



Nepal Safer Motherhood Project
a part of HMGN Safe Motherhood Programme

**Ethnographic Perspectives on Obstetric
Health Issues in Nepal: A Literature Review**

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ABBREVIATIONS

CEDPA	Center for Development and Population Activities
CREHPA	Center for Research on Environment Health and Population Activities
IEC	Information Education Communication
INGO	International Non-Governmental Organisation
NGO	Non-Governmental Organisation
NSMP	Nepal Safer Motherhood Project
TOR	Terms of Reference
VDC	Village Development Committee

1. INTRODUCTION

1.1 Background

This Literature Review has been prepared as a companion document to the report ‘Obstetric Health Perspectives of Magar and Tharu Communities: A Social Research Report’ produced for the Information Education Communication Strategy (IEC) of the Nepal Safer Motherhood Project (NSMP). The Literature Review is intended to set the scene for NSMP’s Increasing Awareness Strategy by giving details of the available evidence of ethnic differences in health beliefs, practices, care seeking behaviour and social support systems. The Social Research Report that accompanies it provides the findings of an in-depth qualitative research study undertaken among two major ethnic groups in the catchment areas of Baglung and Dangadhi Hospitals. Together these two documents are expected to assist the NSMP in tailoring its IEC strategy to the reality of the worldview held by the people in its working area. It is hoped that both the documents will provide useful details to aid the design of appropriate messages, and that these will, over the longer-term, be instrumental in bringing about sustained behaviour change towards an increased use of emergency obstetric services, and contribute to the goal of safer motherhood overall.

1.2 Terms of Reference

This literature review encompasses the following themes indicated in the Terms of Reference (TOR) for the Nepal Safer Motherhood Project Social Research Consultancy:

- Perceptions of maternal health
- Birthing practices (including ritual pollution)
- Indigenous social networks and support structures
- Household decision making structures
- Emergency seeking behaviour.

Within each theme, an attempt has been made to draw on available evidence from the major ethnic groups represented in the three NSMP working districts (Kailali, Surkhet and Baglung):

- Tharu
- Magar
- Bahun-Chhetri
- Newar
- Thakuri
- Low (occupational) castes.

In terms of the ethnic groups that predominate in the three NSMP districts, according to Harka Gurung’s “Social Demography and Expressions” (1998), Tharu are the dominant ethnic group in Kailali (49.5% of the district population). Magars are heavily represented in Baglung (28%) and predominate in neighbouring Myagdi (43.5%). Chhetris account for over a quarter (28%) of the population in Surkhet. Newars, Thakuris, Bahuns, and the low occupational castes are also found in all three NSMP districts but are not dominant compared to their representation in other districts of the country.

1.3 Review Process

Eight days were allocated for this literature review. The first few days were spent contacting local International Non-Governmental Organisations (INGOs) and Non-Governmental Organisations (NGOs) to identify reports or surveys done on any of the themes covered by the TOR, and to obtain copies of them. It was soon clear, however, that there was little that would be useful. Most organisations tend to do baseline surveys that collect information about uptake of existing services and rarely explore in depth the underlying cultural context or perceptions of community members without evaluating some sort of intervention. An exception was Save US who assisted a study in 1994-5 conducted by the University of Wisconsin. The unpublished report of this study by Nissa Erickson is a commendable piece of work. It is also on one of the least studied groups in the NSMP areas, the low castes.

The Center for Research on Environment Health and Population Activities (CREHPA) has conducted many baseline surveys related to maternal health and family planning in various districts of the country. These have been commissioned by a number of INGOs such as Save the Children Japan, Plan International, and the Center for Development and Population Activities (CEDPA). However, these all involved structured questionnaires and very little in the way of in-depth probing around an issue. Results are tabulated frequencies of use of services, or categorised responses to questions. For example, one of the categories for the response relating to failure to use a particular service, or recognise particular symptoms, is "lack of knowledge". A recent paper by Stacy Leigh Pigg in the new journal *Re/Productions* (1999) provides a cautionary note when looking at this type of literature in relation to our research question:

"responses to research questions are so radically removed from the cultural and economic context that interpretation is reduced to simple tabulation. We are left with a very limited and narrow base for authoritative representations of 'local ideas and practices'."

In his book "Decision-making in village Nepal" (1990), Casper Miller wrote:

"the biggest reason for the failure of people to participate in their own development is the absence of rapport and understanding between local people and the officials sent to them from outside the village."

Given the short time for the review, a systematic and time-consuming trawl through INGO and NGO shelves for grey literature and papers was abandoned in favour of a search through the anthropological literature, mostly in journals published in Nepal and held at Tribhuvan University Central Library on the Kirtipur campus. Local bookshops were also a useful source of literature. Options in London was requested to supply hard copies of international literature not easily available in Kathmandu. These were obtained from libraries across London and sent to the NSMP consultant by post. Approximately five days were spent reading all the material collected and writing the review.

This Review does not claim to be an exhaustive review of the subjects covered. There must be other informative sources of literature that have not yet been located. For example, we were unable to trace several documents that look interesting, such as "The interpretation of traditional health practices and beliefs with a community health project in western Nepal" written by Mary Murphy. Other individuals and agencies with unpublished literature relating to the issues covered by this Review are requested to contact the NSMP so that we can share and exchange such information.

2. BACKGROUND ON MAIN ETHNIC GROUPS

This section gives a brief introduction to each of the main ethnic groups living in the districts served by the NSMP.

2.1 Tharu

The Tharu are not one but several of the indigenous tribal peoples scattered all along the southern foothills of the Himalayas in Nepal and also neighbouring parts of India (Rajaure 1982a; Meyer and Deuel 1999). Compared to some of the other hill groups in Nepal such as the Tamangs, Gurungs, Magar and the Bahun-Chhetris, the Tharu have been little studied and knowledge about them is relatively scarce.

Most literature to date concentrates on the Dangaure Tharu of Dang district (Rajaure 1982 a and b, and McDonough 1997). Recently attention has also turned to the Rana and Dangaure Tharu of Kailali and Kanchanpur districts (Gurung and Kittelsen 1996, Kittelsen and Gurung 1999, McDonough 1989, 1997, 1999), the Kathariya Tharu of Kailali (Meyer and Deuel 1999), and the Rajput Tharus of Chitwan (Guneratne 1999). From these, some background on Tharu origins, religion, economy and indigenous social systems can be found. Early records seem to show that the western Terai Tharu were shifting cultivators living on the fringes of the forest and retreating even further into it in the face of encroaching populations, especially Bahun-Chhetris from the hills, after the eradication of malaria in the late 1950s.

Until quite recently, Tharu communities stayed relatively isolated, preserving their separateness and way of life. Even now, after more borrowing and influence in the linguistic and religious spheres, the Tharu still preserve a distinct character, socially and culturally with rich oral traditions of songs and dance. Tharu have their own language which is structurally close to Nepali but still sufficiently different as to be unintelligible to Nepali speakers, though it does not take them very long to learn it (McDonough 1989). Writers studying the different Tharu groups across Nepal all refer to the rapid social changes being experienced and a growing assertion of identity especially amongst the younger more educated and politically active Tharu. Older Tharu do not appear interested in this, and have a more diffuse sense of identity, probably because they do not see themselves as under threat. Tharu also have their own religious specialist although some are more coming to use Bahuns for marriage and other life cycle rituals (Guneratne 1999).

2.2 Magar

Described as one of the oldest tribal peoples of Nepal (Gautam and Thapa-Magar 1994), the Magar are a Tibeto-Burman people originally from the hill districts of Lumbini, Rapti and Bheri zones, but now found over a much wider area (Bista 1996, reprinted from original work of 1967). Traditionally farmers, many have also entered the Gurkha regiments of the Indian and British armies over the last century. Magars are divided into sub-tribes differentiated by linguistic differences, classified as *Magarkura*, *Khamkura* and *Kaika*, the latter spoken by the Magars of Dolpo. The Magars of Surkhet and Baglung are mainly Kham Magars. Originally animist, partly Buddhist, and still mostly endogamous, Magars have lived in close contact with high caste Hindu Bahuns and Chhetris for many years, and some have become what Molnar (1984) describes as "nominal Hindus", having adopted many Hindu customs.

2.3 Bahun-Chhetri

This group has had the dominant role in the modern kingdom of Nepal (Bista 1996). Brahmans (Bahuns in Nepali) rank highest in the Hindu caste system, and, along with the Chhetris, they form the majority (80%) in the hills of western Nepal. Their mother tongue is Nepali, which has been adopted as the language of the state. The Brahmans are the priestly caste and only they can perform many religious ceremonies crucial to the everyday life of all Hindus. Priests are divided into *pandit* (a man who knows Sanskrit well and can conduct lengthy and complicated ceremonies) and the *purohit*, who also knows Sanskrit but his knowledge is more limited. Their

clientele are called *jajman*. Brahmans head the Hindu caste system which links groups in a community and brings them together in mutual dependency (Hitchcock 1980).

2.4 Newar

The Newar people are the indigenous inhabitants of the Kathmandu Valley and are seen in greatest numbers in the capital city. However, as traders, business people, farmers and craftsmen, they have spread all over the country in both the hills and in the lowland Terai. Earliest records of the Newars go back to the 6th century BC, and the Newars were a “nation apart” until the eighteenth century and the arrival of the Bahun-Chhetri outsiders (Bista 1996). There is a separate cultural identity with its own language and heritage, although it is not one single ethnic group in the sense of the Gurungs or Tamangs, for example. Within Newar society there are many clans. Descriptions of the complexities of traditional Newar social and religious organisation can be found in the works of Bista (1996) and Gautam and Thapa-Magar (1994). Important in-depth analyses are by Quigley (1985), Gellner (1992), Toffin (1996), and Lowdin (1998). While these works referred to Newars living in or on the edge of the Kathmandu Valley, the patterns they describe probably hold true for many other Newar communities across the country, about whom very little has been written. No account of Newars living in the Terai was found.

Scholars believe that the Newars were predominantly Buddhist until the thirteenth century when Hinduism began to exert its influence and the two began an easy co-habitation which continues to this day (Bista 1996). Nowadays which of the two categories a Newar falls into is determined by the identity of his or her hereditary family priest (*purohit*). Those with a *Vajracarya* priest are Buddhist (*buddhamargi*) and those with a *Upadhyaya* Bahun priest are Hindu (*sivamargi*).

Newar communities are mostly homogenous and have limited social horizons. Although Newars live in a mainly Hindu environment divided into castes and call upon the services of castes external to the locality for their domestic rituals, the social organization is not founded on a hierarchical opposition of pure and impure, but on a very cohesive clan structure. The clan is the fundamental sociological unit, the “basic molecule of this micro-society” (Toffin 1996).

2.5 Thakuri

Thakuris are high caste Hindu who claim Rajput ancestry from Rajasthan in India (Gautam and Thapa-Magar 1994). They claim to be the aristocrats among Bahuns and Chhetris and demand, and are accorded, the highest social, political and ritual status (Bista 1996). They practice maternal cross-cousin marriage, which Bahun-Chhetris do not. Thakuris are found throughout the western hills, but mostly in the northern districts of Bajura, Jumla, Mugu and Humla.

2.6 Low Castes

There has been relatively much less work on the occupational low castes of Hindu Nepal than the other ethnic groups. In his classic ethnography “Peoples of Nepal”, Dor Bahadur Bista (1996) lumps the occupational castes of the hills and Terai with his chapter on Bahun-Chhetris. Gautam and Thapa-Magar’s Tribal Ethnography of Nepal (1994) accords them more status, and has separate chapters on Sarki (traditionally cobblers and leather workers) and Kami (blacksmiths) but not Damai (tailor) or others such as Sunar (goldsmiths), Gharti, Sunyasi and Bhand. Most low caste groups are found throughout the country, providing services to the higher caste groups and hill tribes.

3. HEALTH BELIEF SYSTEMS AND MATERNAL HEALTH

This is still a very understudied subject in Nepal. A look through the literature has revealed that researchers have just begun to consider this as the momentum behind programmes aimed at improving maternal health grows. A recent study commissioned by the UNICEF Nepal Country Office (Al-Nahi and Post 1998) attempted to look at health seeking behaviour of women in five¹ safe motherhood districts of Nepal. A number of ethnic groups were included² and interviews were conducted with many key informants such as service providers, community leaders and women, but no traditional healers. This follows the common emphasis on the modern health provider system that continues to ignore the perspective of the traditional health belief system and the role of the traditional service providers. There is frequent reference in the UNICEF report to women's "lack of knowledge" when what is really meant is "lack of knowledge according to the perspective of the western health system". The emphasis is on looking at behaviour only from the point of view of the western service provider (uptake of services, monitoring and evaluating impact) and the role of the traditional health system provider is overlooked. Moreover, so far women's own feelings have not often been heard (Arole 1995).

3.1 Tharu

No literature specifically pertaining to perceptions of maternal health amongst the Tharus was found. However, the anthropological literature does help us understand some elements of how Tharus view ill health. Since the village is seen as an area protected by its deities through worship at both individual household (*kurma deuta*, worshipped in the special deity room in the house, the *kola*), as well as village shrines (*bhuiya*), the outside of the village is less safe than the inside. A Tharu's interpretation of this is:

"if one wanders around too much 'outside' (bahira), it is not surprising if one gets ill".

The illness may well be caused by the *bhut* of the 'outside' (Gurung and Kittelsen 1996). This idea is supported by Meyer and Deuel (1999) who describe the fear of the forest amongst the Tharu. The forest is not entered after dark for it houses evil spirits which emerge at times to afflict people and are the cause of much sickness.

A Master's thesis from the Department of Sociology and Anthropology of Tribhuvan University in Kathmandu sheds some light on the importance of the traditional healer or shaman (*bharra* amongst the Rana Tharus, *guruwa* amongst the Dangaura Tharus) in the diagnosis and treatment of sickness in Kailali (Upadhyaya 1989):

"The presence of the shamans in all social and religious activities is a must... if a person falls sick a consultation is done as soon as possible with both the shaman and his instructions accepted wholeheartedly, even if it means having to take out a loan to pay for chickens, pigs or goats to appease angry offended spirits".

Upadhyaya also stresses that the Rana Tharu have a "different world view" to those who enter from the modern health system. The introduction of new ideas relating to health can have a disturbing effect which, if not handled sensitively, will hinder co-operation between people who use indigenous health resources and those who employ new ideas and techniques.

¹ These were Nuwakot, Rupandehi, Sunsari, Banke, Dadeldhura. None of the three NSMP districts was covered

² Newar, Magar, Tharu, Rai, Bahun-Chhetri, occupational castes, Yadav/Ahir and Muslim

3.2 Magar

No specific articles relating to perceptions of maternal health amongst Kham Magars were found. In terms of Kham Magar belief systems about sickness, we can draw from the work of Hitchcock (1980) and his analysis of shamans and their role in diagnosing and treating disease. Hitchcock describes life in the 1960's in a mixed hill community of Magars, Bahun-Chhetris and occupational castes south of Pokhara. More detail about the traditional healer among the Kham Magar is available in French in the work of the French anthropologist Anne de Salles (1991): her work was obtained in time for this review.

Coming to terms with the beings of the supernatural world (*devidauta*) is a part of what most people believe they must do to stay alive and well. These are beings of the land and of the forces controlling health, growth and reproduction. Meeting their demands - which is actually "feeding" them, some with incense and some with blood - is as necessary for the continuation of life as is feeding one's buffaloes with fodder or the soil with manure. The gods and goddesses do good and tend the world: on appropriate occasions such as a naming ceremony or a funeral they must be reached by Sanskrit prayers and the Brahman's ritual fire. But it is the "godlings" (those who eat blood) who cause evil, but can also give protection and cure the sick.

Amongst the Magar there are several specialists who can diagnose and treat illness. There is the astrologer, usually a Upadhyaya Brahman, who has married a Brahman widow and cannot then perform Vedic rites. They determine causes of misfortune by consulting astrological tables.

But most important is the traditional healer or shaman, who can be a man of any caste. The traditional healer among the Magars, as well as many other communities living in the middle hills of Nepal, is the *dhami jhankri*. He has a variety of ways of determining causes of evil, can call evil spirits or godlings become possessed by them, permit them to speak through his mouth, and ultimately control their influence. The godlings do not expect much but are sensitive to slight and become angry and spiteful when they are not given their due. Pregnant mothers and mothers hoping to conceive visit the shaman for spells or go to local shrines to pray that they bear a son.

A considerable amount of research has been conducted on traditional healers such as *dhami jhankris* and their role in the Himalayas. A few notable sources are:

Central Nepal Blustain 1976; Myrdal 1976; Hitchcock and Jones 1976; Peters 1979;
 Miller 1987; Kondos 1990; Acharya 1994
Eastern Nepal Greve 1981/2; Sagant 1988; Gaenzle 1994; Kristvik 1999
Western Nepal Levine 1989

In these, great detail can be found on local variations in the spirit world and descriptions of actual exorcisms. However, looking through these, no specific reference was found to the use of a *jhankri* during crisis in pregnancy, labour or the post-partum periods. For our purposes, this is an important area of study and one that is long overdue.

Shrestha's paper (1997) from Myagdi emphasises the continued belief in the *dhami jhankri*, with the notion that they are "community owned" and not "government owned". Their appeal is complex, but undoubtedly involves their proximity and accessibility, as well as their history and compatible "illness model" of a spiritual cause for most ailments.

Hitchcock (1966) has an interesting story about the possible cause of problems to some women in childbirth. He refers to a *marī*³ in a hamlet in his fieldwork area:

"She came into existence when a woman died in childbirth."

The *marī* is worshipped at the place where her house used to stand. Most persons, including men (except soldiers who die in battle) who die violent deaths, become *marī*. They do not go immediately to be among their

³ This word was not mentioned during our research with the Magar of Ratnechaur in Myagdi

ancestors in heaven but join the earthbound frequently dissatisfied or angry godlings. The *mari* has much potential to harm women in pregnancy and childbirth, and the newborn infant.

Des Chene's paper (1997) amongst the Gurungs includes an interesting discussion of *plah* (soul) and *sae* (site of cognition, memory and the locus of the will, personality), and how these can affect health. *Sae* is shrunken in misfortune or humiliation and a small *sae* in turn will lead to bad judgment, incorrect behaviour and unfortunate events. The concept acts as an ideology that enforces the moral order of the Gurung world, offering an image in which social virtues are rewarded by personal well-being and social failings are punished by a diminishing of self. When *plah* leaves the body, it brings death. *Plah* can leave the body because of weakened physical and also psychological will (shrunken *sae*).

3.3 Bahun-Chhetri

Bennett's papers on Bahun-Chhetri mothers in east central Nepal sheds some light on perceptions of illness, their causes and treatment options, but again not specifically on maternal health (1976a and b). Bennett categories beliefs about illness as those that are "natural" and those that are "unnatural". Natural refers to ailments due to biological failure and usually amenable to cure through western or ayurvedic medicine (practitioners are called *baidhyas*), and local village "common sense", including the hot-cold food practices. Supernatural refers to the effects of sorcery and attacks by evil spirits and even by gods.

Such illnesses must be dealt with through the medicines and rituals of *dhamis*, *jhankris* and *gubhajyus*, or through domestic and community worship of the *devta* or spirit in question. The categories are not mutually exclusive. Villagers say that a *bokshi* (witch) can cast a spell on someone to prevent western medicine from working, so that a *jhankri* will need to be consulted anyway to counteract this. For examples of beliefs and practices about healing, Bennett cites childhood disease, so this does not help us much in terms of understanding local beliefs about maternal health, and especially problems during pregnancy, labour and post-partum.

In the same issue of the Journal Contributions to Nepalese Studies, there is another important paper "Concepts of illness and curing in a central Nepali village" by Linda Stone (1976). This is based on her fieldwork in Nuwakot District amongst predominantly Bahun-Chhetri and Thakuris although some Gurung, Tamang, Magar and low caste groups were also present. Beliefs about illness are complex and multi-layered. What is important about Stone's paper is its discussion about the principles behind the process of becoming ill:

"Central to local conceptions about illness is the notion of the body having multiple links with the metaphysical universe (planets and their gods, evil spirits collectively called lagu, ancestral gods, clan gods), any one of which may be related to illness. Stone details a whole list of evil spirits (bhut, pret, masan, pichas, bir, bokshi, nags, bayu etc) and their origins and powers to cause sickness. If a person becomes sick, a jhankri is needed to identify which of these is causing the problem and to deal with the problem".

Another consideration of the health beliefs of the high caste Bahun-Chhetris in central Nepal is given by Stone in a later paper about food in healing rituals (1983). In this paper, the author concludes that illness emerges as the culturally apprehended outcome of some inevitable conflicts in the village social order. She dwells on the ritual feeding of food offerings to the various spirits of the supernatural world that cause sickness in the community. Her conclusion is that the notions of being "fed", "unfed" and "fed upon" serve as a kind of cultural metaphor through which villagers' physical, social and spiritual relationships are articulated. The "fed upon" are in a physical state of illness, a state that, culturally speaking, represents the negative outcome of a social order based on hierarchy and interdependence amidst scarcity.

3.4 Newar. No literature found

3.5 Thakuri. No literature found (probably similar to Bahun-Chhetris)

3.6 Low Castes

Compared to the other groups, health beliefs and behaviours, social systems and household dynamics are much less described amongst the low caste groups of Nepal (e.g. Damai, Sarki, Kami). Yet it is generally acknowledged that low caste communities generally utilise health services less than their higher caste neighbours.

A thesis written by Nissa Erickson of the University of Wisconsin during her College Year in Nepal 1994-5 provides some practical research results exploring issues relating to women's perceptions of their health and factors influencing their decision-making in terms of health-seeking behaviour. Erickson worked among low caste Moushar (traditionally wood gatherers) and Chamar (traditionally leather workers) communities in Siraha District in the Eastern Terai. Her research was based on qualitative participatory research techniques such as mapping, focus groups and key informant interviews involving 84 women and 16 health service providers (both traditional and modern) and village leaders. The report is unpublished but available from Save the Children US who hosted the study.

Her study emphasises the constant interplay of factors in women's lives (gender roles in the culture), their work responsibilities, caste and ethnic grouping and how much these roles influence their decision-making power, or lack of it, in Nepali societies. A woman's economic security or her distance from a health centre are not the only issues. Her culture-bound belief system, her age and rank in the family, and expectations and past experiences, and those of others around her, in dealing with the health system are also important variables affecting health-seeking behaviour.

She breaks her analysis down in to when, and for what, women seek traditional health care (*jhankris*, *ayurvedic* healer), and when they seek modern health care (pharmacies, health post, hospital), which is a useful approach. Certainly the fact that many women do use traditional healers needs to be acknowledged and not dismissed as mere superstition as it is fundamental to understanding the perceptions women have about the causes and symptoms of different illnesses, and their diagnosis and treatment.

Some of the findings pertinent to this review were:

- how do women define being sick? "we know what sickness is from knowing the differences between what it is like to be well and sick"
- mapping revealed that women perceived the health post to be a long way away even though in terms of actual distance it wasn't very far
- women who had received non-formal education were far more likely to go to the health post for emergencies rather those who had not
- women were perceived as being sick more often than men. This was because "women get possessed by evil spirits more often, evil spirits prefer women" and because "women have babies so we get sick more often"
- all low caste women felt that they were more sick than high caste women because they were poor and lacked proper food and money
- more than distance, lack of money and lack of time due to pressures of work responsibilities were the main obstacles to utilising the health post
- low caste women also reported they were inhibited in using the health post because of the negative attitudes of staff towards them as lower caste, and experiences of past behaviour, often via others
- women reported that "mad behaviour", bleeding excessively in pregnancy and delivery, tetanus, TB, snakebite and *komjori* (anaemia) were the most frightening of their health problems

- all women said they sought help from their husbands in emergencies, as well as from village leaders and neighbours. Mother-in-laws were not reported as being very influential. However when a woman was told not to get care, it was always the husband who had told her, and the reason given was always lack of money
- women can make more decisions about their child's care than they can about their own
- women have an expectation that being sick is just something to put up with. Their overriding priorities are to find enough necessities for basic survival, food, water and fuel
- a woman's sickness is only validated if it seriously affects her ability to work. Thus attention to seeking medical care is only given when it becomes serious enough to hamper work
- the "first *jhankri* and then doctor" theory of decision-making was not found. Women had distinct ideas about who to go to for what (e.g. *jhankris* when an illness is perceived as a spiritual affliction), and there was little step-wise in their approaches. Generally the older and less educated women used the *jhankri* more
- pharmacies and *jhankris* had a relatively high use, and health posts less

Unfortunately there was little specific attention in the study to emergencies relating to pregnancy, delivery and post-partum periods.

4. BIRTHING PRACTICES AND RITUAL POLLUTION

4.1 Tharu

The Rana Tharus do not entertain the orthodox Hindu ideas about women who have been perceived as ritually unclean (Gurung and Kittelsen 1996). “We were told that menstruating women are not prohibited from making food and that there is no avoidance of newborn children and their mothers. Thus Tharu women do not experience the same set of rules and regulations related to their status as do caste Hindu women” (Kittelsen and Gurung 1999). These authors question whether or not this difference will persist as more and more Tharus come under the influence of Hinduization.

However, their comments are in disagreement with Rajaure (1982a) who wrote about childbirth amongst the Dangaure Tharu of Dang Deokhuri District. He described practices that indicate the existence of at least partial beliefs about ritual blood pollution, but ones that are not as orthodox as those amongst high caste Bahun-Chhetri and Thakuri Hindu groups. Women relatives and the traditional birth attendant, called the *sorinnya*, who care for the mother during delivery, do all touch the mother but take daily ritual baths after contact with her. The explanation for this is that the “newly born baby and the mother are polluted and unclean”.

In another paper on the same Dangaure Tharus, Rajaure (1982b) describes some of the beliefs about curing and witchcraft related to childbirth. Tharus believe that sickness in children is caused by *rath lausari*, a malevolent spirit. They do *puja* to him twice a year in every house where there is a woman of child-bearing age. They also offer extra offerings to the spirits of the woman’s natal household when a woman is giving birth to her first child. A certain set of objects is collected and preserved in a small bag on the advice of, and with the help of, the traditional healer called *guruwa* as protection for the mother’s health. Other practices also described include the use of blessed drinks, the wearing of special amulets and the showing of a train ticket to speed placenta expulsion. The placenta (called *purin*) is put in the form of an anti-clockwise spiral shape over a *tepri* (dish-like construction made of leaves) and then taken to the farthest southwest corner of the compound where a pit has been dug for it by male members of the household. It is buried there and covered with stones.

There is very little detail on Tharu birthing practices in the literature⁴. Lamichhane (1993) describes how the Tharu mother is considered polluted until the navel falls off, after which a purification ceremony called the “*ghatwa karaina*” (or introducing to the water source) is performed (this is also described in Gautam and Thapa-Magar 1994, and in detail by Rajaure 1982a).

4.2 Magar

Most information on birthing practices and ritual pollution among the Magar comes from Hitchcock (1966, 1980):

“Childbirth amongst Magars takes place in the small room off the main room, the furthest from the entrance door and the darkest place in the house. Occasionally a woman from the community with a reputation for midwifery will be called, especially when the birth is difficult. Usually a woman asks a neighbour to help or her own daughter, if the girl is above 8. For 10 days the mother and baby remain inside the house out of the sunlight, for the sight of mother and child in a state of pollution is offensive to this holy luminary (the sun god?) They also remain apart from the other members of the family. During this period, a daughter, husband or perhaps the mother’s sister does the cooking. The new mother must not touch the water containers or any of the cooking utensils”.

When the Brahman comes to perform the naming ceremony on the 11th day following the birth, he first purifies the house by sprinkling a little cow’s urine inside and outside. Then he gives a little to each family member so that they can purify themselves by touching it to their lips. Following a *puja*, which he conducts on the verandah, the Brahman writes three names on three leaves from a *pipal* tree, and blows them into the baby’s ear along with a spell in Sanskrit. The naming ceremony, which is always performed by a Brahman, marks the beginning of a child’s life as a unique, named individual. It also permits the mother to become active again and removes the

⁴ The ethnographic details recorded in the NSMP Social Research Report thus appear to be the first describing birthing practices among Kailali Tharu.

pollution of birth from her household and from the members of her husband's lineage. The state of pollution (removed by the *navaran* or naming ceremony), actually begins three months before the child's birth during which time the mother must refrain from active participation in religious ceremonies.

While giving little detail about actual birthing practices, there is an interesting discussion by Molnar (1984) on the beliefs that surround a Kham Magar woman as she gives birth. In Kham Magar belief, transitions between life and death are dangerous; this danger is expressed in terms of pollution. When giving birth a woman becomes polluted. She must remain apart from the other household members and take her meals separately. The house as a whole is also polluted and strict villagers will not partake of food or water from that house until it has been purified. The new mother is forbidden to touch the hearth where the ancestors dwell before purification. In childbirth, a woman is liminal, which means in a transitional state between two states of life, that of being the bearer of a child, and of being a mother with a living infant. The baby is also in a liminal state. Liminal states are dangerous, and people in these transitions are vulnerable to evil forces.

4.3 Bahun-Chhetri

The anthropologist who has written most on Bahun-Chhetri birthing practices and ritual blood pollution beliefs is Lynn Bennett (1976a, 1978, 1983). Her research was based on Bahun-Chhetri women in east central Nepal but her analysis probably holds true for these caste groups over many other parts of the country. Her paper "Sitting in a cave: an analysis of ritual seclusion at menarche among Bahun-Chhetris in Nepal" deals mostly with the beliefs surrounding blood pollution at menstruation (1978). Her analysis focuses on the seclusion of the menstrual woman as necessary to separate the male lineage members from the sexuality of consanguineal women. A woman may not "look upon the face" of her father and brothers for a full ten days after she has given birth and for a full year after the death of her husband. Both are situations, like menarche, which emphasize (though in different ways) the sexual aspect of consanguineal women. All three events are potentially dangerous "outbreaks" of sexuality which can only be controlled within the patrilineal structures of kinship.

Bennett described how the woman in childbirth is kept in a period of seclusion, called *sutkeri* or *kona ma basne* (literally sitting in a corner), similar to the *gupa basne* (sitting in a cave) menstrual seclusion. This shields the woman from the kin of her *maiti* (natal home) until her affines re-assert their patrilineal control and responsibilities at the *navaran* (naming) ceremony. Bennett's constant theme is the dangerousness of women as they go through stages of sexual maturity and transition, like menstruation and childbirth. Another recurring theme is the loss of control that women experience during this period (e.g. are not even allowed to brush their hair).

The paper on menstruation seclusion also touches on labour and delivery, and details many birthing practices amongst Bahun-Chhetri women in east central Nepal. The role of traditional birth attendants (*surehnis*) and other specialists (*dhai ama*), and restrictions of access of other family members are documented. The period of ritual pollution only begins once the umbilical cord is cut, and unless the mother is too ill or weak, she herself will cut the cord because the task is considered highly polluting and she is already in a state of pollution. She also disposes of the placenta herself. These practices have recently been confirmed amongst high caste Bahun-Chhetris and Thakuris in Bajura District (Manandhar 1999). The naming ceremony and the purification rituals are also described. A fuller exposition of all Bennett's fieldwork amongst Bahun-Chhetri woman can be found in her book "Dangerous Wives and Sacred Sisters" (1983), which is based on her Ph.D thesis.

Gray (1985) also deals with birth pollution (locally called *sutak*) in his analysis of Chhetris in the Kathmandu Valley. At childbirth all kin of the child's father become polluted (*jutho*) and must accordingly observe restrictions in diet, worship and washing clothes for ten days. The degree of pollution varies according to genealogical distance. However, as Gray's focus is on how pollution practices reflect genealogical relationships, he gives no actual details of cord cutting, placenta, or touching rules, except for describing pollution as a condition of the physical body which has consequences for all social relations.

In a later section, Gray describes the origins of evil spirits that cause sickness. Most arose from people who had died an inauspicious death and did not die of old age after the contentment of fulfilling their lives as householders. These include *kiche kanda* who are the ghosts of women who have died in childbirth (a belief also held by the Newars who call her a *kichkiniya*).

4.4 Newar

Hindu Newars, as other caste Hindus, regard anything that has touched the mouth of another person as polluted (Newari: *cipa*). However, Newars appear less preoccupied than others about blood pollution, although the extent seems to vary amongst different Newar groups. For instance, some women among the Uray and Jyapu Newar are allowed to cook while menstruating, although they are not allowed to worship either the domestic Gods or the public gods (Lowdin 1998). Most Newars do regard birth as polluting: one is born polluted and is purified (Newari: *nipa* or pure state) only after the *macabu benke* (birth purification and separation) *samskara* (life cycle) rite has been completed. This is performed on the 4th, 6th or 10th day after birth. Birth purification is both auspicious and impure (Gellner 1992).

Gellner (1992) also writes how each caste of Newar has its own traditional ways of performing life cycle rites. For example, some castes do not require a priest for the birth purification (Vedic: *jatakarma*) and conduct things themselves (e.g. Maharajun), and the rice-feeding ceremony is performed not by a priest but by the midwife of a special caste (e.g. Kata of Bhaktapur) who cuts the child's umbilical cord. Some Newars believe that whoever cuts the cord transfers their caste to the baby, and that until the umbilical is cut the baby is casteless. However, it is unclear how widespread this belief is amongst Newars as a whole.

Amongst the rural Newars of the Kathmandu Valley, Toffin (1996) describes how the placenta and umbilical cord of a newborn baby are taken to be buried at a crossroads of two paths to the north-west of the settlement near a stone called *chvasa*. This is also the same place in which they bury the clothes of those who have just died. This site is inhabited by divinities of an ambiguous nature who protect the villagers against the various evils coming from the outside, and especially from epidemics. It is also the object of collective rituals of expulsion twice a year, at *gathamugah* in the dark fortnight of *Shrawan* (July-August) and at *bascahrhay*, in the dark fortnight of *Chaitra* (March-April). On these two occasions, flaming torches representing malefic spirits are thrown out. Similar rites are conducted at a small, unmarked, space at the opposite end of the village, to the south-east (called the *kalka*) where villagers leave the remains of funeral feasts. Family members may not participate in the important lineage *guthi* rituals within a 12 day period after the birth of a child or as long as a girl is undergoing the *bara* puberty ritual. Menstruating women are also forbidden from doing the worship although they may participate in the feast.

A study of traditional birthing and baby care practices was carried out amongst 359 women in 11 districts of Nepal, including Surkhet (Pradhan 1987). The largest ethnic group represented was the Newar (23% of respondents), followed by Magar (17%), Bahun Chhetri (15%) and Gurung (12%). Tharus were the least represented group (9%). While containing much detail about birthing practices and newborn care, the results were presented together with no breakdown by ethnic grouping so it is difficult to differentiate what practice was common in which group.

4.5 Thakuri

No details were found, although Shrestha (1971) does describe ritual related to childbirth, purification and naming in his book on the Thakuris of the Jumla region (in Nepali).

4.6 Low Castes

No specific details found, although it is generally believed that low castes follow the beliefs and practices of the higher caste Hindus. Gautam and Thapa-Magar (1994) described the rituals surrounding childbirth amongst the Hudke or Damai tailor caste of Surkhet. The birth of a son is followed by a *ghmari* feast, with dancing and the slaughter of a goat. *Chhaiti* is performed on the 6th day when another goat is sacrificed. *Navaran*, the naming ceremony, takes place on the 11th day, and the baby is shown to the sun god Surya and the earth god Bhumi. Birth pollution is observed for 11 days, and a priest from their own caste is called, not the Bahun *pandit*. The same authors also briefly describe practices amongst the Kami and the Sarki.

5. HOUSEHOLD DYNAMICS AND DECISION-MAKING

Quoting work done in India by Jeffrey, Jeffrey and Lyon (1989), Pigg writes:

“attempts to use medical and public health services to deal with the problems of childbearing are likely to fail because they address only part of the social, political and economic context within which childbearing women live”.

This is because women are not individual patients, but persons embedded in the hierarchies of family life in which they have limited decision-making power over food, about fertility and so on (Pigg 1999). Data linking such behaviour to maternal health are scant in Nepal.

An important early contribution to this field was the work of Acharya and Bennett (1981). In their in-depth study of women's roles in eight villages across Nepal, Acharya and Bennett recognized that decision-making was an interactive process. They studied different aspects of the decision-making process, including suggestions, deciding, implementing and disagreeing. From their work they found that decision-making was dependent on the dichotomy between men's and women's economic spheres of activity. Where the dichotomy was greatest, men predominated in decision-making. In villages where men's and women's roles were less rigidly distinguished, women had greater decision-making power. Women were more likely to make suggestions than to have the responsibility of making the final decision.

Except for Maithili and Tharu communities, more women than men keep the household cash for food in their control. However, small purchases of food and household necessities were most often suggested by women but actually made by men, though there is some variation amongst ethnic groups. The most important finding in terms of our interest was that, although women frequently take the lead in initiating discussion regarding medical treatment (whether traditional or modern), men were primarily responsible for making the decisions. Again there was considerable variation between the communities, with Bahun-Chhetris and low castes showing least female autonomy, Tharus and Newars intermediate and the Tibeto-Burman groups such as Rai having greater female involvement.

More recently, Shrestha and co-workers (1997) interviewed referrals to Beni hospital in Myagdi District. Ethnic breakdown was not given but Magars, Bahun-Chhetri and low castes make up the bulk of the population there. Their findings showed that more referrals to hospital are decided by the family head, or the village leader, than by the health workers.

Similar studies are time consuming and difficult. To date, mostly people have concentrated on outcome or actual behaviour, but this may not reveal the elements of family interaction that are believed to be significant for understanding household distribution practices. Outcome may be the result of compromise and may not reveal what is considered rationally optimum behaviour by the expectations of influential household members. Those who only observe outcome may underestimate the importance of other factors influencing behaviour. A study of household dynamics will illuminate the cultural, economic and social factors that impede efforts to promote behavioural change (Pivoz and Viteri 1985). Much more data of this type is needed.

5.1 Tharu

It appears from the literature that the Tharu woman has more status, autonomy and decision-making power within the household than her high-caste Hindu counterparts (Gautam and Thapa-Magar 1994). Rajaure (1981) wrote of Dangaure Tharu women in Dang:

"Tharu women have their own personality ...they are not mere shadows of their husbands as they are in a Hindu society."

Kittelsen and Gurung (1999) describe how the difference certainly exists in terms of ritual status:

"Rana Tharu women are, traditionally, not bound by ideologies of female ritual impurity, and they take part in most kurma rituals, both in their father's house as well as in their husband's lineage rituals. Women also take part in rituals at the village shrine and in kurmas where a goddess is the main deity women are even officiants."

Rana Tharu women are not seen as having a ritually lower status than men. There has even been some speculation that aboriginal Tharu society was matriarchal.

Kittelsen and Gurung (1999) attribute much of Tharu women's comparatively better household position to the fact that the bridegroom's family has to pay a bride price to the bride's family as compensation for their loss of a valued daughter. They say that this results in equality between the in-laws during the marriage arrangements and rituals. This is in stark contrast to the high-caste Hindu practice of the bride's family having to endow their daughter with a dowry. For the Tharu, marriage is more of an alliance between two families, and in-law families, called "*samdī*", have a strong relationship bond which emanates from the Rana Tharu value of giving something in return when you receive something. After an engagement has been agreed there is a *bina* ceremony: *bina* literally means giving something to gain something. There is another *bina* ceremony a year later to confirm the *samdī* relationship⁵.

5.2 Magar

Augusta Molnar has made Kham Magar women's social and economic roles, and their role options, the subject of her research (1981, 1984). She found that:

"a sizeable number of Kham Magar women live socially and economically independent of male kin to a greater degree than is commonly reported elsewhere in Nepal".

This flexibility is attributed to a system of matrilineal cross-cousin marriage that links wife-giving and wife-receiving lineages. Women thus retain strong dual kin affiliations after marriage in both their natal and marital lineages. Women's economic flexibility stems from a complementary pattern of responsibility between the sexes in the household and from the delegation of considerable authority over resource allocation to the women. As a result, women enjoy a large degree of economic independence among the Kham Magar and can support themselves in a variety of social situations. This certainly appears in contrast to the autonomy of caste Hindu women, and more similar to the situation described for Tharu women of the western Terai.

⁵ Questions about this relationship were not asked of either Dangaure or Kathariya Tharu in Kotatulsipur, Kailali, during the NSMP Social Research Study. It is recommended that NSMP field facilitators make their own inquiries about this.

Hitchcock's work (1966, 1980) also tells us about relations between husbands and wives and decision-making amongst the Kham Magar:

"The focus for authority and decision-making is the active elderly male. Patterns of interpersonal behaviour help to maintain this unity. Young married couples avoid one another during the day and leave the training and disciplining of their children to the elders. Just as sons are expected to be obedient to the father and to show him much deference, wives are expected to defer to husbands, and to the husband's mother...authority, discipline, deference, self-abnegation, subordination of women are important values in this social system".

But Hitchcock also admits that Magars are more relaxed in this than others in Terai. Living in a nuclear rather than a joint family, there is less tension, and although there is a patriarchal bias, it is countered by things that bring power and independence to the wife. A Magar woman retains a close contact with her natal home, has rights to *pewa* and property, a right to leave and remarry, and plays a vital role in subsistence farming. There is a lack of a rigid division of labour. This all plays a part in mitigating and counterbalancing the culture's patriarchal bias.

Mary des Chene is an anthropologist who has worked amongst the Gurungs in the hills of north central Nepal. An article by her recently published in the *Journal Studies in Nepali History and Society* (1997) throws light on the decision-making process of two women in one household. It is a powerful tale of resistance to social definitions and familial authority, and the impact of such action. The story, and des Chene's eloquent discussion and analysis, serves to provide a contextual picture of the women, caught within the confines of a patriarchal system, permanently displaced and systematically devalued by ideology and in practice. The paper provides an insider's view of how these women attempt to shape their own destinies. Des Chene describes how *bhauju's* (daughter-in-law) place in household dynamics and decision-making is shaped by:

"days of quiet agony in a dark corner".

She also shows how much of the social rules about moral conduct are not verbal but expressed in action, deed and gesture.

The paper is a useful insight into the context of the Nepali woman's understanding of the conditions for action and the constraints within which her difficult choices are made. It helps to understand physical and familial space and its social significance for women. As des Chene points out, the story is neither of a particularly badly, nor exceptionally well-treated, woman, and could be taken as an example of, so to speak, "the average reality". It is also taken from the Gurung tribe (similar to Magar in many ways) in which women "enjoy" a greater degree of autonomy and freedom than do women in other ethnic groups, such as orthodox Bahun-Chhetri women. Even so, the paper emphasises how traditional patriarchal social sanctions and domestic (male-headed) authority guide decisions and determine individual and household reputations. *Bhauju's* meaningful interactions with the household were described as "brief and utilitarian".

While the paper did not involve pregnancy, childbirth or the post-partum periods, it does talk of male members of the lineage clan debating in the courtyard what to do in a crisis (son's death abroad) in which women, even the wife of the deceased, are not included. This perhaps gives us an indication about what they would normally do in an emergency relating to pregnancy or childbirth. In terms of other effects on *bhauju's* health there is little specific, but she had TB and was not allowed to go for treatment. *Bhauju* complains to the author:

"we women must try to live".

The author concludes her paper with the following:

"At present she and other Nepali women must try to live within a state that claims they are revered according to Hindu tradition while implementing laws that ensure they are at the mercy of men's goodwill and love even for basic survival... and such laws also serve to pit women one against another".

5.3 Bahun-Chhetri

Why are Bahun-Chhetri women often unable to take an active part in household decision-making, even those that affect their health? We need to explore the anthropological literature further to understand this matter.

A valuable insight into the process of household decision-making amongst Chhetris in the Kathmandu Valley can be found in the book "The Householder's World", by John Gray (1995). He writes that:

"the everyday world is fundamentally the world of the householder. It is more than a unit of production or organisation. It is the mode of being-in-the-world sanctified in Hindu ontology."

Gray treats domestic life as a "religiously endorsed, culturally valued and socially pervasive mode of being-in-the-world". He treats the household as a structure of consciousness rather than a structure of kinship. He stresses the importance of understanding the nature of the domestic domain, and its relations to other domains of social life, in the understanding of human society. In his experience, caste hierarchy, economic inequality, political dominance, and rules of reciprocity and cooperation guide the routine interactions of villagers.

In a section entitled the dynamics of household relations, Gray refers to the dilemma of the man who has to defer to his mother (his creator) but not antagonise his wife (the mother of his sons and with the capacity to become a witch and do them harm). In general a man will defer to his mother over his wife, which can generate tension in decision-making. In a later section called "domestic kinship as relations of power", Gray refers to decision-making within the household being based on the *mannu parne* (a mode of hierarchical ranking organizing social relations among kin) which dictates practices of respect and obedience, of the wife to the husband, and the husband to his mother. The disbursement of pooled income by any household members is under the control of the male household head. Much of the cash may then devolve to the wife of the household head who is responsible for purchasing and preparing food and other subsistence needs of the family.

In an earlier paper, Gray (1991) attempted to put this household behaviour into its socio-religious context. The Bahun-Chhetri household (*pariwar*) is an institution embedded in Hindu *dharma*. In Hindu society there are two systems categorising people: the division of society into *varna* (castes) and the division of the individual's lifetime into four *ashrama* (stages). Each *varna* and each *ashrama* is endowed with a distinct code of moral conduct. One of these stages of life is that of the Householder (*grihastha ashrama*) whose *dharma* provides the basis for a holistic interpretation of the Chhetri households and the interactions between members within it.

Bennett (1976b) also believes that this is important in understanding women's positions in high caste Hindu society. She writes:

"Village Hinduism, such as practised by the Bahuns and Chhetris of Nepal, represents a perpetual opposition between the loftier ideals of the ascetic (sannyasa ashrama, or yogic dharma) and the more practical ideals of the householder. Village Hindus are of course by and large householders involved in the toils of earning a living and raising a family. Nevertheless their deep involvement with concepts of purity and pollution betrays a strong underlying respect for the values of asceticism. For the things which are considered polluting are almost all associated in some way with birth, death, copulation, eating or defecation - the organic processes of life and the temptations of the flesh which tie men to the samaric round of death and rebirth.... Obedience to the rules for maintaining individual and caste purity is one of the principle means of integrating the ideals of asceticism (for which sexuality and women are dangerous distractions) into the life of the householder (for whom they are a necessity).

Women thus accept their inferior status in relation to men because they have accepted the restrictions placed on them by the dominant ascetic and patrilineal ideology of Hinduism. Bennett (1976b) writes: "Women's ability or inability to make decisions within the household is due to their place within the Hindu patrilineal ideology which places the highest value on the solidarity of male agnates. Women, because they come from outside, remain to some extent outsiders with regard to the whole patrilineal institution, which is ritually expressed by their exclusion from some major ceremonies like *Diwali* and the *Dasain Durgh Puja*".

However, in terms of specific treatment of women and their decision-naming behaviour especially with regard to their own health, both Gray and Bennett do not provide examples.

The team of Morgan and Niraula (1995, 1996) conducted research in Nepal that claimed to look at the associations between ethnic differences in types of marriage, post-marital contact with natal kin and differences in female autonomy and decision-making affecting fertility. However, whilst the methodology is useful, the analysis and conclusions do not help us. They compared hill versus *tarai* communities but failed to differentiate between the ethnic groups in each of them. Whilst the hill area was 60% Bahun-Chhetri mixed with low castes and "Tibeto-Burman tribals" (not named but probably Gurung or Magar), the *tarai* area was 28% low caste untouchables but gave little detail of the rest (varied).

Niraula and Morgan (1996) reflect the assumptions of many that, compared with western settings, the status of Nepali women is low, with low levels of autonomy. In general, Nepali settings are characterized by patrilineal, patrilocal family relations. Men make most social and financial decisions. However, the authors argue but fail to analyse appropriately, there exist regional and sub-regional variations in women's autonomy, and variation by the caste-ethnic mix and history of settlement. To understand what is really going on in household dynamics and decision-making, extrapolating from other findings on household dynamics and female autonomy in decision-making from other work from the same area, or even the same ethnic group, is a dubious exercise. Local investigation needs to be made.

Gittelsohn (1991) undertook direct observation of meals in 105 households, predominantly Bahun-Chhetri but some Magar and low castes too, in central Nepal. He found an overall pattern of disfavouritism of younger adult females (mothers) in the intra-household distribution of food, especially food high in micronutrients and with a high "status". This can be taken to provide more evidence of how status preference works within the household, and how food reflects the hierarchy within the household. Women "get the short end of the loaf" because of their low status and lack of autonomy over decisions relating to food. It is certainly plausible that the same also applies to their own health during pregnancy, delivery and post-partum, although specific ethnic data are still lacking to verify this.

5.4 Newar

The Newar household is called a *syeh phuki* which literally means a narrow patrikin or close kin group (fathers and brothers). The house is the *chey*, the family is the *jawan* and the hearth is the *bhutu* (Lowdin 1998). The head of the household is the *thakali* and is the eldest living male. Formally, major decisions rest with the *thakali* but observations of interactions by anthropologists reveal that important decisions are usually made on a consensus basis and involve the women. *Phuki* members, caste fellows and *guthyars* may also have important advisory functions. The *thakalinakin* is the wife of the senior-most man of the *phuki*, and she has various important ritual functions to perform at life cycle rites.

Lowdin's study (1998) of the use of food as ritual symbolism in Newar society contains an interesting section on the relations between men and women within the family. Newars do not regard men and women as equals, but rather as complementary. Within the household, the women's positions may be strong. The eldest woman (*kucima*) in the house is in charge of the cooking and many important domestic affairs. The Newari woman's standing varies over her life span. Newars value sons highly but they also appreciate their daughters, inviting them back to their natal home along with their husbands, at regular intervals for feasts. Allied to this comes a relatively higher appreciation of the daughter-in-law compared to other Hindu groups.

The Newari woman's life is surrounded by restrictions somewhat more than the man's, particularly between *bara* (menstrual or pre-menstrual seclusion) and marriage. After marriage the mother-in-law is the mistress of the house. She may dominate over the domestic affairs and her son(s) and she holds sway over her daughter-in-laws. In Newar household decision-making, it appears there is theoretically a hierarchy based on seniority, but in practice much consensus debate is involved.

In Newar society, the elders have power and authority and the young exercise no control over the decisions made within the group and are relegated to a situation of dependence. Women are at any age in the same position as

the juniors (*kwokal*) and have little authority or decision-making power. There is a rigorous system of etiquette with rules of codification and subordination according to age and seniority, and the slightest infringement of the honorific rules could endanger the social order:

"One is not free to say anything, anywhere, anytime".

This applies both within the household, and in its dealings with other households. However, according to Bista (1996) a Newar woman in her husband's house has much more authority and freedom than her Bahun or Chhetri counterpart. She is more readily accepted in the extended family group.

5.5 Thakuri. No literature found

5.6 Low Castes. No literature found

6. INDIGENOUS SOCIAL NETWORKS AND SUPPORT STRUCTURES

In terms of social systems and possible support networks that could specifically be utilized in pregnancy, delivery and postpartum-related emergencies, there is little written. But some inferences can be made about who women, and their families, are likely to turn to if such emergencies are recognised.

6.1 Tharu

Rana Tharus live in patrilineal extended households. There may be several households around a courtyard and more than fifty people but as long as they eat from the same kitchen they are one household (Gurung and Kittelsen 1996). The household is the *surmeha ghar* or *pipariya ghar* (the house). The household's patrilineage is called *kurma*⁶, which worships the same lineage deities, and is very important (amongst the Dangaure Tharu, it is called *barin*, Rajaure 1981). Usually all members of a *kurma* who live in one village build their houses close to each other in the same village quarter. This group is the first to be approached for help when a household is in trouble but one also counts on more distant *kurmas* on such occasions. Guneratne (1999) stresses how traditional values and the persisting solidarity of *kurma* amongst the Tharus of Chitwan leads to much communal activity, such as village *pujas*.

Although Tharu villages are organized according to Nepali laws on local organization, they also have their own social and religious leaders. The indigenous elected village leader is called the *bhalemansa*, or the *mahaton* as he is called amongst the Dangaure Tharu of Dang (Rajaure 1981). He is elected by the *kitcheri*, (called *khel* amongst Dangaure Tharu, McDonough 1997), a village council where each household is represented by one male member. The *kitcheri* or *khel* organises all rituals and many of the other administrative aspects of everyday life - it is rarely, if ever, attended by the local *Paharis*, which is what Tharus call Bahun-Chhetris (McDonough 1997).

The seat of *bhalemansa* is open to anyone who commands the respect and confidence of the villagers. He is the senior-most administrator and judge in the village. He settles marriage disputes, decides on fines, and has the last word on village matters, although problems are discussed in the *kitcheri* before final decisions are made. For the ordinary villager, he is still the first person to approach for getting help for the community in emergencies, such as rebuilding a house after a fire (Rajaure 1981). However, he can only really deal with Tharu problems, and not those between Tharu and non-Tharu. The New Era report (1994) on small holder agriculture in several VDC's in Kailali District also reports the important role of the *bhalemansa* (*bhalomansha*, defined as a Tharu chieftain). The authors state that, with the exception of serious crime, all the problems and issues of the community are solved by this indigenous community system. One of the VDC's described is Darakh VDC which borders Kotatulsipur, one of the study areas of the NSMP Social Research.

Another important individual is the village *chowkidar* (or *baidhar* amongst Dangaure Tharus, McDonough 1997), elected on the same principles as the *bhalemansa*. He is the messenger of the village and is responsible for implementing the decisions and plans of the *bhalemansa* and the *kitcheri*, such as organizing road maintenance and other village work, and also protecting and maintaining the village shrine (*bhuiya*).

He also prepares for the rituals, and acts as substitute for the third major player in the Rana Tharu social system, the *gauthehara*, or main village shaman priest. The *gauthehara* is chosen from amongst the *bharras* (called *gharguruwa* amongst Dangaure Tharu) at a village meeting. There are also a number of lesser faith healers called *bharras* in any one village and usually the ones that the villagers turn to when someone is sick.

Rana Tharu clan subgroupings are called *kuris* (Kittelsohn and Gurung 1999), or *gotya* amongst the Dangaure Tharu (McDonough 1997). The *kuri* system is difficult to classify but there is a system of ranked social units which seem to be of most relevance for marriage arrangements. Many people do not seem to know their own *kuri*, which is the Tharu equivalent of *jat*. There may well be indigenous support systems within each *kuri*, but the literature found does not refer to it.

⁶ The existence of *kurma* needs to be checked for Kailali Tharu. NSMP facilitators need to make enquiries about form and function

6.2 Magar

Hitchcock (1980) wrote that the Magars form co-operative work groups and singing groups (cross-caste *rodi* and *jhabre*, *Nachari* all-male Magar) through which people have formed close associations with others who can help them when they are in trouble. They have a value system of *porima*, or *orima porima*, which literally means to lend an arm, (hand). Labour debts seldom go unpaid.

6.3 Bahun-Chhetri

No literature found (the role of *pandit* or priest may be important)

6.4 Newar

Toffin's paper (1996) describes clearly how Newars live in a segmental social system where kinship commands the village community and is its elementary code of reference. The village defines itself as a circle of relatives united by ties of blood and marriage. The values of clan solidarity and territorial identity take precedence over caste principles. Social stratification is for its part not based in Hindu patterns but on the rules of clan seniority and heredity: power is determined by age and genealogical position.

The patrilineage is known in Newari as *phuki* (Lowdin 1998). It denotes males who are agnatically related. Men constitute the core of the *phuki* and women who have married in are not regarded as full members. All Newars are aware of their *phuki* and observe annual ceremonies with all members present. The *phuki* members generally interact at least at the *digupuja* and at life cycle rituals. The *phuki* plays an important role in life cycle rites, for example, at a newborn's *Macabu benke* rite (see later) he visits to "see the newborn's face" and offers coins. The eldest male of the *phuki* is its ritual head and the rest are ranked in order of age seniority. A small group of men, the Elders, collectively called the *thakali*, relying on the apparatus of symbols used in regular rituals and feasting, presides over the destiny of the village. Lowdin (1998) describes how they had a role in childbirth but only in terms of seeing that the appropriate rites are performed correctly (*macabu benke* and *Janakegu*).

A fundamental feature of Newari social organization is the *guthi* (Bista 1996, Toffin 1996, Quigley 1985, Gellner 1992). Its laws are binding upon the Hindu as well as the Buddhist Newars. The term *guthi* derives from the Sanskrit *gosthi* meaning an "assembly, meeting, society, association, family connection, partnership". The *guthi* has been described as a kind of "common trust" consisting mainly of cultivated lands as assets. *Guthi* societies play a crucial role in maintaining the customs and social order of the Newars, although these controlling functions appear to be diminishing. The *guthis* hold annual feasts which by prescribed participation announce *guthi* cohesion, village cohesion, caste cohesion, hierarchy according to seniority and other social relations (Lowdin 1998). The *guthi* decides disputes arising between members and takes actions such as levying fines against offenders.

The *guthi* is a closed association, sometimes described as secret as it does not welcome inspection by outsiders (Lowdin 1998, Quigley 1985). Only members of the *guthi* in question are allowed to participate in the activities of the inner circle. Not being a member of a *guthi*, and particularly the lineage *guthi* is inconceivable to a Newar (Gautam and Thapa-Magar 1994): it is tantamount to severing links with society as a whole. However they also say:

"the Newars are in transition from a cloistered, introverted social group to an emancipated, liberal and unshackled community where conservatives and guthis are slowly being pushed to the rear".

According to Bista (1996) there are three main types of *guthi*: religious, public service and social.

- *digu puja guthi*: This is tied to the worship of the *phuki's kul* (ancestor) deity (similar to *kul devata* among the Chhetri in Kathmandu Valley which probably owes much to contact with the Newars in the late 18th century). Participation in this is perhaps the most important means of regularly re-establishing social identity. The theological identity of the particular gods worshipped is largely irrelevant.

- *si guthi* (death/cremation) or *sana guthi* (mourning): This handles a large part of the practical details in connection with a death. It also organises funerals, maintains temples, rest houses, roads, bridges and parks. Membership is drawn from several extended family units of common residence or locality (*tole*) and not necessarily of common descent.
- social *guthi*: for entertainment, fellowship and activities of common interest. Usually includes members of one common locality.

Membership (members are called *guthiyars* who take turns in managing affairs) of the first two *guthis* is compulsory and inherited through agnatic kinship, whilst the social *guthi* is a voluntary organisation. Smaller *guthis* may also be established for specific purposes, such as the maintenance of a path or temple in which case membership is restricted to close proximity to the object concerned.

Amongst Buddhist Newars the *bahal* is a clearly defined residential unit, more important than the household. There is a roll of members (the *sangha*) which includes all initiated males. The rhythm of life in the *sangha* of a *bahal* is governed by a series of *guthis* (Lowdin 1998). As a large *bahal* may have as many as several hundred members a committee handles the daily affairs. The committee consists of the ten eldest men, regardless of caste, though traditionally in Patan at least only Vajracharya, Bare and Uray live in *bahals*. The elders on the committee are popularly known as *Dasa paramitra*. All of the business of the *baha* and its *sangha* is referred to this committee of ten. The *pujayaipi* (may have other names according to clans such as *acaju* in the *Aca* clan) is a priest who has had a Tantric consecration and disposes of supernatural powers which they are supposed to see during rituals. He must also himself be a household head with no father living. The activities of the priest are generally initiated and controlled by the Elders. There are also mediums, called *dyah ikaymha* or *dyah vaykepi* in Newari, who are sometimes consulted in cases of disease and who have the ability to fall into states of mystical possession (Toffin 1996).

Early writers have talked of the significant roles of the *phuki* and the *guthi* as units for exercising social control (Furer-Haimendorf 1956). More recent studies have found that this is being eroded, and that there is considerable variation between different castes concerning the social control that the *phuki* may exercise. So far no systematic research has been done in this field (Lowdin 1998). Nevertheless the *phuki* and its potential at assisting in raising awareness of signs of maternal health emergencies and uptake of emergency obstetric services is worth investigating further amongst Newar communities in project areas.

6.5 Thakuri. No literature found

6.6 Low Castes. No literature found

6.7 A Special Form of Social Support: The Ritual Friendship or *Miteri*

Ritual friendship or *miteri* (derived from the Sanskrit *mitrata* meaning friendship) is common among many ethnic groups and in many parts of Nepal (Messerschmidt 1982). The *miteri* is a form of fictive ritual kinship contracted between individuals of the same sex, and sometimes by extension, between kin groups, for both instrumental and effective reasons. Messerschmidt argues that the *miteri* serves to cement social interactions between levels of caste in a complex hierarchical system that otherwise separates the members of these endogamous groups, and in a difficult physical environment that forces people to interact closely for resource exchange. Entering into a *miteri* relationship demands obligations, bonds of friendship, close association and mutual aid. Men who form fictive kin bonds are called *mit* and women are *mitini*. The *mit launu* ("forming a friendship") is a ceremony involving the exchange of money and embraces and vows to be friends for life, and to mourn the other's death like a relative. Other expressions to describe *miteri* are: *dharma ista* or *ista sambandh*, meaning friend relative. The *miteri* has been likened to ritual siblinghood and different ethnic groups have different words for it.

Much has been written about *miteri* (known as *tuwachinu* among Newars) amongst the hill and highland peoples of Nepal which appear to have flourished because of the context of intense economic and related social and ideological exchange across the Himalayan belt. Shrestha (1971) writes about ritual friends in his book on the

Thakuris of the northwestern districts of Humla and Jumla, and states that each family has established ritual friendships (*mit*, *hitko istha*, *mathe istha* etc) with some other family or families. These ritual friends not only show mutual affection towards each other but they also help each other materially.

Messerschmidt mostly draws on his own fieldwork amongst Gurungs, Magars and Thakalis of westcentral Nepal, which may be similar to the Surkhet and Baglung areas. He wrote that *miteri* friendships are usually in same caste and religion but not always, and usually the same age, from childhood or adolescence but not always, and that a person usually has a maximum of 4 or 5 *mits* at the same time. The *miteri* can bring together people who are otherwise socially, ritually and economically far apart. After the *miteri* bond is established, those involved no longer call each other by name, but simply say *mit* or *mitini*, plus brother or sister, (i.e. *mit daju*, or *mit bahini*).

The *miteri* is more than an ordinary *sathi* or friend. One of the basic principles of voluntary associations, including fictive kinship, is a sense of shared commitment. In all forms of *miteri* in Nepal the commitment is reciprocal and has social, ritual and sometimes economic components (loans). The main obligations and responsibilities of a *miteri* relationship are that:

- there must be a mutual and generous reciprocity flowing in both directions
- mutual aid and assistance as given when needed
- there is open and generous hospitality
- prescribed duties at life crisis events are observed, such as helping at the funeral of one's *mit* partner or that partner's parent or child.

Such assistance of a *mit* or *mitini* may be specifically requested, or it may be offered and accepted without asking. Astrologers even suggest forming a *mit* relationship when they foresee trouble or are trying to counter bad horoscopes.

Messerschmidt (1982) writes:

"In highly caste-orientated hierarchical place like Nepal miteri provides a certain freedom of expression which is not condoned in normal social intercourse. It provides a measure of relief from the highly restrictive and hierarchical expectations of both caste and kinship. Miteri bonds act as a social bridge across an otherwise highly variegated society, contains affection, and spells out how the people involved MUST interact to solve some of the basic challenges of life."

Unfortunately for our purposes, most work has been done on the male *mits*, and there is almost nothing on the links between women *mitini*. No papers on *miteri*, or other forms of voluntary co-operative associations (such as the *nogur* of the Thakali and the *dhikur* of the Gurung) could be found relating to Bahun Chhetris, or low caste groups in the NSMP project areas. A *dhikur* is a rotating credit association "formed among friends and acquaintances who have similar financial needs and interests... they pool subscriptions and award to individual members, sometimes on the basis of need, and sometimes by lot" (Messerschmidt 1978).

Comparatively little is known about the practice of *miteri* in the Terai, although there are a few descriptions. Amongst the Rana Tharus, a *mit* (ritual friend) is called a *gunj*. With ritual friendship regarded much as a family relation among the Rana Tharus, marriage relations between such friends or their relatives are tabooed (Kittelsen and Gurung 1999). Rajaure (1981) also writes of the *mit-sohri*.

7. EMERGENCY CARE SEEKING BEHAVIOUR

This is a complex area. The title is mainly used to imply a western concept of health “emergency”, involving hospitals, people trained in an alien system of medicine and the use of invasive interventions. However, most of the anthropological literature on Nepal rather deals with crises to health and well-being that are seen to be caused by the spirit/supernatural world rather than the other germ/organic failure world of western medicine.

From the literature found, this section talks about health seeking behaviour in crises, or the steps that people take when anything affects their health in a way that they themselves determine as serious. This may well not be the same as the western concept of an “emergency”.

7.1 Tharu

Despite its misleading title, Lamichhane’s thesis from the Department of Nepalese History, Culture and Archaeology (1993) is a more detailed and thoughtful ethnography on Tharus than most. She describes how women call the “*gharguruwa*” to consult the gods and spirits, and perform spells, when they are in pain in pregnancy, labour and post-partum. Amongst the Dangaure Tharu, the *gharguruwa* is the major holy person in Tharu society and acts as a priest-cum-shaman. During ill health or any kind of trouble, the *gharguruwa* has to discover the cause (which will generally be found to be an unfed or illfed spirit or divinity) and to root it out by animal sacrifice.

From focus groups and interviews with 125 people, Lamichhane (1993) reports that 36% used *jantra/mantra* (*phukphak*) to treat illness, 32% used “*patl*” (puja and offerings to appease evil spirits), 16% used herbs and the same proportion resorted to allopathic medicine. Whilst not helping us differentiate between types of illness or particular conditions (e.g. during pregnancy, delivery or post-partum) this does give us an indication of the importance given to traditional systems of healing. Causes of illness were also investigated. Most people (40%) attributed illness to “the wrath of god”, more than a third of respondents (37%) to *bhutpret* spirits and 10% to *bokshi* (witchcraft). Climate and environment accounted for only 10% and 5% of the responses respectively. Thus, it is not difficult to see why new ideas about unfamiliar hospital services far away from the village still seem alien.

7.2 Magar

From the in-depth ethnographic work of Hitchcock (1966, 1980) and Molnar (1981, 1984), it is clear that Kham Magars have strong beliefs surrounding crises in childbirth and delivery. These beliefs involve the spirit world and bear no resemblance to the medical system that provides health service providers at various levels. A major barrier to the uptake of hospital, and other forms of health care, is that their own indigenous belief system and “knowledge” about problems in pregnancy and childbirth are so strong.

Molnar (1984) writes: “The belief that the woman and child are in transitional dangerous states during childbirth is also expressed in the beliefs surrounding a difficult birth, a still birth or a miscarriage. A breech birth usually results in the death of the mother, as well as the child. A knowledgeable woman is usually called to try and turn the baby around in the womb, but if this tactic fails, the child is believed to bite its mother’s heart and cause her death. If a child is stillborn, or if a pregnancy miscarries, or if the infant dies within a year of birth, the spirit of the dead child or foetus, the *ra*, is believed to wander aimlessly in the realm between the ancestor world and the world of the living. If it is not exorcised by the shaman, the *ra* becomes jealous of a subsequent child’s place in the womb, and will try to kill the new foetus or the mother, or birth. To prevent this occurrence, women who have had unsuccessful pregnancies will sometimes cut the foetus or stillborn infant into several pieces and bury them separately to confuse the *ra*, making unable, informants claim, to find its material body and thus return to haunt the mother. In addition, if a mother and her infant die in childbirth, they are buried separately to protect the family.

Hitchcock also described what happens when a baby dies very young (1966). The *ra* exorcism is conducted by a shaman. Hitchcock suggests that the exorcism provides a symbolic way of removing the psychological

attachment to the new baby that has died. In banning the *ra* from the world of the living, the shaman also brings back the parents who have psychologically followed the child into the world of the dead. Hitchcock also describes the belief that the soul of a person who dies away from home is a fearsome spirit (which is related to a reluctance to move them in an emergency) (*ganse dokhe*).

Molnar (1984) describes Kham Magars religious beliefs thus:

"Their religious complex includes belief in a number of both Hindu-derived deities and local nature deities, belief in ancestor spirits, and belief in a number of malevolent demons, witches, ghosts, and godlings..... propitiation of all these is routinely done to maintain social order and shamanic seances restore this order when it is disrupted. It is only in moments of crisis and distress that the villagers are concerned with the supernatural".

She also argues that women are seen to be symbolically or mystically more vulnerable than men to the non-living realm, so have such crises more often. All this is part of Kham Magar reality of women's health or sickness during childbirth.

Recently, in 12 out of the 40 VDCs in Myagdi district (population is about 50% Magar), MacRorie (1997, 1998) described how difficulties in labour are largely dealt with by traditional means. In a rapid participatory appraisal study of responses to medical crises in the community, he found that few sought conventional health services in reasonable time⁷. Traditional means of dealing with oedema and swelling in pregnancy were described by Des Chene's (1990) story of the Gurung *bhauju*: "an elderly woman cut three slits to "let the pus out".

7.3 Bahun-Chhetri

There is little in the literature about emergency care seeking behaviour among Bahun-Chhetris. In her work from Nuwakot district where Bahun-Chhetris were the dominant ethnic group, Stone (1976) suggested that:

"the hospital is used infrequently or as a last resort, not only because it embodies a system of alien or threatening ideas of illness, but because it lacks institutional success or institutional integration with village life".

Niraula (1994) worked in Benighat where Bahun-Chhetris made up 63% of the population. Here also illness is seen as deriving from a wide range of causes ranging from food to witchcraft, spirits and supernatural events for which modern medicine is regarded as largely ineffective.

7.4 Newar

Again, there is no specific reference to emergency care seeking behaviour at times of illness amongst the Newars in the available literature. However, Furer-Haimendorf (1956) described *guthis* (he called this a *manka guthi*) as:

"specifically for the purposes of economic co-operation and to render then effective economic assistance in times of emergency".

Other writers have also referred to *guthis* as resembling mutual aid societies, but neither these, nor more recent studies such as Quigley (1985) and Lowdin (1998), provide any examples relating to any health emergencies. Gellner (1992) says that it is not usual for *guthis* to give loans to members.

7.5 Thakuri. No literature found

7.6 Low Castes. No literature found

⁷ Such findings are supported by the NSMP's own Social Research in sites in Myagdi and Kailali districts.

8. CONCLUSION AND RECOMMENDATIONS

Concentrating on anthropological research and unpublished baseline reports from INGOs and NGOs working in maternal health, a substantial amount of literature was located and reviewed. Much of this can be helpful in understanding the patrilineal and hierarchical social structures operating in the different ethnic groups, and the limited extent to which women likely to be giving birth (daughters-in-law) are able to influence household decisions affecting their health. It is also helpful in providing insight into the non-western “world views” that influence so much of people’s daily life in these ethnic groups, particularly beliefs and customs surrounding concepts of illness and healing, and the important role of indigenous practitioners.

However, it is clear from this review that there is very little that *specifically* addresses any of the Terms of Reference in relation to women and their families in the pregnancy, delivery and the post-partum periods. Moreover, variations and differences in beliefs, attitudes and social and religious customs are substantial, even within the same ethnic group (e.g. Tharus, Tamangs, and Newars in different parts of the country). It would be rash to assume that what has been described in one area will be the same as that found in the same ethnic group in another area. While we can make extrapolations from available anthropological literature, a more detailed in-depth ethnographic look at each of the ethnic groups within the NSMP catchment area would be filling an important gap in knowledge. There is comparatively less literature on many of the issues of interest relating to low castes and Thakuris, than on Bahun-Chhetris, Newars and Magars, particularly in the Terai.

Western-medicine modeled maternal health programmes concentrate heavily on service provision and client knowledge, or especially what is viewed as the lack of it. But this overlooks other indigenous forms of knowledge that are very important in the daily behaviour of many rural Nepalis. Sometimes even the existence of another type of knowledge pertaining to health and well-being of women is not even acknowledged.

Ethnology differs from the medical sciences in that it is interested in whole systems in which minds, bodies and spiritual forces interact, rather than comparison of cases or isolated behavioural items (MacCormack 1994). The fundamental difference between the two systems is that the traditional system is past-oriented which also makes it rather closed to self-analysis and deliberate consideration of origin (Trawick 1987). “Truth” is handed down from past sources and people are consensual rather than competitive in their attitude towards knowledge. In contrast, the modern system is future-orientated, based upon an ideal of progress and competition with rival ideologies. There is evidence that, because of different value systems, and different aims and expectations of their position in the wider society, to many Nepalis working in the health delivery sector, information is not important (Aitken 1994). This is probably especially true when applied to ethnographic information which documents a belief system that is alien to many of the service providers and is perceived as backward, steeped in ignorance, and acting as a constraint on development.

Health-seeking behaviour is a complex field of social anthropology. More attention needs to be paid to understanding the relationship between conventional and indigenous forms of medical care, the variety and importance of traditional models of illness, the role of the traditional healer, and expectations of what the individual and the community want from their health (all kinds) services. In order to understand what determines a woman’s beliefs and behaviour in relation to her own health, we need to listen to her voice. In the course of this we will need to be prepared to encounter, and find a way to live with, much that differs from the western medical view. But given the extent of the urgent health crisis facing the adolescent girl, the pregnant woman and the mother with her new infant (Baker 1994), it is time to adjust our vision.

This review now concludes with some recommendations for those embarking on IEC strategies related to maternal health in Nepal. These are based on the present state of knowledge about maternal health in and the indigenous belief systems in different ethnic groups which still largely determine women’s own perceptions of well-being and their care seeking behaviour.

- (a) Acknowledge the pluralism of health systems in rural Nepal

The Social Research Report describes how Tharu and Magar women and their families in Kailali and Myagdi rely heavily on the traditional healer and the traditional birth attendants for their health needs. However, they also consult the private medical shops, and to a lesser extent the health post and the trained health service providers at community level. Clearly there is not just one system, but several, operating somewhat antagonistically side by side. This is the current reality and it will take some time to change. Expecting that only one system is going to supplant the current pluralistic arrangement in the short, or even the long term, would seem unrealistic.

Recent work by MacRorie and others in Myagdi district has highlighted the persistence of local community attitudes and practices in the face of increasing availability of modern medical care services (MacRorie *et al.* 1997, 1998). In many rural parts of Nepal, the medical system is pluralistic, combining the choice of both western and non-western forms of health care that are often used simultaneously by the population. Subedi (1989) argues that the presence of medical pluralism is a significant factor which delays use of modern health services. In an eloquent discussion of the intricacies of villager's belief in traditional healers in Nepal, Pigg (1996) also reminds us that we should be talking about a difference between pluralism and not dichotomy. She cautions that there is no clear-cut dichotomy between traditional and modern, and that there are numerous ambiguities and displacements. The surface of the health belief system comprising different elements of both traditional and modern is not smooth, but bumpy and uneven.

There are many that argue that education is the key to reducing pluralism in the health systems. However, increasing levels of education and other associated correlates of development do not necessarily mean that belief in traditional healers will quickly diminish. This was illustrated in the case of the Sherpas of the Khumbu region of east Nepal, an area where well-supplied health facilities and health education programmes had been widespread for at least two decades and where tourism was reaping many more benefits in terms of technology, income and educational possibilities to community members than elsewhere in the country. Nevertheless the spirit medium continued to retain considerable influence, remaining the care provider of choice (Riley and Riley 1978).

Even in the urban capital of Kathmandu, the educated middle classes find that access to the non-western form of health care is often, easier cheaper and involves less risk physical and "social" risk than the western form (Subedi 1989, Streefland 1985). People are also pragmatic: they will test their decisions and the more severe and prolonged the condition, the more likely they are to seek alternative health services when a previously chosen option fails (Justice 1984).

Few would disagree that this still continues to be the case. But how to overcome these delays, as they are themselves a significant contributing factor to high mortality rates among women in Nepal? There is a need to develop a mechanism whereby activities such as informal meetings, seminars and workshops are planned and key people representing the modern and traditional sectors come together to express their views, establish common goals and research projects. The NSMP could consider taking the lead here in the field of bringing together the traditional and the modern in the field of safer motherhood.

(b) Respect what the community knows

As Jordan reminds us in a discussion about training traditional midwives in Mexico (1989), new information is not just poured into a vacuum but interacts with a coherent and entrenched ethno-obstetric system of birth management. Birth for many Nepali women is a normal life cycle event that does not fall into the medical domain at all. Jordan argues that project staff who see themselves as representatives of biomedicine, of science, of the central government and its institutions, and of progress and development run the risk of dismissing the relevance of other people's "mode of being in the world". This will mean that much, if not all of what they say, will fall on deaf ears.

People who staff modern health facilities need to be less deprecatory of these indigenous practices. Acknowledgement needs to be made of the fact that traditional treatment, and the world view that sustains it, have their own rationality and are satisfying in that there is no gap between delivery and expectation - something that can not be said of the western approach. A decade ago, Costello (1989) went as far as to call the *dhami jhankri* that serves many Magar communities around Baglung in central Nepal as the "true national health service" in the middle hills. Indeed, the even earlier words of Wake (1976) still seem pertinent today:

"If health care is to be improved in Nepal 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 the building of hospitals. The problem facing the health worker is one of finding the means of integrating western ideas into the village system, and not vice versa".

Increasing awareness must be a mutually respecting process, perhaps with service providers and those implementing the increasing awareness strategy making as much effort to understand the communities' perspectives as the community is expected to understand theirs.

(c) Coming to terms with the traditional healer

There is a need to come to terms with the traditional healer. There have been examples of successes at training traditional healers to recognise common problems such as dehydration and tuberculosis and refer for treatment in the western system (Oswald 1983, Hoff 1992). The key factor is the building up of an atmosphere of understanding, trust and respect between modern health workers, traditional healers and the communities they serve. The absence of clear recognition by many governments of the potential value and role of traditional practitioners in primary care creates a poor climate for healers and health staff to work together, and tends to reinforce secretive practices (Shrestha and Lediard 1985, Gillam 1989).

If knowledge is power, then the traditional healers have much of it. They have the knowledge that the people believe in, and so far in many areas the traditional healers still hold the power (Pigg 1995). Maybe it is not that modern medicine has to integrate with traditional healing, but rather that the reverse needs to be true (Reissland and Burghart 1989).

(d) Remember that childbirth is a social as well as a physiological event

Much training related to childbirth (e.g. training birth attendants, messages about the 6 cleans, recognising the signs of an obstetric emergency, knowing about a referral system) is based on the notion that the 'cultural' dimension of childbirth can be separated from the physiological dimension. It focuses on a physiological realm divorced from social considerations. There is a danger in such training of merely teaching trainees to sound more modern than to instill new practices. (Pigg 1995, Jordan 1989).

Anthropologists insist that the social aspect of birth can never be separated from its physiological aspect (Pigg 1995). The physical events of childbirth are always taking place within a shared understanding of "the best way, the right way, indeed THE way" to bring a child into the world. A good example is that, for many Nepalis, the pollution that the woman who cuts the cord carries away with her is as real as the umbilical cord itself.

(e) Tackle the language barrier

With the need to classify the maternal health perceptions, beliefs and behaviours of Tharu and Magar groups in Kailali and Myagdi, the NSMP Social Research encountered a language barrier. But this was not the language barrier of English-Nepali-Tharu. It was the language barrier of insider:outsider, the language of one belief system juxtaposed upon another.

In the course of writing both this review, and the Social Research Report that accompanies it, the consultant was, to some extent, forced to induce local realities to conform to development categories, to use categories of language from the western health system and particularly those pertaining to emergency obstetrics. Translating such classifications and categorisations (e.g. normal, abnormal, life threatening, emergency seeking behaviour) was often not straightforward. Sometimes language itself becomes part of the problem.

The reader's attention is drawn to an interesting discussion on the social significance of routine health behaviours affecting Nepalis in their daily lives. A paper by Jackson and Jackson-Carroll (1994) discusses this in relation to responses to diarrhoeal illness among hill Tamangs. The paper focuses on the way in which social relationships, social practices, and expectations about the way the world works create the structure of daily life and help to

determine the normal household response to diarrhoea in a Tamang community. There may be lessons that the NSMP can learn in relation to emergency obstetric care behaviour too. What are the routine behaviours in terms of childbirth and responses to problems at delivery? The authors stress that there is a diffusely integrated pattern of family and community adjustment and response to a problem that needs to be understood.

Health routines express social structures. Routine health seeking behaviour for common problems (for diarrhoea, substitute problems at delivery?) are normal because they fulfill social expectations (towards family, others such as community leaders and people of influence such as the *dhami jhankri*) and sustain social cohesion under familiar but anxiety producing conditions.

The authors conclude by saying that any attempts to override routine responses and impose treatment (for ORT, substitute hospitalisation) according to biomedicine whilst ignoring assumptions about social relations will understandably be met with resistance. For these reasons, they urge, the new messages must fit into the language and practices of the people if it is to be inserted into the health-seeking behaviour routines of everyday life.

(f) Reconcile what the state decides with what the community wants

As long as people are free to choose whichever type of health care appeals to them and seems beneficial, the probability of turning to the indigenous system remains high (Subedi 1989). Recent maternal health literature has been increasingly stressing the need to adopt an alternative approach to reducing maternal mortality in the developing world. There is increasing pressure to develop appropriate participatory methods to introduce safer childbirth practices into rural locations of countries like Nepal *in parallel* with the development of better district-level emergency obstetric services (Chambers R 1997, Kwast 1997, Bolam *et al* 1998). By commissioning this Literature Review and the Social Research in two of its working districts, the NSMP has taken a bold step in acknowledging this. Rather than more rigorously enforcing messages and strategies designed along western health lines and decided at the centre, the NMSMP has recognised the need to understand the local belief system and to reconcile its own objectives with those of the people it purports to serve.

(g) Harness the fluidity of change process

There are optimists who say that behaviour change to the “level” of the western ideal is (and must be) attainable. There are pessimists who say that change to this extent will be very slow to achieve in the face of the persistence of traditional belief systems. But they are also those who focus on the dynamism of the process itself rather than the outcomes.

Everything and everyone is in a process of change. Social processes, economic conditions, availability of services, and belief systems are not static things. They change over time and all processes of change are interlinked with, and effect, each other. Thus while the belief in the traditional healer persists despite the expansion of the western model of health care and its health service providers, the process of how these two systems interact with one another is undergoing change at many levels.

Rather than viewing it as a brake on progress, engaging in interaction with the traditional system and with traditional practitioners and their clients in a way that does not exclude the validity of their approach, will reap benefits. This is because merely by taking that approach will represent a part of the process of behavioural change. Most people assume that it is the western medical system being introduced, and to some extent imposed, that will be the agent of change. But resistance to change is also experienced within the western medical system. Rather it is the “patients”, and others in their social networks, who are the real agents of change. They constrain or negotiate the terms on which modern medicine is to be integrated within the traditional health system (Reissland and Burghart 1989, based on work with the Maithili people of the eastern Terai). To be successful, behavioural change is for everyone, and not just for those traditionally seen as the ones who need to be doing the changing.

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