# Chapter VI

## State Health Strategy, People's Response and Changing Health Awareness

This chapter deals with HMG/N's health strategy in the periphery and how the local people respond to the services provided to them. The changing health awareness of the local people in Banigama has also been documented.

Every state/government has specific policies and strategies to deliver basic services to its people. The role of the government in the social sector, particularly in the delivery of health services, is crucial because there are many programs where the costs of providing services cannot be fully met by the people themselves, even though the social returns may be high. In the area of preventive health, for example, the government has to live up to its fundamental role and provide the services needed to the people in general and particularly to the needy people. Providing health services is also directly linked to human resources development, which is essential for reducing human poverty and improving the quality of life of the general population. In order to meet its social commitments every government allocates a certain percentage of its annual budget to the health sector. However, in most developing countries including Nepal, delivery of health services remains very weak. In the Nepali context, although an extensive network of primary health care centers has been established, it has not been functioning well in many respects. Some of the reasons for this are: lack of adequately trained manpower, medication, equipment and physical infrastructure. Overall, the health sector is crippled by inadequate funding, mishandling of the available resource, limited capacity for supervision, and lack of coordination among the agencies.

There has been a tremendous spurt in the growth of non-governmental organizations (NGOs) in Nepal after the restoration of multi party system in 1990. It is estimated that about 24,000 NGOs are registered in Nepal today. Of the total number of NGOs registered at the social welfare council, approximately 256; i.e. 6 per cent are working in the health sector. The range of services provided by NGOs includes preventive, promotive, curative and rehabilitative services. Some NGOs are working specifically in the field of HIV / AIDS prevention and awareness. HMG/N's strategy has been to involve NGOs in HIV / AIDS prevention and awareness generation activities (MOH, 1999). Unfortunately, NGOs in general operate in easily accessible areas. A pertinent example of this can be cited from the present study area. Currently there is no NGO operating in Banigama area. As HMG/N is committed to decentralizing its activities, the management of the sub health post in VDCs is

being transferred to community management committees. Funding for these health posts will be channeled through local DDC/VDC bodies. Unfortunately, at present the DDC/VDC (local body) is not equipped to monitor the health activities (NPC, 2003).

The conference in Alma Ata on primary health care, conducted with the objective of providing low cost accessible and relevant health care, has recognized the importance of local participation (WHO, 1980). The world summit for Social Development (UN: 1995), has aimed to expedite the effort to achieve the goals of national health-for-all strategies based on equality and social justice in line with the Alma-Ata Declaration on primary health care by developing or updating country action plans or programs to ensure universal, non-discriminatory access to basic health services including sanitation and drinking water to protect health, and to promote nutrition, education and preventive health programs. It further aims that by the year 2000, all the peoples of the world will have access to a certain level of health that will permit them to lead a socially and economically productive life, and ensure primary health care for all. The concept of access assumes a central role in achieving equity in health. The purpose of increased access is to ensure that all people, particularly the most vulnerable groups, women and children, the rural population, the poor, the under-privileged and the marginalized, are able to make use of the health system as appropriate to their need. However, health sociology in developing nations has a far greater challenge to face and a wider canvas to cover as a part of its nature and scope.

Taking these declarations and Nepal's social commitments into account, the government has formulated and implemented a more holistic second long-term health plan (1997 – 2017). It recognized the need for self-reliance, gender sensitization, decentralization, and effective and efficient management to provide equitable access to the quality health services necessary for improved health status of the population (HMG / N, MOH, 1999).

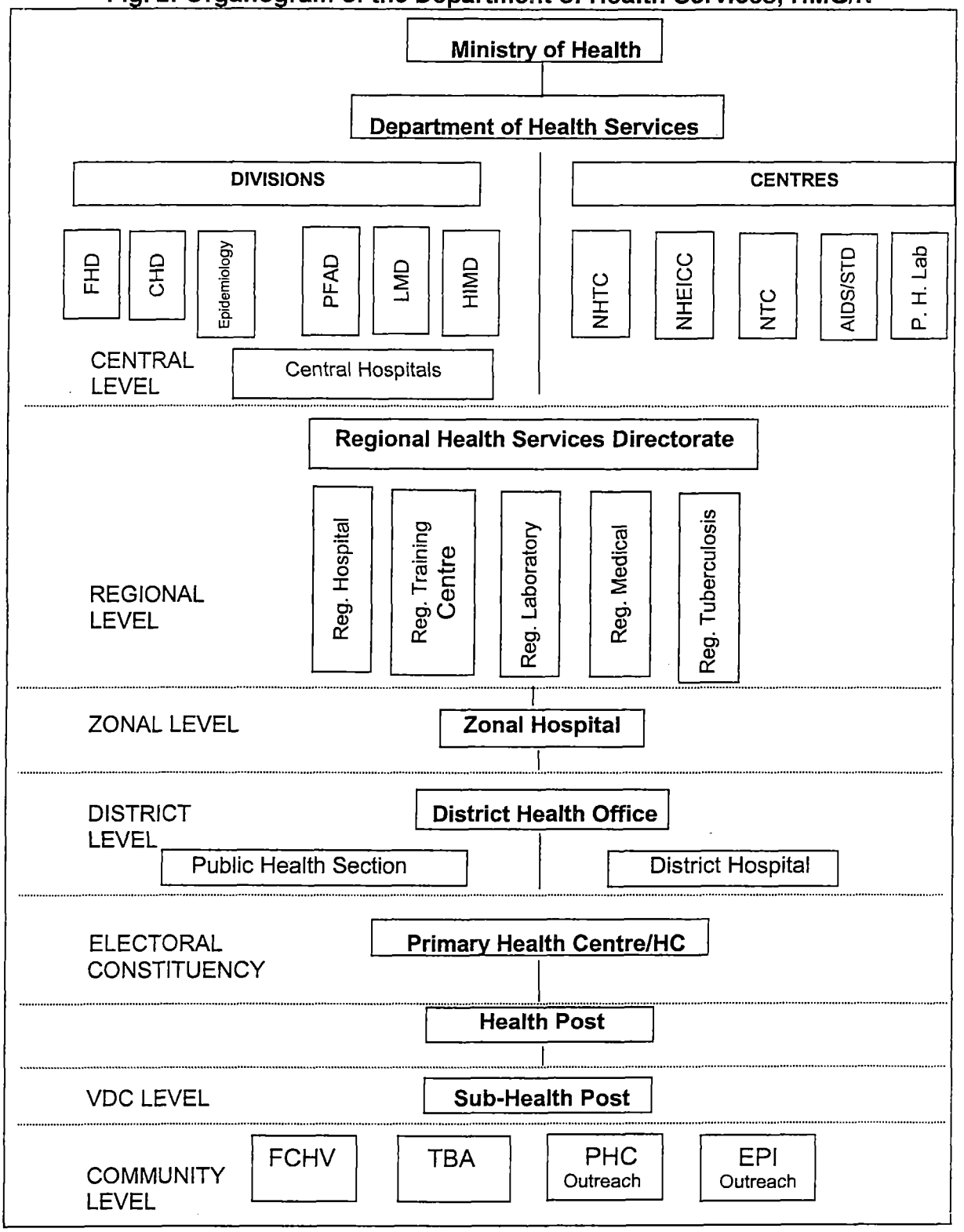
Health problems are not simply confined to health but are also part of larger social problems requiring more advocacy efforts and basic social services. SLTHP has unfortunately been unable to address all these factors. However, the government has felt the need of a 20-year perspective plan and the necessity of addressing the health needs of the following groups whose health needs are often overlooked:

- The most vulnerable groups
- Women and children
- The rural population
- The poor, and

- The underprivileged and the marginalized.

With a view to providing services focusing on the periphery, to the villagers, HMG / N has modified its organogram. The prevailing network of health services is presented in Figure 2.

**Fig. 2: Organogram of the Department of Health Services, HMG/N**




Source: DoHs, Annual Report, 1999/2000

The following paragraphs would give an idea of the health infrastructure currently operating in the periphery.

**Sub – Health Post**

At the VDC level, there is a provision of a sub health post with four staff and an annual allocation of NRs. 25,000 /- for medicines. The health post management committee with the help of the village development committee manages the sub health post. At the community level, there is a provision of four components; Female Community Health Volunteers (FCHV), Traditional Birth Attendants (TBA), Primary Health Care (PHC) and Expanded Program on Immunization out reach (EPI).

**Female Community Health Volunteers**

The government has made a provision for female community health volunteers with a view to providing preventive and primary health services to women by women. The number of such people in any community varies depending on the total population in a locality. To serve 400 people in the Terai, for example, there should ideally be one FCHV in each ward (each VDC is politically sub-divided into 9 wards). But because of limited resources, this mechanism is not in place. The government has therefore modified this approach to establish one FCHV per ward and as a result there are 9 FCHV, one each in the 9 wards of the VDC. The Village Health Worker, a paid staff in the sub-health post, organizes mothers' groups in each of the ward, and the mothers' group, in turn, selects a potential candidate to work as a FCHV in the ward. The candidate is given a 10-day basic training with tiffin allowances. After completion of the training, she is given a health kit with medicine worth NRs 300, which she needs to distribute among the needy in her ward and collect money from the villagers in order to re-fill her kit. So, the kit is provided on the basis of re-cycling the medicine in it. She is also given a small signboard with logo, which she is supposed to hang in a noticeable place in her house. FCHVs are given 3-day refresher trainings twice a year. As she is a volunteer, she does not get any salary.

**Traditional Birth Attendants**

Within the sub-health post, there is a provision for traditional birth attendants to assist the cases of delivery in the village. It is based on the population size; one TBA is recruited and trained to serve every thousand people. Preference is given to those who have already been

assisting deliveries indigenously as '*Sudeni*' and to women of lower castes and disadvantaged groups. VHWs are responsible for identifing potential '*Sudeni*' for training. As this is not done on a ward basis, there may be more than one '*Sudeni*' from one ward. The required number of *'Sudeni'* recruited for a population of the VDC is provided a weeklong training. They also get tiffin allowance during the training period. After the training, they are given a 'safe motherhood kit' for demonstration and sale in the houses where they provide services. Refresher training is arranged for them once a year. Since they are volunteers, they do not get a salary.

**Primary Health Care Outreach**

The second long-term health plan has clearly envisaged the decentralization of primary health care services, but is yet to be implemented. It is stated that the plan will provide for a sequenced devolution of services up to the VDC level. VDC capacities will be developed in order to evaluate the effectiveness of their programs and negotiate for the budgets accordingly in the respective District Development Committees. The DDC and VDC will develop plans for local support and resource generation. Such plans might include the allocation of district resources to the VDC and sub-health post level and include support for local resource mobilization schemes. The money raised through local resource generation is to be kept at the local level and be used to improve the quality of care. The management is assigned to the Village Development Board. The major activity will be to manage medibanks and mobile clinics in the village.

**Expanded Program on Immunization Outreach**

Immunization clinics are organized twice a week in the sub-health post. Polio booths are arranged twice a year in the villages. Polio, measles and neonatal tetanus are still reported in Nepal. The goals of the expanded immunization program was to immunize at least 90 per cent of the children below one year of age against EPI target diseases by the year 2000, and 90 per cent women of reproductive age against tetanus (MOH, 1999).

**People's Response to the Primary Health Services**

The success of any government health initiative or programme largely depends on how the common people respond to them. Health services would have no value unless the local population is served well. Local feedback is vital for the satisfactory functioning of any

organization. Data collected from the interviews with auxiliary health workers, other front line health catalysts and with ordinary citizens have helped us grasp the local views about primary and preventive health in the study area.

**Interview 1 (Key Informant)**

Madhav Regmi, resident of Haraichha VDC-7, has been the In-charge of the sub health post in Banigama for the past year.

While he stressed that the patient flow was increasing, it was clear that patients still preferred medical shops and traditional/faith healers and only went to health posts if all else failed. It is widely understood that the cases of injuries and cuts are brought to the health post but other problems are taken to alternative facilities like faith healers and medical shops first.

Regarding health status, Mr. Regmi said, "The villagers are poor. They are not able to overcome their cultural prejudices. Besides, the health post does not have adequate medication and necessary facilities so the villagers in general are not healthy."

Questioned whether the medicines provided were enough, he said, "We are not able to provide them with even anti diahorrea and de-worming tablets. We just give them the prescription, and when the patients go to the medical shop, the shopkeeper instigates them by saying "I could have given that medicine myself, why do you go to the health post?" When questioned about HIV/AIDS, he said, "I think there is no AIDS patient in the village; even if there are any, they don't come here because HIV can't be tested here. There is also the stigma attached to AIDS, so to save face, they are more likely to go where they will not be recognized, either to the district hospital or to India."

In response to a question about morbidity and mortality among children from birth to the age of 4, Mr. Regmi said, "Child morbidity is high in Banigama VDC. The main diseases affecting children are diarrhea, measles, malnutrition and respiratory infections. It's a pity that we can do nothing for them because the government has not understood the problems faced by the villagers." He referred to superstition, ignorance, illiteracy, social evils and poverty as barriers to preventative health care. He thinks that unless these barriers are eradicated, the health status of Banigama will not improve.

The interview of Mr. Regmi gives us some idea of the poor condition of the health post; it is only just able to provide paracetamol and other ordinary medicines for cuts/injuries.

The case below presents the FCHV's point of view of primary and preventive health.

**Interview 2 (Key Informant)**

Mrs. Ganga Subedi, 29, resident of Banigama VDC-3, has been working as a FCHV and thus gained valuable experience in the health field. When asked about the problems faced by women in Banigama VDC, she said that women of various ethnic groups have differing health statuses. Brahmin/Chhetri women are comparatively more knowledgeable and economically capable. They take care of their health, keep their surroundings clean and understand the importance of immunization. These people are also relatively more supportive of family planning measures and visit the health post for *depo–provera* (disposable) injection in larger numbers compared to other castes/ethnic groups. But the problem is serious among the Tharu, Terai dweller and Untouchable communities as these people are minimally educated, culturally dictated and very orthodox.

She further elaborated that the people of Banigama are illiterate and very poor; as a result, they are rooted in their traditions and superstitions. These are obstacles to a healthy life.

Illustrating the awareness of preventive health care in the village, she says' "When villagers feel well, they do not take heed of the preventative measures to be taken for a healthy life. They think that they will never get sick; even when they do get sick; they consult either medical shops or traditional/faith healers in the first instance.

When asked about the problems she faced while working in the village, she said, "I often get complaints from the villagers for asking for money for the medicine I give them. The villagers say "***Doctornii Didi***" (meaning doctor sister) you get medicine free from the government but ask us to pay. You are already getting a salary from the government. Why do we have to pay?"

She further says that the health kit that she has been provided needs to be recycled. She admits to administering medication free of charge to those who come to her with cut injuries from the field.

She further says, "My health kit is now empty, I told this to Regmi Sir (the health post in-charge) but he told me to collect money from the villagers for treatment. That is impossible; I am tired of asking Regmi sir for medicine and have stopped now".

Although she mentioned her problems, she isn't bitter about it and laughs it off. About the different kinds of immunization available, she said, " I have told married women in the village to go to the health post on Sunday for the Depo–Provera; a reasonable number

of women are now going there. One advantage of this is that while they go to health post, they also take their children and seek treatment for them if necessary."

The case below presents the experience of a TBA working in the village.

**Interview 3 (Key Informant)**

Mrs. Shilu Budhathoki, 58, a resident of Banigama Ward 6, is a trained TBA. She had this to say about the child deliveries in the village, "Before receiving training I used to assist deliveries in our locality on my own, but now that people know that I am a TBA my responsibility has grown. Sometimes, even people from adjoining villages call me. I feel very upset when people do not buy a safe motherhood kit. They feel that their duty is over when they buy a new blade."

She went on saying, "Before my training I was highly respected. People used to feed me "***Masu Bhat***" (rice and meat), and gave new clothes and *Sari*. When a son was born, I was sometimes given 2 pairs of *Sari*. But now I don't get even a simple cup of tea. The villagers think that I am government service holder and get a salary for my duties. What to do? Who understands my problem?"

Similarly, the following interview would illustrate the adequacy of management of the sub-health post by the sub–health post management committee.

**Interview 4 (Key Informant)**

Mr. Jola Ram Tharu, 64, a resident of Ward 2, is the Chairman of the sub-health post management committee. He was ***Pradhan Pancha*** (chairman of VDC) when the Panchyat system was operational in Nepal and has extensive experience of management at the local level.

About the management of the health post, he said, "Some three years ago I was made the chairman of the health post management committee. A meeting was held immediately after I assumed the responsibility but after that no meeting has been called. I don't know how **Regmi Baje** (health post in-charge) runs the health post. Asked about the monitoring from the government and from DDC, he said, "What do they do? They are all working in urban areas. They don't understand how health activities operate at the village and local level. That explains why our health post does not have sufficient medicine, and people are compelled to go either to medical shops or to faith healers."

Thus the information gathered from interview of some key persons working at the field level in the field of health help us draw a close look at the perceptions of front line health catalysts and the sub-health post management in Banigama VDC. The health post is arguably inadequate in meeting local needs, as it does not even have medicines necessary for treatment. Those with complicated diseases are not given medicine but are referred to the district hospital. This is due to the health post's meager budget as well as mismanagement of services. Current health post activities are limited to immunization, inoculation and giving simple medicine, which is clearly not adequate.

The problems faced by FCHVs and TBAs are similar in nature. FCHVs work in the village but are not understood by the villagers. The health kit containing medicine that they are provided once needs to be continually recycled by collecting money from those taking their services. Unfortunately the villagers refuse to pay for the services under the misconception that the health kit is provided by the government free of cost.

The TBAs too have problems in that they are ready to volunteer their services, but in return for respect from the villagers. The villagers think they are paid by the government and do not feel the obligation to offer anything for their services.

Most of the problems above can be attributed to the low literacy rate among Banigama villagers and the prevailing community perceptions on health matters. The government agencies have not done the background work to create an atmosphere conducive for the success of the government initiated health programmes at the local level. Another problem is that qualified health personnel are not given due recognition and trust in the community. The low economic status of the local population and the government's weak health extension network are other factors affecting health services in Banigama.

The following case study would help grasp how the average people of Banigama assess the primary and preventive health services.

**Case study 1 (Household No. 39)**

Garvi Debi Ghwar, aged 52, a resident of Banigama Ward 2, is the mother of five children. With such a huge experience what she revealed points to her ignorance about medical treatment.

Spelling her ignorance about the activities of the primary health center she said, "I don't know much about the activities of the health centre. I never had an injection yet. Whenever I get sick, I just go to the *Dhami* (faith healer)". With regard to the various health

services available in the village, she said, "I don't know anything besides that my 6 month old grand son is sometimes taken to the local health post for immunization."

Being asked about the level of health services in Banigama, she said, "How can I understand that since I am uneducated and have to work the whole day in the field? Maybe 'Sarkar', the government, provides services in the village but I don't know about that. You should ask my husband."

Socio-economic factors also play an important part in generation of awareness about the health services available. The following case would illustrate the impact of socio-economic factors on health awareness on social outcastes.

**Case study 2 (Household No. 25)**

Gangai Chamar, 39 years, a resident of Banigama VDC–1, is a mother of four children. Her understanding of health services is limited. She said, "I don't know about the different kinds of health services provided by different agencies..." She continued," I just go to take Depo-Provera injection in health post."

When asked about what specific roles local communities could play to enhance health services in the area, she said with a sad note," What can we uneducated Untouchables do about it? It's is up to the government run the health post."

From this case study, it can be understood that she does not know about the activities of the primary health center and is discriminated against as she is from the Untouchable group.

The following case study is an interesting example of how people's awareness of modern health services increases when they become economically capable and educated.

**Case study 3 (Household No. 121)**

Rashmi Neupaney, aged 36, a resident of Banigama Ward 6, is the mother of two children. She has land and a grocery shop in the market area. Her major duty is to look after her household chores and take care of her children. During her free time, she assists her husband in the shop. Her life is relatively comfortable.

She was very positive about the health facilities available, saying, "The health post, FCHV, TBA and medical shops are doing their best but due to limited budget and ignorance of the villagers, their works have not been very effective. She further said, "The government

and DDC should be more active and introduce more programs related to health awareness. Healthy life can be had by all when people become more aware of their health."

In the course of the interview, it became apparent that she was taking Depo-Provera herself and also encouraged other villagers to use contraceptives. Her health awareness can be attributed to her high socio-economic status.

**Case study 4 (Household No. 147)**

Lakhan Tharu, 37 years of age and a resident of Banigama VDC–8, is a wage laborer who is just barely able to read a newspaper, thanks to his participation in the adult literacy classes.

As a matter of interest, he was approached for an interview in his house while he was cleaning his cow shed. He immediately accepted our request and washed his hands for the interview. Although he appeared to be somewhat aware of preventive health care, he stated that the majority of villagers are not. When asked about the service provided by the health post he said," I often notice this blatant discrimination in health services at the health post. When rich persons come there, they are respected, get preference for check up and are also advised about healthy habits. But when the poor and the Untouchables come, they are not checked properly". About the villagers' preferred treatment patterns he says." The traditional/ faith healers influence villagers. When the sick people are not cured by traditional/faith healers, then only are they taken to the health post or medical stores."

The cases above indicate that health awareness is largely determined by education caste and income; Untouchables in particular lack basic awareness and are discriminated against. Even those with basic education are as influenced by traditional beliefs as the economically deprived, and may not realize the importance of preventive health. But the case appears to be different with those with reasonable education and income. They are more or less conscious about their health. Rashmi Neupaney is an example of this.

While the cases above illustrate Banigama's existing health situation, the gradual progress of villagers towards modern health treatments is undeniable. The health post, FCHV and TBA are doing their best to promote health awareness and are slowly succeeding, as illustrated by the popularity of the Depo–Provera contraceptive and other immunizations. Even old women completely ignorant of health issues were now realizing the importance of sending their grandchildren to the health post for check ups.

All the health services are conducted by HMG alone through government owned institutions. There is a dire need to transfer the ownership, responsibility, credit and accountability of health services to local governments and local communities. Further studies are, however, needed to identify the benefits from HMG activities conducted in collaboration with the civil society. Such studies should also assess an aspect that the SLTHP does not take into account, the benefit actually gained by local communities.

The Alma Ata Declaration and Nepal's Primary Health Care (PHC) documents explicitly assert that PHC should be adapted to local socio-cultural conditions. In the same way, it should ideally comply with certain economic, political and geographical realities. But a look at the Nepal programme would indicate that the PHC idea of "culture" is somewhat limited and that the relevancy of so-called "cultural factors," particularly traditional medical beliefs to the introduction of modern health programs is not well understood. When local ideas of illness are considered in PHC, they are usually lumped together and negatively branded as "superstitions" or "ignorance". Illiteracy, superstition, social evils and poverty are considered basic health problems in the country equivalent to items like malnutrition and gastrointestinal problems. The under utilization of health services is not considered a serious threat. Health workers, including professionals, interpret the view of local culture incorrectly. For instance, these people largely address "culture" as a potential obstacle to the goals of the primary and preventive health programme.

The SLTHP has been unable to accept that traditional medical beliefs, whether right or wrong, can be positively used to tailor modern health messages to local concepts or perspectives. One of the problematic areas in Nepal's health programme is tied-up with "community participation". Problems arise when a community is to define its own needs. However, before this, the Department of Health Services formulates a programme and budget with the consent of all the District Health Offices. This is then sent back as a programme booklet to all the districts. It also sets the target of activities in the VDC level through the concerned District Health Office. So, it can be argued that the need /programme identification in the VDC/DDC councils is an illusory form of community participation in the health sector. It is apparent that the government's latest strategy, the SLTHP has been unable to tackle the social and cultural dimensions of health and illness adequately.

More strikingly in the health sector, the integration of the 'sociology of health' is missing. For instance, gender and caste/ethnic-related disparities (lack of social inclusion) have not been mainstreamed to ensure equal access for all the citizens. So, the traditional

reliance (target oriented program) needs to be altered by removing the social constraints which have traditionally hampered their access to, and use of resources.

The government, while undertaking the delivery of health services to its people, needs to consider sociological vulnerability, such as social exclusion, lack of social support and stress, poor lifestyle habits of people, poor diets and addictive patterns of behavior. Since sociological studies of health and illness provide a microcosm of the working of the wider society, success of heath delivery also depends on cultural beliefs about the nature and meaning of disease/illness. What illness is and how it is treated is not simply a product of biological imperatives but is an aspect of wider social expectations about what appropriate social behaviour is. The state's failure to conform to those expectations may lead to weakness in the delivery of services. Therefore, the state should bear in mind that illness is as much a social process as a biological product of nature. The role of the state in the provision of health care in a changing political and economic structure of modern societies, because of the consequences of the growth of neo-liberalism claims that the 'community' is the basis for an individual's health. Strong communities, therefore, set examples of favourable social relationships for healthier populations and cost relatively less to the state.

To conclude discussion of the role of the state (Nepal), it is urgently recommended that the structural and cultural characteristics of people be considered while designing peripheral health strategies. Therefore, the sociological knowledge might be used to design public health education programs in particular and the health delivery strategies in general. In other words, the need to ensure the closest possible integration of health and social science would be most beneficial to Nepal.

**Changing Health Awareness**

The goal of primary and preventive health services is to improve the health status of the Nepali people. Timely immunization of children can check the incidence of particular diseases; antenatal and postnatal care to pregnant women can help reduce maternal and child morbidity and mortality. In addition, hygienically constructed toilets, routine hand washing after defecating; and proper of handling of water are precautionary measures against morbidity. Formal health infrastructure is ever changing in accordance with particular societies and time. Changes in the patterns of school attendance, socially mobilized children, kinship, neighborhood, mobility and the introduction of the mass media all contribute to the changing perception of preventive and curative health behaviour.

Mass media, electronic as well as printed, have the power to influence longstanding perceptions in a relatively short period of time. Fifty per cent of the households in the study area own televisions. Among the upper class Brahmin/Chettri households, 63 per cent and Tharu households 52 per cent own television sets. Even 23 per cent of the Untouchable households have access to televisions (Chapter I, Table 1.14). Seventy seven per cent of the local children are enrolled in schools. Again, it is the children of upper class households who are in majority. Encouragingly, however, around 70 per cent of the children from Untouchable households have also enrolled in schools. With such positive changes in the social setup it is expected that the level of health awareness will rise and the people would now be more prone to use modern medicine. The following case studies would illustrate the expanding health awareness among the people of Banigama.

**Case study 5 (Household No. 81)**

Sewali Devi Tharu, aged 28 years, is a resident of Banigma VDC-4. She explained that she is frequently reminded by her 9 year-old school going daughter to wash hands before eating and after defecation. Unfortunately, they do not have a toilet in the house. But the daughter has learnt of the importance of toilets at school and has convinced Sewali to persuade her husband to construct a toilet at home. Eventually, her husband agreed.

The interview also revealed that she had contacted Kala-azar the previous year. Without consulting the faith healers they went directly to the hospital in the district headquarters for treatment. She remembered of frequent transmission/telecast of messages about the symptoms and instructions of how to deal with such fatal diseases. The media thus effected a change in her mind in favour of timely medical intervention.

**Case study 6 (Household No. 158)**

Kumar Adhikari, 44 years of age and a resident of Banigama VDC–9, was saved by his neighbour's insistence that he should go to the hospital when he had encephalitis in September 2001. He said, "Even though Mr. Regmi, the health post in-charge, suspected that I had encephalitis I did not rush to hospital immediately. My neighbour Mr. Kaji Ratna, however, forcefully took me to hospital for treatment just in time. I am told that if he hadn't forced me to go to hospital in time, I would have died".

From these case studies, it is understood that the mass media, schools and the neighborhoods can play catalytic roles not only in preventive health but also in curative health.

Tuberculosis and cancer are proven problematic diseases in the study area. However, the incidence of HIV/AIDS can only be assumed based on the suspicions of health post in charge and medical shops. The probability and documentation of awareness of AIDS, TB and cancer are presented in the following sections.

**An Overview of the HIV/AIDS Pandemic in Nepal**

The social epidemiology of AIDS varies around the world. It can be spread by exchange of blood, but is primarily a sexually transmitted disease. Like sexually transmitted diseases (STD) it is most common among people who have multiple sexual partners.

Concern with AIDS ultimately brings up the need to adopt healthier life styles. This includes offering better health care, and reducing the social and economic inequities that damage health and encourage poor health practices. Educating people about their individual responsibilities for their own health is important, but in a changing the social structure some groups more vulnerable than others.

The first HIV positive case in Nepal was detected in 1988. Nepal conforms to the third pattern of the HIV/AIDS pandemic; i.e., late introduction of HIV, low level of HIV prevalence, and infection traceable to contacts with infected persons from outside the local community.

One of the most significant aspects of HIV/AIDS is its stigma. According to UN estimates for adults and children, by the end of 2001 some 40 million people were living with HIV/AIDS worldwide. And since the AIDS epidemic began, 25 million people have already died. HIV/ADIS will kill more people this decade than all the wars and disasters in the past 50 years. In Nepal, by the end of June 2002, the number of tested HIV positive cases was 2197, while the UN estimation is 34000. The UN further notes that South and South-East Asia are now an epicenter of the HIV epidemic (IFRC, 2002). With its weak health infrastructure, low level of literacy and awareness, and high stigma attached to AIDS it is quite possible that most of the cases of infection remain unreported and undetected and there could be high incidence of silent death because of this killer virus.

HMG/N's National Center for AIDS and STD Control in its quarterly report of June 2002 has mentioned that the majority of the HIV positive cases fall between the ages of 14 to 39 years. Moreover, an overwhelming number of HIV positive cases have been noticed in the20-29 age group.

**Awareness of HIV/AIDS among the local People**

HIV/ AIDS is currently one of the most terrifying diseases in the world. The fact that it does not have a cure and can be easily transmitted simply by neglecting certain norms makes it vital that the Banigama population is aware of this issue. In the present study we have tried to ascertain the level of awareness of this killer virus among the people of Banigama. The general awareness of HIV/AIDS in the study area is presented in the following table. As in preceding chapters, tables here have been based on households and segregated by caste/ethnicity.

**Table 6.1: Households aware of HIV/AIDS**

| Caste/Ethnic Group | Yes | | No | | Total | |
|---|---|---|---|---|---|---|
| | Number | % | Number | % | Number | % |
| Brahmin/Chhetri | 27 | 100.00 | - | - | **27** | **100.00** |
| Tharu | 109 | 95.61 | 5 | 4.39 | **114** | **100.00** |
| Untouchable | 11 | 84.62 | 2 | 15.38 | **13** | **100.00** |
| Terai Dwellers | 19 | 86.36 | 3 | 13.64 | **22** | **100.00** |
| Others | 2 | 100.00 | - | - | **2** | **100.00** |
| **Total** | **168** | **94.38** | **10** | **5.62** | **178** | **100.00** |

According to the data in Table 6.1, a large number of Banigama dwellers (more than 94 per cent) have heard of HIV/AIDS; conversely, 5.62% have not even heard of HIV/AIDS. The understanding of the disease also appears to differ in terms of caste/ethnicity. High classes such as Brahmin/Chhetris and Tharus have a better understanding of the disease process compared to other castes/ethnic groups. This is because of their education, wide exposure and access to various forms of media.

However, there is a marked difference between just hearing about and actually understanding the pros and cons of the disease. The table below presents the awareness of HIV transmittance in Banigama.

**Table 6.2: Awareness of HIV Transmittance**

| Caste/Ethnic Group | Yes | | No | | No response | | Total | |
|---|---|---|---|---|---|---|---|---|
| | No. | % | No. | No. | % | % | No. | % |
| Brahmin/Chhetri | 27 | 100.00 | - | - | - | - | **27** | **100.00** |
| Tharu | 104 | 91.23 | 5 | 4.39 | 5 | 4.39 | **114** | **100.00** |
| Untouchable | 11 | 84.62 | 2 | 15.38 | - | - | **13** | **100.00** |
| Terai Dwellers | 16 | 72.73 | 5 | 22.73 | 1 | 4.55 | **22** | **100.00** |
| Others | 2 | 100.00 | - | - | - | - | **2** | **100.00** |
| **Total** | **160** | **89.89** | **12** | **6.74** | **6** | **3.37** | **178** | **100.00** |

As seen in Table 6.2, Brahman /Chhetris are better aware of AIDS compared to other castes/ethnic groups; their knowledge of HIV transmittance is also comparatively better. The table also indicates that although they have low education and income, the "Others" are highly knowledgeable about the disease. This is because there are only two respondents from this group who, incidentally had knowledge about HIV/AIDS. However, it is quite encouraging that in total a large number of people (89.89) are aware of the HIV transmittance process. It is clearly crucial that the people of Banigama are taught to take proper precautions against HIV to safeguard their health. The local health centers do not have the arrangement for detection of cases of infection and people were not forthright in their answer to a question whether there were actual cases of AIDS in their families and so it was not possible for the present researcher to ascertain to what scale the virus has made its presence in the people of Banigama.

**Tuberculosis**

In spite of the fact that the causative organism was discovered more than 100 years ago and highly effective drugs and vaccines are available making tuberculosis a preventable and curable disease Tuberculosis is a significant public health problem, particularly in the poorer countries of the world. The disease is reported to be prevalent in 40 per cent of the Nepali population. Though TB occurs in nearly all age groups, the greatest morbidity and mortality because of this killer disease could be found in the adults aged between the ages of 15 – 59 (MOH, 1999).

Observations from field visits and interviews suggest that a fairly large number of adults could be having TB in Banigama. Moreover, cigarette smoking, and the *Khaini* and *Surti* culture among males in Banigama increase the disposition of Banigama dwellers towards TB. The lack of civic sense, the habit of indiscriminate spitting, large-scale sharing one bed room, and living in an unhygienic condition often increase the chances of spreading

this highly infectious disease. Houses in Banigama are small with little or no ventilation; so cooking fires tend to produce a lot of smoke that muffles up the whole house. This affects health directly, and has also been suspected as a lead causative agent of T.B. The nutrition deficiency and rampant poverty do not help the cause of fighting against this killer and widespread disease in this part of Nepal.

**Table 6.3: Knowledge of TB**

| Caste/Ethnic Group | Yes | | No | | No response | | Total | |
|---|---|---|---|---|---|---|---|---|
| | No. | % | No. | No. | % | % | No. | % |
| Brahmin/Chhetri | 24 | 88.89 | 2 | 7.41 | 1 | 3.70 | **27** | **100.00** |
| Tharu | 93 | 81.58 | 18 | 15.79 | 3 | 2.63 | **114** | **100.00** |
| Untouchable | 12 | 92.31 | 1 | 7.69 | - | - | **13** | **100.00** |
| Terai Dwellers | 16 | 72.73 | 6 | 22.27 | - | - | **22** | **100.00** |
| Others | 2 | 100.00 | - | - | - | - | **2** | **100.00** |
| **Total** | **147** | **82.58** | **27** | **15.17** | **4** | **2.25** | **178** | **100.00** |

As seen in Table 6.3, 15.17 per cent of the households in Banigama VDC are not aware of TB. And this is more pertinent among the Terai dwellers (22.27 per cent).

From the data above, it can be seen that all castes/ethnic groups have more or less an equal understanding of TB. TB is commonly found disease prevalent in rural areas. Because of this the government has taken measures to increase general awareness of this disease through the mass media. Due to these factors, it can be assumed that the people of Banigama do have basic awareness of TB.

### Cancer

Environmental factors are generally held responsible for 80 to 90 per cent of all human cancers. The major environmental factors identified so far highlight tobacco. Tobacco in various forms (e.g., smoking, chewing) is the major cause of cancer of the lung, larynx, mouth, pharynx, esophagus, bladder, pancreas and probably the kidney as well. It has been estimated that, in the world as a whole, cigarette smoking is now responsible for more than one million premature deaths each year. Excessive intake of alcoholic beverages is associated with esophageal and liver cancer. Dietary factors are also related to cancer. Smoked fish is related to stomach cancer, dietary fiber to intestinal cancer, beef consumption to bowel cancer and a high fat diet to breast cancer (Park, 2000).

**Table 6.4: Awareness of Cancer**

| Caste/Ethnic Group | Yes | | No | | No response | | Total | |
|---|---|---|---|---|---|---|---|---|
| | No. | % | No. | No. | % | % | No. | % |
| Brahmin/Chhetri | 15 | 55.56 | 11 | 40.74 | 1 | 3.70 | **27** | **100.00** |
| Tharu | 93 | 81.58 | 21 | 18.42 | - | - | **114** | **100.00** |
| Untouchable | 9 | 69.23 | 4 | 30.77 | - | - | **13** | **100.00** |
| Terai Dwellers | 14 | 63.23 | 8 | 36.36 | - | - | **22** | **100.00** |
| Others | 2 | 100.00 | - | - | - | - | **2** | **100.00** |
| **Total** | **133** | **74.72** | **44** | **24.72** | **1** | **0.56** | **178** | **100.00** |

As Table 6.4 would suggest, 24.72 per cent of the households in Banigama VDC are not aware of cancer and its causes. Again, 36.36 per cent of the Terai dwellers are ignorant of cancer.

Surprisingly, the Tharu and Untouchable group have basic knowledge about cancer, but Brahmin/Chhetris, although comparatively in a better position than other castes/ethnic groups, are relatively less knowledgeable about this disease. The possible reason for this is that Tharus and Untouchables might have faced a higher incidence of cancer in their communities compared to Brahmins/ Chhetris and so have a better understanding of the disease.

**Summary**

In Nepal, the government has periodically made some attempts to provide health facilities to the population in the periphery. The Nepali government has launched various programs at the village level in line with its decentralization process. In this regard, EPI and FCHV have been popularized among the people. Conversely, other programs such as sub-health posts, TBA and PHC outreach are not as successful, since the extension services and service delivery in the sector remained weak.

In Banigama VDC, the Primary Health Care (PHC) system was not able to gain much popularity. The main reasons behind this are: insufficient financial support, lack of adequate trained manpower and medicine, poor health extension services; and of lack of an effort to understand the local culture by the concerned authorities.

Primary health care workers, including even the professionals, appear to have failed to adapt services to suit the local culture. These people view the local culture as an "obstacle" which merits removal in order to realize the goals of the modern health programme. These people highlight superstitions, ignorance, illiteracy, social evils and poverty as the greatest

barriers faced by the PHC and they do not see faults within the programmes and their execution.

There is, admittedly, a need to modernize the prevalent religious and cultural beliefs to an extent. In addition, the government should also promote health awareness by designing health awareness activities to gradually draw people out of their cultural prejudices.

Various case studies highlight the existing situation to illustrate the changing health awareness in Banigama VDC. The health post, FCHV and TBA have played a key role in generating health awareness among the people in Banigama. Because of their influence, a large number of women were found going in health post for family planning in particular. The FCHVs are popular among the women and have undertaken praiseworthy efforts towards changing health awareness of the local women.

In addition to this, the formal health infrastructure, mass media, socially active school children and neighborhoods also play catalytic roles in expanding not only preventative health awareness but curative health as well. However, the pace is slower than anticipated.

As elaborated earlier, in Banigama VDC, Brahmin/ Chhetri and Tharus occupy the top position in the social and economic hierarchy; Terai Dwellers and Tibeto–Burmans are placed in the middle; and the Untouchable group occupies the bottom place. Brahmin/Chhetris have a better knowledge base overall compared to the other two categories, due to which their perception and understanding about modern health facilities is a step ahead of the other two social groups.

With regards to awareness of life threatening illnesses, the majority of the people in Banigama VDC were found to be fundamentally aware of HIV/AIDS. Even the lowly placed social groups appear to be familiar with the word; this can be attributed to mass electronic media campaigns on the TV and radio. However, there is a marked difference between being familiar with the menace by hearing about it and actually understanding it. "Understanding" here would mean knowing the mechanism of contacting the virus and the methods of prevention and the other related matters.

Brahmin/Chhetris have are highly knowledgeable about HIV /AIDS as a result of their educational status and wide exposure. This level of knowledge is not seen among the Tharu, Untouchable and Terai Dweller communities. Having said this however, the majority is aware of the danger and implications of HIV/AIDS.

The health post was unable to provide any record of HIV/AIDS cases; this is assumed to be the result of the social stigma associated with AIDS, the locals opt to go to either the

district, zonal or even hospitals in India for detection and treatment. The health post in-charge agreed with suspicions from medical shopkeepers that those afflicted with HIV/AIDS in all probability sought further tests in other hospitals out of the locality.

Tuberculosis is another notable disease in Banigama. Interestingly the current level of awareness among the local population is satisfactory. This may be due to the presence of a large number of TB patients in Banigama. Having some basic knowledge about the disease is not the guarantee to promoting of better health. Unless applied into everyday activities, this knowledge has no value. Other factors influencing health were also identified. Almost all the houses in Banigama VDC are *kachha*, and without adequate ventilation. Smoke from cooking fires was seen to muffle the whole house. This is estimated to have resulted in the high incidence of TB in the area. This has possibly been supplemented by another factor: tobacco use. There is a strong smoking, *Surti* and *Khaini* culture among Banigama dwellers, which cause spread of the disease.

Cancer has also been established as a high mortality illness in Banigama. Unfortunately the locals are not as aware of Cancer as they are of AIDS and TB. Interestingly, the government campaign against this disease is not as intensive as that for other diseases. Another curious fact is that awareness of cancer is largely found in the Tharu, Untouchable and Terai Dweller communities in descending levels. This may be the result of larger numbers of people afflicted with Cancer in these communities, especially as a result of the *Surti, Khaini* and smoking culture and alcoholic habits notably among the Tharus in Banigama.

However, it can be stated that the people of Banigama are becoming increasingly aware of health problems and are gradually modifying their everyday activities as well as treatment patterns. As illustrated in the case studies, this is seen in the trend of seeking treatment in the better-equipped district hospital when taken over by an unknown/undiagnosed illness. The fact that a majority of the population displays the inclination to visit the health post for vaccinations and other measures such as birth control are also positive indications of a changing health culture in Banigama.