Nepal Safer Motherhood Project

Managed by Options Consultancy Services,
on behalf of the U.K. Department for International Development (DFID)

Social Research Report

For the IEC Strategy

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Acronyms

DFID	Department for International Development (U.K. government)
FCHV	Female Community Health Volunteer
HMGN	His Majesty's Government of Nepal
HP	Health Post
IEC	Information, Education and Communication
MCHW	Maternal and Child Health Worker
NFE	Non Formal Education
NSMP	Nepal Safer Motherhood Project
PHC	Primary Health Care
CHDK	Clean Home Delivery Kit
TTBA	Trained Traditional Birth Attendant
TBA	Traditional Birth Attendant
UTBA	Untrained Traditional Birth Attendant
VDC	Village Development Committee
VHW	Village Health Worker

Service provider definition

The term "service provider" is used throughout this document in its broadest sense to mean both indigenous providers, such as Untrained Traditional Birth Attendants (UTBA) and traditional healers, as well as the conventional service providers such as Trained Traditional Birth Attendants (TBA) and all staff of the "western" health system. Where the term service provider only refers to one of these types, it is clearly indicated in the accompanying text.

Note on translation

English-alphabet transliterations in Nepali and Tharu are the work of the author. They should be viewed as a rough guide only as they are not based on any recognised system of translation.

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1. SUMMARY

This report describes a **social research study** carried out by the Nepal Safer Motherhood Project (NSMP) in November and December, 1999. The study aimed to describe in detail local terminology, and the processes of decision-making and care-seeking behaviour relating to emergency obstetric and menstrual situations amongst the two main ethnic groups, **Magar** and **Tharu**, in NSMP's operational districts. The purpose of the study was to provide a clearer, localised understanding of the obstetric health perspectives prevailing at community level in order to contribute to the development of NSMP's Information, Education and Communication (IEC) Strategy.

Using a combination of intensive **qualitative data** collection techniques, the study involved 64 community participants in focus group discussions, and 27 service providers and community leaders in semi-structured informant interviews. In-depth case studies were also conducted on nine women who had recently experienced difficulties in pregnancy, delivery or post-partum. Data collection took place in selected wards in one VDC in each of two districts, Kailali and Myagdi (Baglung Hospital Catchment Area). An independent consultant working closely with two NSMP local facilitators implemented the study.

Findings show that beliefs about causes of many obstetric and menstrual problems centre on the activities of the supernatural beings of the spirit world. These beliefs are still widespread and very deeply held in both ethnic groups. They explain much of the care-seeking behaviour in abnormal and life threatening situations as well as the sources of information. The role of the traditional healer (*lamajhankri* among Magars, and *guruwas* among Tharu) is central to this, and leaves the health service providers of the western medical system still largely sidelined, at least in the early stages of an emergency. Apart from the traditional healers, the most common additional sources of help and information are the private medical shop, and the untrained traditional birth attendant, rather than trained governmental health service providers. Decision-making is characterised by many different types of delay at all stages of the process, from the woman's first recognition of something abnormal to a decision to take to hospital. Men generally showed little awareness of women's obstetric and menstrual problems, but some, especially the younger men, did express an interest in learning about it. For their part, women were largely skeptical of any benefit of increasing knowledge of these issues among men. Some traditional systems that can operate to organise and provide help in emergencies were found and are described. Nine case studies of obstetric emergency conditions encountered over the last few years highlight some of the issues emerging from the rest of the data.

Key **lessons learned** from the overall findings are presented as a separate discussion chapter. Differences, as well as similarities, emerged between the ethnic groups, highlighting the need for western health service providers to consider the cultural belief context of their clients at all points of service delivery. Traditional beliefs still take precedence over the modern medical system and delay affects every part of the decision-making process. Sources of information for women are still mainly from traditional providers. Using the analogy of a Nepali proverb, "*a woman in childbirth is like a cow stuck in a ditch*", an argument is put forward about the need to address safe motherhood issues along a continuum, and not just at the emergency end of the spectrum.

Ideas and recommendations for the future direction and implementation of NSMP's increasing awareness strategy are suggested. They include the design of street theatre plays, songs, and stories for use in-group meetings using indigenous languages and local details, terminology and

actual events. Timing and venues for these are suggested, such as the *Magh Sangranti* festival for Tharus in early spring. Talking and listening to, and involving all, is the main recommendation. This refers to all community members and other community-based organisations, as well as all service providers, whether traditional or western. It also refers to a broader interpretation of "safer motherhood". This could be achieved by increasing awareness of adequate nutrition in adolescence and pregnancy, and by promoting self-help techniques for the 6 cleans for the vast majority of women who deliver normally at home. These could act more as lead-ins to the key concern of the project, the uptake of hospital care in obstetric emergencies, whilst also addressing more of the communities' own concerns about women's health during the reproductive years.

2. THE NSMP AND BACKGROUND FOR THE STUDY

The Nepal Safer Motherhood Project (NSMP) aims to support the National Safer Motherhood Programme (SMP) of His Majesty's Government of Nepal (HMGN) by contributing to improved maternal health in selected districts. The NSMP is funded by the United Kingdom's Department for International Development (DFID), and managed by Options Consultancy Services Limited, based in London.

The NSMP has two main components:

1. **Service Provision:** the project aims to upgrade and improve the quality of emergency obstetric care.

2. **Increasing Access:** operating at the community level, this part of the project aims to promote awareness of, and demand for, emergency obstetric services, and to overcome the barriers to women's timely usage of them. An experimental component, it aims to work with village and district level bodies to identify their communities awareness needs, and to assist them in the planning and implementation of their own appropriate IEC strategies to meet that need.

In the two years since the start of the project, activities concentrating on enhancing capacity building at the first referral unit are well underway. During the same period, the second project component focused on establishing entry into the community. Field-staff were trained and supported, and a general **Needs Assessment** conducted during the inception phase (March-December 1997). This Needs Assessment was conducted to identify barriers to access to emergency obstetric services in the three working districts (Surkhet, Baglung and Kailali) served by the project. The following barriers to access were identified, and described in video as well as report form:

1. physical access barriers
2. financial access barriers
3. lack of knowledge and awareness of care during pregnancy, and the danger signs during pregnancy, labour and delivery
4. prevailing attitudes towards pregnancy and delivery which impede the recognition of difficulties and delay or even prevent access to hospital care and treatment
5. lack of a referral system.

NSMP activities then centred around creating an enabling environment for behavioural change, tackling the financial and physical access barriers to emergency obstetric care identified by the community, and increasing the profile of obstetric deaths and disabilities as areas for community concern.

As quality services become available in the hospitals, the focus of the Increasing Access Strategy of the NSMP is shifting towards the development and implementation of an appropriate IEC strategy to increase awareness at community level, and facilitate behavioural change. Working in three geographically distinct and ethnically mixed districts, it was clear that the IEC strategy would need to be sensitive to local differences. Thus a pre-requisite should be an in-depth understanding of the communities' own definitions and classifications of menstrual, obstetric and maternal health issues to give an insight into where these diverge from the terminology used in the project.

Recognising the need for this, a short desk-based L**iterature Review** was commissioned to look into what was already known about these issues.

Taking each of the major ethnic groups represented in the NSMP districts (Tharus, Magars, Bahun-Chhetris, Newars, Thakuris and low occupational castes) in turn, the literature review looked at:

- perceptions of maternal health
- birthing practices (including ritual pollution)
- indigenous social networks and support structures
- household decision-making structures
- emergency health care-seeking behaviour

Summarising a variety of ethnographic information, the review revealed that there was only fragmented written documentation about birthing practices, decision-making, sources of information, health care-seeking beliefs and behaviour, and other related aspects of social organisation in many ethnic groups in the different parts of Nepal, including the project's working areas. From the compilation of the available information, considerable ethnic differences in all these components did emerge, enough to highlight the importance of understanding localised knowledge to the increasing access component of the project. This provides the rationale for the present study, to fill in the gaps in knowledge, to verify what had already been found from the literature within the same ethnic group in other areas, and to clarify where any local differences lay. It was decided that an attempt was needed to provide a systematic detailed picture of community knowledge, attitudes and practices related to the local world view of health and sickness among some, if not all, of the ethnic groups living in NSMP project area.

A draft of the **Literature Review** was prepared in August 1999 and the final version is now available from the NSMP office. It serves as a valuable companion document to this Social Research Report.

3. STUDY GOAL AND OBJECTIVES

As outlined in the Terms of Reference, the overall ***goal*** of the study is to assist in the facilitation of NSMP's IEC strategy by providing a clearer understanding of the obstetric health perspective held by the main ethnic groups within the project area. This includes the discovery of appropriate terminology and methodologies to use in advertising post-abortal care services.

There were four main study ***objectives***:

1. Determine community groupings' classifications of obstetric and menstrual conditions and determine which are considered normal, abnormal and life-threatening

2. Clarify family and community decision-making dynamics and care seeking behaviour in the event of an obstetric or menstrual problem

3. Understand community information flow patterns and determine the sources and availability of reproductive health information for unmarried, recently married and primi-gravida women

4. Explore the community perceived advantages and disadvantages of raising men's awareness of and involvement in obstetric health.

The findings of this Social Research Report will contribute to the development of recommendations for NSMP's future strategy.

4. METHODOLOGY

To achieve the objectives outlined in Section 3, extensive qualitative research was planned with prolonged field data collection in wards supported by the NSMP project. Preparation, data analysis and report writing were undertaken in Kathmandu. This section outlines the study site and population, data collection methodology, and the constraints and potential biases of the study.

4.1 Study site and population

The national HMG Nepal Safer Motherhood programme initially targeted 10 out of the 75 districts of the country. The NSMP currently works in three out of these 10 districts. This study selected two of NSMP's three working districts for the social research. These districts were Baglung, served by Baglung District Hospital, and Kailali, served by the Seti Zonal Hospital in Dangadhi. The remaining NSMP district, Surkhet, was not included in the study because of time and budget constraints. Similar factors determined limitation of the study to one Village Development Committee (VDC) in each of the two districts.

The two VDCs selected were Ratnechaur in Myagdi district, within the catchment area of Baglung District Hospital, and Kotatulsipur in Kailali. Maps showing the location of the two districts, and the study wards and VDCs are given in Appendix II. Ward selection for the study was based on size of population, spread of settlements, and the predominance of the two ethnic groups of interest, ***Magar*** (25% of the total population in Myagdi and Baglung Districts) and ***Tharu*** (50% in Kailali District)[1].

- In ***Ratnechaur VDC, Myagdi*** (Baglung Hospital Catchment area), we worked in four wards (6, 7, 8, 9), which consist of small settlements spread over a hillside above the river valley that forms the administrative border with Baglung district. The elevation range covers several hundred metres (See photo 2). We based ourselves midway in ward 9. These four wards are mixed ethnicity, but a majority of Ale and Thapa Magars living alongside pockets of Brahmins, Chhetris, Thakuris, occupational castes and some Newars. Ward 9 is about two hours walk from Baglung, and one hour from Beni, the administrative headquarters of Myagdi district. Myagdi ranks 22nd out of the 75 districts of Nepal in terms of the United Nations Human Development Index[2] which is based on indicators of literacy, life expectancy at birth and standard of living.

- In ***Kotatulsipur VDC, Kailali*** (Seti Zonal Hospital Catchment Area), we worked only in ward 7 which consisted of 2 large villages, Jokhali and Sungurkal (see photos 4 and 5). Mostly Dangaure and Kathariya Tharu, interspersed with a few houses of high caste Hindus (Brahmins and Thakuris), and a few occupational castes inhabit these Terai villagers. Ward 7 is one hours walk from the small bazaar of Muda on the East-West highway, and three hours from there by bus to the headquarters of Kailali district in Dangadhi. Kailali ranks 59th out of the 75 districts of Nepal in terms of the United Nations Human Development Index (see footnote 2).

A full itinerary of the two fieldwork periods can be found in Appendix 1.

4.2 Study personnel

An ***independent consultant*** designed the protocol and implemented and supervised all parts of the data collection. She also analysed the results and wrote this report and the companion Literature Review. The consultant has a background in anthropology, knowledge of qualitative and quantitative approaches to public health issues, previous safe motherhood field experience in Nepal and speaks Nepali.

[1] Source: H. Gurung, 1998. *Nepal: Social Demography and Expressions*, New Era, Kathmandu
[2] Source: S. Thapa, 1995. The Human Development Index: a portrait of the 75 districts in Nepal. *Asia-Pacific Population Journal :* vol 10, no. 2; pp 3-14

NSMP local staff in both field areas assisted the consultant. Two female NSMP facilitators belonging to the same ethnic group as the study community acted as lead interviewers and as the point of introduction into the community. Both had had already been active in the wards visited for over a year and were already know to many participants. In Ratnechaur, Myagdi (Baglung Hospital catchment), Sangita Shirish conducted interviews in Nepali as the Magar language has not been widely spoken or understood in the area for several generations at least. In Kotatulsipur VDC, Kailali, Tara Chaudhary acted as the sole interviewer as the consultant does not speak or understand Tharu. All taped sessions were then verbally translated by the facilitator from Tharu into Nepali, from which the consultant made field notes in English. One full day was spent with both local facilitators before beginning the fieldwork to familiarise them with the general approach and objectives, go through the protocol, and to discuss details of the local context.

4.3 Data collection

Table 4.1 summarises the data methods used and the number and type of participant by ethnic group.

Table 4.1 Summary of participants by data method and ethnic group

Method	Participants		*Magar*	*Tharu*
Interviews	FCHV		4*	2 **
	TTBA		2	1
	UTBA		4 ***	2
	VHW		1	0
	MCHW		1	0
	Ward Chairman		0	1
	Bhalemansa		-	2
	Chowkidar		-	1
	Desbhandia guruwa		-	2
	Dhami jhankri		4	-
		Totals	**16**	**11**
Focus Groups	Unmarried girls *aged 12-18*		6	6
	New mothers		4	8 ****
	Older mothers		2	0
	Grandmothers *over 50 years*		4	6
	Grandfathers *over 50 years*		8	0
	New fathers		5	5
	Guruwas		-	7
		Totals	**32**	**32**
Case Study			**4**	**5**

Notes:
* not all are Magar: 2 Chhetri
** neither of the Tharu FCHVs had participated in the full FCHV national training course
*** one of these two UTBAs was a male Chhetri, originally from Mustang District and holding a School Leaving Certificate, who had been working as a *peon* in the neighbouring VDC (Jamrakot) for the past 6 years.
**** this figure is based on the number of women who started the discussion and who remained the most vocal

The study used qualitative techniques to collect information based on themes determined by the study objectives. These themes were:

- traditional and current birthing practices (to set the scene)
- indigenous classifications of normal / abnormal / life threatening situations related to obstetric and menstrual health
- decision-making process involved in care-seeking behaviour
- sources of information for women

- the extent to which men are aware of, and interested in, all these issues.

A combination of data collection tools was developed:

(a) Semi-structured interviews: These were conducted with health service providers (see protocol in Appendix III). Participants were Village Health Workers (VHW), Maternal and Child Health Workers (MCHW), Female Community Health Volunteer (FCHV), untrained/trained Traditional Birth Attendants (UTBA/TTBA), and traditional healers (*lamajhankri* in Magar area, *guruwa* in Tharu area).

(b) Focus groups*:* Care was taken to ensure that participants of focus groups (see protocol in Appendix IV) did not include any of the above service providers, community leaders and people active in Mothers Groups. The ideal size for focus groups was between 4 to 8 people. In a few instances, this was exceeded. For example, in the case of the young mothers group amongst Tharu in Jokhali village, the group steadily grew until there were more than 20 women, and as many young children, in the room.

(c) Case studies: A case study is a research technique used to investigate in detail a contemporary phenomenon within its real-life context. In this study, case studies were collected to provide details of pregnancy, childbirth and post-partum experiences. The approach was to encourage people to recount details and to reflect on their feelings, both at the time, and in retrospect. Listening, probing and prompting were utilised to elicit more biographical details and to move on the flow of the dialogue. Cases were chosen because they highlighted issues related to safe motherhood practices that consistently emerged from interview and focus group sessions. The identification of cases was based on informal conversations with service providers and others who knew the community members well. A summary of the nine case studies is shown in Table 4.2:

(d) Aids: The following aids were used to assist in interviewing and documentation:

- *tape recordings* of all focus group discussions, informant interviews and case studies were taken to allow retrospective analysis and clarification of local language. The researchers always fully explained that this was needed to allow for the detailed understanding of local language and terms, and stressed that its use was merely to facilitate transcription in the field. No recordings were ever played back to others. Verbal permission to use the tape recorder was always obtained prior to the start of interviews, and no objections were raised.
- *flipchart pictures* produced for the national TTBA training course by HMGN and Redd Barna, depicting emergency symptoms during pregnancy, delivery and post-partum (see Appendix V). These were used to provoke discussion over causes of problems and differing approaches to seeking care, and the level of awareness of seriousness of obstetric conditions. Any depictions of health-post, hospital premises or staff such as trained TBA or of Clean Home Delivery Kit (CHDK) were first removed.
- *true/false statements* (see Appendices 3 and 4).
- *photography* of study participants, including opportunistic observations of a mother and newborn in place of birth seclusion (*sowri, Tharu),* and a *guruwa* (Tharu traditional healer) performing a *puja.* It was not possible to observe any of the following during the fieldwork period: an actual delivery, any post-delivery purification (*navaran, chokkine din, ghatwa karaine*), or any training sessions related to maternal health.

Table 4.2. Summary of case study characteristics

	Ethnicity	Date	Difficulties experienced	Care providers (in order)	Decision makers	Outcome
1	Magar	1996	Late expulsion of placenta after normal home delivery, followed by post-partum fever and vomiting	UTBA (called but unavailable) MCHW (called for RP) *Lamajhankri* (called for RP) Baglung private clinic then Hospital	Case Case Mother-in-law Husband	Unconscious on arrival at Baglung Hospital, blood transfusion, case discharged after 5 days
2	Magar	1996	Long interval between waters breaking and start of contractions	*Lamajhankri* (2) Baglung Hospital	Mother-in-law Case	Normal delivery, live baby born after performing perineal cut
3	Magar	1996	Late pregnancy bleeding	*Lamajhankri* HP doctor Baglung Hospital	Mother VDC Vice Chairman Husband / VDC VC	Breech baby delivered dead by CS at Baglung Hospital, blood transfusions, case discharged after 7 days
4	Magar	1993	Long labour	UTBA (2) *Lamajhankri* (2)	Case Mother	Normal home delivery, no further complications
5	Tharu	1999	Long interval between waters breaking and start of contractions	TBA HP doctor (called but did not come) *Guruwa*	Case TBA Case	Normal home delivery, no further complications
6	Tharu	1999	Late pregnancy (8 months) bleeding and contractions	*Guruwa* (3) UTBA (2) Medical shop owner (Semri)	Mother-in-law Mother-in-law Husband	Semri medical shop owner gave two injections (unknown), normal home delivery, some post-partum bleeding (no help sought)
7	Tharu	1998	Oedema in late pregnancy and post-partum, post-partum breathing difficulties	UTBA (case's mother-in-law), Semri medical shop *Guruwa* Medical shop (case's brother, maiti)	Case (FCHV) Case Mother-in-law Husband	Mother (FCHV) died at home 2 months after delivery
8	Tharu	1999	Spontaneous) abortion, severe prolonged pain	Semri medical shop UTBA / *guruwa* FCHV Dangadhi / Lucknow hospitals	Case Mother-in-law FCHV own initiative FCHV / UTBA /Case	Severe pains continued after hospitalisation in Dangadhi, Case then made own decision to go to Lucknow, India
9	Tharu	1998	Contractions at 8 months. Twins, second in breech position. Post-partum fever	UTBA *Guruwa* / UTBA (1) UTBA (2) *Guruwa* / Semri medical shop	Case Husband Mother-in-law Husband	First twin died in utero, second twin died after 5 days.

4.4 General approach

Prior to arrival in the district, the NSMP had informed (written and verbal) the district, VDC and ward administration and the community leaders of the purpose and timing of the research study. The consultant and facilitators also introduced themselves and the study to these key people who were present in the locality during the implementation of the study. The consultant and facilitators based themselves in the wards for the duration of the fieldwork.

Prior to participation, the researchers fully explained the purpose and methods of the interviews to all community participants. The style of interview was informal, beginning with introductions and ending with an invitation to ask any questions. Note taking during interviews was avoided so that eye contact was maximised to encourage an atmosphere of attentive listening. Techniques of listening and probing were emphasised. No organised IEC activities took place during the study. It was felt that doing this would confuse people about our intentions and purpose, as well as take up our time. The NSMP facilitators were instructed to make a note of issues arising in relation to particular individuals and to follow-this up later in the course of their normal community-based duties. However, we did ask individual participants if they had any questions they would like to ask us, and we spent some time attempting to answer these at the end of the sessions.

In our dealings with the traditional healers, we aimed to give the impression that we were uncritical, and not disapproving of their work or thought that their methods were inappropriate or dangerous. As we already knew some of the contextual detail about traditional healers (e.g. local names of spirits) and had had our own experiences of witnessing their work, we tried to convey empathy towards their role and take an interest in their techniques, which probably helped in the interviews. Most Magar and Tharu traditional healer respondents did not appear to be reluctant to talk to us, with the exception of the senior *desbhandia guruwas* (see section 5.3*)* in the Tharu area who only responded in very general terms.

4.5 Study limitations

This chapter has described a methodology that combines interviews, focus group discussions, case studies and observations. The strength of this approach is that, given sufficient time, it can provide both depth and breadth to enable deep exploration of issues. However, several limitations to this study should be acknowledged.

- Taking travel ***time*** into account, the actual working days for preparation, data collection and transcription were 11 days in Myagdi, and 13 days in Kailali, both relatively short periods of time for outsiders to conduct qualitative research on potentially sensitive subjects. Ethnographic inquiry normally consists of months of close daily contact, observations and a wealth of detail from discussions. However, given the limitations of NSMP's mandate, which understandably does not include the conducting of lengthy and costly ethnographic research, the study timetable represents a workable compromise between study objectives and project log frame. The collection of good quality data in this short space of time is largely due to the skill of NSMP field staff who had clearly developed considerable trust and rapport with the communities in which they live and work, and were able to facilitate interactions with different community members.

- ***Language*** was another constraint, especially in Kailali. People in Myagdi speak a local dialect of Nepali, with some pronunciation and vocabulary differences, particularly among older people. With a good command of spoken Nepali, the consultant was able to participate actively in the data collection in Ratnechaur. However, this was not possible in Kailali where all participants spoke in the Tharu language and translation from the Tharu language to Nepali was necessary. The NSMP facilitator was the sole interviewer in Kotatulsipur, which meant that gaps in probing were not discovered until the time of interview transcription, and some details were missed. Another difficulty arose because Kathariya Tharu is sometimes

different to Dangaure Tharu, the latter being most familiar to the NSMP facilitator. These factors may have influenced comprehension at times, although the use of tape recordings, which could be replayed, transcribed, and discussed in retrospective discussions to clarify meaning probably kept this to a minimum.

- The presence of outsiders may have led to ***expectations*** on the part of study respondents. Moreover, what people do and what people say they do is not necessarily the same. Self-reported interviews run the risk of having the participants give the 'right answer' based on their perceptions of what changes they are expected to have made, what NSMP has been telling them, and thus what NSMP wants to hear. However, whilst it is difficult to evaluate the extent of this, using locally known and trusted staff and probing of a large number of respondents is likely to have minimized it as a confounder. Traditional healers may have had expectations that we would adopt a critical attitude towards indigenous belief systems and care-seeking behaviour although we did try hard not to give this impression.

- The results of this study should not be used to ***represent*** the picture of care-seeking behaviour throughout the districts of Myagdi, Baglung and Kailali, nor for the same ethnic groups in other districts of the country.

5. STUDY FINDINGS

Data analysis of field notes involved the methodical examination of the content of field notes, interview transcripts and observations by identifying and grouping themes and responses to questions, and then systematically coding and classifying them.

To set the scene, this section begins with an ethnographic account of traditional and current birthing practices in the two ethnic groups. Interspersed with direct quotations, this is followed by descriptive summaries organised under common themes according to the goal and objectives outlined in Section 3. Similarities and differences of views and behaviours are taken into account.

5.1 Birthing practices

(a) Magar

Birthing practices among Magars in Ratnechaur broadly parallel those of other hill groups of western Nepal who have been heavily influenced by the processes of Sanskritization and the spread of Hinduism over several centuries. While not taken to the degree of other more isolated areas such as Bajura[3] where high caste Brahmins, Chhetris and Thakuris predominate and where ritual pollution beliefs heavily influence birthing practices and care-seeking behaviour, some of these can be found with wide variation between individual families.

In Ratnechaur, Magar women giving birth are called ***sutkeri***. They give birth in the *sutkoma*, an area inside the house specially designated for the purpose. This area is usually not cleaned before the delivery, but only freshly plastered (*lipne*) with a mud-dung mixture afterwards as part of purification rituals. A few food restrictions for the *sutkeri* were mentioned: yogurt (cooling), chilli, millet (*kodo*), corn (*makai*), spinach (*sag*), pumpkin (*parsi*) and *pinalo* (causes itching). The normal birthing position for these women is sitting supported by others under their arms, and bracing their feet against something like a wall. At the time of delivery, warm mustard oil is rubbed on the mother's head to speed up the birth process by warming and to stimulate the baby's soul to be born "*atma jancha*".

Older women spoke of **cutting the umbilical cord** (*nal*) with a sickle (*hasiya, asi*) or a meat chopper (*daw*), and rubbing hot mustard oil on the umbilical stump. Younger women and men reported using a blade (*puta*). The cord is normally only cut once the placenta has been expelled. The umbilical cord is cut on the piece of wood that keeps the door closed (*dhokako ogalo*), or on a rupee coin. It is believed that the caste of the cord-cutter is inferred on the baby (*bucchalai dherey bharra lagcha).* It appears that being non-Magar is the important thing as both the low caste

[3] see Manandhar 1999, report for CARE Nepal

UTBA and the higher caste male Chhetri UTBA from Jajarkot reported that the mother herself, mother-in-law or other female relative will usually perform the cut.

Only the cord cutting is significant and the cord-cutting instrument has to be purified by the sprinkling of *sunpani* (ritually cleansing water in which gold has been dipped). **No touching** is theoretically the norm during the *sutkeri* period. No one is supposed to touch the *sutkeri* until *navaran*, but many children do. Most people do not regard this as polluting and, even though such children should be ritually cleansed with *sunpani*, most say they do not bother nowadays. The no-touching rules also appear to break down in an emergency. The response to the true/false statement about touching in fitting was unanimous: while touching in fitting is usually not practiced (e.g. in epilepsy, *chare rogh*), family members will not hesitate to touch if it happens to a pregnant woman. The TBAs should wash with *sunpani* and change her clothes after performing a delivery or visiting a mother for massage during the *sutkeri* period. This is necessary to avoid offending household gods: "*moreko jagane deutalai mandeyna, ma birami hunchu. Tyeskaranle meyle nuhuaera, sunpani chokera, bhitra posnu parcha*".

The **placenta** (*sal*) is placed neatly in a pot (*topari)* and covered with another pot. This "tidying up" of the placenta is apparently done so that the baby will not vomit the breastmilk. The placenta is then taken outside and buried just behind the house (*khorangsa, koringsa)* where no one walks. This burial place must also not look over a temple or a place of worship for *lamajhankris* (*jhankriko than*). There are beliefs that if the placenta is buried a long way from the house there will be a long interval before the next pregnancy. The placenta is buried by the mother herself, her mother-in-law (*sasu*) or the TBA. Her husband will only do it if there is no one else available. Most people described all these details but could not give reasons for them. Old men said that, if a previous baby had died, the new baby's placenta should not be buried near the old one, but taken to a crossroads outside the village to protect the new baby from harm.

The end of the ritual pollution "no-feeding-water" (*pani nakwaune*) period is marked by the ***navaran***. While older women felt that should take place 21-23 days after birth, younger women reported the tendency to perform these after only 3-5 days so that the woman can get back to work in the household. Most people thought that the ideal time is after 9 or 10 days for a daughter and 11 days for a son. The *sutkeri* is restricted from entering a temple until after the rice feeding ceremony (at 5 months for a daughter, 6 months for a son). No Brahmin is required to perform the *navaran,* and only *chelibeti* or *kanyaketi (*non-menstrual or virgin girls) are called for the sprinkling of *sunpani* and cow's urine for "*chokko bhayo*". Some people also celebrate the 6th day after the birth of a son (c*haitan*). A feast is prepared and fed to relatives, neighbours and those who helped at the delivery. A TBA expects and receives some payment for her work at delivery and during the *sutkeri* period. This varies according

to the means of the family, but food, cloth and some money are usually provided. After *navaran*, “protective” symbols (*aitan banaunchan*) are placed under bedding in the baby’s cradle. These are usually a sickle (*hasiya*) that may have been used to cut the umbilical cord, or a *khukuri*. A fishing net (*jali*) was also mentioned, but this practice appears to be in decline.

Death and burial: If a baby dies mid-term then the mother will need to be fed raw chicken to clear her blood and pray for success next time. The dead foetus, and any baby that dies at delivery or shortly afterwards, is buried, preferably by the *sutkeri*’s own brother, in the *pakho* (open uncultivated land, often on a hillside), or in the *khet bharri* (cultivated fields). To appease the dead child’s *atma* (soul), the family will feed the *kanyaketi*, give *dhan dachini* (ritual offerings) and refrain from eating salt. Adult Magars who die normally are taken to family cremation *sansanghats* on the banks of the Kali Gandaki river. However, if a mother dies at childbirth, or before the *navaran* purification, she is not burnt nearby: “*gangale aparbittra huna”.* Some people (older) said that if a baby or its mother dies away from home (termed a violent or untimely death, *bikalma maryo*), they take a piece of the dead body (a finger or a toe) (*masuko tukra*) and bring it back for last rites (*sutiguti*) at the family *ghat*. A small straw effigy (*kusan*) will also be made. This has to be done to appease the patrilineal ancestors: “*aphne kulma jamma garnu parne*”, otherwise household members may be harmed by malevolent ancestral spirits: “*pirit huncha*”. It is also important to perform the *kriya* (death rites) so that the *pirit* do not come to cause harm: “*marera pirit nahos*”.

Miscarriage or spontaneous abortion was described as *bucca niskyo* (the baby came out). Very little detail on local **abortion** practices was revealed as people were reluctant to talk about this[4]. Most used the term “*bucca phaleko*” to describe an intentional abortion. Private clinics in the nearby town of Baglung were cited as the main provider of abortion services. The NSMP facilitator also remarked that other Magars had spoken of the practice of soaking for a long time in the natural hotsprings at Tatopani to induce miscarriage. No one spoke of *dhami jhankri* involvement.

[4] abortion is illegal in Nepal

(b) Tharu

A woman known as *sutkeri* in Nepali is called the ***larkoria*** in the Tharu language. The birthing place is called the ***sowri.*** This is usually a room (*kwanti*) or a partitioned part of the living area on the western side of the house, separated from the *bansaghar* (where food is prepared) and *manjari,* the shrine for household patrilineage (*purkar*) gods. A symbolic border of five long sheaves of elephant grass (*ati bankas*) is placed around the straw mat (*paral*) bedding in the *sowri* by the UTBA/TTBA. In some houses, a fishing net is placed across a window for protection against the entry of witches and spirits that might harm the mother and her newborn. A sickle and an iron hoe (*bowsa*) are also placed in the *sowri*; iron is believed to ward off harmful ghosts*: bhut parachiu chut ha.* During the confinement period the diet of the *larkoria* is not restricted. She is fed meat, dried fish (*sidra*), beer (*jad*), pulses (*dhal)*, and green vegetables, but bitter foods like white gourd (*kohora*; Nepali *gobindho*) should be avoided. On the delivery day itself, all the mother is given is a dish made of molasses mixed with hot water and fried with chilli (*karong pani)*. This is also believed to help with healing if there is post-partum bleeding (*karab khun, gana*).

Ritual pollution no-touching rules during the sowri period do appear to exist among the Tharu but are often very lax and there is a lot of variation between households. This may be due to the lesser effect of Sanskritization among the Tharu who have only recently begun to adopt beliefs and practices that are common amongst high caste Hindus. For example, small children do go and touch their mother in the *sowri* but are supposed to be sprinkled with *sunpani* afterwards to purify them. Some people said they do this while others said it would just take up too much of their time so they don't bother. The grandmothers all talked about TBAs cutting their cords whereas younger women said that often nowadays they did it themselves.

Women used the word *chuttiya* for their menstrual period: literally the period of being ritually polluted. They also used the Nepali expression *mahinavari*. Because of ritual pollution, and fear of witches and harmful spirits, the *larkoria* is heavily restricted in the *sowri* period. She is not supposed to go outside at all except to go to the toilet. When she does so, someone from the house has to follow her, sprinkling water which has been "purified" with a piece of gold (*sunpani chittne)* on her route to purify the areas she has been. In some families, the *larkoria* cannot even use the front door to leave the house – instead a hole is cut for her (and the UTBA/TTBA) in a wall (*bitta*) of the house[5]. The *larkoria* should avoid going out at all at night because this is the time when the ghosts roam: *bhut hincha*, and at any time avoid certain places because of their affinity with harmful witches and spirits (see later in sections 5.3 and 5.5). Whenever she leaves the *sowri*, the *larkoria* should carry the sickle with her for protection against witches and harmful spirits.

[5] This is possible as the wall is made of straw, sticks and mud

Almost everyone calls the **UTBA/TTBA** to attend the birth. For up to 10 days after the delivery, she massages the woman's body (*dhe*), and washes clothes. Some people still reported **cutting the umbilical cord** with a sickle (*hasiya*) although blades do seem to be more frequently used nowadays and are easily available in small village shops. After cutting the cord, the *larkoria* is told to spit three times on the stump, and the UTBA/TTBA holds on to the end to "prevent the cord going back in". She also presses the abdomen to encourage the expulsion of the placenta. Normally the UTBA/TTBA cuts the cord and ties threads on the feet and hands of the baby. Other women say that the UTBA/TTBA holds the cord and the mother herself or other relative cuts it. Whoever cuts the cord can't go into anyone else's house until the baby's stump has fallen off. The no touching rules revolve around the baby's umbilical stump (*lara*, *dhori*). Only when this falls off can the woman perform the ritual purification ceremony (*ghatwa kaireyna*) and return to the normal touching world. Many people also admitted that they have the practice of wriggling the stump in order to encourage it to fall off quickly. In theory, the *ghatwa kaireyna* should take place on the 9th day for a girl, and the 10th day for a boy. As among Magars, the cord is normally cut after the placenta has been expelled (*puren koslesetup*). If the cord is cut before the placenta is expelled the placenta will go up inside the woman and give her pain:

> *"puren upper chaljey, poolkey pet pirey*" (some say it can go right up to smother her heart and kill her).

The **placenta** (*puren)* is placed the right way up in a bowl made of leaves (*mowren; in Nepali malukopat*[6]) with the remaining part of the umbilical cord wound neatly on the top and all covered with a lid of the same leaves. Some bury this just behind the back wall of the house (*dundri*) while others bury it in a corner of the *sowri* area inside the house and a fireplace with iron tripod made on top if it. The general name for the place of burial is the *asurwa*. Placenta disposal has to be done quickly or it is believed that the uterus (*bhandara*) will also fall out. Every placenta from each delivery is buried in a different place. The fire is used to keep the mother and baby warm, and to heat oil for massage, and not for cooking. The fire must be fanned and not blown: it is believed blowing will make teeth fall out. After this the baby is put sleeping on a bamboo tray used for winnowing (*nanglo*)[7] filled with rice grains, which are later given to the TBA.

The **newborn** baby (and up to 6 months) is called *tatak larkaba.* Soon after birth, the *guruwa* is called to perform the *chaur (Nepali: camal) satchne* rice ritual to protect the newborn from witches and harmful spirits:

> *"chaur neysajlesey dher bhut jumrogh lagat; keney kaha ke ra sajetry bhutwa neylagos key ke to hui* – I don't really know why this

[6] These are the leaves used to make leaf umbrellas
[7] see photo 17

is done but it's probably to protect from the ghost (FCHV); *sowri badne (guruwa)"*.

The ritual involves blowing on rice grains and putting these under the baby's pillow. There appears to be no practice of discarding colostrum (*gard dudh*) here.

After giving birth a mother and her newborn are ritually purified in the ***ghatwa kaireyna.*** Only the TBA and mother are involved in the *ghatwa kaireyna* ceremony. There seems to be some rule that non-family members may not watch. In the early morning (*sakara*), when the TBA arrives she throws out all the straw mats (*paral*) on which the mother has been sleeping and the *sowri* fireplace, cleans the room, plasters (*lipne*) the floor, and washes the baby. Then both women go to a river or a canal to wash (*lahar kwor*). They take with them dung, 5 chillis, mustard oil seed, bits of unhusked rice (*dhanko monkun*) from the rice, and red (*sindur*) and black powder. At the chosen site, the woman makes 5 piles of dung, topping each pile with a chilli, *dhan*, and seeds and then given *tikka* (dots of powder). Then both women wash and return to the house where the woman sprinkles *sunpani (sunpani chitne*) everywhere and the purification is completed with a meal of meat and *rakshi*. If the *ghatwa kaireyna* is not done, then the woman and child will be not be ritually purified: *"chutiya palirahat, garehi parat neda chut ney meytat".*

The TBA is paid at the time of the *ghatwa kaireyna*. If the baby was a girl, she will get 40 kgs (*dui manna*) of unhusked rice (*dhan*); if a boy 50 kgs (*dhie manna*). The family will also give clothing and money according to their means.

Death and burial: If the baby dies before the *ghatwa kaireyna* has been performed, *sunpani* is sprinkled all over the house. The baby's body and clothes will be buried in the nearby jungle or other uncultivated place. If the dead baby was premature or deformed[8], pieces of charcoal (*koila*) and stones are buried with the body which is also mutilated by splitting a thumb, or twisting or making slits across the feet, so that it can be identified if it is reborn. For the peace (*dollo, shanti*) of the dead baby's soul (*hansa*, Nepali *attma*), the *guruwa*[9] will perform a *puja* and command the soul to stay in its place and not do harm. Unlike Magars there is no practice of burying dead mother and baby separately[10]. If a baby died before the *ghatwa kaireyna*, then the parents should ideally perform a *lahan* pilgrimage: go to a powerful temple site on *magh sagranti* (1st day of Nepali month of *Magh Jan/Feb*) to wash and pray. They should also call the *guruwa* to perform an *acetta puja* and do blowing: "*arhey birhey garahi bandwa dadahi*". This is to ensure a quick and successful next conception. If a mother and baby die away from home, it is better to bring the bodies back home. All their clothes must be burnt or buried in the

[8] sign of it having been a *dieytu* or goblin (Nepali : *raches*)
[9] *keshaunkar*, see section 5.3
[10] Tara Chaudhary, the NSMP facilitator and a Tharu from Dang, reported that in her area a border of mud is formed between the dead bodies if they are buried together

burial ground (*masanghat*) with them along with rice for the journey (*sahat, sata*) to the next world.

A **miscarriage** is referred to as *angga gayo* or *angga kosiyo, larka*[11] *jaryo* (in Nepali, *bucca niskyo*. The TBA from ward 7 said she had two miscarriages: one was caused by drinking the *larkoria's karong pani* when she was pregnant, and the second was caused by a *bhutwa*. She called the bleeding she experienced at that time *ban gayo*. Several UTBAs said that if a woman has a miscarriage before about halfway through the pregnancy (up to 5 months), then they need not be called. The woman merely has to bathe herself to be purified. However, if the woman is more than 5-6 months term and loses the baby, then the UTBA/TBA should be called to give massage and the woman has to stay in *sowri* for up to 10 days. The expressions *kher gayo and bucca phalyo* usually refer to an intentional abortion. Although we could get only a couple of people to talk about this, it seems that women go to the medical shops in Semri for medicine, or to private clinics in India (e.g. Tikunia).

[11] as among Magars the word baby is used : there appears to be no expression for foetus

5.2 Community classifications of obstetric and menstrual conditions

This section documents the local terminology and classifications for what is considered normal, abnormal and life threatening in pregnancy, delivery and post-partum amongst the Magar and Tharu participants in the study areas. Beliefs relating to causes, and behaviour surrounding care and treatment, are described.

(a) Magar

The normal (*abhitra huncha*) **stages of pregnancy** and labour were described as:

Stage	***What happens***
First few months	miss period, go off food and smells, some food cravings, sore breasts, feel weak and tired
5-6 months	feel movement (*chipine jancha*)
7-9 months	abdomen gets bigger
Start of labour	*beta lagne, kanya bimar*
First stage contractions	*nitanini*
Second stage contractions	*kame beta, chitto chitto natchinchan*

Tables 5.1 and 5.2 summarise the classifications of symptoms, their causes and most common care-seeking behaviours amongst the Magars of Ratnechaur.

Vomiting, abdominal pain, headache, feeling weak and having oedema are all considered by the majority of participants to be **normal** conditions of pregnancy, and a woman is not expected to complain about them: *ruera ke huncha* (what will happen if you cry? Nothing; women still have to work). The classification of any sort of oedema as normal is the most worrying finding:

"gharbhale ho, bucca paebhane thik huncha pacchi"

Almost everyone said this: that any swelling will just clear up once the baby is born. It was thought unnecessary to take any action beyond that mentioned in Table 5.1. Vaginal discharge and some bleeding after delivery were also considered normal, non-dangerous, conditions that required little if no attention.

Dangerous **abnormal** obstetric conditions included vomiting in late pregnancy, fitting and a breech delivery. The words "*okta*" and "*uptharyo*" were used to denote difficulty. Although late pregnancy bleeding was seen as abnormal in that only a minority of women experienced it, it was not always thought of as dangerous. Many thought that it was actually a good thing, signalling the opening of the baby's birth route: "*buccale bato kolyo*". Most UTBAs and some *lama jhankris* said that they could successfully manipulate breech deliveries into the correct birth position using abdominal massage (*pet secne*).

The vast majority of respondents reported that ***lama jhankri*** is normally called for vomiting and fitting, and frequently called to see cases of

retained placenta, breech presentations, and babies presenting head or foot first, in addition to the UTBA/TBA who would probably already have been in attendance. Most people believed that the placenta should be expelled quickly, with most, but by no means all, of respondents including service providers, defining that as within an hour of birth. A few people said that 1-2 days was not dangerous, but most people thought that 4-5 hours was long. More than 12 hours was dangerous as the abdomen will swell up (*burdhi phulcha*) pushing the placenta right up to the heart and killing the mother: "*salle khana sukcha, marna sukcha".* The Newar FCHV in ward 8 reported that everyone calls the *dhami jhankri* for retained placentas. She recalled the case of a female schoolteacher who had apparently waited several hours before calling the *dhami jhankri* out twice and then finally went to Beni where the placenta was manually removed. Everyone believed it was necessary to consult the *dhami jhankri* in the case of retained placenta before taking to hospital to see if it was the work of the witch*:*

> *"bokshile rokeko ho ki bhanera, lamaka jane chalan cha. Lamale acitta lagera, pani muntaera, phukphak garera puine dine".*

Several people remarked that there were two different types of placenta: *lato sal* and *bato sal*. The former comes out quickly with the baby, while the latter is much tougher and will be retained whatever you try and do. Presumably once the role of a witch has been discounted, there is little the *lamajhankri* can do little about the latter.

Fitting was almost always reported due to malevolent spirits or to witchcraft (see true/false statement). Exorcism of the spirits (*utauna parcha*) or appeasing of the witches (*panchai dine*) responsible demands the attention of the *dhami jhankri* in all night seances, at least 3 assistants and a considerable array of sacrificial offerings.

(b) Tharu

The normal stages of pregnancy (*peynaha*) and labour were described as:

Stage	***What happens***
First few months	miss period, feel sick (*ulti, oklas*), strange (*jiu masus garne*)
5-6 months	swollen belly (*pet barhal battis*)
Full term	*din pugil ba*
Start of labour	back pain (*kukur buteyna*) a different kind of abdominal pain (*ewra merky pet pireyna*)
First stage contractions	a different kind of abdominal pain (*ewra merky pet pireyna*). Some may call a UTBA/TBA
Second stage contractions	when the pain makes you cry out (*chutput aeko*: Nepali); fast strong pains (*kame beta, chitto chitto natchinchan*). This is when the UTBA/TBA is necessary

Tables 5.3 and 5.4 summarise the Tharu classifications of obstetric conditions emerging from the study. Again we see that oedema is considered a normal part of pregnancy (*kekro kekro astiyey badah ratin*), usually treated with a poultice of leaves. This will work only if a ghost does not cause the condition, and will be ineffective if a ghost is involved, in which case a *guruwa* will need to be called:

> *"Bhutwa reyhi to ney pushki, sojhey sojhey reyhito pachaka jaiee"* (FCHV).

Other conditions like headache, vomiting, bleeding and fainting are considered normal and a *guruwa* will be called to do blowing (*phukne kam*) and the childbirth mantra (*janmounti mantra*) only if the condition is severe and prolonged. Heavy prolonged bleeding at any stage is thought to be due to a *bhutwa* sent by a witch:

> *"Bhutwa ajey tupgiri ney tu kahagiri".*

Post-partum bleeding is to be expected and the UTBA/TBAs are generally not called. If it goes on a long time (several weeks) then the *guruwa* is called to deal with any witchcraft cause, to do *gurey puja* to all the gods of the woman's natal home, and to look at the rice grains. Heavy bleeding was defined as soaking through a pleated skirt (*lehengar*) quickly. A long labour was described as a night and a day or more, but interpretation will depend on whether or not the start of labour is thought of as the first contractions or the second stage contraction only. There is an awareness that the baby should be born straight, head (*kapar*) first, and that if this is not the case, the UTBA/TTBAs can massage and manipulate the abdomen: *pet marna, chamcham*.

Table 5.1 Magar classifications of obstetric conditions : (a) Normal

Classification	Condition	Nepali / Magar	Belief about cause	Avoidance or care-seeking behaviour
Normal	Vomiting Early / mid pregnancy	*ulti garne*		Avoid food and smells that cause nausea
	Headache	*thauko dukne*		Drink soup made from *karila/iskus* vegetable. Eat raw *iskus* and *methi* fenugreek Grind *asoruko manat/bee* (?) seed into a paste, smooth onto forehead and cover tightly with headband
	Abdominal pain	*Pet dukne*		Avoid sleeping with husband
	Oedema / swelling	*Sunnini, sunniya cha, kuta phalera*	Cold (*sardhi*)	Feed heating (*gharmi*) foods (hot *ghee* and soups) Massage with manure and hot bricks (*aguma secne*) Go to Tatopani and soak in hot springs
			A worm (*kira, khitan*) ingested in food that can't get out of the body	Feed chicken soup (*mawa*) made with alcohol (*rakshi*), and herbal medicine (*joributi*)
			Lack of energy/weakness (*tagat kamjori bhayo)*	Increase food
	Weak / dizzy / fainting		Lack of energy (*tagat napugera).* It will clear up once the baby is born	Feed glucose water, yogurt. If fainting occurs, revive with smelly shoes under nose

Table 5.2 Magar classifications of obstetric conditions, ctd : (b) Abnormal / life-threatening

Classification	Condition	Nepali / Magar	Belief about cause	Care-seeking behaviour
Abnormal	Vomiting late pregnancy / delivery		witchcraft and the evil eye *: bokshile lagyo, akale lagyo*	Most respondents: consult the *dhami jhankri* Vomiting is dangerous because baby can come up the heart (UTBA # 7) A few mentioned they might also take to hospital
	Heavy bleeding late pregnancy / delivery	*sirphuta*		Consult *dhami jhankri* : suspect witchcraft Feed meat, blood and herbal medicine (*joributi)*
	Fitting/trembling	*mursa khayo, mirsi pitera*	witchcraft or malevolent spirits	Consult *dhami jhankri.* Could be life threatening A few mentioned they might also take to hospital
	Breech delivery	*bucca tirso cha*	witchcraft	UTBA/TBA manipulation of abdomen. Some *dhami jhankris* also do this
	Vaginal discharge	*ang pakheko*	Witchcraft	Consult *dhami jhankri* for exorcism (*utaune kam*)
	Delayed expulsion of placenta (anything up to 12 hours)	*sal arkne*	Witchcraft (particularly *ban bokshi*) or malevolent spirit (particularly *chureni dokh*) Also regarded by some as being caused by cold. Appropriate treatment for this involves hot oil massage.	Self-help behaviour : • stuff hair in the mouth to induce vomiting • induce coughing, urination • put baby on the breast (normally done 1-2 hours after birth) • soak rail ticket in water and drink * • drink unhusked rice water (*dhanko pani*) UTBA/TBA behaviour : • massage/press (*secne/chamne)* and blow on abdomen • tie hoe (*kutto/bowsa banera rakchan*) to end umbilical cord Consult *dhami jhankri* who will : • blow on abdomen/water to feed to mother • contact spirit/witch and perform exorcism
Life-threatening	Retained placenta (after 12 hours)	*sal arkne*		After trying some/all of the above with no success, take to hospital (usually Beni)
	Cord around neck			UTBA/TBA try manipulation. Consult *dhami jhankri,* witchcraft cause It these fail, take to hospital (usually Beni)

Table 5.3 Tharu classifications of obstetric conditions : (a) Normal

Classification	Condition	Tharu	Belief about cause	Avoidance or care-seeking behaviour
Normal	Vomiting/morning sickness in early/mid pregnancy	*Gantey, oklas, ulti, ewchar, gin, underma, kanj lagat*	Normal part of being pregnant : *bhani huncha*. Often due to something eaten not settling in the stomach	This will get better by itself once the baby is born *Guruwa* can also do blowing : *phuki dincha*
	Headache	*Muri/murdi peritis, thauka dukat*	Due to cold : *sardi* Normal part of being pregnant : *bhani huncha*.	Press paste made of root (*siurdiko bhot*) onto forehead *Guruwa* can also do blowing : *phuki dincha* Get medicine from the medical shop (Semri)
	Abdominal pain/contractions	*Pet piraina, piret, peru pirel*	The baby is moving about May be a sign that a *bhut* has invaded	Call UTBA/TBA to massage abdomen (*pet dabdab*) *Guruwa* can also do blowing : *phuki dincha*
	Bleeding before delivery	**Annga, kher gayo**	Early pregnancy bleeding due to food the mother ate disagreeing with her If mid-pregnancy, it could be a *chureni bhut* trying to push the baby out too early If in late pregnancy then the baby is trying to come out : "*bucca nikra kojet*" – this is a positive sign of an active baby : *kochelle*	No action necessary in early pregnancy In mid-pregnancy, consult *guruwa* who may have to eject *chureni bhut* by *jarpkhuk* No action necessary in late pregnancy
	Oedema/swelling	*Suwell, subao, pew sujen, subaha, sujhan, suhaju*	Normal part of being pregnant : *bhani huncha* Many say due to cold God's will *: bhagwanko kirpa* May also be due to weakness *: kamjorle*	This will get better by itself once the baby is born : "*aphey majha huncha"* Tie warmed leaves (*mudarko) / s*mear paste of mashed bitter gourd (*koreliko)* leaves on swollen areas
	Weak/dizzy/fainting	*Gumri, chakkar lagat Behos*	Normal part of being pregnant : *bhani huncha* God's will *: bhagwanko kirpa* Could also be due to *bhut*	This will get better by itself once the baby is born If worsens/prolonged, consult *guruwa* who can give herbal medicine *(dubai, jarpat)* and do *gurey*
	Post-partum bleeding	Gana, karab khun	Normal part of being pregnant *bhani huncha.* Necessary for internal cleansing	Feed chilli water

Table 5.4 Tharu classifications of obstetric conditions, ctd : (b) Abnormal

Classification	Condition	Tharu	Belief about cause	Care-seeking behaviour
Abnormal	Waters breaking before contractions start	*Pani kosyo, kose lagal, pani pani girel, pani jursikal*		Consult *guruwa* to do *gurey puja* and childbirth (*janmounti) mantra*
	Heavy (clotting) bleeding late pregnancy/delivery	*Gana, khun (tukra)*	*Bhut* especially *jumjut, jumrogh*	Consult *guruwa* to find out what the *bhut* wants "*bhutlai manauncha*". Nail the *bhut* down (*bhut tokne kam garne*) Take herbal remedies (*jungleko jarpat, biruwa*) Consult medical shop in Semri
	Long labour		*Bhut* especially *jumjut*	Massage abdomen (*pet tijincha, marna, chamcham*), feed *ewshedhi* (*maliko pat*) *Guruwa* does childbirth (*janmounti*) *mantra, gurey puja* and pulls up special plants (e.g. *ultakud*) in the name of the woman
	Fitting/trembling (fever)	*Dubao, luglagaune, phechkur (juri)*	**Bhut *especially* jumjut *and* chiddigunga *(causes madness)*** The evil eye : *aka lageko* Weakness : *khumkom*	Consult *guruwa: gurey garne* to find out what the *bhut* wants "*bhutlai manauncha*". Nail the *bhut.* Take herbal remedies (*jungleko jarpat, biruwa*) Consult medical shop in Semri
	Breech delivery	*Larka berba, berkeybar, birel ratey*	*Chiurenia bhut* has caused the baby to get stuck God's will	UTBA can sometimes manipulate the baby to the birth position May also have to consult the *guruwa* to eject *chureni bhut* responsible if manipulation alone not successful
	Prolapsed uterus	*Dehi/bhandara koseko*	*Bhut* especially *jumjut* : gives much trouble "*bhot jorle butel"*	Consult *guruwa*
	Retained placenta	*Puren arkyo*	*bhut*	UTBA massages abdomen (*pet tijincha, marna, chamcham*), feed *ewshedhi* (*maliko pat).* Stuff leaves*(morenkopat*), hair into mouth to induce vomiting *Guruwa* ties *joributi* around woman's big toe (*bengta*). Perform childbirth (*janmounti*) *mantra.* Pull up plants (e.g. *chakwun,* mimosa) in woman's name.

5.3 Witchcraft and the spirit world[12]

No discussion of the practices, sources of information and decision-making behaviour surrounding sickness in these Nepalese communities can avoid reference to witchcraft and the spirit world. This is because of the fundamental belief in the role of witches and supernatural beings in causing ill health in everyone, including women in pregnancy, during delivery and shortly after birth. Traditional healers, whether Magar *lamajhankris (*known as *dhamijhankri* in other parts of Nepal*)* or Tharu *guruwas*, are the local practitioners who communicate directly with the gods and the spirit world, diagnose the cause of problems in their clients, and effect treatment. They are the people through which interactions between the spirit world, the forces of witchcraft and the human world are mediated and to some extent controlled. Belief in witchcraft, the spirit world and these traditional healers is deeply embedded in many parts of rural Nepal and pervades all generational, caste and gender groups.

This section is fundamental to our understanding of all sources of information, and the impetus behind care-seeking decisions and behaviour at the individual, household and community levels. Far removed from the western allopathic model of health-care, it serves to remind us of the substantial differences in the classifications of causes of sickness, and levels of awareness and understanding within the ethnic groups among whom the NSMP is operating. Table 4.2 shows that a traditional healer was involved in ALL of the nine obstetric emergency cases described here, which account for most of the emergencies that have occurred in the study area in the last 5-6 years. Tables 5.1 to 5.4 show how beliefs in witchcraft and the harmful spirit world impinge on the health of both the mother and baby during pregnancy and the delivery period.

(a) Magar

There are two types of **traditional healers** in Ratnechaur, Myagdi:

- The most powerful is the *lamajhankri*. The *lamajhankri* can do exorcisms, and remove the most dangerous of the spirits, after entering into a dialogue with the gods or their dead teachers in order to discover the best course of action. This work requires years of training and instruction from other experienced *lamajhankris*, often older male relatives. Frequently, a *lamajhankri* receives the call to the profession by being possessed by a god (*deutale pokreko*) in his youth, and may also learn some of his skills through dreams (*mulmantra supanama gurule dinchan*). Some of the equipment for the *lamajhankri* includes *dhupdhar* (light and incense), *rudesari malla* (a bead necklace), and a *charisko tal* (brass plate to drum on). Using these, the gods are called upon to help identify the cause of the trouble and to help remove it:

  "*deuta harnle ke ke bancha, ma tye anusar kam garchu*".

[12] for more debate on this, see accompanying Literature Review

- The *dhami* is a less powerful practitioner who does not have the skills to communicate directly with the gods and the beings of the spirit world. He does not perform exorcisms. His main activities are blowing (*phukne*) on the client and on water over which he has chanted special prayers (*pani manterera*), and administering herbal remedies (*joributi*). The *dhami* may be called first, but if his treatment is ineffective, he refers to the *lamajhankri* for more powerful "medicine". As part of the *dhamis* ritual repertoire, long strips of coloured cloth (*dhojha*) usually red and white, are tied to the branches of trees. Protective charms of herbs and other items such as snake bones are also made for clients to wear around their neck, wrist or waist to ward off evil spirits. *Dhamis* outnumber *lamajhankris* several fold.

Lama jhankris and *dhamis* have their own places of worship and ritual, known as the *jhankriko mandir* or *than*, usually located in some striking natural site[13]. These places serve a very different purpose to the village shrines and temples called *maiko than* or *maiko mandir* built for worship of the gods of the Hindu pantheon[14], and the household shrines where householders worship their patrilineal ancestors (*kuldeuta*) at particular times of year. In the *jhankriko than*, the *lamajhankris/dhamis* congregate at particular times of year (such as the first day of the month of *srawan*, Jul/Aug) to wash, study, do special rites and seances, and feast. The name of this place is also invoked during their work to call up their gods and teachers.

Spirits that cause sickness among Magars

This section is based on the responses of all the traditional healers interviewed in the study. The detail was very consistent.

(i) *Bokshi*

For the Magars of Ratnechaur, fear of the *bokshi (*also called *dahini, laigami, lailogew* and *dusat*) or witch, and *ban bokshi* (forest witch) is very real. A *bokshi* is someone living who can cause harm just by looking at, or speaking about, people or their food.

Sick clients bring rice grains "*achitta liera aunchan*" to the *lamajhankri* for him to use to diagnose the cause of the problem, and determine whether a witch, a supernatural being, or a

[13] such as a cave, a large tree, an isolated river bank, or an unusual mountain boulder
[14] *mai* is a term used for gods or *devi/deuta* in Ratnechaur

disgruntled god is responsible. Then, if a *bokshi* is found, the *lamajhankri* has to persuade her to stop harming the client by having a discussion with her in a séance and promising offerings to persuade her to leave: "*bokshi lageko cha bhane, halaunchan*". This will involve a list of food, drink and other things that are demanded by the witch to persuade her to stop causing the problem. Contact with the *lama jhankri's* god or *guru* through possession may also help the *lama jhankri* decide the most appropriate course of action to appease the witch.

Most people stated that it is very important to consult the *dhamijhankri* before any move to hospital to find out whether or not a *bokshi* (or other malevolent spirit) is responsible.

> *"lailogew chaina bhane matrey hospitallai janchan, lailogew cha bhane lai janna".*

Moreover, if the *bokshi* is not first exorcised then any hospital medicine will be ineffective. This thinking has been around for a long time as people have known about the hospitals in Pokhara and Baglung for many years.

Witchcraft is responsible for many types of sickness in Ratnechaur, including those that affect a woman in pregnancy and childbirth. For example, fitting in pregnancy can be due to a witch:

> "*hamro gauma ta dherey bokshi ko kam huncha, bokshiko kam huna sukcha".*

Heavy or prolonged bleeding at any time may eventually require the attention of the *lama jhankri:*

> *"acitta herera, ke lageko cha bhane, utaune parcha banai dinchu".*

Similarly, vomiting in late pregnancy and delivery is also attributed to a household witch (*gharko bokshi*) or *ban bokshi* and treated in the same way.

Fear of the *bokshi* often means that a woman and her household will not let outsiders know that there is a woman beginning labour in the house. Doing so may mean that the *bokshi* will come and the woman will suffer a long and difficult labour. Many respondents expressed this. Here are the words of an UTBA from ward 7:

> "*yehi gaun gharko chalan bokshi lagcha bhane. Aka parcha, bokshi lagcha, lamo beta lagchan, bhanchan. Manche dekhyo bhane ta, tyo dekanaune thauma lukaera baschan*". (In this village we say that if there is a long labour it is because of the custom of being afflicted by witches, or by the evil eye. So we avoid being seen by the person that could do that to us).

Getting rid of the *ban bokshi* is very dangerous work. The *dhami jhankri* and several assistants need to go to the forest at night and do *puja* in the name of the afflicted person. After making a diagnosis from the *acetta*, finding out what to do from a

conversation with the *bokshi* during an séance, and what the *bokshi* wants (*bidipuruwek*), the *dhamijhankri* will take *chuira* (beaten rice), *pote* (hen), *aina* (mirror), *supari*, *dori* (string), *dhoko* (basket), abir *(*red *tika* powder), kaiyo, and other things to the forest for the exorcism:

"*laera, banma logera puja garnu parcha".*

(ii) *Dokh (dokhalo)*

A *dokh* is the restless ghost of someone who has died a violent or untimely death (*bikalle mareko*) or died young. For the pregnant woman and the *sutkeri*, the ***chureni dokh*** is the most feared being from the spirit world: the *chureni dokh* is the ghost of a woman who died during pregnancy, giving birth or shortly after birth (before the *navaran* ritual).

If identified by a *dhami jhankri,* substantial animal sacrifices are required to appease the *chureni dokh: "dokhlai shanti huncha".* For the mother of a son, a cock (*kukurako balle*) or goat (*boka*) and a hen (*pati*) are required; for the mother of a daughter, two hens. The woman's own brother is summoned to participate in the ritual that can only take place on a Sunday or a Wednesday, not on other days. *Chang* beer and other meat are also necessary for the feast. If a woman dies in late pregnancy or during labour but before the child is delivered, the baby will have to be removed by cutting the woman's abdomen open (*pet chirera*)[15]. This is necessary because the two bodies cannot be buried together: doing so will anger the ancestral spirits (*pitrini*) and the mother's spirit will become a *chureni dokh*. Both bodies are buried in the *pakho (*open ground), and not cremated at the local *ghats* or the Kali Gandaki river. *Dhup dhaja* (incense and cloth strips) must also be provided.

(iii) Mojh

A *mojh* is the malevolent ghost of a dead baby or infant. It is a dangerous spirit that particularly attacks *sutkeri'*s and newborn babies. Most women themselves attributed any problems that their new babies had to the harmful effects of the *mojh: "mojhbata ho".* People guess this themselves and call the traditional healer.

A *lamajhankri* can deal with a *mojh* using his knowledge and skills. He first finds out what the *mojh* wants through a séance. Sacrifice is usually required to persuade a god to kill a *mojh* that is affecting a client:

[15] noone could give us any concrete example of this having been done in the area recently, or anyone who had seen it done. Most people merely said : that's what is supposed to happen

"jhankri (jhak) basera, mareko buccale jun marne. Hamro gyanle marne ho. Tyele saman jutaera, sojhera taraeram kelaincha, kam suru garne".

Ghee, honey, and milk are blown on and then fed to the mother. Then the *lamajhankri* goes to a crossroads at night to sacrifice an old goat or a hen, sprays the blood everywhere and then returns to the client's house for more blowing (*phukne kam*), *mantras* and a feast of the sacrificial food. Then the next baby will be fine.

Once a new baby is delivered, it is important to avoid attracting the attention of a *mojh*. This means being careful to cover the placenta and putting it where so no-one will see it to avoid the risk of the *mojh* knowing that there is a new baby in the house. If a woman keeps having dead babies it is because of *mojh*:

"*bucca junmaune, bucca hune, bucca jane, pheri hune, pheri jane – yo mojhko kam"*

To protect a new baby from the *mojh* (especially if mother has already lost a baby) the *dhami jhankri* will make them a protective pouch charm called a *buti* with herbs and other things for the baby, and feed *joributi* to the mother.

(iv) *Picas*

A ***picas*** or ***pisas*** is a ghost or *bhut* that floats around in the air and will attack vulnerable sick people including pregnant women particularly when the wind is blowing, or when there is fog. *Picas* are usually the unhappy ghosts of people who had problems such as lack of hearing or sight, some other disability or those with poor *karma:*

"karmana chalaeko, pino na dieko, bhiana bhaeko"

Appeasing a *picas* (or other *bhut*) involves making a clump of multi-coloured cloth strips (*dhaja*) and tying them somewhere, saying:

"timro bhag yehi ho, aba hamilai chora"

(this is your share, now go away and leave us alone).

Chicken sacrifice is also usually required. Most traditional healers mentioned that it was always necessary to appease the *picas* before taking anyone to hospital:

"aspitallai janchan bhanda pahila, yahako picasharulai panchaera matrey laijanchan".

(v) Pitrini

Pitrini, pirit*, or* ***pirta*** are the restless spirits of ancestors who have often died away from home. They need to be persuaded to go away by the traditional healer:

"*kulpitra lageko bhane utaera chordinchu*"

Pitrini only sometimes effect pregnant and *sutkeri* women, and are not as dangerous as the *bokshi, mojh* or *chureni dokh*. If a *pitrini* is caught causing sickness by the traditional healer, a ritual involving *tantramantra* and blowing is required.

"sat basko sipka, meyle dinchu phu garera samatna dinchu, yo pitra lageko manchelai. Tyo aphey bolna talcha"
(I sit down with seven sticks, blow on the affected person, and drum the brass plate. Then the *pirit* speaks through the voice of the sick person and says who it is: "*ma pahile mareko manche chu*", and also what it wants. All this is called *tantramantra* – then I feed it and the person will get better).

To ward off potential mischief, traditional healers perform a yearly ritual (called the *duleherlo)* for the *pitrini*[16]. This involves making *chang* (beer) catching fish in the river, cooking rice and *roti*, and ritually feed the pitrini. Failure to do this properly will bring misfortune: nothing will go right, things will be spoilt and people will be sick.

(b) Tharu

There are several kinds of traditional healers in Kotatulsipur, with a confusing variety of titles. ***Guruwa*** is the collective term used for all of them. However, there are three basic types. These have different skills and functions that need to be understood in relation to their dealings with sick clients and the beings that cause illness:

- The most powerful *guruwa* is the ***buihiruwa* or *desbhandia.*** He looks after the village gods (*deuta*) and does *pujapat* (worship rituals) to them at the village shrine (*maruwa; deuta than* in Nepali) twice a year. These rituals are to ask the gods to spare the villagers from disease and natural calamities *(havaibatas chalcha*, *saisumput baibarkat*):

  The more important of these two rituals is the *lowangi puja* held in the Nepali month of *mangsir* which is called *aghan* in Tharu (Nov/Dec). Every household has to send a representative. *Rakshi* (*daru*) and rice (*camal*) are taken to the *maruwa* and sprinkled over everyone. Then the *desbhandia/biuhiruwa* calls the gods into the body of the *keshaunkar* who then demand offerings (*prasad*) such as *rakshi*, sacrificial meat (*bhakal*), *battasa* (sweet balls). This *puja* also involves the piercing of the *guruwa's* tongue with an iron trisul (*jibim tursul chirena*). The blood that falls is used as an offering to the goddess Kali.

  The second of the annual *maruwa pujas* is the *Dhuria or Hareri puja*, performed in the Nepali month of *jestha* (May/June) around the time of rice planting. This *puja* is only attended by men *(tharu, kisanlog*) and involves the invocation of the goddess Tara: at this time all women go

[16] This is supposedly similar to the Bahun's *saradi* ritual for the dead.

out of the village to sleep, cook, and stay for a few days. Another *puja* called the *Bajhihar/Bajahar puja* is also done at this time. This is for the protection of the rice fields from diseases and pests, especially the *gandi kuji* and the disease known as *dahiya.*

- The next *guruwa* of importance is the ***keshaunkar***, a *guruwa* who, like the *desbhandia,* can achieve possession by the gods: *susaunne* (Nepali *deuta aune*) *guruwa*. He works together with the *desbhandia* and was described by some as his apprentice or student*: chela*. The *desbhandia* does the *duruha/acetta herne* (see below) and makes contact with the gods who tell him which spirit is causing the trouble, and then the witch or *bhutwa* is grabbed *(samatcha*) by the *keshaunkar*[17]. The common practice is then to nail (*thokthak*) the offending spirit to a tree or a wooden post so that it can no longer cause trouble. Only those *guruwas* who are favoured by the gods can attain these skills.

- There are a number of collective words for all other ***guruwas****: dorahia (buneyna guruwas*), *gharguruwa, karduniya*, or *acharahua.* They can all read the rice grains to make a "diagnosis" (*achetta banaune*), know the appropriate ritual incantations (*jantamantra*) for what they diagnose, can do blowing (*phukphak)*, and can do the appropriate ritual sacrifices *(achar)*. Any of these can be called to a sick person, including a pregnant woman or a *larkoria*, and who comes will depend on who is the nearest and most quickly available.

All *guruwas* have the potential to be *desbhandias*. Their promotion by the village depends on their skill and experience, and their success rate. As one *guruwa* put it: to look after the village you need a lot of knowledge "*gyan*". Selection is determined by *kojnebojne* by village household heads at the *bhalemansa'*s house (see the section on *bhalemansa*, 5.8 b). Almost all *guruwas* learn their craft through older men, usually their own relatives, so that it could almost be said that the profession is inherited.

There are several types of rituals *(puja)* conducted by *guruwas* in addition to the ones mentioned above:

- Preferably performed by a *desbhandia/biuhiruwa* or a *keshaunkar guruwa,* the ***Darahia*** *puja* is performed twice a year, in the Nepali months of *jestha (*May/June) and *kartik (*Oct/Nov) for each married woman in the house. If this is not done, then babies will be sick and women might be sterile.

[17] This is the fundamental difference between the Magars in which the *jhankri* works alone calls the *bokshi* into his own body and speaks in his voice. Among Tharu, the b*okshi* is called by the *desbhandia* but grabbed by the *keshaunkar.*

- All *guruwas* can be called upon to do the ***janmounti mantra***. The *puja* will please the gods and goddesses[18], benefit the delivery process, and create a happy and auspicious environment for the new baby. This will usually be done after the baby has been born in a straightforward delivery, or at some point during labour if there are complications, such as long labour (over several days and nights), or the delayed expulsion of the placenta[19]. At this point, many *guruwas* will also ritually pluck certain plants in the name of the *larkoria* for things like long labour and retained placenta (e.g. *ultakud* - a root, *chakwun* - mimosa). A *janmounti mantra* should not de done if there is another pregnant woman in the same house as this might cause her to miscarry. The *janmounti mantra* also contains some verses that call for the speedy expulsion of the placenta.

- The most common work done by guruwas are *pujas* for the evil eye, and for relieving many types of sickness involve looking at the rice grains, incantations, blowing and making ritual offerings (collectively called an *achar, or duraha lowseta or* **gurey** *garaihey*). There are several parts to this ritual:

    Reading the rice grains - achetta herne: this involves looking at rice grains on a brass plate, tapping the plate and chanting incantations and humming[20]. Other things needed are red and black *tikka* powder, pieces of wood, and strips of red and white cloth for tying around a stick and burying on a path. The *guruwa* sits facing west and circles lighted wicks (*patibeytney*) over the offerings. This puja tells the *guruwa* what the problem is likely to have been caused by and what sort of *gurey puja*, or other action, he will need to take.

    Ritual offerings - duraha* or *achar lowseta: this part of the ritual involves the simulation of ritual offerings to the gods by giving *tikka* to "sacrificial" chickens. This was observed in Sungurkal (see photo). The *acharahua* is seen sitting behind his ritual grid, giving *tikka* to two chicks (*kukurako chulla,* one male *chingra,* and one female *chinguria).* This *gurey puja* was to protect his breastfeeding daughter-in-law from any harmful effects of *bhutwa: bhutwalai manaune*. Alcohol (r*akshi)*, water (*jal*), copper coins, flowers, cloves, cardamom, oil, hard-boiled egg, and other things are needed for the *gurey puja.*

- *Guruwas* also have a role in periodic ceremonies for the household gods in which households give a feast for their peace of their dead ancestors

[18] most commonly *bhagwatimata* and *saraswatimata*
[19] For all of these the *guruwas* stay a little outside the *sowri*
[20] These incantations were not understood by the NSMP facilitator

In terms of their **role in reproductive and obstetric health**, *guruwas* claim to be able to treat sterility and irregular menstruation (*katjeyt*). The *guruwas* that we spoke to said they have dealt with headaches, bleeding, vomiting, but not fitting (though have heard of it being done elsewhere) in pregnant woman, and bleeding and retained placentas during and after delivery in *larkorias.* When *guruwas* do a *gurey puja* for a woman in labour they do not see her but do it nearby.

An important finding was that, although most agreed that *guruwas* are called for most sicknesses in Kotatulsipur (*jun sukey bela)*, the difficulties sometimes faced by women in pregnancy and delivery have a **low priority** in the scheme of the *guruwas* work. The *desbhandia* and *keshanunkar* said that they did not usually assist in the case of a sick pregnant woman or *larkoria*, unless it was a very serious case. This was mainly because they were seen to be too important and the work required for the treatment of most *larkoria* is simple (*sano kam*). It would thus be beneath their status. They say that this sort of minor work will be done by the other more junior *guruwas*. Attacks by *jumjut* and *chiurenia* on individual women during childbirth are not seen as important and are only worth the attention of the lesser village *guruwas.* They are not the concern of the most senior or experienced who involve themselves with the good of the whole village and the things that determine its survival: crops, epidemics, animal fertility, water supply, and weather conditions.

Spirits that cause sickness among Tharus

Tharus believe that the fundamental cause of all sickness is **god's whim**: "*deutaharako jus*". The gods can get greedy or jealous or dissatisfied if people to do pay them enough attention, and can summon up harmful forces that cause sickness and trouble (*khankinj*) in the human world. In the words of a TBA, Tharus are: *bhutwaha jai ho* (a *jat* that believes in *bhut*). In the words of a *guruwa*: we have every kind of wind and every kind of ghost:

"harek kisimkey beyal, harek kisimkey bhutwa!"

The spirit or **ghost** of a dead person is called a *bhutwa.* If this *bhutwa* is unhappy it might come back to its house and frighten the occupants. Bhutwa cause also cause a wide range of illnesses including pneumonia[21], leprosy, cough, fever (*juribukar*), and many other conditions. There are also ghosts that stick to particular houses (*khardunna bhut*) and those that roam about (*dunniyako bhut*).

[21] caused by the maribhut called survasringar mari

Tharus also believe in **witches** (*bokshiniya*). These are real people who can also attack those who are sick (*bhadra bigral, koke bigryo*) and vulnerable. A woman in *sowri* and her newborn are particularly vulnerable to attacks from witches and *bhutwa*. If witches and *bhutwa* are found to be causing sickness, then the *guruwa* needs to be consulted to make the person well (*subhisatha/chikun hugil*).

Here are the main sickness-causing beings in Kotatulsipur:

(a) *Jumjut, jumrogh*

The *jumjut* is the most dangerous for humans, and particularly so for newborn babies as it can even kidnap them away and take them into the jungle. This is why a *larkoria* should avoid going into the jungle or near particular favourite trees such as the *simal* and the *aphorrukh* (*jumjut lagat*). A baby that dies in childbirth or shortly afterwards, and whose body changes colour before death, is believed to have been attacked by a *jumjut* (*jumjut rogh lagat)*. What we might term a cot death is also believed to be caused by the *jumjut* coming into the *sowri* and squashes the newborn baby while trying to sleep with its mother. The *jumjut* is also dangerous for pregnant women. It can disguise itself as the husband and sleeps with the wife. If the woman gets pregnant with the *jumjut*'s child, she will have problems (such as obstructed labour, retained placenta) at childbirth, and could even die.

(b) Chiurenia and dunuwa

The *chiurenia bhutwa* is the restless spirit of a woman who has died during pregnancy (*gharbhachurel*) or in the *sowri.* It is the most dangerous spirit for mothers and their babies, and can be fatal. In pregnancy the woman can be attacked by the house *chiurenia* (*gharbe chiurenia ait).* A *larkoria* in her *sowri* is very vulnerable to the *sowriya chiurenia.* She is also at risk if she goes outside, and there are some particular places she should avoid, such as the jungle, riverbanks (*ghatbhat*), or near the banana tree (*kiyarama chiurenia ya rahat*). The *chiurenia* will follow a *larkoria*, find out where the baby is, and then pinch it (*chiktat*) to make it cry all the time. The *chiurenia* is also dangerous for pregnant women. Much like the *jumjut,* the *chiurenia* can disguise itself as wife and sleep with the husband. If the *chiurenia* gets pregnant with the husband's child, then when the woman next gets pregnant she will have problems (such as obstructed labour, retained placenta) at childbirth, and could even die.

To get rid of a *chiurenia*, two *guruwas*, and preferably including a strong one like the *keshaunka*r, will go to the jungle with *rakshi* and

water and look at rice grains to call the gods. Then the *keshaunkar* will become possessed and, with his incantations, will grab the *chiurenia*, immobilising her by nailing her to a tree with iron nails (*kata*). The *chiurenia* likes offerings of red *tikka* powder (*sindur*) in her *prasad*, and rakshi and meat. Such puja has to be done outside the village.

The *dunuwa* is the partner/husband of the *chiurenia*. Together they work as a team. The *dunuwa* lives in big trees in the jungle, especially ones that drip sap, such as the *pipal* and the *bar*. The *dunuwa* will take the place of a baby and drink all the breast milk and sleep with the *larkoria*. Meanwhile the real baby, deprived of its mother's milk, will get sick and may die.

(c) Bokshiniya

This is the cause of all the trouble. The *bokshiniya* is a living person, usually a woman although it can also be a man, who has sinned a lot (*papi*) and dislikes other people. The *bokshiniya* doesn't often do the harm herself. She sends the *chiurenia* to do harm to particular people, and the *chiurenia* can't do anything without the command of the *bokshiniya*.

(c) General comments

In addition to the details described, there are some generalisations and observations that can be made from the data about the traditional healers in these two areas.

***Ethnic differences*:**

There are many similarities between the roles and work of the Magar traditional healers, and the *guruwas* of Tharu Kailali. The Magar *dhami* who just does blowing (*phukphak*) and ritual incantations (*mantras*) but no exorcisms is similar to the Tharu *guruwas* who perform the *gureys*. In contrast, the Magar *lamajhankri* who can communicate with the gods (to find out what to do) and the spirit world (to find out their demands) has a more extensive repertoire which goes beyond simple blowing and incantations to spirit possession and exorcism. He is similar to the Tharu *deshbhandia* who uses the *keshaunkar* as the mouthpiece of the gods or spirits in the seances. *Lamajhankris* and *deshbhandias* have more knowledge and experience and thus more power and prestige in the community. For both areas, the key belief is that the traditional healer needs to call up the gods to send the harmful spirit away. Without the traditional healer interacting with the gods, the spirit, and thus the sickness, will not be solved.

However, there are differences too. The *guruwas* say that there are different *bokshi* and *bhut* in the hills. There is also a fundamental difference in that the *lamajhankri* can call the gods and spirits into his own body and speak in his voice, whereas the *deshbhandia guruwa* calls them so that another *guruwa* (usually the *keshaunkar)* can grab and immobilise them (by nailing to a tree).

Role in the community:

There is no question that these traditional healers are very important to community members in diagnosing and treating sickness:

> "*yo chalan thiyo - ajhey cha*" (it was the custom, and is even today).
> *"yeti kina sikista birami bhayo bhane, lamajhankri jane chalan thiyo. Gayo pacchi sancey pani huna thiyo, atharbar sancey pani hundeyna thiyo. Kehi cheyna, lamjhankrisaga bharba koji garnu parthyo. Ahile pani janchew, janey paryo". (whatever the type of sickness there was the custom of going to the lamajhankri. ***)*

The experienced low-caste UTBA in Jamrakot, Myagdi said that a traditional healer was called at some point to <u>all</u> the deliveries that he has attended. Traditional healers say they do not expect much payment for their work beyond the food associated with a treatment, and sometimes cash according to people's means. In the words of a *guruwa* from Kotatulsipur: "I don't get paid. It is my duty (*khartabey).* However, community members themselves complain that some traditional healers are more "greedy" than others.

Both *guruwas* and *lamajhankris* acknowledge that they have the greatest success in dealing with what we would term psychiatric conditions. In Tharu the term *borel* denotes madness: in Nepali this is *bowla*. Jungle *pujas* involving nailing down *bhutwa*, all-night seances surrounded by family members and friends, and sacrifices of meat have a high rate of success in these types of cases. Many highly educated and well-travelled Nepalis frequently consult traditional healers for such conditions.

Signs of change:

Almost all participants, including service providers, still thought that it necessary to consult the *lama jhankri* or *guruwa* before going to hospital:

"*Tharujat binaney guruwa baleyla ney jewey huit aspital*" (TTBA ward 7)

Some traditional healers told us that they are referring people, including women having difficulty in delivery, to hospital. In the words of a *dhami* from ward 8 talking about long labour:

> *"pani manterera phukera dinchew : hunerey yehi huncha, nahunelai aspital lai jane baneko chu"* (I give water which has been ritually treated and blow. If this works, then fine, if not, then I tell them to take to hospital).

However, it was not easy for us to find actual cases. Signs of change are perhaps restricted to traditional healers knowing that it is a wise strategy to claim that they are making referrals. An investigation of the "referred by" response to questions on reaching hospital might be a useful future line of inquiry.

Relationship with the allopathic medical system:

The relationship between the traditional healers, and the private and governmental practitioners in the western medical system, cannot be described as one of mutual trust and respect. Magar *lama jhankris* complained that they are not served in medical shops once shopkeepers come to realise who they are. The arrival of hospitals is not viewed as a positive development by many *guruwas*. They say that this has coincided with the arrival of new diseases. Years ago, they say, their *guruwa* forefathers treated dysentery (*haiya*), typhoid (*mahamari*), measles (kosra), and snakebites but there were no diseases like encephalitis. They also claim that doctors in hospitals give date-expired medicines that can kill people. In contrast, both the guruwas, and the community in general, had considerable faith in the private medical shops in Semri and elsewhere. This may be based on good experiences with treatment but may also be due to some shop owners are themselves being Tharu, being available out of hours and apparently willing to sell medicines on credit.

Herbal remedies:

The role of herbal remedies is important. This study did not collect much detail on what is probably an important area of investigation in relation to treatments for conditions in pregnancy, delivery, post-partum and post-abortion. A Magar *lamajhankri* did admit that *joributi* from the forest (such as *nilmusi*) and *buttis masala* (a preparation available in the bazaar) are given by traditional healers to women to regulate the menstrual cycle and for menstrual problems, and for vomiting in pregnancy (if this has first been found not be caused by a witch):

> "*laigami lageko cheyna bhane, kochurlai phukera khana dinchu*".

Tharu guruwas also make use of herbal remedies and jungle medicine but were more reluctant than the *lamajhankris* to give any details.

5.4 "Life threatening" or fulfilling one's fate?

Objective 1 of this study was the identification of situations classified as "life threatening". It could be argued that this is a term that can only be interpreted in its western medical sense. Participants of this classified some conditions as normal, to be expected in pregnancy and delivery, and even if they were uncomfortable were nothing to worry about (e.g. headache, vomiting, bleeding, oedema). Other conditions were more serious as they represented some sort of abnormality for which diagnosis and care should be sought (e.g. heavy clotting bleeding, retained placenta, long labour). However, even these conditions were not life threatening in themselves, but were only so if the spirit responsible was particularly strong, the person affected particularly weak, and the traditional healer consulted unable to cope. All these will be pre-determined by the person's fate, which is the only thing that can determine the termination of life.

Participants were asked whether they agreed or disagreed with the statement: when a woman dies during childbirth it is due to her fate. There is nothing anyone could have done to save her". With just one exception, everyone agreed with it.

Magars used the word "*pitho*" for fate (literally your flour is finished). Other common expressions were:

"*lekhanta pugera maryo, alpakalma maryo"*, and
"*nimtimey yestey re cha, yaha babile lekhderecha* (her time was this, god had written it on her forehead).

In terms of what this means to women about to give birth, there is an acceptance that some women will have difficulty and die while others will not. For those who have difficulty, beyond the normal recourse to UTBA/TTBA, traditional healers, the medical shop, and maybe lastly the hospital, there is nothing anyone can do to prevent death if fate intervenes. There was little sense that some conditions were life threatening and would result in death if not treated:

"payo ramrey payo, napayo bhane, maryo"
(we either give birth well or we die – Magar mothers).

Beliefs amongst Tharu were much the same. Expressions about the lifeline being finished (*manna woragilis, siddha woragilis*) and fate being written on your forehead (*bhagye lekhal ewtra ralehis*) were common among Tharu participants. Young Tharu men said that seeking the appropriate care is important (if it's a *bhut*, get a *guruwa*. If it's not then get a doctor), but whether she lives or dies will depend on her credit (*myad*). Old Tharu women in Kotatulsipur attributed a miscarriage (*angga jancha*) to:

"bhagwanko lila, dusmanko khel"
"god's will or an enemy's play (e.g. sending a witch or spirit)".

Another woman (case 5) described life and death for women in delivery being due to:

"*apan bagh, guruwankey jus" (*your luck and the guruwa's power).

For their part, the *guruwas* themselves said that if their *gurey pujas* fail to work then whatever happens will happen according to god's will: *bhagwanko barosa/boros*".

5.5 Decision-making and care-seeking behaviour

Analysis of the data revealed that there were a number of important determinants of decision-making and care-seeking behaviour common to both areas visited in the study. This section looks at each of these as separate themes.

The whole process of seeking care in an obstetric emergency begins with the woman's own personal threshold of what constitutes a difficulty. Before looking at who is called, why and when, we need first to look at what influences a woman in making her initial decision to let others know about her condition. It appears that two things largely determine this:

- the woman's own level of knowledge (depends on sources of information – see section 5.6)
- her ability/inability or willingness/unwillingness to express what is happening to her to others (shyness, shame, fear)

Beyond this, things beyond the woman alone determine care-seeking behaviour, mainly by:

- the type of people around her who will make decisions
- the proximity and availability of the care provider/s
- community beliefs about the appropriateness, cost and efficacy of care provider/s
- the time involved in the sequence of decision-making and actions that she and other people make (delay)

We begin with the woman herself. This is followed by a consideration of when decisions to seek care are made and what delays are involved, and who makes the decisions.

(a) Shyness, shame (*laj*) and fear

It is difficult to know whether *laj* means shyness or shame. *Laj* is a complicated and multifaceted phenomenon that permeates so many features of daily life that it is difficult to analyse, and participants themselves have rarely, if ever, done so. Nevertheless, some attempt is necessary, as *laj* is the main reason that most women, and men, give for the delay in seeking care of whatever sort in an obstetric emergency.

Almost everyone agreed with the true/false statement: bleeding is shameful. No woman should talk to anyone about it".

"*Takkey milcha"*, they said, and "*sabhandha laj ho*".

Only the young *bhalemansa* of Sungukal disgreed:

> "*yehi thik ney ho. Laj manna. Apan jivan buchaik parel* (no, that's not right. We shouldn't be shy. We should try and save our own life).

Examples of *laj* causing delay in decision-making and care-seeking behaviour at times of obstetric emergency can be found in the Case Studies. Here are a few more examples:

> In her 9th month of pregnancy, a 36-year old Magar woman recalled how she started bleeding (*khun ayo*) early in the morning before anyone in the house was awake. She didn't want anyone to know so she sat outside on the verandah trying to cover up the increasing pool of blood with her clothes. When she heard anyone coming near she pretended to be asleep. Eventually her mother-in-law (*sasu*) asked her why she was just sitting there but she still didn't say what was happening. She was too shy/ashamed (*lajre saramle*). Her sister-in-law then saw her, guessed that she was probably in labour and told this to the *sasu*. It was only when the *sasu* asked a direct question that the woman admitted that was bleeding heavily and her contractions had begun.

> An untrained Magar TBA was 18 years old and in her first pregnancy. When she was 9 months pregnant she tripped over and fell down while carrying a heavy load. No one was around. Her in-laws and husband were away. She noticed soon after she fell that there was no movement from the baby but she didn't know what to do (*thaha ney*) and didn't tell anyone what had happened. About a week later contractions began very slowly and there was some bleeding. She still told no one out of *laj*. One morning she went to cut grass and fainted when she got home. Her husband called another UTBA for help. She gave massage and fed glucose water. The baby was born dead.

In the Tharu area, beliefs about *laj* are much the same. Unmarried women could not be persuaded to talk about how they felt about menstruation (*bahira sureko*). They would not even mention the word blood when we asked them what happened, they merely said that they had stomach pain (*pet pirel*). When we tried to probe, they eventually retorted it is not our custom to talk about such things with strangers and they only do so sometimes with their closest friends. "Hill people (*paharis*) might talk about this, but we do not", they said. One said: "I have been menstruating for four years but I still haven't been able to talk about it to my mother – she also hasn't asked." These girls greeted our questioning about telling anyone when your period is missed with much embarrassed laughter:

> "How can we tell anyone this, we're much too shy. We may be happy about it but we can't speak of it. Everyone will know when the belly swells and the baby will come so why bother to speak of it. You just count the months yourself".

Old Tharu women said that menstruation is the first time that a girl learns how to be shy (*laj*). She must hide her blood from others and keep away from the temple and the household shrine (*manjari*).

***Laj* is not just related to bleeding**. It can relate to any event in the pregnant and post-partum state. A 40-year old Magar woman spoke of her shyness to tell even others in her family that she had felt the baby move, and admitted that she would not have been able to tell anyone if she thought the baby had stopped moving. Similarly, most Tharu participants said that *lajgye* stops them telling people they are pregnant. They just wait for others to guess when they see the swollen abdomen (*pet bharri dekhera)*. Tharu grandmothers seemed to think that girls today are not as shy as they were themselves. In their time they wouldn't talk about it with anyone – just wait until pains started and then call the TBA and only then when she asked about the timing of the missed period would they begin to talk. These older women could not even say the word for pregnant, and used expressions like *tira/dir hina* (large abdomen).

***Laj* is not just related to a woman's reproductive state.** It is found at any time that a woman becomes different, or is required to speak or act outside her normal homebound position. A Tharu Ward Chairman recalled a recent village meeting when all women were called and asked to state their names. They all ran out of the room. The same meeting was convened in a neighbouring village, but this time the organisers locked the doors so no one could run away. Eventually everybody said their names, and listened. In Ratnechaur, the hardest group of Magar people to talk to was the young women. In eight days living in the village and talking to many people, no young women at all came forward until the last evening. While this may have been due to heavy workload at the time, it was also due to shyness. At the beginning these young women could not even be persuaded to say their names. In this sense, *laj* has its roots in the gender inequities in society in which women are at best not expected to, or at worst, prohibited from, speaking aloud about personal matters. Old Tharu women confirmed this when they said that women have more *laj* than men. For their part, men say that they generally do not ask their wives intimate questions which would make the women shy.

From the data, it is clear that *laj* is frequently synonymous with fear: fear of social sanction, of what people might be saying**, fear of a loss of prestige.** In this sense it is more like **shame**. This was expressed by a group of Magar mothers who said:

> "We don't tell people (when we have difficulties in pregnancy and labour) because they would all laugh and say "why are you bothering to tell us. It happens to us all and it's nothing special so it's not necessary to broadcast it". If we speak then our prestige will go, people would talk badly of us: *hamile bhanera ijjatle garda, kura katchew"*.

People are generally critical of those who make a fuss, a scene, especially the most junior women in the house (the *bowari*, the daughter-in-law). Tharu grandmothers said that if a woman has a long labour people will say it's because she told other about her condition when she should have kept quiet. They also agreed that household prestige is the most important thing and this determines *laj* behaviour: *ijjat ta subsey bharre lah ho".* Magar grandfathers said that speaking of some things, like bleeding, is a "sin" which will bring a loss of prestige (*ijjat, risivi*) on the house. Why is this so important? It is important because social status and restrictions of social mobility define and maintain the *status quo* in Nepali society.

Laj may also be a cover for **fear** (*daraune*). Magar women made the point that many women nowadays are shy to speak about being pregnant because, in these days of heavy family planning education, if they already have several children people might be very critical.

Fear of attracting the malevolent attention of the *bokshi* is also often cited as a factor for keeping quiet about the state of pregnancy and delivery. The Brahmin MCHW in Ratnechaur admitted that when she is called out to attend a *sutkeri* she is usually asked not to tell anyone else the real reason for the summons but to say she is going to attend a sick child or old person. This is to prevent a *bokshi* finding out that she is going to a *sutkeri* place and following to cause trouble. "Once labour starts", said a Tharu mother, "we should shut all doors and windows so that the bokshi doesn't hear. We will call the UTBA/TTBA and *guruwa* but we do no make it widely known". The young men also gave this explanation for keeping quiet about the start of labour:
"*bhut lag jeyhi keyke aura jahan te ney buttaik pane*".

(b) Decision delays

We have seen that a woman's own sense of *laj* is an important factor affecting the time taken to make a decision to seek care. This may only happen when the woman feels so sick that she can no longer do her work. In the words of a Tharu FCHV:

> "*jabasam kam garaseki tup sum ney batheyhi* (as long as you can work you don't tell anyone)".

"Eventually", says a Magar grandfather, "just like you know when you're very hungry and you have to ask for food, so when a condition gets serious you have to tell someone about it because your soul (*attma*) is crying".

Firstly, **whom does the woman tell**? Frequently this will depend on who is nearby in the immediate family, her husband, and her **mother-in-law**, father-in-law and sister-in-law. Women are not encouraged to tell their mothers or sister from their maternal home, and it is considered inauspicious for a baby to be born in the *maiti*. Much will also depend on the relationship and sympathy (*dailo chan)* between mother-in-law and

daughter-in-law, said a 40-year old Magar woman, soon to become a mother-in-law herself. If you have bleeding after birth, the amount of work you will be asked to do depends on the *sasu*. A young Chhetri FCHV in Ratnechaur complained that she is not permitted to go for antenatal checkups by her *sasu.* In both areas, the *sasu* is a key decision-maker regarding a daughter-in-law's health, and she is often the first to know about the labour. The male UTBA of Jamrakot near Ratnechaur is almost always called out to problematic deliveries by the *sasus*. Many *sasus* also do much of the dirty work (*gin lagne kam*); cutting the cord and burying the placenta.

After family members have been told, **who is then called or consulted**? Which care providers are the most frequently used? While there were some exceptions,

Table 5.5 generally summarises what the data showed as the pattern of care-seeking behaviour:

Table 5.5. Most common care providers, in descending order of priority

	MAGAR			**THARU**		
	Care provider	***Time***	***Cost***	***Care provider***	***Time***	***Cost***
1	*Lamajhankri*	*	*	Mother and *sasu*		
2	UTBA	*	*	UTBA +	*	*
3	Health post staff	**	*	*Guruwa*	*	*
4	TTBA #	*	*	Medical shops (Semri)	*	**
5	Beni medical shops	***	**	Health post staff	**	*
6	Beni hospital	***	***	Hospital / clinics in India	****	***
7	Baglung medical / clinic	****	***	Dangadhi Hospital	****	***
8	Baglung Hospital	****	****			

all the TTBAs in this area have only recently been trained
+ there is only one TTBA nearby, in ward 7

The general picture emerging from **Ratnechaur** was as follows:

- The woman and her *sasu* usually try and manage the birth themselves

- Some may decide to call the UTBA/TTBA[22] when the second stage of labour starts, when the pains are so strong that the woman can no longer do her work.

- FCHVs may visit and suggest the health post or hospital.

- At this stage, senior family members may decide to call the *lamajhankri*. Sometimes if the first is not successful a second one is called.

- Someone may go to the health post or Beni for medicines or bring back the “doctor”.

- The ward chairman or VDC Vice Chairman may be asked for advice and help. The traditional Magar system of reciprocal help (*arma parma)* may be activated (see section 5.8).

- After all this, the *lamajhankri* or the UTBA/TTBA usually have the final say on referral to hospital.

The general picture emerging from **Kotatulsipur** was as follows:

- The woman and her *sasu* usually first call the UTBA/TTBA when the second stage of labour starts, when the pains are so strong that the woman can no longer do her work. This might be a long time after her contractions have begun, or after waters have broken (see case 5).

- If the UTBA/TTBA[23] has trouble, a second UTBA may be called. Many people said that it was unnecessary to take people to hospital as the UTBA/TTBAs can manage everything: “*aspital ney jarit parat. Sureyni kam gaidarat*”.

- If FCHVs are consulted they may be the first ones to suggest the health post.

- At this stage, senior family members may decide to call the *guruwa*.

- Often more than one *guruwa* is involved in a treatment. If the first *guruwa* has no success he will call on others in turn, often

[22] although there are a few trained TBAs in the area, people mostly call the UTBAs
[23] only 1 TBA in the area

according to seniority, starting with the most junior and working upwards. If it is decided that a ghost needs to be nailed down (*bhutwa tokne*), then two *guruwas* need to work together, and one of these should preferably be the *keshaunkar*, who may not be immediately available. This can take considerable time and will certainly contribute to the overall pattern of delay in seeking appropriate care. In Kotatulsipur ward 7, there were about 11 *guruwas* within about 30 minutes radius.

- Someone may now go to the Semri medical shop for medicines or to bring back the “doctor”.

- The *bhalemansa,* ward chairman or VDC Vice Chairman may be asked for advise and help. The UTBA/TTBA might also decide to call the *bhalemansa* if she thinks that the condition is very serious. This may cause even more delay as it will take time to call the *chowkidar* and send him to call people for a meeting, and then have the meeting to make the decisions.

- After all this, the *guruwa* usually has the final say on referral to hospital.

There can be any **number of delays** (Tharu: *garduk*) at each of these stages. People may not be available immediately. Guruwas and UTBAs may call others and discuss the problem. The community leaders may need to call a meeting and organise assistance. Added to this, there is fear. No one will want to suggest a long journey as there is a fear of dying on the journey, and the person to have suggested it will get the blame[24]. People will start to speak that the person might not have died if she had stayed at home. The NEWAR FCHV of ward 8 in Ratnechaur expressed this:

> *“parhe lekheko bhae pani, budy matrema lamajhankrika biswas garcha… dherey gardeyna. Antim pugera bulla ho. Antim pugera matra garcha. Antim pugera gae pachhi ta bacna garho huncha. Pheri health post garda maryo “yehi bac thiyo ki, yehi laeko ho ki ?”, bancha”.*

This woman expressed concern that if anything happened to a *sutkeri* woman who was taken to hospital on her advice people would lay blame on her if anything went wrong. This would then hamper future relations with, and her reputation within, the community. So there was a reluctance to insist, and a hope that family members themselves would take the initiative and make the suggestion.

The **cost** involved in a trip to hospital can act as a deterrent and cause delay, as people discuss whether it is really necessary and try and find the money required. A Magar *lamajhankri* said:

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[24] this might suggest that a wide dissemination of messages would help “spread out the blame”

> "*yahako chalan ke cha bhane, pahile aspital logyo bhane paisa dherey karch huncha, bimari pani sancho hunna, tyo bhaekohunale, pahila yaha lama jhankri garera matrey lai jancha*" (if we take to hospital first it will be expensive and the person might not also get better, so this is why people first bring to the *lamajhankri*).

The TTBAs in both areas also thought that this was related to the reason people, especially the low castes, tended not to call them, fearing that they would refer to hospital which would incur great expense. One Magar TTBA thought that people were calling her less because they thought she would make them pay for the CHDK. The group of old Tharu women said they did not know a case of anyone being taken to Dangadhi hospital. The older women say that they hardly know of a case of anyone being taken to Dangadhi:

> "maybe the Pahari's go there", they said "but we don't. We only talk about going to hospital if we are about to die: *jeba mara mara garat, tup aspitalley jina bat gartey*".

Obviously, the **distance** from the hospital has implications for cost. The single bus fare from Muda on the highway to Dangadhi is 70 rupees, and the journey takes at least three hours. The private medical shop and "doctors" in Semri in the neighbouring VDC of Bonia is only half an hour's walk across the fields, even less by bicycle. Even the Indian border is only a couple of hour's bicycle ride away. In Ratnechaur, as awareness about the upgraded facilities and skills of Baglung Hospital are not yet widely known, most people still prefer go to Beni Hospital for emergency care. It is only one hours walk and within the same administrative district, Myagdi, whereas Baglung is 2 hours and in another district. One of the most active TBAs in the area had a bad experience herself in Baglung hospital and always refers her cases to Beni.

For their part, the traditional healers talk proudly about not getting paid. Here is what the Kami *lamajhankri* said in Ratnechaur:

> "I don't care about the money and never say it's going to cost this much. Whatever people give me is fine, even nothing. This is my work, which is sometimes very hard "*dukkiya kam ta ho*". But my sons are fine. I am fine. That is enough for me."

Other traditional healers talked about doing the work as their duty to use their gifts by serving the community (Tharu: *khartabey*).

Even without the incidental factors such as weather and road conditions, it is not difficult to see how the cumulative effect of even some of these delays in getting a woman to hospital on time could be fatal. Whatever the reasons, decisions are made late in obstetric health terms and a complex pattern of delay has emerged as a characteristic of care-seeking behaviour of whatever sort in these communities.

(c) The main decision-makers

In general, the *sasu,* UTBA/TTBA and the traditional healer are the three main decision-makers in both areas.

In a culture that respects the authority and wisdom of older people, the important role of the ***sasu*** is expected. A Magar FCHV who had already been for antenatal checkups, recalled how she turned to the advice of her *sasu* when her waters broke but her contractions didn't start. The *sasu* called the *lamajhankri* and the contractions started. Another FCHV from Ratnechaur told us that she believes that people only listen to her and take her advise because she is older woman (*jetani)* and not because she is an FCHV.

Community-based care-providers (FCHVs[25], UTBA/TTBAs) themselves had strong belief in the role and efficacy of the traditional healers. The Chhetri FCHV said that she advises people to go to the *lamajhankri* first and then to the hospital if labour is long. The same is true for any emergency because it is first important to find out if a witch is involved: "*bokshi lagne ki deuta lagne*". The Magar FCHV of ward 7 gave an example of a neighbour who had persistent nosebleeding, and went to hospital for medicine. The bleeding started again as soon as she came home. When the *lamajhankri* dealt with it, the bleeding stopped and did not recur. The FCHV argued that the reason it didn't get better the first time was that she hadn't gone to the l*amajhankri* first*:*

"yaha nagae ta u pani huncha ni. Aspitalko awshedhi lagdeyna".

A *dokh* was making it bleed and that *dokh* had to be exorcised.

Similarly, everyone goes to the *lamajhankri* during pregnancy and labour at least once. An important impetus for calling the traditional healer during pregnancy and delivery is for peace of mind: *manko shantilai.* Many UTBAs also gave examples of their belief in the power of the traditional healers. The low caste UTBA from ward 7 recounted how she had gone to the *lamajhankri* when she had had a long labour[26]. The baby had been born 10 minutes after the *lamajhankri* had finished his *puja*. For those born and raised in the communities in which they work, being trained in western allopathic health care issues appears to make little difference to the belief in witchcraft. If you don't go to the traditional healer first, then hospital medicine won't work.

On the periphery: The other western system care providers are still on the periphery in terms of providing care to women in obstetric emergencies. In Ratnechaur the health post staff are sometimes sought, and some problem cases do make it very late to Beni. In Kotatulsipur, it is the private medical shop owners that people turn to for help when complications arise. They go in search of medicine and treat the

[25] neither of the FCHVs in Kotatulsipur have been fully trained
[26] 9 PM until 6 PM the next day

pharmacists as doctors. Some make the trip to neighbouring India for treatment rather then choosing Dangadhi hospital.

5.6 Sources of information

This section considers the sources of information about health in pregnancy, delivery and post-partum for Magar women in Ratnechaur and Tharu women in Kotatulsipur. The main finding is that most people still receive their information from within their own families (down and along the generational and familial lines of authority), and from the traditional care providers within the community itself (the traditional healers and the untrained birth attendants). This is because of two things: other service providers are not readily available or in close proximity to the community, and there is as yet no sufficiently proven belief in them which is close to replacing the established belief system.

Within the family

The mother-in-law and sisters-in-laws are the people that most women turn to for help and advice about what is normal or abnormal in obstetric health. Mothers and sisters also play a role in a minority of cases. However, it is doubtful whether this involves much actual information giving related to the causes and development of any condition. It may simply involve instructions to the woman about what is expected behaviour for her, instructions that she will follow.

> "We learn from the old people", said the unmarried Tharu girls in our focus group. "They tell us what we should do and we do it. The old people get their information from the *guruwas* and other old people. That's the custom: *pahiluk chalan hui*".

Within the family, there is also the attitude of "*kamandi*" (Nepali) which means that people tend to dismiss problems saying "nothing will happen to me". A Tharu FCHV from Jokhali recalled how she had advised people to go to hospital on several occasions, but both times had been overruled by the *sasu* and father-in-law of the woman concerned, who said there was nothing to worry about. One of these cases was a girl with severe diarrhoea, who died because her grandparents had said it wasn't necessary to take her to Dangadhi.

Traditional birth attendants

Magar women sought out UTBAs over TTBAs for their information needs in pregnancy and childbirth. The two most popular TTBAs in the area were untrained, and both were non-Magar. While this might be coincidence, it may also reflect problems in the selection of Magar women to be trained as TTBAs. One of two UTBAs had learned her knowledge whilst working as a servant for a doctor in India. Word had spread that she had experience of deliveries when the family had returned to Nepal 15 years ago. This woman said that she has performed manual placenta removals and can successfully manipulate breech births. In contrast, the Magar TTBA in ward 9 said that she had not been called by anyone since doing the course earlier in the year, and felt that the community were

content to rely on the UTBAs and the *lamajhankri* that they knew. Whatever the reasons, it is clear that the information based on the national TBA training curriculum is limited in Ratnechaur. In Kotatulsipur, the situation was much the same. Only one TBA had been recently trained. All other TBAs were untrained, although their names are now written on a waiting list of people at the VDC office.

It was not possible during the course of this study to make a proper evaluation of the information given by these UTBAs to women of reproductive age. Such an assessment would be a useful exercise in the run up to any programme to impart new information.

FCHVs

The two areas differed in the capacity of their FCHVs. In Ratnechaur and the surrounding area, all FHCVs had received the full training (15 days) and had several refresher trainings (2 days). In contrast, there were no properly trained FCHVs in ward 7, Kotatulsipur. One had died in childbirth the previous year (see Case Study 7) and her replacement had not yet been trained. The FCHV in Jokhali had only received refresher training as she had replaced the trained FCHV who had left the area. Both acting FCHVs are illiterate although they have recently attended NFE classes. They are not generally called to help with deliveries, saying that only the UTBAs or TTBAs are called. However they have occasionally gone to a *larkoria* in difficulty of their own accord to see if they could help. One FCHV is the daughter-in-law of a *guruwa* so she often finds out who is having problems when he is called out. However, as the national FCHV training does not include details of recognising emergency conditions during pregnancy, delivery and post-partum, it probably makes no difference in terms of FCHV's being an influential source of correct information.

The health post

In both areas, the number of people who mentioned seeking care and receiving information from government health posts was low. There were complaints about irregular clinics, attendance by men and not women, off-hand and curt behaviour of some staff, and periodic lack of drug supply including family planning pills and injections.
In Kotatulsipur, where FCHVs have to attend the monthly clinics run by the health staff in the village, both Tharu FCHVs were of the opinion that few women underwent antenatal check-ups: "*kohi kohi manney ney jaceyi".*

When women do seek these service providers and are provided with information it is not always well received or understood, as it just serves to emphasise the gaps between generally illiterate local farming women and educated service holders, often from outside the local area. A group

of Magar mothers complained at getting irritated by people who gave them lectures about the need to rest when they were pregnant.

> "There is no chance of rest as there is too much work to do" they said: "*yahako aram garne kurey cheyna*".

This brings into question the issue of the appropriateness of the information already available, from which lessons may be drawn as to which pitfalls to avoid in future increasing awareness activities. Most Tharu women did not understand Key Nepali words such as sutkeri and gharbhavastha. Almost no one knew what the *sutkeri samagri* (CHDK) was either, except for a few who said they had heard a radio feature about it, or had had contact with a TTBA.

The few health post staff that were in post to interview[27] tended to display either a dismissive attitude towards local customs and beliefs, or an unrealistic assessment of how important they still were. The Village Health Worker (VHW) in Ratnechaur thought that only 5-10% of people still believed in the *lamajhankris*, an assessment not borne out by our contact with many community members of all ages. The VHW appears to grossly underestimate the importance of traditional healers as a source of information. Though many people are skeptical about some *lamajhankris* and some practices, and certainly acknowledge that some are better than others, this does not yet appear to have shaken their overall belief system.

The medical shops

These private medical outlets staffed by people with only minimal training in health are an important source of information to women and their families in both the communities studied, but particularly in Ratnechaur. Many younger women in Ratnechaur reported that they had been for medicine during pregnancy and for bleeding after delivery in Beni and Baglung. Tharu women in Kotatulsipur go to the shops in Semri, and Lokria, both about half an hour away.

Private medical shops give advice as well as dispensing unprescribed medicine based on symptom descriptions from a third party and without ever seeing the patient. In Semri there were also reports of staff making home-visits in obstetric emergencies and giving saline (and possibly oxytocin?) injections. There were two additional perceived advantages of the medical shops for Tharus in Kotatulsipur: two of the shops were owned and run by Tharu-speaking Kathariya (the other was a Thakuri Malla), and they often gave medicine on credit.

Hospitals

Hospitals are much less regarded as sources of information than they are as places of last resort. In Ratnechaur, women that do go to Beni or

[27] only done in Ratnechaur, brief meetings only in Kotatulsipur

Baglung for their antenatal checkups only do so if they have other business in town and rarely make a special trip for that purpose. The information they receive there does not necessarily result in them going to hospital for their delivery. In Kotatulsipur, no one goes to a hospital for information. For Tharu women, Dangadhi is only one of the hospitals of choice in the area. In other health emergencies such accidents, people may go to Tikapur (Kailali) on the Indian border (3 hours by bicycle) and then to Lucknow and Pulia. The attitude about hospitals was summed up by the Ward Chairman of Sungurkal who said:

> "just like it will never occur to you to walk carefully until you trip in a ditch, women having babies never think of going to Dangadhi. It's not that it's impossible, it's just that we don't think of it: *manai phela ney parel ho, dimak mey ney sujal ho*".

Outside agencies

NSMP is the most active outside agency working in the field of maternal health in these two study areas. No other agency is active in Ratnechaur VDC. Other outside agencies active in Kotatulsipur are the Red Cross (who distribute the CHDK), and BASE[28], which is supported by Save the Children USA, and has recently been focusing on raising awareness, providing information for health[29]. BASE has run trainings for TBAs and for *guruwas*[30] in Kailali. NSMP has conducted a body mapping exercise, and has supported the establishment of Safe Motherhood Committees and Mother's Groups who receive basic orientations on health, hygiene and other matters.

Despite this activity, there still appears to be a long way to go before such inputs have a significant effect on people's awareness and decision-making in obstetric emergencies. A Magar UTBA, who had recently participated in an NSMP body mapping course (7 days), recounted the story of her daughter who had oedema and bleeding before delivery but was too shy to tell her husband's family. She came to her *maiti,* but only told her mother after she had guessed: "*hamile thaha paera matrey bulla bhanyo*". Her contractions started to come quickly and her mother sent her home (*maitima hundeyna*).

[28] BASE has an office in Josipur, about one hour away from Kotatulsipur by bicycle
[29] a two day training on pneumonia for FCHVs took place during our visit
[30] only the *desbhandia* and not all *guruwas*

She thought it was preferable to go home rather than to the hospital as home was closer and she might delivery on the way. If she delivered on the way to hospital then things could be bad and if anything went wrong people would blame her. Fortunately, the baby was delivered at home and both are fine. But the lesson is that this service provider had received appropriate information very recently but did not use it to effect safer care-seeking behaviour at the crucial moment.

5.7 Awareness among men

This section looks at men's involvement of support for their wives during pregnancy and childbearing, the level of men's knowledge about abnormal obstetric conditions, and whether or not they express any interest in increasing their own awareness in these matters. As both Magar and Tharu men broadly displayed similar trends and responses, they are treated together.

What do men know?

Men's overall level of knowledge about what happens to a woman in pregnancy and labour, and what are the danger signs, was very low. Men admitted this themselves: "We have no knowledge of this, we are not the "caste" that gives birth: "*Tharu maneynto kuch neybo ney kare*" said a Tharu village leader[31]. Women agreed that this was so.

All men agreed that women tended to suffer more sickness than men, and attributed this to repeated childbearing, constant work, and worrying: "*chinta huncha*". Interestingly, Tharu and Magar women also remarked that women are more vulnerable than men to attacks by the *bokshi*, but either group of men did not mention this point[32]. Although they were able to describe most of the emergency symptoms shown to them in the training pictures, they only saw the fitting as dangerous. A common attitude was

> "oh, it's just pregnancy. It will be over quickly and there are mostly no big problems".

None of the Magar young men were able to describe the details of what happened at delivery, who did what, why and when. The level of awareness was extremely low.

What help do men give?

Almost all women asked said that men knew nothing of childbirth and took no interest in it. Older Magar women said that men didn't help in their time, and they don't help now. One younger Magar woman recalled how she had a long labour and her husband knew but still went off to play cards and drink *rakshi*.

> "*Ke garne*, what to do, men are like this. Men don't feel the same when people get sick "*man attiney kisimko huncha*".

This woman ended up in Baglung having the baby and her husband didn't know till a few days later. Her story is not unusual. We heard many similar tales of male non-involvement from both communities.

What did the men have to say for themselves? The majority of men admitted that they were either away from home, or stayed away from the

[31] this was said by the *chowkidar* of Sungurkal whose wife had recently lost twins (Case Study 9)
[32] Are only women conditioned to believe this?

house, during the delivery period. Only several out of over 20 respondents said that they helped in any way, mostly by calling others (UTBA/TTBA, traditional healer), going to buy equipment (blade), and advising their wives not to carry heavy loads during pregnancy or too soon after delivery. This was partly attributed to the whole issue of loss of prestige (*ijjat jancha*), caused by being seen to do any work that is not traditionally in the male domain. The *bhalemansa* of Jokhali said that this stopped men from doing more as they were afraid of people speaking against them. Only if there was no one else around would it be acceptable.

Most men showed a lack of imagination when thinking of what sort of help might be possible: “we can’t give birth ourselves, and can’t go in the *sowri*, so there is nothing we can do to help” said a group of Tharu young men. Only a few mentioned cooking for their wives during this time, and only if there was no one else around. Young men described their wives’ deliveries, recounting a series of decisions (to get UTBA/TTBA, *guruwas*, Semri doctor) but they always appeared passive in the process, particularly in the early stages, allowing one care provider to make the next decision. Only a few were the first to know of the onset of labour and even fewer were important decision-makers about the type and timing of care (an example of this is the VDC Vice Chairman in Magar Case Study 3. From Table 4.2, summarising the case studies, the husband appears as a decision-maker in only 5 out of 9 cases, and even then he was usually one of the last in the list.

Men also raised the subject of shyness, *laj,* saying that they felt shy talking to us about these matters. The male UTBA from Myagdi (Jamrakot) felt that there was little point in getting men to help from both the man’s and the woman’s point of view. As there would be several women around, any man that stayed would be shy in front of so many women. He also gave an example of his own wife who initially resisted his request to perform a manual placenta removal because of her *laj*.

Would men like to know more?

We asked whether or not men agreed with the statement: “Childbearing being is women’s business, and men do not need to know nothing about it”. At first the men always agreed with this but after more probing began to concede that as the child was created by both parents that men might be able to take more responsibility to protect the health of their wife and child during pregnancy, delivery and post-partum. We asked for men’s’ suggestions on how best this might be achieved? They recommended orientations and trainings[33] in general terms but were not specific about content. They stressed that it was no use just providing such things for the women as men too needed to understand. Most agreed that it would be better to have women run the trainings as a man would just have

[33] When this was mentioned by the *bhalemansa* of Jokhali, his wife, who was passing by at that time, interjected that men would not be smart enough to learn any of it!

learnt everything from a book or a training, whereas a woman could speak with experience. One or two argued against this saying that men would be too shy in the presence of a woman. In a focus group with young Tharu men, a discussion ensued between one participant who complained that it was useless to speak about such painful matters in public. The others accused him of having no feelings for his wife and children in not being interested in finding ways to help them.

Traditional healers are influential men in their communities. How interested are they in becoming more aware of an alternative system of knowledge relating to women's reproductive health? At least the younger ones appeared to be interested:

> "*Bharria ta bharria hui. Hamar bhat dure manbar, turinkey bhat hamrey mun bi*" (It would be good to know more). We should respect your knowledge and you should respect ours. We should be like brothers (*daadubhaiya*) and exchange what we know"). (Tharu young men)

What did women think of increasing awareness among men? Most were skeptical of success. Many said that even if men knew more they still wouldn't care: "*wasta gardeyna*" and it would be a waste of time: "*matlab ney raktey*". A minority did concede that it would be a good idea: "*mujha to huit*" (Tharu young mothers).

Nevertheless, among men there was an overall willingness to talk and interest was expressed in increasing awareness among most of the younger men, including the younger *guruwa* and *lamajhankris*. One *lamajhankri* quoted a proverb (*ochan*):

> "*kowlow paryo gai, kuna paryo sutkeri*" (we think that this can be roughly interpreted as "a cow in a ditch is in difficulty just like a *sutkeri* in her corner – both need the application of knowledge to get out safetly").

5.8 Systems of help at community level

This section describes what indigenous community systems are already in place in the two areas and that do already assist women in obstetric emergencies. Among Magars this is limited to a custom of reciprocal help, whereas among Tharu there is an indigenous long-established leadership system headed by a *bhalemansa* that operates as a cohesive instrument at village level and is frequently used to facilitate care for people in difficulty. The section concludes with some detail on the ritual friendship or *mit* system, found in many parts of the country, and takes a look at how strong this is today in the study areas.

(a) Magar

In Magar communities there is a traditional system called *orima porima,* which means giving help to others. In Ratnechaur, this was called ***arma parma*** *bolaera* or *parma lagaune jane.* It acts as a system of reciprocal help obligations such that one gives help to a neighbour who will then repay in kind at a future date. No money is involved, except that if people are unable to provide help they may send money instead. Help is requested at times of excessive work such as in the fields at harvesting and planting, for collecting stones to build houses, and wood for funeral rites. It is also requested in health emergencies, especially for carrying people to hospital, when as many as 20-30 people may give support. This system is mentioned in Case Study 3 and was also invoked, but not carried out, in Case Study 4. There is no community tradition of keeping money aside for certain purposes. However, everyone agreed that this would be a useful thing to do for dealing with health emergencies including obstetric ones. The NSMP is supporting the establishment of an Emergency Fund that has mostly been well received in the area.

(b) Tharu

Tharu villages in Kotatulsipur and elsewhere have their own indigenous organisational system pre-dating that of the state and district administration. This system centres on elected male leaders called *bhalemansa* and *chowkidar*.

The ***bhalemansa*** acts as a community leader and performs many duties for the village. Sometime during the first week of *Magh* (Jan/Feb) around the time of the *Magh Sangranti* festival[34], a village elder's council (*charbhaiya*) meeting is held with representatives from each household to propose, discuss, and nominate, leaders. In the case of several nominees, the *bhalemansa* and his assistant, the *chowkidar* are selected by *goti halne*: drawing straws. The council meets every year and it can decide to either retain the present incumbents or reject them and nominate replacements. The process of

[34] The *Magh Sangranti* festival of spring is the biggest festival for all Tharus in Nepal

selection is called "*kojnebojne*". It is also a time when the *kamaiya* (bonded labourers) shift allegiance between landowners (*mahaton, jamindar*).

The word *bhalemansa* literally means "big gentleman". The duties of the *bhalemansa* are to welcome outsiders and provide hospitality[35], meet government people, organise help for people in times of trouble, and generally oversee the welfare of the village. Whereas the election of the ward chairman is often determined by party politics, and his role is to represent a link between village and state, the *bhalemansa* is more concerned with individual welfare and village organisation. The Ward Chairman has a budget from the VDC so can buy things, whereas the *bhalemansa* can only raise money from the people. The wife of the *bhalemansa,* the *bhalemansingia*, can also wield influence and has prestige within the village. In some places the authority of the *bhalemansa* has declined and some places do not even elect anymore, but in some areas the system still remains very strong.

The *bhalemansa* is expected to organise assistance if a person is taken very sick. After being informed, it is the *bhalemansa*'s responsibility to arrange a council meeting (*charbhaiya)* to discuss whether it is appropriate to send to hospital or call a *guruwa*:

"*sab jana salla garhi, aspitallai jaina ho ki, guruwa bolaina ho*".

He can convene such a meeting at any time, with the help of the *chowkidar*, and organise transport and money. The sick person might be carried in a cart, or on a wood/string bed (*katiya*), walk or go by bicycle.

The ***chowkidar*** (also called *agariyaha*) is the village messenger and village guard. He works as the assistant to the *bhalemansa*. He is selected in the same way as the *bhalemansa*, and the *desbhandia*, in a *kojnebojne* village council meeting. One of his most difficult tasks nowadays is dealing with *dacoits* (bandits) and forest guards (*banjaj, banpali* in Nepali) who frequently demand food and alcohol from villagers in return for protection. The *chowkidar* is also responsible for calling people for the monthly clinics run by the health post, such as those with children needing vaccination, and pregnant women to attend the antenatal clinic. The *chowkidar* receives an annual payment[36] from the village. Around *Magh Sangranti*, each household gives him 18 kgs (6 *paseri*) of unhusked rice (*dhan*), 10 kgs (4 *paseri*) of husked rice (*camal*), and several kilos each of mustard seed and pulses (*dhal*).

Together the *bhalemansa/chowkidar* team also acts as arbitrator in disputes between villagers, and between villagers and the outside system. They also pass on messages from the VDC and District offices and gather people for trainings and meetings called by the government or NGOs such as BASE.

(b) Ritual mit friendships

[35] We benefited from this obligation to help. The *bhalemansa* of Sungurkal arranged for his ox cart (*dollop/laria*) to transport us and our luggage to the highway, saving us 1 hours walk
[36] similar information about village payment to the *bhalemansa* was not obtained

In many parts of Nepal, there is a tradition of making ritual friendships with people of the same sex. Usually in the same age and ethnic group (though not always), this custom of making friends is called *mit banaune*.

Among the Magars of Ratnechaur, many participants have formed *mit* friendships. In theory, male *mit* friendships are more likely to persist as men do not leave their homes at marriage. However, this is counter-balanced by the fact that many men leave the area for work. The picture from the Tharus of Kotatulsipur is similar. Here, male *mits* are called *gochalis*, and females usually *suki*[37] or *gocha*. People do still help their *mits* if they can, especially if they are nearby. The unmarried girls we talked to say that they had all formed *mit* friendships and gave their friends special pet names. The young men also said they had formed friendships which they called *mister*, *dost*, and *sangari*. Men also said that they made more friendships of this sort than women did.

In both areas, most participants doubted whether or not *mits* helped each other at times like an emergency in childbirth, mainly because there would be too much shyness or *laj* involved. *Mits* call each other at times of celebration and feasting; they are not usually called in times of trouble. In that sense they appear to be “fair weather friends”: at times of trouble family takes precedence and is expected to bear the bulk of the burden. Although apparently still strong among the older generations (some of the older women in the focus group were calling each other *gocha),* most people seemed to think that the custom is on the decline as people marry and move around further afield than before.

[37] other names used were *goihi, sanjkhari, suchi/yar/saki/aar*

Magar Case Study 1

Retained placenta and vomiting: delayed care sought in Baglung, 1996

Lal Kumari Thapa is about 40 years old. She has 4 children, and lost her first baby at 5 months. This is the story of her last pregnancy.

"When I was much younger I lost a baby at 5 months. After my last baby three years ago I had been very weak (*tagat cheyna*). During that pregnancy, my whole body had ached, I got breathless and I had some swelling. But what to do, I still had to work.

During this last pregnancy, at 9 months I had a fever that lasted 3 days. I didn't eat at all. I didn't know that I should go for a check-up and I went back to my work as usual. But I was feeling ill. One morning, I woke early with labour pains. I told my mother-in-law and she told my husband. Quite quickly, about 9 am, the baby was born. I felt very thirsty. The placenta didn't come out.

I can't remember well what happened after that as I kept fainting. We sent a message to call the UTBA from Jamrakot, but she was busy and couldn't come. My mother-in-law gave me some chicken soup and some rice water (*dhanko pani)*, but I kept vomiting. After about 5 hours the placenta still hadn't come. About 2 pm, I asked my husband to call the MCHW from the Chewra Health Post which isn't very far. Baglung is very far and I didn't know anyone there.

About the same time, my mother-in-law decided to send the *acitta* to the *dhami jhankri* and to call him to see if there was anything he could do. While both the MCHW and the *dhami jhankri* were on their way, the placenta came out. When they both got the message that this had happened, they both returned to their homes.

For the rest of that day and night, whatever I ate or drank I just kept vomiting, and the vomit was green. The next morning my husband said that I should go to the hospital, and he arranged a *dhoko* basket to carry me to Baglung. As well as my husband, two other men from my house came too. First we went to a private clinic but the "doctor" there sent us to the government hospital. At about 10 am we reached the hospital - this is only what I know from others as I had collapsed by then with a high fever.

For the next two days and nights I was at the hospital on a saline drip as people searched for blood. On the third day, blood was found.

When the blood had finished, I was very hungry and eventually I was allowed some food. It was cold rice but I ate it like it was the most delicious *bhoj* (feast). I had abdominal pains for several days. While I was in the hospital I had many injections.

My sister and other relatives from my *maiti* came to stay at the hospital, and they massaged me with warm oil and heated bricks. After about 5 days in the hospital I came home, with lots of medicine to take for nearly a month".

Magar Case Study 2

Generational conflict in decision-making in a long labour, 1996

Dil Maya Thapa is a 23 year old woman educated to class 5, living in ward 7. Her husband is now the ward chairman. They have 2 children. This is the story of Dil Maya's first pregnancy, and shows how early decision-making was dominated by Dil's mother-in-law and two lama jankhris.

"I had a difficult pregnancy. I was sick for the first 5 months with almost daily vomiting and I hardly ate anything. I asked my sisters-in-laws if this was normal and they said "*tyestey ho:* that's the way it is". Once when I was staying at my *maiti* (maternal home) and was feeling really sick, I went to the health post and the doctor there gave me some medicine. But it made me even worse and I stopped taking it. After that I didn't go back to any health post or hospital for any check ups because I was afraid that they would give me more medicine and it would make me sick.

On the day my contractions started, I noticed when I woke at about 6 am that I had leaked water: *pani sudh bhayo*. At 8 am, I found that I couldn't urinate. There was no one else in the house. My husband and mother-in-law (*sasu*) had left the house very early. I began to have contractions and I called the *didi* from a neighbouring house. She said the baby is coming soon, and then left to do her work. But the pains just went on and on, and got stronger and stronger, and still the baby didn't come.

By early afternoon, I called the *didi* back and said that I thought I should go to the hospital, and that if I died I'd die there and if I survived I'd survive there:

"malai hospital lai dinu. Ma mare bhane hospitalma marchu, bhaje bhane hospitalmey bajchu bhanera didilai bhane. Didile manche jamma gare dinu bhayo".

About then, my mother-in-law returned to the house and thought that the labour was going on too long. At 4 pm, she consulted a *dhami (herera, ra panisani phukera*) who said that the baby would be born by 7 pm.

"Yeso kehi bhaeko ta, jhankri bolaune bhanche kye re yaha ta. Sasule bhanne pacchi, mane paryo mahile ta bolaune ichhar thiena, tara sasu le garda, gare. Malai ta tyeti biswas thiena, tara sasule huncha ki bhanera bolaeko. Malai ta biswas lagena bhae pani, 7pm paid huncha bhanera arkole baneko thiyo. 7pm kurda pani bhaena."

Here there's a habit of calling the *lama jhankri* whenever anything happens. My *sasu* wanted to call one so I had to agree even though I didn't want the *lama jhankri.* I don't believe much in them. At 7 pm, the baby hadn't come.

My sasu then called another *jhankri*; *utae diyo, haliyo, lageko*) who said the long labour was due to a bad influence and that after he had performed his ritual incantations (*mantras)* the baby would be born within the hour.

But we waited for another two hours. Only then some of the neighbours started to say*: yo huna bhayo ta hunthiyo. Aba bhaene - logi halna parcha bhanera*: this isn't working, this shouldn't happen. We should take her now".

Dil Maya says that she had wanted to go to the hospital much earlier but her *sasu* had wanted to call the *jhankris* first and she felt she could not argue with her *sasu*. Her husband was still absent from the house (he was drinking with

friends but no-one knew where to find him).

Over these last few hours, the *didi* had been calling the neighbours and invoking the custom of voluntary help in a crisis: *yo kisimko appat parda kyere, swyog magye pachhi dine chalan cha".* When people give this sort of help, there is an obligation on the family who receives the help to reciprocate if called upon in the future. At 9 pm, 10 people (2 women and 8 men) carried Dil Maya in a basket (*dhoko)* to Baglung hospital, arriving about 11 pm.

The baby was safely delivered twenty minutes later, after performing a perineal cut. Dil Maya and the baby were examined at 10 am the next morning and she was discharged. Dil Maya's husband had also arrived by then after discovering his wife's absence from home when he arrived drunk later the previous night. The family bought another *dhoko* from the bazaar and carried the mother and newborn home. No one was given any money for helping Dil Maya get to hospital, although at the *navaran* ceremony a few days later, they were invited for food and drink.

Magar Case Study 3

Health post staff and District Vice Chairman help a woman hemorrhaging in labour: mother survives after removal of dead breech baby in Baglung Hospital, 1996

Putali Thapa is now 32 years old and has never received any formal education. When she was 17, she gave birth to a live baby that died one hour after birth. After the baby's body had been buried, the lama jhankri was called so that the mojh could be killed (mojh marnu paryo) and to prevent unfortunate things happening to the next children (arkho bucca naramrohos). After that, Putali bore three children. What follows here is the story of her last labour three and a half years ago as told to us by Putali herself, and her mother, Asari Thapa, who lives nearby.

During the pregnancy, Putali did not have any antenatal check-ups and no one had ever examined her to discover the position of the baby.

Putali recalls:

"I was in my tenth month. I had gone to work in the fields (*bharri)* when suddenly I began bleeding and then collapsed. I sent my eldest daughter to get my mother, Asari, for help. I don't remember much. There was a lot of blood and it was clotting (*tukra tukra bogeko*). I thought that when I collapsed the baby was still moving."

When Asari arrived soon afterwards, she found her daughter lying in the field in a pool of blood and very distressed. She lifted her up and helped her back to her house. Asari recalls:

"Putali was full-term so I guessed that the baby was coming. Although I didn't know about how to help delivering the baby, I thought that I should stay with her and that she shouldn't be left alone. I didn't know what else to do. Gradually people in the village came to hear what had happened and to see what they could do to help.

No one was quite sure what was best, although some people did suggest calling the *lama jhankri*. My other daughter (*maili chori*) arrived and was worried that the baby was already dead. She said: "*yesko pet bhitra mareko cha ki* ?".

At about 5 pm , the Vice Chairman of the District (*upahadhski*) arrived and said that the "doctor" (in-charge) at the health post should be called and he went himself to get him. We were all getting very worried by then. They returned in about an hour with some saline solution to inject into my daughter. The doctor said "*kehi ni hunna:*

it's nothing, she'll be fine". He thought that the saline would revive her.

But she didn't get any better and she was still bleeding. Then she fainted (*behos bhayo*) completely at about 7 pm. It was then that my husband (Putali's father) decided "no, we should take her to Baglung". And the Vice-Chairman said "if she stays here she'll die".

Putali remembers little of what happened over the course of the next few days:

"I don't remember what happened after I fainted. Some people had been called and I know the *upadakshi* was called and the man from the health post. But after that I kept on fainting. I thought I was going to die. I said that to my mother."

Putali also talks about the community help the family received at this time:

"In our area we have a custom of *arma parma* (sometimes called *orima porima*) or "s*wyog garne ho" (*to give help*)* which means that we give help to people who ask, and they their families will reciprocate another time. No money is involved".

Her husband, other daughter, the Vice-Chairman and his wife, and two other neighbours went with Putali to the hospital. When she arrived at the hospital, the baby was removed but it was already dead: "*underkey bitter hey maral rahey".*

Putali was apparently unconscious for nearly three days. She received 2 pints of blood. On the day of Putali's crisis, her husband had been away driving a mule train. He only heard a few days after Putali had been admitted into hospital when he passed through Baglung. He came to the hospital immediately with money for drugs and food, and stayed with her until she was taken home.

Putali came home after seven days. She remained weak for a long time. The baby had been breech. Then hospital staff said that if they had left it any later that Putali would also have died.

Magar Case Study 4

A progression of responses from *sasu*, UTBAs, *lama jhankris* and the woman herself to a long labour, 1993

Iba Kumari Thapa is now 27 years old, and has 2 sons aged 10 and 6. Iba has attended primary school. This is the story of what happened at the birth of her younger son.

"After an evening meal, my waters broke (*pani bogeko*) and water came all night. My contractions also began in the night.

The next day at about 5 pm we called an old UTBA (now dead) who massaged me. About an hour after that we called the *lama jhankri*. I can't remember who called the *lama jhankri* - maybe it was my own mother who had come to help when the neighbours had told her that I still hadn't had the baby. I don't have any mother-in-law. The *lama jhankri* came and did *phukne kam* and then went away. I was finding breathing difficult.

A second *lama jhankri* was called (I don't know which one). He said that a *chureni dokh* was stopping the baby being born which he would have to exorcise. A second UTBA was also called who massaged me again.

My husband had left the house that morning and didn't come back all day. He was playing volleyball with his friends and drinking *rakshi*. He knew that I had started labour that morning but didn't come home to find out if I had had the baby.

Eventually I told my mother that I wanted to be taken to hospital: "*Meyle beta kataune sukena bhanera, meyle apheyle baneko. La, malai chitto bajaarma laijane bhanera bhaneko*". My mother told the others and they started to get everything ready, the *dhoko* (bamboo carrying basket) and people who help carry me. But as they were doing this the baby was born.

My mother told me to stuff hair in my mouth to make myself sick and the placenta would come out. I did

this and the placenta came out after about 15 minutes and was buried behind the house (*gharko kharangsama)*. The UTBA cut the cord after the placenta had come out".

Tharu Case Study 5

Lack of information: waters break, contractions begin three days later, 1999

Pushpa Chaudhary is an uneducated 25 year old woman from Jokhali village. Her first daughter had died at 5 months old from diarrhoea. She then had a son who is now 4 years old. This is the story of the birth of her second daughter about 9 months ago. It highlights the lack of information available on a potentially serious obstetric situation: a long gap between waters breaking and the onset of labour contractions.

"In my 9th month of pregnancy, I started to leak water. This went on like I was urinating every half an hour for two days - there were no pains. Towards the end of the first day, I called the TBA myself but she said it wasn't time for the baby to come. She came sometimes to give massage and told me to call her when the pains started.

All the next day I was alone, there was no one else around to help me. I didn't know what was happening to me or what I should do. Everything was soaked - I just cried, lay down and waited.

At night when my husband came home I told him, but he didn't care. I am the younger of two wives (*sewta*). He was drunk, ate his dinner and did nothing. We live separately from my husband's parents so they didn't know either.

In the early morning of the third day, strong pains began (*bhot jorle butel*) and I called the TBA again myself. In the afternoon, the TBA also sent for someone to call the doctor from the health post but he never came - apparently there was another woman in labour nearby and he went there by mistake instead.

I felt very weak by then as I hadn't eaten for three days because I was worried about what was happening. Also the custom here is that women don't get fed rice on the day of birth and I had thought that I was going to give birth anytime.

I called the *guruwa* (*deshbandhia*) who did "*gurey puja*" and "*achetta herne*", and said that the TBA knows what to do. Then he left. After a while, the TBA and I both began to worry that the baby would already be dead inside. I hadn't felt it move for a long time. At last, about 1 in the afternoon, the baby was born. It came out in a membrane (*jalli*) which the TBA ripped open. The baby only cried after one hour.

The placenta came out immediately but the TBA didn't bury it for 3 days. She just wrapped in a cloth and left it in a corner of the *sowri* where it stank and attracted flies. She only buried it when the stump (*dhori*) fell off and then she buried them together by the river.

On the first day I drank hot chilli water with oil (*korang pani*). I did the purifying ritual *ghatwa kaireyna* after 3 days. I wiggled the baby's stump to make it drop off quickly.

I have never heard anything about a clinic and going for check ups or injections in pregnancy".

Tharu Case Study 6

Bleeding before and after delivery dealt with by *guruwas*, two UTBAs and the owner of a private medical shop, 1999

About 7 months ago, this case suffered from bleeding in late pregnancy and post-partum. The pregnancy bleeding was attributed to witchcraft, and the post-partum bleeding considered normal. Her name is Devi and she is the daughter-in-law of the village leader, bhalemansa, of Jokhali village, ward 7. She is about 20 years old, and very shy.

"I knew I was pregnant when I didn't like the smell of any food and didn't feel like eating, I didn't tell anyone and I didn't go for any check-ups even though I knew all about the clinic and the neonatal tetanus injection. I was too shy (*laj*). I didn't tell my husband anything - he guessed at about six months when he saw my belly was getting rounder.

In the 8th month, I started to bleed and had abdominal pains. I told this to my mother-in-law after a few weeks when the bleeding hadn't stopped. It kept on coming all the time and was quite heavy, and I was always having to wash my clothes. I was scared because I didn't know what was going to happen.

When my mother-in-law found out, she didn't say anything to me, she just called the *guruwa*. The *guruwa* said that a ghost (bhutwa) caused the bleeding and that he would have to grab it and nail it down (*gurey karne, kata leke bhutwa tokne).* He did this and I stopped bleeding that day. But it started again a few days later and continued intermittently until the baby was born one month later.

When my contractions began (*peru pirel*), I started bleeding heavily again. This time the blood was black (*kalo*). I had been pounding rice all day (*dhiki kutne, camal khelaune*). I kept going back to the house to change cloth as it kept getting soaked with blood. I had felt some pain in the morning but it didn't get really bad until the evening when I told my mother-in-law.

She called the UTBA who came and stayed with me all night but the baby didn't come until *koluwajun* (morning mealtime about 10-11 am) the next day. During the night my mother-in-law had called 3 *guruwas* one after the other, and another UTBA. One UTBA held me while the other massaged by abdomen (*pet suharai*). I was bleeding up until the time the baby was born.

During the night my husband went to try and find a "doctor" in Josipur but couldn't find him. When he got back he sent his elder brother to Semri to call the "doctor" from there. That doctor came to the house early in the morning and gave me 2 injections and the baby came out very quickly after that.

One of the UTBA's cut the cord - I didn't look. The placenta came out quickly but I didn't see what happened to it. By then I was exhausted and near collapse. My own mother arrived then and took over looking after me. I had post-partum bleeding (*gana*) for a month or so and sometimes it was quite heavy again. I didn't tell anyone about it, not even the TBA. She had told me to expect some bleeding for several weeks so I didn't think it was anything to worry about".

Tharu Case Study 7

Suspected eclampsia causes the death of an FCHV in 1998

About a year ago, the FCHV of ward 7 died several months after giving birth (probably from eclampsia). During late pregnancy and after the delivery, she had suffered from oedema, and had breathing difficulties. No one that we talked to had considered these as either abnormal nor life threatening. Her mother-in-law is an experienced UTBA who has been helping at deliveries in the area for 16 years.

The FCHV's mother-in-law is called Jirai. She is about 45 years old with 4 children of her own. This is what she had to say:

"I found out that my daughter-in-law was pregnant after three months. She didn't tell me herself (*laj man thiyo*) but I guessed because she went off some of her food and had other food cravings. She went to the health post early in her pregnancy and took an injection. She was an FCHV so she knew what to do.

I noticed at about 8 months that she had swollen feet, hands and face. When I saw this I got her *mudarko pat* (*mudar* leaves) which I warmed at the fire and tied to her swollen legs. Women often get swelling in pregnancy - we call it *subao*. I don't think that she had any headaches or fever, just the swelling.

One evening in her 10th month, her labour pains began. We had just eaten our evening meal and were getting ready to sleep. My son called me and said his wife was complaining of pains and I went to give her some massage. She had been planting rice all day and hadn't told anyone that she had been having pains - she only said when she got to the house and the pains were strong.

About "*bhinsar*" (3-4 am), the baby was born. It was their first son after three daughters. The placenta came out quickly. I cut the cord and did everything. We didn't call anyone else. Her feet and face were swollen before the baby was born but this reduced after the delivery. But I noticed she was swollen again after about 10 days when we did the *ghatwa kaireyna*. But she was fine and was working (*nengti garti*). She didn't complain of headache or dizziness and she didn't faint. She could work. She was breastfeeding so she can't have been too sick.

But after *ek pakh* (15 days) she got worse, and couldn't breathe properly (*suk dum*). She stopped eating and her milk dried up. She went to the medical shops in Semri and I called the *guruwa* who did a *gurey puja*. After that she improved for a few days and then got sick again.

After two months my husband took her to her *maiti* (maternal home) in Palmanpur (25 kms) for several weeks. There her brother has a medical shop. When we heard that she was better (*ek dam barihar*) we sent a *laria* (bullock cart) to collect here - it got here in the evening. But as soon as she got here she was breathless again

and I said that she should go straight back to her *maiti* because here she kept being attacked by a ghost*: pukkey yaha aera bhut lagcha*. *Bhutwas* like sick vulnerable people. But my daughter-in-law refused to go saying that she had medicine from her brother's shop, and that she wanted to do her work. So she stayed.

The next morning she got up early, did her work, ate her rice and went to sit with her baby son in the courtyard. She said to me as I passed her "*mao, ajh din ney kattut ho"*: (mother-in-law, it's a very long day today). But I said "it's only just morning" and then went inside the house. Then she went to pick up some clothes drying on the line and tripped over a log and fell down. Her eldest daughter came running to tell me what had happened.

I ran outside and saw her lying on the ground. I couldn't lift her up, I could only put her head on my lap. I started to cry - what's the matter? But she couldn't reply. There were two breaths and some teardrops on her face. She couldn't speak to me, and then she died. After a while I sent for the *guruwa* who took a long time to get here and there was nothing he could do.

I wish I hadn't gone inside when I did. I went to look after another *nati* (grandchild) and I also didn't feel very well and wanted to sit down. Everyone had been with her when the new baby was born, but she died all alone. Why was she so weak? Most likely it was just her time to go: "*dina watra ralahis; usko din ney tyethi ho".*

Jiria's son, Padam Bahadur Dangaure, is about 28 years old. He works as a *mistri* (mechanic) and is often away from home. He was away in Tikapur at the time of his wife's death. He told us that although his wife had some swelling she wasn't ill as she was able to work: *kam karey. kas biraita ney raha. Suwena biram raha.* He also said that there was no need to call anyone as his mother was a TBA and his wife herself was an FCHV.

On the day the FCHV died, the village men, including her father-in-law and all the *guruwas,* were away in the jungle cutting *kar*, elephant grass. Her husband was in another area for his work - he did not find out about her death for a few days. Three months after her death her husband remarried.

Tharu Case Study 8

Miscarriage complications lead to Dangadhi and hospitals in India, 1999

Maharajin Kathariya is about 22 years old and lives in Sungurkal village, ward 7. She has attended Non-Formal Education classes and is active in the Mother's Group. She has two sons aged 7 and 5. This is her account of a spontaneous abortion at three months which happened about 6 months ago. It highlights the positive influence of an FCHV as a source of information, and a variety of decision-makers that led to journeys to seek care.

"My husband visits me once a year in Magh on annual leave from his job in Pune, India. I knew I was pregnant straight away after one month. That was in the month of *Magh (*Jan/Feb*)*. Two months later, in *Chaithra (*Mar/Apr*)*, I began to get abdominal pains and they got worse and worse until I thought I was going to die.

I didn't go to the village clinic for any check-up. I felt too shy. I asked for some medicine for my headache (*thauko muriya")* from the "doctor" in Semri but when I went back again he realised that I was pregnant and refused to give me any more.

Eventually I told my mother-in-law. She said let's wait "*ek pakh*" (a fortnight), after which I still wasn't better so she called the UTBA and the *guruwa* (UTBA's husband) as well. The FCHV also came as she had heard about my difficulty - she is the daughter-in-law of the UTBA and the *guruwa*. The UTBA massaged my abdomen. The *guruwa* did his rituals "medicine" (*gurey ewshedhi).* They both came everyday and said there was nothing to worry about: "*kutch ney*". Another UTBA was also called from Semri.

But after 2 weeks, they all began to say that there was nothing more they could do and I should go to Dangadhi. The *guruwa* said that his *gurey* were not working. I began to get headaches and some dizziness (*chakka aune*). Everyone started saying that I was going to die. The TBA told my mother-in-law that she didn't know how to save me. She said: the blood can't get out - that's why there's so much pain."

Then the FCHV started saying that it would be best to take me to Dangadhi, otherwise I would probably die. We went to the Ward Chairman, a relative, for help[38]. He loaned us 3000 rupees (*rin*) at 5% interest, which has still not been repaid. I was unable to work at all during this time. I really thought I would die.

So after a month of pain, I eventually went by our own *loria* (*wooden wheeled* buffalo cart) to Muda and from there took a bus to Dangadhi. My father-in-law and my own brother and his wife from Semri came with me on the journey. I don't remember much about it as I was nearly fainting from the pain and very weak. I hadn't eaten anything for many days. It took all day to reach the hospital.

At the hospital I was examined, had an injection, some saline and given lots of pieces of paper with writing on it. They said they would need to clean me out *(sapha garne)* as the baby was dead and all in bits, and I was taken to another room. I don't know what

[38] *this case occurred a short time before the NSMP introduced the Emergency Fund concept into the area*

happened - they put me to sleep. Like this the baby was removed: bucca gayo, aishin huil.

When I woke up I felt a lot better and stayed for two nights before going back to Muda by bus and by cart to my house.

But quite soon the pains came back. There was no bleeding, just pain again, just like I was a piece of liver being squeezed! But I didn't tell anyone as I was taking medicine and the Dangadhi doctor told me I would be fine.

After several more weeks of pains, I decided to go to India. I made the decision myself and I went to Lucknow with my brother and his wife. We have relatives there. It took a day travelling to get there. From Lucknow, we contacted my husband who came to visit me from Pune and brought some money.

After I got back from Lucknow I had my first period which lasted 10 days and was very heavy. But I wasn't worried - I was happy and relieved (*ek dam majha lagyo*) and I felt much cleaner.

I was surprised to have this problem as my first two deliveries had been very easy and quick: *ek chin ma*. I am now planning to be sterilised".

Tharu Case Study 9

Despite dead twins, post-partum hemorrhaging and fever, the woman stays at home throughout, 1998

Last year, 29 year-old Hira Mati Baraik (Kathariya Tharu), the wife of the Sungarkul chowkidar, gave birth to twin girls. The first was born normally but died five days after birth. The second was breech, eventually delivered dead by a UTBA. The antenatal clinic staff, UTBAs and guruwas had not realised that there were two babies until the first baby was delivered. Hira was very ill after the delivery but eventually recovered slowly at home. We spoke to Hira, her husband and one of two UTBA involved in her case. Hira has three children and is heavily pregnant again - for the seventh time. She lost two previous babies at birth: their deaths were attributed to the witchcraft of "jumrogh".

"Last year I was taking *gulabchukki* (family planning pills) as I didn't want to have another baby. But when I went to get my supply from the Ward Chairman's house (where BASE supports a clinic), there was no stock for two months. Then I got pregnant.

After three months I went off my some food and then had cravings for other foods. I also got a mouth ulcer so that it hurt to eat. My husband and parents knew about the pregnancy but I hadn't told anyone else. We do not live with the extended family, so no one else knew.

I went to the village antenatal clinic at 6 months and at 7 months. After that there was no clinic in the village. I felt very shy as the "doctor"[39] was a man, but still I went and let him touch my stomach. He said everything was fine. But I didn't tell him I had been having pains. I didn't have any injections. The second time I went the "doctor" didn't even speak to me[40], just pressed on my stomach when I was lying down.

By the 8th month, my mouth really hurt and I couldn't speak at all. We called the UTBA about this time because I felt a bit awkward with some abdominal pains, but she said everything was fine after touching her stomach. She also said it was nearly time for the baby to be born: *din pugil ba.* But it was only 8 months.

Shortly after that, still in the 8th month, my waters broke over about three days. I didn't have any pains. There was no bleeding either but I had headache and generally felt ill (*khanjkinj).* I told my husband about it. He thought it was nothing to worry about, but we went to ask a *guruwa* who told us that it was not due to a *bokshi*, that he didn't need to do a *gurey puja*, and that we shouldn't worry. We didn't tell anyone else or call anyone. My husband was also shy to speak of this to anyone. Like this, slowly the babies were lost: *asti karat karat 8 mahina bucca bigral*.

After that, I went to catch fish all day and when I got home I started having pain and headache. I sent my son to get my husband who was working elsewhere. He went straight to get the UTBA but almost as soon as they returned, the first baby was born, at about 5 pm. It was very quick - like the time it has just taken you to take my photograph. There was a lot of water too with the baby and a little bleeding started.

Then the TBA said there was a second baby but that it was stuck and wouldn't come out. The bleeding got worse. The first baby was lain down on the floor with a piece of cloth over it[41]. The cord wasn't cut as we had to wait for the second baby to come and the placenta to come out.

[39] not clear whether this was the Sub Health Post in-charge or the Village Health Worker
[40] possibly a language barrier?

[41] it was the month of *mangsir* (Nov/Dec) so it would have been quite cold

After several hours, still the second baby wouldn't come out. So the *guruwa* was called. Women in pregnancy are very vulnerable to attacks from the bokshi: *gharbhakey bela bohot bokshi lagat".* In my case, the *bokshi* was stopping the baby being born. The *guruwa* did *gurey puja* and fed me some *joributi* (herbal) medicine.

My mother-in-law also decided to call a second UTBA at about 10 pm. She was worried about the trouble her son would have if I died. She had wanted to bring a woman from Semri but I urged her to call another one from here as I had heard that two women had recently died attended by the Semri woman. I said: either I'll die, or you call her. It's up to my *bhagye* - luck".

At nearly midnight, the second TBA arrived and said that "this will be very difficult. The baby is breech. We may be able to get it out but it is probably already dead and we may also not be able to save you". But she massaged and pushed at my stomach and told me that one hand was coming out first and that the baby was in the *jalli* (membrane). Then she stuck her hand inside me, ripped the *jalli* open and pulled the baby out. It was already dead.

(continued)

Tharu Case Study 9 – ctd-

The placenta came straight out with the second baby. The TBA cut the cord with a blade and buried the placenta in a corner of the *sowri* and lit a fire over the burial place. Both babies had been about the same size.

There was a lot of bleeding after the second baby was born: *khun ek dam ab maihikey ney dekhaw*" but I tried not to look. I remember trying hard not to faint. I kept thinking about what would happen to my other children if I died.

For several days I continued to bleed and it was coming in bits (*tukra tukra*). I also had fever for several days after the delivery and until the *ghatwa kaireyna* which we did on the third day I had hot sweats then cold chills. I felt very tired and slept a lot.

On the night after the *ghatwa kaireyna*, the first-born baby began to cry and wouldn't stop - that's when the *jumrogh* came for it. I woke my husband who gave me the baby and I tried to feed her. But I did not have any milk and she turned her head away as if she wasn't interested. She had been taken by the *jumrogh*. Then on the 5th day in the evening, she died.

I stayed in the *sowri* until the 8th day even though both my babies had died. Then the TBA told me I could leave and go to another place to sleep, and we fed her meat and *rakshi*.

After this I felt very weak *(mey komjor hoginu)* for a long time. I also got fever a lot and sometimes I was delirious, talking in my sleep saying people were coming to get me: *ajhi katri garkutey bisna mormis chalosub bhagadi.* My husband thought I was going mad and called the *guruwa* who did a *gurey puja* for me.

The *guruwa* said it was because the ghosts (*bhutharu)* were coming at night and scratching me with iron nails. In the day I was fine, but at night whenever I went outside I saw someone looking at me, giving me the evil eye (*uhey lagal rahey*) and then I would faint. My husband thought I was going mad. My husband also went somewhere and brought me some medicine - I don't know where from and I don't know what it was. I wasn't well enough to walk anywhere or even sit on a bicycle to go anywhere so my husband went by himself.

Very slowly I got better but I didn't want to eat anything except fruit. My husband went to India and brought me back lots of apples. Gradually I got my appetite back but it took nearly four months before I could do normal work again. It took a long time to feel strong.

I don't know what happened to the bodies of the two babies. My husband dealt with all that - he must have buried them somewhere but I don't know where. He didn't tell me.

Even when I had collapsed after the second baby was born, no one talked about taking me to Dangadhi. I have heard that if there is difficulty then it is best to go to Dangadhi but I never thought that this would happen to me. My other deliveries had been very easy, just like passing urine!"

7. LESSONS LEARNED

Section 5: Findings described the results of interviews of a large number of Magar and Tharu men and women of all ages with a variety of roles and responsibilities within the household and the wider community.

Many people appeared to be very frank. Some were more hesitant and reluctant to reveal details. Younger, better educated, people were usually less hesitant to discuss *laj* and the lack of involvement of men than the older people. Ordinary community members were eager to share their beliefs and opinions, whereas some service providers seemed worried that we were out to trick or evaluate them in some way. Traditional healers were sometimes unforthcoming about details of their work and the spirit world. While there were exceptions under every theme, some overall conclusions will now be summarised in the form of lessons learned.

1. Differences between the two ethnic groups

This study has revealed that there are similarities, but also many differences between Magar and Tharu beliefs and behaviour surrounding pregnancy, childbirth and the post-partum state.

There are **similarities** in some birthing practices and in the belief in a period of ritual pollution. There are similar beliefs that sickness is caused by the malevolent work of witches and spirits of the supernatural world. There is a predominant belief in one’s fate being the determinant of living or dying from sickness if the traditional healer fails to effect a successful treatment. Both communities turn first to traditional healers and untrained traditional birth attendants as sources of information and care providers during the childbirth period. There is relatively much less recourse to other care providers from the western medical system, the trained TBAs, the FCHVs, the health post staff and the hospitals. Decisions affecting women during pregnancy and during childbirth are largely made by the senior household members, particularly the mothers-in-law, and the UTBAs and traditional healers. As the other players are consulted much less they are less frequently involved in the decision-making process. Delay occurs at all levels of the decision-making process. Men in both communities have a very low level of awareness of the problems and risks women can face during pregnancy and childbirth.

However, there is a multitude of **differences** between the two communities. Each ethnic group has its own terms and expressions for the processes surrounding pregnancy and childbirth. Each ethnic group has its own way of describing how the human world and the spirit world interact and how sickness and trouble can result. The two types of traditional healer have different ritual paraphernalia and different types of rituals. The Tharu have a more complicated system of practitioners than do the Magar, with specialisations and different roles to deal with different

situations. Even within the Tharu there are many differences, beginning with language. Many expressions, beliefs and behaviours of the Kathariya Tharu were unfamiliar to the NSMP Tharu facilitator who is a Tharu from Dang but has lived amongst Dangaure Tharu all her life. One of her main observations was that Kathariya women seemed “bolder” than their Dangaure counterparts, less bound by *laj*, less concerned with loss of prestige and more inclined to speak out.

These ethnic differences lie in the detail, the language and the characters involved. An understanding of these differences is crucial to the tailoring of appropriate increasing awareness messages. Without acknowledging and incorporating them, the level of understanding among different ethnic groups will be low, and acceptance, and the behaviour change that is assumed to follow on from this, will be slow in coming.

2. Traditional beliefs still take precedence over the modern medical system

Many traditional beliefs about the causes of ill health in pregnancy and childbirth do not fit neatly into the modern health system model on which the NSMP is based. Witches and harmful spirits of the supernatural world are frequently responsible for many of the normal as well as abnormal conditions experienced by some women at these times. Because of this, decisions are made to seek care from those care providers who have the appropriate skills and experience. While some are aware of a different belief system and of some danger signals, the traditional healers and untrained traditional birth attendants are still the care providers of choice for the vast majority of deliveries.

In both areas, there is a persisting belief in the role and efficacy of traditional healers, and perhaps more so in Kotatulsipur than in Ratnechaur. Such beliefs are still strongly held by different community members, and even by many service providers who have been exposed to the alternative theories and practices of the western medical belief system. The efficacy of the traditional healers has been proven for centuries, still reinforced almost daily, as traditional healers have success in their dealings with a wide range of health problems in both their human and animal clients. Of course, this is not a new finding, and some of these issues were brought out in the NSMP videos. However, this study has provided more detail drawn from the responses of participants who had an opportunity to reveal their beliefs and behaviours to outsiders using a less intrusive methodology.

3. Divergence of normal/abnormal classifications

The use of the terminology "normal, abnormal and life threatening" does not translate well. To the Magar and Tharu, a condition is only serious/difficult (*apphatbiphat, katpat*) if it means that the woman is too ill to work. The expectations for, and pressure on, a woman to perform her duties (*nengti garti*) is so great that only a really debilitating condition will mean that she withdraws her labour and takes to her bed.

Some conditions classified as dangerous, and even life threatening, by western medical knowledge, are not perceived as such by many people, including indigenous service providers in the two communities. These include oedema, and some bleeding both pre- and post delivery, both of which are considered normal conditions of pregnancy and delivery, and to some extent post-partum. There was also a lack of awareness that a long gap between waters breaking and the birth might be a dangerous condition.

How long is a long labour? When is a placenta "retained"? Details about what is considered long will depend on when the condition is recognised as starting, and on how time is measured. Many people regarded the start of labour as the fast painful contractions of the second stage, and this is when many would inform others and seek help. But this was not true for all women, some of whom clearly counted the time from their first contractions. Increasing awareness messages will need to differentiate between these, and to find appropriate ways of dividing segments of time so that peoples' descriptions fit into the project's own terminology. For example, hours were rarely used to describe time. Instead the time taken to cook the family rice (1 hour), or the time between different locally recognised segments of the day and night (e.g. *bhinsar* before dawn, *sakara* early morning, *koluwajan* morning meal, twilight and the evening meal, the dead of night) were calculated. In general people in both communities talked in 5-6 hourly blocks which were marked by the position of the sun and the timing of a main meal.

4. Complex pattern of delay affecting every stage of the decision-making process

The most striking finding about the decision-making process is the extent and complexity of delay. Delays in recognizing, and acting upon, emergency signs and conditions occur at all points of the care-seeking behaviour continuum. These can begin from the time a woman first suspects that she is going into labour or seeing a symptom, to the time when a decision may be made, usually by others, to take her to the nearest hospital. An attempt to summarise these many causes of delay follows:

(a) The women

- delay caused by *laj,* shyness and shame about revealing intimate matters

- delay caused by a high pain/discomfort acceptance threshold among women which emanates from their subordinate position, especially in relation to mother-in-laws. Women also feel unable to make a fuss because of fear of bringing a loss of prestige (*ijjat*) on the house

(b) The household

- delay caused by fear of witchcraft in calling others from outside the household
- many conditions thought of as normal resulting in a delay in recognising that a situation needs to be communicated to a potential care-provider
- delay caused by fear of potential expense in calling a TTBA, or a doctor from a private medical shop
- delay among family members caused by fear of potential expense, discomfort and the dangers of the journey especially at night, and of dying en route in making the decision to go to hospital
- delay among family members caused by a fatalistic attitude towards death. There is a belief that there is little anyone can do when one's "time" has come which, in combination with the other delays, dulls the urgency to act quickly
- delay caused by reluctance to risk treatment at hospital in the face of past bad experiences or information received from others in going beyond the community limits to transport a family member to a distant and unfamiliar hospital environment.

(c) The first care-provider

- delay in finding the care-provider and bringing him/her to the house
- delay in the time it takes for *lamajhankri/guruwa* to do *puja*
- delay among UTBA/TBA and traditional healers in calling others to help if they are not successful in dealing with the problem
- delay in repeating a *puja* or technique, or trying another one
- delay in referring to hospital for fear of blame if something goes wrong

(d) The community

- delay in spreading the news and organising appropriate assistance (transport, money, people to accompany.
- delay among community members caused by a fatalistic attitude towards death
- delay caused by reluctance to risk treatment at hospital in the face of past bad experiences or information received from others
- delay in referring to hospital for fear of blame if something goes wrong

It is clear that many of the early delays occur even though the care-providers (e.g. UTBA/TBA, FCHV, *lamajhankri/guruwa*) are nearby, cheap (free) and accessible day and night.

5. Limited uptake of services provided by the western medical system

The *bhalemansa* of Jokhali said:
"no one goes to Dangadhi (hospital), we don't take them. We can fix everything here: *ney jeyta Dangadhi, landeynan. Yahain thik hojait to ka leyjinaho*".

His words were echoed by many men and women of all ages, and by Magars as well in relation to Baglung hospital. This is not due to hospitals being too far away as the other western care providers such as trained TBAs and health post staff are closer by and still relatively underused. It is more a reflection of what has already been described above: that there other places that people prefer to go to, and other people they prefer to call, because of their health belief system. There is an exception to this sidelining of the western health system, particularly in Kotatulsipur, and that is the use of the private medical shops. It may not be very popular to conclude that the western medical system still remains on the periphery for most Tharu and Magar women seeking care in Ratnechaur and Kotatulsipur, but that is what the data have revealed.

6. Sources of information are still predominantly from traditional local providers

Older family members, and traditional care providers (UTBA and traditional healers), remain the predominant sources of information to women in pregnancy and childbirth. Health post sources are less reliable and accessible, especially when staffed by people who do not even speak the same language. Private medical shops are important sources of information, especially for Tharus in Kotatulsipur. Radio and other media sources are of negligible importance given the poverty of most families, and illiteracy of most women. At the bottom end of the scale of sources of information are the hospitals.

7. Men admit they know little but some would like to learn

There does appear to be potential in adopting a strategy that makes men more aware of safe motherhood issues. Men's current level of awareness about the risks of pregnancy and childbirth is very low. However, although initial questions about this almost always elicited a negative response, as probing proceeded more positive attitudes emerged, especially among younger men (including the community leaders and even some of the younger traditional healers). The younger ward chairmen and *bhalemansa*, and traditional healers in both communities seemed more amenable to having their beliefs and practices challenged. The *bhalemansa* of Sungurkal was particularly receptive. He said: "all this comes from previous generations and now everyone should be deciding for themselves."

8. A women in childbirth is like a cow stuck in a ditch

"*Kowlow paryo gai, kuna paryo sutkeri*" *(see section 5.7). A cow cannot get itself out of a ditch without the help and knowledge of others. A* sutkeri/larkoria *woman cannot get back into the 'normal world' without the help and knowledge of others. This offers a fitting analogy of the dependence and powerlessness of women*

during pregnancy and childbirth. This study has documented how often it is that people other than the woman herself provide the information, make decisions and seek the care-providers.

We have seen how even some women "empowered" with skills and knowledge (such as FCHVs and trained TBAS) have still been helpless in the face of pressures to conform to what is the expected role of a woman in these circumstances. For example, it is striking how many things in both Magar and Tharu belief systems have the effect of restricting women's movement, and their autonomy. Beliefs about witches in jungle and the surrounding areas watching you, especially when you are menstruating, pregnant or nursing infants, may have something to do with women's overall restricted movement around their community. Rules about not going to particular places, and when and what might happen, have the effect of internalising fear within them and discouraging women from venturing very far from their homes. Whatever the cultural justification, the effect is clear. Women do not enjoy the same rights of movement as men. While these issues are not as pronounced as in some other western districts of the country (e.g. Accham, Bajura) they are still present nevertheless.

A cow stuck in the ditch may stand quiet, not cry out and so will not attract attention. A woman in pain or bleeding in pregnancy may not cry out because of *laj.* Does *laj* matter? Yes, because this *laj* results in delay. Because of *laj*, women delay in telling others about their condition, and their family's delay in making decisions to seek care. Is *laj* just a cultural trait that can be left well alone? No, it is an inappropriate behaviour in the context of women's health. Ways need to be found to challenge it by those committed to safer motherhood in Nepal.

What has all this to do with an increasing awareness strategy for the NSMP to promote the uptake of hospitals in emergency obstetric situations? It demonstrates how the prospective "patient" cannot be seen in isolation from the context in which she is not a patient or stake holder but a woman with little autonomy or decision-making power, even over her own health. Increasing awareness must acknowledge and address all those who influence this and uphold the social rules and constraints. Addressing the increasing access strategy messages on the sutkeri/larkoria*, and on her alone, would be like trying to help the cow stuck in the ditch by just throwing down a rope without holding on to the other end. Addressing the messages to everyone may even mean that the woman will not get stuck in the ditch in the first place.*

9. Some community social systems exist that can help women in emergencies

The NSMP's goal of increasing women's access to emergency obstetric care is assisted by several indigenous community social systems in the two study locations, and probably elsewhere in districts that are inhabited by the same ethnic groups. Magars have a tradition of reciprocal help

(*arma parma*) that is sometimes used to help women in obstetric emergencies. Tharus are potentially even better served with their community organisational system of *bhalemansa* and *chowkidar* which provides ways of cooperating, passing information and facilitating help. However, it appears that most families still try and cope alone given some of the issues outlined in section 4 above.

8. RECOMMENDATIONS

The main aim of this study has been to describe the local beliefs and behaviours relating to menstruation, pregnancy, delivery and the post-partum period commonly found in the Magar and Tharu areas under scrutiny. An attempt has also been made to discuss these in relation to the issues of importance to the NSMP, that of sources of information, dynamics of decision-making, community systems of help and the level of awareness of men. Some general lessons learned from the data have been presented in Section 6.

This report now concludes with some brief ideas for the development of the IEC strategy of the NSMP. The recommendations listed here are made without any knowledge of the plans already on the table, nor the constraints of the project log frame, including time and budgetary deadlines. They are merely ideas that have emerged during the course of the fieldwork, while analysing the qualitative data, and while compiling the bulk of this report. Increasing awareness: how can it be done?

1. Listen to all, talk to all and involve all

This recommendation refers to involving **all people** in the increasing awareness strategy: men and women, leaders and followers, young and old. For example, working with some traditional healers and not others will only lead to a fragmented awareness and new points of resistance. Remember that, in the case of Tharus, the most important *guruwas* are not often involved in delivery cases, but will still need to be included because of their much greater sphere of influence than the other *guruwas*. However, this is not the same as specially targeting traditional healers for training, but rather incorporating them more in the whole process of dialogue.

This recommendation can also mean involving **all aspects of safe motherhood** and not just those focusing on obstetric emergencies even if that is the key long-term objective. Health and safe motherhood for these women operate in a continuum of daily concerns that do not exist in isolation from anything else: water, food security, agriculture productivity, and their environment. People in the community do not see childbirth the way the NSMP does. For them, there is no compartment called “decision-making in obstetric emergencies”. For them, all that they might recognise is a general and holistic approach that looks at improving the health of women, and on what happens to them during pregnancy and childbirth. People already know that most women produce babies without major problems, albeit with varying degrees of pain and discomfort. Questions posed to us showed that women, and their families, were more interested in learning about what they could do to improve their health generally than about the process of going to hospital if things went wrong.

As the project enters the arena of increasing awareness, there is perhaps a balance to be found between finding ways of improving things along the continuum (which is how

the community sees things) or concentrating on where the risk is greatest (which is where the NSMP sees the issue). As the community do not see the risks as great, then a point of entry may be to take a more broad approach to safer motherhood. For example, orientations to all about the 6 cleans, supporting the demand and supply of the CHDK, or improving awareness of the reasons for women's lack of energy might be manageable places to start. These are relatively straightforward issues that could be incorporated into the IEC strategy, perhaps as introductory modules and possibly beginning with adolescents, before the project really tackles the more difficult and unfamiliar issue of hospitalisation. This would give a lead in to the key part of the strategy without appearing too intimidating, and would also give people some immediately accessible and practical tools that they could use themselves.

This recommendation could also be taken to mean talking to **all those who are working at grass roots level** with community leaders and with community members. For example, in Kailali, BASE has been active for a number of years and has trained traditional healers in various topics. What were these? Did any relate to maternal health? How effective were they? What sort of issues, problems emerged? The Red Cross may also be informative.

2. How can this be done: ideas for tools

Alien tools should be avoided. Pictures, graphics, etc. should be carefully designed using local facilitators and should be piloted and revised. It was interesting to see that the pictures from the TBA training manual were often misunderstood by many people (particularly pictures of bleeding in pregnancy, heartburn, oedema and signs of eclampsia). Check the existing content of IEC material, (e.g. there appears to be little on waters breaking and what to do if contractions do not start).

A potentially more familiar approach would be one that supports the oral tradition. Messages could be conveyed in the form of songs, dances, street dramas, or puppet shows. Some of these can re-enact real cases (as a story or *kata*, e.g. write up case studies as plays). They might highlight, in the words of one Ward Chairman, "the crying soul (*attma*) of a woman who is bleeding, but hasn't told anyone and can't get help". They could also pose some hypothetical, maybe even, unbelievable or provocative scenarios to stimulate debate/reaction (e.g. a female *bhalemansa*, a man giving birth). For example, among the Tharu, the content of the *janmounti mantra* could be explored and perhaps secularised. Could it be adapted with new messages with the co-operation of the *guruwas*? The intention would be to "ring bells so that people will take notice (*chunnta lincha*)" rather than recite messages of instructions that people are supposed to follow. The content should emphasise existing things in the local context that support information giving and co-operation in times of difficulty (*arma parma*, ritual friendships) and be woven in the language, analogies and proverbs of the ethnic group concerned.

3. When can this be done: ideas for venues

Introducing messages and new ideas to improve awareness can be maximised by choosing the right time and place. Some ideas for these have emerged from the study, particularly in relation to the Tharu communities.

(a) Tharu: Target the *kojne bojne* times that surround the Magh Sangranti festival. This is Jan/Feb, so it is probably too late to prepare for 2000) but it could be observed this year in different places, and more details could be determined from interviews with key people. Other possibilities are the *Lowangi puja* (*kartik/mangsir* or Oct./Nov./dec. 2000), and the *Dhuria* and *Bajahar pujas* in *Jestha* (May/June) for which there is still time to prepare. These are all times when the whole village is together and both men and women are either active participants or observers at the same venue. The community leaders themselves also agreed that these would be potentially useful events at which to launch awareness campaigns: "*wustey bela mujar reyhi munkha choppak parat*" (Ward Chairman of Sungurkal). Target the times after the main *puja* when people come back to the *bhalemansa*'s compound to prepare the feast, accompanied by entertainment in the form of singing and dancing. Maybe the *bhalemansa*'s wife could be a key figure in facilitating this. Other times when all the members of the village council (*charbhaiya*) are present, such as at other times like *nikasi puja* (Dasain/Tihar) and *Nag Panchami (Guria).* There was also mention of a time when all unmarried girls get together and dance (called *chirey?*) and have a feast (*bhoj*). This usually takes place in *Chaitra/baisakh* (March/April/May). This might be a good time to teach safe motherhood songs and other activities. In this way, suggested some respondents, the songs will become a habit and the messages they contain will gradually be taken up.

(b) Magar: Compared to the Tharu, no obvious venues emerged, except for the main festivals such as Tihar and Dasain when many people congregate together for singing and dancing. Local field staff should look into this again, as this aspect of the protocol was not very deeply explored in Ratnechaur.

4. Who should be involved: ideas for identifying community catalysts

While everyone needs to be involved because everyone needs to be made more aware, there are those who will be more receptive than others to new ideas. A *bhalemansa* participant used the analogy of seed planting:

"A new message is like planting a new variety of seed and then watching in which places and conditions it will grow. Some people will notice this better than others and it is those people who can best nurture the new plant to maturity until

it starts to yield a successful crop. [Such people are the community catalysts]. When everyone can see how well the plant is growing, then everyone will want to have that type of land and to recreate the same conditions [that the catalysts do] so that they can also grow such a plant".

Those with the most interest, those who are the most receptive to taking new ideas forward within their own communities, will emerge and can nurtured the idea and then take it forward to a point where the critical mass takes over.

The study data suggest that the young are the most likely to be the community catalysts rather than the old, but there may well be exceptions to this. But older adults have to be encouraged to participate in the process without such pre-conceptions. The organisation, HelpAge International, would be the first to provide examples of how some of the most dynamic community catalysts bringing in behaviour change have been the older adult. Whether the young *bhalemansa* or ward chairman, or a young woman active in a Mother's Group or Non-Formal Education Group, or a TTBA, or an older adult who commands respect, act as the community catalysts, they next need to be helped to generate their tools to take things forward.

What about NSMP's own staff? How can they support this strategy? Here are some ideas:

- Share in the experiences of other INGOS, NGOS, not just in safe motherhood but in other successful or innovative examples of community interaction, (e.g. NEWAH in water and sanitation messages, other organisations who have trained *dhamijhankris* such as BASE, SCF).

- Find ways of becoming more familiar with the methods and the value of qualitative research, perhaps by a visit to the Sociology Department of Tribhuvan University, observation of Ph.D. or MA anthropology students doing fieldwork, informal seminars with researchers who can present in Nepali

- Periodically provide informal opportunities for field staff to collect, assimilate and share this type of information with others, and to emphasise it as an important part of their role in the community. To give field staff space and time to pursue potential lines of inquiry that they have noticed themselves during contact with the community

5. Draw up local time calendars

These are needed for the next year/two years (for the day/week/month/year) to:

(a) determine how time is measured (to compare with what is considered "long")

(b) locate the timing of important local events, such as the main festivals (e.g. Magh Sangranti *for Tharu) mentioned in this study*

6. Moving into new districts

The wealth of detail discovered in this study point to the need for such ethnographic information to be collected much earlier on in proceedings if NSMP is considering moving into new areas. Such information should truly be a baseline to describe community beliefs and behaviours before people are "contaminated" with the hospitalisation, in order to act as a form of qualitative monitoring indicator by which progress can be assessed.

7. Dissemination

In order to continue the debate on increasing awareness within safer motherhood, the NSMP should take a leading role in disseminating its methods, successes and failures, and findings. Articles in Nepal-based journals like Face-to-Face, and international journals like Reproductions, or Social Science and Medicine, could be considered. Presentations to others working in this area in Nepal could be made periodically to stimulate debate and to exchange ideas and experiences with other people working in this field.

8. Acknowledge and address the rights of women

HMG Nepal is a signatory to a number of important conventions and treaties relating to women's rights. Safer motherhood is not just a health issue, and much of women's ill health is determined by their subordinated social and political circumstances. In recognition of both of these, the NSMP should give legitimacy and visibility within its increasing awareness strategy to the questioning, and in some instances, protesting of religious and/or culturally based traditions that are detrimental to women. More attention needs to be paid to how these act as barriers to the achievement of safer motherhood for all women, regardless of their caste, ethnic group or age. Similarly, the NSMP should include reference to the universal right that women everywhere have to modify customary practices that discriminate against women.