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This is a special issue CERID's Education and Development enclosing the paper presented in the conferences on "Gender, Education and Development" and "Indigenous Knowledge and Health Practices" (21-22 December, 2005). The conferences and the publication of this issue are parts of the Higher Education Link Program supported by the British Council. The Link Program was started in 2000 between CERID, Tribhuvan University/Nepal and Liverpool John Moores University/UK, CERID has established links with two Central Departments of Tribhuvan University: Home Science and Women's Studies and Sociology and Anthropology. The focus of the Link Program is on the research in the areas of Indigenous Knowledge and Health Practices, Gender and Education, and Reproductive Health.

The papers presented in the conference on Gender and Development discusses various critical aspects of gender and underlines the efforts to address gender-related issues. This area is of high importance of Nepal because the country is now facing severe challenge faced in achieving gender equality in all aspects of life, particularly education. The challenges relate in the main to Nepal's commitment to achieving the Millennium Development Goals and the EFA goals. Nepal has also pledged in this respect to our national as well as international resolutions regarding gender issues. The current conditions and the trend in the country show that the goals are miles away and too difficult to achieve.

The papers presented in the conference Indigenous Knowledge and Health Practice land on a unique, and very potential area, for Nepal to address. Nepal is a mosaic of several social groups different in terms of ethnicity, language and castes and living in contrasting geographic region -- the Himalayas, the Mahabharat Mountain Range, the Siwalik Hills and the Terai Plains. The social groups have their own unique lifestyles - and knowledge and health practices, many of which have now been marginalized by the modern systems of healing and cure. There is therefore a great need to understand the indigenous systems and their development potentials before they become extinct.

This issue of CERID's journal is an attempt to share the contents of the conference with its readers. I hope the publication will help to enhance the critical understanding of the gender and health practice issues potential and open up new venues for discourage and interaction.

I would like to extend my sincere thanks to the paper presenters for their valuable contributions and to the academicians and professionals who inspired us to bring out this publication. I am confident that the support and goodwill of our contributors and readers will continue as ever.

I would also like to take the opportunity to express my sincere appreciation and gratefulness to the British Council/Kathmandu for their kind support which not
only helped forge fruitful linkages between higher education institution in UK and Nepal for academic discourage and research but also made this publication possible. Sincere thanks must also go to Liverpool John Moors University - particularly to Dr. Sara Parker, the Link Coordinator whose cooperation and proactive support have helped to make the linkage activities including the conferences an this publication a good success. The Chairpersons and faculty members from the Central Department of Home Science and Women's Studies and the Central Department of Sociology and Anthropology do deserve our special thanks for their kind cooperation and effective partnership in all the link activities in Nepal. Finally, I thank all the staff member of CERID and the people from outside CERID who worked hard for the production and publication of this special issue.

Hridaya Ratna Bajracharya
Executive Director
April 2006
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Sharing Experiences of REFLECT in Sikles: 
A Collective Reflection

Nanda Shree Gurung
Dr Sara Parker,
Laxmi Dhital,
Kiran Bohara,
Ganga Maya Gurung

Introduction

This paper will first provide a brief overview of the Nepal and the Annapurna Conservation Area Project and then move on to look at how and why REFLECT came to be introduced into the Sikles sector of ACAP. Drawn on the research undertaken by Sara Parker and the experiences of her fellow authors in facilitating REFLECT centres or supporting the project the key outcomes of REFLECT are discussed in some detail. Finally, the lessons that have been learnt by the authors are explored in order to make recommendations for the future of the project.

The Annapurna Conservation Area Project – the role of education

Nepal has long been considered a leader in the field of conservation and development (Heinen & Kattel 1992, Heinen & Yonzon 1994, Pretty & Pimbert 1995, Wells 1993). The Annapurna Conservation Area Project (ACAP) was one of the first Integrated conservation and development programmes launched in Nepal by the national non-governmental organisation King Mahendra Trust for Nature Conservation in 1986 (Gurung and DeCoursey 1994, Parker 1997). ACAP covers over 7,600 sq km in the Western Himalayas (see Map 1) which is recognised as an area of biological and cultural diversity (Gurung & DeCoursey 1994). It has been cited as “one of the more advanced and ambitious integrated conservation and development projects” (Brown & Wyckoff-Baird 1992 p51) and the approach has been replicated in Nepal. ACAP aims to address the limitations of the National Park policy and the nationalisation of resources such as forestry. It provides a framework through which local communities could be reinstated as the custodians of their own environments by the formation of Conservation Area Management Committees (CAMCs).2

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1 Dr Sara Parker is a Senior Lecturer in Geography at Liverpool John Moores University, Laxmi and Kiran have been supporting REFLECT in Sikles and Ganga Maya and Nanda Shree Gurung are REFLECT facilitators and committee members of the CBO the Madhi Khola Women’s Association

2 Initially called Conservation and Development Committees (CDCs), these committees are supported by Government regulations such as Conservation Area Management
A comprehensive Conservation and Education Programme (CEEP) supports CAMCs in increasing the levels of awareness, points out environmental problems and suggests potential solutions for the local level. Conservation education is considered to be the backbone of the ACAP success (Gurung and DeCoursey 1994). CEEP aims to raise awareness and thereby foster direct action towards projects being planned, implemented and monitored by local institutions (CAMCs). In particular, it is concerned with facilitating action that is aimed at protecting the environment and ensuring that local resources are used and managed in a sustainable manner. According to Gurung and DeCoursey (94): “Unless awareness is raised among the users of the resources, both local and outsider, sustainable development cannot be achieved” (p189). CEEP has three major components that aim to promote sustainable development: formal Education, extension programmes (informal) and non-formal education programmes.

This paper focuses on the experience of the authors within the Sikles sector of ACAP (see Map 2 below). In particular, it examines the experiences of non-formal education in the village of Sikles and Parche in Parche VDC, Kaski District of Nepal (Map 3).

Regulation (CAMR) and Conservation Area Management Directive (CAMD) passed in 1996. They provide legal recognition to the CAMCs and clearly spell out “the function and authority of the CAMC to plan, implement, monitor and control the resource conservation activities within their VDC boundaries” (ACAP 2002 p5).
Map 2 Location of ACAP and Sikles Sector within Nepal showing VDCs

Parche VDC is dominated by Gurungs (66.79%), the remaining population being of Damai and Sarki groups (Table 1). This compares to a national average of the 'Dalit' community of 15% (DFID 2003). Over 60 percent of the population rely upon agriculture as the main occupation and the literacy rate is estimated to be 18.6% for males and 30.4% for females. Further, a survey showed that approximately 30% of Gurungs in Sikles and Parche classed themselves as illiterate compared to over 50% in other ethnic groups. This is higher than the national average for rural areas of 22% (NRC-NFE 2003). In the study area ACAP found that one of the first requests made by local women was for non-formal education programmes in their areas.
**Table 1** Distribution of ethnic groups in Parche and Thumakodanda VDC

<table>
<thead>
<tr>
<th>VDC</th>
<th>Distribution of ethnic groups</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Gurung</td>
</tr>
<tr>
<td>Parche</td>
<td>66.79</td>
</tr>
<tr>
<td>Thumakodanda</td>
<td>22.63</td>
</tr>
</tbody>
</table>

**Key**

<table>
<thead>
<tr>
<th>Caste</th>
<th>Also known as</th>
<th>Associated occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gurung</td>
<td>Tamu</td>
<td>Various</td>
</tr>
<tr>
<td>Bishwakarma</td>
<td>Kami</td>
<td>Blacksmith</td>
</tr>
<tr>
<td>Pariyar</td>
<td>Damai</td>
<td>Tailor</td>
</tr>
<tr>
<td>Nepali</td>
<td>Sari</td>
<td>Cobbler</td>
</tr>
<tr>
<td>Brahmin</td>
<td>Baun</td>
<td>Priests</td>
</tr>
<tr>
<td>Other*</td>
<td>Various</td>
<td>-</td>
</tr>
</tbody>
</table>

* Including Chettri (warrior) and other ethnic groups


**Table 2** Socio-economic and education indicators of Parche and Thumakodanda VDC

<table>
<thead>
<tr>
<th>VDC</th>
<th>Population #</th>
<th>Household #</th>
<th>illiteracy rates</th>
<th>SLC %</th>
<th>Migration %</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Male Female</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parche</td>
<td>3772</td>
<td>620</td>
<td>18.6 30.4</td>
<td>2.2</td>
<td>18.05</td>
</tr>
<tr>
<td>Thumakodanda</td>
<td>4870</td>
<td>854</td>
<td>16.6 26.5</td>
<td>2.7</td>
<td>14.39</td>
</tr>
</tbody>
</table>

SLC – School Leaving Certificate
Source: IPRAD (1999)

ACAP responded to requests for adult literacy and provided both basic and advanced courses in Sikles and Parche in the early 1990’s soon after it began working in the area. From 1994-1995 five basic classes ran in the Sikles sector. However, high drop-out was noted. The reasons for the drop-out were marriage, pregnancy and even harassment by men in the time of class attendance (ACAP 1995).

Between April 1995 and April 1998 interviews and participatory observations were conducted with a range of key stakeholders within ACAP including local women, traditional local leaders, CAMC members, social workers, members of Ama Tolis (Mothers' Groups), local teachers and children in the Sikles sector as
Sharing Experiences of REFLECT in Sikles: a Collective Reflection

well as the ACAP staff working at both the local level and the Directorate level. Whilst a number of strengths were noted (in relation to the CEEP) it was concluded that ACAP did not fully meet the demand for adult literacy. Although many women had completed the basic and advanced literacy courses, many felt they were in need of more literacy and suggested a need for a post-literacy programme. The ACAP staffs were aware of this demand. One OIC noted: “Women are greedy for literacy.” By failing to meet the demand for education ACAP failed to meet its aim for CEEP to take a significant step towards integrating the needs and opinions of the disenfranchised into village decision-making” (Gurung & DeCoursey 1988 p15). Secondly, issues of exclusion and marginalisation were highlighted as social customs prevented women from ‘traditional occupational castes’ (in particular, Kami, Damai and Sarki) from entering Gurung households where the literacy classes took place. Sara had noticed this before during her stay in Sikles when she had observed groups of women sitting in the balconies outside the houses where classes were running. Even though they could barely see through the wooden-framed windows, they were trying to learn to read and write by listening. This had moved Sara and led her to question why this need for literacy was not being met. At the same time, as these observations were made, interviews with ACAP staff suggested that non-Gurung members of the community were harder to motivate and could be as easily integrated into the participatory process as the Gurung members of the community. It was suggested that by improving the access of these groups to education they could be more fully incorporated into ACAPs’ participatory process (Parker 1997). Further, observation of ACAPs literacy classes led to the conclusion that although the text reflected local issues they were delivered in a didactic manner. The teaching methods were very traditional and formal and failed to engage the learners as expected. This lack of participation in classes was found to contribute to the high dropout previously noted (Parker and Sands 1997). Taken together, these findings suggested that a more participatory and engaging form of non-formal education would be more appropriate for ACAP. Before visiting Nepal in 1996 Sara Parker & Rose Khatri (see Sands) had attended the launch of REFLECT in London and explored this further with Actionaid whilst in Nepal. A brief overview of the underlying principles of REFLECT will do good before we move on to explore its impact in the study area.

REFLECT in Nepal

Regenerated Freirean Literacy through Empowering Community Techniques (REFLECT) was developed by ActionAid UK, which blends the Freirean theory of conscientisation with the practice of Participatory Rural Appraisal (PRA) (Archer and Cottingham, 1996a, 1996b). Through blending the philosophical approach of Paulo Freire and the techniques developed within the field of PRA, REFLECT addresses some of the key concerns regarding the co-option of participatory
development (Chambers 1994, Cleaver 1999, Cooke & Kothari 2001, Francis 1996, Gaventa & Cornwall 2001, Hickey & Mohan 2004, White et al. 1994, White 1996). Secondly, it removes the dependence on external change agents, for PRA tools are transferred to the local level and embedded within the educational process. There are no ‘teachers’ or ‘educators’ in the REFLECT approach; facilitators are trained to engage as co-learners in the circles that they establish within their communities. Further, REFLECT imaginatively channels PRA techniques towards more radical ends and hence overcomes the lack of overt political analysis often missing in much of the PRA discourse. It can prevent the ‘educator’ or ‘teacher’ imposing his or her own ideological views on the participants (Blackburn 2000, Kane 2001). According to Chambers (1994), the process of PRA, if done well, can promote a creative learning process whereby knowledge is not only shared but also created. The use of participatory techniques and tools enables the participants “to analyse their world and can lead to their planning and action” (p1266). The key to this process is ‘doing it well’. REFLECT by locating PRA tools at the local level and emphasising the role of the facilitator as a co-learner attempts to overcome such limitations. The participatory approach is fundamental to the success of REFLECT. According to Archer and Cottingham (1996b), ‘literacy itself does not empower people.” (p87). However, literacy programmes “can be very empowering if the literacy process is interwoven with other processes through a well-structured participatory methodology” (ibid.). Providing good quality participatory training and mechanisms for ongoing support is seen as vital to the REFLECT process (Phnuyal 1998, Phnuyal et al 2002, Popkins 1998, Riddell 2001).

By utilising participatory techniques participatory participants decide on the issues they wish to discuss and explore, thus reversing the dependence upon externally generated programmes and material, and this in essence, is an empowering experience (Fiedrich & Jellema 2003). Feedback from Nepal highlights how the nature of the process can itself be empowering, as participatory methods begin with everyday and immediate experiences of the participants, and this helps people overcome a sense of inferiority that may often characterise more formal learning situations (Education Network 2003, Sitikhu et al. 2000. Sikdhel et al 2004). It enables participants to value and use their own indigenous forms of knowledge and communication. Mohan (2001) provides us with evidence from the field that organisations using the REFLECT approach are successfully incorporating more indigenous facilitation methods of communication into their work such as dance, song and story telling.

It was felt that REFLECT offered a potential model to address some of the limitations that were being talked by the participants in the study area. Research visits to Nepal by Sara in December 1997 and April 1998 enabled her to feedback this information to ACAP and the local people in the Sikles sector and played an important role in engaging the local people in setting the research
agenda. In particular, feeding the results back to the field in 1997 and 1998 underpinned the introduction of REFLECT into the study area and the move of the research from participatoriness to actionoriented-ness. ACAP was unable to launch REFLECT in 1998 but local people who had been consulted during previous research were keen to find out more, as Ganga Maya explains:

Sara had come here before and she was very curious to know if the children in the village were going to school or not. She was also interested to see the difference between the girls and the boys. She had a lot of interest and love for the people of Sikles, so she started to think about how the people could get a better education. She talked to us about REFLECT and asked if it could be effective in Sikles or not. We discussed this in our village with the Ama Toli (Mother’s Group) and other people. We felt we had decided and we were interested to find out more, so we found three people and we went to have some training in REFLECT.

It was as a result of this training that REFLECT was introduced into the Sikles sector of ACAP in October 1998.

**Introduction of REFLECT in Sikles and Parche**

Funds were obtained for training and three people were selected and trained at the local level on the REFLECT approach in November 1998. After this, three REFLECT circles were established, one each in Sikles, Parche and Yangjakot. The local participants chose to call these circles Chalphal Kendras (Discussion Centres) and hence shall be call them DCs from here on. The DCs run from September to April every year and run six times a week - each time in the evening after the women have finished their household duties. The Centres close in the monsoon season as the women are busy planting rice. Two people, Laxmi Dhitai and Kiran Bohara, were taken to support and manage the Discussion Centres, to address the need for ongoing support and training (Riddel 2001, Popkins 1998, Sitikhu et al 2000), and to establish a line of communication between Sara Parker (in the UK), the funding agent UWCSEA (in Singapore) and the participants in the Sikles sector of ACAP (Nepal). This paper now moves on to explore some of the outcomes of the Chaiphal Kendra process.

**Participation – creating spaces to meet**

Since 1998 the Chalpal Kendra has numerically increased from 3 to 10 and the number of participants has risen from 37 to over 120 in 2004. Over 30% of the participants are from the ‘traditional occupational’ castes of Bishwa Karma (Kami), Pariyar (Damai) and Nepali (Sarki) (see diagram 1). This is a positive step towards change, as these are the exact groups ACAP found so hard to ‘mobilise’. One of the three facilitators (trained) was from the Nepali caste, and he runs his own centre in the neighbouring village of Parche.
Ganga Maya explains how the Chalphal Kendras managed to attract high numbers of people for diverse participation as follows:

When we started REFLECT we sat in the meeting place and we talked. The first thing we constructed was a social map to help us identify the local, e.g. if there is a tap around. With the social map placed before us needs, we got to discuss to know our communities better. Before REFLECT came, we did not know anything about social maps nor did we know how to make them. Training helped me to facilitate the session because the participants made their own social maps. We saw many problems in our community and we had to decide which one was to get the first priority. In my ward, Dhaprangthar, we realised that we did not have many community meeting places and this prevented Gurung and non-Gurung people from coming together and meeting. Household heads would not allow non-Gurungs to enter the house. So they could not come to the centre. We discussed deeply how we could resolve this problem and decided to construct a ‘Samaj Ghar’ (community house). We decided this would be the best way to provide the opportunity to everyone to come to the Chalphal Kendra. It would be a benefit to the community and an asset to the whole ward. A community house would be the property of the ward but it would have to give Dalits the rights to be there. So we got the help of the VDC Chairman and ward members. As soon as the community house was constructed (see the photo below) the non-Gurung people started to come there.

We formed the key word Samaj Ghar. We then learnt other words and the participants improved our literacy skills. We came up to realize that the community house was a place of solving the problems we were facing in our community. Before REFLECT came, we did not know anything about the PRA
Sharing Experiences of REFLECT in Sikles: a Collective Reflection

(participatory rural appraisal) methods. Now we are using them to identify new problems and solutions to them. I have gained many new experiences in Sikles and I am proud to share them with you all.

Photo 1 Meeting hall in Dhaprangthar, Sikles and the participants gathering in the centre

At the start, the participants sat separately. After a discussion on key words such as Society, Social Status, Untouchable and Oppression. We saw there was no reason for people to sit separately, and the centres became more integrated. The facilitators met for training and evaluation workshops. The experiences in Sickle reflects changes that have taken place in other parts of Nepal as a result of REFLECT being introduced into communities (Shrivastav & Gautam 2001).

Positive outcomes

A number of other changes were noted in Sikles and Parche. The following diagram shows how these range from access to literacy classes and from increases in participation to increase in women’s empowerment (see Diagram 2 below). Changes in relations between different caste groups has also been noted. The participants are taking good strides towards becoming active community matters.
Diagram 2

Changes through REFLECT

<table>
<thead>
<tr>
<th>Access and Participation</th>
<th>Practical Literacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Access of women to the local resources</td>
<td>• Literacy being used in the daily activates</td>
</tr>
<tr>
<td>• Involvement of women to solve the local problem</td>
<td>• Participant herself can be REFLECT Facilitator</td>
</tr>
<tr>
<td>• Education and Literacy</td>
<td>• Helping to the studies of their children</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Women Empowerment</th>
<th>Changes through REFLECT Chalpal Kendra</th>
<th>Caste Empowerment</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Leadership Development</td>
<td>• Participation of women to the local decision making process</td>
<td>• Respect to the other castes is being developed</td>
</tr>
<tr>
<td>• Participation of women to the local decision making process</td>
<td>• Women are being changed as a local counselor</td>
<td>• Not being excluded from the opportunities due to caste disparity</td>
</tr>
<tr>
<td>• Women are being changed as a local counselor</td>
<td>• Women as a mediator for the change</td>
<td>• Respect to the ability of others</td>
</tr>
<tr>
<td>• Women as a mediator for the change</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stepping towards being self dependant</th>
<th>Institutional Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Group working to try to solve the local problems at the local level</td>
<td>• Formation of the Local CBO with the women's leadership</td>
</tr>
<tr>
<td>• Looking out the possibilities at local level for the skill development (for the group)</td>
<td>• Development of group leadership (Women)</td>
</tr>
<tr>
<td></td>
<td>• Development of Institutional relationship</td>
</tr>
<tr>
<td></td>
<td>• Development of group ability/Action</td>
</tr>
</tbody>
</table>

Practical literacy, access and participation

An increase in women's ability to read and write was noted. It was a result of their participation in the Chalpal Kendra. A woman reported that her husband was initially hesitant to allow her to go to the centre but seeing her progress and ability to read, he now actively encourages her saying, “Please go, do not be late I'll do the housework for you." Another participant from Dhaprang Thar, aged 22, noted in 2001 that she was " Completely illiterate before joining the centre. " I did now my best to learn and know a lot. I have learned a lot and gained confidence. REFLECT has given me wider knowledge and I think I can even run the centre myself. So I am dreaming to be the facilitator, but as I am a participant, I do not know whether it will be good or not to be the facilitator”. In 2004, she began to run her own Chalpal Kendra in a neighbouring locality.

Women share their experiences in the centre and encourage each other to learn more. Learning to read and write was one of the major motivating factors. They
are extremely proud of their improved literacy skills and ability to help their children with their homework. One participant said, “I am feeling proud and excited because I can read and write now. This I did not expect when I joined the centre”. Another woman: “Now we know the importance of education and we should all make our children literate.

Visual and verbal communication skills had also developed as the participants gained experience of undertaking participatory activities. They had produced a wide range of materials: social maps, seasonal calendars, preference-ranking matrices, time-lines, songs and stories. The materials were displayed on the walls for use in future classes (see photo 2 below). Litho machines had been purchased to copy the materials. Equally important, development of literacy and visual skills had increased the confidence of the women in expressing their views verbally, both within the centres and outside. A participant: Chalphal Kendra has enabled us to speak confidently in the group. I can’t deliver my views like a leader but I can present my views in the village gathering now”. We could see the outcomes of this process in greater detail when we examined the actions undertaken by the discussion centres in the Sikles sector.

Photo 2: Women constructing and discussing a range of material produced in the Chalphal Kendra

From literacy and communication to action

Variety of actions were reported: from individual actions such as participants giving up smoking or objecting to their husbands’ gambling habits to actions done for the community at large (see Diagram 3). The participants had changed their behaviours after discussing issues in the centres and encouraged others in their families to do the same. Examples of this include proscribing drinking at certain times of the day and in certain places. The women discussed gender inequality. They had come to realise the importance of educating their daughters and other children. Nanda Shree explained at the conference:

You are all educated and are from urban areas so you know very well about the importance of education. By joining the Chalphal Kendras mothers have come to realise the importance of education. Previously they did not take much care about their children. When their children came home from school they had lots of
household tasks to do. This was especially true for mothers. But now the
mothers are encouraging their daughters to study. They are looking after their
children's study. There is a difference which you can see and this is because of
REFLECT.

Clean up campaigns, initiated by ACAP, suffered lack of commitment, but now
they are taking place regularly. Children and men from the communities in which
the Chalphal Kendras participated in the activities. My meeting halls have been
built, trails have been repaired, and water taps have been installed. The extent to
which these actions had influenced ACAP's previous extension activities could
not be fully determined. However, the fact that members of the traditional
occupational castes now join in these activities suggested that REFLECT had
created a space for the wider community to participate in the decision making
process. The previously excluded people are now eager to join in the activities.

Suggestions were taken to organizations such as the Village Development
Committee and the Conservation Area Management Committee. The
construction of the meeting halls was a prime example of this process in action.
Other changes had been encouraged through this process and the participants
reported that they felt they had now "developed the 'we' feeling" as they
cooperate within the community to implement the project. Nanda Shree explains:

We cannot tell the men in our village to wash the pots or do this or that. The
attitudes of fathers and brothers gradually are changing. At first, the women
were hesitant to share their ideas with men. Men dominated our society. But
now we are going to meetings and speaking out as woman. Men now allow us to
speak more and more. We have an Ama Toli (Mother's group) in each ward and
they are supporting our activities and social events. That is why we are getting
respect from men. Now we talk even at the ward meetings and that is the result
of our training in the Chalphal Kendra. We are all equal and we go together -
male and female, father and mother - to meetings and for action. We work
together. In fact, the VDC chairman himself says that in Sickles women's
development is almost complete. What our community now needs is a male
development programme.
One of the major outcomes of the Chalphal Kendra process has been the formation of an autonomous community based organisation. In the third year of running the facilitators realised that there was a need to create a more systematic form of management for the Chalphal Kendra so that they could formalise the process and put more of their initiatives into practice. First of all, Management Committees were formed, and this led to the establishment of the Madikhola Women Development Organization (MWDO), Sikles Kaski, in May 2003 in order to improve the sustainability and autonomy of the Chalphal Kendra. This CBO plays a vital role in managing the REFLECT process.

The focus of MWDO is to work with women Groups, traditional occupational caste groups and farmer groups. One a CBO member said, “CBO has jus been established and we are just learning to run it. However, the REFLECT centers are running on behalf of our CBO. We are also making coordination with other organizations” (pers comms 2004). Compared to other experiences of REFLECT in Nepal, the establishment of the CBO is a significant outcome (Education Network 2004). It is unusual for REFLECT programmes to be launched without the impetus of a national or international NGO supporting the process.

**Management Committee and Community Based Organisation Formation**
Building the capacity of local women to run the CBO is seen as vital to the success of the CBO and the Chalphal Kendras. Training events were being put in place to support the women in their endeavours to raise funds to help them to continue to participate in actions that improve their communities. Support from organisations such as the Education Network had played an important role in the development of the CBO and the support would continue in the near future.

Monitoring and evaluation workshops had played an important role in providing a space for the Chalphal Kendra facilitators to meet and plan their future work. Such meetings were important also to the formation of the CBO and had enabled the women to take control of the programme and develop their own skills and sense of identity. The funding for these workshops had been provided by UWCSEA. It is important to note here that the funds for the local initiatives such as trail repair, tap repair and building the community houses had all been raised at the local level. This showed that with a small external support and by providing time and space for local people to meet and discuss local issues a number of positive outcomes could be achieved. This would help both the individuals involved and the community at large.

**Challenges to the process**

Due to the recent unrest in Nepal many agencies had to withdraw. In the case of Sikles ACAP has withdrawn from the area and there is a lack of resources at the local level for community development projects. The decline in the number of tourists visiting the area has been a problem, and this, coupled with the fact that funding from UWCSEA has now finished, has left the process in a very precarious condition. Without internal or external funding the achievements of the Chalphal Kendras will only be limited. The CBO is seeking for ways to address this problem. The current political climate has made this a challenging for the CBO. It remains to be seen how successful the CBO will be in seeking
alternative forms of funding (Bohara et al 2005). Political instability in Nepal has made it difficult for support workers to visit the area. Workshops have to be organised in Pokhara rather than Sikles to overcome some of these problems, but this reduces the level of local participation that has been so important for the success of the Chalpal Kendra.

Ganga Maya and Nanda Shree feel that the current situation has prevented the CBO from doing any major activities. The CBO has organised two Women’s Day celebrations that previously were organised by ACAP and has also taken on the role of managing a local tree nursery (in the absence of ACAP). Ganga Maya and Nanda Shree have been active in presenting the outcomes of the process by attending national events such as the Regional Workshop of REFLECT in Dharan [Eastern Nepal], which was jointly organized by Action Aid Nepal and Education Network Nepal in 2004. The presentation of this paper (with Sara Parker) at the CERID conference has provided a forum for them to share their ideas and achievements.

Conclusion

This paper demonstrates that the introduction of REFLECT into the Sikles sector of ACAP has given a number of positive outcomes at the local level. It has highlighted that even limited support to local women can help to achieve much. All the writers of this paper are proud to be associated with the Chalpal Kendra process and they will remain committed to its continuation in the future. They have benefited in different ways from their involvement and they will welcome any opportunity that will be available to share their experiences.

Key lessons learnt:

- Support initiatives that are grounded in the principles of participatory development can, when embedded at the local level, create a wealth of outputs.

- Local people have both imagination and capacity to solve local problems and respond to the challenges that society and its customs put up. The creation of a space for the Chalpal Kendra to be inclusive is one good example of this.

- Whilst women dominate the Chalpal Kendra classes, members of the community have also been successfully engaged in approving and implementing the actions that had been discussed within the centres.

- Many communities exist within the Sikles sector and the participants in the Chalpal Kendra draw on a wide range of network. It is not argued that there is a ‘community of women’ or even a ‘community of Chalpal Kendra
participants’. Individuals in these centres participate in many other forums within the community. However, Chalphal Kendra has undoubtedly provided an extra arena in which people are free to participate if they so choose.

- An important factor in this process is the allocation of space for the local participants and facilitators to reflect on the achievements and develop plans for future actions.
- The process has enabled the participants (and the facilitators) to take important steps towards being self-dependent,
- It is important to acknowledge that funding plays an important role in enabling the women to put their idea into action.
- Through forming the CBO it is hoped that alternative sources of funding and support could be acquired in order for the CBO to realise its full potential and continue to support the Chalphal Kendras in the future and build new avenues of work.
- One of the major achievements of REFLECT in the study area is the extent to which the local participants have taken the ownership of the programme and sustained it over the past six years. The establishment of the autonomous CBO and the Madhikhola Women’s Development Organisation is the testament to this ownership. Though still in its infancy and faced with a challenging political environment, the CBO has engaged in a number of activities and continued to support the Chalphal Kendras in the study area.

Working as a team has been a rewarding experience in many ways. For Sara it helped to maintain a link to Sikles and facilitate the introduction of REFLECT into the Sikles sector to meet the women’s demand for non-formal education in the village. To Laxmi and Kiran it provided an opportunity to work with the facilitators and participants of the Chalphal Kendras as well as the community member who have got involved in the formation of the community-based organisation. It enabled Ganga, Maya and Nanda Shree to provide a non-formal education programme that seems to be meeting the needs of many of the women who live in their own wards. All of us will in continue, in some way or other, to work with the people in Sikles whose work and experiences filled us all with inspiration.

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Empowering Nepalese Women towards Fertility Planning

Ishwari Acharya*

Background

Education is vital to ensuring a better quality of life and a better world for human beings. Raising the women’s educational status and working for women’s empowerment is considered crucial to the success of many intervention programs including the programs initiated for fertility reduction. It is expected that a better status and more autonomy in decision making will empower women to have more control over the productive resources and the utilization of resources provided to them to improve their status. Education and awareness play an important role in fertility planning. Through education women become aware regarding its important determinants (nutritional status, maternal age, birth control, spacing of births, antenatal care etc.). These determinants appear to be easily controllable with adequate education and awareness (BITS, 2001).

Women’s educational status and fertility rate in Nepal

The educational attainment of Nepalese women, who constitute more than 50% of the total population of the country, has shown an increasing trend over the last two decades. Table 1 shows the increased rate of literacy and education levels of females and males from 1981 to 2001. In twenty years, female literacy has more than tripled. At the primary level girls constitute 45.9% of the total enrolment. At the secondary level the per cent of female enrolment increased from 15.9% to 30.3% between 1981 and 2001. In SLC there was only a slight increase between 1991 and 2001. Intermediate and above, the per cent remained static between 1981 and 1991. In 2001 it reached 5.3 per cent although it was half the male proportion.

In spite of the gradual slide-up of women’s literacy and education level, the fertility rate is declining (from 5.6 in 1981 to 4.1 in 2001) (Table 1). It is thus clear that the incline rate of education has led to the decline rate of fertility.

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Table 1

<table>
<thead>
<tr>
<th>Educational status and fertility rate of Nepalese women</th>
</tr>
</thead>
<tbody>
<tr>
<td>-----------</td>
</tr>
<tr>
<td>Literacy, level of education</td>
</tr>
<tr>
<td>Illiterate</td>
</tr>
<tr>
<td>Literate</td>
</tr>
<tr>
<td>No schooling</td>
</tr>
<tr>
<td>Primary</td>
</tr>
<tr>
<td>Secondary</td>
</tr>
<tr>
<td>SLC</td>
</tr>
<tr>
<td>Inter and above</td>
</tr>
<tr>
<td>Fertility rate (birth per woman 15-49 years of ages)</td>
</tr>
<tr>
<td>5.6</td>
</tr>
<tr>
<td>HiD index</td>
</tr>
<tr>
<td>GDI Value</td>
</tr>
</tbody>
</table>

Sources: CBS: Gender disaggregated indicators, Nepal 2002
Acharya, Meena. Efforts of promotion of women in Nepal 2003

Gender disparity in education

In Nepal gender disparity in literacy and education is decreasing very slowly though. There is a wide gender gap in access to education. According to Census 2001, the overall literacy rate is 54%, but only 42.5% women are literate (men 65.1%). Even at the primary level the number of girls is not equal to that of boys. The number of women SLC and above and at graduate and higher degree levels is only 43.6 and 23 respectively for every 100 men. This ratio has increased from 28.2 and 22.5 respectively at both the levels compared to the 1991 figures (Acharya, 2003).

The disparity is more severe region to region and urban to rural. Though the overall women’s literacy rate in Nepal is 34.9%, it comes down up to 9.19% and 11.52% respectively in the remote western districts (Mugu and Humla).

The Informal Sector Research and Study Center puts the overall fertility rate of Nepal at 4.1. It is 2.1 for urban areas and 4.4 for rural areas. It shows that the rate of fertility per woman is higher in rural areas than in urban areas. But women’s literacy and education rates are higher in urban and access-easy districts than in rural and remote districts. For example, in Kathmandu district the literacy rate for both sexes is 77%, (female 66.44% and male 86.35%) and HDI is 0.603. In Humla district the literacy rate for both the sexes is 26.62% (female 11.52% and male 40.66%) and HDI is 0.244. This also proves that the higher the
Empowering Nepalese Women towards Fertility Planning

education level of women, the lower is the fertility rate. The HDI value is higher too. The main reasons for the higher fertility rate of rural women are identified as the lower rate of education and lack of employment opportunities.

It is a well known fact that there are discriminations against women in various fields and there is gender inequality in education. The exclusion of Nepalese women from literacy and education has resulted in their non-empowerment leading to low efficiency and low productivity of human resources (Bhadra, 2003). Women’s low efficiency and productivity has hampered their decision making power, which in turn has led resulted in high fertility.

Linkages of female literacy, fertility, Human Development Index (HDI) and Gender related Development Index (GDI)

The Table below reveals that there is a strong inverse relationship between the female adult literacy rate and the female fertility rate (the higher the literacy rate, the lower the fertility rate). It implies that the higher the fertility rate, the poorer is the country and the greater is the gender discrimination in human development. Table 2 also points out that higher the female literacy rate, the richer the country and the less the gender discrimination in human development. So there is a linear relationship between fertility rate, human development index and gender-related development index. Also, with the increase in the female literacy rate HDI increases whereas GDI decreases.

Table 2

<table>
<thead>
<tr>
<th>Country</th>
<th>Adult literacy rate: (% ages 15 and above) 2002</th>
<th>Total fertility rate (birth per woman, (15-49 years) 2002)</th>
<th>Human Development Index Rank</th>
<th>HDI Rank Value</th>
<th>GDI Rank Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Norway</td>
<td>-</td>
<td>1.8</td>
<td>1</td>
<td>0.956</td>
<td>1</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>89.6</td>
<td>2.0</td>
<td>96</td>
<td>0.740</td>
<td>73</td>
</tr>
<tr>
<td>India</td>
<td>46.4</td>
<td>3.0</td>
<td>127</td>
<td>0.595</td>
<td>103</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>31.4</td>
<td>3.5</td>
<td>138</td>
<td>0.509</td>
<td>110</td>
</tr>
<tr>
<td>Nepal</td>
<td>26.4</td>
<td>4.3</td>
<td>140</td>
<td>0.504</td>
<td>116</td>
</tr>
</tbody>
</table>

Source: UNDP, Human Development Report, 2004
Empowering Nepalese Women towards Fertility Planning

There is gender inequality and discrimination in education and women are victims of it. It is clear from the table that the higher the rate of education, the higher is the human development index and the lower is the gender-related development index. This leads women towards fertility planning.

Here are a few cases which support the need of education for women for fertility reduction. Three women who had two or less children were selected. A question was asked to them: "What encouraged you to plan your family size?" Their responses were analyzed in qualitative terms.

**Case 1**
Shrijana Neupane (name changed), 35; Bachelor degree holder; employed in Nepal Bangladesh Bank at New Baneshower; married and with one son of 12 years. She lives with her husband and son at Bhimsengola New Baneshower-34. She said, "My education delayed my marriage. I got married at the age of 24 and have only one child. I decided to plan my family and was successful in convincing my husband and in-laws." She added, "My education only helped me get good job which has made me economically independent, decisive and self-aware."

**Case 2**
Rama Dulal, 46; Master level education; employed in the Department of Roads; registered auditor. She lives at Nava Srijana Tole of KTM-10 with her husband and has two children aged 19 and 20. Mrs. Dulal said, "I had the capability to observe and study the women who were in better social and economic positions and had two children. I decided to make my family small and to be an independent, self-reliant and productive citizen. So I gave begot only two children on a small spacing so that they could be brought up simultaneously to make me free soon for my career development. It was the education I acquired which encouraged me to do so."

**Case 3**
Namita Uprety, 26; lives with her husband and in-laws at Nava Srijana Tole, KTM-10. She was married at the age of 21 after she got through her Proficiency Certificate. She gave birth to a baby (girl) one year after her marriage. Just a couple of days back she underwent permanent family planning. She has now joined college for the BBA course. She has the ambition to earn the degree of MBA and get employment in a foreign venture (a bank). Namita answered a question, saying, "I was aware of the problems a woman faces when she bears many children. When I was studying in class 10, I was determined to have only one child. I told this to my would-be husband and he agreed."

The above-mentioned case studies make it clear that education is the only asset of women, which brings self-awareness to them, makes them able to make decisions and helps them plan their fertility. Education also provides employment opportunities and empowers for a better living.
Empowering Nepalese Women towards Fertility Planning

Education and fertility reduction

For women, lack of educational opportunities leads to lack of employment opportunities. It keeps them economically poor and they lag behind in the acquisition of knowledge, information and skill. This deprives them of self-awareness, decision making power and self-esteem without which they cannot break the traditional barriers and utilize the provisions provided to them for fertility planning. In the absence of fertility planning women are likely to have more children. This will demand more time, energy and other resources and affect their health and education. This will ultimately make them less efficient and less productive for the society.

The following lay-out presents a conceptual framework which shows women’s educational needs for fertility planning. High fertility entails a high opportunity cost for women in their economic endeavors (Bhadra, 2003). A good economic status helps to utilize the health provisions for both the mother and the child. Education provides employment to women and empowers them to make decisions on fertility planning.

Conclusion

Education helps women break the vicious circles of ignorance and exploitation and empowers them to improve their lives (MOES, 2003). The Constitution of Nepal 1990 has guaranteed equality of rights for all citizens (women and men). But the Nepalese society and its traditional customs and values have restricted women from moving forward for their advancement. The existing gender disparity has kept the educational status of women in a low profile. Though women’s participation in education and other spheres of life has been noted as very important since the Sixth Five Year Plan, women have not been able to exercise their rights to education fully. For lack of education, they fall behind men in socio-economic political and decision-making. Many empirical studies have indicated the low education status adversely affects women’s fertility planning in general and their status development in particular. If the women have access to education, they would have access to economic and other resources, and their decision making power would get stronger. They will be able to contribute to the national development effort by using their potentials.

There is gradual decrease in the national fertility rate. Here it can be said that if the literacy and education levels of women go up rapidly, the fertility rate of women also would decline as rapidly. Women should be empowered to use the health and fertility determinants and decide the number of children accordingly. Education needs to be geared towards bridging the gender gap in education.
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Figure 1

Educational need for fertility planning and women’s empowerment
Researching Gender and Education in a Situation of Conflict: Experiences of Gender and Development Project in Nepal

Kay Standing and Laxmi Dhital

Education for women’s empowerment and gender equality are the key to the establishment of human rights in situations of conflict, yet the education of girls is often the first amongst the areas to suffer from the impact of civil war. There has been little work on the challenges to researching education in a situation of conflict, and drawing on the experiences of research in Nepal. This paper examines both the methodological issues facing researchers and the practical issues of girls' access to and involvement in education under conditions of conflict.

Despite the efforts made by the government and NGOs to raise awareness of gender issues, education in Nepal, is skewed in favour of boys. There are vast geographical and socio-economic diversities presenting a multiplicity of ethnic and cultural groups. However, across all regions and social groups, girls' access to education, participation and achievement are significantly lower than those of boys. In addition, the conflict situation has had an alarming impact on girls' access to education in rural areas and for NGO-run non-formal education programmes which aim at increasing women’s literacy. Schooling is also frequently disrupted by bandhs strikes etc. The paper presents the experiences and findings of a study project theming on the conflict and its impact on school. It also draws experiences and findings of an earlier study on "Gender and Experiencing in School" conducted by CERID with DFID support in the area of Gender and Development (GAD). The GAD project aimed at identifying gender issues in education and areas of good (and bad) practice in public schools and made policy recommendations for improving gender equality in education. The research took place in public schools of Kathmandu Valley and it looked at secondary schools in urban, semi-urban and rural areas. The conflict affected the GAD project. A subsequent study was then conducted in a conflict-affected district to examine more closely the impact of the conflict on schools.

About the Study

The project Gender Experiences in Schools looked at 11 public secondary schools within and around Kathmandu Valley. Classroom observation took place in different subjects of Grade IX, interviews were held with teachers, parents and community members, and focus group discussions were organized with students.

* Kay Standing is a lecturer in John Moores University, UK and Laxmi Dhital is a research associate for GAD, Kathmandu.
Separate focus group discussions were conducted in schools with girls and boys. In addition the school record form was used to collect information on enrolment, promotion, drop-out and repetition (by gender and caste). The results revealed that despite government plans little had changed from what it was earlier (e.g. Sibbons, 1998). Pedagogy had remained teacher-centred and gender discrimination had remained rife in both the curriculum and management of the school.

Lack of toilet facilities militate against girls' participation and schools are unsafe places for girls as outsiders freely enter schools without prior permission. Girls schooling is further distracted by the unequal distribution of tasks. Girls have to spend more time than boys away from school to participate in both agriculture and household works. Parental attitudes are adverse to girls' education.

The study found that girls' attendance at school was irregular in rural areas between April and October (from the time of corn sowing in April to the main festivals of Dashain and Tihar in September and October). In comparison, boys schooling was disrupted only in May and June, the months for rice planting. Girls were deprived of homework opportunities. They reported that they had little time for study at home. Their diaries revealed that they had to spend most of their time on household tasks (cooking, washing, cleaning, fetching water, look after siblings, carpet weaving and so on). In contrast, boys' role responsibility was fetching water, which gave them enough time for study and other activities.

The research also found that boys were transferred to 'better' schools (private boarding schools). Girls remained in less 'prestigious' school. Girls' transfer was higher in the urban areas.

Caste or ethnicity affects enrolment. There were only 65 indigenous group children (41 boys and 24 girls) and 13 Dalit children (7 boys and 7 girls) enrolled in school. High caste people e.g. Brahmins sent their boys to private schools. Even subject choice was also parental. Girls left home after marriage.

This research study took place in a situation of conflict. The researchers were unable to visit some schools due to the conflict.

This situation made us feel a need to assess the impact of conflict on girls' education. So on completion of the initial research report, we decided to return to one of the schools visited earlier to assess the impact of the conflict. This became possible because the researcher had developed close links with the community and had developed a level of trust. In the field visits interviews/discussions sessions were conducted with the children, teachers and the community people. Critical reviews of other research reports and publications were undertaken to understand the situation critically. Some of the findings are discussed below.
Researching Gender and Education in a Situation of Conflict

Context

Fear of violence had become obvious. There were reports of women and children used as human shields (Perry, 2002) and of rape and sexual abuse of women by both the Maoists and the government forces. Women could not go safely into the jungle to cut grass and collect fuel-wood, nor could girls travel safely to school in rural areas (Shakya, 2003; Nepal news 2005). Because of the fear of conflict many young men had fled, or been displaced, from rural areas and many others had been killed in the conflict, leaving the double burden of agricultural and household work to women and girls, again disrupting girls participation in school and with threat to women's safety (Shakya, 2003).

Conflict in Schools

The government has included girls' education as a separate issue in its development plans and made specific programmes for the all-round development of girls (Thapa, 2003). However girls' participation in formal and non-formal education is low. The school is looked as at a key to promote a unified vision of Nepal as a nation state (Caddell, 2003).

Since February 1996 the Communist Party of Nepal (Maoist) had been waging what it called people's war. The resultant conflict had escalated since 2001. International concerns were growing about human rights abuses by both the government forces and the Maoists (Amnesty International 2002). DFID (2003) has noted that between 1996 and 2003 over 7,000 people were killed as a result of the conflict, and this figure rose to 12,000 in 2005 (Amnesty International, 2005)

The table below provides an overview of how the conflict affected children.

<table>
<thead>
<tr>
<th></th>
<th>TOTAL</th>
<th>Boys</th>
<th>Girls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feb 1996 – Sept 2005</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of children killed</td>
<td>419</td>
<td>295</td>
<td>124</td>
</tr>
<tr>
<td>Number children physically injured</td>
<td>454</td>
<td>272</td>
<td>128</td>
</tr>
<tr>
<td>Children and teachers abducted</td>
<td>29,244</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arrests by security forces</td>
<td>230</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of children orphaned</td>
<td>8000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jan 2005 – Sept 2005</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Killed by rebel groups</td>
<td>46</td>
<td>35</td>
<td>11</td>
</tr>
<tr>
<td>Killed by state security forces</td>
<td>6</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Cross fire</td>
<td>6</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Number children killed</td>
<td>58</td>
<td>42</td>
<td>16</td>
</tr>
</tbody>
</table>

Source: CWIN (2005)
The education of women and girls had been disrupted and women’s human rights had suffered as a result of the conflict.

Problems of women and girls are greater in the Mid-Western and Western Region mountains where poverty is most acute, services are least accessible and gender discrimination is most dominant. These regions were the hearts of the Maoist insurgency, exacerbating poverty and further hampering women’s access to health services and education. The Maoists had an agenda of land reform and equal property rights for the marginalised ethnic groups, Dalits, and women. The Maoist had support of rural women due to their focus on fight against gender oppression - which varied by district and by caste.

School education has been severely disrupted by frequent strikes and large numbers of teachers and students have been taken away by Maoists for ‘re-education’ (Nepal News, 2004). Children including girls are used in combat situations, to provide ammunition or care for the wounded (Amnesty International, 2002). There are reports that the Maoists used the 2003 ceasefire to recruit secondary school children aged between 15 and 18 as child soldiers (Amnesty International, 2004, Cadell 2003).

Although schools were declared ‘zones of peace’, violence continued to escalate in and around them. Social trauma prevailed in schools. There were some evidences of sexual violence including rape and child bride.

Safety

The children expressed their concern about safety:

“Our teachers and parents are not sure of and confident about our security. For example, we informed our teachers that we would meet them for discussion on the current conflict situation. They were afraid and reluctant to allow us to meet them. They thought we might have links with the Army or the Maoists. The teachers also advised us to wear the school uniform even though it was the summer vacation time. They told us to inform the school administration before preparing to go home. You can imagine from this what the situation was like.”

Impact on students: Fear of violence

Issues of girls’ vulnerability in school have been highlighted in other research projects (Save the Children, 2004). The researchers found that many parents refused to send their daughters to school, fearing that they would be at the risk of abuse, and girls themselves expressed fear about personal safety during walk to and from school and whilst in the school.
Detention

"Once, my sister’s friend was coming to our home. The armies arrested her, saying she was a Maoist, which was not at all true. After keeping her in the army post three to four hours they released her because of the help of local villagers. Such cases are very common these days. Girls feel very insecure and a lot of girls have left school because of the fear of rape and abduction". (Girl of Class IX)

Precaution

"We girls always feel insecure and go to school in groups as far as possible. Our parents are also worried about us. They remind us that since they cannot give us security, we should take precautions against any possible untoward event. If we got information about the Maoist or Security activities, we did not go to school. So irregularity in school is very common. We also do not walk alone and do not go out in the night." (Girl of Class X)

Teasing

"Armies used to tease girls. Once I was coming back home from a place. I met armies on the way and they teased me a lot. They looked at me very suspiciously. They asked for my ID card. Unfortunately, I did not have my ID card with me. They talked about arresting me. I became afraid, but in the mean time one of my relatives arrived and he saved me. If my relative had not helped me I would have been punished badly, for no good reason." (Girl of Class X)

Enrolment/Drop out

Even before the conflict broke out in 1996 access to education in Nepal was limited, especially for girls, Dalits and other disadvantaged groups. Attendance was low and drop-out and failure rates were high. Schools were used as recruitment centres by both sides of the conflict. Schools were frequently disrupted by bandhs (strikes). These interfered with the quality and continuity of education and important exams had to be postponed. Attendance rates dropped as children were displaced or had to migrate, and fear prevented children from attending school.

Closure of school

"Sometimes our school remains closed because of bandhs. Our study has been disturbed and our courses could not be completed on time. Maoist students would to come to school frequently for influence. Like any other school, our school closed for many days in a month last year. This hampered our study and frustrated us. We did not know why the school was closed." (Boy of Class IX)
No Exam

“Some months ago they (Maoists) had taken away 12 persons. Later, they returned 7 persons and detained the other five. The trend is that the Maoists make children their activists after they complete the final examination of Grade X. Last year, a friend did not appear at the final exam of Grade X for fear of being abducted. He was talented. Once the students had gone to Sindhuli to take the SLC examination. The army found a Maoist membership card in the possession of a girl and detained the girl for three days. Because of this she had to give up the examination and suffered mental torture.” (Boys of Grade IX)

Fear

“Maoists come to school from time to time, step into the classroom and start giving orientation to students about their politics. Once they took us to a rally at a place which was far from our school. We suffered from hunger and thirst. We were afraid of the government security forces. They could come and kill us.” (Boys of Grade IX)

Choice of Course

“Until a couple of years ago the C.M.A course was popular with the rural students because it helped you get a job easily. Now no one wants to study it. It is because the Maoists often take these students for the primary health care of their militants. Now, those who did the CMA course are either involved with the Maoists or have escaped to urban areas.” (Girls of Class IX)

Dropout from school

The conflict appears to have led to girls' drop-out (more than boys'). Rana-Deuba (2005) found that 203 children of 227 families had dropped out, citing the conflict as the main reason. Of these 55% were male and 45% female. However a reason for this could be the fact that boys' enrolment is higher than girls' in the overall population (Rana-Deuba, 2005:19)

The researchers found that boys, aged 16-17, dropped out either to join the security forces or the Maoist rebels or for work in India or the Gulf states.

Rana-Deuba (2005) found that only 39% of children, who had dropped out of school due to displacement, returned to school. As the school remained closed long-term and the academic calendar did not work, parents were compelled to pull their children out of school and involve them in the labour market in the urban areas. The study found that the migration of students from rural to urban areas was rapidly increasing. Parents sent their sons to expensive private schools in urban areas but continued to send their daughters to the government schools or withdraw them from the school. In the western part of Nepal, the practice of child marriage is rapidly increasing. The purpose is to protect girls from being abducted.
Parents’ fear

“On our way to school we see stray bombs. For fear of the bombs, we change the way. Sometimes we do not go to school, or return home halfway. We do not tell our parents about this because they would be afraid and not send us to school”. (Girls group).

Recruitment

Both the government and Maoists deny recruitment. However there is evidence of children being used as soldiers, spies, messengers and couriers. Both sides recruit and use boys and girls although duties for girls and boys may differ.

Allurement

Three ladies from our village have joined the army under compulsion. Ninety percent boys of our village have joined the army because it is easy to get military job. Armies persuade us to join the army. They allure us, saying, “You do not have to do hard work and do not have to go to the battle front either. You only have to take care of the injured armies.” (Boys’ group)

Difficult task

“I was forced to go with them and they had given me a bag to carry. It was about 30 kg. I carried it for 2 hrs. I was about 13 yrs old. I cried under the weight of the bag. The skin on my back peeled off. I did not know what materials there were in the bag. After some time they opened bag in front of me and it was full of bombs. Thus, we have to carry their bags and if we refuse to do so, we are beaten. The army came to our village time and again.” (Boys of Class IX)

Psychological effects

There was conflict-generated psychological trauma among the students. They kept away from going to toilet or class, and travelling in the school bus for fear of bomb blasts. At an early age, children reported and those who were affected had developed feelings of revenge. Children had gone from population plays (e.g. hide and seek) to war games.

Change of games

“Even Small kids are also affected by the conflict. While playing the games, children imitate the Army and the Maoists and fight each other. Traditional games are gradually giving place to new games. Small children have the fear of darkness. They do not go out of the house after sundown because of fear.” (Boy’s group and Girl’s group)
Other studies have pointed out behavioural changes in children caused by the conflict. According to Rana-Deuba, 73% children reported an increase in terror and fear, and 10% reported fear during their return from school.

The wider community is also suspicious and afraid of strangers.

**Teachers**

There are reports of teachers being abducted and interrogated by both sides and of the Maoists threatening teachers into making donations of certain percentage (some times as big as 10-25%) of their salaries. This has a detrimental effect on the teachers' regularity and quality of education.

**Problem of teachers**

“The Maoists threaten the teachers from time to time and had force them to donate. So for fear of the Maoist the teachers are unable to concentrate on teaching and the method. This has eroded the quality of education.”

**Use of School/Community**

Both parties had been using the school premises as shelter, rest places and training spots as the following quotes from research shows:

**Schools as meeting places**

“Community and parents are badly affected by the conflict. When a cross-fire occurs, the Maoists use the community as their safety place. They use the village homes and schools their meeting place and shelter. They order the community members to attend their meeting, which is compulsory and very dangerous. When the army comes, they just shoot at the people without recognizing them. Our school is near to the main road. It is a very appropriate place for the Maoists to organize meetings or put up cultural programs. When they go back, the security come and ask several questions. The community finds it very uncomfortable to inform the security about the activities of Maoists. It is often a and vice versa.” (Boys’ group and Girls’ group)

**Less fear**

“Our school is situated in a semi-urban area. Security forces can come to our school easily and within a short time - from the city. We feel safer than the village schools peers. The conflict situation has not affected our school so much. However, we have heard a lot about incidences of kidnapping, crossfire and use of force on child soldiers. This creates fear in our mind.’ (Boys)

The diagram below illustrates the impact of the conflict on the schools:
Conclusion

Schools have become the most affected places. Since 2002 the National Coalition for Children as Zones of Peace (CZOP) has been calling for the rights of children to be recognised and the schools have been declared ‘Zones of Peace’. The education of children, especially that of girls, is suffering because of the conflict, and schools need to be places of safety, as one child stated:

“The government is responsible for solving the problem - and the Maoists too. We are compelled to support only one - the government or the Maoists. The schools in the urban areas are comparatively peaceful but the rural schools are suffering (from both sides). The schools should be considered as the Zones of Peace. When the government is unable to solve the problem, how can we? We can only request both sides for peace”.
Introduction

According to Dale, Development is a broader and more diverse concept, denoting improvements in the quality of life of people, extending much beyond direct gains from increased production of commodities and services (Dale, 2000, p.17).

The common social indicators of development are:

- Average expected life length at birth (life expectancy)
- Infant mortality rate
- Calorie consumption per capita
- Proportion of under-nourished children
- Hospital beds, usually per 1000 inhabitants
- Literacy rate
- Rate of enrolment in primary schools
- Proportion of houses with piped water in urban areas
- Average number of persons per room (usually in urban areas) (Dale, 2000, p. 24).

However, Ferguson limits the meaning of Development. He gives the sole responsibility of development to the government. According to him, development is something that only comes through government action. Lack of development means the result of government negligence (Ferguson, 1997).

Escobar says that people have conceived the meaning of ‘development’ not as a cultural process but as a system of more or less universally applicable technical interventions intended to deliver some ‘badly needed’ goods to a target population. As a result, the invention of the technical interventions in the name of development became a force destructive to Third World cultures, ironically in the name of people’s interests (Escobar, 1997). Referring to Escobar, Unterhalter and Pieterse state that development is the model of the industrialized world to
Gender Discrimination in Education and its Impact in Women's Development

expand westernization, capitalism and the imposition of harmful values (Unterhalter, 2005 & Pieterse, 2001). The imperialism and dependency theories also see the development model as the main root of the misery of the developing countries (Holtz, 1995, p. 4).

Nowadays, globalization which is considered as development has a negative impact on the developing countries (Escobar, 1997). Globalization or development is a weapon used by developed countries to expand their hegemony in developing countries. For example, the expansion of the American products such as Coca Cola and Fanta in the Third World countries has affected the production of soft drinks of those countries. Here, what I mean is that the concept of 'development' is narrowed down by powerful countries. President Truman narrowed down the meaning of development by using the word 'underdeveloped' thus making discrimination between countries. (Esteva, 1997, p. 8 & 10). The meaning of development has been just the opposite of what the developed countries think - which is like Brazilians saying 'no' to say 'yes' (Esteva, 1997, p. 8).

Gronemeyer has used the word 'help' [which means development] to define the 'exercise of power'. In the name of help (for development) the northern countries are applying their hegemonic attitude without letting people feel the power that is guiding them (Gronemeyer, 1997, p.71). The American hegemony in Iraq, which is considered as development by the America and its supporters, is clear from President Bush’s request for $70 billion to the Congress in March 2003 to fight the war in Iraq out of which, only $2 billion was to go as humanitarian assistance (Unterhalter, 2005). A similar meaning of development could be found in Robinson-Pant’s paper “Development Discourse”. She says that in the name of providing financial and other support to literacy programs, the donors are exercising their power. She compares development with colonial discourses. Development discourse is embedded in the ethnocentric and destructive colonial discourses designed to perpetuate colonial hierarchies rather than to change them. It has defined Third World peoples as the 'other', embodying all the negative characteristics (primitive, backward and so forth) supposedly no longer found in modern, westernized societies (Robinson-Pant, 2001).

Ferguson has raised questions on the aid programs that failed to help the poor people. The World Bank working in Lesotho could not uplift the economic status of the poor people. That's why Lesotho has served as a labour reservoir exporting wage workers to South African mines, farms and industry (Ferguson, 1997).

It is not that foreign programs introduced in the developing countries in the name of development have not been able to help. Aid agencies in most of the countries of the world are playing good roles in the development of those countries. Many programs related to socio-cultural and physical development are
in operation on foreign aid. In Nepal also, many programs such as preventing women and girls trafficking and skill development are being run with the support of various international organizations and agencies.

According to Groffin, equal treatment of women in order to release the talent, energy, creativity and imagination of half of the population of the world is development. He also takes women’s liberation as the sign of development. When there will be equality, there will be rapid growth (Pieterse, 2001). The development of women covers a wider area including socio-political awareness, culture, education, etc. Education is, on one hand, part of development and, on the other, it contributes to different aspects of development.

Efforts have been made at international level to support women’s development. The Millennium Summit of the UN in 2000 adopted the Millennium Development Goals (MDGs) to put development at the heart of the global agenda and set targets for poverty reduction, elimination of illiteracy and discrimination against women (Unterhalter, 2005). The aim of MDG is to cut extreme poverty by half, ensure that every child has the opportunity to go to school and live a long and healthy life, and bring discrimination against women to an end (United Nations Country Team, 2005). Challenging educational discrimination against women, Goal 3 of MDG seeks the educational opportunity for girls (United Nations Country Team, 2005).

Gender discrimination and its impact on Education and Development

Bhasin refers to the word ‘gender’ as the socio-cultural definition of man and woman: how societies distinguish between men and women and assign them social roles (Bhasin, 2000). It means the difference between men and women is not only biological but also societal. The culture of the society has classified men and women as masculine and feminine and such a classification has the paved way for gender discrimination (Bhasin, 2000). According to Abbot and Wallace, the feminists have proposed seven perspectives on gender. Their theories are built on the oppression of women and the strategies for overcoming it (Abbot and Wallace, 1997). The seven feminist perspectives on gender are: (1) Liberal feminists believe in immediate struggle against discrimination against women. They suggest legal and other reforms in this connection, (2) Marxist feminists flout women’s oppression in public production, (3) Radical feminists point out male’s control over females and suggest fight for female freedom, (4) Materialist feminist, argue that, being a social class, women are exploited. They are subordinated by men, (5) Dual-systems feminists assert that women’s oppression is an aspect both of capitalism and patriarchal relations, (6) Post-modernists say that discourse from a woman’s point of view is lacking, and (7) Black feminist’s perspective on gender is the liberation of Black people, including women (Abbot and Wallace, 1997). All these feminist perspectives apply by and large to
Nepal's context. There is legal discrimination: only sons can inherit paternal property. Women are paid less in labour market. Any kind of decision is made by men. Even though polygamy is illegal, it is in practice. Women are used as capitals. The society is patriarchal. All these show that women are not liberated. Gender discrimination in Nepal is found on the age-old caste system. Women of higher castes such as Brahmin and Chhetri oppress the women of other castes such as Gurung, Tamang and the untouchables (Bista, 2004).

Gender discrimination also exists in education. The rights for gender equality are inextricably linked with rights for education (Unterhalter, 2005). Education for All (EFA) assessments carried out for the Dakar revealed some startling gender inequalities in the lower levels of educational achievement of girls - even in countries with high rates of enrolment, such as South Africa and Bangladesh (Gardiner, 1999; Chowdhury 1999; UNESCO, 2000 as cited in Unterhalter, 2005). A majority of the estimated 855 million people of the world (one-sixth of the population) are girls and women without access to schooling (UNGEI, 2002 as cited in Unterhalter, 2005). But Buchert has given a different figure of girls/women's literacy. She says that one seventh of the world's population, i.e., 880 million, is illiterate, of whom two-thirds (550 million) are women (Buchert, 2002).

In Nepal girls' enrolment for the primary level of education is less than 45%, which drops down to 40% at the secondary level, to 30% at the college levels and less than 15% at the university level. The figure is lower in scientific and technical fields (Bajracharya, 2005). Here, 40 percent of girls are married by the time they are 15 (UNESCO, 2003). This has affected their education because they are not sent to school after marriage. Chameli, a character in Robinson-Pant's paper "Development discourse" could not continue her formal education after marriage whereas her husband remained at school even after marriage (Robinson-Pant, 2001).

Parents provide less education to girls than to boys because they think that for girls household works are more important than schooling. They are more concerned about the safety/security of their daughters (Bajracharya, 2005). This is the main reason why girls' enrolment for the lower secondary and secondary levels is lower than that for the primary level. Parents are traditionally biased against girls and they take the investment made on their education as sheer wastage because they go another family after marriage. UNGEI claims that girls' education is a fundamental human right, underpinning all other rights and an essential element of sustainable human development (UNGEI, 2002, p. 3 as cited in Unterhalter, 2005). Robinson-Pant also has pointed out that literacy is not for functional skill but for imparting the ideology of literacy i.e., ideology of empowerment (Robinson-Pant, 2000).
Educating the girls is the best single investment a developing country can make. Educating women and giving them equal rights increase their productivity, raise outputs and reduce female poverty. They also increase children’s chances of survival because only healthier and better educated women can take better care of their children (The World Bank, World Development Indicators, 2002 as cited in Bajracharya, 2005). Investing in the education of girls now is one of the best ways of ensuring that future generations will be educated (UNESCO, 2003).

**Relationship between Gender Discrimination and Women’s Development**

Gender, like ethnicity, class or the notion of marginality, shapes social structures and relations in education and many other spheres.

Bajracharya, in the book *Cultural diversity and gender* underlines the lower status of women in civil service. Women’s representation in civil service is less than 8% and only 4% are working at officer level (Bajracharya, 2005). *Institutional Analysis*, a study conducted by the Ministry of Education and Sports (MOES) also shows that there are only 4 percent officer level women working in the government sector (Bista & Carney, 2004).

I had a recent experience in this regard. I was involved in a mini-research titled “Training for the Class II officers of the government agencies in Nepal” in connection with my M. Phil. course. I had to interview a group of training participants. I tried to include women participants in the interview but I could not find any. In the group of twenty-nine participants (Class II officers) there was not a single woman participant. I was amazed and asked the training program coordinator about this. He reported that there were no women working in the higher posts. There were just 2% in judiciary and 6% in the former Lower House of the Parliament.

A country cannot develop fully until its women are developed. They are equal partners in development. Considering women’s lesser participation in developmental activities, the government has brought programs exclusive to women. Programs such as Production Credit for Rural Women (PCRW) and literacy program integrating income-generation and women empowerment have been conducted to enable women to participate in the development process. NGOs and INGOs are ahead in this matter. But, as Robinson-Pant says, development activities are imposed - rather than self-generated and only symbolize the authority of the aid agency over local women (Robinson-Pant, 2000).

In Holtz’s view, the unsatisfactory rate of sustainable successes in the development processes of many countries is obviously also due to inadequate
consideration for participation and involvement of women. Hence, promotion of women is a development policy imperative (Holtz, 1995, p.26).

Areas such as income generation, education and job training including preventive health care are included in programs for women’s empowerment. However, concepts have emerged, which show exclusive concern for women’s influence in the family, community, state and development policy, and so aim at strengthening their influence and powers (Holtz, 1995, p.26).

Women are tightly bound with the society and culture. Maddox has tried to show this in his paper “Assessing the impact of women’s illiteracies in Bangladesh: An ethnographic inquiry”. Fatema is a woman who works as a literacy mediator helping local women in their literacy practice. But she was unable to introduce new literacy practices into her family (Maddox, 2005). She could not work as a change agent in her family because the family did not accept her as such. This is an example of gender discrimination that has affected development. Education is the best thing - the best investment by the family - but it has suffered due to gender biases and discrimination even by parents.

The cultural traditions, principally those based on gender and caste and, to a certain extent, ethnic identities, had come under serious criticism over the last decade. Nonetheless, these traditions are widely and deeply entrenched and are inherently oppressive and discriminatory to the attainment of MDGs among girl children, women and low-caste group’s ethnic groups (United Nations Country Team, 2002).

Education is more than the development of reading and writing skills. Bringing changes through social practice and relationships and negotiating new social practices and relationships are related to literacy i.e., education (Maddox, 2005). Education thus, helps to build up other qualities such as negotiating with the new social roles and identities that contribute to self-development. Countries such as Bangladesh and Nepal have taken literacy as a development activity.

People need to realize that women are equal partners in development. If only men are invited to participate in developmental activities, then development will be incomplete. Both men and women should work on an equal footing. Efforts must be made to give women self-esteem and authority to decide. Women need self-confidence, education and the power to take charge of life, and school is the place for acquiring all these qualities (Venkatram, 1995:29).

Effectiveness of Nepal’s Gender Policy and Programs in Education

Nepal is a country with more women than men. According to the Population Census 2001, male and female populations are 49% and 51% respectively. But in the case of education, it is just the reverse. Girls are far behind boys in education. Boy’s literacy rate is 65% and girls’ only 42% (CBS, 2001).
The government has formulated specific policies for the promotion of girls' education. Most of the policy efforts are concentrated on primary education (CERID, 1997). Emphasis has been given to recruiting as many female teachers as possible in the primary school. The policy of recruiting at least one female teacher per primary school has been replaced by the policy of appointing at least two female teachers (among four teachers). (MOES, 2003). Nepal's EFA Plan of Action has emphasized gender parity and equality, which is one of the goals of EFA. The government has a target of achieving gender parity in primary and secondary education by 2005. The year 2015 has been set as the ultimate time for achieving gender equality in education (UNESCO, 2003).

The government is endeavouring to achieve the Millennium Development Goals (MDG) by 2015. The MDG and Education for All (EFA) programs also include the target of attracting more girls to primary school through awards of scholarships and recruitment of more female teachers (Bajracharya, 2005). Promoting gender equality and empowerment of women is another target of the goals of the Millennium Development Goals (MDG). The target is to eliminate gender disparity from primary and secondary education by 2005 and from all levels of education by no later than 2015 (United Nations Country Team, 2002). The government has sought to move towards gender parity in school education by instituting special incentives that motivate girl children to enrol in schools. All primary schools must hire at least one female teacher to play the role model for girls (United Nations Country Team, 2002). The government is committed to raise the female literacy rate to 55 percent by the end of the Tenth Plan (2007). It will also increase the size of scholarship programs for poor and deserving girls, hire more female teachers and eliminate gender bias from the school curriculum (Bajracharya, 2005).

However, there are some shortfalls in the implementation of the gender policy. For example, the implementation of the female teacher policy is found to be ineffective owing to: inadequacy of teacher quotas, absence of clear policy guidelines, unavailability of female teachers in the local community, lack of (proper) coordination among different local actors, school principals and SMC members, poor implementation guidelines, preference for male teachers, and the reluctance of women to go and work in rural areas (Bista, 2004, p.9). The policy of recruiting two female teachers is yet to be implemented. There is still a lack of SLC-pass girls for the teaching job, especially in the remote areas. Lack of residential facility and security measures for female teachers has been a problem. (Luitel, 2004, p36).

The government has been conducting scholarship programs for promoting access of the economically and socially disadvantaged girls and children to primary education. But the distribution system does not ensure that poor and deserving children will continue to receive the scholarships till they complete primary education. The impact of scholarship programs is minimal in increasing
enrolment and retaining children in the school. The reasons for this are: limited amount of financial assistance, inadequate scholarship quotas, failure to distribute scholarships on time, and lack of transparency in of distribution. (Bista: 2004, p12). The educational policies are not stated in a gender-sensitive manner. Although the Acts and Regulations do not explicitly discriminate against girls gender, neutrality has indirectly affected girls’ participation in education (Bista: 2004, p.13).

Conclusion

Education is one of the development agendas that can curb gender discrimination. It takes a long time to get the outcome of education. The gender discrimination has a direct effect on present-day development efforts. The efforts made to minimize gender discrimination are yet far from adequate. In order to facilitate development in the days to come it is important to completely eliminate the gender discrimination in education as well as in other areas of creative activities.

References


Girls in Science and Technology Education

Prof. Rukmini Bajracharya*

Nepal's democracy has now entered the stage where democratic evolution and sustainable development call for increased and effective participation of both men and women in the social and economic development of the country. In spite of the declaration of gender equity and women's empowerment in Beijing, Nairobi and other places, the promises made in international conferences and in the constitutional provisions and national development plans, there still exists a wide gender gap in the Nepalese society.

Many national and regional seminars have been conducted to analyze the educational situation of Nepal and to develop educational strategies for improving the 10+2 system in the country. But the prospects of success are hindered by many constraints and challenges. One realization by the Board of Higher Secondary Education relates to its science and technology curriculum. It feels that the curriculum has to be revised as required by the changing context and the development needs of the country.

Development and utilization of science and technology culture have been recognized as means to help people's lives in a meaningful way, ensuring improvement in the quality of life. The acquisition of appropriate concepts, skills and attitudes in science and technology education is vital to the improvement of the socio-economic condition of a tradition-dominated country like Nepal. It is therefore important that young people be made aware of the benefits of science and technology to meet the needs of the changing environment and of the evolving trends of education worldwide. This study has been undertaken with a view to evolve a strategy for increasing girls' participation in science and technology education. Since specialization in science begins from the higher secondary level of education, the study focuses on girls studying science at that level.

Research Objectives

Objectives of the study:

1. To undertake a review of the national education plans and of the curricula related to girls in science and technology education - in view of gender
2. To identify the interests and performances of girls studying physics, chemistry and biology in the higher secondary schools

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3. To obtain and analyze the opinions of science teachers, parents (of girls) and other stakeholders such as curriculum experts in science education and women scientists on how to motivate girls to embark on science careers.

4. To recommend girl-friendly strategies in STE on the basis of the study outcome.

**Strategies adopted for the study**

1. Review of related documents which included:
   - Major educational policies and programs for girls
   - Review of higher secondary science curricula

2. Field study regarding:
   - Girls' interest in STE
   - Girl's performance in STE
   - Opinion of non-science girls
   - Teachers' views
   - Parents' views
   - Views of women scientists
   - Views of science curriculum experts

**Review of the Major Educational Policies and Programs for Girls**

Different programs were conducted to provide education for all girls. One of the effective policy steps was the recruitment of female teachers in primary schools. This policy showed a position result in remote districts. Girls' enrolment increased in the schools having female teachers.

Another effective program was the distribution of various incentives (in cash and kind) to girls and children of disadvantaged communities. The incentives distribution improved the enrolment of the children in the schools of remote areas.

For the secondary level there were a few scholarship programs such as local scholarship for grades VI-VIII and upgrading scholarships for grades IX to X (for girls). For the higher secondary level, there was only one scholarship program, which was offered to the girls who wanted to be primary or lower secondary teachers. They would be provided hostel facilities, too.
Review of Higher Secondary Science Curricula

- The higher secondary science curricula of biology, chemistry and physics were reviewed with respect to gender.
- There is no gender-specific term or item of reference in the curriculum component units of the three subjects: physics, chemistry and biology. All the terms were only technical and neutral.

Findings from field study

The information collected during field study are presented below.

(a) Girls’ interest in science/technology:
- In general girls chose science on their own interest. They did so in the hope of getting good jobs in the future. They liked the institutes because of their good reputation, quality of education, friendliness of teachers, and the good lab, classroom and library facilities provided. A few girls joined science under parental pressure.
- Almost all the girls preferred biology and chemistry to physics. They found physics an abstract subject. Girls are nature-loving so they liked biology most. Since chemistry is related to daily life practice, they liked this subject too.
- Most of the girls showed interest in medical subjects. Some liked to be engineers and others liked to be computer scientists. A few girls liked other subjects such as nursing, biochemistry, microbiology, pharmacology and environmental science.

(b) Girls’ performance in science
- Teachers are the persons who could be expected to give accurate information about girls’ performances in the schools. Also, girls themselves can give some judgment. These two stakeholders presented the following pictures:
- Girls were more regular in class than boys.
- Girls completed the assessments on time whereas boys did not.
- Their exam scores were much better in practicals than in theory papers.
- Girls secured good marks in biology, average marks in chemistry and low marks in physics. There were, however, some exceptions.
- Their performances in practical works also were better than those of boys.
Their performances were better in course-related activities than in out-of-course (extracurricular) activities.

(c) Responses of non-science girls from case studies

During the interview, some non-science girls said that they were also interested in studying science because it provided good job opportunities. They added that they joined Humanities or Management because of the lower tuition and admission fees. Thus, one can conclude that many girls who are interested in science are not able to take science due to the low economy of the family.

They suggested the following for attracting more girls to science:

- Scholarship for girls doing science
- Lower admission/tuition fee in higher secondary school
- Free textbooks and uniform for girls
- Good library in the school
- Rest room for girls
- Job guarantee for girl science graduates
- Good teachers in schools

(d) Girls' participation in in-class and out-of-class activities

Teachers and parents were the best informants as regards girls' participation in in-class and out-of-class activities. Also, they were the stakeholders who knew more about how to increase girls' admission to STE.

Teachers' views

- Girls' participation was better in co-curricular activities than in extracurricular activities.
- Their participation in class was lower than that of boys. They usually did not put questions to the teachers in the class. They asked questions only if their friend circles were active.
- If the teacher grouped them for a particular exercise or problem-solving, they work enthusiastically. They said that teachers' behavior and competency were very important for them.

With regard to participation in class they made the following suggestions.

- Need of frequent counseling (by the teacher)
- Group work related to environment protection in the school or community
Presentation of topical analysis (as individual endeavour)
Debate on scientific/technological topics
Competition in songs and poems (on nature conservation, for example)
Project work (group or individual)
Teacher-student interaction within and outside classroom
Awareness program for parents and other concerned people
Field studies pertaining to science

Parents’ views
Most parents wanted their daughter to become medical doctors or engineers. They stated that would bring prestige
Some parents said that what their daughters would like to be in the future depended on their own (daughters’) choice.

For the motivation of girls for science they suggested the following:
Scholarship for girls
Nominal admission/tuition fee
Good school management
Good school environment
Good lab, class and library
Accountable and skilled teachers and principals
Good friend circles
Proper counseling (by teachers and parents)
Incentives like medals, gifts and words of encouragement

Views of Women Scientists
Their responses were positive. According to them, STE provides good job prospects. Time is changing so girls should take interest in STE.

For motivating girls to STE, they identified three main thing; scholarships for deserving girl students; awareness programs for parents, community people, girl students and political leaders; and job guarantee for women having done science and technology.

(e) Views of science curriculum experts (higher secondary level)
The responses were very interesting. There was a suggestion for the inclusion of girls' psychological traits in the curriculum. Their suggestions were as follows:

- The higher secondary science curricula does not show any gender discrimination. But the discrimination is there in the society. Parents' perception of gender is deeply rooted in Nepalese culture, so they provide technical education to their sons and general education to their daughters.

- The science curriculum is outdated because most of the topics included in it are theory-oriented and abstract. Some contents are not consistent with the curriculum objectives. So the science curriculum should be reformed with learning inputs requiring co-curricular activities.

- Practical manuals include examples showing boy activities. Teaching manuals also contain such examples. So the manuals should be revised with respect to the learning needs of girls as well.

- There is a big gap between SLC science and higher secondary science. Therefore, concerned institutes and HSEB should address this problem so that the science curriculum is serially graded upward - from grade I to grade XII.

- Many teachers are neither trained nor qualified so they are not able to implement the curriculum properly. Hence, the teachers should be provided training on the implementation of the curricula and the use of teaching and evaluation modalities.

**Recommendations**

The following recommendations have been made (as strategies) in three categories, based cumulatively on the views and suggestions of girl students doing science, non-science girl students, science teachers, parents, science curriculum experts, women scientists of Nepal, and on the outcome of the workshop and case studies of school drop-out girls.

**Category I: Policy and program**

To increase girls' participation in science education:

- There is no seat reservation for girls in STE. It is therefore strongly recommended that a seat reservation of at least 30% be made for girls.

- Most of the higher secondary schools are based in Kathmandu Valley. Many girls are interested in studying science but they cannot take science because of the weak family economy. Science education facility at the higher secondary level is not available in the rural and remote parts of the country. The government should therefore adopt the policy
of establishing at least one higher secondary school with science in every district of the country. Higher secondary education should be free for all rural girls.

- There should be more scholarship programs for deserving girl students doing science. This will motivate girls to study science.

- Previous research studies have shown that girls' enrolment has gone up in the schools which have female teachers. So government should recruit female science teachers in higher secondary and secondary schools of rural and remote areas of Nepal. This policy would definitely bring more girls to science.

- In Kathmandu Valley, the government should adopt the policy of making the admission, tuition and other fees in science teaching institutes not only uniform but also nominal. It is one of the prime demands of the students. The students have long been facing problems because there is no uniformity in fees of the private schools.

- The government (HSEB) should launch mass awareness programs on the importance of STE for girls, parents, community people, younger generations (e.g. secondary level students) and political persons. This will help to decrease gender discrimination against girls in education.

- It is necessary to provide job opportunities to science graduates and under-graduates. There should be a policy in this regard.

**Category II: Upgrading of higher secondary schools.**

- Schools and institutions should do the following:

- Concerned schools should provide girl students incentives such as text materials, stationery and tutorials. This will help to increase the number of girls in STE.

- Other modalities to attract girls to the study of science (as suggested by teachers, parents and women scientists) are as follows:
  - frequent counseling for girls by teachers and parents
  - good behaviour of science teachers, male students and school principals
  - good lab, classroom, library and girl-friendly environment in the schools (female toilet, girls' room and good friend circle).

- This study showed that girl students were very regular in class and completed their assignments on time. It is to be noted that their participation and achievement were better in practical works than in theory. So the teaching-learning modality should include group work,
project work, field study, debate and other co-curricular activities in
science.

Category III: Improving the higher secondary curriculum

There is a need of introducing change in the higher secondary science
curriculum. Revisions have been made from time to time but they were mere
patchworks. Actually no improvement has taken place. The higher secondary
science curriculum should be improved/reformed as per what is given below:

• Outdated topics such as taxonomy, hypotheses etc. should be deleted.
  Some old topics which are still a need should be provided, only briefly
  and as basic knowledge.

• Addition of girl friendly sub-topics covering the use of cosmetics and
  pertaining to cooking, cleaning, washing etc. should be made (in
  chemistry). Similarly, addition of more topics in reproductive health, test-
  tube baby, genetic cloning, environmental protection etc. (in biology),
  and more examples related to everyday practices such as use of
  electricity, daily appliances and machines (in physics) should be added.
  Inclusion of mathematical knowledge for practical (daily) life should be
  given in modes of games. This type of reform will attract more girls to
  physics and mathematics.

• Teaching manuals and students’ practical manuals need to be revised.
  They should be made gender-friendly and provide examples of girl
  activities.

• There are no appropriate textbooks in science for higher secondary
  education. One has to waste time searching for books to complete a
  topic. Therefore, it is strongly recommended that HSEB take this
  problem seriously and do what best it can in this direction.

• Teachers are to be exposed, through trainings, to the techniques of
  curriculum implementation and evaluation modalities.

• Examination in higher secondary science education has not been
  consistent with the curriculum content and the teaching-learning
  process. So HSEB should address this problem (as soon as possible).

• There is a big content gap between the SLC science curriculum and the
  higher secondary science curriculum. Therefore, concerned institutes
  and HSEB should address this problem so that the science curricula are
  serially graded upward from grade I to grade XII.
Integration of Gender Course in Higher Education: On Account of Women's Empowerment Effort

Prof. Dr. Indira Sharma

Gender equality has recently been a subject of much concern in the sphere of development. A change in the status of women vis-a-vis that of men has become a pertinent issue in development planning. In this context, a significant change in women's movement was started in 1975 and women were declared 'women in development' (WID). Their direct role in production, and hence in development, came to be recognized.

It is an established fact that women's overall socio-political and economic status can be improved only by empowering them (Acharya, 2003). Empowerment could be defined as "the process of gaining control over the self, over ideology and over the resources which determine power" (Batliwala, 1994). Empowerment also means voice and influence over economic and political decisions affecting life. Hence, women's involvement is seen as necessary for development projects in all spheres including education.

Education is one of the main sectors through which women's empowerment could be addressed. In this context, the need for incorporating a separate discipline in women's issue at the higher level of education was felt towards the end of the Women's Decade (1975-1985) during which women in Nepal also were exposed to global, regional and national level women-related issues. As a result, the Central Department of Home Science, (TU) introduced a separate subject covering relevant women-related issues in its MA course in 1989. The subject was "Women and Development". This was a significant step towards regularizing women's studies as a separate discipline in the academic area.

Later, it was decided that a separate course with ample focus on women, gender and related issues should be initiated. So the Home Science Department started work to open a new course on Women's Studies in 1993. After three years of continuous effort, the one-year Post Graduate Diploma in Women's Studies was finally sanctioned by TU in February 1996 - on the condition that it should be self-sustained. Thus, the teaching in Women's Studies in Tribhuvan University started in September 1996. This course specifically focused on gender and development, emphasizing women-related issues with the following vision.

Vision

To contribute to the creation of a gender-friendly egalitarian society

* Chairperson, Central Department of Home Science and Women's Studies, T.U., Kathmandu.
Mission
To prepare knowledgeable and committed development specialists and agents through multi disciplinary gender studies

Goal
To prepare academicians, researchers, practitioners and leaders through higher education in Women’s Studies

Objectives
- To provide basic concepts, theoretical knowledge and practical skills related to gender and development
- To promote research and analytical skills of graduates in gender issues
- To give momentum to the advancement of women
- To strengthen women’s role in the development process through gender-focused education
- To produce gender experts who can create a new framework for interpreting the social world
- To prepare a cadre of professionals who can work as activists for the empowerment of women and the gender-balanced society

Teacher training: This program started with 15 well trained teaching staffs from the Central Department of Home Science and also from the Central Departments of Management, Political Science, Culture, Psychology and Economics. A six-week long "Gender and Development" training program for the teachers was conducted for the course in Padma Kanya Campus with the financial support of Canadian Cooperation Office (CCO). Not only CCO but various other organizations like British Embassy and individual donors from Canada and USA also came forward to provide (preliminary) logistic and other supports. SANGAT has provided the teachers training on gender and women's issues. It is still continuing its support by training teachers every year. Similarly, SNV/Nepal has helped to conduct a Refresher’s Training program.

Documentation and Resource Centre (DRC): The Department has its own DRC, which has more than 5000 books, reports and other publications on its account. Asia foundation, B.P. Koirala Memorial Foundation, American Cultural Centre and Friederich Ebert Stiftung (FES) supported DRC by providing numerous books and publications on gender and women's issues.

Curriculum: The curriculum of Women’s Studies has the following major components:-
- Gender concept and theories
Integration of Gender Course in Higher Education

- Women in development
- Women in politics, public policies, planning and legal system
- Research methodology based on gender perspective
- Thesis writing on gender/women’s issues

With research methodology and thesis writing as one paper, the curriculum is divided into four papers each of 100 marks. The teaching schedule is 18 hours of class per week and 760 classes are conducted within the fixed duration of the course.

Unlike the traditional approach which simply imparts a broad theoretical base, the approach in Women’s Studies focuses on study and research for the empowerment of women. It deals with the world of women - their daily lives, sexuality and emotions. The Women’s Studies (WS) program is not like any other course; it is rather a product of a political and exploratory act that transcends the field of knowledge by ushering in a new revolutionary way of thinking which empowers a woman to think and act as an equal and active member of the civic society.

Field research

It is one of the major components of the curriculum. For the past eight years the students have been conducting field research in collaboration with different NGO's and INGO's under the supervision of various faculty members of the Women's Studies program.

Field researches conducted in this Department include:
- Study of the economic and political status of women
- Study of family planning services in rural areas
- Assessment and review of early marriage practices (certain communities)
- Impact of micro-credit projects on women
- Poverty alleviation through women’s empowerment
- Gender dimensions of tobacco use
- Perception regarding use of tobacco
- Effects of tobacco use on maternal health and child morbidity
- Study on young girls’ reproductive health awareness
- Alcohol consumption and domestic violence
- Male’s migration and its impact on their wife and child(ren)
• Counseling and rehabilitation of survivors
• Trafficking of girls and women

Because of the research credibility of the Women’s Studies program many NGOs and INGOs have come up with support. These organizations are WHO, UNFPA, UNICEF, Plan International, PDDP, Asian Development Bank, Care Nepal, CECI, CCO, Australian Embassy, AusAid, Heifer Project International, Action Aid Nepal, National Labour Academy, Resource Centre for Primary Health Care (RECPHEC). Thus, the WS program was able to obtain the cooperation and good will of so many organizations.

The Department also got the opportunity to carry out a study on the "Effectiveness of women targeted programs" in 2003 for the National Planning Commission’s Central Monitoring and Evaluation Division. The study covered six districts- Dhankuta, Saptari, Lalitpur, Salyan, Parbat and Kailali.

Exchange program and Networking

The Department of Women’s Studies has established a networking of several organizations, doing gender and women-related activities, by exchanging publications and experts at the international level. It has already established exchange linkages with Akershus University College/Norway and Cari Von Ossietzky University of Oldenborg/Germany. At present, it is in the process of establishing similar linkage with the Department of Gender Studies in Liverpool John Moore University/UK, University of Oslo/Norway and Tibetan University/Tibet. Volunteers from Canada, Srilanka and Australia have worked in the Department for seven years and joined the network.

Other Extracurricular activities: The department invites guest lecturers and resource persons to deliver lectures on the burning issues of women’s empowerment and gender. Creative interactions take place between the resource persons and the participants. This Department celebrated a Reunion Program in 2003 where gold medals were awarded to outstanding students and letters of appreciation were handed in to two eminent personalities, Dr. Meena Acharya and Prof. Dr. Leela Devi K.C. who had worked dedicatedly to establish the WS program and are still contributing to it in several ways.

Impact of women’s study program on women’s empowerment: A study (Thapa, 2003) conducted to assess the effectiveness of Post-Graduate Diploma in Women’s studies program revealed that this course gave new knowledge to 97% of the students. 92% of the students could utilize this knowledge in their profession and were successful in changing the perceptions of individuals at the household level as well as at community level. Their affiliation with social organizations has significantly increased.
Increase in the household decision making was reported by 52 percent of the respondents. Almost all respondents (95%) were found trying to bridge the gap in gender equality at home and in the community. This program was reported to be very useful for women development, improving women’s status, creating awareness about women issues, building a new perspective in gender relations and giving new dimensions to self-identity.

The Women’s Studies program has achieved a high degree of success in building up the confidence and the decision making power of its graduates. 95.5 percent of the respondents have become more confident and 82.5% have become more decisive. There was also a suggestion that emphasis should be given to the provision of education and gender sensitization programs. Earnest efforts to change traditional norms and values, proper evaluation of women’s work, collective movement of women, facilitation of gender-friendly policies and programs, and mainstreaming of gender in the national agenda have been identified as other valuable means of empowering women. This course has enabled students to raise questions on gender discrimination. It also has empowered its students to demand, discharge and disclose in a manner which, in the traditional norms, were utterly unthinkable.

In due consideration of the need of the Women’s Studies program, the Ministry of Women Children and Social Welfare (MOWCSW) has since 1997 been motivating the participation of women in this program by establishing a scholarship of Rs 1,00,000. The scholarship goes to deserving students on the basis of their academic qualifications, ethnicities and the places of residence. So far 65 students have benefited from this scheme.

**Publications:** The Women’s Studies Program of the Central Department of Home Science has been publishing a Newsletter (biannual) since 1999. It has so far published 11 issues. In 2002 it also started publishing the journal of Women’s Studies titled “Hamro Sansar” (annual). So far the journal has gone through four issues. This department has published a compilation “Gender and Democracy in Nepal,” which contains seminar and conference papers on gender/women issues. Publication of an Annotated bibliography of the theses and field research works and a book on gender issue is in the process.

**Workshop/Seminarsand Professional Training:** Another series of activities to empower women was the organization of seminars/workshops, and rallies to celebrate the International Women’s Day involving various GOs, NGOs and INGOs. These interactive events are held on a regular basis on issues exclusive to women’s status in Nepal. WS has so far organized various seminars, workshops and symposiums on issues like

- Women’s empowerment and microfinance
- Women’s property and legal rights
Integration of Gender Course in Higher Education

• Gender issues in Nepal
• Development strategies on women's rights.
• Political empowerment of elected women members of Kathmandu Metropolitan City.
• Gender, development and democracy
• Dissemination of CEDAW Report in UN
• Conflict, peace and women's voice
• Violence against women
• Peace, justice, human rights and democracy
• Seven-day refresher training for the professionals of Women’s Studies program.

The participants of seminars/workshops and trainings, besides the WS program members, include representatives of INGOs, NGOs, GOs, women activists and leaders in the field of gender and development.

The Post Graduate Diploma in Women's Studies is currently in its tenth year of operation catering for around 30-40 students every year. Till the last academic year (2005), 318 students have completed this course. A large number of graduates in Women's studies are spread throughout the country and working at different levels for the empowerment of women. In this way the academic program of the Central Department of Home Science and Women' Studies has become the pioneer educational organization in Nepal, producing highly qualified human resources.

References


Thapa, Neeta (2003) “A study to assess the effectiveness of Post Graduate Diploma in Women's studies program” Unpublished thesis submitted to Women’s Studies Program
Traditional Food and Health Beliefs

Manodhara Shakya*

Introduction

Food is an essential element of life— for being alive, growing, keeping healthy, and for strength to work and undergo physical, mental and social processes of life. Obviously, food is not just for taste or hunger; it has social, emotional and cultural attributes too. Food has thus become a social symbol— art, value and ethics. Food is therefore the concern of dietitians, nutritionists, doctors, sociologists and anthropologists as well as food artists and inventors.

Food practices in Nepal, particularly in Kathmandu Valley, has evolved based on many things— seasonal availability, religious beliefs and festivals, experiences and traditional knowledge. Combined, all these may be termed ‘indigenous food beliefs’.

However, in modern times external influences have made strong encroachment on food practices and knowledge. Before it is too late, it is necessary to understand and assess the traditional beliefs and practices. With this thinking a small study was undertaken at personal level. This paper is an outcome of the study.

The objective of the study was to explore and interpret different food and health beliefs prevalent in the Nepalese society of Kathmandu Valley and to analyze the underlying concepts. An attempt was also made to relate the beliefs with the modern food analysis.

This study is based on the information collected through consultation of literature, interview with rural housewives from Tokha VDC and Mana Maju VDC of Kathmandu, Bungmati VDC and Bandegaun of Lalitpur, and teachers of Padma Kanya Campus. Obviously, therefore, the study was exploratory in nature. The information as well as the propositions developed have a limited generalization scope. Nevertheless, an attempt was made to analyze the extents of the beliefs across families and communities.

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Culture and Food Items

Nepal is rich in culture and customs. Food is one of the important components of cultural activities and customs. Season is one of the important determinants of food selection for a cultural celebration. The Hill regions of Nepal generally have six seasons. There are different festivals in different seasons. The festivals call for and highlight the importance of foods of the season.

Similarly, rituals and celebrations constitute special social events. These rituals and events are celebrated by eating specific food items considered important for them. The following is a description of season-specific and event-specific food practices and beliefs.

**Seasons, festivals and food**

from central to outer circles:

*In different seasons different food items are available. The Newar communities of the study areas and the Valley as a whole have nick named some festivals and special days after the special food of the day. For example, Maghe Sankranti*
which is celebrated on the first day of the month of Magh (Mid-January), has the nickname Ghyo Chaku Sanhu. Chaku (molasses) and Ghyo (ghee) are the essential items of the day. Tarul (yam) and Tilauri (candy made of molasses made of sesame seeds) are no less important. One interesting thing in the Newar communities of the study areas is that a married woman should not eat Chaku at her husband’s home until she attains a motherhood. She has therefore to go to her maternal home to take part in the food ritual. Lodwin (1996) looked at this ritual as one encouraging women to bear children.

The full-moon day in late Shrawan or early Bhadra (July-August) is special. On this day the Tagadhari Hindus change their sacred threads (Janai). So the day is known as Janai Purnima. It is known by the nickname of Kwati Puni in the Newar communities in Kathmandu Valley. Kwati (soup of nine mixed bean sprouts) is the essential food of the day. The nine beans are: black gram, Bengal gram, horse bean, broad bean, soya bean, Mastyang, small peas, big peas, white beans. Kwati is believed to bring good health for the year. It makes one strong and it purges one’s stomach.

The full-moon day of the month of Poush (usually November) is called Sakimana Puni. The meaning of Sakimana in the Newari language is boiled colocasia which is eaten along with boiled sweet-potatoes and dry roasted beans and grains. The food items make part of the Mandap in most of the Buddhist vihars and temples. Similarly, Yomari Punhi is another popular celebration observed every year on the full-moon day in late Mangsir. Yomari is the confection of rice flour from the new harvest. The rice dough, shaped like a fig and filled with molasses and sesame seeds, is steamed to prepare Yomari. Children groups go door to door in the evening singing and begging Yomari.

In late Bhadra or early Ashwin (August-September) Kathmandu becomes vibrant with a week-long festival of Indra Jatra. The main food item of the festival is Samaye Baji (consisting of black soyabeans, puffed rice, grilled meat pieces and ginger etc.). On the full-moon day of this festival children visit doorsteps begging Samaye Baji. The national festival of Dasain in the month of Ashwin (September-October) is celebrated for almost two weeks. Meat is the central food item of the festival. Similarly Sel Roti and variety of citrus fruits and dry nuts are the main food items of the Tihar Festival.

Important life events/rituals and food

The life of a person in the Nepalese society is marked by different age-specific events such as birth, rice feeding ceremony3 (Pasni), Ehi4, Bara Tayes5 (Gupha

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3 Rice feeding ceremony marks the first introduction of solid food. It takes place when the child is 5 or 6 months old (girl: 6 months, boy: 5 months).
4 Ehi is a Newari ritual of symbolic marriage of girl to the Bal fruit representing the eternal
Rakhne), Vratabandha, marriage, Jya Janko etc. Different food items are considered important for these events. The Sagun ritual marks all the important auspices of life including childbirth purification rite, rice feeding ceremony, birthday, initiation celebration, marriage, and starting of major undertakings and also the major events that, according to Lowdin (1996), mark the entry of the individual into a new status. Sagun is bestowed to land achievements/accomplishments or to wish prosperity. Egg, fish, Bara and yoghurt are the essential Sagun items.

One interesting food item of birth ritual is a paste preparation usually of rice flour. It is the essential food item of the traditional cleaning ritual after childbirth in some Newar communities. There are, however, some food items which on serious days, such as the days of mourning, e.g. meat, salt and spices.

During a Vrata (fasting) which signifies soul and body purification, only Sattvik foods (purely vegetarian, without fermented item, without spices, without foreign and unknown food items, self-cooked) are taken - one time only on the day.

**Pure and impure food**

Food is considered pure or impure depending upon the food type, source and handling. Fruits, fresh vegetables, whole grains, milk, and milk products are considered pure food items. Some vegetables such as onion and garlic are however not considered pure, possibly because of their strong smell. Similarly, tomato is not considered pure. Meat and alcohol are considered lesser and impure food items.

Such considerations regarding food are related to the Sankhya doctrine of three Gunas: Sattva, Rajas, and Tamas. Accordingly, Sattva is said to bring knowledge and spiritual happiness, Rajas restlessness and misery, and Tamas heedlessness, lethargy and sleep. Three categories of foods are associated with these three Gunas. Sattvik food is a pure vegetarian food that includes milk, ghee, fruits, nuts, whole grains and fresh vegetables. It is prepared with purity of mind and body and is served in a smaller quantity. It is said to give mental peace and nobleness. Rajasik foods are royal foods, non-vegetarian, fresh and vibrant in nature. Meat and eggs obtained from hunting are considered clean and fit. Rajasik foods are considered to induce, passions, ego, selfishness, violence, ambition etc. A Tamasik food is considered impure and dull. It includes meat,
Traditional Food and Health Beliefs

alcohol, and fermented items. Tamasik foods are considered to excite lethargy and negative emotions such as anger, jealousy and greed.

Purity consideration has other implications in the food practices. In the Hindu society, food prepared by a lower caste is considered defiled. Even water is considered polluted if it is touched by a person of a low caste. Another purity concern relates to the concept of Jutho. Food that has been partly eaten is considered Jutho. Food item served in a dish from which a person has already eaten are also considered Jutho.

Boiled rice is considered only half-pure or impure. It is therefore avoided on ceremonial occasions including feasts, fasting, mourning ceremonies and Shraddha (memorial rites performed to satisfy deceased ancestors) etc. Beaten rice is considered not impure. Similarly, rice pudding prepared in milk and ghee is also not considered impure.

Purity concerns of food are found to vary with situations. People, when observing Vrata strictly follow the Sattvik food prescription. Some respondents were found to restrict only to fruits and milk/yogurt. This applies to the Puja to Mhadeva, Narayana and Buddha. However, among the Newars animal sacrifice and alcoholic beverages are not only permitted but culturally prescribed for the worship (Puja) of Devi, Kali, Bhairava. The food offered to the deities is received as Prasad or blessed food.

Hot, Cold and Neutral Food

One of the important concepts is the concept of cold and hot food. Most food items are categorized as hot, cold and neutral. Hot food items are said to have heat-generating properties and cold food items cooling properties. Some food items are neutral. Accordingly, good health and illness are related to balance and imbalance of hot and cold foods. Food items perceived as cold are to be avoided during fever, cold, weakness or when one needs extra energy and nutrition. They are preferred during the hot season. Hot food items are to be avoided when one needs to cool off and they are preferred for extra energy and as nutrients.

Other studies (Foster 1994, Pool 1987) have described hot and cold as a feature of cultural groups in the Islamic world, Indian sub-continent, Latin America and China. The studies show that in these cultures the binary system of classification includes much more than food: medicines, illnesses, mental and physical states, natural and supernatural powers. Sharma Subedi (2002) writes that the concept of hot and cold balance is a basic principle in Ayurveda and Tibetan medicine.
This study lists up some food considerations of the respondents:

**Hot, Cold and Neutral food**

<table>
<thead>
<tr>
<th>Food items</th>
<th>Hot food</th>
<th>Cold food</th>
<th>Neutral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cereal group</td>
<td>Wheat, millet, rice bread, Chapatti and beaten rice</td>
<td>Barley</td>
<td>Cooked rice</td>
</tr>
<tr>
<td>Pulses group</td>
<td>Yellow lentils (Rahar), Bengal gram (Chana), dry pea, horse gram, cluster bean, roasted beans</td>
<td>Green peas, Masyang, yellow lentil, soybean</td>
<td>Musuro, boiled potato, green lentil</td>
</tr>
<tr>
<td>Vegetable group</td>
<td>Potato, sweet potato (baked/fried), yam, garlic(leaf/bulb), water cress, spinach, colocasia tuber, bitter gourd, snake gourd, dried leaves, bamboo shoot, saffron and nettle</td>
<td>Pumpkin, radish, cabbage, tomato cauliflower, radish leaves, rape leaves, mustard leaves, spinach, egg plant, cucumber</td>
<td>Boiled potato</td>
</tr>
<tr>
<td>Fruit group</td>
<td>Mango, jack fruit, guava, pomegranate, banana</td>
<td>Papaya, , apple, banana</td>
<td>Lemon, orange</td>
</tr>
<tr>
<td>Animal group</td>
<td>Chicken, goat, pigeon, chicken egg, buffalo milk, clarified butter</td>
<td>Duck, sheep, pork, duck egg, milk, yoghurt, buttermilk, cows milk</td>
<td></td>
</tr>
<tr>
<td>Oil</td>
<td>Mustard oil, sesame oil</td>
<td>Coconut oil</td>
<td></td>
</tr>
<tr>
<td>Spices</td>
<td>Onion, garlic, chilly, ginger, pepper, celery seed, dili seed, cumin seed, saffron, chilly, fenugreek seed</td>
<td>Aniseed, coriander seed</td>
<td></td>
</tr>
<tr>
<td>Beverages</td>
<td>Alcohol, tea, coffee</td>
<td>White beer (rice beer/Jand)</td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td>Jaggery, honey</td>
<td>Sugar, salt</td>
<td></td>
</tr>
</tbody>
</table>

**Other beliefs regarding food and health**

Traditionally, certain foods are considered beneficial to health and others harmful.

**Beneficial foods**

- *Jwano (celery seeds) upgrades milk production in lactating mothers*
- *A warm cup of milk every day helps keep health in good condition*
- *A spoon of ghee everyday enhances bodily strength*
- *Dhind and gundruk keeps the body robust*

These beliefs are found to have strongly influenced food practices in the communities selected for the study. The first two points above are widespread and the last two are predominant only in the villages.
Curative foods

- Many of the respondents strongly believe that some food items have curative effects.
- Ginger juice with honey, and water boiled with cumin seeds, celery seeds, turmeric powder, and Jimbu help cure common cold and cough
- Fresh yoghurt, yoghurt seasoned with fenugreek seeds, and Simal achar for curing diarrhea.
- Soup of Gahat (horse gram) for relief from the problem of Patthari (gall-stone)
- Nettle soup for swelling
- Mint, fresh coriander, cold water extract of coriander seed for headache due to heat
- Boiled water with saffron seeds and sugar (Misri) for dysentery
- Baked egg, mashed liver, mashed green gram, Bhringaraj (wild green) for nightblindness

Harmful foods:

A rhyme on which food brings what harm in what condition says:

*Bihanako bimiro diunsoko rayo belukako mula kalako bhai*

(The Bimiro fruit in the morning, mustard leaves in the afternoon and radish in the evening are like brothers of death)

Similar conditions with negative effect (as pointed out by the respondents):

- White pumpkin causes abortion
- Wheat bread causes headache due to acidity
- Raw radish causes cough and gastric problem
- Sheep meat causes swelling and joint pain
- Bitter gourd causes low pressure and weakness
- Guava and pomegranate cause constipation
- Sour food and fruits cause cold and fever

Scope and Extents of Food Belief

There are many cultural, ethnic and minority groups in different geographical regions of Nepal. Obviously, therefore, we come across different beliefs and their variations at regional or community levels. However, it was surprising to note...
that variations existed even among the four sample villages in Kathmandu Valley. Nevertheless, it was found that some beliefs were widespread, some were limited to the local community and some were typically family-specific.

Examples of widespread beliefs:
- White pumpkin causes abortion
- Green vegetables cause cold and cough to lactating mother and baby
- Yoghurt has a cooling effect
- Chaku and Sakkhar (Molasses, jaggery) have heating characteristics
- Honey causes abortion

Examples of beliefs limited to the community:
- Rural Newar communities believe that Thon (white beer) helps produce more milk during lactation
- Brahmin and Chhetri communities believe that jwano (celery) soup helps to produce more milk during lactation.

Examples of family-specific beliefs:
- Cauliflower causes acidity/gastric problem
- Thon (white beer) causes asthma
- Snail meat cures soar eyes
- Papaya causes abortion
- Those who eat chilly or drink beer or strong alcohol will not have worms.

The concepts of hot and cold foods are quite widespread in Kathmandu Valley but the criteria for classifying food as hot and cold are often not clear because they are not based on logical or principles. Meat is classified as hot and cold. For example, chicken, goat, and pigeon are considered hot food whereas duck, sheep and pork are perceived as cold. Foods that are classified as hot in one family, culture, or region are not necessarily classified as such in another. For example, corn porridge, peanuts, black gram, spinach and banana are perceived as hot in some families and cold in other families. Most vegetables and fruits are considered hot or cold. Cereal is counted as hot rather than cold or neutral. A study undertaken in Kirtipur indicated variation in the hot, cold and neutral classification (Subedi, 2002).

Modern Food Analysis and Traditional Belief

Modern food analysis does not mention any food as hot or cold. The modern food concept is based on three essentials for the body: operation of the system (energy-giving food), growth and maintenance (body building food) and defense
against disease (body-protecting food). There are six important nutrients which are essential to life: protein, carbohydrate, fat, vitamins, minerals and water.

Nevertheless, when it comes to analyzing the benefit or harm to the body the traditional beliefs do agree and disagree with the modern analysis. Here are some examples:

**Agreement**

- Celery seeds soup is considered hot, especially when given to lactating mothers. Modern analysis shows it is a rich source of protein, fat, calcium and iron which help to produce more milk.
- Traditionally it is believed that Lapsiko Aachar cures common cold. Modern analysis also takes it as a rich source of Vitamin C.
- Clarified butter gives strength and energy. Modern analysis agrees with this.
- Bara (cake) prepared from black gram is considered as hot and difficult to digest. According to modern analysis, protein content in black gram is high. A protein-rich food eaten in a big quantity is difficult to digest.
- Pomegranate helps to increase blood volume and gives strength to the body. It is a good source of iron and energy. According to modern analysis, iron is essential to blood. It is good source of physical energy.
- Baked egg, mashed liver and mashed green gram cure night-blindness. These food items are good sources of protein, Vitamin A/carotene, iron and fat which are necessary for eye-sight.
- Mixture of egg and milk, liver, green gram soup and steamed green gram bread, and soup of goat leg are considered healthy food. From the nutritional point of view these are good for boosting the quality of health.

**Disagreement**

Traditional food beliefs do not always agree; rather, they are contradictory.

- Leafy vegetables are considered as cold. They cause diarrhea and cough therefore they must avoided (for up to three months) by lactating mothers. Modern analysis says that green vegetables are rich in iron, calcium and carotene which are good for lactating mothers.
- Fruits cause cold and cough but modern analysis shows they are good sources of Vitamins-C and minerals which help to cure cold.

It is now obvious that traditional food beliefs and practices are composites of seasonal moods and availability, ritual values and emotions, social customs and values, and symbolic representation of events. Modern analysis on the other
hand, relies on food composition and the physiological and chemical processes and properties. There is therefore a big scope for understanding the two systems and judiciously combining them for the holistic benefit of human beings - socially, emotionally and physiologically.

Already there is an emerging effort to understand food values and their attributes, particularly health attributes. The emerging trend is to understand the traditional beliefs and practices with empirical evidences rather than disregard them.

**Medical effects of food**

<table>
<thead>
<tr>
<th>Nuts</th>
<th>Horse radish</th>
<th>Chinese Mushroom</th>
<th>Blood thinner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clean nose; sinuses</td>
<td>Garlic</td>
<td>Pepper</td>
<td>Chronic bronchitis</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Corn, barley, rice, etc</td>
<td>Onion</td>
<td>CHD</td>
</tr>
<tr>
<td>Livers hepatic cholesterol</td>
<td>Caffeine</td>
<td>(Seafood Omega-3 FA)</td>
<td>Lowers blood triglycerides</td>
</tr>
<tr>
<td>Anticancer</td>
<td>Yeast</td>
<td>Polyphenols in tea</td>
<td>Antiviral</td>
</tr>
<tr>
<td>Diarrhea</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Conclusion**

Food beliefs and practices in Nepal are tied up with the seasons and the environment and often with festivals and rituals. The inter-connection goes beyond the availability of and access to food items to specific meaning and values that are culturally constructed. Obviously, food practices have both depths and dimensions to sustain the beliefs and practices in the traditional Nepalese
society. This emphasizes the point that food is not only a biochemical compound with objective attributes, it has psychological and social values which are beyond the understanding of modern science.

However, now there is a growing awareness that traditional food and health beliefs often embody ages of experiences and knowledge. Some of the beliefs are important and even provide insights for modern understanding. Others are simply carried on without apparent meaning or values. There is, therefore, a high scope for further studies in the area of traditional beliefs and practices for developing holistic and critical understanding regarding food and its implication on physiological, emotional, cultural and well-being of man.

There is hope in the currently emerging trend. The new trend is re-discovering the importance and potential of traditional/indigenous knowledge, adding the modern ways of seeking empirical evidences. The recent trend calls for critical understanding and wisdom to look into food beliefs and practices with regard to their values - healing value, clinical value, nutritional value and cultural value – all in a holistic way.

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Indigenous people of Nepal and their healing practices

Narendra Phuyal

Indigenous people

The Nepal Gazette (February 2, 2002) has identified 59 groups of indigenous peoples and nationalities in Nepal. They are classified as people living in the Mountains, Hills, Inner Terai and Terai. In the classification, the Mountain region covers 18 types and the Hills region 23 types. Likewise, in the Inner Terai and Terai the numbers of indigenous groups are 7 and 11 respectively. Such groups of people are deprived of basic services including health. The health indicators of the indigenous peoples show a high death rate, a high infant mortality rate and a low contraceptive prevalence rate.

The government has realized the need to bring these groups into the national mainstream of development. It admits that despite various provisions made in the periodic plans the socio-economic condition of these groups has remained in extremely low. Separate treatment of the IPs and nationalities as such is an indication of the government's concern for raising the general socio-economic status of these people. The doctor-population is very small in Nepal. The indigenous peoples of rural and remote areas of Nepal do not have access to medical treatment. So the traditional healers from different cultures are providing primary health care in these areas.

The government of Nepal has a challenge. It has to raise the health standards of its people in the rural and remote areas. This situation has been created by the weaknesses of the government at the program implementation level. The rural people are not getting even primary health care locally. They are dying of diseases like diarrhea and fever. In this context, the indigenous people of Nepal are feeding their own medical knowledge with information drawn from other cultures.

Indigenous knowledge

A World Health Organization (WHO) report shows that there are 400,000 traditional health practitioners in Nepal and about 80% people of the rural people are dependent on the traditional health care system. Indigenous knowledge is being used in primary health care. Nepalese healers have a good knowledge of herbal plants, which they are using as magic. But the country is losing its right over indigenous knowledge of traditional healers. Outsiders are using herbal

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Indigenous people of Nepal and their healing practices

plants of the country. Herbal plants and indigenous health knowledge and practices have not been documented in the concerned ministries.

Indigenous health practitioners

It is estimated that in Nepal more than 80% of the population use herbal medicines. Traditional healers are an important asset. Hence, delightful healers, religious faith healers, conventional midwives, shamans, Ayurvedic doctors, bonesetters and others are providing health services to the people. People in rural areas are receiving health care services also from practitioners of indigenous medicine. Informal healers such as Kojus, Jhankris, Gubhaju, Tantriks and Jhankris, Vaidyas and Kavirajas are the medical practitioners of the Mid-hills and Terai. They use herbal plants as medicines. There are many Ayurvedic practitioners who have a family tradition of several generations. May be, most of them have not received formal/ academic education.

In the remote areas of Nepal, traditional practitioners use locally available plants for treatment. The healers are not Ayurvedic practitioners. They are faith healers who differ culturally and communitywise. Kojus are popular in the Gurung community of the Hills and Mountains.

Jhankris are popular in the Tamang communities in the Hills and Mountains. Gubhajus are popular in the Newar community. Tantriks are popular in the Brahman and Chhetri communities. Dhamis and Guraus are indigenous healers of remote Mid-hill and Terai. They use herbal as well as faith-healing methods. Jhankris are traditional spiritualists of the Mountains and the Mid-hills of Nepal. Amchis are Tibetan medical practitioners of high Himalayan altitudes. The following table shows the distribution of traditional health service providers in different communities of Nepal.

Major ethnic/ caste groups of Nepal and traditional health service providers

<table>
<thead>
<tr>
<th>Ethnic/Caste Groups</th>
<th>Percentage</th>
<th>Traditional Health Service Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brahmin</td>
<td>12.74</td>
<td>Dhami, Jhankri, Phukphake, Vaidya, Kaviraj, Tantrik</td>
</tr>
<tr>
<td>Damai</td>
<td>1.72</td>
<td></td>
</tr>
<tr>
<td>Kami</td>
<td>3.94</td>
<td></td>
</tr>
<tr>
<td>Sarki</td>
<td>1.4</td>
<td></td>
</tr>
<tr>
<td>Thakuri</td>
<td>1.47</td>
<td></td>
</tr>
<tr>
<td>Chhetri</td>
<td>15.8</td>
<td></td>
</tr>
<tr>
<td>Newar</td>
<td>5.48</td>
<td>Gubhaju, Vaidya, Aaji, Tantrik, Dyoma/Dyobhaju</td>
</tr>
</tbody>
</table>
Indigenous people of Nepal and their healing practices

<table>
<thead>
<tr>
<th>Tribe</th>
<th>Percentage</th>
<th>Healing Practitioner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sherpa</td>
<td>0.68</td>
<td>Amchi</td>
</tr>
<tr>
<td>Tamang</td>
<td>5.64</td>
<td>Jhankri</td>
</tr>
<tr>
<td>Rai</td>
<td>2.79</td>
<td>Dhami, Jhakri</td>
</tr>
<tr>
<td>Gurung</td>
<td>2.39</td>
<td>Koju</td>
</tr>
<tr>
<td>Magar</td>
<td>7.14</td>
<td>Jhankri</td>
</tr>
<tr>
<td>Limbu</td>
<td>1.58</td>
<td>Dhami, Jhankri</td>
</tr>
<tr>
<td>Muslim</td>
<td>4.27</td>
<td>Hakim, Maulabi</td>
</tr>
<tr>
<td>Tharu</td>
<td>6.75</td>
<td>Gurau, Tantrik</td>
</tr>
<tr>
<td>Teli</td>
<td>1.34</td>
<td></td>
</tr>
<tr>
<td>Chamar</td>
<td>1.19</td>
<td></td>
</tr>
<tr>
<td>Yadav</td>
<td>3.94</td>
<td></td>
</tr>
</tbody>
</table>

Source: CBS 2001

Sudeni

Sudenis are traditional midwives of Nepal who look after childbirth. The Ministry of Health has produced Sudenis, who have been providing services to the rural communities. People believe in Sudenis all over the country. Both the traditional and modern Sudenis are giving services in the rural and remote areas of the country where people have no access to modern facilities. They use herbal plants in their own way.

Cultural context of indigenous health practices

Indigenous medical knowledge is deeply rooted in the tradition and culture of the Nepalese society at large. Most of the rural people of Nepal believe in local healing systems. Traditional healers are the first choice. Healers use an extensive knowledge of herbal medicines and function as spiritual authorities on healing practices. Herbal medicines are used as remedies for human as well as animal illnesses.

Seasons and festivals linked to health beliefs and practices

Hinduism and Buddhism are the sources of many of the traditional beliefs and practices. Family celebrations and community festivals are linked to seasons. The following are examples of the seasonal celebrations and food/herbal practices.
### Months | Festivals | Food/Herb
---|---|---
**Magh** (Jan-Feb.) | Maghe Sakranti, Seto Machhendra Jatra, Saraswati Puja, Swasthani Vrat | These festivals fall in the winter season so people eat hot and warming foods like ghee, Khichadi, Chaaku etc. Such foods help them maintain their health. They are said to possess health and medicinal properties.

**Phalgun** (Feb. - March) | Losar, Mahashivaratri, Holi/Fagu Purnima | It is the winter season so people eat hot and warming foods like ghee, Khichadi, and Chaaku. Such food helps people maintain their health.

**Chaitra** (March - April) | Chaitra Dasain, Ghodejatra, Ram Nawami | At this time it is neither too hot nor too cold so people can easily digest high-protein foods like meat and maintain their health.

**Baisakh** (April - May) | Nepali New Year, Bisket Jatra, Raato, Machhendra Jatra, Buddha Jayanti | Green vegetables, sweets, bread are the main food items of the season. This season is hot and high-protein foods cannot be digested. So people eat low-protein foods.

**Saaun** (July - Aug.) | Gunla, Nagpanchami, Janai Pumima | It is the rainy season. People are engaged in their fields. Due to rain the environment is generally cool so people eat high-calorie and high-protein foods like Kwanti and meat.

**Bhadu** (Aug.-Sept.) | Gai Jatra, Krishnastami, Teej | People usually eat sweets and participate in cultural entertainments. In this season rice plantation is already over and people have free time.

**Asoj** (Sept-Oct.) | Indra Jatra, Balkumari Jatra, Dashain | This is the beginning of the winter season. So for health as well as for celebrating the festivals people eat protein-rich foods like meat, cereals.

**Kartik** (Oct.-Nov.) | Tihar, Chhath | People get engaged in harvesting and storing their agricultural products. They celebrate the festival of Lights and eat sweets of different forms and tastes.

**Mansir** (Nov.-Dec.) | Vivaha Panchami, Bala Chaturdashi | The agricultural products, which were stored, are offered to gods and eaten.

**Poush** (Dec-Jan) | Yamari Punhi or Dhanya Poomina | Newar people eat Yomari made with dough and Chaku (inside). It is said to prevent cold-related diseases.

### Problems
- The government is not clear about the role and importance of the traditional healers.
The problems faced by traditional healers are multiple. They are as follows:

- The government has no interest in the traditional healers’ participation in the national health care system and programs.
- No dialogue between traditional healers and the government.
- There is no trust between traditional healers and health workers trained in the allopathic system. This has produced conflicts.
- Indigenous health practices are mostly hereditary. There is no sharing of the knowledge with youths.
- There is no institution to preserve indigenous knowledge and practice through awareness programs at the community level.
- No research on IK of the people.
- Pocket-based NFE packages on indigenous knowledge are not developed.
- Indigenous knowledge and practices are not integrated into the formal education system.

**Suggestions**

Here are some suggestions for resolving the above problems:

- Institutions should be developed to preserve IK through awareness programs at the community level.
- Indigenous knowledge and practices on health should be integrated into the education system.
- There should be a government policy traditional healers and healing.
- Healing practices should be fully incorporated into the health system, based on the culture and needs of the community.
- There should be a close relationship between health workers and traditional healers in the rural community.
- The roles and responsibilities of traditional healers must be identified and clearly defined.
- Non-formal training package should be developed at the local level to preserve herbal plants and promote their uses for human and animal illness.
- Nationwide participatory research on IK and health practices should be organized for the preservation and use of the herbal plants.
Indigenous people of Nepal and their healing practice

**Conclusion**

Indigenous knowledge and herbal plants are scattered all over the country. Both the herbals and IK are important for human life. It is high time that the traditional healing systems were evaluated on cost-benefit and socio-cultural importance. Traditional healers can be brought into the nation's health care delivery system. They can play a significant role in helping the rural community to upgrade its health quality and quality of life. It is important to collect information about the attitude, knowledge and practices of traditional healers and give them proper and adequate training in the use of medicinal plants.

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Indigenous Health Knowledge in Nepal: Exploring the way forward to promote, protect and sustain

Rose Khatri*

Introduction

Indigenous Knowledge is now regarded as a valuable commodity in human development, both locally and globally. This paper examines recent international dialogues and proposals put forward in an attempt to promote, include, protect and where possible to exploit Indigenous Health Knowledge (IHK) for its commercial use in the international pharmaceutical market. This paper examines these global developments with specific reference to Nepal and identifies the opportunities and barriers in both the protection and inclusion of indigenous health knowledge and practices in health development strategies.

Three specific issues are raised in this paper. The first one examines the move towards inclusion and integration of indigenous health knowledge and/or traditional medical practices into national health systems. This inclusion and promotion in national health systems suggests an increasing disillusionment with bio-medically based health care.

The second issue is the exploitation and globalization of indigenous knowledge for the international pharmaceutical market. International agreements and treaties developed through the World Trade Organisation (WTO) and most specifically the TRIPS agreement, highlight an opportunity for governments to take control of, own and exploit natural resources within their own borders. This though has profound implications for poorer countries and their ability to exploit these resources. Whilst India is leading the way within the South Asian Association for Regional Co-operation (SAARC), it is not without its detractors. Nepal as a new member of WTO can adopt strategies similar to those adopted in India when it lacks the infrastructure and expertise to do so?

The final issue here questions the move to exploit indigenous health knowledge for the international pharmaceutical market. The recommendation here is that an emphasis should be placed on the protection and sustainability of indigenous health knowledge for local use and health development. It is quite apparent that poorer countries struggle to compete in the global market place. Furthermore, the health system in Nepal remains underdeveloped and under-resourced and thus before jumping into the commercial world of pharmaceutical development and competition, which may actually lead to decreasing access to medicines as

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prices rise, shouldn’t the emphasis be on local health development? This paper offers no solutions to the questions posed. Rather, it hopes to generate further dialogue and discussion with individuals, groups and organisations in Nepal who are currently working to promote, protect and sustain indigenous health knowledge.

In this paper is globalization viewed as a set of interrelated processes in the economic, political, social and technological fields. It is the development of ideas and knowledge that go beyond the local or national sphere and become universal through the interplay of the global political economy. Globalization is not viewed here as a recent phenomena but as an evolutionary process; linked initially to mercantilism and developed more formally through colonization and, since the end of the second world war, through the endorsement of modernization (Galinas 2003). Globalization is profoundly a cultural system and one which is dominated by western political, economic, social and scientific values and aspirations. Thus in this paper globalization is viewed as part of the ongoing western ideal of human development and progress - though not as one that is all the way fair or necessarily sustainable. The globalization of indigenous health knowledge in particular has provoked an interesting international debate, which involves economic, scientific, legal, as well as cultural concerns (Eyzaguirre 2001; Takeshita 2001; Timmermans 2003).

This paper starts with an overview of indigenous health knowledge and practices. It analyses how and why indigenous health knowledge and practices had been marginalised or excluded from health development in the past and why there has recently been a move to re-embrace and include them in national health policy. It will identify and analyze the opportunities for and barriers to the inclusion of indigenous health knowledge and practices in Nepal. It will then go on to examine, in detail, the global debates surrounding the exploitation and protection of indigenous health knowledge. The exploitation or globalization of indigenous health knowledge for the international pharmaceutical market is discussed vis-à-vis the TRIPS agreement and the concerns raised by bio-piracy. Finally, the paper explores the prospect of protecting and sustaining indigenous knowledge primarily for local use and health development.

Indigenous Knowledge

Indigenous knowledge can be viewed as locally situated knowledge which relates, more or less, to a set of common values, beliefs and practices of a particular tribal group, kinship or indigenous community. It is also referred to as “traditional knowledge”, “folk knowledge” “ancient wisdom”, “local knowledge”, or “ethno science” (Brokensha et al 1980; Carmen 1994; Agrawal 1995). Indigenous knowledge is often regarded as unscientific, static and closed-minded. However, according to Sillitoe (2000:4), “it can be and normally is flexible, acceptable and
innovative”. Woyek & Gorjestani (1998: iv) state that what makes indigenous knowledge different from scientific knowledge is its uniqueness to a particular culture. In other words it lays no claim on universality, as in the western scientific tradition.

Clearly then, indigenous health knowledge relates to local beliefs and practices linked to the realm of medicine or traditional healing systems. These local practices may include substantial systems of medicine such as Ayurveda, Unani and Traditional Chinese Medicine (TCM). Most often in Nepal indigenous health knowledge and related practices are local and have specific cultural roots with healers often referred to generically as shamans. Most practices will combine herbal medication and some form of spiritual healing (see Adhikiri 2006 and Pauydal 2006 in this volume).

According to WHO, approximately 80% of primary health care need is met by indigenous health care practices in the rural developing world (WHO 2002). This is either because local healers are the first choice or because other forms of health care, and particularly those that are bio-medically based, are simply not available (Kunwar & Adhikari 2005). In the past the emphasis has been on developing and promoting bio-medically based health systems to meet population health need. However, more recently, there has been an increasing awareness of both the value of traditional and local health practices and the need for their inclusion in national health systems. The leaders of the SAARC nations noted in 1998 that the region had a rich heritage of traditional health practices (THP) and observed, “regional cooperation in their area would be worthwhile and relevant for meeting the basic health needs of the people” (SAARC 2006). Despite this acknowledgment the first Conference to initiate this regional cooperation was not convened until 2003. The most recent Leaders’ Summit in 2005 went one step further by agreeing on collaboration in the production of medicines, and most significantly stated that “steps should be taken to promote traditional medicines and to protect the intellectual property rights related to them as a matter of regional priority” (ibid: 2006).

Thus an area that was once the preserve of a few interested anthropologists has now become a potential for big business - something to be exploited for economic gain. Exploitation, however, has marred the international market and global development since the Europeans set sail in the 15th century. The question now is whether national economies can both exploit and protect their own natural medicinal resources at the same time?

Exclusion of Indigenous Health Knowledge

It is well known that the colonization and exploitation of peoples and their resources was a key aspect of western economic and social development (Carmen 1996; Latouche 1996). Colonization, however, not only exploited
people, it also subordinated their local beliefs and practices. This subordination included what Garner (1996:89) refers to as the “partial and uninvited importation of modern institutions and culture”. This subjugation and exclusion has been particularly true of indigenous knowledge in health and healing practices (Gish 1979; Samson 1997; Shrestha 2002). Communities and groups who adhere to traditional belief systems and indigenous health knowledge were and are still often viewed as ill educated, backward, or even uncivilized (Hobart 1993; Kolawole 2001). Shrestha (2002:107) wrote of how “missionaries mocked our local medical practices and made us feel ashamed of them”. Yet indigenous health knowledge and healing practices have had to meet the needs of local communities over many centuries and continue to do so. This exclusion of non-western values, beliefs and knowledge has been a key facet in globalizing human development. These processes started largely with the discovery of the “New World”, were laid down more formally through colonization and are maintained through contemporary global development initiatives.

The ideals of global development are maintained, largely through the theory and practice of modernisation (Leftwich 2000; Schech & Haggis 2000). Modernisation is said to offer a rational approach to global development, one based on scientific, secular and liberal ideas, which will transform the so-called traditional or third world societies into modern and progressive ones (Banuri 1990; Hobart 1993). Conceptually globalization could be regarded as the latest version of modernisation, the latest epiphany, which emphasises the market rather than the state in the quest for human progress and social well-being. A key aspect of modernity has been the development and global spread of western biomedicine with a concurrent universal “cultural rejection” of indigenous health knowledge (Phillips 1990; Tandon 1996; del Castillo 2002). This rejection filtered down through international development agencies and organisations into national governments and health systems. Biomedicine is fundamentally based on western scientific knowledge which, according to Tausig & Subedi (1997:42), “regularly clashes with indigenous health knowledge values and beliefs”.

The globalization of biomedicine as the preferred system to facilitate health development was central to the ideas and initiatives of WHO in the post-war era (Phillips 1990; Macdonald 1992). The focus of these health development initiatives (HDI), according to Pigg (1995:48), was “to spread scientific medicine and health knowledge in places where only idioms of healing exist”. Problems of expense, inequity and sometimes inappropriateness of biomedicine led to the idea Primary Health Care (PHC), a new mode of health development (WHO 1978). PHC was based fundamentally on the idea of inclusion and participation of peoples at the community level (Oakley 1989; Macdonald 1993). It was to include, or even integrate, indigenous forms of knowledge and traditional health practices into local health provision (Gish 1979; Reissland & Burghart 1989; Hyma & Ramesh 1994; Seneviratne 2000). There is scant evidence in Nepal that
PHC has fulfilled the early promise of HFA, nor particularly included peoples nor their knowledge and practices into local health provision (Oswald 1983; Stone 1986; Pigg 1995). Whilst there are some examples of inclusion, it has however, been clear from research in the field that it was more important to get biomedical knowledge in rather than include local knowledge and practice in PHC systems (Parker 1988; Tausigg & Subedi 1997; Pigg 2002). Times are changing however, and indigenous health knowledge and traditional medical practices are now seen as valuable resources to both national governments and international development organizations.

Inclusion of Indigenous Health Knowledge and Practices

The inclusion of indigenous knowledge in health development, research and practice has doubtless increased, yet is still considered as an under-utilized component (Woytek & Gorjestani 1998; Sillitoe et al 2002; Ho et al 2003). Although still under-utilized indigenous knowledge is no longer an excluded element of global development discourse and associated programmes. The World Health Organization (WHO), for example, has developed a number of projects and publications referring to indigenous knowledge and traditional medicine (WHO 2000; 2002; 2003). The United Nations Development Programme (UNDP) is also a keen advocate of indigenous knowledge (UNDP 2000). Furthermore, the World Bank also promotes research and development projects to promote indigenous knowledge (Woytek & Gorjestani 1998; Gorjestani 2000). The World Development Report for 1998 stated, “knowledge, not capital, is the key to sustainable social and economic development”. They go on to state, “building on local knowledge, the basic component of any country’s knowledge system, is the first step to mobilize such capital” (cited Gorjestani 2000:4).

The move towards inclusion embraces several key aspects of both economic and health system development. It is notable that the integration of modern and traditional medicine into national health systems in China, India, Brazil and Korea and, to a lesser extent, the Philippines and Vietnam, reflects a time of significant economic development in these countries. Economic development and the ability to challenge the might of the western industrialised countries have enhanced both national pride and the ability of these states to promote their own health governance and strategies. The capacity of these governments to develop policies and strategies to integrate traditional medical practices highlights advanced political and legal developments and practices. Under present conditions in Nepal this kind of legislation will not be prioritized. Also, the ability to exploit their natural medicinal resource base for the international pharmaceutical market is clearly not possible for Nepal and other countries in the region, which have smaller economies and underdeveloped technological infrastructures.
Nepal's problem of economic and technological underdevelopment is compounded by its lack of political stability and ability to facilitate health governance. The dominance of allopathic and particularly biomedicine dominates health policy development in Nepal and, as such, Nepal would seem to be out of step with health developments taking place within SAARC. Also, whilst Nepal has recently implemented an Ayurveda Health Policy which aims to utilize local herbal resources and provide Ayurvedic services in both local and secondary health sectors; some regard this as inadequate compared to developments afoot across the region (Singh (undated); Jha & Kannan 2005). Jha and Kannan (2005) maintain that there are many problems still inherent with regard to the integration of modern and traditional systems in Nepal. This includes the lack of government recognition of the role and value of indigenous health knowledge and practice for the health system. They talk of the lack of dialogue and trust between the government system (allopathic or biomedical), and indigenous health practitioners. Like many authors in the past, they recognize indigenous health practitioners as potential allies in the development of primary health care services and see them as having a "significant role in helping the rural community to improve its health and quality of life" (ibid: 3).

Koirala and Khaniya (2005) estimate that the number of indigenous or traditional health practitioners in Nepal totals some 40000, though this is probably an under-estimation. Thus, a large number of people are still predominantly reliant upon their knowledge and skills in local level health services. Despite an ongoing governmental ambivalence towards indigenous health practitioners, they remain a legitimate health practitioner in their own communities. This indicates that the Nepalese government is out of step not only with regional developments but also with international strategies supported by the likes of WHO and the World Bank. It also excludes important ideas, knowledge and research gathered by an increasing number of natural and social scientists and organizations interested in this field of study. Clearly, this is not seen as a priority under the current national administration and it maybe a concern which is irresolvable for some time ahead. As such, peoples' health needs in Nepal, especially in the rural areas, will continue to be managed and treated by local healers and herbal medicines (Rajbhandari et al 1999; Adhiari & Pauydal 2006 in this volume). However, these local practices and medicines are under threat from an increasing interest in indigenous health knowledge for commercial exploitation.

**Indigenous Health Knowledge and Global Health Market**

The most profound interest in indigenous knowledge has taken place amongst the large multinational pharmaceutical corporations and their intrepid scientists. Although the exploitation of botanical plants for pharmaceutical use is not new, advances in western science, particularly biotechnology have not only increased this exploitation but have heightened global awareness and concern of these
practices (Swiderska 2001; Gurry 2004). This exploitation is increasingly dependent on indigenous knowledge, particularly with reference to the knowledge of medicinal plants and the genetic resources they harbour. Utilization of this knowledge by the global health industry is evident with large pharmaceutical companies in competition to find the next “cure” or “magic bullet” for a whole series of modern diseases and ailments (Kirkby 2004). One of the ironies in this area of health research and development as Earthwatch (1994:73) stated is that whilst “one quarter of the world’s modern medicines are derived from or copy the compounds found in tropical plants, yet the cultures that have collected such a lore over generations are now in danger of forgetting it.”

The implementation of the Trade Related Intellectual Property Rights (TRIPS) agreement for members of WTO has several implications for the exploitation of natural medicinal resources and their development for the international market. Many authors highlight a series of both positive and negative outcomes linked to this development. Although in theory the agreement is based on the goal to enhance the social and economic welfare of populations, in practice, it would seem to be self-serving in that the richer advanced industrial nations can carry on exploiting the natural resources of others in the name of medical science and progress. Whilst the intention of the TRIPS agreement is that all member countries should develop the necessary legal framework to protect and patent their own medicinal knowledge, a major question is “can they”? Whilst the Indian government has recently approved a Patents’ Bill this has, however, taken a significant amount of time and expenditure (Shore 2004). India also has a large number of nationally based pharmaceutical companies which already exploit many natural resources within their own borders, and some say beyond (Singh undated).

India has both the technical and legal know-how to exploit natural medical resources. Also, it has a functioning government and whilst not all groups in Indian society are happy with the outcome, it clearly identifies an inequality between those countries, which can exploit and those, which cannot. Balasubramaniam (2002:4) concurs when he states that “a large number of developing countries do not have the resources to implement and enforce an efficient and effective intellectual property regime”. Even if they manage to implement a legal framework, there is no guarantee that they will have money and power to uphold their rights in international disputes. Nepal clearly is not in the same position as India, economically, socially, legally nor politically to implement such a policy. If there are benefits to reap from this development then Nepal, according to Bhatt (2006), will need to improve its human resource and infrastructure in relation to both the development of its pharmaceutical industry and of its public health system.

Whilst India is going full steam ahead with the development of patents under the TRIPS agreement in the name of progress, some believe it will actually
undermine its own pharmaceutical companies (ICTSD 2005). Clearly, India has succumbed to the pressures imposed by the TRIPS agreement whereby governments should seek methods to protect IPR predominantly through the patenting of knowledge, ideas and products. This is despite the reports that suggest that it is contrary to the benefit of poorer countries (CIPR 2002; Correa 2002; Dutfield 2002; Oxfam 2003). Nepal must consider their options very carefully and ensure that access to basic medicines derived from the natural resources in-house are not traded off in the hope of competing in the international market. Nepal will also need to consider methods to protect and sustain its natural resources at a time when the emphasis is on exploitation.

Protection and Sustainability

A major global concern with regard to indigenous knowledge is its protection and sustainability. The International Convention on Biological Diversity agreed on three goals in relation to traditional knowledge (Cited Cox 2000):

- To respect, preserve and maintain
- To insist on wider application
- To encourage equitable sharing of benefits

Although there is evidence to suggest that the second goal is on the international development agenda, the other two are more difficult to facilitate. Some believe that even though the convention is important, it does not go far enough to protect indigenous knowledge from bio prospecting and bio-piracy (Takeshita 2001). Furthermore, Ho et al (2003:4) discuss the lack of critique and opposition to "reductionist knowledge systems of the west that has provided the intellectual impetus for globalization and marginalized some IK systems or even driven them into extinction". Increasing evidence suggests that benefits to the local communities and therefore the source of indigenous knowledge are negligible (Seneviratne 2000; CIPR 2002; Sahai 2002). The companies and the ultimate sources of their good fortune the World Trade Organization (WTO), however, rarely address the question of sustaining indigenous knowledge.

Issues of rights and laws to protect indigenous knowledge, and ensure that the holders of the knowledge are rewarded equitably are currently under review (Dutfield 2002; Ho et al 2003; Reyes-Garcia 2003; WHO 2004). Timmermans (2003:751) talks of the importance of establishing links between "commercial, conservation and developmental goals, and to formalize and thus reinforce, the (moral) rights of the holder over their knowledge". Swiderska (2002:2) suggests a number of clauses to protect indigenous knowledge and talks of rights, which he refers to as "the ancestral rights of indigenous and local communities". He also suggests that the community must decide how local knowledge is to be used with
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the state/technical experts as facilitators; it must that local use is prioritised over commercial/scientific use.

Several reports suggest that cataloguing or recording of indigenous knowledge is the cheapest and most sustainable way forward for poorer countries to protect valuable indigenous knowledge (Woytek & Gorjestani 1998; CIPR 2002; Shore 2004). This relates to what Dutfield (2002) refers to as "Defensive Protection", whereby the knowledge holders are able to protect and provide evidence, if necessary even in courts of law, that someone else is using their knowledge without permission. The Indian government seems to be leading the way with the development of what has been called the Traditional Knowledge Digital Library. This $2 million initiative is a clear attempt to protect knowledge and to stop claiming it as their own and patenting the end product (Biswas 2005). This is an impressive and somewhat daunting task, as the codification of indigenous knowledge will be time consuming. This is particularly so with respect to oral knowledge which will be significantly more difficult to translate and codify. The aims of this process are to counteract bio-piracy, but also to make it available for nationally based scientists to exploit. However, providing data bases also leaves the field wide open to exploitation by international bio-prospectors and external pharmaceutical companies (Sharma 2004). In a way the Indian initiative will be a test case for other countries to follow if successful.

Opportunities for protection and local use

The countries of South Asia have become increasingly concerned and pro-active in the exploitation and protection of indigenous health knowledge and healing practices. Several regional meetings have taken place to share knowledge, ideas and methodologies to protect and use indigenous health knowledge in public health systems. Balasubramaniam (2002) recommends that the development of health systems should ensure access to medicines for the poor as part of a broader poverty eradication programme. A first important step towards sustainable solutions is the WHO collaborative initiative to monitor and analyse the impact of the TRIPS agreement on drug prices; the development of generic drugs; and the development of drugs for diseases such as malaria, TB and HIV. In a recent meeting of the Indian Science Congress Professor Richard Ernst called for a South Asian Union to "promote peaceful interaction and scientific cooperation between member countries" (cited Padma 2006:1). Yet according to SAARC, this collaboration is well underway, and, as such, may highlight the lack of knowledge - across regions and within countries, across different groups and organizations - about the activities aiming at promoting and protect indigenous health knowledge and traditional medical practices.

Despite the plethora of meetings the international rules and laws on the protection of indigenous knowledge are still not agreed on. WIPO provides
numerous guidelines on how governments, communities and individuals can take
measures, legal if necessary, to protect or indeed patent knowledge (see Gurry
2004 for example). WIPO, alongside WHO, UNCTAD and (to a lesser extent) the
World Bank is quite obviously committed to the inclusion of indigenous
knowledge in development, and these organizations are working towards its
protection and contributing to the legal debates with regard to IPR benefits. There
is some evidence that some indigenous groups/communities are able to receive
benefits in lieu of their knowledge (see IIPI 2004). However, Takeshita (2001:2) is
not convinced that the international development is becoming any fairer and
views many of the development aspects as part of the wider “hegemonic
discourse that appropriates nature, indigenous populations and their knowledge”.
This is view shared by many individuals and organizations working towards
alternatives in globalization practices (Fisher & Ponniah 2003; Madley 2003).
Health for All must remain an international and national priority and governments
must not loose sight of their populations’ health needs. There is ample evidence
that despite the rhetoric of international health development the lion’s share of
research, development and resources still go to the richer industrial nations and
their perceived pharmaceutical needs (Carpenter 2000; COHRED 2000).

Conclusion

Whilst the international race is on for the exploitation and the protection of natural
medicines for pharmaceutical use, there are still questions, which have not been
satisfactorily answered with respect to sustainability and local level health
development. Local peoples have been reliant upon nature and traditional
practices to supply treatment for health need and sickness, yet there is a real
danger that the emphasis on research, production and marketing of the
medicines, ultimately for economic gain, could leave millions without access to
any health care at all. The promises of HFA remain unfulfilled and despite the
Millennium Development Goals and Health 21 serious ill health and diseases
persist in Nepal. The pharmaceutical industries place emphasis on finding cures
and treatment predominantly for the western countries. Research and
development of medicines with which to treat the diseases that threaten most of
the poorer countries such as TB, malaria and HIV/AIDS are critically under-
resourced. This paper maintains that local medicines and practices should
remain largely that. Questions arise as to whether the recent embrace of
indigenous knowledge by the larger development institutions and organizations
are merely a smokescreen, another way of avoiding questions and providing
solutions to the gross inequalities that persist on a global scale. Indigenous
health knowledge is not a panacea for development; it is something, which
should be protected and allowed to flourish in the communities it stems from.
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Introduction

The traditional medical science system of Nepal is based on the principle of Ayurveda, which is one of the valuable sources of medical knowledge developed by ancient physicians. The knowledge of Ayurveda had remained open to all. With the passage of time, the true knowledge of Ayurveda came to be used in a wrong way in competition with the modern medical science. So the real traditional physicians are disappearing or are at least losing their confidence. This negative situation, if is not well realized, it will lead to a big loss of human knowledge necessary for the suffering mankind. There are still so many medical problems which are yet unsolved.

Ayurveda has eight branches or sections and sixteen basic sciences for medical practice. They are: Internal medicine (Kayachikitsa Tantra), Surgery (Shalya Tantra), Cranial-organo medicine (Shalakya Tantra), Pediatrics (Kaumarabhritya Tantra), Toxicology (Agada Tantra), Spiritual healing (Bhuta Bidya), Purification of genetic organs (Vajikarana Tantra), and finally, Long life and good health (Rasayana Tantra). And the sixteen basic sciences are: Medical philosophy, Principle of three pathogenic agents, Principles of diagnosis, Principles of treatment, Five Therapeutic Cleaning Procedures, Principles of treatment, Study of life span, Psychology, Hygiene, Dietetics, Anatomy & Physiology, Physics, Pharmacology, Botany, Zoology, Alchemy, and Pharmacology.

All the medical problems which are recorded and studied very well are classified into the eight sections or branches. Some of the problems are solved and some are still to be studied. In fact, the eight branches of Ayurveda deal with these solved and unsolved medical problems. The historical background of different schools of these sections is very important for understanding the development of Ayurveda.

Each basic science has its own theoretical and practical field. Medical philosophy (reality of life elements and fundamental constituents of objects), pathogenic agents (nature of the disease, approaches to diagnosis and treatment) and therapeutic cleaning method are one group of basic sciences. In the same way, the study of life span, psychology, hygiene, dietetic, physics, anatomy & physiology, botany, pharmacology and zoology are classified as the second
Traditional Ayurveda, the Indigenous Knowledge and Health Practice in Nepal

Ayurveda is an ancient original science of life. It is related with several intellectual understandings and skills. The science of Ayurveda does not follow the rules of modern science. It is based on the reality of cause and effect, which is the truth and reality of the universe. The presentations of Ayurvedic science and modern science are different; however, the aim of both of them is the same to cure.

Ayurveda is not a folk treatment. Its fundamental principles are based on the theory of balance of the bodily systems: the nerve system (Vata), the artery system (Kapha) and the vein system (Pitta). A balance of these three systems constitutes good health and imbalance or over-balance is the cause of sickness. The approach to restore the balance of these systems is what we know as Cure. Ayurveda presents this principle of diseases and cures. It is on this principle that the subjects of anatomy and physiology are studied - to understand the body and the mind and their relationship.

How people die and how they struggle against death is another major subject of Ayurveda. This subject presents a lot of information concerning immunity and long life.

Diseases are classified as two categories: one with physical disorder before symptom and another without physical disorder before symptom. All the diseases are included in the first category and are classified on the principle of the theory of balance. They have clear formulas for diagnosis and treatment. The second-category diseases do not follow the principle of balance. They are diagnosed and treated under spiritual healing principles. This is the subject of treatment based the unseen biological aspects. It deals with the concept of religious and psychological approach.

Different people have different natures. They are classified into the three major categories: those of nervous a nature, those of an aggressive nature and those of a delicate nature. This develops the body and mind relationship differently. The study of this is a unique subject of Ayurveda, which is primarily concerned with the mind, the body and the disease.

There are three different sources of medicines: plants, animal products and minerals. In Nepal near about 500 plants have been studied and tested for medical purposes. The section of botany concerned with Ayurveda deals with these plants with concern for their habitation, physical properties, and medicinal uses including toxicology and diet.

Zoology concerned with Ayurveda deals with animal products and their tastes, physical properties and medicinal uses.
Ayurveda deals with minerals for their taste, physical properties and medicinal uses including ancient chemistry and toxicology. Ancient chemistry uses minerals to neutralize their toxicity and to oxidize them for harmless use.

The study of physics concerned with Ayurveda deals with twenty physical properties, six tastes and five fundamental elements, all related to matter. Body, matter, drug and diet proportionately related to maintain a balance. This, in fact is the main base of Ayurveda for a logical presentation of pharmacology.

There are many forms of drugs decoction, powder, pills, fermentation, extracts, tinctures, alkalines, oxides, ashes, pastes etc. The main aim and theory of preparation of these drugs is based on how the body accepts them, without any side effect, to counteract the morbid condition.

Health is the balanced stage of the bodily elements and their physical systems. To maintain the balance proper diet, hygienicity and mental, and physical habits and behaviours have to be regulated with understanding. What has to be eaten, for examples, should be carefully decided based on daily food, water, seasonal effect, neatness, physical exercise etc.

Anyone can easily get some knowledge of Ayurveda. That is why Ayurveda is so advanced. The thousands of books written by different Acharyas at different times stand a proof of this.

The importance of traditional Ayurvedic medicine was well recognized by the people in the past and it still has a good reputation. But the future of it is not clear. Some of the causes of it are inadequacy of educational facilities, lack of a clear-cut national policy, and misuse of the profession. In ancient times, education depended upon good teachers (physicians) and dedication to study. A good doctor meant a physician who was conversant with all the areas of Ayurveda including theory, practice and preparation of medicines. Modern medical science does not believe in the theory of balance which, as stated above, is the fundamental principle of Ayurveda. Modern medical education encourages the students to study modern medicine on the notion that Ayurveda cannot be scientific without the knowledge of modern medicine. This is not true.

This is the reason why the future of Ayurveda is not bright from today’s point of view. There is still time to think about it. If we do not think, the intellectual standard of Nepal in the field of Ayurvedic science will erode. Negligence about it is the negligence of human talent.

Health is wealth; we have to think about it. One who is sick looks for cure. He is not concerned with any therapeutics. He only need is cure and good health. This is the fact and everybody must realize this.

Ayurveda does not claim that it can cure all diseases. In the same way, there are many diseases which modern medicine cannot cure. They can be cured with
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traditional Ayurvedic treatment and medicines. It is this aspect which underlines the need of traditional Ayurvedic treatment for the new generation. The new generation has advanced with a realistic approach for better health. So far as Ayurveda is concerned, it offers good prospects.

Ayurveda means the science of life and the life is the state of being healthy for happiness. Happiness and suffering are two contrastive states. Mind cannot be active without proper functioning of the bodily organs. Mind by nature rejects suffering because happiness is the goal of life. But suffering is a truth and reality. In this sense, mind concentrates on the body to avoid suffering - for happiness. Suffering in the medical term indicates that something is wrong in the constitution of the mind and the body.

The constructive and destructive factors of the body are directly related to life. Happiness as a result of balanced life is related with the constructive factor, which encourages the mind to lead the body to its proper functioning, and the suffering as a result of imbalanced life is the destructive factor, which pushes the mind to be alert to restore balance within the body constitution. In this sense, balance is health and imbalance is sickness.

Thus, the knowledge gained of the balance of the two factors is the main subject of study in Ayurveda. Therefore, Ayurveda as a science of life deals with good life and bad life and for that matter with happy life and unhappy life.

History of Ayurveda

Ayurveda started from the Vedic times. According to the Puranas, Ayurvedic knowledge was delivered to the world by Brahma. There are four Vedas, Rig, Sama, Yajur and Atharya. These Vedas were written 3-5 thousand years ago. The Vedas, especially the Atharva-Veda, contained the medical knowledge which was the basics of the principles of Ayurveda. The knowledge of Vedas was the contributions of the Rishis and Munis of different times and different places. It is well known that they were highly learned sages and saints who devoted their lives to the understanding the reality of the universe.

Aryavarta, the land of the Aryans, covers a wide area surrounding the Himalayas, where these Rishis and Munis lived. Today, the area covers countries like Nepal, India, Pakistan, Bhutan and Bangladesh. The ancient civilizations of these countries were influenced by the unique intellectual contributions of these Rishis and Munis. In different times and situations these Rishis and munis divided Ayurveda into the eight sections or branches for ease in study and learning. There are different schools and traditions to teach these eight sections of Ayurveda with related sciences. These traditions are still going on in Nepal and abroad. In Nepal there are about eight hundred families of traditional Ayurvedic physicians. They pass down their knowledge, from father to son, with additional
experiences. People have been benefiting from this knowledge. The plants which they need for treatment grow in different climates of Nepal. They prepare their own medicines. They have a good reputation and received moral support of the people. However, in the present situation is not conducive to the progress and development of their practices.

Around about 700 B.C. there was a famous Rishi called Bharadwaja who is considered the top Ayurvedic physician. History says that he was the first teacher of the Rishis & Munis. He learned Ayurveda from Indra, the king of Gods. Indra learned Ayurveda from Ashwinis, who were the physicians of Gods. Ashwinis learned Ayurveda from Prajapati who himself had learned it from Brahma. This anecdote is interesting but there is no authentic proof of who these peoples actually were.

A big medical conference was held under the chairmanship of Bharadwaja in a Himalayan valley to share the knowledge of Ayurveda and to encourage the scholars to compile the medical knowledge gained by different scholars from time to time. The result was the composition of Charaka Samhita, (the text of internal medicine), Susruta Samhita, (the text of surgery), Kashyapa Samhita, (the text of pediatrics) and so on. These books in their renovated forms are today very popular among Ayurvedic physicians.

Present situation of Ayurveda in Nepal

In Nepal many people still believe that Ayurvedic medicine can cure many chronic diseases - even those diseases which allopathy doctors cannot cure. In villages and cities many people depend on Ayurvedic treatment. Surprisingly, for chronic and complicated cases people prefer Ayurvedic treatment. Even for a surgical case they first go to Ayurvedic medicine. The reason for this is that it is cheap, has no side effect, and goes to the very root of the disease eliminating the cause.

There are three categories of Ayurvedic medical practitioners in Nepal.

1. Those trained in schools and colleges and holding degrees and certificates. Officially, there are about 230 Ayurvedic physicians of this category in Nepal.
2. Those trained privately on the father-son or teacher-pupil line and therefore holding no certificate and degrees. They are called Vaidyas. They are well trained in both theory and practice. There are about 800 (officially).
3. Semi-trained healers who practice as astrologers, priests, saints, herbalists, spiritual healers, hair-cutters and so on. There is no limit to the number of healers of this category. But WHO and Nepal Ayurvedic Medical Council mention about 400000.
But the heavy domination of modern allopathic medicine and its advertisements has made it difficult for the last two categories of Ayurvedic practitioners to survive professionally. They have a lot of confidence, and dedication but they cannot compete. The degree-holding Ayurvedic doctor's negative attitudes towards the Vaidyas and semi-Vaidyas (healers) and even the rules and regulations have made it almost impossible for the traditional practitioners to carry on in their field of work. Actually speaking, Nepal Ayurvedic Medical council has already declared the vocation of the traditional practitioners null and void in 2003. Only those who came from a university with certificates or degrees could practice. This has frustrated all the traditional Vaidyas and healers and compelled them to divert from their field of work. In this way, Nepal's indigenous health practice has been endangered. Now, in Nepal, Indians and some foreigners are dominating in the name of Ayurveda.

Without traditional Vaidyas and healers there will be no good status of Ayurveda, no herbalists, no alchemy, no medicine, and no treatment in the villages. Only a handful of degree-holding Ayurvedic physicians know how to prepare medicines from plants and herbs because they have only a little practical experience. Practical knowledge is more important than a theoretical base.

Around the world more and more people are taking interest in Ayurveda ancient science of treatment. They have realized that the treatment with natural herb, and plants and minerals is more effective than treatment with chemical medicines. Considering this, WHO has encouraged the advancement of knowledge of Ayurveda and its methods of treatment and made special programs for the period 2002 to 2005. Even European countries have Ayurvedic schools and hospitals. On the lead are Holland, Germany, and Italy. Italy accepted Ayurveda as an alternative medicine in 2003. In China, traditional medicine and modern medicine go together in hospitals. In India there is a big business in Ayurveda. In Sri Lanka the government has further emphasized the development traditional Ayurvedic medicine.

Also the 23rd SAARC health ministerial level meeting made a decision to award 8000 dollars to those who work in the field of traditional medicine. Surprisingly, it was proposed by the then health minister of Nepal who was unaware of the poor situation of traditional practitioners of his country. Today most of the medicines, cosmetics and even tea are sold under Ayurvedic names. More and more companies are manufacturing herbal medicines. Even allopathy doctors prefer recommending Ayurvedic medicines and treatment. But in Nepal the officially recognized Ayurvedic physicians freely recommend allopathic medicines. The condition of the only government Ayurvedic hospital is so miserable. Many scholars, doctors and patients come to Nepal for Ayurveda.
Present situation of traditional health practitioners in Nepal

The present situation of the tradition health practitioners is not good. Their future is not clear. They are carrying on their medical practice hanging between the government law and the system. The barrier, which Nepal Ayurvedic Medical council has put in, is the age barrier. Only those who are of the age of 50 by February 2002 can be legal practitioners. Also, they need to be registered by February 2003. This is ridiculous and humiliating. But the health practitioners are carrying on their tradition because the people want them and need them. There is no alternative for the villagers.

Causes of the decline of indigenous knowledge and health practice in Nepal:

1. More economic investment in other medical sectors
2. Heavy competition
3. Ego of the Ayurvedic doctors and health-related administrators
4. Highly dominating Indian influence in the production of medicines, education, books, etc.
5. People with less experience and knowledge handling complicated cases
6. Misuse of herbal preparations
7. Lack of government support to raise the status of traditional Ayurvedic practitioners
8. Lack of confidence even in some practitioners about passing on their knowledge and experience on to the new generation
9. Lack of enough knowledge of preparing Rasayanas and lack of identifying plants
10. Lack of ability to convince the patients
11. Lack of pure herbs and minerals
12. Treatment by ignorants and quacks
13. Lack of cooperation/co-ordination even among the practitioners
14. Lack of books and other publications.

To improve the situation the following measures are recommended:

1. The government must support the traditional practitioners because in Nepal the number of allopathic and Ayurvedic doctors is not yet sufficient.
2. Traditional health products must be purchased and distributed (by government) to local hospital and clinics.
3. The government must grant patent rights to the local traditional Ayurvedic herbal products.
4. Indigenous knowledge of preparation of medicines must be encouraged.
5. Traditional practitioners must be given opportunities to participate in governmental seminars, workshops and forums.
6. There must be practitioners’ representation in the Nepal Ayurvedic Medical Council and the related departments.
7. The government must give opportunities for further study to the children of the health practitioners in their related fields.
8. Concerned quarters must clarify that Ayurveda is not a folk treatment.
9. Traditional medical practice must be legalised.
10. And, finally, the precious indigenous knowledge of health practice should not be grounded for the sake of certain selfish interests. If we lose our tradition and culture we get nowhere.
Indigenous Medicinal Knowledge among Tharus of Central Dang
A note on gastro-intestinal diseases

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Introduction

Tharus are one of the indigenous people scattered over the southern foothills of the Himalayas. A greater part of their population resides in Nepal. Some Tharus are scattered in the adjacent Indian districts of Champaran, Gorakhpur, Basti, Gonda and Nainital (Rajaure, 1981). Tharus are considered as one of the oldest groups of people inhabiting the Tarai plains of Nepal. They usually live close to heavily forested areas [Bista, 1996]. Although agriculture has been their main occupation, the Tharus of Dang have lived in close association with forests since 1408 BS (1352 AD) (Gautam, 1987).

Indigenous medicinal practice, an outcome of a chain of trials and errors, is counted as very much reliable and in Tharu communities it is very common till date. Traditional healers, the Guruwas, are highly respected in all Tharu communities. They attend on the sick as a symbol of their faith, and in addition to performing their religious roles (worshipping the relevant supernatural or divine power), they help the diseased persons by providing herbal medicines with which they are familiar (Adhikari, 1997). The Tharu people prefer indigenous health care to modern medicine. The Guruwas have a rich knowledge of indigenous healthcare practice and medicinal values of plants. Due to the present drive for modernization, indigenous knowledge of medicinal herbs and their use is on the verge of extinction, because it is limited to oral tribal folklore. Thus, feeling the need to preserve the existing indigenous knowledge so that it would gain wider acceptance and application in modern medicine, this exploratory research tries to reveal indigenous knowledge pertaining to the use of medicinal plants in the treatment of gastrointestinal problems.

Study Area

The study area lies in the central part of Dang dun which covers an area of about 4000 hectares within 28°02'45" N to 28°06'30" N latitude and 82°19'40" E to 82°25'21" E longitude. The study area has a sub-tropical monsoon type of...
climate and a more or less sloping landscape with an altitude ranging from 581m to 714m above the sea level. About 60% of the area is cultivated and 10% is covered by dense vegetation (HMG – DOS, 1999a & b). The study was conducted in the very old Tharu settlements of Manpur, Jitpur, Narayanpur, Chaghun, Aspari, Teghara, Jamera, Bagaushi and Bhela villages and adjoining areas. Here, Tharus, Brahmins and Chhetris are the major ethnic groups. Other ethnic groups like Thakuri, Yogi/Puri, Kami, Damai, Sarki and Gaine are also found. Tharus constitute of about 40% of the total population (DDC, 1999).

Methodology

During the study, basically an exploratory approach was employed with the aim of documenting the indigenous knowledge pertaining to the use of medicinal and herbs plants. All the information presented here was collected during field visits (October 1998 to October 1999). Detailed interviews and discussions were carried out with the traditional healers and elderly people of Tharu communities. Information on plants with medicinal properties and on their use and mode of administration was collected. Plant specimens were collected with the help of Guruwas and local Tharu students.

Plant specimens were identified with the help standard literature (like Hooker, 1872-1897; Hara et al, 1978, 1979 & 1982; Malla et al, 1986) and by comparing them at the National Herbarium, Godavari and the Central Department of Botany.

Results

The Tharus of Central Dang are found to possess a very rich knowledge of the medicinal plants. They were found to treat 9 gastrointestinal illnesses with the help of a total of 38 plant species. Both cultivated and non-cultivated plant species have been documented. The plant species used to treat particular diseases are presented with brief descriptions of the parts used, use methods, dosage and mode of administration. The family (given within brackets) and the local name (in italics) are stated alongside the botanical names. Local names in Nepali are denoted by (N) and local names in Tharu by (T).

**BLOOD TOGETHER WITH STOOL**

*Shorea robusta* Gaertn. [Dipterocarpaceae] *Sal* (N), *Jinaintha* (T)

Powder of dry sap is mixed with honey in equal proportions. 3- 4 pinches of this mixture is taken to cure the problem in which blood exudes together with stool.

**CHOLERA IN INFANTS**

*Acorus calamus* L. [Araceae]  *Bojho* (N), *Baj* (T)
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Amulets of rhizome pieces of *Acorus calamus* and cloves of *Allium sativum* are worn for prevention of cholera, especially by children.

*Allium sativum* L. [Amaryllidaceae] *Lasun* (N), *Nasun* (T)
Amulet of cloves and rhizome pieces of *Acorus calamus* are worn for prevention of cholera, especially by children.

**CONSTIPATION**

*Abras precatorius* L. [Leguminosae] *Ratigedi* (N), *Titihir* (N)
Paste of 1 seed is taken for relief from constipation.

*Bauhinia variegata* L. [Leguminosae] *Koiralo* (N), *Kuilar/Kasnar* (T)
About 1 teaspoonful fruit ash is taken to cure constipation.

*Carica papaya* L. [Caricaceae] *Mewa* (N) Intake of ripe fruits helps to cure constipation.

**DIARRHOEA & DYSENTERY**

*Acorus calamus* L. [Araceae] *Bojho* (N), *Baj* (T)
Amulets of rhizome pieces are worn for prevention of diarrhoea. (In this case, Guruwa delivers certain *mantras* while giving the amulet to the patient to wear).

*Achyranthes aspera* L. [Amaranthaceae] *Apamarga* (N), *Ultakunr* (T)
Half a glass of root juice is taken thrice daily for relief from diarrhoea and dysentery.

*Bauhinia variegata* L. [Leguminosae] *Koiralo* (N), *Kuilar/Kasnar* (T)
About 1 teaspoonful fruit ash is taken to cure constipation.

*Curcuma angustifolia* Roxb. [Zingiberaceae] *Karya hardi* (T)
Paste of a rhizome (about the size of a thumb) is taken to control diarrhoea.

*Euphorbia hirta* L. [Euphorbiaceae] *Doodhe jharra* (T)
About 1 handful of root juice is taken to control dysentery.

*Euphorbia royleana* Boiss [Euphorbiaceae] *Siundi* (N), *Sihunr* (T)
Latex is applied around the navel to control diarrhoea in infants, especially breast-feeding babies.

*Mangifera indica* L. [Anacardiaceae] *Aanp* (N), *Aam* (T)
A glass of cold infusion of the bark is taken (single dose) to control diarrhoea and dysentery. If necessary, it could be taken of 2 times (maximum) a day.

*Mirabilis jalapa* L. [Nyctaginaceae] *Ghuneshra (T)*

½ glass of rhizome juice is taken to control dysentery.

*Musa paradisica* L. [Musaceae] *Kera (N)*

An unripe fruits (1/2) is consumed with curd to cure dysentery.

*Oroxyllum indicum* (L.) Kurz [Bignoniaceae] *Sontata (T)*

A glass of infusion prepared by crushing 3-4 seeds is taken to control diarrhoea and dysentery.

*Psidium guajava* L. [Myrtaceae] *Amba (N), Amrut (T)*

Cold infusion of bark is taken to control diarrhoea.

*Punica granatum* L. [Polypodiaceae] *Anar (N), Darim (T)*

Infusion of the fruit epicarp is taken to control diarrhoea.

*Rhus javanica* L. [Anacardiaceae] *Bhakimlo (N)*

Half a handful of powder of flowers and fruits is taken with curd or honey to control diarrhoea and dysentery.

*Shorea robusta* Gaertn. [Dipterocarpaceae] *Sal (N), Jinaintha (T)*

2 pinches of powder of dry sap is taken with hot water to control diarrhoea.

*Syzygium cumini* (L.) Skeels [Myrtaceae] *Jamun (N), Jam (T)*

Cold infusion of bark is taken to control diarrhoea.

*Tinospora cordifolia* (Willd.)Meirs [Menispermaceae] *Gurjo (N), Gurja (T)*

Juice of stem (about ½ glass) is taken to control dysentery.

*Woodfordia fruticosa* (L.) Kurz [Lythraceae] *Dhairo (N)*

A handful of flowers is taken with curd to cure dysentery.

*Ziziphus mauritiana* Lam. [Rhamnaceae] *Bayer (N), Bair (T)*

Root juice (2-3 tea spoonful) or 3-4 young buds are taken to cure dysentery. Diluted root juice (2-3 tea spoonfuls of juice in a glass of water) is taken to control diarrhoea.

**FOOD POISONING**
Rouvolfia serpentina (L.) Benth. [Apocynaceae] **Sarpagandha (N), Dhamal biruwa (T)**

Juice of about a finger-long root is taken, to cure food poisoning.

**GASTRIC PROBLEMS**

*Cautleya spicata* (Smith) Baker [Zingiberaceae] **Gande (T)**

4-5 pinches of rhizome paste is taken daily to cure gastric problem.

*Curcuma angustifolia* Roxb. [Zingiberaceae] **Karya hardi (T)**

Rhizome paste (about 2 tea spoonfuls) is taken thrice daily to cure gastric problem.

*Plumbago zeylanica* L. [Plumbaginaceae] **Chito (N)**

An amulet of roots is worn to cure gastric problem.

*Rouvolfia serpentina* (L.) Benth. [Apocynaceae] **Sarpagandha (N), Dhamal biruwa (T)**

Juice of about a finger-long root is taken, to cure gastric problems.

*Stephania japonica* (Thunb) Miers [Menispermaceae] **Batulpate (N), Ghaupatya (T)**

Roots are woven into a net-like ring and worn like a belt, placing the ring around the navel, to control gastric problems.

*Urtica dioica* L. [Urticaceae] **Sisnu (N), Susna (T)**

Root infusion is taken to cure gastric problems.

**INDIGESTION**

*Argemone mexicana* L. [Papaveraceae] **Bharbhanda (T)**

Juice of 10-12 seeds is taken to improve indigestion.

*Bauhinia variegata* L. [Leguminosae] **Koiralo (N), Kuilar/ Kasnar (T)**

2-3 pinches of seed powder is taken with hot water to control indigestion.

*Bombax ceiba* L. [Bombaceae] **Simal (N), Semra (T)**

Bark powder and molasses are mixed in equal proportions. 2 pinches of this mixture are taken to fight digestion difficulty.

*Cannabis sativa* L. [Cannabaceae] **Ganja (N)**

Leaf powder and molasses are mixed in equal proportions. About 1 tea-spoonful of this mixture is taken to improve digestion problems.
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*Mallotus philippensis* (Lam)Muell-Arg.  [Euphorbiaceae] **Ruini (T)**
Dry sap, exuded at the points burrowed by insects, is powdered. 1-2 pinches of this powder are taken with hot water to control indigestion.

*Raphanus sativus* L.  [Cruciferae] **Mula (N), Morai (T)**
Powder/Paste of 7-8 seeds is taken to cure indigestion.

*Sapindus mukorossi* Gaertn.  [Sapotaceae] **Rittho (N), Raintha (T)**
Seeds are baked in hot ash and the inner white material is ground. 1-2 pinches of this powder are taken with hot water twice daily to control indigestion and abdominal pain.

**VOMIT**

*Achyranthes aspera* L.  [Amaranthaceae] **Apamarga (N), Ultakunr (T)**
1/4 glass of root juice is taken for an instant stop of vomit.

*Allium cepa* L.  [Amaryllidaceae] **Pyaj (N)**
About 3-tea spoonfuls of bulb juice are taken to stop vomiting.

*Piper nigrum* L.  [Piperaceae] **Marich (N)**
Fruits are chewed to prevent vomit.

**WORMS**

*Carissa carandas* L.  [Apocynaceae] **Karaunda (T)**
One tea-spoonful of root juice is taken daily for 3 days to cure worms problems.

*Cirsium sp.*  [Compositae] **Muryakatar (T)**
Root juice (2-3 tea spoonfuls) is taken to control worms.

*Imperata cylindrica* (L.)Beauvois.  [Gramineae] **Siru (N), Chutki (T)**
One glass of root infusion is taken once daily, after dinner, to fight worm problem.

*Rouvolfia serpentina* (L.) Benth.  [Apocynaceae] **Sarpagandha (N), Dhamal biruwa (T)**
Root infusion (about ¼ of a glass) is taken to cure worm's problems.

**Conclusion**

Guruwas are generally the older members of the Tharu communities. They are very knowledgeable and are highly respected even in the non-Tharu ethnic groups. Guruwa is the first person to visit for an illness. Any illness is referred to
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be the act of ghosts and spirits by Tharus. Ethno medication, in most cases, involves certain rituals performed with mantras and the application of herbal medicines. Among the 9 ailments reported, most are treated with the help of more than one plant species and a single plant species is used to treat more than one illness. Although Tharus extracted plant resources from forest areas in the past, they now make use of many plant species that grow naturally in and around their settlements. They have started to cultivate the plants.

Although Tharus have changed their traditional habits a lot, whatever indigenous medicinal knowledge remains is of great value. Further, pharmacological screening may prove the validity of indigenous healthcare practices documented here. Once the validity is thus proved, indigenous knowledge can get wider acceptance and this would help a lot to uplift health facilities in a country like Nepal. Interaction among Guruwas from different villages could help to further enhance their knowledge and accept more efficient practice mechanisms that will ultimately help the general public. Encouraging the cultivation of medicinally valuable plants would help to improve the economy of Tharus and preserve the biodiversity of the region.

References


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Indigenous Healing Practices among Tharus of Amrai Village in Dang

Kamal Adhikari*

Introduction

The creativity of mind coupled with the faculty of rational thinking has enabled man to adapt to a distinct and particular ecological, social and cultural setting. This has empowered him to evolve a culture that serves as the basic bonds of social existence. The daily concerns of health and healing also fall under the prevailing norms and values of each social group around the world. The practice and process of thinking and rationalization on health, illness and healing get moulded from the cultural context and within the intellectual level of the concerned community. The community’s fundamental concepts remain more or less fixed as stereotypes or, say, even as prejudices or pre-conceived notions which are liable to change only slowly with the exposure they manage to get to the outside world. The choice of appropriate treatment strategies, adopted by human beings, is determined by their knowledge, experiences and beliefs that lie deeply rooted in the particular socio-cultural system they live in. A kind of an indigenous healing system which bears the stamps of the corporate efforts of a group of community people is among the key strategies of survival, both social and biological. Indigenous healing connotes a traditional or folk healing system that is by and large guided by tradition, culture and the belief system. In a culturally well knit society this practice occupies a dominant role in the health delivery system. The practitioners of indigenous healing systems have their own ways of defining health, identifying and categorizing illnesses and selecting health care options. Indigenous healing practice actually bears on a traditionally inherited set of beliefs and practices on the basis of which the healers diagnose and cure the illness without disturbing the socio-cultural fabric. Out of a strong sense of inquisitiveness I have attempted to shed light on the indigenous healing system of the Tharu community which I have been curiously observing since my childhood days.

Methods and Materials

This paper is prepared on the basis of a research work on “Indigenous Healing Practices in Nepal - A Case Study of Tharus in Amrai Village” of Dang district in the Mid-Western Development Region of Nepal. The research investigated the Tharu’s views on the causes of illness and the factors to be considered for a

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particular medical choice in compliance to their socio-cultural system. A total of 109 households of Tharus of the village were surveyed during field work. The tools such as case study, observation, interview and key informants survey were used to collect information from the field. The study focused only on the indigenous healing practices of the Tharus so the information about medical practices of the other communities was not collected. However, two types of literature, one focused on the indigenous healing practices in general and the other on the Tharus ethnography were reviewed. The facts as presented in this paper are therefore pertinent to the research work. In this paper, an attempt has been made to make the findings as comprehensive as possible along with some highlights on the theoretical perspectives concerning health, disease and healing as well as on the future prospect of the indigenous healing practices of the Tharus in the changing context.

Theoretical Perspectives on Health, Disease and Healing

In a broader sense, human health is understood as an interplay of physical, psychological, spiritual, religious, socio-cultural and environmental aspects. WHO (1978) defines health as a state of complete physical, mental and social well-being and not merely as the absence of disease or infirmity. Ayurveda, the science of life, defines a healthy person in terms of balance of body humors, proper functioning of all the body elements and the pleasant disposition of mind, soul and sense organs (Udupa: 1975). The word “disease” becomes synonymous with the word “maladjustment”. It expresses a temporary state of living cells in conflict with environmental challenges and trying to cope with them and survive (May 1958). In Medical Anthropology of Nepal, Subedi (2001, 153) views that health can be taken as biological phenomena but the knowledge, value and social fabric in terms of which people interact with their natural habitat affect the distribution pattern of diseases in a particular population. In other words, there is an intimate linkage between disease, medicine and human culture. According to Haggard (1929), diseases may be divided into three classes: one, which are entirely mental; two, those which are physical but tend to cure themselves; and three, those which are physical but do not tend cure themselves. Eighty to ninety percent of all diseases belong to the first two classes. The methods that have been used to treat diseases seem at first sight to be numerous and dissimilar; they are all simply variations of three basic measures: faith healing, hygienic therapy and drug cures. In faith healing attempt is made to remove the morbid state by means of influence exerted upon the mind. The hygienic therapy is founded on the recognition of the fact that the body tends to cure itself and that people recover from diseases. The measures of treatment are thus designed to supply the conditions under which they get well to assist the body to cure itself, and to minimize the effects of the disease. Such measures of treatment include rest, sunlight, bathing, fresh air and diet. They
also include anti-toxins and curative serums. Drugs may be used for different purposes. They may be given as an antidote to specific diseases. In various stages of civilization each of the methods of treating diseases have periods of ascendancy. In the lowest levels of civilization faith-healing predominates, while in the highest levels hygienic therapy predominates, but is assisted by moderate use of drugs. Thus, for any kind of treatment, the patient should have complete faith on the treatment pattern adopted by the medical practitioners. It becomes necessary to apply a treatment method in which a patient has faith. In this connection it is relevant to put the view of Ember and Ember (1980): Medical research suggests that psychological factors are sometimes important in illness. Patients who believe that medicine will help them often recover quickly even if the medicine is only a sugar pill. Similarly, Heggenhougn (1991) observes that the process of healing often functions within a bio-social-psychological matrix with considerations given to psychological, spiritual and social as well as physical factors. According to Stein (1990), medical anthropologists have contributed much to the understanding of the interplay between patient’s and healer’s health-related beliefs, values, decision-making strategies, actions, powers, and statuses. Psychoanalysis offers an additional understanding of the conscious and unconscious, preconscious, and unconscious factors in all realms of mental operation and action. It helps, for example, to account for the nature of beliefs and for the choice of, and investment in, specific health beliefs

People and Practices

Tharus are one of the indigenous tribal peoples scattered all along the southern foot-hills of the Himalayas from Bhutan in the east to the Nainital Terai of India in the west including the whole of the Terai portion of Nepal (Srivastava quoted from Rajaure:1997, p. 1). Most Tharus believe that their ancestors had come from Rajputana in India at the time of the Islamic invasions (Bista: 1980). Regarding their origin, the Tharus of Amrai said that their ancestors had migrated to Dang district in ancient times from the southern part of the Terai region of Nepal. The Tharus look Mongoloid with their nasal roots somewhat depressed; they have short low noses. Their skin pigment is dark. The main occupation of Tharus is first agriculture and then livestock-rearing. Most of them are non-vegetarian and their staple food is rice. Joint or extended family is the common family pattern. The oldest member, called gardhuriya, heads the family and the person called mahato heads the village. Tharus practice their own tribal religion, which consists of worshipping a number of spirits and some Hindu deities. A person called guruwu (faith healer) who plays a key role in the community is responsible for executing religious functions as well as for providing healing services, often faith healing.

To give a brief overview of the indigenous healing practices of Tharus, the findings of some studies and research works, which were reviewed for the
research works, are mentioned here. In an anthropological study of the Tharus of Dang Deukhuri, Rajaure (1977) explains that a Tharu shaman (guruwa) knows the methods of finding the cause of an illness. The malevolent spirits are checked either by pleasing them with causal offerings or by controlling them through spell, threats or other methods of magic. Mc Donaugh (1984), in a fieldwork carried out in the Tharu communities of Dang, shows the key role of guruwa in warding off spirits in order to protect members of the community from illness. Bista (1980) mentions that the Tharus of Chitwan, Nawalpur, Dang Deukhari, Kailali and Kanchanpur still practice the traditional. Tharu religion and culture employ guruwa who involves the deities of his patient to protect him or her from illness People worship and make offerings in the shrines when inhabitants of the village fall ill. Gautam (2044 B.S.) shows that the Tharus are afraid of bhuta-preta (evil spirits). When someone in the family becomes ill, the head of the family first goes to guruwa for a diagnosis and cure of the disease. The guruwa performs paati (a method of diagnosing illness) ritual for this purpose. If the patient is not cured, then only he or she is carried to allopathic doctors. Tharus are experts at healing wounds, boils and fractures. About the Tharu communities of Koshi Zone Regmi (1973) mentions that the Tharus still believe in dhami-jhankri, bhuta-preta and boksa-boksi. Dhamis are men whose co-operation and leadership is inevitable in some rites, functions and weddings in the Tharus community. They recite different mantras to cure patients. However, they have now lost their power of treatment more than before. Therefore, Tharus are now attracted towards allopathic medicine. In Tribal Ethnography of Nepal, Gautam and Magar (1994) mention that either mahato or guruwa is presides over pujas and festivals among the Tharus of Nepal. Beliefs in witches and evil spirits are so great among the Tharu people because they are mostly poor and illiterate. Thus, when any disease hits them, they put the blame on he angry gods or the mischievous bhuta-preta, and sometimes on the evil eye of the witches that live around. The custom of phuk-phak (healing by blowing mantras by guruwa) is prevalent. The healing techniques of the Tharus are explained mainly in terms of tuna-muna (spell), paati and jharfuk (blowing off with mantra). In fact, Tharus cure all diseases not only through faith healing but also through the use of herbs, insects having medicinal values, animal urine or blood, bones and meat, minerals, ash, soil, etc. In this paper, an attempt has been made to highlight the techniques of Tharu indigenous healing in a more or less comprehensive way.

**Major Findings**

In this section, the major findings concerning the indigenous healing practices of the Tharus of Amrai village are presented with necessary elaboration. The findings are organized under the headings such as Perception towards Causes of Illness, Places for Treatment, healing Techniques and Future Prospects of Indigenous Healing System.
Causes of Illness: Perceptions

Ethno-medical studies have established that a particular population have their own system for identifying and categorizing illness, their own therapy and their own rules for changing treatment and evaluating deficiency, even though they now choose treatments from several different traditions (Yodder: 1991). Tharus have two different concepts regarding the causes of illness. Possession by bhuta-preta and boksi (evil spirits), which dwell in the Tharu community as a part of their broader cultural system, is responsible for causing illness. The influence exerted by the evil spirits produces some sorts of physical or psychological disorder and unrest. Likewise, harmful germs that emerge, in bodily organs, out of the physical world and unhygienic dietary habits contaminate the blood and impede the smooth functioning of the body cells. The first category is solely attributed to the commonly held traditional belief. Data show that Tharu’s belief in the supernatural intervention as a prime cause of illness is deeply rooted in their minds regardless of age, sex, literacy level and economic status. This invalidates the commonly held views that the Tharus are prone to the indigenous healing system because of their poverty and illiteracy. Nevertheless, the difference in their viewpoints is constructed out of their interaction with the outer communities. The more social exposure they have to other communities the less faith they tend to have less faith in the indigenous healing system.

Places for Treatment

Medical pluralism is a characteristic feature of many communities. In most of the countries in the world, a majority of rural as well as urban populations have varieties of health care options available to them. According to Heggenhougen (1991), these health care resource options are of both allopathic and “traditional” kinds. Many people use a variety of health care resources either alternately for different ailments or simultaneously, serially or intermittently, for one ailment over time. Choices usually seem to be the result of a rational process related to the perceptions of health, illness and appropriate treatment rooted in the particular culture. Tharu indigenous healers also deal with the ailments by means of indigenous healing techniques. If Tharus assume that the illness is caused by germs, then after consulting guruwa, they consult baidawas (practitioners of herbal medicine) who administer herbal medicines or insects having medicinal values. If both attempts fail, they visit allopathic medical practitioners. The preference of one over the other depends on the firmness and extent of the belief system and on the strengths of the previous experiences with similar illnesses. The Tharus often fulfil their health needs from both indigenous healing systems and modern allopathic medical systems as none is adequate to deal with the health problems they are with confront. The health delivery system is determined by the facilities available to them and by their belief system. Field observations showed that the health delivery system installed by the government sector is not
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adequate and is generally beyond their reach. Of all the Tharus contacted, 81.65% gave first priority to indigenous healers and 18.34% to health posts or hospitals. But depending on the type and severity of the illness, they visit hospitals as well if they did not find getting the treatment by indigenous means effective. Data also showed that of the 31 patients under survey, 67.74% went to hospitals after they did not get cured by indigenous healers whereas 32.25% continued their treatment with the indigenous healers in the locality (Adhikari, 1997). This fact shows that Tharus are still greater attached to the indigenous healers. They believe that in some cases, particularly in basic fracture, snake-bite and dog-bite, the efforts of even allopathic doctors is less effective those of the gurwas and baidawas. Nevertheless, the modern medical system is taken as the ultimate option.

Indigenous Healing Techniques

Tharus often have three types of indigenous healing techniques: faith healing, physiotherapy and use of herbal medicines. Faith healing is practiced by ghar-guruwa (family medicine man who moves about in the village performing worships and doing jharphuk) and desbandhya-guruwa (who claims to have a lal mohar stating his ancestral family priest-hood for all Tharu people). The faith healing technique comprises jharphuk and food/beverage/blood offerings and is employed mainly to ward off evil spirits by means of exorcism. In a simple case of possession the jharphuk technique is applied while in a complicated food and beverages like rice, raksi (home-brewed wine), raw eggs and blood of a rooster or pig are offered. In faith healing, the gurwas diagnose an illness by different means: paati-basne (diagnosis done with recitation of mantras along with a to-and-fro movement of a lighted paala (earthen saucer) which is hung under hand using three thin threads, achhayata-herne (reading by rice grains), and naadi-chhamne (seeing the pulse on the wrist).

In physiotherapy, hot and cold bath and massage (for joint pain, stomach pain and gout) are done. Massage of the body parts is done mostly by baidawas and sudinis. In herbal remedy, different parts of plants such as barks, seeds, leaves, gums, roots and flowers are used to cure ailments depending on the nature of illness. In some cases both herbs and mantras are also used together to cure illness. For example, jantar (amulet stuffed with medicinal herbs and treated with a mantra) is prescribed to cure ear pain, impotency, diarrhea, and possession by evil spirits. Likewise, powder, juice and paste of herbs) are administered to cure problems like excessive bleeding in delivery cases, fractures, boils and wounds, diarrhea, fever, worm infection, snake-bite and dog-bite, etc. As reported, Tharus use a total of 102 types of medicinal herbs to cure 34 different ailments. Amaicho, Pakhanbet, Pudina, Timur, Bojho, Rudhilo, Kutaki, Ultekuro, Pitma, Bilauni, Gumpati, Kalo Besar, Dadmar, Harjor, etc are some of the herbs used by the Tharu communities for curative purposes. The Tharu healers said that they
acquired the knowledge of healing and medication in different ways: by informal learning from guruwas and baidawas, by simple observation and by using personal experiences. Some healers also got the knowledge and skill of treatment from their ancestors in their dreams. The Tharus have the belief that the use of medicine, whether allopathic or herbal, becomes fruitless if evil spirits have attack during patient medication.

The Tharu indigenous healers are also recognized by non-Tharu communities to solve the problems of possession by bhutwa (spirits), fracture, snake-bite and dog-bite, stomach pain, etc. They are also consulted for sick milch cows and buffaloes, solving delivery problems of cattle and protecting crops from epidemics, natural calamities and hailstones. The pahadi people (hill people) pay them high respect. It was sound that the Tharus also consulted, the pahadi native healers, for a cure of illness caused by evil spirits. This sort of mutuality has helped all to fulfill the requirement of health service delivery mutual benefit. The Tharu healers do not demand fee for the service they provide. But they accept both money and food as remuneration if they are provided by the patients voluntarily. In some cases, even a bowl of jand (home-made beer) is accepted. They heartily take these offers and do not discriminate between the patients on the basis of wealth, sex and social status. During field work, it was found that only male Tharus were recognized as guruwas or baidawas.

Prospect of Indigenous Healing System

The advance in modern allopathic medicine has very much improved people's health quality. But this statement does not apply to a majority of Nepalese people, especially Tharus. There is a big gap between the health requirement of the people and the services rendered to them. In such a situation, the requirement of health delivery is by and large fulfilled by the indigenous healers. The government of Nepal has officially recognized and supported the allopathic medical tradition and formally trained Ayurvedic practitioners. Allopathy is not available to a large number of people. It is estimated that only 10 to 15% of the total population in Nepal have access to allopathic medical services and that too, mostly in the urban areas (Ali 1991, 7 as quoted from Subedi: 2001, 153). This figure clearly shows the social legitimacy of other medical traditions. Thus the accent on allopathic medicine alone would not help. More latent in this analysis is a challenge to allopathic medicine itself, showing that there are other ways of thinking about suffering and handling bodily afflictions at personal and group levels than those offered by bio-medicine (Subedi, 2001:153).

The findings of a few case studies concerning the Tharus of Amrai village are presented here. Khairi Kumar Chaudhari, a locally renowned baidawa, puts his view thus: The patients’ insistent pressure compelled me to get engaged all the time in treating them but I couldn’t earn enough from the indigenous healing...
practices alone for my subsistence. So I planned to introduce allopathic medicine despite the fact that the Tharu community had a strong belief in the traditional healing practices. At the same time, Tharus have an attraction for the modern allopathic treatment. Therefore, patients prefer to have treatment at such places where both facilities are available. Keeping this in mind, I started practicing the modern allopathic medicine as well. Similarly, Thakur Prasad Chaudhari, a famous guruwa of Amrai village, believed in the effectiveness of the Tharu indigenous healing practices. He stated: The influence of supernatural forces exists in human life. So guruwa is as important as an allopathic doctor and herbal practitioners to overcome the health problem being faced by Tharus. Epidemics occur in a village due to the displeasure of a devi (goddess). In such a situation I can control the problems to some extent by making some offerings and worship to the devi. The villagers believe that if the guruwa becomes angry, misfortunes could take place in the village. Therefore, no one would dare defy the power of guruwa openly. I could cure even terrible burn cases by means of jharfuk. I haven't suffered from any serious illness so far. I once suffered from boils and ear-ache. I did jharfuk myself and used a herbal medicine. I ain't satisfied with the health facilities provided by the government, because they are not only inadequate but also limited to the rich. Prithipal Chaudhary (aged 70): The effectiveness of guruwas and baidawas has not decreased yet nor is it likely decrease in the future. But the inclination of Tharus towards indigenous treatment has been decreasing gradually due to the growing impact of allopathic medicine and to the slow effect of medicinal herbs they take. Previously, guruwas cured most of the diseases but now no one depends much on them. However, I still prefer indigenous healing in cases like fracture, dog-bite, snake-bite, delivery problem, bhakala (pneumonia), epilepsy, wounds, stomachache, etc. Buddi Ram Chaudhari, a literate member of the Tharu community: In some cases, Tharus are reluctant to accept the modern medical facilities due to the discriminatory behavior that the allopathic medical practitioners show towards them. Even today most of the Tharus have more faith in indigenous healers than in the allopathic doctors. Indigenous healers are easily approachable and their service is compatible with the local tradition. If an evil spirit attacks the person, a medical doctor can do nothing but guruwa can ward off the evil spirit and can cure the patient. In case of an illness caused by germs or by poison, the use of herbal medicine or allopathic medicine is inevitable. There is the need of both jharphuk/tunamuna and modern medicine to overcome health problems.

Conclusion and Recommendations

In spite of a strong socio-cultural bias, the Thar’s’s attraction towards indigenous healing practices has been declining gradually over time. The knowledge and method of treatment are often confined to the healers. There are no written documents about the healing system. The knowledge is transferred orally from
Indigenous Healing Practice among the Tharus of Amrai Village Dang

one generation to another and from person to person - as a legacy. The healers, though they have been locally recognized as patrons of the healing tradition, are not formally recognized by the government. The irony is that these healers are marginalized and their contributions are overlooked, and the government is seems reluctant to regard their contributions as a vital part of the total health delivery system in Nepal. This situation has made the Tharu indigenous healers indifferent to their own healing practices.

In fact, the Tharu indigenous healers want to preserve their culture of healing by passing on their knowledge to their successors or to any one who is interested to accept it. Tharus not only acknowledge indigenous healing as their tradition but also regard it as a strategy to safeguard them and their socio-cultural and natural environments. Knowledge and practice of treatment, especially tunamuna and jharfuk, are regarded as an integral part of the Tharu culture. Tharus have no access to modern allopathic medicine. None of the healing systems whether it is, indigenous or modern allopathic, is enough to fulfill Tharus health needs. The government has neither provided them with an adequate and affordable health delivery system nor has recognized the Tharu indigenous healers as part of total health delivery system. It seems that the survival and growth of indigenous healing system of the Tharus are impossible.

The health condition of people cannot be improved by simply imposing medical facilities. It needs people's strong willingness to adopt a particular medical facility suitable for their socio-cultural context. This is true for the Tharus as well. The role of Tharu medical practitioners such as guruwas, baidawas and sudenis could be willing to adopt new healing options which does not disturb their value system. In a research conducted in Syangja, Dolkha and Kanchanpur districts, Shrestha and Lediard (1980:88) state: Traditional local healers like Dhami-Jhankris can play a culturally viable and cost-effective role in Nepal’s struggle to design a strategy could help and support the indigenous network which provides millions of Nepalese with credible and comprehensive messages about health. Costello (1990:22), as quoted from Sigdel (1998:18), also found the important role of traditional healers in a hill district in the Western Development Region. He writes: "Well respected, sometimes feared, and with a strong sense of vocation, these men represent the true ‘national health service’ in the middle hills". But how to integrate a culturally sensitive indigenous healing practice (for example that of Tharus), into a broader medical system is a pertinent but unaddressed issue. The medical anthropological and ethno-medical perspectives should be taken into account to explore the hidden facts about the indigenous healing system. It is important to allow the prescriptions of indigenous healing practices in cross-cultural and evolutionary perspectives alongside the modern scientific systems. The Tharu indigenous healers could be a viable means in improving health delivery because of their strong hold over and an effective functional network with their communities. An initiative should therefore be taken to empower the Tharu
indigenous healers and to document their knowledge of treatment so as to establish their identity and recognition in the society and preserve the big knowledge they have acquired from generation to generation, for improving the health delivery system in the days to come.

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Indigenous Healing Practice among the Tharus of Amrai Village Dang


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Indigenous Knowledge of Acute Respiratory Infections Management Among Different Caste/Ethnic Groups in Nepal

Madhusudan Sharma Subedi

Introduction

Acute Respiratory Infection (ARI) is considered to be one of the major killers of children worldwide, particularly in developing countries. About four million deaths are caused by ARI worldwide (WHO 1997) and in South East Asia alone every year 1.04 million children die of ARI (Onta and Yengden 2003). In Nepal, ARI is one of the major causes of childhood morbidity and mortality, with an episode of 4-6 times per year per child (Sharma and Tuladhar 1990, quoted in Onta and Yengden 2003:5). In 1997 the Ministry of Health had estimated that up to 30,000 children in Nepal were dying annually from pneumonia alone and the figure has remained almost the same down to this day. However, the problem magnitude and management of ARI in Nepal differs by ecological region, caste/ethnic group and economic status. This paper focuses on the indigenous practices of ARI management in five different caste/ethnic groups in Nepal.

The Nepal Demographic Health Survey 2001 estimated infant mortality to be 64 per 1,000 live births. The high mortality rate is attributed to numerous factors. Childhood pneumonia is the leading cause of death of children under 5 years of age. Nepal’s low treatment rate of expected pneumonia cases is to blame for high fatality rates. Only 15%-18% of all pneumonia cases are brought by caretakers to Health Facilities, according to HMIS estimates (JSI, WHO and UNICEF, 2002).

The Ministry of Health recognizes that ARI is one of the major public health problems in Nepal with children of less than 5 years. The National Control of ARI Program is an integral part of primary health care and has been accorded high priority. The program recognizes the important role of mothers and other caretakers in identifying the type and severity of ARI and the appropriate management including the need for home care and the need for referral to health facilities. The main objective of the ARI program is to reduce the under-5 ARI-related morbidity and mortality and improve the child health status in Nepal.

Methods and Materials

In cross cultural studies of many illnesses, it is important to highlight the research process in which medical anthropologists engage when identifying methods and...
research issues appropriate for the study of specific illnesses within a specific population (Nichter and Nichter 1996). In every culture, illness, the responses to it, individuals experiencing it and treating it, and the social institution related to it are all systematically interconnected (Kleinman 1980). A focused ethnographic study was carried out among mothers of five different caste/ethnic groups to find out their perception; understanding and care-seeking practices related to ARI, in particular pneumonia. The main purpose of the study was to identify the terms used locally by the mothers to describe respiratory illnesses among children and to determine whether they recognized the key symptoms of ARI, in particular pneumonia, including the severity of the problem. Differences and similarities among illnesses were focused for exploring the mothers' knowledge of the causes of ARI and for the prevention and cure of the illnesses.

Fieldwork was carried out in four districts—Morang, Sunsari, Makwanpur and Chitwan. Altogether five caste/ethnic groups were selected as study populations - Brahmin/Chhetri, Tamang, Tharu, Musahar and Muslim. Various qualitative data collection tools and techniques like individual interview schedules and four to five focus group discussions (FGDs) in each caste/ethnic group were organized to elicit information on different aspects of ARI and the management practices of mothers of different caste/ethnic groups.

<table>
<thead>
<tr>
<th>District</th>
<th>Caste/ Ethnicity</th>
<th>FGD Respondents</th>
<th>Mothers With Sick Child or Past ARI Episode</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morang</td>
<td>Tharu</td>
<td>39</td>
<td>20</td>
<td>59</td>
</tr>
<tr>
<td>Morang and Sunsari</td>
<td>Musahar</td>
<td>38</td>
<td>20</td>
<td>58</td>
</tr>
<tr>
<td></td>
<td>Muslim</td>
<td>39</td>
<td>20</td>
<td>59</td>
</tr>
<tr>
<td>Makwanpur and Chitwan</td>
<td>Brahmin/ Chhetri</td>
<td>43</td>
<td>20</td>
<td>63</td>
</tr>
<tr>
<td></td>
<td>Tamang</td>
<td>39</td>
<td>20</td>
<td>59</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>198</td>
<td>100</td>
<td>298</td>
</tr>
</tbody>
</table>

Table 1

With the help of the mothers who agreed to participate in the study a list of health care providers, whom they most frequently consulted for ARI and other health problems, was prepared which included traditional healers, government care providers, private practitioners and drug store persons.
Indigenous Knowledge of Acute Respiratory Infections

Table 2

<table>
<thead>
<tr>
<th>District</th>
<th>FCHVs</th>
<th>VHW/AHW/ MCHW</th>
<th>Private Practitioners/ Drug Stores/</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morang</td>
<td>6</td>
<td>2</td>
<td>4</td>
<td>12</td>
</tr>
<tr>
<td>Sunsari</td>
<td>6</td>
<td>8</td>
<td>1</td>
<td>15</td>
</tr>
<tr>
<td>Makwanpur</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Chitwan</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td>18</td>
<td>16</td>
<td>9</td>
<td>43</td>
</tr>
</tbody>
</table>

Interviews and interactive dialogues were conducted with different health care practitioners. The interviews focused on assessing their knowledge and practical skills related to ARI including pneumonia management.

Major Findings and Discussions

Background Characteristics of the Respondents

Altogether 298 mothers with children below 5-years of age were included in the study. Mothers of 21 to 25 years of age formed the largest group of the respondents. The mean age of the respondents was 25.7 years.

Table

<table>
<thead>
<tr>
<th>Age</th>
<th>Brahmin/ Chhetri</th>
<th>Musahar</th>
<th>Muslim</th>
<th>Tamang</th>
<th>Tharu</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>16-20</td>
<td>7</td>
<td>14</td>
<td>13</td>
<td>13</td>
<td>12</td>
<td>59</td>
</tr>
<tr>
<td>21-25</td>
<td>38</td>
<td>22</td>
<td>21</td>
<td>18</td>
<td>22</td>
<td>121</td>
</tr>
<tr>
<td>26-30</td>
<td>15</td>
<td>16</td>
<td>15</td>
<td>19</td>
<td>12</td>
<td>77</td>
</tr>
<tr>
<td>31-35</td>
<td>2</td>
<td>2</td>
<td>6</td>
<td>7</td>
<td>6</td>
<td>23</td>
</tr>
<tr>
<td>36+</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>2</td>
<td>7</td>
<td>18</td>
</tr>
<tr>
<td>Total</td>
<td>63</td>
<td>58</td>
<td>59</td>
<td>59</td>
<td>59</td>
<td>298</td>
</tr>
</tbody>
</table>
Indigenous Knowledge of Acute Respiratory Infections

Of the total number of respondents 147 were literate and the rest were illiterate. Of the literate respondents 48 had school education; 10 were high school graduates and only two had completed the intermediate level of study. A high proportion of Muslim and Musahar women were illiterate compared to Brahmin/Chhetri and Tharu women.

Table

### 4 Educational Statuses of Respondent Mothers

<table>
<thead>
<tr>
<th>Educational Level</th>
<th>Brahmin/Chhetri</th>
<th>Musahar</th>
<th>Muslim</th>
<th>Tamang</th>
<th>Tharu</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illiterate</td>
<td>11</td>
<td>43</td>
<td>44</td>
<td>31</td>
<td>22</td>
<td>151</td>
</tr>
<tr>
<td>Literate</td>
<td>43</td>
<td>15</td>
<td>15</td>
<td>28</td>
<td>34</td>
<td>135</td>
</tr>
<tr>
<td>SLC or Above</td>
<td>9</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>Total</td>
<td>63</td>
<td>58</td>
<td>59</td>
<td>59</td>
<td>59</td>
<td>298</td>
</tr>
</tbody>
</table>

The source of livelihood for a majority of the respondents was agriculture followed by wage labor, and service. Musahar and Muslim mothers, excepted, most other mothers reported that income through service or agriculture or both was enough to meet household expenses. Since the Musahars were landless and did not have much access to other resources and services, they were completely dependent on wage labor.

Table 5

### Sources of Income of Respondent Mothers

<table>
<thead>
<tr>
<th>Major Source of Livelihood</th>
<th>Brahmin/Chhetri</th>
<th>Musahar</th>
<th>Muslim</th>
<th>Tamang</th>
<th>Tharu</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agriculture</td>
<td>36</td>
<td>0</td>
<td>2</td>
<td>24</td>
<td>35</td>
<td>97</td>
</tr>
<tr>
<td>Service</td>
<td>36</td>
<td>0</td>
<td>2</td>
<td>13</td>
<td>22</td>
<td>54</td>
</tr>
<tr>
<td>Wage labor</td>
<td>0</td>
<td>58</td>
<td>55</td>
<td>22</td>
<td>2</td>
<td>137</td>
</tr>
<tr>
<td>Total</td>
<td>83</td>
<td>58</td>
<td>59</td>
<td>59</td>
<td>59</td>
<td>298</td>
</tr>
</tbody>
</table>

More than 50% of the mothers had got married below the legally required age. Child marriage was common in the study groups. Most of the respondents were married between 16-20 years of age. The reason for early marriage mentioned was the restlessness of the parents to transfer the responsibility of providing economic and social support to affinal kin religious beliefs, and social sanctions.
Most of the respondents had their first children at 16-20 years of age. The age between 20 and 30 is the safest period for a woman to attain motherhood (Grover 1991). It was also mentioned that mothers had exercised little control over their bodies or their sexuality during their first and second pregnancies.

The number of live births given by the mothers varied from one caste/ethnic group to another. The Muslim mothers had a higher number of children than their Musahar, Tharu and Tamang counterparts. The Brahmin and Chhetri Mothers had a lower number of children.
Recognition of ARI Signs and Symptoms

Each ethnic group had different terms and expressions to recognize and interpret ARI signs and symptoms. Cold was considered as an illness common among children. It caused frequent sneezing, blocked or running nose and difficulty in breathing. For example, Brahmin/Chhetri mothers in Chitwan believed that “rugha” (cold) took 7 days to get cured with or even without medicine and hence was not considered serious enough to call immediate medical attention.

Mothers frequently cited cold wind, use of excessive cold water, breast-feeding mothers or children eating cold food, and change in weather as some of the causes of cold. Mothers believed that home remedies could cure cold within a few days.

Most of the FGD participants felt that it was very normal for the child to suffer from cough and did not require medical intervention. Inability to hold back the mucous and cough were considered as symptoms of cough and cold.

They believed that keeping the child warm, applying Vicks, oil massage, frequent drinking of boiled water, hot drinks specially prepared to soothe the throat, and warm food cured cough and cold. Most of the mothers, especially Tharu, Musahar and Muslims mothers, resorted to medication if the symptom continued for 2 days or more. They administered medicines like Paracetamol and cough syrups which they kept at home.

The findings indicated that the mother got worried when the cough did not go away and the child suffered from fever. It is at this moment that she consulted medical or drug-store practitioners. For example, Brahmin and Chhetri mothers in Chitwan said, “We rush the child to the medical practitioner if the child gets cold, cough and fever.” Giving boiled water, warm food and keeping the child’s chest warm were some of the measures taken at home. Almost all the mothers mentioned that they consulted the local traditional healers first to ward off evil spirits and appease the angry deities around. Some of the symptoms of cough, cold and fever as described by the mothers were restlessness, irritation, loss of appetite, sleeplessness and mild uneasy breathing.

Respondent mothers of all ethnic groups were very familiar with the term ‘pneumonia’. Pneumonia was understood as the combination of cough, cold, fever and fast/difficult breathing. It was considered severe. A vast majority of the mothers mentioned that their children had pneumonia at least once. They said that pneumonia was one of the major health problems in their community.

Brahmin and Chhetri mothers believed that only good medical practitioners and strong medicines could provide a quick cure. They mentioned that since they sought the help of medical practitioners at an early stage, they did not have to spend much money on the treatment. Mothers were aware of the fact that cough
and cold, if not taken of care of properly, might develop into pneumonia. On the contrary, Musahar mothers visited medical practitioners when the case became serious and they often paid more for the treatment. It was found that some of the Musahar mothers had spent as much as Rs. 5,000 at a time for treatment of pneumonia.

Table 9
Terms and Expressions to Describe Pneumonia and Danger Symptoms

<table>
<thead>
<tr>
<th>Brahmman/Chhetri</th>
<th>Tamang</th>
<th>Tharu</th>
<th>Musahar</th>
<th>Muslim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Swah-swar garne/Chhito ferno (fast breathing)</td>
<td>Kokha hane (chest in-drawing)</td>
<td>Jar aune (fever), Khokee lagne (coughing)</td>
<td>Aankha munne (staring for a long time)</td>
<td>Jukam, Thandi, Bhukar (cough, cold, fever)</td>
</tr>
<tr>
<td>Chhito swash gyan (noisy breathing)</td>
<td>Ghyar ghyar garne (noisy breathing)</td>
<td>Swah Swah garne (difficult breathing)</td>
<td>Naak sur sur karche (breathing problem)</td>
<td>Naak sur sur karche (breathing problem)</td>
</tr>
<tr>
<td>Ghyar ghyar garne (noisy breathing)</td>
<td>Na nabh ra khaji (inability to cough out mucus)</td>
<td>Aama ko dudh khana nasakne (inability to cough out mucus)</td>
<td>Ghyar ghyar garne (inability to suck)</td>
<td>Paja Marche/Khapche (chest in-drawing)</td>
</tr>
<tr>
<td>Saas pherna garo (difficulty in breathing)</td>
<td>Ghyar ghyar garne (noisy breathing)</td>
<td>Koka dumaiche (chest pain)</td>
<td>Duddh nakheyche (inability to suck)</td>
<td>Cup bhaelache (cough)</td>
</tr>
<tr>
<td>Kokha Hanee (chest in-drawing)</td>
<td>Koka dumaiche (chest in-drawing)</td>
<td>Ghanti ghar ghar karche (noisy breathing)</td>
<td>Nacha lagche (inability to cough out mucus)</td>
<td>Thandi ka lagche (coughing)</td>
</tr>
<tr>
<td>Dum phulne (swollen breathing)</td>
<td>Koka dumaiche (chest pain)</td>
<td>Jaal Jar (Shivering fever)</td>
<td>Paaj mariche (chest in drawing)</td>
<td>Ultri aune (vomiting)</td>
</tr>
<tr>
<td>Chhat pataune (restlessness)</td>
<td>Ghanti sar sar lazi (noisy breathing)</td>
<td>Ghanti ghar ghar Karchhe (noisy breathing)</td>
<td>Chaatpat garne (restlessness),</td>
<td>Ma ke dudh nakhaihe (inability to suck)</td>
</tr>
<tr>
<td>Salang sulung hune (weakness/convulsion)</td>
<td>Na khaji, (mucous flow)</td>
<td>Dublaidai jane (weight loss),</td>
<td>Bachha roiche (crying)</td>
<td>Ultri-Aune (Vomiting),</td>
</tr>
<tr>
<td>Sarri/nidhar tato hune (increased body temperature)</td>
<td>Nodpa (cough),</td>
<td>Dhekarwa (convulsions)</td>
<td>Baukhami (crying)</td>
<td>Bhukh na lagiche (no appetite)</td>
</tr>
<tr>
<td>Nasutne (inability to sleep)</td>
<td>Jar khaji (fever)</td>
<td>Rune (crying)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sutrakahane (prolonged sleep)</td>
<td>Aankhami (inability to eat)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Khana kam khane (loss of appetite)</td>
<td>Po boba (swollen stomach)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dudh nakahane (no sucking)</td>
<td>Simbutu khaji (cold sweat)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Knowledge about Causes and Treatments of ARI

Most of the mothers narrated past ARI episodes. They believed that poor diet, continued diarrhea, prolonged cough and fever, physical weakness and
excessive use of cold water were some of the causes of danger signs. The common practice was to wait and watch for a couple of days before seeking medical help. If the symptoms did not wear out or the child’s condition did not improve, then they sought medical help. It was noted that the mothers changed care providers. They visited either well-known local medical practitioners or hospitals/private clinics/nursing homes. Over 50% of the mothers reported they had done so.

An emerging pattern of care-seeking was noted. The sequence of care-seeking was home remedy, help from traditional healers, medication, and visit to the private practitioners and government health facilities. Most of the mothers went to traditional healers. They believed that if an evil spirit, angry ghost or cult deity had caused the illness, no treatment would have an effect until it is appeased. Only the traditional healers could ward off evil spirits and appease angry deities. Hence, the mothers combined both traditional healing and medical care. Hospitals were considered as the last resort.

Most of the Tamang, Musahar and Muslim mothers did not seek medical help even if the illness looks a serious turn. In many cases financial constraint was the main reason.

In general, Muslim and Musahar mothers were found unconcerned about the need to take care of their children in terms of hygiene, sanitation, feeding, clothing and so on. In contrast, economically well-off and educated mothers belonging to Brahmin/Chhetri, Tharu and Tamang communities were found to rush to health care providers immediately upon noticing the danger signs. Such mothers were very particular about feeding their children on time, keeping them clean and ensuring proper clothing. Almost all mothers mentioned that it was quite common for their children to have mild diarrhea. The general trend of cure was the use of home remedies.

If the health of the child did not improve with home remedies, the mother would go to consult a traditional healer. Several mothers reported such consultations. Guruwa was the traditional healer of Tharus, Bhombo of Tamangs, Ojha of Musahars, Maulvi/ Mulla of Muslims, and Dhami/Jhankri of Brahmins/Chhetris.

The traditional healers, practiced *Fuk-fak* (use of *mantras*) to ward off evil spirits and to appease deities. The practice of giving a *Jantar* (amulet) was very much prevalent in the Tharu community. The Tharu child is given a *jantar* specially prepared by Guruwa when suffered from *dulki jar* (shivering fever).

Respondent mothers, irrespective of caste/ethnicity, education and economic status, ritually consulted the traditional healers. They also believed that until the evil spirits were cast-off or deities were appeased, medicines would have no effect. Health workers, on the other hand, mentioned that the tradition of consulting traditional healers was the major cause of delay. They suggested that
mothers be made aware about the cause, sign and symptoms of ARI and the methods of treatment.

Most of the mothers stated that they applied Vick to the throat and chest to ease breathing. They gave cetamol to control fever and headache and cough syrup for dry as well as cold cough. These medicines were easily available in the local drug and general stores. Most of the mothers were found to combine self-prepared medication with a home remedy. It was also observed that mothers kept a set of medicines at home.

At least a drug store was found in each study community. Most of the drug stores were run by the people who had received training and obtained licenses for running drug stores. The drug stores were considered friendly because they are familiar with local terms and expressions and spent time with mothers discussing about their problems. They even provided service and sold medicines on credit. Most of the drug retailers also mentioned that the local people relied more on them than on the government health facilities. It was observed that antibiotics such as Amoxicillin, Ampicillin, and Sporidex were frequently dispensed to the clients, which provided immediate relief to the children. If the antibiotics did not work then druggists would advise the mothers to consult private doctors at the district hospital or private clinic.

Knowledge of Preventive and Curative Measures

Mothers were familiar with the concept of preventive care. They had a set of prescribed traditions to prevent illness. Generally, all caste/ethnic groups did two things in this respect. They worshipped gods and goddesses. Worships were done both at the household and community levels for the welfare, good health and prosperity of all the people. For the worship occasions they cleaned their houses and the surroundings, which was very beneficial from health and sanitation perspectives. Secondly, mothers believed that common cough and cold could be cured with home remedies. They reported that they took special care of the children by giving them wholesome foods and oil massage and stopping them from playing in dusty and smoky environments.

Some of the home remedies measures most commonly used for cough, cold, fever are listed below:

- Massage of warmed mustard oil on the child and the breast feeding mothers
- Massage with warm mustard oil seasoned with methi and garlic
- Light massage on chest with a mix of cow ghee and camphor
- Warm mustard oil seasoned with jeera and marich (cumin and pepper) for the scalp and forehead
- Use of hot drink prepared with turmeric powder (haldi paani)
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- Application of crushed garlic on the scalp and forehead
- Application of kerosene on the forehead of the child
- Keeping the child away from dust and smoke
- Keeping the child warm with extra clothes
- Cleaning the nose
- Giving water boiled with ginger
- Application of *rudilo* (coral jasmine) on the body
- Giving warm milk with pure ghee to drink.

Allopathic medical practitioners mentioned that most of these preventive practices were beneficial for keeping children healthy.

Thus the mothers' indigenous knowledge of the use of locally available medical plants and food preference seemed to be very important for ARI cure management.

Mothers were aware that certain food items were harmful for breast-feeding mothers with sick babies. Hot, sour, oily and bitter food items were avoided. Almost all the mothers had the notion that the quality of food taken by a breastfeeding mother directly affected the health of the infant. *“If you eat cold foods like banana, Kalo Dal, lady’s finger, Kubhindo, and green leafy vegetables during the winter season, your child suffers from cold and cough. This happens because cold passes on to the child mothers’ milk.”* However, a few participants, particularly those belonging to the Musahar community said they did not abide by such food rules because they could not buy alternative foods. They had to eat whatever was available to them.

**Table 10**

<table>
<thead>
<tr>
<th>Food and Fluids Avoided</th>
<th>Special Food Taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cold food (in terms of temperature)</td>
<td><em>Dal-Bhaat</em> (Rice and lentil soup)</td>
</tr>
<tr>
<td>Sour and spicy food</td>
<td>Warm water</td>
</tr>
<tr>
<td>Oily food</td>
<td>Masoori Dal (Lentil soup)</td>
</tr>
<tr>
<td><em>Kalo Dal</em></td>
<td>Roasted potato</td>
</tr>
<tr>
<td><em>Bhindi</em> (lady’s finger)</td>
<td>Fish</td>
</tr>
<tr>
<td>Cold water</td>
<td><em>Tulsi</em> leaves with warm water</td>
</tr>
<tr>
<td><em>Khesari Dal</em></td>
<td>Warm water boiled with ginger/ pepper/turmeric powder/Tulsi leaves</td>
</tr>
<tr>
<td><em>Kubhindo</em></td>
<td>Meat (local chicken)</td>
</tr>
<tr>
<td><em>Lauka</em> (Bottle Gourd) Green vegetables</td>
<td>Tea prepared with <em>Marich</em> (pepper)</td>
</tr>
</tbody>
</table>
There was a common understanding among all the groups that mothers should avoid consuming liquor, smoke or tobacco especially when the children were sick. A sick child is also kept from hot, sour, oily and spicy food and from cold food items like pumpkins. Hot-cold reasoning underlies several perceptions of illness as well as preventive practices related to different health problems in many cultural groups in the Islamic world, the Indian Sub-continent and Latin America (Pool 1987; Nichter and Nichter 1996; Foster 1994; Subedi 2001).

Health Seeking Behavior and Qualities of Care

The wait-and-see attitude was more prevalent among the Tamang and Musahar ethnic groups. Brahmin and Chhetri mothers were serious and sought medical help immediately "It is not wise to take risk in the case of babies", they said.

For most respondent mothers, the first point of medical contact outside home was the nearest medical shop. Mothers were selective about private practitioners in regard to the nature of the health problem of the children and the attitude of the practitioners. Some practitioners were very famous for the treatment of child-related diseases.

Young, educated and economically better families from Brahmin and Chhetri communities consulted the private practitioners or visited the health facilities quite on time. The economically poor Tamang, Musahar, Muslim and Tharu families did not do so.

Mothers from all communities were serious about the health problems of their children below six months and sought prompt help of qualified health care providers they considered the best. "We cannot take undue chances about our babies’ health," they said.

Mothers were skeptical about the quality of care given at the government-run health facilities. Even mothers who lived nearby did not visit these facilities because the quality of medicine was poor and the service time was not convenient. It was mentioned that they only gave tablets (Goti or Gotia) and no advice.

Even though the private clinics were expensive, most mothers preferred going to them. Private clinic services were available almost round the clock and were easily approachable. Besides, the treatment they provided was more effective. Mushroom growth of private clinics and development of roads with transportation facility had made them more easily accessible. Most of the communities had one or two very popular and accessible practitioners. They were much preferred by the mothers.

Hospitals were not much preferred because of distance and inconvenient service hours. Hence, mothers visited them only when the condition of the children
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worsened and/or when the referrals were made by the government health facilities or local private practitioners. The hospitals were viewed as the last resort.

Administration of Medicines: Practice

Mothers often followed the instruction of health-care providers regarding medicines, especially antibiotics, but rarely did they comply fully with the instructions. They discontinued medicines after the health of the child started improving visibly. The mothers mentioned that they stopped giving antibiotics when their children resumed eating or playing normally. Such practices often resulted in a stock of unused medicines at home. The left-over medicines were re-used if the child suffered from the same illness again. In addition, it was revealed from focus group discussions that some of the mothers did not even buy complete doses.

Conclusion

ARI was a common health problem and the term ‘pneumonia’ was a house term for all the study groups. Each caste/ethnic group had its own terms and expressions for respiratory illnesses. Health-seeking by mothers for their sick children varied from one caste/ethnic group to another. The practice of home-medication was found very common among mothers. Mothers preferred drug stores and private clinics to the health posts, and visit to hospitals was perceived only as the last resort.

Mothers belonging to Brahmin/Chhetri and Tharu communities were quicker in approaching the health care providers than mothers of other communities. Musahar mothers waited for 4-5 days treating the child with home remedies.

Most mothers did not really understand what antibiotics were though they had given it to their children. For them it was a medicine that was effective in improving the conditions of their children. They bought it when a similar symptom appeared. Most mothers discontinued medicine as soon as the health of the child improved and kept the left-over of the medicine for future use.

The economic condition of the family was affected the care-seeking behavior. Financial constraints normally prevented families (mothers) from seeking the help of health care providers. The education status of the mothers prompted the mother to seek the help of care providers. Educated mothers aware of danger signs were seen to be more prompt in consulting health care providers.

Distance and accessibility to health care providers determined choice of health care providers. Health providers in the proximity meant more. However, the limited service hours of public health facilities were inconvenient for mothers.
The lesser the age of the child, the more serious the mothers were in going to health care providers.

Mothers considered cold, cough and loose motion as common illnesses and hence these were not considered so serious as to call an immediate medical attention. However, mothers took special care of babies at the household level. Preventive measures were less in practice among Tamangs, Musahars and Muslims communities. Preference for and avoidance of certain foods and fluids and use of locally available medicinal plants were common in all caste/ethnic groups. Household-based medication, consulting traditional healers, using over-the-counter medicines and visits to allopathic medical practitioners were common. These resorts, however, are not linear and straightforward in nature.

Awareness and knowledge level of mothers regarding danger signs showed a time lag between child illness and obtaining health care. The lesser the knowledge, the longer was the time lag. Belief and trust in traditional healers and practices (including home therapies) were a crucial to care-seeking. However, the more "perceived" knowledge of and trust in traditional home therapies (not always helpful) meant a greater time lag. Therefore positive household remedies should be encouraged and harmful practices discouraged.

References


