Conclusion

I

The present study on *Sociology of Health and Illness: A Case Study of Banigama Village Development Committee of Eastern Nepal* was designed to explore the existing health/illness perceptions and behaviour among the residents of Banigama VDC. The main objective of the study was to analyze and highlight the influence of socio-economic factors like caste/ethnicity, income and landholding as well as education on health and illness. Efforts were also made to assess the functioning of the government-run health infrastructure and its impact on the changing health perception of the people in the study area. An important highlight of the present study has been to explore the highly important yet hitherto neglected aspect of women's perspective of health.

Health status is uniformly poor in Nepal. There is a remarkably high incidence of parasite infestations, oro-faecal diseases such as cholera and typhoid, acute respiratory infections, and morbidity associated with pregnancy and childbirth. While there is no hard data indicating health status along ethnic lines and income levels, but it is almost certainly worse among the poorer sections of society. This is because their lower nutritional status makes them more susceptible to disease, and also because they are least likely to have access to either curative or preventative health services. The study seeks to determine socio-economic and cultural influences on perception and behaviour towards health and illness, and also identifies the various modes of treatment (medical pluralism) currently adopted to fight sickness. Furthermore, the study is designed to illustrate changing traditional belief systems and how their current influences on the local health culture. Other integral components of the study are women's problems and perspectives on health and illness, and HMG/N's primary and preventive health services in the periphery.

The study proceeded with a conceptual standpoint that health behaviour of a given community reflects its socio-economic conditions and the shared perceptions and that the health culture is an extension of the shared culture of the community. Again, the shared culture and the shared perceptions of the community are not static; they respond to the forces of change, internal as well as external, at the individual, familial and community levels. At the analytical plane we always tried to locate the health behaviour and health practices in the scale with tradition and modernity in it's opposite ends.

The present study is based on both primary as well as secondary data consisting of both qualitative and quantitative data for macro and micro level information. Field observations, interviews, case studies and survey method were used to collect primary information. Country level socio-economic and political, as well as health-related information has also been reviewed. Secondary information was compiled from the sources like the National Planning Commission (NPC), Central Bureau of Statistics, Ministry of Health (MOH) publications as well as other relevant sources. The macro-level information was collected from the census reports, and other pertinent published materials. Information at the Village Development Committee level was also collected. Both descriptive and analytical methods have been followed for interpretation and presentation of the data and case studies have often been used to support and substantiate the quantitative information.

II

The multiple castes/ethnic groups in the study area have given rise to a uniquely eclectic mixture of traditions and perceptions in all facets of life, including health. The classification of groups into castes/ethnic groups is based on the caste hierarchy generally prevalent in Nepali society and is derived from Hindu religious texts. These lay down the division of Hindu society into four orders (*Varna): Brahmin*, (traditionally priests and scholars), *Kshatriya* (rulers and soldiers), *Vaishya* (merchants) and *Sudras* (peasants, laborers, servants). Untouchables – these days referred to as 'Dalits' (*Kami, Damai, Sarki*), are outside the *varna* scheme and have been regulated to do what is considered grabby work, and, as a result, have been traditionally considered impure, and labeled as 'Untouchable' by higher castes. Considering that caste and class in this part of Nepal go hand in hand - the Brahman/Chhetri and Tharu groups could be loosely classified as "high class"; Terai dwellers and Tibeto-Burmans as "middle class" and the Untouchables as "lower class". The term class here does not fit into the Marxist scheme and perception of class; members of these loosely constructed classes, however, have differential access to social opportunities and "life chances" to use Weberian terminology.

The Tharus, who constitute the ethnic majority in Banigama, are probably the earliest settlers in the Terai, yet they are not included in the Hindu caste system and are identified by the generic term 'Tharu'.

Among other groups are inhabitants of Terai origin such as the Yadav, Dhanuk, Mandal, Ghwar, Koiri, Khawas, Batar, and Mushar. These groups of people are often referred to as *Madhesi* (Terai dwellers). In the study area there are a few Tibeto-Burmans like the Newars and Tamangs. As a matter of interest, Newars have their own internal caste system, which is not explored in this study. The Tibeto-Burman groups are classified as *Jan Jati* in Nepal.

Discrimination along caste lines is clearly reflected in peoples' differential access to health services as the caste hierarchy functions on the principle of pollution and purity. Those who belong to lower stratum occupational castes such as blacksmiths, tailors, and cobblers (*chamar* and *sarki*) are considered impure and are labeled Untouchable. Politicians and social activists, however, refer to this group as 'Dalit' over the past 10-12 years. The Untouchables are generally segregated in ghettos devoid of social amenities including health services and are discouraged from seeking health services in centrally located facilities in the village. This lack of opportunity on the one hand and the desire to use modern medical services on the other (which they cannot afford) enhances their vulnerability to numerous illnesses. They tend to blame themselves for their predicament saying ' it is in our fate and is because of our poverty'. Clearly, this promotes discriminatory and exploitative structures, which in turn, impede the enhancement of overall health status in society.

Although there is a general and clear trend that people are drawing positive approach towards modern medicine and treatment, the study unearths a few basic discrepancies which still persist in the health status and health culture across the social/caste groups. A recapitulation of the major findings of the respective chapters would reveal the impact of deep-seated attitudes towards local traditions, socio-economic status and literacy.

III

The socio-economic profile of the study area has been taken into account for drawing an understanding of the health scenario in the study area. In general, health is largely determined by the shared culture and perceptions and habits on the one hand and by the socio–economic status and education, health infrastructure and health campaign on the other. Money can bring improved health services and environmental improvement; likewise, education can improve health behaviour and can help prevent illness.

In Banigama VDC, the Brahmin/Chhetri and Tharu groups are comparatively better placed in terms of economic status, house type and education and have wider exposure to the modern health facilities and opportunities outside. Other castes/ethnic groups like the Untouchables and Terai Dwellers do not have the same level of education, income or exposure. No Brahman/Chhetri of more than six years of age has been found to be illiterate; 40 per cent of their population has completed secondary education. The literacy level in the Tharu and Tibeto-Burman communities is also satisfactory, as about 35.09 per cent and 50 per cent have completed secondary education in these groups respectively. In contrast, literacy among the Untouchable and Terai Dweller groups is highly disparate from the Brahmin/Chhetri and Tharu groups as the greater number of these people is barely literate. This is of utmost importance because literacy and academic status have a direct impact on perceptions of health and on standards of living in general.

Again, the study indicates that education level has a bearing on people's income. In general, those with wide exposure and knowledge tend to have the necessary skills, information and money to utilize their skills appropriately to generate income from hitherto unexplored areas. In Banigama, the Brahmin/Chhetris are generally in the higher income bracket compared to other castes/ethnic groups. Being educated, people in this group do not depend only on agriculture but utilize their skills in other diverse fields to augment their income. While the Tharus are economically better placed, the Untouchables and Terai Dwellers are often poverty infested. They are involved in limited income generating works, and constantly shift to new jobs in order to earn a living and maintain a healthy life. The class-gap is reflected in the health-seeking behaviour of different groups of people: when the poor and uneducated fall ill, they first approach the *Dhami, Jhakris* - (traditional / faith healers). Only if they are not cured, they go for modern medical treatments. However, it is noteworthy that the trend of visiting medical shops in Banigama has taken a lead in recent years, among all treatment seeking modes.

Interestingly, it is not only the poor people of lower classes who are influenced by traditional beliefs, the so-called higher class people among the Brahmin/Chhetris and Tharus are also bound by certain cultural predispositions. These people also believe in traditional faith healers, but with the marked difference that they do not rely on such healers completely, or for too long. Another direct impact of income and education could be noticed on sanitation. The educated were clearly more aware of the repercussions of unhygienic conditions and found paying greater attention to sanitation in their houses. The

Brahmin/Chhetris appeared to have realized the importance of proper disposal of human excreta and constructed lavatories in their houses, but other groups like such as the Tharu, Untouchables and Terai Dwellers do not seem to be as aware of the primary factors affecting health. Most of the members of these groups still use open spaces, riverbeds and barren land for defecation. When asked why they have not made toilets at home, almost all said that they lacked the resources needed to do so. Looking beyond this 'excuse' one has to see reason in the fact that they are not fully aware of the implications of unsanitary conditions for raising the standard of living and for the well being of the community as a whole. If they are mindful of health and truly lack resources, they can at least make a simple pit toilet, which does not cost much and which would have ensured better health. Health behaviour thus proves to be a matter of the shared culture and perceptions of the community, which cannot be explained only on economic terms. Almost all the people of Banigama drink tube well water, which, considering its depth at source cannot be considered safe as it has the potential of transmitting waterborne diseases. Clean drinking water pipelines are available elsewhere in neighbouring localities although the people of Banigama do not have access to this facility yet.

Another socio-economic factor that appears to have a direct bearing on health awareness in Banigama VDC is tenural status. The Brahmin/Chhetris and Tharus are generally the landowners and they draw higher returns from agriculture. Even within this group, the Brahmin/Chhetris are better placed in terms of property rights than the Tharus; in contrast, 50 per cent of the Tibeto-Burmans, 61.54 per cent of the Untouchables and 63.64 per cent of Terai Dwellers are landless labourers.

Involvement in a wider social circle is also taken as an indicator of better health awareness, which facilitates the transmission of a diverse range of knowledge and awareness. In Banigama, some people are affiliated to organizations such as the VDC or work as volunteers to some other organizations. Those affiliated to the VDC are local politicians including the ward-level politicians such as ward members. As far as women's affiliation is concerned, two were ward members and two were working as community health volunteers. We observed that those associated with organizations were relatively more knowledgeable in matters relating to health and illness. They were more familiar with the need and importance of personal hygiene, toilets, safe drinking water and environmental sanitation. We noticed that a higher percentage of the members of the Brahmin/Chhetris and Tharus are affiliated to different organizations compared to Untouchables and Terai Dwellers.

Interestingly, Brahmin women affiliated to organizations seemed to be more familiar and exposed to the services provided by the sub health post in Banigama. Two women from this group were female community health volunteers; they worked as agents of change by passing on their knowledge of preventive and primary health care to others in the group. This suggests that organizational affiliation enhances not just individual awareness and behaviour but potentially it can change the shared perceptions of the larger community as well.

Almost half the population of Banigama is dependent on agriculture for their living; the other half is engaged in different occupations (in both private and government organizations), in addition to agriculture-based activities. Some work in private organizations like shops and seasonal off farm activities and a few are employed in government agencies and in schools. Some others were also engaged in small village businesses, as well as wage labourers and tailors. Caste/ethnic group wise, the Brahmin/Chhetris are mostly found engaged in agriculture, service and in agriculture together with part time waged labor. The Tharus are mostly engaged in agriculture, service and agriculture together with service. The occupation of the Untouchables is different in this respect; they have specific designated jobs that follow from their caste affiliations. For example, the *Chamars* (shoe makers) work with shoes, the *Kamis* (blacksmith) work with iron, the *Damais* (tailor) are traditionally occupational tailors. In addition to the caste occupations, these people are also engaged in agriculture and as wage laborers. The Terai Dwellers are mostly found working as wage laborers, in service and agriculture, while the Tibeto-Burmans are mostly engaged in trade and as wage laborers.

House types are not only the indicators of socioeconomic status; they also indicate the level of health consciousness of the inhabitants. The study found that the houses in Banigama VDC, whether of Brahmin/ Chhetri or other groups, are mostly *kachha* houses. Such houses not only reflect absence of affluence but also reflect the material cultural tradition of the people in this part of Nepal. The *kachha* houses generally lack proper ventilation; during heating and cooking, smoke muffles the whole house. Such houses thus could foster illnesses such as TB patient and acute respiratory problems.

The study noticed the silent penetration of consumer culture in the study area and how it is gradually becoming a strong determinant of social status. People's exposure to household possessions such as television, radio and own modes of transportation had a positive impact on the level of health awareness. The Brahmin/Chhetris possessed the most expensive items such as TVs, motorcycles, radios and bicycles. Other castes/ethnic groups

like Tharus, Tibeto-Burmans and Untouchables owned comparatively less of these consumer items. Possession of such items increases people's access to diverse information, and thus brings about a change in their perceptions and behaviours. This has been particularly noticed in the success of the government's electronic media based health campaigns against AIDS, TB, and the literacy campaign.

Overall, it was noticed that socio–economic and cultural factors affect people's health perceptions and health behaviour directly. By virtue of their greater control over economy and education the Brahmin/Chhetris have greater exposure to mass media and to the outside world. These people utilize their knowledge and skills to broaden their perception, and thus inch towards a healthy living. Conversely, the middle and lower classes have relatively low incomes and education. Due to lower socio-economic status, the Tibeto-Burman, Terai Dwellers and Untouchables are not able to acquire knowledge to match that of the Brahmin/Chhetris and therefore have lesser access to the means of healthy life. The lower classes, the Untouchables in particular, have even lesser access to the means of a healthy life as they are both economically and socially deprived.

Economic status is an important determinant of community health. It was clearly seen in Banigama that those with poor economic conditions couldn't afford even basic health services, hygienic and nutritious diet, proper education, healthy housing and healthy habits. Thus, poverty has been recognized as a leading factor in the low quality of health in Banigama.

The economically better off classes have both the means and the resources to gain information and act on it scientifically. The middle and lower classes are economically deprived and therefore they are more influenced by socio-economic and cultural factors. Although some of middle and lower class people could be fairly well aware of the importance of good health because of their education, they are unable to translate their awareness into practice due to poor economic conditions. In marked contrast, the uneducated and economically poor Terai Dwellers and Untouchables have full faith in the Gods and they believe healthy life is only possible by appeasing the Gods. They were inclined to accepting what life throws at them. They also had a greater tendency to attribute serious illnesses to witchcraft and sorcery and often depended on *Dhami-Jhakris* to drive out evil spirits. The study suggests that if all groups were greatly influenced by the local culture, the economically deprived Untouchables and Terai dwellers were more so.

Traditional habits and perceptions can sometimes be contrary to healthy behaviour. Some practices relating to newborns could be referred to in this context. As per local custom, childcare in Banigama involves oil massage and placing oil inside the ear to clean it. Putting of oil inside the ear is not medically recommended, yet all villagers appear to maintain this tradition. Again, the practice of cutting the umbilical cord using blades can make both mother and child susceptible to tetanus. Illness is by and large attributed to displeased deities or evil spirits, and dealt with by carrying out a myriad of rituals. Even the well-off and knowledgeable Brahmin/Chhetris are not free of such practices and superstitions and depend on traditional faith healers, quacks and *Dhami – Jhakris.* This group is however different from other groups in that it does not depend on faith healers alone but also seek medical treatment simultaneously.

In Banigama, the women are more influenced by local cultural mores than the males. This includes participation in various religious rituals e.g. ritual fasting on different occasions like *Teej, ShivaRatri* and *Rishi Panchami* for their husband's longevity.

As in other cultures, certain practices in Banigama have been identified as vices affecting the local community socially and causing health problems. Culturally, alcohol is a taboo in Brahmin/Chhetris households; it is however ritualized and very much a part of consumption culture of other castes/ethnic groups. The Tharus, Terai Dwellers and Tibeto-Burmans consume excessive alcohol, mostly the local varieties, putting them at risk of various alcohol related health problems. Another vice in Banigama is tobacco chewing - the prevalent *Khaini* and *Surti* culture suggests the villagers could be vulnerable to diseases like TB and cancer.

IV

Another vital aspect of health care is medical support services. Clearly, Banigama lacks sufficient health facilities in the village to cater to the needs of all the villagers. The local medical shops, which function as the popular source of treatment, are run on profit motives; none has qualified medical practitioners. This means that complicated health problems go undiagnosed. There is also a health post facility in Banigama but it is minimally equipped and unable to match the services provided by the medical shops. The health post consists of a single room with four paid staff, and is allotted medicines worth a meager NRs 25000 annually, which is hardly sufficient to meet the expenses for 3-4 months. In addition, the

medicines arrive at the health post close to or after the expiry date, and so are often of no use. As the health post is unable to provide adequate service to the villagers the latter either seek treatment in medical shops or consult traditional faith healers.

There is a Primary Health Center (PHC) in Jhorahat, only two kilometers away from Banigama. It has 11 staff altogether, however, the posts for the medical officer, lab technician assistant and accountant were vacant at the time of our field study. The OPD charge was a reasonable NRs 3, but the health center could not provide the necessary medicines and people had to buy them from medical shops. PHC receives medicines worth NRs 50,000 annually but again, like the health post, the medicines have a very short shelf life. Because of the inadequate services at the health post and health center, the local people continue to bank on the cultural/home remedies in the initial stage of sickness and come to these institutions as the last resort.

With regard to health services, the FCHVs and TBAs are the primary providers of health care in Banigama VDC, who work in conjunction with the sub-health post. The successful child immunization campaign is an indication of the influence and impact of this partnership. While it is undeniable that the changes taking place in Banigama with regard to health are slow, it is nonetheless an encouraging trend that changes, however gradual, are leading to modifications in the behaviour of the local people. This can be seen in better awareness among families of the need to maintain environmental sanitation in the house and the comprehension of the scientific causative agents of diseases.

The new generation goes to school and understands the need to live healthy lives. Children have been known to insist their parents abandon unhealthy practices like using tobacco, and adopt hygienic practices such as washing their hands before eating and maintaining general hygiene.

V

Three distinct modes of treatments (or medical pluralism) were noticed in Banigama, which could be termed as the *Popular sector, Folk sector* and *Professional sector*. The popular sector consists of health care conducted by the ill themselves, their family members, relatives and neighbours. The folk sector includes health care conducted by various informal institutions; and the professional sector includes medical practitioners.

Socio-economic status plays a vital role in the plurality of health behaviour and determines the treatment patterns. Needless to say, the better affordability and understanding of the problem one could always have wider options for seeking the types and places for treatment.

People opt for their preferred mode of treatment according to the socio-economic status as well as the condition of sick person. In Banigama VDC, people depend on medical shops, then on traditional / faith healers and on health posts in order of preference. But those with higher income seek treatment with private practitioners. Often, scientific treatment is mostly limited to medical shops as most indigenous "doctors" lack any medical training. Such alternative practitioners also appear to be popular as their consultation charges are relatively low and they do not demand payment immediately. The popularity of medical shops could be understood in the light of ill management of the health post, and easy accessibility of these shops in the village. However, the traditional pattern of treatment is also deeply rooted and *Dhami-Jhakris* are still highly esteemed and sought out even by the educated and rich.

This assortment of treatments available means that the people of Banigama have developed their own treatment patterns and also reflects a confused state of mind. While cuts and external injuries are taken to medical shops and health posts, fractures are taken to the district hospital, as appropriate treatment is not available in Banigama. Likewise, ailments like jaundice are taken to the *Ayurvedic Baidhya*, while cases of stomach pain, fever and headache are taken to traditional faith healers.

Health seeking behaviour depends not only on socio-economic factors but also on cultural factors. Some cultural norms pose particular concern to the health of the community, e.g. the traditional four day confinement for women during monthly menstruation and the 13 day *Kiriya* (confinement for mourning) followed by sons and widows during the first 13 days of a parent's/husband's demise. As those in confinement are considered impure, access to medical treatment in this period is very difficult and can lead to further complications and even death in extreme cases.

However, a lot of changes have taken place in the perceptions and treatments regarding health and illness due to the influence of FCHV, TBA, Health Post, as well as accompanying socio-economic changes. These institutions are working for the enhancement of the health of Banigama people; while FCHV and TBA are targeted at women the FCHVs are committed to increasing women's awareness and direct participation in different

activities related to health. While the condition of health post is pitiable, it is providing valuable service by hosting women and child immunization campaigns as well as a resource center for health awareness. Even the profit oriented medical shops can be considered as forces of change as they provide, at times, the advice on matters relating to health.

VI

Nepal, including Banigama VDC, is undeniably a male dominated society. The notion that "women are expected to be seen and not heard" opens up the possibility of numerous health problems for the women, which are not voiced or addressed by the larger society. In order to have some understanding of the problems relating to women health we undertook an investigation into women's problems and perceptions regarding health and illness.

Male domination is apparent in many facets of everyday living in Banigama. Women traditionally view husbands as *Malik* (master or God) and do not go against the will of the husband. Women are generally not involved in household decision-making but relegated to household chores only. While there is a marked disparity in the socio-economic status of the various castes/ethnic groups, the status of women is fairly consistent across caste lines. Not only does the local culture suppress women's activities outside the household, it also restricts participation and decision making in families. This could be illustrated by the fact that women are not aware of many health issues and depend on senior households family members to take a decision about the treatment of their ailments.

Certain local traditions have been identified as catalysts to female health problems. The early marriage, which is widely prevalent in the area, is there not only due to lack of education, but also because of social support. Parents wish to marry off daughters before menstruation to obtain *punya/dharma,* meaning religious righteousness. Early marriages are the norm in Banigama, with the uneducated marrying off daughters as young as 14/15, and 50 per cent of the girls have been married off between 16 and 20 years of age although the comparatively better educated Brahmin and Chhetris are somewhat aware of the repercussions of early marriage and have a tendency marry off their daughters between 21 and 25 years. Early marriages are still deeply rooted in the Tharu community. Early marriage means that the newly married girl may not be physically and mentally ready to conceive. Beside, she may not have adequate knowledge about safe motherhood and proper infant care.

As a result of continuing deprivation and discrimination in the household as well as in the larger society, women often do not get enough nutrition during pregnancy and delivery. Low calorie intake during pregnancy results in illnesses such as anemia and fatigue. Weakness in mothers prevents adequate nutrition reaching the newborn and in extreme cases both the mother and child may lose their life.

Another health hazard resulting from early marriage is frequent miscarriage. Miscarriages are noticeably more common among the 'Untouchables' compared to other castes / ethnic groups. This can be attributed to a combination of many socio-economic problems like poverty, illiteracy, custom of early marriage and social restrictions on appropriate treatments.

For the purpose of evaluation, pre- and post-natal checkups and safe child delivery systems can also be considered as illness. Data reveal that only about 50 per cent of the married women of reproductive age (MWRA) in Banigama had access to antenatal check ups in one form or other. Surprisingly, study findings also reveal that most women have not been able to access TBA services. Nearly 70 per cent of the births in the locality take place in the absence of TBAs, with more Brahmin/Chhetris and Terai dwellers women delivering babies safely in the presence of TBA compared to the Tharu and Untouchable women.

Sexual intercourse is an integral aspect of marriage, yet unhealthy sex behavior is another great problem faced by the women in Banigama VDC. Privacy is essential for healthy sexual relations and a separate sleeping arrangement for couples is a must. The study, however, found that only about half of the households in Banigama have separate rooms for the couples. The provision of a separate bedroom is associated not just with economic status but also is culturally dictated. Unfortunately, this can result in sexual tensions between couples that can affect the family relations adversely.

The communities in Banigama generally lack adequate sex education. Women from most groups view sex as just a means to satisfying their husbands and reproduction. This perception appears to be determined by the socio-economic conditions, education, income and an understanding about the role of sex in a relationship. Thus, the higher castes/ethnic groups generally have a healthier attitude towards sex.

The social stigma, and taboo associated with sex is a byproduct of women's cultural suppression and socio-cultural restrictions. This stigma compels women to bear sexual abuses by husbands in silence.

It is interesting to note that the majority of people in Banigama across caste/ethnic lines are aware of contraceptives. Again, awareness and adoption of measures vary in proportion to the socio-economic factors, particularly education. The higher income, better-educated Brahmin/Chhetris have shown greater inclination to adopt family planning measures to space births than the less educated yet economically stable Tharus. The Untouchables and Terai Dwellers are minimally literate and have not realized the importance of using contraceptives for infant, mother as well as general well being of families.

Discrimination against women is once more apparent in the general preference for the type of birth control adopted across caste/ethnic boundaries. While men generally shy away even from purchasing condoms, the women are seen approaching health centers for oral pills and other temporary birth control measures. The women also put up with the resulting side effects such as backaches, headaches etc. This trend continues with permanent birth control measures as well. While the males refuse vasectomies on the grounds of potential impairment of physical abilities, their wives are conditioned to undergo hysterectomies.

However, there is an undeniable change in the awareness and attitudes towards health among women in Banigama. The educated younger generation of women now nurses a wider outlook of health related issues and other issues of life. Even, the mothers and grandmothers have realized, from their own experiences, the potential harm of many of the local traditions and are now very proactive in bringing about changes in their approach to health and life. These women had a role in promoting the trend of antenatal and postnatal checkups, regular immunization and family planning as part of the safe motherhood campaign. This trend is visible in all groups, but is strongest in the Brahmin/Chhetri and Tharu groups and weakest in other groups.

The female community health volunteers (FCHVs) have played the most important part in the promotion of women's health in the area. The FCHVs are active in increasing women's awareness of health issues and encouraging their participation in the heath programs provided by the government. Other factors in this transition process are the immunization services and health awareness programs provided by the health post free of cost. Women are generally aware of issues such as HIV/AIDS and freely shared with us information about health with family members as well as neighbours.

The safe motherhood campaign can be considered a success in Banigama and is of great relevance not just for women, but for the community as a whole, as it promotes better

maternal and infant care, awareness of the importance of nutrition and hygiene, regular checkups and immunizations.

VII

The health sector is treated with utmost importance in an underdeveloped, welfare state like Nepal as it has the potential to influence many other sectors of civic life. The HMG/N has duly launched a number of programmes to improve the health of the people, particularly in rural areas. Generally, Nepal lacks major support infrastructures in all sectors of civic life, including health services. Although an extensive network of primary health care centers have been created, they have not been functioning well due to problems such as lack of trained manpower, inadequate supply of medicines, insufficient budget and the geographical constraints. In recent years, the HMG/N has displayed a commitment to decentralize the delivery of health services. According to the decentralization process, the government has tried to facilitate peripheral health services through health posts, FCHV, TBA, PHC outreach and EPI outreach. The management of sub health posts in VDCs is being transferred to community management and funding for them will be channeled through the local DDC / VDC bodies.

The health post is one of the cheapest sources of health facilities available in Banigama. Lack of adequate medicine and budget has cripple the effectiveness of the health post and it often has to restrict its activities to referring patients to the district and zonal hospital.

The FCHVs are very popular in Banigama as they work among the women to promote their health and health awareness. There is a provision of one FCHV for every ward. The FCHVs are volunteers who work under health post, but they are gradually becoming frustrated because their role as government volunteers is generally misunderstood in the village. After an initial 10-day government funded training they are given a starter kit of medicines, but after that they have to fend for themselves by providing health services and using the fees they receive to update medicines in the kit. Unfortunately the general impression among villagers is that the FCHVs and TBAs are government employees and that there is no need to pay for the medicines and services they provide.

The TBAs have limited work in that they specifically assist deliveries only. There is a provision of one TBA per thousand people and training priority is given to women

indigenously working as *sudden (traditional midwives)*. There should ideally be nine TBAs in Banigama but presently there are only four. A large number of women have admitted that they delivered babies with only informal, traditional home support.

Another programme related to preventative health services in the periphery is EPI outreach. The nation-wide immunization process to eradicate polio has been very effective, as has been immunization against tetanus and the campaign for Depo-Provera - the family planning devices for women.

Although the FCHV, and EPI have gained popularity and people have responded positively to them, lack of budget, adequate manpower, and the absence of proper co-ordination and monitoring have dug into the effectiveness of the government health services in the area. Apart from government facilities, medical shops have also played a significant part in uplifting the health status and awareness of villagers in Banigama. Government propaganda through electronic media to promote health awareness has actually been stronger than the health extension services provided.

While the government is launching numerous programmes to increase public awareness of various diseases and health hazards, most people are not even aware of what the DDC and VDC are doing and they do not understand what is happening and what should be done. There are two levels of health priorities in Banigama. While TB, AIDS and Cancer are prioritized at the national level, Kala-azar, Malaria, and Encephalitis constitute the major health challenges in Banigama. The local hot climate, mosquitoes, unsanitary environment, and unsystematic housing have resulted in the increase of mosquito vector illnesses. Until 1950s and 60s Malaria was another highly troublesome disease in the area, but with focused government intervention it has almost been eradicated in the past few decades.

With reference to public awareness of health issues, people's awareness on fatal disease like AIDS, TB, and Cancer is surprisingly high and this can be attributed to the government's campaign on mass media. While awareness of HIV/AIDS cuts across all groups, it is mostly the Brahmin/Chhetris who have a clearer understanding of the transmission process.

We have observed that the stigma attached to HIV/AIDS is preventing many people from being tested, and this promotes the silent spread of the disease. Thanks to the government campaign, awareness of TB is also evenly spread out across all groups with the exception of the Terai Dwellers. Interestingly, the awareness of cancer in the general

population is much less compared to that of AIDS and TB. The Tharus are also better informed about the disease than the Brahmin/Chhetris.

In our study, education, income and caste factors have emerged as the major determinants of changes in perception and behavior of the people. Education has been seen directly influencing people's income, exposure to information and to the outside world, personal capabilities and the level of understanding of issues relating to health.

With no one illiterate and 40.73 per cent of its members completing secondary education, the Brahmin/Chhetris and Tibeto-Burmans are comparatively better educated than other castes/ethnic groups in Banigama. The Tibeto-Burmans appeared doing well in terms of education although they are lagging behind in other sectors. The Tharus, the Terai Dwellers and finally the Untouchables follow them in terms of achievement in the field of education.

Generally, education fosters better comprehension of science and technology, and help people overcome the spell of many traditional superstitions and help them embrace logical reasoning. This encourages health awareness and promotes the demand for environmental sanitation, clean drinking water, and healthy cultural norms. As an example, while 81.48 per cent of the better-educated Brahmin/Chhetris have constructed toilets in their houses, other less educated castes/ethnic groups have not viewed toilets as a basic need and do without toilets.

Clearly, Banigama is a prismatic society where one can see an intriguing blend of scientific processes and deep-seated cultural superstitions. Here, as in the rest of Nepal, faith healers and medical practitioners exist side by side, providing services to both the literate and illiterate sections of society. While there is a noticeable shift towards modern medicine across caste/ethnic group boundaries, the Brahmin/ Chhetris are seen to be leading the march towards modernization whereas other Tharus, Terai Dwellers, Tibeto-Burman and the Untouchables are seen lagging behind, somewhat.

VIII

One can draw some theoretical inputs from the present study to further sociological understanding of the relevant fields. In the introductory chapter of the present dissertation we referred to some relevant theoretical propositions; our effort now would be to look back

and establish the possible linkages between those propositions and the theoretical inputs that the present study offers.

The Functionalist theory, basically the Parsonian perspective, emphasizes the role of medicine in maintaining social harmony; the sick, according to this view, are brought to normal physical condition in order to save society from physical disintegration, the health system thus playing a very crucial functional role. The socially managed traditional health system in an underdeveloped social setup like Nepal have been playing this functional role over the historical periods and have taken institutional forms, strongly entrenched in the ideology and health practices of the people. The state run health network and health services, which have a recent history particularly in rural Nepal, also stem from an integrationist perspective as the welfare state's prime objective is to integrate its population into the system by addressing the concerns of people's life and death or by resorting to "bio-politics", to use phrase of Michel Foucault (see Foucault, 2000). The strategy here is to integrate people by meeting the basic necessities of people en route participatory development. The common people are thus targeted for their integration into the system both ideologically and in practice.

Manuel Castells (1977; 1978), from a Marxist-Structuralist perspective, has located the functionality in State sponsored means of collective consumption, such as education, social services and health which are aimed at reproducing labour power for the capitalist social order. The state control and restructuring of the collective consumption is accounted for by Castells as meeting requirements for the reproduction of labour power and social cohesion, and to overcome a potential contradiction between the profitable production of exchange values and the necessity for the consumption of the use values. Castells drew his model from his experiences in France and the USA, the states having a strong state and highly organized capitalist class, which together can manipulate the means of collective consumption to suit their interest and the interest of the social order. Nepal, however, presents a case where we have a weak state, highly underdeveloped means co collective consumption (including health network) and not-so-articulate capitalist class, which can maneuver everything of the system to further their interest. The state in Nepal, therefore, intends to promote the means of collective consumption from the bio-political considerations. The primacy here might not be the class interest but politics. Primacy of politics here means that the ruling powers resorts to bio-politics in order to maintain their hegemony.

In an underdeveloped system like Nepal the state, however, is always incapable of providing an adequate health service to the full satisfaction of the people. The lacuna in the government run health system are many and the inadequacy and insufficiency of the system allow and at times compel people to fall back on the traditional medicine or to seek health services from the market, which are always beyond the means of most of the people in a poverty-stricken social setup like Banigama. The affluent few in the middle and upper classes can reach out to the private health system, which again is performing a functional role in a stratified social order. In a socially and economically fragmented social order with a weak state provided health network people are thus free to chalk out their health strategy according to their means and shared knowledge. The obvious result of this is health pluralism where no particular health tradition, traditional or modern, is having its complete hegemony.

Again, one has to approach the question whether the existing forms of health services are perfectly functional and adhere to the ethos of sick role as advocated by Parsons with a fresh look. Parsons' argument that medical professions are motivated by factors other than making money, e.g. genuine concern for patients, which he tried to amplify with his notion of medical professionals as gate-keepers and guardians, does not hold much ground in the context of Banigama. The present study has pointed, contrary to Parsonian proposition, to some areas of tension, which could be treated as a departure from the sick role ideal. The growing trend of commercialization of the health services might not prove to be functional from the point of view of the impoverished sections of population in Banigama. Their continued dependence on the faith healers and the untrained medicine shopkeepers questions the acceptability of the modern medical services. The inevitable fall-out of the existing medical services would therefore defy the functionality and integrative power of the prevailing medical services. The existing caste-class differentiation is found to be a decisive factor in people's differential access to health awareness and to modern scientific treatment; the differential standard of living is clearly reflected here. The differential access to modern medical treatment does not, in any way, conform to the idea of social integration.

The Marxist approach, contra the functionalist one, emphasizes on the causal role of economics in the production and distribution of disease, putting profit ahead of health. This approach is also critical of the conflicting and exploitative nature of medical services provided by the medical professionals through an individualized explanation of disease. The Marxist argument is that the mode of treatment of disease itself is a dictate of the capitalist society; when health services are commodified the medicine industry thrives in the profit

making business. In this arrangement the physicians, the nursing home operators earn a share of the generated profit, but they primarily further the interest of the industrial capital. The functionalist ethos, people's right to health and health services - are all lost in the wilderness of health market and profit making. Since the health services are highly technical the illiterate and impoverished and unformed villagers end up being cheated by the private operators of the health services. The non-transparent mode of operation of the private controlled health system in the urban areas makes the illiterate service seekers vulnerable to cheating and exploitation. According to the findings of this study, mostly the high-income groups access health services from medical shops and qualified private practitioners. Such findings only resemble the model of Marxist/political economy of health to some extent, because the majority of the people receive health services from medical shops. Only a minority among the high-income group benefits from the services of qualified private practitioners. Although not too many people are in the net of the private health services now in the years to come this sector would spread its wings to take in more and more people.

The ethno-health culture of the people and the government sponsored scientific modern medicine are at loggerheads and in that battle the latter emerges as the winner most of the times. The modern medicine, along with its associated ethical values and norms, thus has a steam rolling effect on the ethno-medicine. The contraceptive pills, two children norm, the chemical drugs are prescribed to the people, both by trained and untrained practitioners, and the innocent patients are expected to buy and consume them without having any transparent access to information relating to the ill effect of all these in health, economic and social terms. There are therefore signs of regimentation of the health system by the modern medicine and market combine and that people are gradually freeing themselves from the clutched of traditional medicine and exploring the field of modern medicine. The fragile looking government health network often falls prey to the market pressure and makes way for the private health network. The prospect of participatory development in the health sector is thus put into jeopardy.

The people, although constrained by illiteracy, social backwardness, poverty and lack of information, act on the basis of their own reasoning and understanding of the objective conditions, the realities of the life world. The plurality in health culture and health seeking behaviour of the individuals and groups could be explained by the fact that they approach health and illness from their respective understanding of the situation they live in. The hangover of the cultural traditions and that of their lived experiences cannot be wished away

in understanding why particular individual or group resorts to a particular health behaviour. The existing mode of health practices again is not static as the people always reflect back and forth between their existing perceptions and the newly emerging perceptions offered to them by the forces of change. Keeping the plurality, dynamism, and tension in the existing health culture of Banigama we need to be eclectic in our theoretical approaches.