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THE SOCIO-CULTURAL ASPECTS OF HEALTH

“If health care in Nepal is to be improved, one must start with the assumption that the villagers’ faith in their own healing techniques - be they herbal or ritual - is not going to be shaken by the occasional visits of medical teams or even by the building of hospitals.”

Blustain, 1976.

Dor Bahadur Bista in the introduction of his book (1) writes: “The most important effect of this has been the absolute belief in fatalism: that one has no personal control over one’s life circumstances, which are determined through a divine or powerful external agency.”

Nepal being a multi ethnic society, it is no surprise that the various groups have their own concepts of disease, various methods of warding it off and also for dealing with illnesses.

As is done all over the world, the Nepalese too pray to various deities for protection, not only at times of stress but for comfort and well being in future years. There are even specific deities to whom special offerings and requests can be made. Thus in the valley, or in the greater Kathmandu area, there are specific temples where worship can be done for a particular purpose.

Sital Mai	In the Pashupati area to protect against smallpox.
Kandutathan	At Kupondole for ear ailments.
Bhatbhatini	For children when frightened by spirits.
Swayambu Ajima Sarati Maya	For wellbeing of children.
Santaneswar Mahadev	For infertility.
Gyaneshwar Mahadev	For infertility.

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Kumbeshwar

Water pot god of Lalitpur has an accompanying **Naag** and the spring water coming out is said to cure several skin diseases including leprosy.

Prof. Macdonald in the introduction that he has written for CJ Miller's book (2) states that "the **jhankri** is a caste and social free-wheeler. ...the **jhankri** is, to some extent, prior to the official arrival of Hinduism, the creator and the maintainer of certain forms of religious centralisation in the Nepalese hills."

Lediard, co-author of another work goes on to state in the introduction, "the specialists who can best care for Nepal's major ailment are those who are administering daily to most of the health needs in the village: the faith healers - the **dhamis** and **jhankris** of Nepal." (3) Other investigators have mentioned traditional healers such as **aamchis** who have the background of Tibetan medicine and bring in concepts of the body becoming hot or cold as a result of eating hot or cold food. In the same system of medicine other practitioners such as **lamas** gave the concept of **lu**, said to be inhabiting watercourses and when offended then leading on to afflictions such as skin eruptions or even insanity. This investigator felt that allopathic medicine rather than displacing the traditional healing practices tended instead to be integrated in into a network thus creating a pluristic form of health care being practised in the country (4).

Though Judith Justice mentions also **jharnes** and **fuknes** she found in her investigations that the ill generally "waited in the house to get well." The next recourse was to use herbal and dietary remedies (5). Lediard and Shrestha estimated that there were between four to eight hundred thousand faith healers in rural Nepal. This by all accounts is a fantastic statement and is perhaps dependent on what is one's definition for the term. Other workers have quoted this and whilst looking at the types of practices conducted in and around Kathmandu, have noted interesting points. There are what the author has termed as "popular healers" and one criteria for their classification was that patients had to wait a long time to see them! The brief consultation, routine and quick treatment by an unknown practitioner in a new locality were the other features (6). These "popular healers" could be a **jhankri** or spirit-medium, a **tantrik** or healer practising tantrism or even a **deuta** ie. healer possessed by a mother goddess. This investigator Skultans commented on the

fact that some of these traditional healers made, “somewhat eccentric use of a stethoscope” in their practices.

The gist of all this is that the government health services - the health posts and hospitals were the “last choice” in spite of the fact that the treatment given by the traditional healer were by no means cheap, as has been reported by Maybin of SCF at Sindupalchowk (7). Chalker, who worked with BNMT in Eastern Nepal has also confirmed the findings that the traditional healer is the first provider of health care (8).

Most of the research work by international researchers in these aspects of health, about which we ourselves have not cared very much, has been done after the political changes of 1950/1. Linda Stone, another researcher in Nepal, has after her work at Nuwakot district reported that villagers though having high respect for western medicine are somewhat reluctant to accept it (9).

It is in this context that one should review what has been written about medicine in Nepal by a Western investigator Streefland (10). His conclusion is that:

1. Different medical systems can co-exist. Each whilst having its own expertise will generally cater for the common ailments.
2. People may adopt behavioral aspects of medical systems without fully understanding the theories involved.
3. People’s actual health behaviour in situations results after considering the pros and cons that exist.
4. Another factor was the costs of health behaviour, in relation to what people can afford and to the quality of services that they will get.

Thus in the case of Nepal the lot of the Nepalese, especially those in the rural areas is that they first seek treatment from the system/form near at hand. Shrestha in listing these, states that the Sherpas of the Everest region usually applied the paste from the **Sharma guru**, whilst the Jyapoo of Kathmandu valley used a preparation from the **Ghod Tapre** to heal their cuts and wounds (11). In the first instance this means the use of herbs by the herbalists. This has existed since time immemorial and traditional healers such as **dhamis** and **jhankris** also use plants as their means of cure. Then there are the other healers such as **gubaju**, **jhar phuke** and **sudeni**. Besides the ones enumerated above, there are also the **ayurvedic** practitioners and of late, the

Tibetan medicine men. As has been reported by Streefland, people move from one system of medicine to another, from one interface to another.

In Nepal, in all areas where medicine is available a certain amount of self-care takes place. This brings up the concept of self medication. Whilst the principle of self-care is good, the idea of self medication may not be. Buying simple remedies over the counter is permissible and the many medical halls cater to this demand but some form of control of drugs, especially the dangerous and powerful antibiotics, must be enforced. The DDA is trying to do something about this by compiling the National List of Essential Drug in 1988 and then its first revision in 1992 and the last in 1997. Drugs have now been categorised into 4 groups for:

- hospitals
- health posts
- sub-health posts
- primary treatment level

To guard against the dangers of over the counter sales the owners or dispensers at the medical halls or pharmacies have been given condensed courses on this subject. A recent comment about the state of affairs is as given below (12).

“Self medication is quite common in Nepal and some 90% of drug sales occur in the private sector, mainly through retailers without training in pharmacy.”

A recent investigator regarding medical practice in Nepal felt that the practice of medicine was becoming more broad based with the new students from the Institute of Medicine, who were opposed to the existing “source force” and were hankering after change in the type of medical practice in the country (13)

A report by Moin Shah et al (14) has stated that the Government health services are providing barely about 10% of all consultations for people seeking health care.

The delivery of health service care is also very much dependent on the current thinking that prevails at that time. Presently due to the paucity of funds it has been suggested that the private sector should pick up the bill for much of the tertiary care that is provided. A World Bank document of 1993 states that hospitals absorb as much as 40-80 % of public spending on health in the developing countries. It notes too that tertiary care hospitals are

crowded with patients who could be more cost effectively treated at the more accessible district hospitals or health centres (15).

The interesting point that needs to be noted about Primary Health Care facilities is that there are a number bilateral and multilateral agencies which are or have been working in the various districts of Nepal. Of the 75 districts different agencies have been involved in various districts from time to time.

State of the Child in Nepal

Work by Nabarro at the MCH clinic at Dhankuta in 1977 had shown that for the programme to be successful it was necessary to have both social and economic development in the villages concerned. Nepal Children's Organisation (NCO) and Save the Children Fund (SCF) began to participate in integrated rural development programme and the Child Health Support Programme (CHSP) to act as a catalytic and integrating agent. This led to successful projects for income generation in livestock and agriculture. Teacher training in health, nutrition and agriculture was also started (16).

A final report by Nabarro after seven years of working in a village gave some interesting findings (17). In monsoon months food is scarcest, work hardest and infections most frequent. Long term requirements must be fulfilled so as to improve the socio-economic conditions if the percentage of malnutrition is to decrease. Basic requirements were identified as mobility, a system of providing medical care and additional food. It was also pointed out that it was not enough to treat just the severely malnourished children but to give them nutrition education, plus to monitor the effects. This particular experience showed that whilst nutrition education for mothers and supplementary feeding were popular, the reality was that many mothers may be unable to follow the advice and those that are in dire need of it *viz.* the poorest may in fact be left out.

“Among Rai and Sherpa women, forestry, nutrition and health care are linked together though women's use of Jangal resource for household nutrition security— Rai women use jangal ingestibles as a regular supplement in their diet, while most Sherpa women gather them seasonally for variety and taste.” (18)

Existing Health Delivery

What has been accepted even by the authorities is that the health services provided by the government reach no more than 10-15% of the population and that even after a great deal of resources put in and effort expended (19). The usual finding at a time of survey is that the institution is closed or working at minimal state for want of staff, supplies. Justice when doing her research as early as the late seventies, had commented about the relationship of culture and health planning. Writing about the pros and cons of the ANM programme she had stated that it's functioning was such because it had ignored social and cultural information in health planning and the traditional expectation of women (20). She had also drawn attention to the seen but till then unacknowledged fact regarding the peon in Nepal. This lowest ranking worker in the health field performed many basic crucial functions in the delivery of health services at the local level. These included dispensing medicines, dressing wounds and injecting parenteral preparations, thus perhaps of even entitling him to the title of the invisible health worker of the system (21). This finding had been belatedly confirmed by a cartoon published by the **Gorkhapatra**, government media on 6th February, 1994. It is published here with permission of the editor.

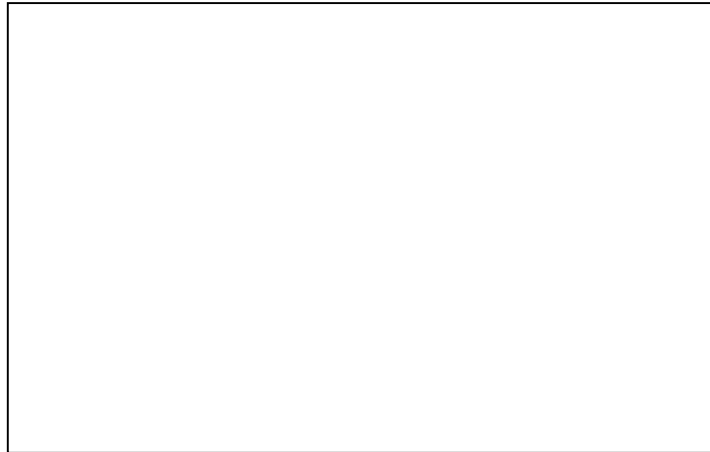


Fig. 1. Peon / doctor situation.

“Only the pay is that of a peon, Sir. The work itself is that of a doctor. The doctor comes but once a month, signs the register and then goes off.”

The opinions expressed is that the local peon is the only permanent feature of the health institution in the rural area. Being a local man he understands and knows not only the language but also the people all around. His wants are few, he is not enamoured for promotion and thus not liable to be transferred. Though respected by the people he is likely to listen and carry out the wishes of the village elders. Through rain and hail he is likely to be at his post. Thus he is truly a “man of the people”.

Subsequent confirmation of this fact again occurred on the occasion of the evaluation of the Health Development Project done in 1994 in the Surkhet district (22). It is perhaps in recognition of this fact that SCF UK has had training courses specially tailored for the peons, and traditional healers in special areas such as diarrhoea and family planning in four districts of Nepal (23)

Health Care in Nepal vis-a-vis elsewhere

An article by Prof. Milton Terris in 1980 (24) had simplified the world health systems into three basic types :

Table 4.1 Types of Health Systems

Type of Health	Area of World	World (%)	Regions
Public Assistance PRE-CAPITALIST	Developing Countries	49	Asia, Africa, Latin America.
Health Insurance CAPITALIST	Capitalist Industrialised Countries	19	West Europe, North America, Australia, N.Z., Japan, Israel.
National Health Service SOCIALIST	Socialist Countries	33	9 Socialist and Communist Europe 4 in Asia, Cuba.

It must be noted that these are not watertight compartments and in some societies the systems overlap. Furthermore these systems are not permanent

and some form of change ie. revision or replacement is taking place most of the time.

Public Assistance

This means that for the majority, basically the poor, health care is provided through a network of government hospitals and health centres and that these are paid for by general taxation. As payment for services provided is generally low, physicians supplement their income with other work such as private practice. In some places there may be services for special workers eg here in Nepal in banks, industrial areas and corporations.

Health Insurance

Here also there is a wide variance in the services offered. In some countries eg. Israel, insurance is non-governmental, in some eg. USA, it is non-governmental and governmental and in others it is purely governmental eg. Canada, Denmark and New Zealand.

National Health Service

This covers the whole population and services are provided by salaried physicians and other health personnel. Practically all the services provided are free except for drug charges prescribed in ambulatory care. Preventive measures are also emphasised to a far greater extent. The characteristics of this service are:

1. Community and factory health centres close to the people.
2. Creation of sectors or units to provide services to a particular unit.
The staff of that unit are responsible not only for curative services but also for promotion of health and prevention of disease.

However though the concept is clear the functioning may not always be so clear cut. One needs only to consider the cases of the United Kingdom and Sweden to show this. Both have been put in the Health Insurance group as this is dominant, but they occupy an intermittent position between Health Insurance and a National Health Service. The United Kingdom and Sweden also illustrated that the National Health Service is not restricted to socialist countries. Though the costs are fantastic, the ideal and rational form of health

care is through a National Health Service. The provision of such health care delivery usually comes about following general dissatisfaction with the services being provided.

But not everybody agrees with this and Prof. Milton Roemer of the University of California, who had worked in Nepal some three decades ago has a more comprehensive categorisation encompassing 150 nations (25). This work done in 1981 put them into the six categories given below:

Table 4.2 Health Systems Types and Nations following them

Health System Type	Illustrative Nations
Free Enterprise	Australia, USA
Welfare States	Italy, New Zealand, Sweden, United Kingdom, Belgium
Transitional Developing	Chile, Iraq, Mexico
Underdeveloped	Ghana, Ethiopia, Nepal, Tanzania, Liberia
Industrialised Socialist	Czechoslovakia, USSR
Agrarian Socialist	Angola, China

NB. Countries such as Czechoslovakia and USSR are no longer the same entities

However by 1990 Roemer felt that though the health system in all the countries of the world had some existing differences it was possible to classify them along two dimensions (26) viz. by :

- i. their level of economic development
- ii. the general ideology of their health policy.

The level of economic development could be graded into three grades from the highly developed to the developing. Similarly the health policies practised in the world he graded into the four approaches viz.:

1. Entrepreneurial having minimal intervention.
2. Welfare-oriented with moderate intervention, with regard to ways of economic support.
3. Universal coverage having extensive economic support and patterns of service delivery.
4. Socialist ie. government operations rather than free market dynamics.

Roemer felt that from the three levels of economic development and the four gradations of health policy it was possible to derive a matrix of twelve types of health system.

This brings up the question and consideration of the current system of health care delivery in Nepal. Perhaps one can say we started with a Public Assistance System, although very restricted and have tried to evolve another very limited National Health Service of some sort.

In the case of Nepal it must be noted too that the amount of finance for health care is very limited. However a fairly large amount of money is spent by the sick and their caretakers for the attainment of health. During the **post andolan** years the amount of budgetary allocation for the social sector, which includes health, education and other social services has continued to increase. However the amount of money spent by the government per annum per person on health care came to a meagre \$ 1.30 (27).

What one has got in our underdeveloped health care system can be equated to the flow of care existing in a developing country as shown by John Fry (28). This is shown on the next page.

This illustration is perhaps a little bit out of date in the sense that we also have specialists though not in large numbers but nevertheless providing health care to the people of Nepal. They are all living up to the maxim of Louis Pasteur, "To cure sometimes, to alleviate often, to comfort always" which as an objective of Primary Health Care has been modified as:

"To cure sometimes, to relieve often, comfort always and to prevent hopefully."

But these are changing times everywhere. One has only to think of former Soviet Union, Eastern Europe and Africa to realise that the world is not the same as it was even five years ago. There has been a partial breakdown of health services in former communist states and things are in a

Fig. 2. The flow of health care delivery.

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pretty bad state. Previously the environment was the responsibility of the sanitary-epidemiological services and the health system was given the task of promoting a healthy lifestyle (29). What is in store for us in the future has yet to be chalked out.

Private and Free Mix

The private medicine up to the time of the **jana andolan** was minimal. Now however with the focus on the starting of nursing homes and private medical colleges, one can say with certainty that things are definitely going to change.

In Conclusion

A substantial amount of the work on the social and cultural aspects has been done by expatriates in this country. Some have spent considerable time to study and note their findings whilst others have cast but cursory glances and reported on the same. One such worker, after considerable period in the country has reported on various aspects of Nepalese life. Her findings following research work on PHC is worth noting (30). It was reported that there was enthusiasm for PHC concept in Nepal. The findings showed that whilst the intention to address local interests and to promote community participation was well intentioned, in reality the socio-cultural processes have been overlooked. The problems identified by this work were:

- i. PHC as such failed to appreciate the values of the villagers and the perceived needs. Whilst authorities stressed on health education, the villagers wanted modern curative services.
- ii. PHC implementers view the rural culture disparagingly as a barrier to health education.
- iii. More attention needs to be paid to the villagers' ideas about health care and the existing traditional cures.

Justice (5) also, studying the health posts and the health delivery system felt that the community volunteer concept was not really viable. Her main reason for stating this was that whilst volunteers were expected to do 6 hours of health motivation work each week, the powers that be gave little consideration as to whether the volunteers had the spare time for such work. The irony was that whilst these poor village farmers were expected to do such

motivation work free - their supervisors **viz.** the Village Health Workers got paid for preventive and some motivational work.

In this context an experience at Baglung prompted Costello to make suggestions regarding strengthening of PHC in the district (31). It called for inclusion of the District Health Service Administration, health post and the various categories of health workers providing service at grassroots level. The plea is made to shift the focus of attention from the capital city to reproducible types of schemes at the District level. It is interesting that the focus of the WHO has now shifted to the district level. The subsequent restructuring of the health services of Nepal has also been made to be at the district. It is with this concept in mind that the newly started medical college in Dharan viz. the BP Koirala Institute of Health Sciences (BPKIHS) besides its various objectives will be providing services, information and research currently in the districts of Sunsari, Dangkuta and Morang.

One other aspect that has come to the fore during the last few years has been the question of ethics in the medical practice conducted in this country. Discussions on this, on the setting up of medical colleges and in the doing of renal transplants, mainly on expatriates with unrelated organ donors took place.

Finally there had been a charge that Nepalese doctors were involved not only in "medical politicking" but also in politics at the national level. The common charge of course was that the medical person, be it a s/he communicated many of the personal advancement actions or interests at the time of "feeling the pulse" of the person in charge. As this position itself was multicentric, the levels at which the effect of this was felt were many. There is also a feeling that gross politicisation of health services has taken place as evidenced by the fact that mass transfers and sudden postings tend to occur each time there is a change in government. The four years from 1995-1998, though exceptional has even seen cabinets under five prime ministers. The health ministers too have taken decisions, which in itself may be immature and biased, on the advice of their respective "think tanks", interested in settling personal scores rather than in the best interests of the country. Some outsiders have thus commented on the "source & force" required in the matter of placements or career advancements in Nepal. All these need to be looked at in the context of the "Hippocratic Oath" or various other codes of conduct that are supposed to be lived up to.

Whilst a number of doctors have occupied the health portfolio, some have taken charge of other departments and one has even become prime

minister (See Annexure IV). This is straight forward functioning but what people are more worried about are the surreptitious involvement in politics. This was expressed during the course of the NMC/NMA Seminar in Sept. 1995 when it was stated that those desirous of playing politics should do so openly and not make the hospital the playground. The vernacular **Deshanter** weekly of Sept. 10th, 1995 expressed this very aptly by way of a cartoon by **Huscand** on the front page. It is published below with the permission of the editor.

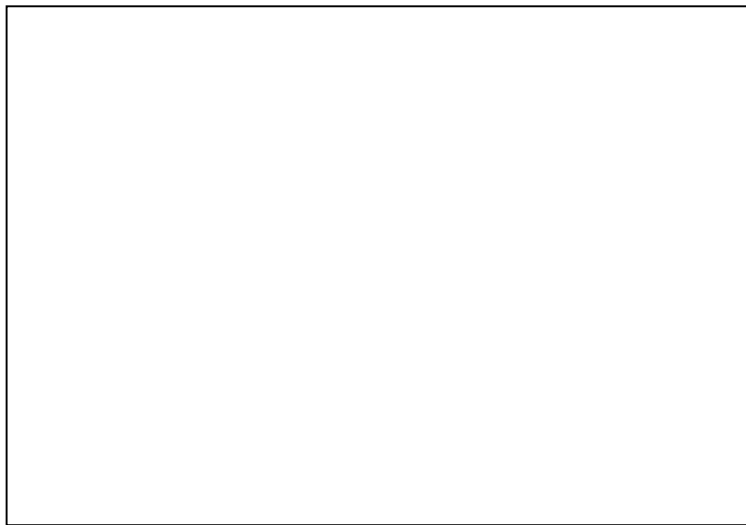


Fig. 3. Attitude of doctors.

*Really, are these doctors examining the patient or are they playing politics...?

On the other hand Dr. Gro Harlem Bruntland, WHO Director General is expected to brave politics in the name of science. Some of her sayings which are thought provoking are given below:

“Why should you leave politics, which is the most important thing happening in a democratic society, to somebody who does not understand science ?”

“No field of medicine is closer to politics than public health. You cannot implement it without making it a political issue.”

Dr. Bruntland says that she “could do much more in politics than medicine to change society in the way you think is right.”

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The present trend is for expenditures in the social sector to be increased, but Nepal’s current position is not satisfactory in comparison to the expenditures in the social sector in some other SEAR countries in 1993.

Table 4.3 Comparison of Government Expenditures

Country	Percentage of central govt. expenditure on:		
	Health	Education	Defence
India	1.9	2.2	14.5
Indonesia	2.7	10.0	6.2
Myanmar	7.4	17.0	32.7
Nepal	4.7	10.9	5.9
Sri Lanka	5.2	10.4	11.4
Thailand	8.2	21.2	17.2

Source: World Bank, World Development Report, 1995, New York

There is a move to try to change this in what has come to be known as the 20/20 initiative. (See Chapter 6)

The bottom line in all this is that Nepal has the 152nd position among the 174 countries in the Human Development Index. The HD Report–1998, which has been brought out by UNDP is based on various indications pertaining to the country. The fact that Nepal’s position in that gradation has moved up two positions since last year is not of much comfort to the poor Nepali.

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