a conception that touching males or traditional faith healers pollutes them as well and is considered a great sin. So during the menstruation period, they go to an unfamiliar medical shop and as far as possible avoid direct contact with the shopkeeper when taking the medicines.

The following case study documents the general mode of treatment when the females are polluted.

Case no. 7 (Household no. 6)

Gyanu Subedi, a 28 year old Brahmin, resident of Banigama VDC -1, and the mother of three children, was living happily in a small family.

She had two buffaloes and a cow. Her husband looked after the livestock and she shouldered the responsibility of household chores and looked after her children. She never went to work in field as she was Brahmin and also physically weak. She looked sickly and had been suffering from stomach pain time and again.

When this researcher reached her house, she was lying on the verandah floor. She shifted a bit further in the corner asking the researcher not to come closer as she was menstruating. When questioned about the health awareness during menstruation, she said, "When I have menstruation, I don't go anywhere for treatment because others get polluted when they touch me during the course of examination". From her, the researcher came to know that she had finished her regular medicine for stomach pain but was planning to visit the *Janne Manchhe* only after her fourth day.

Summary

Discussion in this chapter suggests that the Banigama dwellers are clearly greatly influenced by medical pluralism. People have differing perceptions that influence their health awareness. Medical pluralism in Banigama VDC is explained by the fact that besides home remedies, people seek treatment from medical shops, grocery shops, knowledgeable persons,

traditional/faith healers, quacks, health workers, health posts and private qualified practitioners.

Caste/ethnicity, land holding, income level, education awareness and culture of the people greatly influence their health awareness. Health awareness differs largely in terms of caste/ethnicity. In Banigama VDC, Brahmin/Chhetris are considered high castes; Tharus and Terai dwellers are considered middle castes while the Untouchable castes are placed at the bottom of the caste hierarchy. It has been generally found that the Brahmins and Chhetris are more knowledgeable compared to the members of other castes/ethnic groups in Banigama, and go to medical shops and health posts more often to seek medical treatment.

All castes/ethnic groups in Banigama have placed their preference for the medical shops on top of all the modes of treatment they seek because the medicine is easily accessible there and they do not have to pay for the doctor's prescription. Another factor that influences their preference is that they do not have to waste time and that they often develop familiarity with the medical shopkeepers pretending to be qualified medical practitioners. The latter, however, is primarily interested in pushing medicine sales. The case studies presented show that the majority of interviewees showed preference for the medical shop for the treatment. In case no.1, Madan Tharu cited the accessibility of medical shop as an advantage. In contrast, Ramchandra Tharu in case no.4 prioritized the traditional healers. He was greatly influenced by the traditional faith healers because his family members were treated satisfactorily by them. From this it can be argued that he was influenced by the "Demonstration Effects".

Among the castes/ethnic groups, the Tharu and Terai dwellers are found more in the habit of seeking treatment from the traditional faith healers and appear to be greatly inspired and influenced by them.

The health seeking behaviour in Banigama is also seen to be greatly influenced by the size of land holdings. The landless or those with very little land, show a preference for traditional faith healers as these people are constrained by the compulsions of subsistence economy and their faith in traditional pattern of healing. But as the size of land holding rises, there is a proportionate decline in the use of traditional mode of treatment. Those with more than 5 hector of land show a clear preference for private qualified practitioners. This can be attributed to their access to a sound material base and to their greater awareness of health and illness. There is a general belief that private practitioners provide better care in the village, which is costly and can be accessed by the people with sound economic base. Table 5.2 presents the health-conscious behavior of households in Banigama VDC according to their

land holding. As in earlier cases, medical shops appear to be the first place visited by all households irrespective of land holding. The shopkeeper listens to the symptoms recounted and prescribes medicine. It was noticed during fieldwork that the locals tend to incorporate the visit to medicine shops for the needed medication into their routine visits to the Bazaar.

Another factor determining health awareness is income. Without income no one can expect quality treatment. In general, people who have high income are economically prosperous and think critically, so they do not waste time by consulting faith healers but go to formal health centers for treatment straight away. In contrast, the economically backward do not have the means to take the sick to appropriate centers for quality treatment although they are conscious of the importance of good health. In Banigama VDC, the Untouchables are economically and socially deprived and are not allowed to enter houses of higher castes/ethnic groups. People of higher castes/ethnic groups do not even drink water touched by them. These people generally do not have good education and have comparatively low incomes. This economic limitation is an obstacle that prevents them from taking sick family members to the district hospital or to any other good health center for the further treatment.

Our observations highlight the increasing popularity of medical shops in Banigama VDC. In average more than 50% of Banigama residents stated that they prioritize medical shops for treatment. The medical shops have become the cheap and popular place for treatment as this mode of treatment does not involve consultation fees. Medical shops are also easily accessible whenever required. Interestingly, households earning less than NRs (5000-10000) annually are clearly dependant on traditional faith healers. Traditional faith healers are deeply rooted in the study area and are in great demand among the locals for treatment. Their value among the rich households (whose earning is >25000) however, is nominal compared to that among the poor ones (whose earning is between NRs 5 000 and 10 000).

Similarly, the mode of treatment also differs depending on the nature of disease/health problem. Simple health hazards such as superficial injuries and cuts are taken to medical shops. Fractures are taken to the district hospital as the medical shops are not equipped to deal with fractures. Diseases such as Jundice are referred to Ayurvedic Baidhyas. Problems such as stomach pains, fevers and headaches are taken to traditional/ faith healers.

In Banigama VDC, FCHV and TBA are also seen to be working actively. These are the institutions working among the female population. A large number of people in the study area are aware of FCHV and TBA health facilities.

Interestingly, only a few among the respondents admitted of the habit of visiting the health post in the first instance. This could be because the public health system has failed to generate enough confidence in the public about the value of the services it offers through the health posts. The sub-health post only receives medicine worth NRs 25000/- per year, which is adequate for just 3- 4 months. In addition, the health posts can only stock simple medicines such as paracetamol, and not the other essential drugs for the everyday use of the people or for the treatment of critical cases.

In addition to the mismanagement and inadequate medicine the health post is often constrained by the superstitious mindset of the health staff and their discriminatory treatment of the people belonging to the lower castes. We have seen, in case No. 5, that when Rajani Kami (Blacksmith) came for treatment during menstruation, the attending health worker did not want to touch her as she was considered polluted. So, both the notion of pollution and caste background of the patients are seen to influence their treatment even in government supported health post.

Although some of the respondents in the case study prioritized medical shops for treatment, traditional methods of treatment are deeply rooted in Banigama. So, in general, the Banigama population gave preference to medical shops as the initial point of consultation, then to traditional faith healers, and only then to the sub health post in that order.