## CHAPTER 2

### Medical Anthropology in Nepal : Scope and Objective of the Study

The subdivision of medical anthropology today called ethnomedicine is the lineal descendant of the early interest of anthropologists in non-western medical systems. Beginning with their earliest field research, 100 years or more ago, anthropologists routinely have gathered data on the medical beliefs of the peoples they studied, in the same way and for the same purpose that they have gathered data on all other aspects of culture : to have as complete an ethnographic record as possible. The diligence of early anthropologists, and of explorers and missioneries who also gathered data on the peoples whom they discovered, or among whom they worked, is well illustrated by the first comparative worldwide survey of beliefs conducted by Clements about disease causation - now nearly half a century old - that cites 229 sources, a high proportion of them ethnographic. Prior to Clements, the noted British physician/anthropologist W.H.R. Rivers published an epic - making study in the field of medical anthropology, entitled Medicine, Magic and Religion. To Rivers we owe important and basic concepts, especially the idea that indigenous medical systems are social institutions to be studied in the same way as social institutions in general, and that indigenous medical practices are rational actions when viewed in the light of prevailing causation beliefs. Counterbalancing this positive legacy, we may also note that it is Rivers, more than anyone else, who bequathed to us the

unfortunate stereotype that has dominated studies of primitive medicine almost to the present, the idea that religion and medicine are always intimately liked together, so that one can be studie only in terms of the others. This stereotype, uncritically accepted by a majority of anthropologists during the last half century, has seriously limited us in our understanding of non-Western medical systems.[1]

Needless to say, neither Rivers nor Clements nor any of their contemporaries engaged in collecting data on primitive medical system had any idea that they were doing "medical anthropological" research, but it is through such efforts that ethnomedicine owes its origin, and came to be defined as "those beliefs and practices relating to disease wihich are the products of indigenous cultural development and are not explicitly derived from the conceptual framework of modern medicine".[1]

As our primate ancestors evolved into human form, the disease they brought with them, and those acquired along the evolutionary ways, became social and cultural facts as well as pathological stages. For human beings disease threatens not only the well-being of sufferers and their fellows, but also the integrity of the community. Illness and death are disruptive events that impose high economic, social and psychological costs wherever they occur. Quite apart from humanitarian reasons, therefore, it is of primary importance to the members of every group to try to maintain their health and to restore health to those who fall ill.

Every human community has responded to this challenge by developing a medical system, i.e. the pattern of social institutions and cultural traditions that evolves from deliberate behaviour to enhance health. Written sources tell us about the history of some medical systems. In addition to contemporary scientific medicine, we know much about the origin and development of traditional Chinese medicine, Indian Ayurveda, Moslem Unani, and ancient Greek medicine and its modern descendants the humoral pathology of Latin American and the Phillippines. Other medical system of those people who until recently have lacked a literature reveal little of their medical history. However, through the studies of anthropologists and others such as missionaries and doctors, these alternative medication practices have also been receiving some attention.

Since the end of World War II, anthropologists, both sociocultural and biological, have turned in increasing numbers to the cross-cultural study of medical systems and to the bioecological and sociocultural factors that influence the incidence of health and diseases. In part their interests have been theoretical, and in part their interests have been applied, motivated by the belief that anthropological research techniques, theories, and data can and should be used in programmes designed to improve health care.

Today anthropologists with these interests work in shcools of medicine, nursing, and public health; in hospitals and health

departments; and in traditional university anthropology departments. They do research on topics such as human evolution, anatomy, pediatrics, epidemiology, mental health, drug abuse, AIDs, definition of health and disease, the training of medical personnel, medical bureaucracies, hospital organization and operations, the doctor patient relationship, and the processes of bringing scientific medicine to communities that previously have known only traditional medicine. These anthropologiests are usually called 'medical anthropologits' and the field they represent is the new anthropological subdiscipline; 'medical anthropology'. As can be seen from the kinds of activities in which the medical anthropologists engage, the field embraces many perspectives and foci of concern. Conceptually these may be ranged along a continuum, one end of which is marked by a biological pole, and the other, by a sociocultural pole. Toward the biological pole we find those anthropologists whose dominant interests include human growth and development, the role of disease in human evolution, and paleopathology. Towards the sociocultural pole it includes traditional medical systems (ethnomedicine), medical personnel and their professional preparation (traditional providers and modern providers both), illness behaviour and alternative or self-medication practices, the provider/consumer relationship, the dynamics of the introduction of western medical services into traditional societies, and psychosociocultural phenomena (mental illness, etc.).

## 2.1 Hypotheses

In recent years the field of medical anthropology has grown rapidly, but since this is a relatively new field, a widely shared definition of the field itself, and agreement about the boundaries is emerging slowly among the cultural anthropologists. One definition is that medical anthropology encompases the study of medical phenomena as they are influenced by social and cultural features, and social and cultural phenomena as they relate to medical practices.[2] Also, medical anthropological enquiry elucidates the factors, mechanisms, and processes that play a role in or influence the way in which individuals and groups are affected by these problems with an emphasis on patterns of behaviour.[3] In any case, what is of prime importance is the fact that a greater understanding of behaviour relating to health and diseases enables one to effectively intervene in social welfare measures.

This study concerns with the socio-cultural pole especially on ethnomedicine and other alternative medication practices, and as such, falls within the broad encompass of medical anthropology in Nepal.

In Nepal, a modern medical system is not yet widely prevalent. In modern medicine, as it has developed, over the past three/four centuries in the west, it is assumed that medicine will be administered by qualified and authorised

medical practitioners. It is true that the medicine-man formed a distinct category in most of the primitive civilizations but the requirement of patient being treated by a duly qualified doctor has become a characteristic of modern society.

Partly because of historical reasons and partly due to various socio-cultural and economic reasons the situation is to a large extent otherwise in Nepal. Despite the growth of modern medical facilities in the recent past the people do not always report to a duly qualified doctor, but rather they seek medical advice privately and not from the government run hospitals and dispensaries.

For the purpose of the present study all situations where the illness/sickness are not treated by a duly authorised medical practitioner was considered under the categories of ethnomedicine and other alternative practices.

Given the inadequacy of available information on this subject in a country like Nepal, the proposed study is bound to be in a large measure descriptive and exploratory. The recipe of ethnomedicine has been unearthed rather elaborately. And, a few, tentative hypotheses have been formulated so that the perspective while conducting the field enquiry is consistent. Even a casual acquaintance with the situation in Nepal will convince anyone that

ethnomedicine and other alternative medication practices are more prevalent than modern medicine. But why so? The affected people may resort to them either because they have complete faith or because they have no other option. It may also be that the different medical systems are not competitive and are taken recourse to under different situation. These medical systems may also have their own target populations. The factors of age, sex, level of education and income, religion, ethnic affiliation, rural-urban background, etc. may also be some of the determinants of health related behaviour.

The objective of the present study was to assess the different medications and therapy methods used by the local people. The knowledge, attitude and practice (KAP) of providers and users was studied in the context of the socio-cultural setting that is particular to the Kingdom of Nepal.

The study has tried to shed light on why such medical practices have persisted and also whether, and to what extent it is beneficial for the people, so that health planning for the future may be done more meaningfully.

## 2.2 Scope of the Study

Ethnomedicine and other alternative medical practices by the local people have taken various forms depending on who administers what medicine to whom and how.

Sometimes it happened that even when modern medicine was used, it was done without the advice of a regular doctor. Such cases occured when a person consumed medicine on his own or procured it from someone who did not possess the necessary knowledge in medicine. In such cases it was immaterial whether the medicine administered was the correct one.

Such cases have occured in the following ways when medicine is provided by:

(a) i. Health Assistants and Nurses;
ii. Pharmacists;
iii. Community Health Leaders;
iv. Midwives;
v. Village Health Workers.

(b) i. Kirana Shop Keepers (Grocers);
ii. Injection-Doctors; and
iii. Sudenis-Dhais (Partially trained or untrained Midwives).

There are other cases where diseases are treated in the traditional way as in the following:

(c) By Faith Healers :

i. Dhami-Jhankri;

ii. Ojha;

iii. Fedangwa-Bijuwa;

iv. Baidang-Jharphukey;

v. Pandit-Lama-Gubhaju-Pujari (Priestly People); and

vi. Jyotishi (Astrologer).

(d) Traditional Medical Providers:

i. Baidhya/Kabiraj; and

ii. Jadi-Buti Wala (drug peddler-herbalists).

The above categories may be defined situationally and otherwise as follows:

The Health Assistants and Nurses do not have the necessary authority to prescribe modern medicines. But they often do so under situations not always under their control.

Many pharmacists run medical shops where the regular doctor doing their business privately are available for consultation in select hours. But, based on some knowledge that they have, and also acquire, the pharmacists often suggest drugs to the patients who prefer to consult them, and sell the requisite medicine from their stores. As to why people consult the pharmacists the reasons are diverse. First of all, no extra fee is charged generally by the

pharmacists for such consultation who are more interested in selling the wares under their possession. Also, they prescribe in such limited doses as are within the financial reach of the client and do not make a fuss about the requisite quantity of medicine that have to be consumed over a certain period if long-term adverse effects are to be avoided thereby saving the expenses of the patient for the time being. The Pharmacists also willingly become the providers if the patient or anyone just steps in and asks for any medicine and pays for it.

The Community Health leaders are those in Nepal who have been trained over a very short term (one or two weeks) course for a very specific four or five disease situations. In fact, they are trained for preparation and ready supply of oral rehydration solution to the needy, elementary maternity and child care problems, and sanitation etc. But in the remote villages of Nepal, they perform often the role of a doctor under diverse situations outside their jurisdiction.

Similarly, the Midwives also who have a very specific training sometimes become the consultant for various diseases for people who ask for their experiences and services.

The Village Health Workers are like the Community Health Leaders trained for a very short period but with the

difference that they are trained specially on the preventive side, that is, sanitation, water pollution, environmental preservation, etc. Because of their door-to-door service practices, they are readily available for everyone creating opportunities for misuse of their authority.

Kirana - Shop keepers (Grocers) are those who hold shops of daily uses (rice, pulse, oil, soaps, etc.). Besides the other materials or goods, they sell certain types of medicines such as paracitamide, analgesics, synalgesics, metronidazole, eye and ear drops and certain types of antibiotics in the capsule form etc. People contact them and buy those medicines for prompt reaction or recovery. The people are acquainted with them directly or through their neighbours whom the shopkeepers oblige on the basis of demand.

Injection doctors are another category of medical service providers. They have no authority to prescribe medicines but only may have training for pushing injections for a short period. Persons without training also know how to inject from their own practice or seeing others. They are nominal in the Nepalese villages but have a great value to provide services.

Sudenis and Dhais (partly trained or untrained midwives) are the assistants of trained midwives especially helping during the delivery of infant. But they do not hold

any training even short-term. They are the traditional midwives providing services during pregnancy, child care, oiling or massaging the mother and their babies, breast washing, making sterilized bottle feeding and keeping tidy the child and his belongings. They sometimes treat the mother and the child using many local ingredients on the basis of their knowledge, experiences or learning from others.

Faith healers are various, and some of them are as follows:

The Dhami-Jhankris are regarded to be the representatives of the supernatural powers, and with their aid they can cast off evil spirits that cause affliction to people. While curing the patient through some ritual practices, they are held to be in communion with gods and goddesses. And, in that state, they thrill their body, use grains, grasses and bamboo sticks. They also beat drums, chant sacred lores (mantras) and sprinkle rice and other liquid matters upon the body of patient and around. Through such practices they are said to help cure the patients, and command a high prestige in the community.

Among the Shaman healers, Ojha is the expert and ranks in a higher status than others. Usually he does not see the patient unless referred by Dhami-Jhankri and other exorcists. He treats only the most acute and chronic cases.

The Ojhas are very few in number. Their charge are also higher than that of others.

In the Limbu and Rai communities the shaman curers are called as Fedangwa and Bijuwa. Fedangwa is a powerful Dhami-Jhankri, who in his trance beats a bronze plate by a stick, wearing a white and long robe and garlands made of different objects. He sacrifices the animals, chickens etc. But Bijuwa are like thd Baidang and Jharphuke who do not thrill body and do not use drum set but worship and throw the evil (lago) spirit.

The Baidang-Jharphuke are like the Bijuwa (in Limbu and Rai communities), who provide their services to all people in all communities. While curing the patient through some ritual practices, they are held to be in communion with supernatural powers. But, in the state, they do not thrill their body, do not use bamboo sticks, and do not beat durm. Without doing so, they only chant sacred lores (mantras), sprinkle rice and other liquid matters, use grains, grasses and other objects upon the body of patient and around. Through such practices they are said to help cure the patients, and command a high prestige in the community.

Priests are known by different names in different communities and religions. Pandits and Purohits are the priests in the Hindu community, Lamas in the Buddhist especially in the Tamang and Bhote communities and Gubhaju

in the Newar Buddhist community.

The Pandit is a priest who has knowledge of Sanskrit and scriptures, but the Purohit is an experienced person who knows the worshiping methods and practices. Lama in the Tamang community, holds Gumba (monastery) training for fixed period of time and Gubhaju also holds the training in the Buddhist temple. Pandit, Lama, Gubhaju have the same status and preserve the right to read out the Puranas (epic relating to gods and goddesses). Through such practices and worship they remove the bad influences of evil planets upon human life, help cure the patients and they hold a high prestige in the Nepali society.

Persons having the knowledge of casting and examination of horoscopes, help the people mostly in the preventive medication. They mention the methods and procedures to be observed to save oneself from the bad effect of the graha (planet). They also predict the past, present and future, even though they generally prefer to refer their clients to the priests in case anything gets wrong.

There are mostly two categories of Traditional Medical Providers 1) Baidhya and Kabiraj, and ii) Jadi-Buti Wala (drug peddler-herbalist).

Baidhya and Kabiraj are the traditional mdical providers who sometimes have a formal qualification in their profession, but often they only possess some knowledge learnt from their seniors

or through hereditary practices. They not only prescribe Ayurvedic medicines but also sell them. Besides the selling of Ayurvedic medicines manufactured by the Ayurvedic pharmaceutical companies, they also prepare the medicines themselves using local herbs, herbals and other local ingredients. These medicines are prepared for selling purposes locally, and not commercial stock-piling.

The Jadi-Butiwala (drug peddler-herbalists) are those who do not have any formal academic grooming for their profession. But they are self-experienced, drawing upon knowledge from their seniors, neighbours and relatives. Some of them are also hereditary practitioners. The major practices of them are to prepare herbs and herbals in a form that are easier for the users. They sell those herbs-herbals and other local ingredients through their personal contacts and advertisements. Their medicines, sometimes, are sold after using some sacred lores (mantras). They also provide amulet for the protection from evil spirits.

A large corpus of ethnomedicine is derived from the knowledge and practices of these Baidhya-Kabirajes and Jadi-Butiwallahs. Apart from them, Janne-Manchhe or knowledgeable elders in the locality or the people at large are also practitioners of ethnomedicine in a considerable way. Whenever a disease-situation occurs, the Janne-Manchhe, or even the neighbours and visitor step in and provide voluntarily their limited expertise. Such advice may lead one not only to

ethnomedicine but also to various types of alternative medication practices not always duly recognised by law. Even modern medicine is not ruled out, because anyone may suggest the application of any medicine which might have been useful in a more or less similar situation elsewhere or on another occassion. To appreciate all these, one must remember that unlike as in the western societies, where unnecessary narration of physical complaints to each other during a social gathering is against the established norms of etiquette, diseases are a lively item of discussion among people in Nepal when they meet among themselves. And, under such situations, asking for or rendering advice is not regarded as unwarranted.

Despite the health facilities provided by the government more than 50 per cent of health problems never reach the health services. They are treated through a system of ethnomedicine and plural medications which is based on home-remedies. Other methods of unconventional treatments include commercial sales of over the counter (OTC) drugs often combined with religious healing practices, and culturally based treatments which are economically beneficial to the people.

So it was important to examine in detail -

(i) The kinds of providers, consumers and the referral system;

(ii) Socio-economic aspects of ethnomedicine and other alternative medications; and

(iii) The various methods of medication.

## 2.3 Overview of Literature

Studies on ethnomedicine and other alternative medication practices have been done by various organizations and scholars. But all such studies do not describe and explain ethnomedicine and alternative medication practices in all its social aspects as a whole. For obvious reasons, every study has a partial focus on specific areas and topics. Nevertheless, many of them are useful and, hence, have been drawn upon for their methodology and contents.

Among the occassional studies that make references to the cultural and behavioural aspects of ethomedicine and alternative medications by the local people, more appear to have been done in the USA, or Europe or in Africa than in Asia.[4] The kinds of drugs used and geographic distribution of primary health care in Guatemala and Belgium,[5] the medicalization of social life through self-medication in el. Salvador,[6] study of injectionists and "quacks" in Thailand,[7] the system and practices of traditional medicine in Africa; and Asia,[8] Chinese acupuncture,[9] hypnotism practices in Africa and South Asia including India,[10] Socio-economic factors effecting the psycho-therapy and alternative medications in South Asia,[11] and utilization of self-care and cost patterns of referral in rural areas of India and Nepal[12] are some of the relevant and helpful references that have helped us to formulate the problem for the purpose of the present study.

Haak, H. and Hardon, A.P.[13] in their study have shown how the indigenous medical concepts are being applied to western pharmaceuticals. They found that the integration of western pharmaceuticals into the local culture is achieved in various ways:

(a) Traditional concepts of efficacy are used to describe their effects;

(b) Western Pharmaceuticals are sold alongside other daily requirements in small neighbourhood shops;

(c) Pharmaceuticals are used in a culture - specific way; and

(d) Pharmaceuticals receive local names and conversely, give their names to traditional medicines. All too often programmes for rational drug use focus on health care providers, on the assumption that their education will lead to a more rational drug use. Prescription - only drugs, however, are used widely in self-medication, the practices are culture-specific and can not be ignored.

Herxheimer, A. and Stimson, G.V.[14] have argued that people assign meanings to medicines and that these meanings differ between groups and within the between cultures. People's medication practices and beliefs are discussed extensively. It is concluded that most treatments of every-

day illness are not obtained from a doctor. Self-treatment is the norm.

Tan, M.L.[15] raised questions about the validity of labels such as 'western', 'alternative' and 'traditional' as applied to medical systems. Pluralism in diagnostic and therapeutic procedures must be recognized even within one system. A review of socio-historical factors that influence medical systems highlights important processes such as cultural reinterpretation and indigenization that characterize 'traditional' medical system.

Overgaard, L.B. and Holme, H.E.[16] have analysed medicine behaviour seen from the user's point of view.

Conrad, P.[17] has also presented a paper with an alternative patient-centred approach to managing medications. The study focuses on the meaning of medication in people's everyday life and looks at why people take or donot take their medication.

Blum, R. and Kreitman, K.[18] described the factors that affect the habits of medicine users. They show how self-medication varies with the symptoms of the patients, their sex and also their lack of knowledge of the current use of medicines. Foster, G.M.[19] suggests that modern medicine in recent years has become the first choice for most traditional peoples most of the time. With respect to the

use of traditional curers in primary health care, it is pointed out that :

(a) they are not replacing themselves;

(b) they may have become 'neotraditional curers' making extensive use of modern drugs; and

(c) spiritualist curing is replacing much traditional medicine.

Geest, S. Van der, et. al.[20] are of the view that anthropological field research does not suggest that programmes for 'rational drug use' can be easily implemented. The commercial context of medicines and the new meanings they acquire in local settings give rise to very complex situations.

The study by Ashraf, A., et.al.[21] disease and health care in rural Bangladesh sought to find out how the fields of traditional, folk and allopathic medicine were related to each other and what processes could be discerned in these interrelationships. The outcome was that traditional medicine has almost disappeared in this area.

Batia, J.C. et.al.[22] studie 93 traditional healers in three states of India showing that they are increasingly using modern/allopathic medicines in their practices.

As far as Nepal is concerned, various studies have been made in the field of health practices and health status

covering both the modern and traditional system of medical care. But a few major studies that have been kept in view while conducting the present one are described below on the basis of their focus and coverage:

Health Administration

Justice, Judithene had done a study in 1981 on health planning in Nepal. She discussed the system and structure of health administration in the past as also the contemporary period.[23]

K.K. Kafle has examined the current situation regarding training for health workers at various levels in the prescription of durgs. Important criteria for the rational use of drugs are :

National drug policies based on the essential drugs concept, accurate information to health care professionals, and effective national system for excluding needlessly expensive and harmful drugs. Problems and constraints include lack of adequate drug information, inadequate drug supply and non-utilisation of services. Recommendations are made as to how the situation could be improved.[24]

Community Health Services

Various studies in this field have been carried out. The performance of health workers in primary health care in Nepal,[25] the five year (1974-79) experience of a community health programme in Lalitpur (Kathmandu Valley) to train local indigenous midwives,[26] an account of basic health care work done from 1979-1982 in Dolakha district (Nepal) as part of the IHDP[27] may be mentioned in this connection. Poverty, unhealthy living conditions and malnutrition, the latter particularly among women and children, as contributory to poor health and the evolution of Nepalese primary health care (PHC) system has been described by Mathema.[28] The purpose of the study in Sindhupalchowk (Nepal) was to document the nature of available indigenous and modern nutrition and public health service in rural communities.[29] Over the last decade many developing nations have embraced primary health care (PHC) within their national health plans. Linda Stone in her study has emphasized community participation and basic health care for th poorer sections of society. She found a contradiction between the stated PHC intention to address local interests and promote community participation on the one had and the actual approach taken on the other.[30] In the last two decades, the great expansion of primary health care in the rural areas of developing countries has not been matched by significant improvements in health standards and Nepal is no exception. Traditional healers have been used as go-

between to overcome these difficulties as has been observed by Oswald.[31]

Providers and consumers, and their knowledge, attitude and practice (KAP)

Burghart presents a detailed case study of an exorcist (psychotherapy) in rural Nepal who has abandoned the explanatory paradigm of exorcism and taken up certain aspects of Brahmanical tradition, medical science and temple healing in order to establish a place of medical resort, called the Tisiyahi Klinik.[32] A large mojority of the rural population in Nepal is still served by traditional practitioners who rely on local resources for their drug requirements.[33] The Kathmandu valley is taken as an example of an area where a plural medical system consisting of western medical practitioners, traditional healers and popular healers flourishes.[34] Study was carried out by New Era (an NGO working in Kathmandu in Nepal) to obtain a better understanding of a few categories of health workers.[35] Traditional medicine still plays a major role in the diagnosis and treatment of diseases, although modern methods are being introduced as more hospitals are built and put into operation.[36] An attempt to provide information on some aspects of general pharmaceutical practice employed by the traditional healers of central Nepal was made by Bhattarai.[37] The results of a pilot project which was conducted in order to assess the possibility of using trained traditional medical practitioners (TMPS) as a

motivator in the promotion of family planning (FP) and health education are also available.[38] An account of the efforts made by SCF project to work in cooperation with traditional healers and to offer them training in some allopathic techniques has been presented by Dhakal.[39] Some of the descriptions about the use of local medicines in specific diseases is presented in a study of traditional methods of treatment by Kafle et.al.[40] Contributions to Nepalese Studies brought out a special volume on health. In it there are several articles. They give a historical account of health services in Nepal and also present a very general picture of different types of health services that are available to the peopel.[41] Another volume of this kind is that written by Pradhananga[42] in which organizational structure and development of health services in Nepal have been presented. The role of the traditional birth attendant (TBA) in FP/MCH in Nepal is available from Verderese's article.[43] Attempts have been made to explore and interpret the beliefs about the causes of illness as perceived by the Newar people in Kirtipur,[44] and Bhaktapur, Nawal Parasi and Illam,[40] and also in Dhorpatan in Western Nepal.[45] An analysis of food transactions in Nepalese villages provides an interpretation of the cultural place of illness within high caste Hindu tradition.[46]

S. Lechner-Knecht in a brief article on Ayurveda in Nepal and India has drawn the attention of scholars to the beliefs underlying the perception of many Nepali people

concerning the origins of illness and the role of faith healers like the dhamis and jhankris in their cure. Ayurvedic drugs are derived from animal substances, plants and mineral products. These three classes os ingredients may sometimes be combined. Nepal is a country particularly rich in botanical variety, he notes, making it an ideal place for the development of herbal medicines. The government encourages the cultivation, drying and export of medicinal plants, and there is provision for Ayurveda in medical education programmes. Despite this, however, people are tending to turn away from Ayurvedic and towards western medicine, and students are preferring to study the latter. Ayurveda demands a larger healing process, greater dedication from the medical practitioner, and a more intense relationship between healer and sick persxon than modern medicine. But according to him each approach has much to offer the other, and, he even recommends courses in Ayurveda for western trained doctors and pharmacists.[47]

A.K. Sharma has given an outline of the history of traditional medicine, some of the methods used by traditional medical workers and the difficulties in evaluating traditional medicine. A basis for evaluation and research work is given and comparisons are made between traditional and modern methods of drug classification and mode of action. With some modifications, recommendations made by the World Health Organization for the integration on traditional and modern medicine are endorsed.[48]

A bio-anthropological study was conducted on the Sherpas of upper Khumbu (3500-4050m), Nepal and their migrant counterparts in the lower altitudes. This study examined the impact of altitude on human biological traits with suggestions that there may not be variations in ethnomedicine and plural medications at the local level due to altitudes.[49]

Statistical/demographic Studies

Population monograph of Nepal 1987 provides the general statistical report upto 1981,[50] and the statistical year book gives health statistics.[51] Other data on budget allocation and utilization, etc. are also available from a publication of Management Science for Health.[52] There are estimated to be about 2000 Ayurvedic practitioners in the country of whom about 500 are institutionally qualified.[53] Reports on the evaluation of basic health services provides statistical analysis of both traditional and modern medical programmes implemented in Nepal.[54]

## 2.4 Sources and Methods

For the proposed research work, data have been collected from the following soiurces:

A. Secondary data : Secondary data has been collected from-

(i) The available literature as surveyed above; and

(ii) Offical publications e.g.- Census, Statistical Year Book, Country Health Profile, records of the district council, records of the village development committees, etc.

B. Primary data : The district of Makawanpur in the Narayani Zone, Central Nepal has been selected for intensive field study. The district is multi-ethnic with hills and flat lands, as is characteristic of Nepal.

Within the district, out of 43 village Development Committees two Village Development Committees were selected for detailed investigation.. They were Makawanpurgadi Village Development Committee (MGC) in the hills and Padampokhari Village Development Committee (PPC) in the Terai making the MP cluster for the purpose of this study. The MP cluster was selected in such a way that they were representative of the ecology and the ethnic characteristics. Given the administrative pattern of Nepal the two Village Development Committees have 18 wards (villages) and

3200 households. These households were arranged according to ethnic affiliation and ten per cent from each strata were selected randomly for detailed study. In all, 319 households were spotted for collection of data about the sickness and medication pattern. These households provided all information about the consumption of ethnomedicine and prevalence of other alternative medication practices, on the basis of which a general picture has been obtained and presented in different chapters. The providers of ethnomedicine and practitioners of other alternative medication were separately identified from the MP cluster by asking questions about them from the consumer households, and they numbered 41 of whom 2 happened to be randomly selected in the sample of the consumers as well. From these providers all relevant information were collected about their profession and practices. The intensive field survey was conducted between October 1989 and June 1990, even though a few more quick visits were made subsequently to fill up the gaps as and when noticed.

There were three schedules for respondents at the level of:

(a) household;

(b) individual - sick and medicated; and

(c) providers of medical services.

Apart from the canvassing of the above schedules, data have been collected through case studies, face to face interview, observation and ethnomethodological devices. A chief goal of ethnomethodology[55] is to study how the people in the course of their ongoing social interactions make sense of various 'indexical expressions'. It is primarily concerned with studying the common sense features of everyday life with emphasis on those things that 'everyone knows' about diseases and medication including psychotherapy. Thus both, verbal and non-verbal behaviour are taken cognizance of to facilitate a better and holistic understanding.

In the following chapters the development of medical education, and also the description of structure and pattern of medical administration will be provided first so that the relevance and scope of ethnomedicine and other alternative medication practices in Nepal may be better appreciated. This will be followed by two separate chapters on ethnomedicine and other alternative medication where the methods, providers, and consumers will be studied in depth. And, finally, before we reach the conclusion, there will a chapter on the socio-cultural framework of medication, based on our field-work in the study area above mentioned. In the concluding chapter, some general observations will be made in the way of summing-up and also some implications for policy planning will be highlighted.

## REFERENCES


1. Foster, G.M., Anderson, B.G. (1978): Medical Anthropology, Afred A. Knopf, New York.

2. Lieban, Richard W. (1973): "Medical Anthropology", in Handbook of Social and Cultural Anthropology, J.J. Honigmann, ed., Chicago, Rand McNally.

3. Fabrega, Horacio, Jr. (1972): "Medical Anthropology", in Biennial Review of Anthropology, B.J. Siegel, ed., Stanford, Calif: Standford University Press.

4. Sjask, Van Der Geest. (1982): "The illegal distribution of Western medicines in developing countries", in Medical Anthropology, Vol 6 (4).

5. Saldon, Annia. (1981): "Physical access and utilization of health services in rural Guatemala, Social Science and Medicine, Vol. 15. Marieen, Foets, et. al. (1985): "The Primary health care Project in Belgium", in Social Scienc and Medicine, Vol 20 (3). and Robert, Trotter II (1981): "Folk remedies as indicators of common illnesses", in Journal of Ethnopharmacology, Vol. 4.

6. Annae, Ferguson. (1981): "Commercial Pharmaceutical Medicine and Medicalization: a case study from El. Salvador," in Curative Medicine and Psychiatry, Vol. 5.

7. Clark, Cumingham. (1970):"Thai Injection doctors", in Social Science and Medicine, Vol. 4.

8. Bonnerman, R.H. et. al. (1983): Traditional Medicine and health care Coverage, Geneva, WHO.

9. The Academy of Traditional Chinese Medicine (1975): An outline of chinese acupuncture, Peking (Beijing), Foreign Language Press.

10. Sorbin, T.R. et.al. (1972): Hypnotism, New York, Irington.

11. Nicther, Mark. (1978): "Pattern of resort in the use of therapy; systems and their significance for health planning in South Asia" in Medical Anthropology, Spring 1978 and "Playing for what ails you" (1978) in Social Science and Medicine - 17.

12. Parker, R. et.al. (1979): "Self care in rural areas of India and Nepal" in culture, Medicine and Psychiatry, Vol. 3.

13. Haak, H., Hardon, A.P. (1988): "Self Medication Indigenised Pharmaceuticals in developing Countries, widely used, widely neglected" in The Lancet (2).

14. Herxheimer, A. stimson, G.V. (1983): "The use of medicines for illness" in Blum R., Herxheimer A., et.al.eds. Pharmaceuticals and health policy; HAI paperback edition, reprient by Social Adult Ltd.

15. Tan, M.L. (1989): "Traditional or Transitional Medical Systems? Pharmacotherapy as a case for analysis" in Social Science and Medicine, 29 (3).

16. Overgaard, L.B., Holme, H.E. (1985): "The active medicine user" in Scandina vian Journal of Primary Health Care, 3.

17. Conard, P. (1985): "The Meaning of Mediciations: Another Look at Compliance" in Social Science and Medicine, 20(1).

18. Blum, R., Kreitman, K. (1983): "Factors Affecting Individual Use of Medicines" in Blum, R., Herxheimer, A., et. al. eds, Pharmaceutical and Health Policy; HAI paper back edition, reprient by Social Adult Ltd.

19. Foster, G.M. (1984): "Anthropological Research Perspectives on Health Problems In Developing Countries" in Social Science and Medicine, 18(10).

20. Geest, S. Van der, Hardon, A.P., Whyte, S.R. (1990): "Planning for Essential Drugs; are we missing the cultural dimension? in Health Policy and Planning, 5(2).

21. Ashraf, A., Choudhary, S., Strafland, P. (1983): "Health, Disease and Health Care in Rural Bangladesh" in Social Science and Medicine, 16.

22. Batia, J.C., et. al. (1975): "Traditional Healers and Modern Medicine" in Social Science and Mediciune, 15-21.

23. Justice, Judithene. (1981): International Planning and Health: An anthropological case study of Nepal, Ph.D. dissertation Submitted to the University of California, Berkelay.

24. Kafle, K.K. (1987): "Drugs information, Education and Training on the Rational Use of Drugs"- Paper Presented on an Workshop on Rational Use of Drugs, Kathmandu.

25. Institute of Mecidine (1985): Report on Performance of Rural Health Workers in Nepal, Institute of Medicine and Department of Health, Kathmandu.

26. Mogedal, S. et. al. (1979): The Traditional Birth Attendent in the Health Care System, Nepal Medical Association, Kathmandu.

27. Achard, T. (1983): Primary Health Care in the Hills of Nepal, Integrated Hill Development Project, Kathmandu.

28. Mathema, P. (1987): Primary Health Care in Nepal, Vijaya Ram Mathema, Kathmandu.

29. Shrestha, V. (1986): "Family Level Perception of Nutrition, MCH and PHC Programmes in Sindhupalchowk" in the Journal of the Institute of Medicine, June 8 (2).

30. Stone, Linda. (1986): "Primary Health Care for Whom? Village Perspective from Nepal" in Social Science and Medicine, 22(3).

31. Oswald, H. (1983): "Are Traditional Health the Solution to the Failures of Primary Health Care in Rural Nepal?" in Social Science and Medicine, 17(5).

32. Burghart, R. (1984): "The Tisiyahi Klinik, Nepalese medical centre in an intracultural field of relations" in Social Science and Medicine, 18 (7).

33. Kurup, P.N.V. (1983): Primary health service programme, Nepal (traditional medicine, Assignment report, WHO-SEARO, New Delhi.

34. Skultons, V. (1986): "Popular healing in the Kathmandu Valley" in Lancet, May 3 (1).

35. New Era. (1986): Health manpower staffing pattern review, Integrated community health services development project, Kathmandu.

36. Horseley, J. (1978): "Medicine amongst the mountains: the medicine of poverty" in Practitioner 220 (1315).

37. Bhattarai, N.K. (1987): "Traditional Pharmaceutical Practice in Central Nepal" in Nepal Pharmaceutical Association, 14 (1,2).

38. Shrestha, R.M. et.al. (1980): Faith healers: a force for change, UNFPA-UNICEF, Kathmandu.

39. Dhakal, R. et.al. (1986): Traditional healers and Primary health care in Nepal, Save the children Fund.

40. Kafle, K.K. et.al. (1984): Traditional methods of treatment in Bhaktapur, Nawalparasi and Illam, a research report mimeo.

41. Institute of Nepal and Asian Studies, (1983): Contributions to Nepalese studies, Special issue on health. Vol. 3, INAS, Kathmandu.

42. Pradhananga, Yogendra (1979): Health and Health Services in Nepal, Mrs J.M. Pradhananga, Bhaktapur.

43. Verderese, M., et.al. (1975): The traditional birth attendent in Maternal and Child health and Family Planning, WHO publication No. 18, Geneva.

44. Devkota, P.L. (1984): "Illness interpretation and modes of treatment in Kirtipur", in Contributions to Nepalese studies, 11 (2) Research Centre for Nepal and Asian studies, Kathmandu.

45. Murphy, M.C. (1983): "The integration of traditional health practices and beliefs with a community health project in West Nepal", in Journal of the Institute of Medicine, 5 (2).

46. Stone, Linda (1983): "Hierarchy and food in Nepalese healing rituals", in Social Science and Medicine, 17 (14).

47. Lecher Knecht, S. (1978): "Ayurveda, Jahrtausen-dealte Heil- und Lebenskunde in Nepal und Indien. Teil 2" in Med Klin Feb.

48. Sharma, A.K. (1979): "Quality Control standardisation of traditional medicines", in Journal of Nepal Pharmaceutical Association, Kathmandu.

49. Gupta, R. et.al. (1981): "The Sherpas of Eastern Himalaya; a study on genetic Polymophisms" in ISL.Tech. report no. anthropo 8/81.

50. Central Bureau of statistics (1987): Population Monograph of Nepal. National Planning Commission, CBS, Kathmandu.

51. Central Bureau of Statistics (1989): Statistical Year book, NPC, CBS, Kathmandu.

52. Management Science for Health (1978): Expanded analysis and work plan: Integration of health services, AID/NESA-C, Kathmandu.

53. Kurup, P.N.V. (1982): Training and utilization of practitioners of traditional medicine in PHC- Nepal, Assignemnt Report, WHO- SEARO, New Delhi.

54. USAID, WHO and HMG (1975): Report on the evaluation of Basic Health services in Nepal, USAID, Kathmandu.

55. Kenneth, D. Sailey (1979): Methods of Social Research, The Free Press, New York, Collier Macmillan Publishers, London.