CHAPTER 7

CONCLUSION

Although the literature is scarce, the phenomenon of ethnomedicine and other alternative medication practices is wide spread in Nepal. The paucity of research on it is most probably due to the heterogenous character of the phenomenon which renders research difficult. It amy also be due to the complex problems the country is suffering from requiring immediate attention.

For the socio-economic development health is one of the highest ranking priority in man's hopes and aspirations and, at the sametime, is also a valuable asset. Attention to health helps to improve the quality of manpower essential for the national development. Improvement in this field is a promising entry point to break the vicious circle of poverty and stagnation. Health is most decisively affected by the comprehensive set of decisions at the micro level. The determinants of these decisions are socio-economic status of the family, education, cultural values and the disease environment. Therefore, health care should be rooted in the family, and changing the state of poor health is possible only with sustained improvement in the standard of living of the users through balanced socio-economic and cultural developments. Health is both an instrument and a product of development and cannot be viewed in isolation from other social elements. It would be worth noting that income, living conditions, nutrition, and education are some of the major elements having reciprocal relationship with health.

Some of the major problems related to health in Nepal are malnutrition, bad sanitory situation, inadequate housing facilities, germ and parasite infected water, and other (such as poverty, illiteracy, ignorance, etc.) socio-cultural problems. Also, one of the major causes of poor health is insufficient health institutions and health manpower. There were only 34 hospitals with 625 beds, 24 dispensaries and 63 Ayurvedic dispensaries in 1959/60 in Nepal. In 1988/89, the total number of hospitals and hospital beds were 120 and 4,620 respectively. Accordingly one bed was available for 3,992 persons. Besides the 120 hospitals, there were 16 health centres, 155 Ayurvedic dispensaries and 816 health posts providing health care services in the country. The number of doctors in 1989/90 were 951 and one doctor was available for 19,392 persons; the number of nurses were 2,990, that is, one nurse for 6,166 persons. Further, the number of duly qualified vaidyas and kavirajes were 229. Thus, there was only one vaidya/kaviraj for a population of 61,727. Out of 951 doctors, about 150 have so far been produced by the the Institute of Medicine, Nepal and the remaining got training in other countries.

In per capita terms, health expenditure of Rupees 44 in 1987 was low in comparison with other Asian countries. The allocation for health from the national budget rose from 3.4 per cent in 1981 to 4.9 per cent in 1985, with an additional 2.6 per cent allocated for drinking water systems. Health expenditure totals approximately 1.4 per cent of GNP, and approximately 40 per cent of the health budget is devoted to primary health care. The

eventh Plan proposes to allocate 30.2 per cent of the total budget to social services, with 4.6 per cent allocated to the health sector.

Although the percentage allocated to health from the national budget remained more or less the same (between 4 and 5 per cent), there has been an increase of 76.6 per cent in the actual amount of allocation (an increase from Rs. 231.5 to Rs. 409 million).

The infant mortality rate per 1000 live birth was 106 in 1987 and in 1989/90 there were about 111.5 infant deaths per 1000 live births; combined infant and child (0-5 years of age) mortality rates probably varies between 160 and 220 per year per 1000 population.

Further, in 1983, safe water was available to 71 per cent of urban and 11.3 per cent of rural population; for hygienic disposal of wastes facilities were available only to 16.2 per cent of the urban and 1.0 per cent of the rural population.

The commitment of the nation to attain the social objective of health for all by the year 2000 has already been proclaimed. Attending to the global appeal of the 'Alma Ata Declaration by World Health Organization in 1978, Nepal received forceful guidelines to gear the efforts of development towards attaining a standard of living adequate enough to lead a life of human dignity. To this effect, basic need of food, clothing, shelter, education, health and security are aimed to be provided by the

year of 2000. By that time, the country expects to increase the life expectancy at birth to 65 years, and to bring population growth rate down to less than 2 per cent.

Primary health care (PHC) services has been identified as the basic needs in the field of health because it alone could lead to improvement in health standard of the general population in view of the related environemntal, social and economic problems. The PHC is related to appropriate education regarding simple preventive measures, and provision of safe drinking water, clean environment, and essential drugs. The programmes include basic preventive and curative health services, family planning services, epidemic and respiratory disease related services, rehydration services, extended immunization services, development and expansion of health orgaization and health manpower.

The following working policies are being adopted in the implementation of primary health service programmes:

i. Health posts at the level of Ilakas in all districts will extend as integrated services for effective delivery of primary health services;

ii. Where there is a health post besides the hospital such a health post will be integrated with the hospital;

iii. Integrated health post will be established in town development committees, where there are no regular hospitals;

iv. Sub-health posts will be established with people's participation in every Village Committee in order to reduce the physical distance between the health service institution and the community. Extended health services of the health posts will be provided through these sub-health posts.

v. There will be a Community Health Volunteer at every ward. They will provide health education and simple curative services related to primary health services;

vi. District, town and village Committees will mobilize local resources besides government resources for necessary medicines and equipments in district hospitals and health posts.

vii. District hospitals will be established in every district. Management and reforms of hospitals will be undertaken in order to develop health services, along with the referral system;

viii. Emphasis is laid upon domestic production of essential drugs. Quality and standard of medicines is to be established in accordance with national drug policy;

ix. Preference in recruitment and posting of rural health workers will be given to local health workers with local experience in health projects. Provision will be made for their training for career development;

x. Ministry of Health will launch programmes in coordination with Ministry of Education for population education and female literacy, Ministry of Agriculture for provision of nutritional food based on local resources, and Ministry of Water Resources and Ministry of Local Development for clean drinking water and environment.

xi. Establishment of hospitals, health posts and nursing homes in the private sector with own finance will be encouraged according to standards laid down by His Majesty's Government.

xii. Ayurvedic institutions also will be developed.

xiii. Coordination and participation of social service national coordination council and social welfare organizations, local committees and class organizations will be promoted to create a better awareness and also to effectively reach the people.

Widening people's participation in national development, is progressing gradually. Therefore, plans have been made to strengthen information education and communication activites at district and village levels in order to raise community awareness and stimulate participation.

To address the shortage of trained manpower in health management and lack of built-in-monitoring and evaluation mechanisms, training programmes and institutional development activities are being strengthened and periodic exercises in management and evaluation promoted.

The provision of adequate supplies of drugs and equipment continues to be hampered by the lack of funds and transport, and over-reliance on external supplies. To remedy this situation, Royal drugs Ltd. and the Singha Durbar Vaidya Khana need to be strengthened, and support is needed for warehouse construction and providing vehicles for internal transport.

But, despite these efforts, the utilization of whatever health facilities exist is limited by lack of motivation among health workers, particularly at district and health post levels; and the lack of knowledge and health consciousness among the rural people.

Thus, in Nepal modern medical system is not yet widely prevalent. Partly because of historical reasons and partly due to various socio-cultural, economic and administrative reasons, the people do not always report to a duly qualified doctor, practicing either privately or in the government run hospitals and dispensaries.

Despite the facilities provided by the government on health sector, more than 50 per cent of health problems never reach the health services. They are treated through a system of ethnomedicine and other alternative practices which are based on home remedies, commercial sales of traditional and modern medicines in Over-the-Counter Sale (OTC) often combined with religious practices.

There is a strong tendency to view the problem of health care as involving two systems only: western and traditional medicine. The problem as it has been seen, does not fully fit in with any strait jacket classification. This view of the problem is, infact, highly simplistic; consequently, policy decisions based on the assumptions that underline it may be unrealistic.

One of the most striking things about the contemporary alternative health care scene is the vitality displayed by traditional systems and their practitioners not in carrying on in an unchanged fasion, but in adapting their etiologies, therapies, and rituals to meet the expectations of their traditional (and new) clients who are also adapting to the modern world and its ways. Of the contemporary alternate health care systems spiritualism and other forms of faith healing are very important.

Although spiritualism cannot be described as an outgrowth of shamanistic practices, the similarities (beliefs in spirit possession, a medium who enters into a trance to communicate with the unseen, etc.) are notable. In this sense spiritualism can be viewed as civilizations attempt to structure and pattern and validate the near-universal belief in spirits that harm human beings, if they disobey the social norms. Not only in the MP cluster, but also in other parts of Nepal, spiritualistic practices might have persisted at least in part as a response to the psychic needs of newly urbanizing and modernising people.

From an etiological view point, diseases can be subsumed under the rubrics of personalistic and naturalistic categories. But, as with all generalizations, there are loose ends that do not neatly fit into this grand schema. The widespread belief that strong emotional experiences such as envy (to desire to have somthing), fright, grief, and shame can cause illness does not fit into either major category. Or perhaps we should say that, depending on situation and circumstance, these belief may fit into either category. Sato-illness caused by fright. (Sato janu) - widespread in MP cluster, is illustrative. A person may be frightened by a ghost, a spirit, an encounter with a devil, or by something as simple as stumbling near water and fearing death by drowning. If the agent intended harm, the etiology certainly is personalistic. But accounts of such

encounters often suggest chance or accident and not purposive action. And, in fearing death by drowning, no agent is present.

The common explanation as to how fright causes illness among the village children is also illustrative of the problem in calssification. The souls of small children, the chief victims, are believed to be loosely attached to their bodies; they may be dislodged either by fright or by a hungry or malicious ghost that enters the body and "steals" the soul 'atma'.

The evil eye is also difficult to categorize. It is thought by many persons that human agent (witch, bad eye, etc.) as a consequence of envy, conciously or unconsciously, produces illness in another person or causes damage to some possession of the individual envied. Most commonly the envied object may be a healthy child, but domestic animals, automobiles, or almost any other object that one might desire is a potential victim of the "eye". The glance of the envious person is believed to cause the child to fall ill, the animal to sicken and die, or the automobile to break down. It is only the shamans, who can throw the evil eye.

In the cluster, the people, in a very general way, identified the naturalistic causes with disturbances in the equilibrium of the three humors, the tridosha, of the Ayurveda. And, to restore humoral balance with medicine, they did not hesitate to contact the vaidya/kaviraj that were available.

It is not going too far to say that if we are given a clear description of what a people believe to be the causes of illness, we can in broad outline fill in the other elements in that medical system. To elaborate, personalistic etiologies logically require a particular kind of curer, a shaman or other diviner, to determine not only the immediate cause of illness but, more important, to find out who lies behind the cause. Naturalistic etiologies require a different kind of curer, such as physician or herbalist who knows the medicines and other treatments that will restore the body's equilibrium. Neither personalistic nor naturalistic causality explanations can really handle the concept of contagion (transmission of a disease by contact with a diseased person); only with the development of the scientific concept of pathogens can the transmission of disease from one person to another be easily explained. Modern allopathic medication is used for this kinds of diseases.

The prevalence or diverse systems of treatment and cultural beliefs side by side creates problems for the 'modern' doctors, and some of these are as follows:

The patients may report late because they have first consulted various other practitioners (shamans, priests etc.). They see no contradiction in using various healers and methods consecutively or simultaneously. Also, the patients expect consultation and even treatment to be a

family affair. They do not expect to be isolated from their families. Everyone wants to be present and know the doctor's opinion and advice. Sometimes, the patients may offer irrelevant information or emphasize details that appear to others to be trivial. This includes their recent diet and symptoms such as dry mouth, burning body etc. which appear to them to indicate a garmi disease, or body aching or swelling sardi. Male patients are very concerned about nocturnal emissions of semen as Hindu scriptures describe this as leading to loss of body strength and sexual potency. Fever(Jwaro) may mean any symptoms suggesting garmi disease, and not necessarily temperature elevation. The indigenous practitioners examine up to 3 pulses in each arm, so that patients may feel that examination of one pulse is inadequate.

It is regarded as inauspicious for a person to die in hospital, as this might lead to his spirit becoming a lagu and thus disturbing his surviving relatives. This often leads to undignified conflict between relatives and doctors. Because the responsibility of death rites rests upon the eldest son, it is of utmost importance that a women bear not only children but male children. Infertility is therefore regarded as a serious problem and family planning will not be accepted by a man who has only daughters. certain people, especially Newars, will often not permit causes or epidemics or certain diseases to be brought to the attention of doctors because of the special relationship of those

diseases with devis. This has led to difficulty with smallpox vaccination and in treatment of children with severe measles.

The fact that sick people resort to medicate with local resources and unqualified medicine sellers, even in the presence of qualified health workers, is explained in various ways on the basis of findings. While medicating locally, both local providers and consumers, some emphasize the greater accessibility of such medicines, others emphasize the social distance between health workers and sick people, some emphasize the belief on the medication system. A particularly interesting view, by the respondents, suggest that sick person and local providers both have more confidence on their practices. Sometimes, it is also pointed out by both the consumers and providers that modern medicine does not eliminate the sickness and diseases permanently because of their prompt reactions. The disease is only suppressed and may show up again. Also, modern medicine is unsuited to throw off the evil eye. In such cases, the use of modern medicine may do more harm than good. Further, modern medicine is not only more costly but cumbersome as well because various pathological tests are involved. So, much time is wasted which everyone can not afford. The practitioners of modern medicine are business-minded people who have little time and inclination to ask about all antecedents of a disease, unlike the shamans. Also, they are unable to make any forecast of the life of a man. Hence,

they are not believed to be competent enough to handle human afflictions.

In contrast, consumers-providers relationship in the case of ethnomedicine and other alternative practices (leaving aside OTC sales a personal use of modern drugs) is a long and close one. The providers know the whole hereditary history of the consumer so that they evoke strong attachment and faith in their clients.

Some of the consumers, who practice ethnomedicine and other alternative medication locally are very critical of the medical consequences of the use of ethnomedicine and other alternatives practices, but most of them also mention that such medication practices play a useful role in primary health care which would otherwise remain unfilled.

The practical conclusions that may therefore be derived from this study are: in the first place, much research needs to be carried out before anything more definitive can be said about the practices of ethnomedicine and other alternatively practiced medication system. It is obvious that such research has to be done in a both cautions and intensive way.

A second conclusion is that the existence of ethnomedicine and other alternative medication practices can not be simply ignored to set up a better primary health care system. Should the present ethnomedical providers be trained for this purpose ? Or should those medications and home

treatment be enhanced ? No conclusive answer can be given immediately, but it is suggested that appropriate authorities should not rush to any hasty policy decision on the matter.

The third conclusion is that the development and incorporation of indigenous medicinal plants that have been found to be efficacious should be taken up earnestly in order to decrease the cost of pharmaceutical products and to advance primary health care in areas where synthetic drugs are scarce. The pharmacopoeia of ethnomedicine should be further enriched by more intensive as also extensive studies in all parts of Nepal so that the positive side of one's heritage may be promoted. Modern pharmaceuticals have become improtant ingredients in the treatments of many traditional practitioners, and their importance increases steadily. The stereotype of the traditional practitioner working with herb and herbal remedies and the modern doctor using modern pharmaceuticals is no longer true in Nepalese villages. And, remembering that vegetable drugs are always safer than chemical ones, this stereotype should not be allowed to continue.

This study also shows that people's attitude and behaviour towards medicines are related to a variety of socio-cultural factors. Some of which are obvious: social class, accessibility of drug supplies (the health posts,

health manpower, etc.), financial resources of the household, social relations, etc. What perhaps is less evident is the impact of the organisation of health services on people's attitudes towards medicines, and also the general spread of education, areas which require more systematic attention and research.