Introduction

The Problem of Study and its Context

The present thesis entitled ***Sociology of Health and Illness: A Case-Study of Banigama Village Development Committee (VDC) in the Eastern Terai region of Nepal*** is a micro level empirical study in the area of health behaviour and health culture of the people living in a relatively backward village of Nepal. The study is set out to explore the socio-economic and cultural setting the people studied, the state-sponsored health infrastructure they live with, people's perceptions of health and illness, their persistence with traditional health practices, the perennial health problems that their social setting offers, and peoples responses to the modern health system and its impact on the changing health culture. Generally speaking, the state of health and illness of the people and the mode of treatment of ailments are largely determined by the prevalent socio-economic and cultural factors. The study is inclined to a sociological approach to health as it would try to construct a social and cultural narrative of health behaviour and health perspectives. This study aims to examine the perception and behavior of people towards health and illness and the mode of treatment they resort to by applying a comparative method in terms of caste/ethnicity and class, as well as income and educational status of the households. Besides, the influence of traditional beliefs on the perception of health and illness, and the modifications in these beliefs in the context of modernization of traditional norms are also examined. The exogenous forces like the state policies and programmes, the welfare policies (of which health policies are a part), and development package, people's exposure to outer world, the role of NGOs and individual agencies, if any, and their influence on the present health culture of the people would also be addressed in the present study.

In studying the health perception, health culture and health behaviour of the people of a locality we have referred to (a) the traditional context, i.e., the traditional social and cultural set-up the people live in, peoples' traditional health perceptions and practices; (b) the state sponsored health services available in the area and other institutional initiatives in the area of health - their effectiveness and lacunae; (c) the privately developed health network and health services; (d) peoples' initiatives in promoting a modern health culture; (e) the perennial structural problems people suffer from in the transition to a modern health culture; and (f) the influence of the socio-economic factors like class, caste and ethnicity, education, and gender

that influence the health culture of the people under study. The population of study and the context present a picture of a locale in the changing mould: a tendency to stick to the tradition, a change over to modern and an admixture of tradition and modernity. The traditional-backward setup we are studying is constrained by the structure but it gathers forces from within and without which can lead to restructuring of the traditional patterns of health practices and health behaviour. The emerging rationality, peoples' continuous effort to make the best use of the opportunities available to them by the system and peoples' potential to play the agency would reflect back on the tradition to bring about changes. The people, the agency cannot operate without being influenced by the state, the dominant society, the penetration of the liberal ideals, the values of the market society and the increasing tendencies to devalue the public health care system and increasing penetration of the private health care system. Thus the dominant urban health culture would have its influence on the local rural health culture.

There is a general problem with health awareness. In the villages of Nepal, unless and until people become bedridden, they do not consider themselves sick. Generally, people are less conscious about their health and the need for sanitation than they are for other basic needs. For instance, they do not necessarily consider diarrhoea as a symptom of sickness. People are not aware of healthy living habits, such as preventing water-related diseases through good hygiene and use of properly constructed latrines. Overwhelmingly, villagers still use the roadside, open fields, riverbeds, and bushes - and not latrines - to relieve themselves.

Babies are commonly delivered at home. Moreover, it is carried out in a traditional manner by women conducting the delivery themselves without any assistance at all or with only a family member or neighbour to help. Village culture has not internalized the need and importance of a trained birth attendant at the time of delivery. Women are generally not aware of the need for antenatal and post-natal services. Unsurprisingly, maternal deaths rate is one of the biggest health problems in Nepal. The government of Nepal has formulated peripheral health services in order to combat the challenges cited above and to improve people's access to health services nationwide. In spite of this, however, there has not been a marked improvement in the heath of the population.

Although the health infrastructure available at the village development committee level is far from being adequate, people, by and large, have still not been able to make the optimum use of the services. When the local people get sick, the general tendency is to

consult their traditional healers (*dhami / jhakries*). Even though such consultations actually cost relatively more (both in cash and kind), there is a prevalent misconception that treatment at the health centres is more expensive. Two main reasons for such phenomena justify this behaviour. Firstly, the health infrastructure is severely underdeveloped. Most health personnel at rural health centres examine patients in the clinic and prescribe medication to be bought from a nearby shop. This is because most health posts stock only minimal amount of limited medicines. Secondly, with respect to traditional treatments, the villagers perform the rituals recommended by the traditional healer and pay in kind by providing chicken, goat, and rice etc. So, no immediate cash is required. Moreover, the traditional healers' assurance that they need not pay in cash until they are better is unwittingly deceiving as villagers do not compute the value in cash of the items given to the faith healers at the time of their illness. The third stage of the treatment pattern is for them to consult quacks, ordinary shops or medicine shops. Health centres are generally viewed as the last resort if all else fails.

These are some of the glimpses of how the overall health culture in the locality is still largely in the traditional mould. But this does not in any way suggest that things are not changing. People with education, relatively better off class background and with grater outside exposure might be coming out the traditional health culture and are approaching health problem with more rational, modern and pragmatic outlook. The research problem for this study arose from this conceptual position. What are the socio-economic characteristics of the people in the study area? What are the socio - economic and cultural factors that influence the health and illness perception and behaviour of the people of the study area? What is the general perception and belief of the local population towards health and illness? What is the mode of treatment - the medical pluralism - against sickness among the people of the study area? Other problems concerning women's problems and perspectives on health and illness and the factors influencing this are also of importance as they have a direct bearing not only upon women's health alone but also on the health of the whole family. It is equally important to analyse how traditional belief systems are changing and how this influences the health culture at present. The role of the government in enhancing the health status of the contemporary rural Nepali society and has also been addressed as an important research problem.

The Problem in its Historical and Social Context

Nepal is a small South Asian Himalayan Kingdom with an estimated population of over 23 million people. The total area of the country is 141 thousand sq. km. Nepal lies along the East meridians of 80^0 4' and 88^0 12' and the North parallels of 26^0 22' and 30^0 27'. India borders Nepal on the West, South and to the East; the Tibet region of the People's Republic of China lies to the North. Although a relatively small country, Nepal is diverse both demographically and geographically. Ecologically, the country is divided into three distinct topographical regions: the Mountain, Hill and Terai (plains). Two-thirds of the country is hilly and mountainous and one third is low-lying plains. The population of Nepal includes both Indo-Aryan and Mongoloid strains and their blending and coexistence has been shaped by Nepal's history, culture and civilization (Kansakar, 1989). There are more than 61 ethnic groups speaking around 60 different languages in Nepal. About 81 percent of the population depends on agriculture, out of which approximately 85 percent is dispersed in rural areas with limited resources and poor infrastructure.

Socio-economic conditions have been known to influence human health. For the majority of the world's people, their level of socio-economic development primarily determines health status, e.g. the per capita Gross National Product (GNP), education, nutrition, employment, housing and the political system of the country all have direct bearings on livelihoods. The Nepal Living Standard Survey of 1995/96 estimated that 42% of the population is living below the poverty line. This data was based on the official poverty line of NRs. 4,404 per year. The human development index (HDI) of the UNDP provides Nepal's current overall Human Development Index ranking-which is 129, lower than all its South Asian neighbours except for Bangladesh. This level is consistent with other socio-economic indicators for Nepal (UNDP, 2001). A striking feature of Nepal's social poverty is the low literacy rate. The 2001 census claims that the overall literacy is 53.7 percent. Male and female literacy is 65.8% and 42.5% respectively. The mean year of schooling of males and females is 4.45 and 2.25 respectively. The overall life expectancy in Nepal is 59.5 yrs. Of which the life expectancy of males is 59.3 yrs and females 59.8 yrs, only marginally higher than that of male counterparts. The per capita of the country in terms of US $ in 1999 is $ 221, which is the lowest in South Asia (CBS, 2001).

Health status is uniformly poor in Nepal. There are remarkably high incidences of parasite infestations, water borne diseases, acute respiratory infections and morbidity associated with pregnancy and childbirth. There is no data on health status along ethnic lines

and income-levels, but it is almost certainly worse among the poor because their lower nutritional status leaves them more susceptible to disease. The poor are also least likely to have access to either curative or preventive health services. The health of many families is so badly affected that it impairs their ability to work. This drains total labour productivity, reduces personal incomes and increases the dependency on breadwinners in the family. Nepal, being a patriarchal society, unavoidably has gender disparities in health and illness that result in discriminations against women in health care. Hygiene and sanitation in villages is poor. In rural areas the proximity of animals such as cows, goats and buffalos to the family living quarters encourages the spread of disease through faeces and insect vectors; as a result, the incidence of diarrhoea is widespread.

The amalgamation of such socio-cultural, economic and political factors and also the intermingling of ethnic factors has resulted in an assortment of treatments for illnesses including home remedies, quacks and traditional/faith healers. People believe in '*Karma*' and *'Punar Janam'* (rebirth). Nepali society is predominantly Hindu and believes in the existence of a supreme universal spirit. Hinduism affects family life, food, dress, health and illness and even architecture. Each caste/ethnic group worships their specific deity and most tend to be fatalistic. Unexpected happenings in all aspects of life are generally accepted with a resigned *'Mero Bhagyama Yahi Thiyo'* meaning 'it is fate'. Illnesses are attributed to displeased deities, and speedy recovery is sought by consulting traditional/faith healers for treatment with vows to make pilgrimages and sacrifices to their chosen deity once they are better. Belief in witchcraft and sorcery exist even today in rural societies of Nepal. Some people believe a person may inherit black magic from parents or others. Belief in witchcraft and sorcery are one way of explaining the inexplicable, controlling the uncontrollable and accounting for the problem of evil. Rural communities also consult *'Dhami* and *Jhakri'* for treatment. These Shamans are considered to have certain powers that come from direct contact with the supernatural. They are believed to be able to cast out evil spirits, especially by curing diseases, and can therefore be considered as providers of religio-ethnomedical services.

Even today, people first attempt to treat illnesses with household based self-medications including herbal remedies. *Ayurvedic Vaidhya* (herbal practitioners) treatments are also sought. Most ethnic groups in the villages of Nepal have designated opinion leaders "*Janne Manchhe* (knowledgeable person)" from whom they seek advice for treatment of illnesses. Religious belief and rituals are also seen to help people to cope with illnesses. For most people, religion is a matter of following traditions; people worship as their ancestors

did. Religion is a fundamental feature. Each society has different forms of religious activities and expressions of religious behaviour.

Geographically, Nepal is divided into three ecological regions the Mountains, Mid hills and Terai. With a few exceptions in the three ecological regions, generally the Tibetan speaking people such as the Sherpas live in the Mountainous regions. Various Tibeto-Burman and Indo-Aryan people inhabit the Mid-Hills. The plains region of the country, called the Terai, stretches East to West across the South of the country and is inhabited by various indigenous peoples. People of the Hills origin call the Terai *'Madhes' (mid land)*. Although Hill origin people (Brahmin, Chhetri and others)- the *'Parbate'* have been migrating extensively all over the Terai regions, the caste consciousness or the sense of the hierarchical ordering of social categories has not disappeared. Because of this, *Parbate* Hindus and Terai Hindus share many customs. But there are considerable differences in the rituals performed by Hindus and Tibeto-Burman speaking people. Newars belonging to the Tibeto-Burman ethnic group have an exceptionally organized caste system which serves as an internal stratification of the ethnic community. The Tharus are an indigenous group and are probably among the oldest groups to inhabit the Terai. They are unlike other Terai dwelling groups ethnically and closer in features to the Tibeto-Burmese groups residing in the Mid-hills. Bista (1980) notes that separate studies by Mahalanobi, Majundar and Rao have all established the Tharus to be of certain Mongoloid decent. Other Terai dweller groups are the same as those in North India such as Yadav, Dhanuk, Mandal, etc.

Although only 18% of the total land area is under cultivation, Nepal has an agrarian economy that engages over 80% of the population. 40% of the GDP comes from the agriculture sector, and subsistence agriculture by and large dominates the traditional agriculture system. The Terai is considered the agricultural backbone of the nation. Economically speaking, the structural stagnation in the Nepali economy and society over a long period of time has restricted occupational and social mobility of the population. Some critics view agricultural failure as the root weakness of the entire economic base of Nepal. The stagnation of urban areas and absence of capitalist development are other crucial factors retarding Nepal's development (Blaikie, et. al, 1980).

This subsistence-based livelihood deprives most Terai dwellers of basic education and nourishment. In most cases they lack modern social amenities and opportunities for occupational mobility. Terai villages tend to be devoid of both economic development as well as cultural modernization. In spite of the constitutional prohibition of caste discrimination,

the caste system is deeply rooted religiously, socially and economically in rural societies. As mentioned earlier, women there are massive gender disparities in male and female literacy and health status. But all hope is not lost. By the amendment to the National code during the International Women's Year, certain changes have been introduced in the status of women. Daughters have been granted equal rights to sons to ancestral property rights if she remains unmarried after the age of 35. The minimum age of girls' marriage with guardian's consent has been set at 18 years in an attempt to discourage child marriages. The law also prohibits dowry. While the legal enforcement of these endeavours is economically unfeasible today, it is commendable that these steps have been taken, albeit on paper.

Health and Illness in the Present Context

This study was conducted in Banigama VDC, which is geographically situated between the Indian frontier and foothills of the Himalayas. The Hill people refer to Terai dwellers as "*Madhesi*" which is still a continuous designation of the "Terai" people (Yadav, 1984). The Terai people have strong ties with the border people in Northern India by a network of ties involving kinship, religious obligations, common myths and economic activities. Culturally these people are distinct from the Hills population and retain their ways of life in spite of the dominant Hills culture. Over the past few decades, Hills people have migrated and settled in the Terai bringing their own traditions with them. This trend of migration escalated after the 1950s-1960s after the eradication of Malaria in the Terai. The major focus of the government during 1950 and 1960s in the health sector was Malaria control. People in the study area believe in supernatural powers and attribute illnesses to displeased Gods and evil spirits. They equate illness with other misfortunes. People in the study area are seen to resort to both traditional and modern medicine for treatment. For most illnesses they first utilise home remedies, specific dietary regimes, quacks, faith and traditional healers. Health centres and hospitals are often the last resort and sought only for serious or persistent illness. Ayurvedic and Indian herbal medicines are used and practitioners are also consulted where available. Some people belief in witchcraft and sorcery and even attribute low crop yields to sorcery. When family members get sick they suspect somebody as being a witch and casting an evil eye. *Dhami/Jhakris* are consulted and several rituals including animal sacrifices carried out as instructed by the faith healer.

Even though 80 percent of diseases are caused by water, it is still not perceived as a threat by the rural population. People do not have ready access to safe drinking water, do not take regular baths, and many do not have toilets. Because of these unhygienic behaviour patterns, the incidence of diseases, most of which are preventable, is high. Except for diseases believed to be caused by spirits, people appear to be comfortable mixing their treatments and using whatever they perceive to be effective. In addition to their caste and ethnic values, language group and social status, the attitude of health workers towards patients is also seen to influence the effectiveness of health care delivery. This is clearly reflected in the comparatively worse health condition of occupational caste groups. It is, however, rational to infer that health and illness is undoubtedly a more complex phenomenon in Banigama and is influenced by many determinants, such as economic condition, education, caste/ethnicity and cultural attributes.

The significance of the caste system in Nepal

It is believed that the caste system was introduced in Nepal as early as the first century A.D. during the medieval period. The caste system was made rigid and was greatly favoured by the rulers. The people of Nepal have become greatly influenced by the distorted meaning of caste. In the modern period[1] caste became a state-protected ideology and violation of caste norms led to punishment.

The traditional view of caste is derived from sacred Hindu texts that divide Hindu society into four *varnas* (orders): Brahmin, (traditionally priests and scholars), Chettri (rulers and soldiers), Vaishya (merchants) and Sudra (peasants, labourers, servants). Untouchables - these days termed 'Dalits' (occupational castes such as Kami, Damai, Sarki) are outside the *varna* scheme and have been regulated to doing what is considered dirty work and as a result are considered impure, and therefore labelled 'Untouchable' by higher castes/ groups.

People with so many different origins and cultural backgrounds can not possibly be arranged into strict social frameworks. However, the values of the Hindu caste system tend to pervade the entire Nepali society. As a result, people outside the caste system - the Tibeto-Burmans, such as Gurungs, Magars, Rais, Limbus, Tharus etc. - are tempted to rank themselves within the traditional Hindu caste hierarchy, seeking a relatively high position either equal to or just beneath that of the Chhetris, who are ranked second in the caste

[1] The history of modern Nepal begins with Prithivi Narayan Shah, King of Gorkha, who was enthroned in 1742 A.D (Regmi, 1999).

hierarchy (Bista, 1992). In today's Nepal, they are labeled as ' Janajatis ' and are not included under the conventional Hindu hierarchical caste structure. The 'Janajatis ' are for the most part indigenous people. The caste system, although legally abolished since 1963, is still entwined in Nepali society today (Sharma, 1999).

Despite the Hindu predominance, Nepal is an ethnic mosaic and represents cultural plurality. In the Nepali context in general there are three areas that impact the accessibility of services significantly. These are caste/ethnicity, gender, and interactions between traditional and modern systems. Power and control of resources are determined primarily by three key factors: gender, wealth, and caste or ethnicity. Wealth can be acquired, but gender and caste are inherited characteristics. These key determinants are firmly embedded in indigenous social, cultural, religious and economic systems. Each is important in order to understand the reasons for the preference given to particular health services in terms of its impact on the allocation of resources and types of participation likely to be encountered. The existence and manifestations of gender discrimination are relatively straightforward: men have more power and hence better control of resources than women. Although Nepal's legal code is continually being challenged and modified to provide basic inheritance and other legal rights for women, gender based equality still has a long way to go.

The process of changes in Nepal began only in 1950 when the century old autocratic Rana government was overthrown. Nepal's socio-political system may be called a patrimonial system. The country has a continuous history of Royal dynasty since Prithvi Narayan Shah, the founder of modern Nepal, integrated numerous states into a unified Nepal in 1768-69 (Regmi, 1999).

After the decade long autocratic Rana regime was overthrown in early 1951; Nepal had a parliamentary system for about 18 months, which was dissolved in 1960 after the establishment of the new Panchayat system. The multiparty system was restored in 1990. The first periodic plan to chart out Nepal's development was initiated during the Panchayat system in 1956.

Caste/Ethnicity in the Context of the Present Study

The study area - Banigama VDC is inhabited by a majority of Tharus, who are outside the caste system and identified by the generic term 'Tharu'. Tharus are probably the earliest settlers in the Terai. S.K. Srivastava argued that the Tharus are a Mongoloid people or

predominantly so, who, with time, successfully assimilated non-Mongoloid physical features (Shrivastava, 1958).

Among other groups in the study area are Brahmin/Chhetris who are generally referred as' Parbate' (Hills) Hindus. Their ancestors have migrated from the Hills and settled in Terai. Brahmin/Chhetris occupy the upper most stratums in the Hindu caste hierarchy. Brahmins, besides their chosen occupations, also serve as family priests.

Similarly, in the study area there are inhabitants of Terai origin such as Yadav, Dhanuk, Mandal, Ghwar, Koiri, Musahar etc. These groups are often referred as *Madhesi* (Terai dwellers). Apart from the recent *Parbate* (Brahmmin/Chhetri) migrants, the majority of the people in the study area are indigenous and recognized as such by the Hindu caste system. There is, however, an"Untouchable" group that is considered impure and shunned by this system. Untouchables such as Kami (blacksmith), Damai (tailoring group) and Chamar (shoemaker) are also residential in the study area.

Apart from inhabitants of Terai origin, the study area also includes a few Newars and Tamangs, both Tibeto-Burman groups. Newars have their own specific caste system. Nepali (1988) observed that Newars have typical Mongoloid physical characteristics (Nepali, 1988). Prof. Bista noted that Newari society is structurally complex with many different caste groups, yet fail to observe rigid principle of cleavage and vertical hierarchy. Whatever socially regulative councils were operative among the Newars originated before the introduction of the caste system and have a professional or trade basis (Bista, 1992).

Basically, caste/ethnicity in the study area can be categorized as Brahmin/Chhetri, Tharu, Untouchables, *Madhesi* (Terai dwellers), and the others. The others group includes Tibeto-Burmans (Newar and Tamang) who are a minority in Banigama VDC.

Traditional/Faith Healer in the Context of the Study Area

People belonging to all the castes/ethnic groups of Banigama VDC believe that illnesses are caused by displeased deities. All resort to specific home remedies and traditional healers before consulting medical practitioners. There is a gradual increase in the trend of consulting medical shops for allopathic medicine as well as patronage to schools and health-posts. Villagers recount their problems in the medical shop and are prescribed medicine based on their verbal account and, by and large, not on the basis of clinical examination. Locals have made it a habit to visit medical shops, give an account of ill household members and purchase medication prescribed by the shopkeeper when they come to the Bazaar for other business.

Brahmin/Chhetris have their *'Janne Manchhe'* (to chant mantra) who works as healer for curing the sick. For instance, if someone has sinusitis, he takes a sickle and draws a line on the floor chants a mantra touching the forehead of the sick several times. People of this group consult quacks, medical shops first. Treatment is sought at health posts only if a sickness persists. They also consult Vaidhya for herbal medicines.

Tharus comprise the largest group in Banigama VDC. Tharus have *'Badghar'* (opinion leader), sometimes also called *'Bhalamansa'* whom they consult not only for advice concerning treatment but also for several other activities in their day to day life. In general, Tharus have strong ethnic solidarity controlled and guided by the institution of *'Badghar'* (a house where moral leadership exists). Generally, the eldest 'Badghar' is the leader. It is not necessary that the 'Badghar' should be from the high-income group. Tharus also have faith healers traditionally known as '*Guru*wa'.

The *Madhesi* (Terai dwellers) also have their 'Janne Manchhe' whom they consult when they get sick. In the *Madhesi* group *Dhami* provides the services of traditional healing. In some cases a specific *'Naut'* (a barber) also performs this job.

In general, in the places (notably in the Mid-Hills of Nepal) with Tamang (Tibeto-Burman) majority are guided by their opinion leader 'Lama', who also performs the job of traditional/faith healers, but since there are only few Tamangs in Banigama VDC, they do not have a 'Lama'. It is the same case with the Newars in Banigama VDC.

Interestingly, despite their specific origins, all ethnic groups share the services of faith healers interchangeably. Occupational castes do not have their own traditional/faith healers but rely on whomever they can please or gain sympathy from.

Class in the Context of the Study Area

In this part of Nepal, as in other parts in the country, social structure is hierarchical in terms of its socio-economic and political arrangements. Following the Max Weber's approach, homogenous groups can be grouped into similar classes particularly in terms of their land holding occupation and annual income. High caste people dominate as they have more agricultural land, generally richer and hence powerful. These people dominate over the poor and low castes as the latter groups are poor and dependent on the rich for their livelihood and hence have little control over the life chances.

Health and Illness as a Social Construction

Health and Illness are not absolutes but matters of individual perception and definition. Defining health is a difficult task as it varies with time and culture. All cultures have their own perception of a 'healthy' individual, illustrating the vital role that the social construction of reality plays on our lives. The simplest and most universal definition of health is the absence of disease. Health is undoubtedly a more complex outcome, influenced by many determinants such as social and economic conditions and education. Poverty and discrimination (sexual, social and others) are also indirect factors that are too often ignored or neglected.

In 1941, international health experts categorized three basic components of "health" as physical, mental, and social wellbeing (WHO, 1946). To this, Henslin (1997) has added a spiritual component and defines health as more than just the absence of morbidity. A truly healthy person not only feels physically good but also has a realistic outlook on life and gets along well with others. Good health enables people to enjoy life and adjust for themselves (The World Book Encyclopaedia, 1996). Likewise, illness can be either mild or serious. They can strike almost any part of the body, and affect a person's mental or emotional health.

Nearly everyone becomes ill at one time or another. Scientifically, we know that illness is caused by tiny living organisms such as bacteria or viruses invading the body. These tiny objects, commonly called germs, are scientifically referred to as micro organisms. Illnesses caused by these beings are known as infectious diseases. All other illnesses can be grouped together as non-infectious illnesses. Some illnesses occur chiefly in certain climates and geographical regions while others strike mainly during certain seasons.

Diseases have troubled human beings throughout history (Ibid, 1996). The majority of rural people in Nepal still believe that illnesses occur because of displeased deities and other misfortunes. Even the dimensions of health, then, are subject to debate. If we have to agree on the components of health, we would still be left with the question of what makes someone physically, mentally, socially, or spiritually "healthy". Again these are not objective matters, but vary from culture to culture. In a pluralistic society, they even differ from one group to another. As with religion, the concern of sociologists is not to define "true" health or "true" illness. Instead, it is to analyze the effects that people's ideas of health and illness have on their lives, and even how people determine that they are sick (Henslin, 1997). Even after devising such a holistic definition about health and illness, it is indeed difficult to conceptualize and standardize positive health with specific clear-cut attributes and criteria.

However, in the process of pointing-out the most relevant factors that determine health, three broad categories emerge:

- Social values and individual behaviour,
- Environment and disease pattern, and
- Health care delivery systems.

Approaches to Health and Illness

The major sociological perspectives on health and illness are as follows:

a) Functionalist approach
b) Conflict approach
c) Symbolic inter-actionist approach
d) Labelling approach
e) Feminist approach

a) Functionalist approach

Talcott Parsons was the first among the sociologists to develop the concept of the sick-role, and his functional perspective had extensive bearing for long on the sociological research related to the field of health. This perspective begins with the assumption: if society is to function well, its people need to be healthy enough to perform their normal roles. This means that society must set up ways to control illness.

Three components, namely the concept of the sick role, gatekeepers to the sick role and doctor-patient relationship emerge from this perspective.

The Sick Role

Talcott Parsons (1951) pointed out four elements in his concept of the sick role- that the sick are not held responsible for being sick, they are exempted from normal responsibilities; that they don't like the role; and they should get competent help so that they can return to their normal routines. It also argues that those who do not seek competent help are considered responsible for being sick. In modern societies, people can absorb a greater degree of illness or disability, but in agrarian societies the issue of worker's availability is a much more critical concern (Conrad and Kern, 1994). However, there could be many other ambiguities in the sick role in real life situations. It can be hypothesized that the major ambiguities may be derived from the societies of the developing countries and could also be 'gender' differences in the sick role.

Gate Keepers to the Sick Role and Doctor-Patient Relationship

Parsons has argued that physicians serve as gatekeepers to the sick, identifying the condition and designating people as ill or recovered. Parsons equates the doctor patient relationship with the relationship of parents and children (Parsons, 1951).

However, a patient cannot be considered as a passive object just like a machine. So, it gives an impression that Parsons functionalist concept of "doctor-patient relationship" is partly influenced by bio-mechanical model of health. He considers treatment as a process of social interaction between two people which can be considered as an art as well as science. In this regard King elaborates that both physician and patient perceive each other and interact on the basis of their reciprocal role expectations (King, 1962)

In spite of criticisms of the Parsons theory on health and illness, sociologists continue to rely on it.

b) Conflict approach

The primary focus of this approach is how people struggle over scarce resources. In this approach, *medicalization* of society refers to the growing role of medicine as a major institution of social control. For Marxists, the existence of a curative rather than preventative approach of health care is a consequence of capitalism. They attempt to link diseases to structural economic and political development. The Marxist approach emphasizes the casual role of economics in the production and distribution of disease, as well as the role played by medical knowledge in sustaining class structure. The hypothesis of this approach is based on the assumption of a conflictual and exploitative society, putting profit before health. It can also be stated that medicine serves as a key function in capitalist societies (White, 2002). People's status in terms of whether employed or not, the income earned, and possession of wealth and property is closest to Marxism in explaining inequalities in health (Bernard and Burgess, 1996).

c) Symbolic Interactionist Approach

This approach focuses on micro-level study of the role played by health care professionals and patients. We can see the interaction as a "performance", shaped by the environment and audiences in each medical tradition which is constructed to provide others with "impressions" that are consonant with the desired goals of the actor (Goffman, 1959). This approach also deals with self-medication, self-diagnosis and self-treatment. In the dramaturgical perspective

developed by Goffman, the entire world is a stage, and each of us chooses props and scripts suitable to support the roles we choose to play. One of the most central elements of these accessories is our physical body, and health can have an important effect on the kinds of roles that we can play successfully. This approach to health and illness helps us recognize the relative quality of illness. What is regarded as illness in one time or place will not be regarded as illness in another; what is regarded as an illness for one group will not be regarded as illness to another. This approach also explains that decline in religious belief in general in the twentieth century has also lessened other beliefs, which attributed almost any illness to sinful behaviour. Nonetheless older ideas still persist, and social stigma is still attached to certain illness (Goffman, 1968).

d) Labelling approach

This approach in particular deals with studying deviances. This approach advocates that, just like the regulators of social control - such as judges and police - label criminals, health care professionals have power to label certain persons as sick. Such labels reshape how others treat us and how we see ourselves (Becker, 1963). Goffman gave much impetus to the labelling theory with his analysis of the inner workings of a mental hospital, reported in his book 'Asylums'. Goffman's sociology might be called the sociology of the forgotten. Embarrassment, uneasiness, self-consciousness, awkward situation, faux pas, scandals, mental illnesses are his significant subjects (Collins and Makowsky, 1998).

e) Feminist Approach

This approach criticizes sociology as a whole for adopting a male perspective and marginalizing the role of females in society. Their postulate is that the way in which people are socialized into masculine and feminine social roles have a determining effect on their health and illness. The tenacity they put forward is based on the hypothesis of being exploitative and repressive of women through patriarchy. According to them, diseases are caused by carrying out the social role enforced on women by patriarchal men. Their claim is that even if *medicalization* takes place, it is centred only on the female's reproductive life cycle. They also charge the medical profession by arguing that medical profession has enforced conformity with patriarchal norms (White, 2002).

These various approaches to health and illness are not mutually exclusive. It was recognized that health, illness and mechanisms to restore one to health are intimately related

to socio-economic and cultural factors. However, definitely health is of a multi dimensional nature. Definitions of health change with time and culture. The simplest definition of health is the absence of disease. Health is a complex outcome, influenced by many determinants such as the social situation, economic conditions; others including poverty, discrimination (sexual, social vulnerability and others) are less direct but still too often ignored or neglected. So, socio-economic and cultural dimensions of health and illness are most important variables in the health of individuals and societies.

A Brief Review of Literature

This section presents a brief review of some pertinent literature on health and illness, which bear some relevance for the present study.

In ancient times, medicine was dominated by magical and religious beliefs which were an integral part of ancient cultures and civilizations. From a sociological point of view, disease is considered a social phenomenon occurring in all societies and defined and fought in terms of the particular cultural focus prevalent in all societies (Suchman, 1963). The simplest definition is, of course, that illness is just the opposite of health, i.e.; any deviation from normal functioning or state of complete physical or mental well-being since health and illness are mutually exclusive. The sociological imagination suggests that significant improvement in the nation's health will require changes in social institutions.

Health and illness are determined by supernatural, psychic, and interpersonal forces within a closed system of thought and belief, whose logic is that of the "self-fulfilling prophecy (Merton, 1949). Explanations for illness are limited in range, and fixed. When evidence contrary to traditional interpretations is encountered, there is a tendency to develop "secondary elaboration" that excuses or explains it away (Evans-Prichard, 1969). With limited exceptions, illness in most rural societies is believed to be caused by evil thoughts, feelings, or motives of other people through the medium of sorcery or witchcraft (Leslie, 1998). The level of knowledge, health beliefs and practices in relation to specific cultures should be examined to determine the health-seeking behaviour of any group. Social networks with multiple social bounds and restrictions maintain existing health beliefs, whether popular or scientific (Chrisman, 1977). Health is influenced by behaviour, and behaviour is influenced by beliefs. Hence, the understandings of beliefs can be of great help in formulating effective health policies which meet the requirements of ethical values and social justice. Every society has its own cultural ways of thinking about the human body and explaining the

multitude of ills. In some societies, for example, certain kinds of illness and even accidents are thought to have occurred because of a failure to fulfil obligations to living kin or dead ancestors (Evans-Prichard, 1937). However, the dominant, scientific model of cause of disease today draws attention to the part played by invasive micro organisms, pollutants and inherited traits (Dubos, 1959). As a result, many older assumptions that illness was due to moral lapses on the part of the suffering individual are no longer so common. However, Goffman has argued that older ideas still persist, and social stigma is still attached to certain illness (Goffman, 1968).

Nepali society is predominantly Hindu. Hindus believe in the existence of one supreme universal spirit that affects all aspect of human existence and in "*Karma*" which maintains that the present life of human beings is not an isolated existence but only a link in a series of existences. The soul within a body never dies. It is only the body that dies and is born again and again. Hindus also believe in "*dharma*" or virtue, which is said to lead to the correct path (Melkote, 1991). Hindus worship many Gods. Nepali social structure is characterized by a caste system in which people are believed to be born to a certain status that they must occupy for life.

People's perception and behaviour towards health and illness in rural Nepal have not progressed as well as they have in urban areas. The meaning of health has not been fully understood or safeguarded. Health services of the government are not effective mainly on account of the poor national infrastructure. As a result, the health status of the Nepalis is poor. People rely on both traditional and modern therapeutic traditions. A brief review of pertinent work in the Nepali context on the subject of health and illness is presented below.

Subedi notes that different medical traditions in Nepal co-exist very well. Each tradition has its own expertise, especially with respect to certain illness. In many cases, the question of which specialist to consult depends on the nature of the illness. For example, people seek *Ayurvedic Vaidyas* for Jaundice and *Dhami-Jhakri* and *Jharphuke Vaidya* (faith healer) or other local healers to drive out evil spirits. Minor discomforts, wounds and sores are often treated at homes with remedies based on food items and herbs; for more serious injuries, hospitals, clinics or health posts are consulted (Subedi, 2001).

As far as traditional healing is concerned, Gartoulla (1998) asserts that in Nepal, credit for creation of the Universe is frequently given to supernatural powers, Gods and Goddess. The concept of '*atma*' (spirit or soul) is also important in understanding the health care practices in rural Nepali communities. He further talks about "*Dhami* and *Jhankris*"

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(Shaman-healers) who are perceived by people as chosen by the Gods to serve and nurture their wishes. These healers play a vital role in maintaining good health in various communities, viewing illness as having spiritual causes (Ibid. 1998).

Sharma (1973) has advocated that most of the leading divinities manifest themselves through a human medium via oracles, which in the local parlance is called the '*Dhami*'. The institution of '*Dhami*' is based on the principle of reincarnation. When a '*Dhami*' dies, the vacated position is filled-up by another person of the same family. Spirit possession is defined by Hitchcock and Rex as an altered state of consciousness on the part of an individual as a result of what is perceived/believed to be the incorporation of an alien form with vital and spiritual attributes, e.g.; the spirit of a superman form such as a witch, sorcerer, God, Goddesses, or other religious divinity (Hitchcock and Rex, 1976).

Fisher (1987) opined that at first glance it may seem merely exotic or 'romantic' to study traditional healers, but in fact further advancement in the health of Nepal's citizens will be possible until their indigenous medical practices and beliefs are understood – firstly because such knowledge is vital for successful public health planning. Secondly, it is at least an open, empirical question that people may be better served by traditional practitioners than we assume. A distinctive conceptual organization of the Newar culture throws light on the common understanding of the causes of disease. Illness for the Newars of Kirtipur is a state in which many natural and supernatural forces partake (Devkota, 1984). As with many other traditional communities, the traditional interpretation of illness goes far beyond exploring the ambiguous causes and their appropriate remedies.

The number of traditional healers in Nepal is very large, which can itself be taken as an indication of the legitimacy of the system. One study estimated the number of various categories of local faith healers from between 400,000 to 800,000 (Shrestha and Lediard, 1990, cited in UNICEF, 1992). The majority of sick persons in rural areas who eventually visit the dominant allopathic health posts have first consulted traditional healers (UNICEF, 1992). In this regard, L. Stone in her study found that in general, the failure of home remedies to cure the sick invites intervention from community-level healers. Such healers base their treatment on an intimate knowledge of the sick person and the latter's physical and social nature, divination/ancestor invocation and herbal remedies. Healers often specialize in particular techniques and the specialist consulted is determined by particular illnesses (Stone, 1976).

Similarly, Streefland has pointed out that because of fatalistic belief patterns in Nepal, the most widely perceived medical system is faith healing which plays a vital role in Nepali society especially when a family member suffers from chronic illness and also when people are childless (Streefland, 1985). Another study by the Nepal South Asia Centre (NESAC) indicates that almost all households, at least at the initial stage of sickness, utilize the fairly wide stock of intergenerational as well as newly acquired knowledge and practices of healing to nurse the sick back to good health. The localized nature of the society, limited access to, and relatively low quality of public health institutions and the prohibitive costs of allopathic medicine and modern health services also force most households to rely on home remedies which span from divination to faith healing and the use of local herbs (NESAC, 1998). This invites analysis of medical pluralism from different angles. Components common to all are the coexistence of multiple traditions of medicine, which are called folk sectors, popular sectors and professional sectors. However, the indigenous system is more established in rural areas.

The study reveals that hygiene, sanitation, and nutritional status are poor in Nepal. In rural areas the proximity of animals such as cows, goats and buffalo to the family living quarters encourages the spread of disease through faeces and insect vectors and the incidence of diarrhoea is wide spread. Over half of the children under five years suffer from moderate to severe malnutrition (Savada, 1993). Water quality is one of the main issues challenging Nepal. Studies have indicated that much of the poor health of communities in the country is due to the lack of safe, potable water (HMG,N/IUCN, 1988, Adhikari, et. al. 1986, ADB 1985, CEDA 1989, Pradhan et. al. 1995, Upadhyay, 1993).

Gender disparities in health care, nutrition and literacy are significantly noticeable among females in Nepal. After the first year of life, female mortality is higher than that of males. For every 100,000 live births between 1980 and 1987, 850 women died as a result of pregnancy or childbirth (UNICEF, 1987; 1989). A striking feature of Nepal's social poverty is the low level of literacy among women. The literacy rate was recorded at 53.7 per cent in the 2001 census. Literacy among women was only 42.5 per cent. The low level of female literacy and the widening gap between male and female literacy are major constraints to the effectiveness of socio-economic development programs (CBS, 2001).

Linda Stone describes the relationship between certain socio-cultural factors and Primary Health Care (PHC) activities in rural Nepal. There is a contradiction between the stated PHC objective of addressing local interests and promote community participation on

the one hand, and the actual approach taken on the other. Specifically it argues that PHC is encountering problems in Nepal for three reasons:

1. PHC fails to appreciate indigenous cultural values and perceived needs. In particular, PHC is organized primarily to provide health education. Villagers, by and large, value modern curative services and feel little need for new health knowledge.

2. PHC views rural Nepali culture only pejoratively as a barrier to health education.

3. In attempting to incorporate Nepal's traditional medical practitioners into the program, PHC has mistakenly assumed that rural clients passively believe in traditional practitioners. In fact, clients play active roles and are themselves in control of the therapeutic process. Thus instead of attempting to recruit traditional practitioners to do its work, PHC should recognize the precedent for community practitioners in Nepal's traditional medical system and respect indigenous ideas and values that traditional practitioners already possess (Stone, 1986).

Data reveals that only about 48 per cent of the population has access to safe drinking water and only 6 percent of the total population has access to proper sanitation facilities. 45% of households can now access medical service within a travel time of 30 minutes as result of large-scale establishment of health posts after 1990. Approximately 5.37% of GDP is spent on health, which compares favourably with other South Asian countries, but 75% of the expenditure is made in the private sector. The number of people living in absolute poverty has nearly doubled in the past twenty years to 9 million, roughly 45% of the population. The incidence of poverty varies across castes (ethnic groups, place of residence, occupation and family size (UNDP, 1997). It can be argued that all these indicators have a direct or indirect impact on the health and illness pattern of its people.

At present there are several agencies involved in health care financing, though household expenditure is considered to be the largest source of health care financing. A higher proportion of health services in urban areas are provided by the private sector through formal private clinics and nursing homes. These nursing homes witnessed a mushrooming growth in urban areas with the launching of the World Bank funded structural adjustment facility in 1985. The government remains the second largest source for health care. The

overall per capita health expenditure is approximately NRs. 439.44. In national terms, the Ministry of Health's (MOH) contribution per capita health expenditure is calculated at NRs. 74.27 (MOH, 1995).

A larger proportion of health sector expenditure is paid by each household directly out of their pockets. Health economics in Nepal made its beginning only in 1989 (Ibid, 1995).According to the Multipurpose Household Survey conducted by Nepal Rastra Bank, the Central Bank of Nepal, out of the per capita monthly household expenditure in 1993/94, the share of household health care expenditures as a percentage of the total private consumption is assumed to remain 4%, slightly higher than that of 1984/85 (3.73%).

Health services are most effective if they are compatible with the expectations and needs of the people, open to communication with the personnel providing the services and have easily understood systems. With respect to the 1991 National Health Policy, the 8th Plan (1991-97) brought a new dimension into the health sector of Nepal. Establishment of Primary Health Care Centres (PHCC) in each constituency, Health-Posts (HP) or Sub-Health Posts (SHP) in each VDC, female community health volunteers (FCHV), trained birth attendants (TBAs), outreach clinics and Extended Program on Immunization clinics at community levels are the basic health infrastructures identified by the authority. Nepal's 9th Plan has given an even greater priority to the health sector. Regarding the issue of health for all, the 9th plan acknowledges that more efforts have to be made towards achieving targets of women's and children's health as committed at the international level on various occasions by His Majesty's Government of Nepal (HMG/N). The plan has addressed in improving the national health status through equitable access to quality health care for all. The current 10^{th} plan's main focus is on poverty alleviation through income generating ventures, and has components that are aimed at improving the national health status both directly and indirectly (NPC, 2003).

Health for all has been a long-standing goal of successive Nepali governments from the early days of Nepal's Basic Needs Program in the 1980s to the more recent approval of the Second Long Term Health Plan (HMG/N: MOH, 1997). Despite sustained improvement during the past 40 years, health conditions in Nepal remain far from satisfactory. Large numbers of babies and young children die, and many that survive are plagued with illness. For the predominately rural population, adult life is physically demanding and life expectancies are estimated at 59.3 years, among the lowest in Asia (CBS, 2001). It is

estimated that only 10 to 15% of the total population in Nepal has access to allopathic medical services and that too, mostly in the urban areas (Ali, 1991).

The literature reviewed indicates that there is an absence of in-depth analysis on the influence of socio-economic factors on local perceptions and behaviour towards health and illness in Nepali society. With this impetus, the present study examines the influence and role of noted socio-economic and cultural factors on health and illness.

Objectives of the Study

The present study is designed to focus on the 'Sociology of Health and Illness' with reference to the people's perceptions and behaviour about health and illness in Banigama VDC in the Eastern Terai of Nepal. More specifically, the following are the objectives of this study:

1. To draw-up the socio-economic profile of the study area. In any society, it is believed that the general level of health and illness in terms of its understanding, perceptions and behaviour is influenced by the socio-economic characteristics of the people. Therefore, this objective of documenting such profile is of paramount importance.

2. To identify the influence of some socio-economic and cultural factors on the perception of health and illness behaviour among the people of the study area. The present study aims to explore the differences in perception and behaviour about health and illness in terms of people's caste/ethnicity, size of land holding, income and level of education in order to document whether socio-economic and cultural factors influence the health and illness of the people in the study area or not.

3. To determine the general perceptions of the people of the study area about health and illness. The present study aims to look into the people's understanding about why they get sick or what causes illnesses. This important objective of the present study has been explored in terms of the variations in the perceptions of groups in terms of specific socio-economic factors.

4. To identify the preferred modes of treatment of the people of the study area. One of the important objectives of the present study is to explore the medical pluralism in the study area to highlight the coexistence of multiple overlapping traditions of medicine in the study area. This objective is also important in order to explore the variations in

treatment patterns across the socio-economic and cultural factors in the study area and to explore how the traditional belief systems are changing and the influence it has on the health culture at present.

5. To examine women's problems and perspectives on health and illness in the study area. Women's health behaviour and perspectives on various health and illness issues not only have implications on their own health but also impact the health of the whole family. Therefore, this objective is of major importance for the present study.

6. To document HMG/N's efforts at strengthening its health policy and strategies in relation to its health delivery in the periphery. The study aims to look into the government's effort in delivering peripheral health services in the process of raising the health status of the general population.

Methodology

The present study is based on primary as well as secondary data. Both qualitative and quantitative data have been drawn from macro and micro sources for preparing the present dissertation. For country level socio-economic and political and health related information, secondary information was accessed through various published materials. The collection of macro-level data and information was completed by consulting the census reports, and other published materials.

Banigama VDC is situated in the North-eastern part of Morang District in the Eastern Development Region. The total area of this VDC is 2323 hectares. According to data provided by the Village Development Committee (VDC) office, the total population of this VDC is 8442 of which 4247 are male and 4195 are female. The total number of households (HHs) in the VDC was 1680. Banigama VDC is 17 kms from Biratnagar, the district headquarters of Morang district. An asphalt road passes from the North-east part of the district leading to the district headquarters. Farming is not only the main occupation of majority of the populace, but is also the means of survival.

Banigama Village Development Committee was chosen as the study area. The field survey was done at two levels. The VDC level information was collected from the VDC office. A VDC is the lowest administrative/political/development unit in Nepal. There are 65 VDCs in Morang district. Banigama VDC is one of the Terai VDCs in the district, and is

further divided into 9 wards. The rationale behind selecting this VDC for the study lies in its transitional character, which is neither a rural nor an urban settlement. This VDC is in the process of growth, expansion and in a process of urbanization considering the level of its infrastructure as compared to other VDCs. It therefore complies with the aim of this study: to document health and illness of a transitional society. Banigama's multi-caste and multiethnic nature provides a unique opportunity to investigate the health and illness behaviour across various castes/ethnic groups. Another reason for considering Banigama VDC was its better accessibility, in terms of communication, compared to other VDCs of similar nature.

In the course of this study, data were collected through a sample survey rather than the study of the whole population. A simple random sampling technique was employed to select the sample households. The sample size was large enough from the statistical point of view to represent the population significantly, while simultaneously contributing to meaningful interpretation of the findings. Caste/ethnicity stratums of HHs were prepared based on listed ward-wise HHs. Using a random sampling technique, a sample of 10 per cent from each of the 9 wards was drawn using a random table. So, a total of 178 HHs constituted the respondents of this study. Women of the sample HHs were also interviewed separately with a view to incorporate women's perspectives.

An interview questionnaire cum schedule was used as a tool for conducting a social survey by which the required data were gathered. Simple and direct questions were included in the questionnaire to gather information of personal, health and illness related behaviour of the people of the study area. The noted affecting variables, namely age, sex, caste/ethnicity, education, family size, size of agricultural land, tenure status, annual income and health awareness were enumerated. The researcher, with the help of two qualified local women of Banigama VDC, collected the necessary information. In addition to this, the researcher talked informally to several respondents, key informants and health providers of the area to solicit information mainly for qualitative responses which could not be captured by the survey method, to have some idea of cultural practices, local beliefs and perceptions. Case studies have been presented intermittently to supplement the findings of this study. Visits to the village health-post and the primary health centre in the constituency level of the area helped gather relevant information. Fieldwork in this respect was carried out between September 2001 and February 2002.

The respondents were contacted at their houses either in the morning or in the evening without disturbing their regular work schedule. After establishing an initial rapport with the

respondent, the purpose of the study and the intent of the interview were explained. Full assurance of the confidentiality and academic purpose of the information disclosed was given in order to gain their confidence.

Data obtained from the field was edited, compiled, categorized and analyzed in accordance with the objectives of the study. Descriptive statistical measures such as frequency and percentage were used when necessary. Data processing and analysis was done through computer software.

Limitations

This study was undertaken to have a grasp of the "Sociology of Health and Illness" in general and the perceptions and behaviour of the inhabitants of Banigama VDC in particular. As far primary data is concerned, the study was limited to one VDC and covered only selected variables. Several activities related to health seeking phenomena could not be observed during the course of interview period and had to be recounted by the respondents.

The time-factor and economic resources handicapped the investigator as a student, so samples from a number of VDCs and a relatively large sample, which could have given a more comprehensive and convincing view of the problem, could not be obtained.