

HEALTH SEEKING BEHAVIOUR OF
RAJBANSHI COMMUNITY IN
BAIJANATHPUR AND KATAHARI OF
MORANG NEPAL

Nawa Raj Subba

2001

Copyright © 2001, Nawa Raj Subba

1

Summary

Nepal is a country of multi cultural, multi-religious, multi-lingual, pluralistic and mosaic society. Ethnic communities have their own distinct healing practices. It has been widely felt that access of modern medication in the rural as well as in urban community is very low; despite the service outlets have been made available even at periphery level by government. Health Care practices - Modern, Traditional, Self-medication, Alternative are existed in almost each and every community, are indispensable part of our health system. Merely establishment of Sub-Health Post, training for Health Workers cannot ensure the access of health service, also requires attempt on the Socio-economic assessment, cultural and behavioural diagnosis.

Rajbanshi are one of the ethnic groups, living in Morang and Jhapa districts. Their estimated population is fairly above than 0.1 million (CBS, 1991). This study was an exploratory, descriptive, cross-sectional, and qualitative study based on household survey. Study has assessed the disease prevalence, healing or caring practices and determinants of health seeking behaviour.

This study was undertaken in two Village Development Committees (VDC) of Morang district with the Specific objectives of: (1) to find out the practices of using traditional and modern medicine in the community. (2) Assess the satisfaction and dissatisfaction with traditional medicine and modern medicine or health services available. (3) Assess the expenses on health care. (4) Know various methods of self-care and types of therapies used by consumers. Attempts to 175 households' visits were made particularly head of the households as respondents of the study. A Rajbanshi graduate and one more interviewer were trained prior to going to community. With the help of these two-trained interviewers, the researcher had carried out interviews and conducted Focus Group Discussions.

Major findings:

Rajbanshi ethnic in Katahari and Baijanathpur VDC were found having literacy rate 65% in the taken sample. Principal occupation is agriculture. Majority of people falls in the category of having no land to less than 2 bigahas. Average family size is 5.76 persons. Attempts to interviews with mostly head of the 175 households were made in two VDCs. And there were 61% male and 39% female reported sick.

Common type of ailments was reported such as headache, bodyache, weakness (50.8) and then ARI (44), fever (30.8), Eye/ENT(18.8), diarrhoea (13.7) was reported respectively. Distribution of reported illness was highest on over 66 year of age then 55-65 and 46-55 years of age respectively. People were found adopting Modern medication, Self-medication and Alternative-medication. Dhamsi Jhakri/Shaman, retailers were common practices under self-medication. 72.0% patients used private clinics whereas only 15.4% patients had used health post service.

Poor were adopting self-medication higher than other economic strata that was found statistically significant ($P=0.0160$). Similarly, rich were adopting alternative medication more than poor that was statistically highly significant ($P=0.0000$). Uneducated people used self-medication more than educated that was found statistically highly significant ($P=0.0000063$).

An average treatment cost has found Rs. 1031.64 ($SD=6$). 73.1% patients were reporting to be unable to afford the expenses for treatment. They had taken either loan (14%) or had to sell land, animals, grains or personal belongings (53%). The bulky proportion (57.8%) expenses felled on buying drugs and for fees (19.55%) thereafter, for transportation 5%, helper 3.74%, others 13.84%. Therefore, the concern of unaffordability of treatment cost for modern medication is one really striking.

Utilization of PHC services: They were found familiar to go to EPI-Camp (79.4%) for getting vaccination for their children. They are also familiar with FCHV and recognize her services. Most of the people know their FCHV (50.2%) and used to take service from her. On the other hand, more than 89.2% population was found still unknown to MCHW, TBA and PHC-ORC and its services.

Cost: The proportion of people paying between Rs.51-200 was 39% of sample. But average expenditure per patient was Rs. 1031.64 (i.e. mean; and $SD=6$) for a treatment. It is unaffordable for 73.2% people; so, they take either loan or sell their belongings to accomplish the treatment. Most of the proportion of their expense goes for buying drugs and paying fees. Rest portion was expensed for transportation, helper cost and other.

Satisfaction: Rich were found satisfied with alternative medication that was found statistically significant (0.0050). Educated were also found satisfied with alternative medication that was statistically highly significant ($P=0.0000$).

Recommendations:

Based on the findings, following recommendations could be made as follows: Since majority of the poor people go for self medication and the private clinic was perceived to be expensive; the personnel of the self-medication or service provider such as Dhami/Jhakri/ Shaman, retailer need to be oriented on referral system. Since 73.2% people are unable to afford treatment; free mobile health camp should be provisioned for the poor. Since 89.2% of the population was unknown to MCHW, TBA and PHC-ORC services; training and awareness program should be provisioned to both service providers and users.

Chapter- I

1.1.Introduction.

Access of modern medication in the rural community is very low even series of service outlets are being provided by government. HMG has attempted service deliveries through extensive outlets for periphery people. But there are many questions arising about quality, access of service and acceptance of services. Merely establishment of health institutions, training of health workers cannot ensure health service without assessment of their socio-economic status, cultural and behavioural diagnosis. Since a complete health system approach has not yet been considered, any progress report published by government or NGO are found unable to reflect holistic situation of a health system. Since, traditional medicine exists in all cultures to degree and terms such as traditional medicine; indigenous medicine or folk medicine etc. These are used to describe as Local practices. These medicine dates hundred or even thousands of years depending on the country and culture concerned. Because two thirds of the world's population (mainly in the developing countries) relies entirely on such Traditional medical therapies, WHO has declared its intention actively to encourage Traditional medicine worldwide in order that their goal of Health for all can be attained. It is interesting that even where western medical care is available, the majority of the people in the third world choose to remain loyal to its indigenous medical systems. The WHO has pledged itself to foster realistic approach to traditional medicine; to explore the merits of Traditional medicine in the light of modern science in order to discourage harmful practices and encourage useful ones; and to promote the integration of proven valuable knowledge and skills in traditional and western medicine. A WHO report indicated , for far too long traditional system of medicine and modern medicine have gone their separate ways in mutual antipathy. (Annex - IV)

While explaining the worldwide prevalence of Alternative Medications Agarwal (n.d) in his book *A guide to Alternative Medicine*, two-third of the world's population is still being treated by traditional health workers especially in underdeveloped and developing countries according to the estimate of the WHO. Considering the importance of these practices, WHO has recognized its value and included these in their ongoing programs achieve the goal of "Health for All"

Nepal is a country situated in between China and India. It is in brick shaped, east west length is 885 Km, and North-South mean width 193 Km. It's total area is 147181 Sq. Km. Total population of Nepal in 2000 is 229,03,598 (MOPE). Nepal has got topographically three belts upper Mountainous, middle Hill and lower Terai region extending east to west. Despite being small in area and population, there is wide variation socially, culturally and geographically. Mostly due to geographical reason there is less access of health services in the remote areas.

Nepal has a population of 20 million (1996) and this is steadily growing at 2.1% annually. There is world's highest mountain towering above populated valleys, Himalayas and plains. It is land locked country, bounded to the north by Tibet region of People's Republic Of China and to the south east and west by India. There are more than 75 ethnic groups religiously consisting of Hindus (89.5%) and Buddhist (5.3%), Jain (0.1%), Christians and others (0.23%). The different ethnic groups have their own dialects; however Nepali is the Lingua franca. Nepal is one of the least developed countries in the world with per capita income ranging from US\$ 180 to 200 per annum. The existing health situation is characterized by severe shortage of basic requisites such as sanitation, sanitation, safe drinking water, appropriate nutrition and health services. Immunization coverage is low, there is high rate of unmet demand of family planning services/ devices and several epidemics, diseases leading high rate of morbidity and mortality in the country. The life expectancy at birth is around 55 years (HDR1998), IMR is 79/1000 LB, MMR 539/10000 LB, CMR 118/1000 LB, TFR 4.6 per woman, CBR 42/1000 population, CDR 13.3/1000 population (CBS, 1995, NFHS, 1996).

Modern health facilities provided by HMG/N are grossly inadequate especially in areas of difficult terrain due to roads and shortages of medical and paramedical staff. According to the reports of DoHS 1998 there are 3187 SHPs, 764 HPs, 11 Zonal hospitals, 14 DPHOs, 61 DHOs, 117 PHCs/HCs, 155 Ayurvedic clinics. Besides there are 894 doctors, 1220 nurses, 42427 FCHVs, 12682 TBAs and more than 4000 VHWs. Some of the districts out of 75 are without district hospital and the performance of SHPs and HPs and PHCs delivery in the rural areas is far from satisfactory. The utilization rate of of SHPs and HPs is averaging 0.2 visits per person per year (Asima, 1991). There is thus clearly a gap to be filled up. The population will either be visiting the conventional traditional health practioners or private drug retailers for their needs. Due this circumstances and doctor- patients' uncontrolled ratio, doctor could not provide efficient services. Thus patient's satisfaction is not found satisfactory.

Kafle and Gartaula (1993) have pointed out that developing countries have insufficient financial means to purchase drugs; and frequently management and health care infrastructure are less than adequate the availability of essential drugs in the rural areas. As a result, people have to rely on the health care system and herbal medicines where these are still available. Nepal is no exception to the above. The government owned pharmaceutical organization is unable, due to financial limitations, to ensure an adequate supply of allopathic drugs throughout the year. It is estimated that less than 20% of rural

health care are provided by public health care institutions. Most of the year people are thus forced to turn to the market for their health care. This consists of drug shops and various types of practitioners of traditional medicine (Ayurvedic, Chinese, Homeopathic etc.). Also included in this category are spiritual practitioners such as shamans, priests, dhams/jhakris and astrologers. People also have the option of using herbal medicines (root, grasses, plants etc.) which they can either collect themselves in the forests or purchase from practitioners or shops.

There are so many communities; strata of society or group of people and Indigenous people, which are, still far from access of health services both in remote and urban areas. As we know that socio - economic, cultural, genetic as well as educational factors determine the health of people. Therefore there are variation of disease prevalence and health seeking behaviors of different groups of people accordingly in the country.

Gartoulla (1998) wrote a book entitled *Therapy pattern of conventional medicine with other Alternative Medication*. He found that Alternative medication practices in Nepal are a distillation of Nepalese culture and also acculturation through a long and slow process of history... Even today, there are such wide differences in the beliefs and practices of the various tribes within Nepal that any attempt to generalize must be hedged with caution.

1.2.Statement of Problem

Globally, the figure presented in WHO (1997) report suggested that only 30% people are getting health service from local health providers. A report by Moin Shah et al, cited from Dixit (1999), has stated that government health services are providing barely 10% of all consultations for people seeking health care. Dixit (1999), referring to Shrestha R., Shrestha M., highlighted the existing health delivery system of Nepal, what has been accepted even by the the authorities is that the health services provided by the government reach no more than 10-15% of the population. It is also noted from the study undertaken by Chalker, who worked with BNMT, cited from Dixit (1999), the traditional healer is the first provider of health care. It lets us to rethink why people are not accepting the health services provided by the government for such long time. Why those people are reluctant to accept the health education message or are proven untouchable to them though several decade long IEC intervention. These are such problem, which need to be assessed today.

Agarwal (n.d.) in his book entitled *A guide to Alternative Medicine* writes in a very strict sense Traditional medicine is the original medicine but factors such rapid development in the field of science and technology, social and political reasons, organized efforts of medical and health industries, westernisation etc. have led the traditional and age old time tested systems of health care into a depression. People naturally started assuming that newer and more expensive care must be better and guided by the medical profession; they were brainwashed into believing that anything that was not Orthodox western medicine was either harmful or useless. This led to legislation, which controls the practice of medicine by people who are doctors in most of countries.

Agarwal (n.d) has made remark that as with so many things today the whole subject revolves around money. Orthodox medicine receives billions of dollars to set up theories, test them and report on the results. Almost no funds are available in the traditional medicine so the research does not get done. It's vicious circle. No money, no research. No research means there is naming it as such unscientific. And this led lagging behind to such traditional medicine that is serving two third populations.

Usually government as well as NGOs reports is having reflection of merely achievements as service provided through programs quantitatively. This is more likely as a view looking from their side. In the same time there is always lacking of holistic picture of a health system comprising of both qualitatively and quantitatively. Because we can not ignore any practice of a community in the endeavor of assessing their health seeking behaviour.

Therefore there is a place for qualitative study about Rajbanshis' health seeking behaviour that explore their behaviours, perception, as well as suggestion that could facilitate by providing information about their health service utilization process, affordability, and satisfaction.

1.3. Rationale of the problem.

As we go through the community it is easier to rectify that there are certain group of people having lower living standard, low social status as well as poor health status. Most of the indigenous people are not interested for education may be due to their culture, economy or low educational status or else. Being deprived in education they naturally lag behind by socially, economically as well as in health status. HMG/MLD National Committee for Development of Nationalities, *Prospectus(2000)* has noted, there are more than 61 ethnic groups in the country. Subba (1999) feels that these ethnic people have been marginalized since last 40 years so they are now deprived and far from access of any facets of development. Bhattachan (2000) has advocated the need of social justice for indigenous people; which are deprived and marginalized since unification of Nepal.

Due to the limitation of time shortage and given the inadequacy of available information on this subject in country like Nepal, the proposed study is bound to be in a large measure descriptive and exploratory. The A few tentative research questions have been formulated so that the perspective while conducting the field enquiry is consistent. Even a casual acquaintance with the situation in Nepal will convince anyone that Health seeking behaviour and users satisfactions from medication practices are more prevalent in modern medicine then ethno or alternative medicine. But why so ? The affected people may resort to them either because they have a complete faith or because they have no other option. It may also be that the different medical systems are not competitive and are taken recourse to under different situation. These medical systems may also have their own target population. The factors of age, sex, level of education and income, religion, ethnic affiliation, rural-urban background etc. may also be some of the determinants of health service use and satisfactions.

According to M.P. Shrestha (Lecture 14.8.2000) there are more than 76 Traditional Health systems existing in Nepal. And Nepal Health Research Council has also set due priorities for research in the field of traditional medicine. I think, efforts should be made to recognize the practices of traditional medicine and modern medicine found in the Rajbanshi community. With this study it is been expected to assess the impact of health service provided by the government in the group of people.

Gartoulla (1998) has mentioned in his book *an introduction to Medical Sociology and Medical Anthropology*; despite the health facilities provided by the government more than 50% of health problems never reach the health services. They are treated through a system of ethnomedicine and plural medications, which are based on home-remedies. Other methods of unconventional treatment include commercial sales of over the counter (OTC) drugs often combined with religious healing practices and culturally based treatments, which are economically beneficial to the people. Medication differs in levels of :- (1) The kind of providers, consumers, and the referral system; (2) Socio-economic aspects of ethnomedicine and other alternative medications; and (3) The various methods of medication.

Gartoulla has also given importance assessing Ethno-medicine and therapies as health care practices due to following reasons. First, the progress of western medical education is a recent phenomenon in third world. Secondly, institutional infrastructure for reaching modern medical treatment for everyone is far from adequate. Thirdly, the spread of general education itself is not yet satisfactory. Due to all these and others causes, ethnomedication and other traditional healing practices have continued to be our endeavor. UNICEF (1996) in *Atlas of South Asian Children and Women* outlines that the formal government health system is primarily allopathic. There are as many practitioners of Ayurvedic, Unani and Homeopathic medicine as practitioners of allopathic medicine. These alternative medical systems are prevalent in the private sector, and are popular among lower socio-economic groups.

“Needless to say, neither Rivers nor Clements nor any of their contemporaries engaged in collecting data on primitive medical system had any idea that they were doing research on health seeking behaviour and consumers satisfactions, but it is through such efforts that health care practice owes its origin, and came to be defined as “those belief and practices relating to disease which are the products of indigenous cultural development and are not explicitly derived from the conceptual framework of modern medicine”. (Foster,et,al 1978 and Gartoulla, 1998).

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

to the members of every group to try to maintain their health and to restore health to those who fall ill. (Gartoulla, 1998).

Every human community has responded to this challenge by developing a medical system, i.e. the pattern of social institutions and cultural traditions that evolves from deliberate behaviour to enhance health. Written sources tell us about the history of some medical system. In addition to contemporary scientific medicine, we know much about the origin and development of traditional Chinese medicine, Indian Ayurveda, Muslim Unani and ancient Greek medicine and its modern descendants the humoral pathology of Latin American and the Philippines. Other medical system of those people who until recently have lacked a literature reveal little of their medical history. However, through the studies of anthropologists and others such as missionaries and doctors, these alternative medication practices have also been receiving some attention. (Gartoulla, 1998)

In recent years the field of public health has grown rapidly, but since this is a relatively new field, a widely shared definition of the field itself, and agreement about the boundaries is emerging slowly among the community health scientists. One definition is that public health encompasses the study of medical phenomena as they are influenced by social and cultural features and social and cultural phenomena as they relate to medical practices. (Lieban, 1973) Also, public health enquiry elucidates the factors, mechanisms and processes that play a role in or influence the way in which individuals and groups are affected by these problems with an emphasis on pattern of behaviour. (Fabrega, 1972) In any case, what is of prime importance is the fact that a greater understanding of behaviour relating to health and diseases and enables one to effectively intervene in social welfare measures. (Gartoulla, 1998)

Self-medication comprises of Shaman/Dhami/Jhakri, Herbal/ root/ plant etc., drug retailers, grocery, kit bag, neighbour, following old medicine and prescriptions etc. Likewise, an Alternative medication consists of Ayurvedic and Homeopathic medication along with traditional practices as explained in self-medications. Popular medicines are both self medication and alternative medications. The reason, why they used to go to health facility and what was the outcome as satisfaction; is one of the essences of this study. In Nepal a modern medical system is not yet widely prevalent. In modern medicine, as it has developed, over the past three, four centuries in the west, it is assumed that medicine will be administered by qualified and authorized medical practitioners. It is true that the medicine-man formed a distinct category in the most of the primitive civilizations but the requirement of patient being treated by a duly qualified doctor has become a characteristic of modern society. (Gartoulla, 1998). Partly because of historical reasons and partly due to various socio-cultural and economic reasons the situation is to a large extent otherwise in Nepal. Despite the growth of modern medical facilities in the recent past the people do not always report to a duly qualified doctor, but rather they seek medical advice privately and not from the government run hospitals and /PHCs/HPs/SHPs. Researcher has also collected their perception of health services, service providers and their suggestion and expectation as well.

Chapter- II

Literature Review.

2.1 Global Situation.

Studies on health seeking behaviour, self-care practices have been done by various organization and scholars. But all such studies does not describe and explain this issue in all its social aspects as a whole. For obvious reasons, every study has partial focus on specific areas and topics. Nevertheless, many of them are useful and hence, have been drawn upon for their methodology and contents.

Researcher has been reviewed on disease prevalence and health-seeking behaviour related literatures. The literature has used both primary and secondary sources such as articles, journals, magazines, abstracts, leaflets and books. Researcher finds some studies done about disease prevalence and health seeking behavior in particular district and group of people. But nothing literatures found about Rajbanshi community on disease prevalence and health seeking behavior.

Bastola (1999), cited from Gartoulla R.P.; in his thesis paper has stated as among the occasional studies that make references to the cultural and behavioral aspects of health care practices and medications by the local people, more appear to have been done in USA, or Europe or in Africa (Sjask, 1982). The kinds of drugs used and geographic distribution of primary health care in Guatemala and Belgium (Saldon, 1981), the medicalization of of social life through self medication in el. Salvador (Anne, 1981), study of injectionists and quacks in Thailand (Lark, 1970), the system and practice of traditional medicine in Africa and Asia (Bonnerman, 1983), Chinese Accupuncture (ATCM, 1975), Hypnotism practices in Africa and South Asia including India (Sorbin, 1972), Socio-economic factors effecting the psycho-therapy and Alternative medications in South Asia (Nichter, 1978), and utilization of self-care and cost patterns of refferal in rural areas in India and Nepal (Parker, 1979) are some of the relevant and helpful reference that have helped us to formulate the problem for the purpose of the present study.

Chaturvedi,et.al explain the health seeking behaviours and users satisfaction from services of the people of south Asian people in the UK experience greater delays than Europeans in obtaining appropriate specialist management, but the causes are not known (Chaturvedi,et.al, 1997) In the Health behaviour ethnology, Kilonzo,et.al describe as human plague has been an important public health problem in Tanzania for over century. Efforts to cures the disease through conventional methods have been applied every year but plague cases and death continue to occur in area. (Kilonzo,et.al,1997). This means patients /users satisfaction would not be satisfactory due to the presence of problem/ diseases.

Other studies have done by different scholars explain that the cost of treating the disease in the country has not been documented in Ghana (applies to Nepal too). Knowledge about the cost of treating malaria can affect the health care seeking behaviour of people

and justify increased expenditure for malaria (disease/problem) control. (Aseno,et.al,1997). One of the health education messages given in sexually transmitted disease (STD) control is patient's adopting appropriate health seeking behaviours. This includes reporting to health facilities for appropriate diagnosis and treatment. Of the total 74.5% admitted to self medication before reporting to the clinics for STDs (Adu,1997).

Health seeking strategies and sexual health among female sex workers in urban India indicate that women's understanding of (sexual) health, treatment-seeking and service utilization are shown to be generally (biomedically) appropriate, but subsequent "non-complaint" therapeutic practices give cause for concern. Operational research and policy formulation on the provision of effective health services (Evans,1997) suggested. Explanations for illness used by Ciskeian villagers (South Africa) to account for conditions ranging from diarrhoea and tuberculosis to anxiety and hypertension (Segar, 1997) suggest the patients satisfactions from the treatment is inadequate. A study in Philippines by Buston in January 1992 shows that malarial cases was substantial under reporting and there was strain specific immunity establishing the incidence (Bustos, 1997) lead users towards chronic problem and while contacting to healers made more critical and doctors treatment took long time which made them unsatisfactory for them due to their own causes but blame to providers services.

Modern medication practices (Allopathy) is scientific because of enormous research accomplished, so, it has got predominant role in the health system of country. Contrary to this, Self-medication is an often chosen practice in Nepal. Gartoulla (1998) has stated as self medication consists of drug shops and various types of practitioners of traditional medicine (Ayurvedic, Chinese, and Homeopathic etc.). Also included in this category are spiritual practitioner such as shamanism, priests, dhami/ jhakri, and astrologers. People also have the option of using herbal medicine (roots, grasses, plants etc.) which they can either collect themselves in the forests or purchase from practitioners or shops.

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

Traditional concepts of efficacy are used to describe their effects; Western pharmaceuticals are sold alongside other daily requirements in small neighbourhood shops; Pharmaceuticalls are used in a culture-specific way; and Pharmaceuticalls receive local names and conversely, give their names to traditional medicines. All too often programs for rational drug use focus on health care providers, on the assumption that their education will lead to a more rational drug use. Prescription only drugs, however, are used widely in self-medication, the practices are culture-specific and cannot be ignored.

Herxheimer,A. and stimson, G.V. have argued that people assign meaning to medicines and that these meaning differ between groups and within the between cultures. People's medication practices and beliefs are discussed extensively. It is concluded that most

treatments of every day illness are not obtained from a doctor. Self-treatment is a norm. (Herxheimer,et.al 1983).

Tan, M.L. raised questions about the validity of labels such as 'western' 'alternative' and 'traditional' as applied to medical systems. Pluralism in diagnostic and therapeutic procedures must be recognized even within one system. A review of socio-historical factors that influence medical systems highlights important processes such as cultural reinterpretation and indigenization that characterize 'traditional' medical system (Tan, 1989), Overgaard, L.B. and Holme, H.E. (1985) have analyzed medicine behaviour seen from user's point of view.

Conrad, P. (1985) has also presented a paper with an alternative patient-centered approach to managing medications. The study focuses on the meaning of medication in people's everyday life and looks at why people take or do not take their medication.

Blum, R. and Kretman, K.(1983) described the factors that affect the habits of medicine users. They show how medication varies with the symptoms of the patients, their sex and also their lack of knowledge of the current use of medicines. Foster, G.M. (1984) suggests that modern medicine in recent years has become the first choice for most traditional peoples most of time. With respect to the use of traditional curers in primary health care, it is pointed out that: they are not replacing themselves; they may have become 'neotraditional curers' making extensive use of modern drugs; and Spiritualist curing is replacing much traditional medicine.

Geest, S. Van der, et.al.(1990) are of the view that public health field does not suggest that programmes for 'rational drug use' can be easily implemented. The commercial context of medicines and the new meanings they acquire in local settings give rise to very complex situations.

The study by Ashraf, A.,et.al. (1983) disease and health care in rural Bangladesh sought to find out how the fields of traditional, folk and allopathic medicine were related to each other and what processes could be discerned in these interrelationships. The outcome was that traditional medicine has almost disappeared in this area.

Batia, J.C. et.al.(1957) studied 93 traditional healers in three states of India showing that they are increasingly using modern/ allopathic medicines in their practices.

Self-medication: WSMI (2001) says "Self-medication is the use of specifically designed, labelled and authorized medicines available legally without prescription for the treatment or prevention of common illnesses, which can be recognized by the people. Traditional medicine frequently is not included in the national health system. If traditional medicines are legally available without a doctor's prescription, then they are included in what we call self-medication. Self medication as perceived by different scholars in the past is as follows

The active medicine user fall under self-medication. (Overgaard,1985)
Parker defines self-care as culture, medicine and psychology of people. (Parker, 1979)
The illegal distribution and use of western medicine is self-care. (Sjaak,1982)

Lay diagnosis and practice of any medications and popular healing practices is self-medication. (Chaturvedi, 1997)

Any object used for illness is self-medication. (Herxheimer, 1983)
Self-medication is indigenised pharmaceuticals in developing country. (Haak,et al, 1988)

Self-medications is that medications which are applied by users either contacting to providers or self except the present prescriptio of a duly qualified medical practitioners (Gartoulla, Ferguson, Geeest, et.al)

Traditional and transitional medicine system is the component of self-medication. (Tan, 1989)

Popular medicines are those which are used as polypharmacy, ethnomedicines, herbal and amulet objects, animal objects selected either by users or given by sellers/ providers. Ethnomedicine is that the herbs and herbals used by local people collected from local yards and have shamanistic usage.

Traditional medicine includes both ethnomedicines, shamanism, priesthood and worshipping together.

Commercial pharmaceuticals medicine used by self either buying directly or by provided by untrained retailers is also called self-medication. (Ferguson,1981, Ashrof,et.al)

Individual use of medicine is self-medication. (Blum, 1983)

The overwhelming belief and practice of herbal plants as medicines and use of allopathic medication by kit box (bag) is self-medication. (Bennerman, 1983)

WSMI (2001) has pointed out that Alternative medicine is medicine which is outside the regular allopathic medicine. Similarly Alternative medication as perceived in the past:

Alternative medicines are defined by the health seeking behaviour. Those medicines used by the users at second time than the first time.

Self-medications, popular medications, ethnomedicine or traditional and or alternative medicines have been used in different situations.

Mabuhang (2000) wrote an article entitled *Policy approaches to indigenous people's health issues* where he has mentioned a lot about Indigenous people especially the relative situation with reference to different conference, declaration and global data as well. It is now almost three decades before for the first time, when population was considered as an integral part of socioeconomic problem, the *Bucharest Conference*, 1974 has said:

It is recommended that health and nutrition programs designed to reduce morbidity and mortality be integrated within a comprehensive development strategy and supplemented by a wide range of mutually supporting social policy measures, special attention should

be given to the formulation of policies to widen their coverage so as to reach, in particular, rural, remote and underprivileged groups.

Mexico Conference on Population and Development (1984), cited from Mabuhang(2000), also gave guidelines for government as:

Government should, as a matter of urgency, make universally available information, education and the means to assist couples and individuals to achieve their desired number of children...Particular attention should be given to those segments of the population which are most vulnerable and difficult to reach (UN, 1995).

Bucharest conference highlighted the increase attention should be paid to relative importance of various socioeconomic and environmental factors in determining mortality differentials by region or socioeconomic and ethnic groups. Later Mexico Conference (1984) recommended that "Government should ensure the rights of indigenous and other groups."

Under its plan of action, after twenty years of efforts made in population and development, the International conference on population and development 1994, cited from Mabuhang (2000) has said:

Indigenous people have a distinct and important perspective on population and development relationships, frequently quite different from those of the populations with which they interrelate within national boundaries. (UN 1994)

In May 1994, the forty-seventh World Health Assembly adopted resolution WHA 47.27, in which it called upon the Director General, *inter-alia*, to increase cooperation between the World Health Organization (WHO) and other United Nations Organizations to help meet the health needs of indigenous people, provide member states with technical support, to assist governments and IPs in addressing health needs in culturally effective manner, to consider the contribution WHO might make to promoting respect for, and maintenance of, indigenous knowledge and to ensure that relevant research projects undertaken by WHO and other United Nations Organizations were conducted in consultation with, and for the benefit of indigenous people and communities(Daes,1996; cited from Mabuhang (2000).

The world women's conference -1995 held in Beijing uncover," *the major barrier for women to the achievement of the highest attainable standard of health is inequality, both between man and women and among women in different geographical regions, social classes and indigenous and ethnic groups"* Mabuhang (2000).

The World Summit for Social Development was held in Copenhagen on March 6 to 12, 1995. The largest gathering yet of world leaders - 117 Head of States or Governments came together to talk about global responsibilities for the eradication of poverty and unemployment and fostering of social integration. In the final declaration among others, among others, direct reference to IPs health is found commitment 6(g) (cited from Mabuhang (2000):

Recognize and support the right of indigenous people to education in manner that is responsive to their specific need, aspirations and cultures, and ensures their full access to health care.

International Consultation on Health of Indigenous Peoples, held in Geneva from 23-26 November 1999, organized by the World Health Organization. In the part 1, declaration focuses the rights and interests of world's IPs. Declaration affirmed "the right to the highest attainable physical, mental, social, cultural and spiritual health and survival, commensurate with Indigenous Peoples' definition of health and well being." It was called on the WHO to make a substantial contribution in the context of the International Decade of Indigenous People (1994 to 2004) (cited from Mabuhang (2000)).

The second part of Geneva declaration says: "IP's concept of health and survival is both a collective and individual intergenerational continuum encompassing a holistic perspective incorporating four distinct shared dimensions of life. These dimensions are the spiritual, the intellectual, Physical and emotional. Linking these four fundamental dimensions, health and survival manifests itself on multiple levels where past, present, and future co-exist simultaneously. For indigenous peoples, health and survival is a dynamic equilibrium, encompassing interaction with life processes and the natural law that govern the planet, all life forms, and spiritual understanding. Expressions of culture relevant to the health and survival of indigenous peoples includes, but is not limited to individual and collective relationships, family and kinship systems, social institutions, traditional justice, music, dances, ceremonies, rituals performance and practices, games, sports, language, narratives, mythology, stories, names, land, sea and air and their resources, designs, writings, visual compositions, permanently documented aspects and form of indigenous culture including scientific and ethnographic research reports, papers and books, photographs, digital images , films and sound recordings, burial and sacred sites, human genetic material, ancestral remains, and artifacts (cited from Mabuhang(2000)).

Kleinman (1984) has noted that the individual, family and community assume a vital responsibility for health promotion as well as for the curative care of its members. In many society as much as 70-90% of all curative activities may take place within this network. Several studies, carried out in western and non-western societies, support this statement (cited from Mabuhang (2000)). Global situation in changes in the rank order of diseases is also of great concern. CHD for instance considered rare before two decades has now become common in urban Nepal. World Bank has assessed the global situation in this changing pattern issue of disease prevalence. (Annex - III)

IPs Health Indicators in Comparison of Non-IPs by different Regions of the world.

Region	Rate of Disease	Mortality Rate	IMR	LE
Arctic, Russia.	Rate of disease prevalence 50% higher among IPs than NIPS. Meanwhile psychological disorders were 2.5 times high among IPS.	Death Rate is 10.4/1000 among IPs against 6.6/1000 among NIPS.	IMR is 48 to 53 per 1000 among IPs against low level among NIPS.	IPs 54 yrs. NIPs 65
Alaska.	Pneumonia among native people Prevalent 60 times more than US population.			
Australia.	During 1979-91, aboriginal areas have the higher rate of diseases, Infection and parasites(22 times), Cancer of Cervix 12 times, diabetes 17 times in females. RIT(12 times for female),Genito-urinary system(17 times) and Homicide(15 times for female)		IMR has declined for IPs but it is still over 3 times higher than National average.	IPs: M-54 F-61 NIPs. M-72.8 F-79
Bolivia.	among the IPs children live birth about 20% die before attending their first birthday.			
Canada.	By the age of 19 yr. 63% of Indians and Inuit smoke against 43% for NIPs,Cancer is increasing in IPs		IMR is 28/1000 which are 3 times	IPs- NIPS-
India.	About 63% of villages in the state were declared malaria affected in Manipur.		A total of 3,821 Korcu IPs children <6 died in the past 4 years from Starvation/malnutrition	
Mexico.	About 12% of IPs children die before reaching school age against 4.8% of general population.			
Panama.			The highest MMR was reported in the Kuna community of San Blas.	

Source: WHO,1999. Note: LE= Life Expectancy. M=male, F=female, IPs= Indigenous Peoples, Non-IPs = non-indigenous peoples, IMR= Infant Mortality Rate, MMR= Maternal Mortality Rate.

Indigenous Peoples:

World Bank (1991) proposed the following definition of IPs:

"A close attachment to ancestral territories and to the natural in these areas; self-identification and identification by others as a member of a distinct cultural groups; an indigenous language, often different from the national language; presence of customary social and political institutions; and primarily subsistence oriented production."

ILO's convention 169(ILO,1996) says, cited from Mabuhang (2000):

" Peoples in independent countries are regarded as indigenous people on account of the descent of the population who inhabited the country, or geographical region to which the country belonged at the time of conquest or colonization or the establishment of present state boundaries".

Health Seeking Behaviour : WHO defines *Health* as a state of complete physical, mental and social as well as spiritual well being not merely the absence of disease and infirmity. Oxford Learner's dictionary defines *Seeking* means having, doing, looking etc. and *Behaviour* means habit, performance, culturally and socially motivated activities. Health Seeking Behaviour is an usual habit of a people or a community that is resulted by the interaction and balance between health needs, health resources, socio-economic, cultural as well as political and national/ international contextual factors. Health Seeking Behaviour in this study as assessing the habits of Rajbanshi in the use of modern, self and alternative medications. It also explores the causes, cost and satisfaction of treatment and practice.

Modern Medicine: Allopathic medicine prescribed by duly qualified medical practitioner. Second contact as an alternative usually found after self medication.

Alternative medicine: as indicating Ayurvedic and Homeopathic medication only.

Self-medication: Kafle and Gartaula (1993) and Gartaula (1998) have categorized self medication as Shamanism, Priest, Dhama-Jhakri, herbal, drug retailers, grocery, kit-bag, drug peddler, neighbour, following old medicine prescriptions etc and except the present prescription by a qualified medical practitioner. *Worship* of god as well as go to the traditional healers are accepted practices, while getting sickness are commonly. Anybody readily do this practice herself or himself even before start any treatment. So, Self medication has comprise of Herbal, Drug retailer, Grocery, Kit bag, Drug peddler, neighbor, and following old medicine and prescription and traditional healers as well in the study.

2.2 Studies related to health seeking behaviour in Nepal.

According to Dixit (1999), the reality is that the expansion of the health has not occurred, neither in the government nor the private sector to the extent that is even required for the increase of the population. Onta (2000) feels, commitment of the government towards assuring health of people can be largely assessed through analysis of the national public policies of the country. To ensure that every citizen has equal opportunity of access to

health services and no one is left out and marginalized, the health system should be guided by the spirit of social justice and equity.

In Nepalese belief, illness is often associated with spirit possession therefore the appropriate healer is the faith healer. Blustain (1976) suggests that if health care in Nepal is to be improved one must that the villagers faith in their own healing techniques be they herbal or ritual is not going to be shaken by the occasional visits of medical teams or even by the building of hospitals. Chalker et al (n.d.) also suggests, in the countries like Nepal, Government should be concerned with traditional health care and professional traditional practitioners and are drawn into partnership with the government health delivery system, in order to provide basic health care to rural people.

Poudel et al (1998) has undertaken a study conducted in Kavre district. It was found that 100% of the sample respondents have ever been to a traditional healer for any kind of treatment during their lifetime. Among them 75% used healer during last six months for their last sickness. Whereas 91.6% respondents have first report to healer even though healing practice of healer did not satisfy majority (61.66%). Mostly the healer used multiple healing practices like blowing with wisdom (95%), worship (37.5%), Egg sacrifice (15.83%) etc. Whereas animal sacrifice was rarely practiced (10.83%) and found no other harmful healing practices was there. Majority of respondents (65.84%) provided in their home like alcohol, meal, cigarette, cereals etc. as a treatment charge. The respondents used healer because of their strong cultural belief and long term relationships.

They have find in their study conducted in *Kavre* district of Nepal that there are significant relationship between educational level of respondents and utilization of healer, economic status of the family and the utilization of the healer. Whereas there are no relationship between utilization of healer with other variables like distance of health institutions, types of family and age of the decision makers on health seeking behavior in the family.

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

Jaustice, Judithene had done a study in 1981 on health planning in Nepal. She discussed the system and structure of health administration in the past as also the contemporary period. K. K. Kafle has examined the current situation regarding training for health workers at various levels in the presentation of drugs. Important criteria for rational use of drugs are:

National drug policies based on the essential drugs concept, accurate information to health care professionals and effective national system for excluding needlessly expensive and harmful drugs. Problems and constraints include lack of adequate drug

information, inadequate drug supply and non-utilization of services. Recommendations are made as to how the situation could be improved (Kafle, 1987).

The performance of health workers in Primary health care in Nepal, (IOM, 1985) the five year (1974-79) experience of a community health program in Lalitpur (Kathmandu valley) to train local indigenous midwives, (Mugedal, 1979) an account of basic health care work done from 1979-82 in Dolakha district of Nepal as a part of IHDP (Aehard, 1983) may be mentioned in this connection. Poverty, unhealthy living conditions and malnutrition, the later particularly among women and children as a contributory to poor health and the evolution of Nepalese primary health care (PHC) system has been described by Mathema (1987). The purpose of the study the study in Sindhupalchok of Nepal was to document the nature of available indigenous and modern nutrition and public health services in rural communities (Shrestha, 1986). Over the last decade many developing nations have embraced primary health care (PHC) within their national health plans. Linda stone in her study has emphasized community participation on the one hand and the actual approach taken on the other (stpmc, 1986). In the last two decades, the great expansion of primary health care in rural areas of developing countries has not been matched by significant improvements in health standards and Nepal is no exception (Oswald, 1983).

A study in alternative medications indicates various forms of health seeking behaviours of the consumers in the communities of Nepal (Gartoulla, 1998). Ethnomedicine are the primary concern of medications in Nepal (Gartoulla, 1998). Essential drugs utilization in TU teaching hospital indicates most of the drugs in antibacterial group were from essential drug list (Kafle,et.al 1988) which reduced the cost for people. Laboratory use for urine examination brought another report to support patients satisfactions in Nepal (Tuladhar,et.al,1987). The unpublished report of child survival pharmaceuticals in Nepal indirectly explains patients satisfactions and behaviours (MSH, DMP, New Era, DDA, BNMT, IOM, 1988). Medical services stands for clinical contraceptives and VSC in Nepal (Bhatta,1990) explains patients satisfaction; Drug funding schemes in Nepal shows 13% of the population attended a health post or hospital each year (Chaler,1997) which means health seeking institutions in the hospital/ HP is poor. Quality control of pharmaceuticals and medicines in Nepal has about 350 samples to analyze (Karkee,1994) indicates poor services. Self medication and its impact on essential health drugs schemes in Nepal indicates more than 50% people contact /practice self medication Gartoulla,1992 Kafle et.al,1993). Drug prescribing in-out patient in Teaching hospital explains vitamins and minerals were prescribed in more than 20% of cases (Kafle,et.al,1991) means patients have a financial burden and the long term consequence is almost dissatisfactions. Almost any drug may give rise to problems of used improperly, but there are certain drugs which are especially problematic (Joshi,et.al, 1991). Physician's practice pattern; private safer indicates the fact that generic prescribing in the private sector is almost non existent (Ghimire, 1992) in Nepal. Average number of drugs prescribed per patient was 8.1 (Joshi,et.al, 1992) means burden financially affecting patients satisfactions negatively in Nepal.

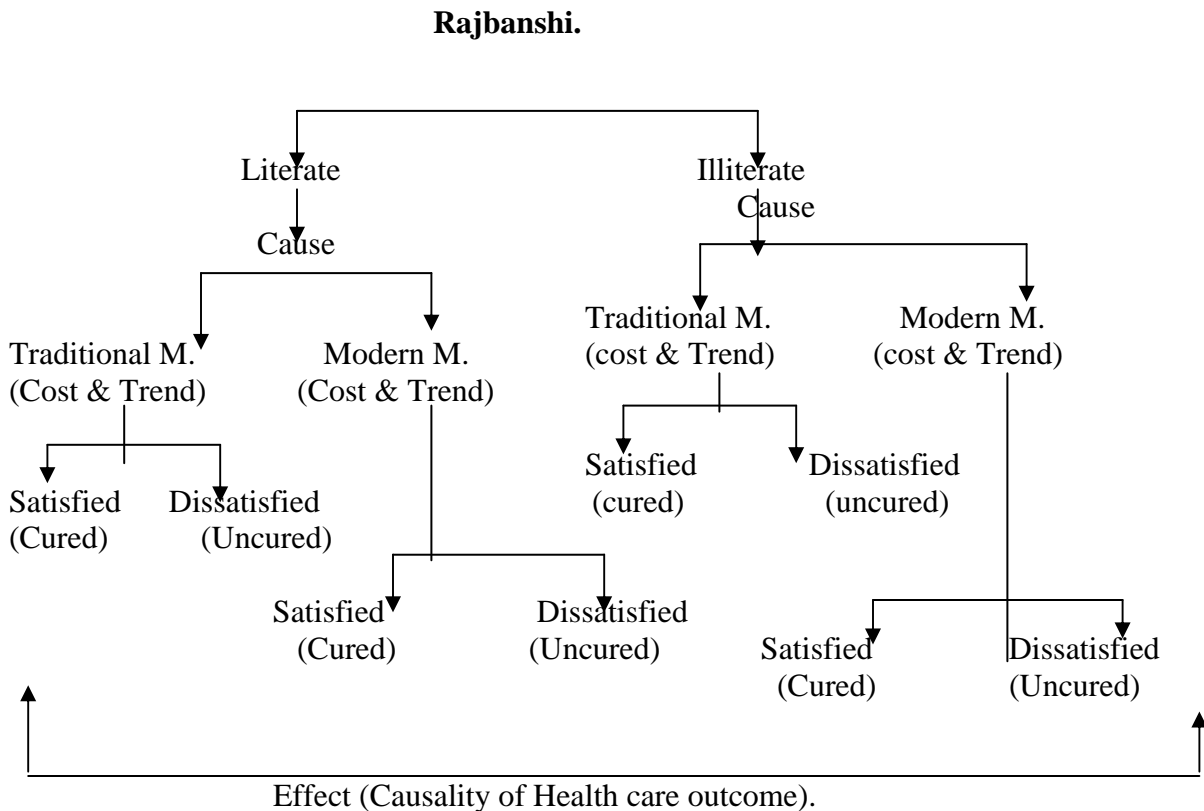
Thus, many literature and studies indicate the importance of the explorations on health seeking behaviour and consumer's satisfaction from service providers. They are searching options which is less expensive, adjustable, faith and affordable. This study assesses what types of medication are being used by consumers and what about the satisfactions.

Chapter-III

3. Methodology.

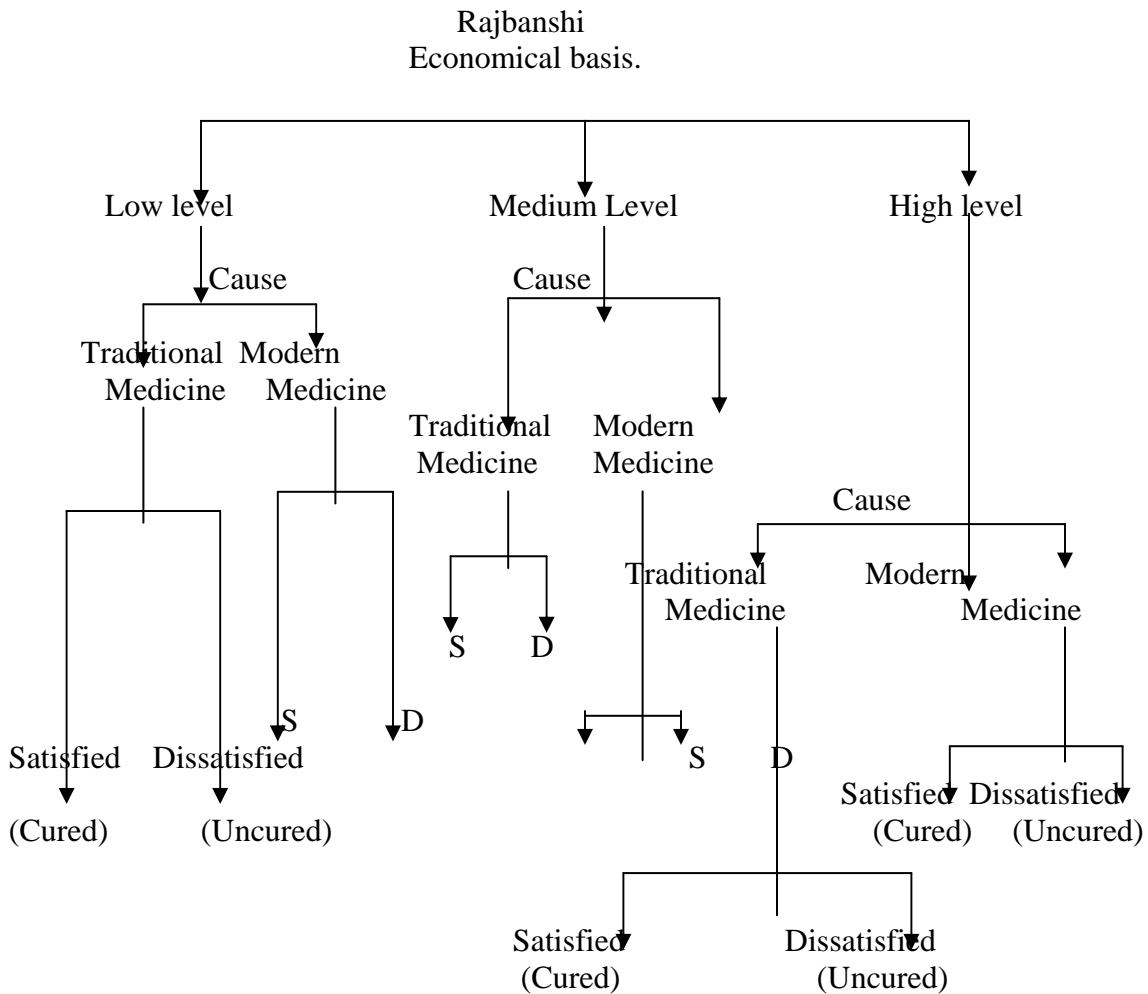
Methodology Framework

3.1. Educational basis: Rajbanshi both literate and illiterate were selected and assessed whether or not they were getting satisfaction from Traditional medication or Modern medication. Researcher has assessed the reason for choosing health services, treatment cost and trend.



The above chart indicates the possible factors associated with medication pattern as well as local healing practices. The possible indicators for both literate and illiterate are: cause, cost and trend, cured/uncured satisfactions/dissatisfactions from traditional and modern medications. This provides the entire process of why they choose the specific system or practices.

3.2. Economic Basis: To assess the sickness, affordability, satisfaction on the basis of economic status is essential. So, researcher has done study on this issue. It was assessed the treatment cost, and what they do people those who are unable to afford.

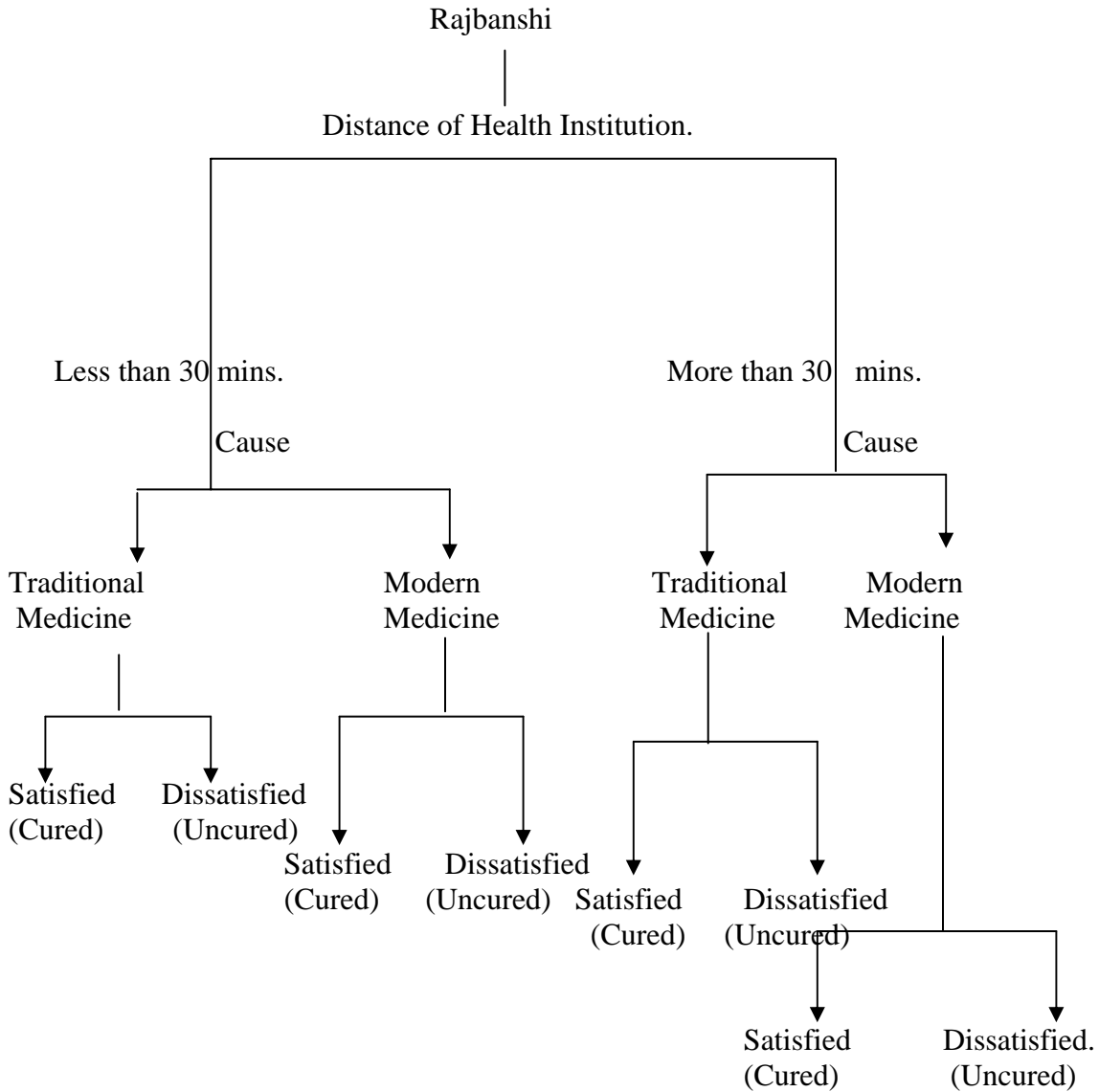


Note: Economic status: 0-1Bigahs=Low,1.1-4 Bigahs = Medium,4.1above=High Level
Animal husbandry, types of houses, family size are other elements to select economic status.

The above chart indicates one of the major factors determining health, i.e., and economic base. The indicator for determining the health on it- the economic level on which decides to medicate locally that might be traditional or modern one.

S = Satisfied, D = Dissatisfied.

3.3. Distance of Health Institution: It is a researcher's concern what is the role of distance for choosing health facility. So, it was also assessed as a determinant of choosing health facility.

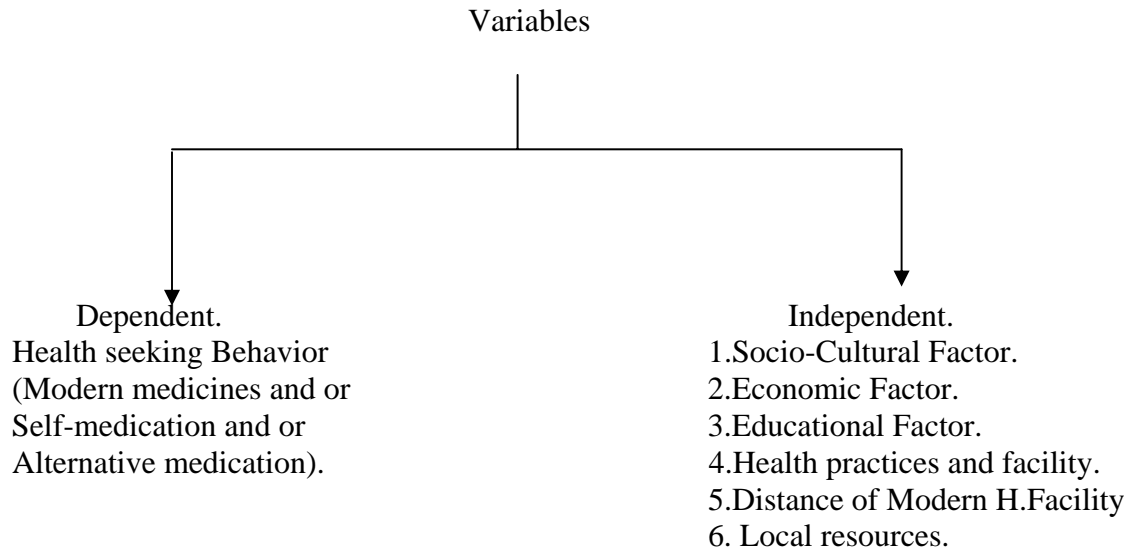


Note: Both modern health institution and traditional all sorts institutions/persons.

The indicators shown above for determining home treatment is long distance to reach government health institution which are categorized as <30 and >30 minutes of walking/ bus transport. And due to the distance for medication they choose (either traditional or modern) the level of their satisfaction from treatment has been seen and also cured and uncured. Thus, distance is a major component of home treatment.

3.2 Variables.

For this study, the dependent variable is Health Seeking Behaviour and or self-medication, and or alternative and or popular medications in community level. The independents are local resources, socio-economic-cultural factors and distance.



For the above indicators it was observed that the dependent variables were determined by the independent variables. Self-medication was done due to their long-term relationship (cultural relationship), with local providers, low cost, easy to meet, healers come to user's house, walking distance, socially accepted and culturally sanctioned.

3.3. Operational Definitions of Variables.

Health Seeking Behaviour: It is the treatment seeking behaviour of Rajbanshi community for the latest illness as reported by them. This will be categorized as (a) Modern medication as Hospital, HP/SHP and private clinic (b) Alternative medication such as Ayurvedic, Homeopathic and Unani system of medication; and (c) Self-medication such as Dhami/Jhakri (Shaman healers), drug retailers, grocery keepers, drug peddlers, household medicine and other than modern and alternative medication.

Dhami/Jhakri = Shaman who exorcise evil spirits from the bodies of sick people and they use drum and sticks in their nightlong healing rituals.

Education:

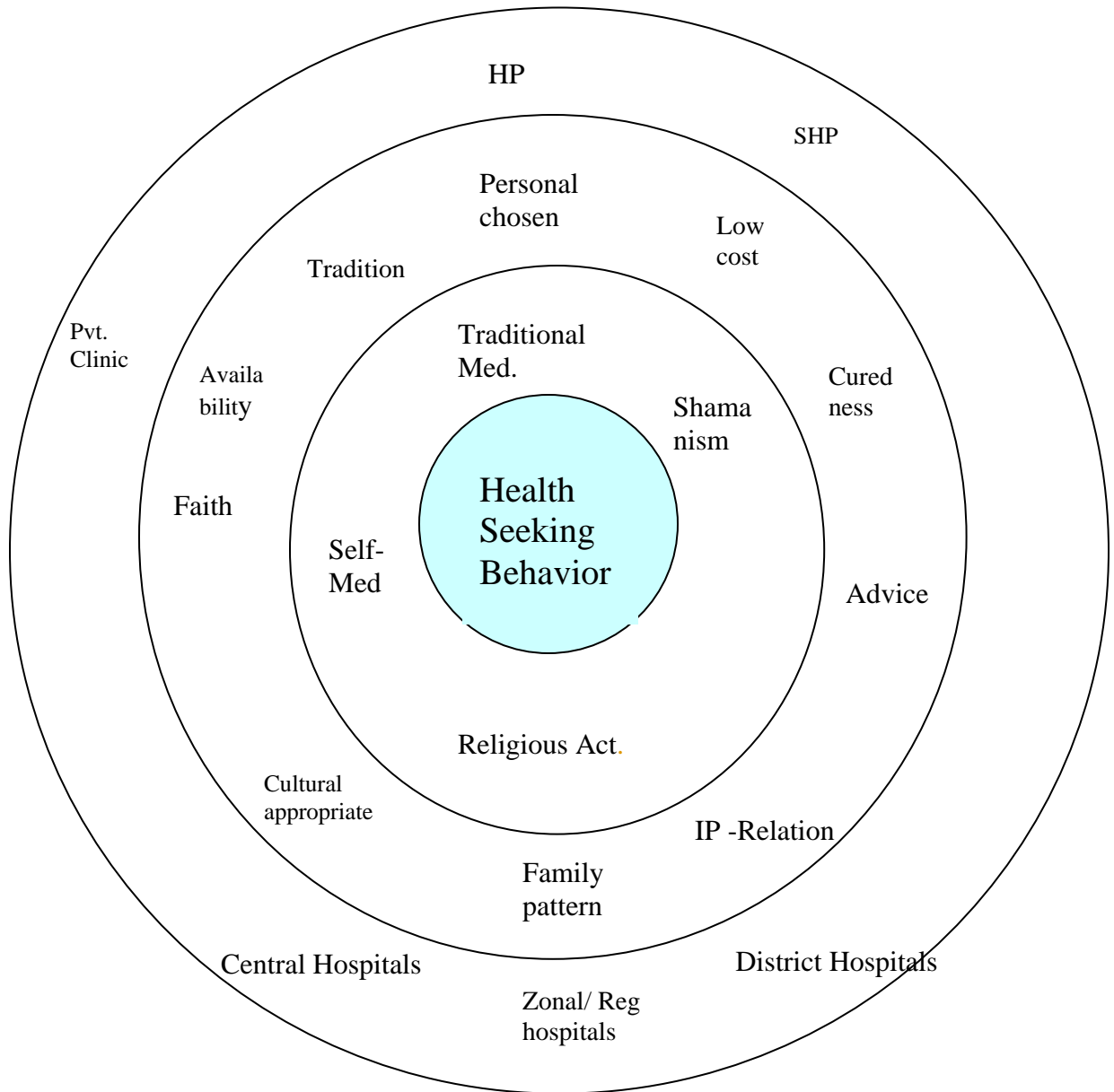
Uneducated = Illiterate and literate below SLC.

Educated = as SLC, IA, BA and above.

Economic status:

Possession of land as reported by the respondents which was categorized as:
0-2 Bigahas=Low, 2.1- 4 Bigahs = Medium, 4.1 Bigaha above=High Level.

3.4 Conceptual Framework. (For qualitative analysis).



The determining factor of health seeking behaviors has been conceptualized as above. Health seeking behavior is closely related with traditional medicine, Shamanism, religious act, self-medication etc. These are also influenced by tradition, family pattern, cultural appropriateness, faith, low-cost, inter-personal relationship, curedness, advice from siblings/relatives, availability, personal chosen etc. Availability and access of modern medication facilities such as SHP/HP, Hospitals, and private clinics determine the health seeking behaviour of a community.

3.5 Research Questions.

1. What are the practices as well as cause in seeking traditional and modern health cares?
2. Whether they are of satisfied or not with their medications and behaviors?
3. What is the cost for curing an illness or disease or cost borne for their medications?

3.6 Limitations:

1. Availability of sufficient medical facilities in Biratnagar which are nearby of these VDCs has played a bias role in the study.
2. Only past three months history has been taken during filling the questionnaire. So, it may produce variation in morbidity data and be unable to represent morbidity of a complete whole year.
3. Since, only two VDCs - Katahari and Baijanathpur which are situated nearby Biratnagar; were subjected as a sample; may not represent the picture of whole Rajbanshi.
4. It may represent the cross-sectional picture of only Katahari and Baijanathpur VDCs of Morang district.

3.7 Objectives.

General Objectives:

To assess the health seeking behaviors in Rajbanshi community.

Specific Objectives:

To find out the practices of using traditional and modern medicine in the community.

To assess the satisfaction and dissatisfaction with traditional medicine and modern medicine or health services available at the community.

To assess the expenses for their health expenditure.

To know various methods of self- care and types of therapy used by consumers.

3.8. Study Design.

This was an exploratory, descriptive and cross-sectional study based on household survey the quantitative analysis and Focus Group Discussion (FGD) and observation for qualitative information. This study has assessed the healing and caring practices under health-seeking behavior of Rajbanshi community.

3.8.1 Study Area.

This study was conducted in two different Villages, Katahari and Baijanathpur of Morang district, selecting purposively based on thick settlement. Morang is a district having 49 Sub-Health Post, 11 Health Post, 7 PHC, One district level Rangeli Hospital and regional level Koshi zonal Hospital. These two VDCs are located nearby the Koshi zonal Hospital Biratnagar.

3.8.2 Study Population.

Both male and female were taken as study population. Those who have ill/ sick/ disease or medication within three months were the study population and mostly the head of

household was the respondent for quantitative and mostly users were for FGD for its quantitative information.

3.8.3 Sample Size.

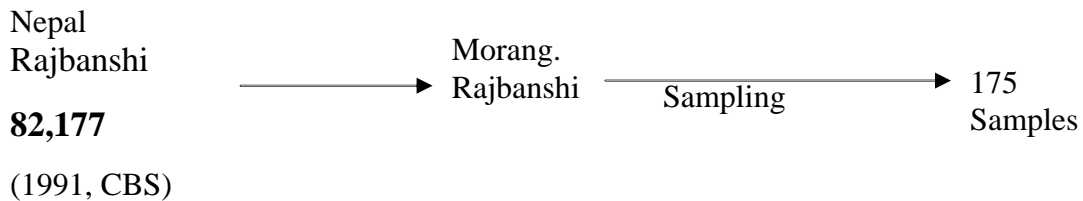
According to a study conducted in Kavre district it was found, more than 90% people are using traditional medicine. So, we have, $p=90, q=10$.

Required Sample size $(n) = 4pq / L^2$

If, $L = 5\%$ of $p. = 90 \times 5/100 = 4.5$

$n = 4pq / L^2 = 4 \times 90 \times 10 / 4.5^2 = 3600 / 20.25 = 175$.

Total



175 households of two VDCs were selected from the VDCs rosters using random number table for convenience and to cover the expected households.

3.8.4 Process:

1. The households were visited on the basis of random number table. They were asked relevant questions with the history of illness/disease within three months from interview date. Of those who were ill/sick person of the above criteria, only demography was taken. And the case was only consulted for detailed information.
2. Roster analysis of VDC, DDC.
3. Secondary Sources.
4. Instruments.
5. Consent-Verbal
6. Interview.
7. Focus Group Discussion. The participants for FGD were requested to have one and half an hour's sessions for the reason of their self-medication during household visits. Personal contacts with self medicated population within three months of study period were made to have 8 persons one FGD and total ten FGD with 80 persons.

3.8.5 Instrumentation.

Development of Tools.

Structured and in-depth questionnaire was prepared to interview the people having disease or not. So, the interview would explore their health-seeking behavior.

1. Individual Interview.(With schedule i.e. questionnaire to be applied for provider, user or respondents)
2. Observation of medicines if any.
3. Focus Group Discussion guidelines.

3.8.6 Data collection procedure.

At first there was a visit to DDC, DPHO and VDC to have a meeting for discussion about its relevance and its importance of study. It was expected to have permission from concerning authorities as well as attempted to ensure their necessary help.

3.8.7 Ethical Consideration.

The purpose of this study was to give first preference to the respondent at the time of interview. Data was collected with verbal consent not forcefully. There was taken care of full confidentiality.

3.8.8 Data generation, data storage and data safety procedure.

At the end of the day it was ensured completeness and accuracy of filled questionnaire.

All information belonging to respondents are kept confidential.

The result will be used only for the purpose stated in study.

3. No information will be published which will break the anonymity of the respondents.

3.8.9 Data Processing.

First, all data collected was coded as required then all data collected was entered into a computer for data processing. After this, analysis was carried out with the software EPI-Info-6 in the compute to get result or outcome. The information of Focus group discussion were transcribed and generalized manually.

3.8.10 Analysis.

Basically this study was done on quantitative and descriptive methods; qualitative methods were used manually while analyzing the data. The main focus for quantitative was given on frequency, mean and percentile. These all was calculated by using above mentioned computer or EPI-Info-6 software to see related significance test. For this it was used chi-square test in computer.

3.8.11 Interpretation.

All the data was tabulated with various types of singular or cross tabulation. Charts and tables are being used to analyze the data and to summarize the data.

3.8.12 Discussion.

After accompanying the analysis and interpretation of data the discussion was held based on objectives and indicators. Regular consultations with guide were made.

3.8.13 Write-up.

Discovery draft was prepared first and Investigator revised this. Then this report was submitted to supervisor and other experts for necessary guidance and revision. For the second time it is again be revised and corrected then submitted to supervisor. Now this report will be finalized and documented as a thesis report. The final report has documented as a thesis report and has submitted to research committee.

3.9. Relevancy and Applicability:

This study has measured the level of use of modern, self and alternative medicine as well as status of literacy, economic condition, and distance of health facility. It has assessed the level of satisfaction with their traditional healers and health facilities in the community. As stated in the introduction, statement of problem, conceptual framework and rationale of study it is now almost been clear that the identification, assessment, and description of health status, health practices of a Indigenous people (i.e.Rajbanshi) would be a substantial as well as potential outcome for the community self and for other relevant authorities. District authorities, concerning government authorities or NGO/INGO could take benefit from result of the study. In the context of implementation of decentralization, bottom up planning process, the behavioral picture of a particular ethnic group could provide some picture for planning process. Therefore this study is a dedication for Rajbanshi ethnic group. So, this study has a potential that can supplement for the assessment of overall health system of the country.

3.10 Validity and Reliability of the Tools.

- Validity and Reliability were maintained by pretest and necessary modification.
- Consultation was done with supervisors/guide/subject experts.
- Other concerned persons were requested to read the questionnaire and give feedback.
- Fieldwork was done by researcher self.
- Data were gathered promptly after collecting from field.
- Scientific tools were applied.
- Feedback from workshop will be honored.
- Respondents were mostly head of the households with the age group of 20-65 yrs.
- Eight persons in one Focus group discussion were collected according to the WHO FGD manuals.

Chapter-IV

4.1 Findings and Presentation of data.

4.1.1 Economic Condition.

Most of the people were occupied in agriculture sector. And rest involved in working as labour, business, service and dependent.

Table No.1: Occupation.

Occupation	Number	Percentage
Agriculture	91	52.0
Business	11	6.2
Service	14	8.0
Labour	42	24.0
Dependent	17	9.7
Total	175	100.0

Table 1 presents people how involved in different occupation. The figure shows that out of 175 respondents; 52.0% people (91) was engaged in agriculture followed by 24.0% (42) labour, 9.7% (17) dependent, 8.0% (14) service and 6.2% (11) business.

Table 2: Land.

The information on land of the respondents had taken to know their economic status.

Economic Status	Number	Percentage.
0-2 Bigahas (Poor)	107	61.1
2.1-4 Bigahas (Medium)	22	12.5
4.1- above (Rich)	46	26.2
Total	175	100.0

Table 2 presents the economic status of people in terms of having land. People having more than 4.1 bigahas were found 26.2% (46), people having land between 2.1 to 4 bigahas 12.5% (22) and people having no land to 2 bigahas were 61.1% (107) in the Rajbanshi community.

Economic Condition and Sickness.

Table 3: Economic Status and Sickness.

Here the land proportion and sickness has been shown to know the sickness status associated with land ownership.

Economic Status (Land)	Sickness.	Proportion Percentage
0-2 Bigahas (Poor), (N=107)	107	100.0
2.1-4 Bigahas (Medium),(N=22)	22	100.0
4.1- above (Rich), (N=46)	46	100.0

The table 3 indicates that out of the total 175 respondents, 100% (107) poor people were getting sick likewise medium 100% (24) and rich 100% (46) were reported sick.

Medication	Poor (n=107)	Medium (n=22)	Rich (n=46)	P - Value.
Modern Medication	104 (97.2)	20 (90.9)	44 (95.6)	0.3871
Self-Medication	68 (63.6)	14 (63.6)	18 (39.1)	0.0160
Alternative Med.	19 (17.7)	7 (31.8)	40 (87.0)	0.0000

Table 4: Economic condition and medication.

There is close relationship between economic status and health seeking behaviour.

Table 4 presents that 97.2% poor, 90.9% medium and 95.6% rich people were adopting modern medication respectively. Poor 63.6%, medium 63.6% and rich 39.1% people were adopting Self-medication respectively. Similarly Poor 17.7%, medium 31.8% and rich 87.0% people were adopting Alternative medication respectively. There was no difference in the use of modern medication among different economic level that is statistically insignificant (P= 0.3871). It was found that there has highly significant practice of self-medication been adopted by poor i.e., statistically significant (P=0.0160). Likewise, rich are largely adopting alternative medication that is statistically highly significant (P= 0.0000).

4.1.2 Education

Majority of people was uneducated as shown in the following table. Out of the 175 respondents 35.4% (62) were illiterate, followed by literary only 38.8% (68) both combined as uneducated 74.0%, SLC 20.5% (36), intermediate 3.4% (6), and BA - over 1.1% (2) altogether 26.0%.

Table 5: Educational Status.

Educational Status	Number	Percentage
Illiterate	62	35.4
Literate only	68	38.8
SLC	37	20.5
Intermediate	6	3.4
BA and above	2	1.1
Total	175	100.0

Table 5 presents the educational status of the Rajbanshi in Katahari and Baijanathpur VDCs. In this study Illiterate and literate only were taken in the category as Uneducated and SLC to above are being taken as Educated. There is 74 percent uneducated population which determines for having self-medication and or followed traditional healing practices.

Table 6: Education and Sickness.

Education	Sickness (n)	Percentage
Educated	45	26.0
Uneducated	130	74.0
Total	175	100.0

Table 6 presents the status of sickness on the basis of educational level in the community. It shows that out of 175 respondents; uneducated 74.0% (130) and educated 26.0% (45) were found to be sick.

Education and Medications

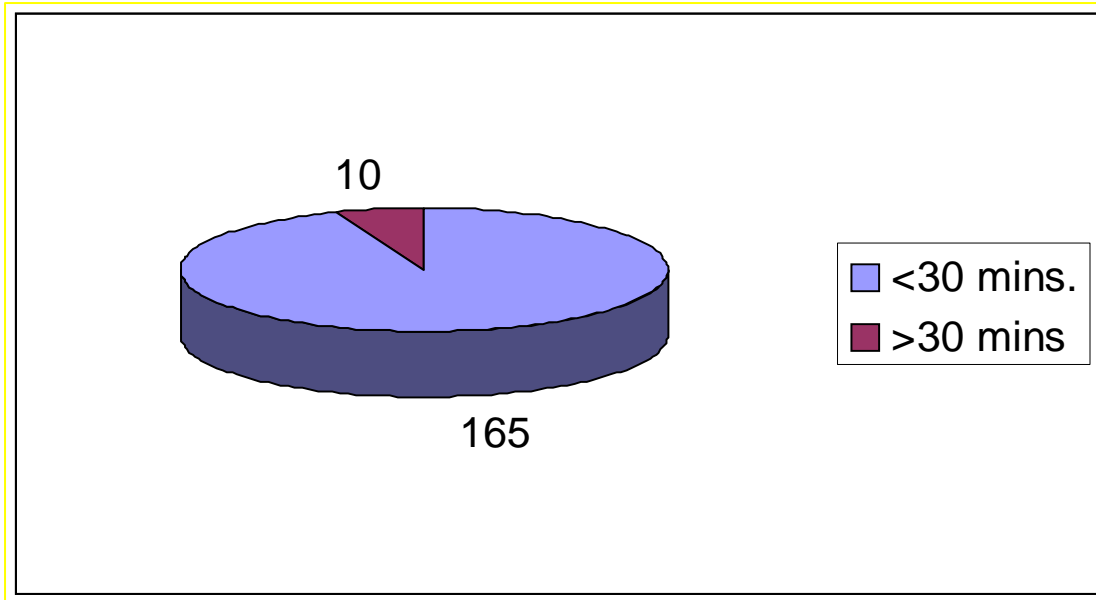
Table 7: Education and medication.

Medications	Uneducated (n=130)	Educated (n=45)	P - Value
Modern Medication	126 (96.9)	42 (93.3)	0.3753
Self-Medication	85 (65.4)	14 (31.1)	0.0000063
Alternative Med.	27 (20.8)	13 (28.8)	0.2635

It was found that there was no difference in the use of modern medication between educated and uneducated that is statistically insignificant ($P=0.3753$). But use of self-medication by uneducated was significantly higher than educated that is statistically highly significant ($P= 0.0000063$). And there was no difference in the use of alternative medication between educated and uneducated that is statistically insignificant ($P= 0.2635$).

4.1.3 Distance of Modern Health Facilities and trend of using medication:

Figure 1: Showing the number of people with their distance for modern health facility. Outs of 175 respondents 94.2% (165) were living within 30 minutes walking/ transportation distance.



4.1 Reported Illness.

In accordance to Prescription, observation, and history taking; diseases were noted in the survey. Headache/bodyache/ weakness - such type of symptomatic ailments were found mostly in the community. And then ARI, fever, eye ENT/oral problems, diarrhoea/ dysentery, Gastritis, Skin disease, TB, R. Arthritis, was reported respectively. The disease pattern may not resemble with national status. It may due to the coverage of illness history of only past three months.

Table 8: Illness condition encountered in Rajbanshi community.

S.No.	Diseases	Frequency	Proportion
1	Headache,bodyache,weakness	89	50.8
2	Acute Respiratory Infection (ARI)	77	44.0
3	Fever	54	30.8
4	Eye/ENT/Oral Problems	33	18.8
5	Diarrhoea/Dysentery	24	13.7
6	Gastritis(APD)	24	13.7
7	Skin diseases	13	7.4
8	Tuberculosis	10	5.7
9	Rheumatoid Arthritis	9	5.1
10	Asthma (COPD)	7	4.0
11	Dogbite	5	2.4
12	Typhoid	4	2.2
13	Paralysis	4	2.2
14	Accident/Fracture	3	1.7
15	Diabetes	3	1.7
16	Jaundice	2	1.1
17	Gynae/Obs.	2	1.1
18	Kala-azar	1	0.5

(Note: Response by duplication; one person had more than one problem/ illness. Thus, of the total 175 respondents, 364 responses on illness found. The average illness found to be 2.0.)

They reported that the illness nature changes as the weather changes. When the old prescription at their home were analysed, the disease such as ARI, TB, Kalazar, Asthma were mentioned clearly in the prescription by health care providers. Some cases were observed by the researcher himself. Headache/ bodyache/ weakness was reported by 50.8%, ARI by 44.0%, Fever by 30.8%, Eye/ENT/Oral by 18.8%, Diarrhoea by 13.7%, Gastritis by 13.7%, skin diseases by 7.4% respectively.

Morbidity by Sex.

Figure 2: Latest sickness according to sex.

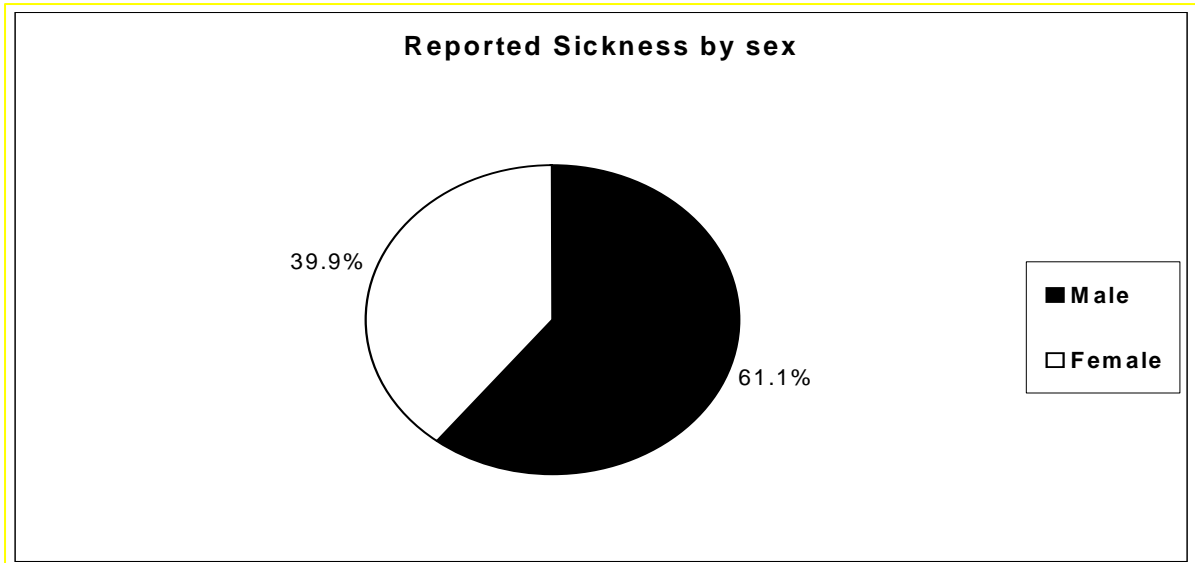


Figure presents as males were found to be reported sick by 61.1% and female by 39.9%. This might be due to the gender bias in the facility and opportunity to report the illness problems in the health institutions. Rajbanshi females are powerful at household decisions but outdoor facilities are minimum by local tradition.

4.1.5 Use of PHC-Services.

Table 9: Use of PHC services by any member of the Rajbanshi households in the last 3 months recall period.

PHC Services	Service takers (n=175)	Proportion Percentage
EPI Camp	139	79.4
FCHV	88	50.2
VHW	50	28.5
MCHW	19	10.8
PHC-ORC	16	9.1
TBA	10	5.7

Most of the people were found using EPI-camp (79.4%) for immunizing their child. Half of the people have taken service by the FCHV (50.2%). But TBA, PHC-ORC and MCHW were of relatively low access. However, it was encouraging to note that majority of people were aware of immunization.

4.1.6 Use of Health Care System.

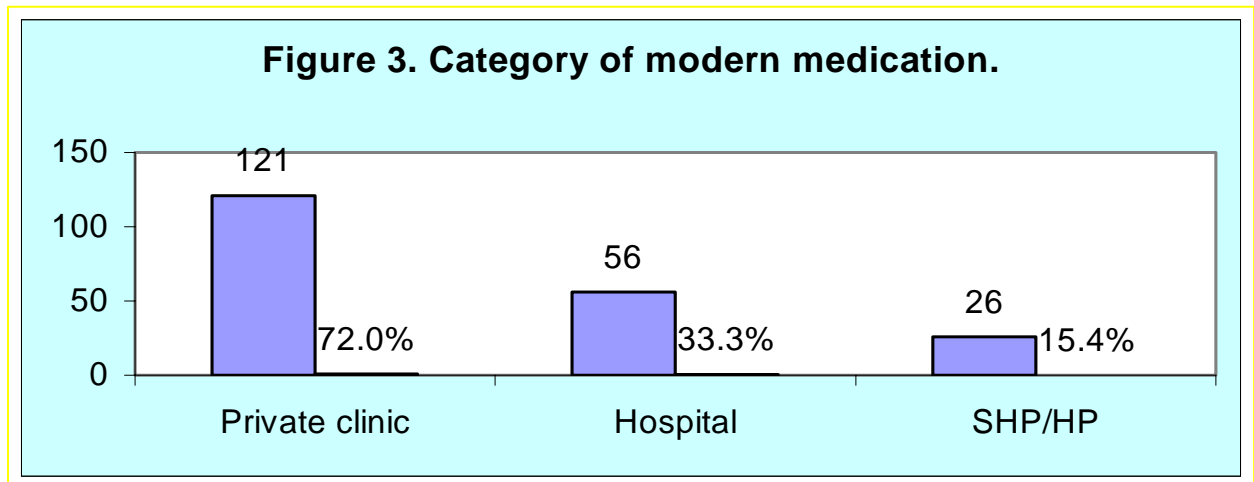
Modern medication means allopathic medication through health care providers followed after self-medication an alternative.

Table 10: Medication sought by the family in any kind of latest illness in the past three months.

Medication	Number (n=175)	Proportion Percentage
Modern medication	168	96.0
Self-medication	100	57.1
Alternative Medication	40	22.8

Table 10 showing the pattern of health care practices adopted as 96% people are adopting modern medication as an alternative after self care. Alternative medication was adopted by 23% either in Homeopathic or in Ayurvedic one. This indicates that poly-practices in poly-pharmacy and or in polyclinics/HP/SHP/PHC/Hospital are the indicators of Rajbanshi health seeking behaviour.

Figure 3: Illustrates the category of modern medication.

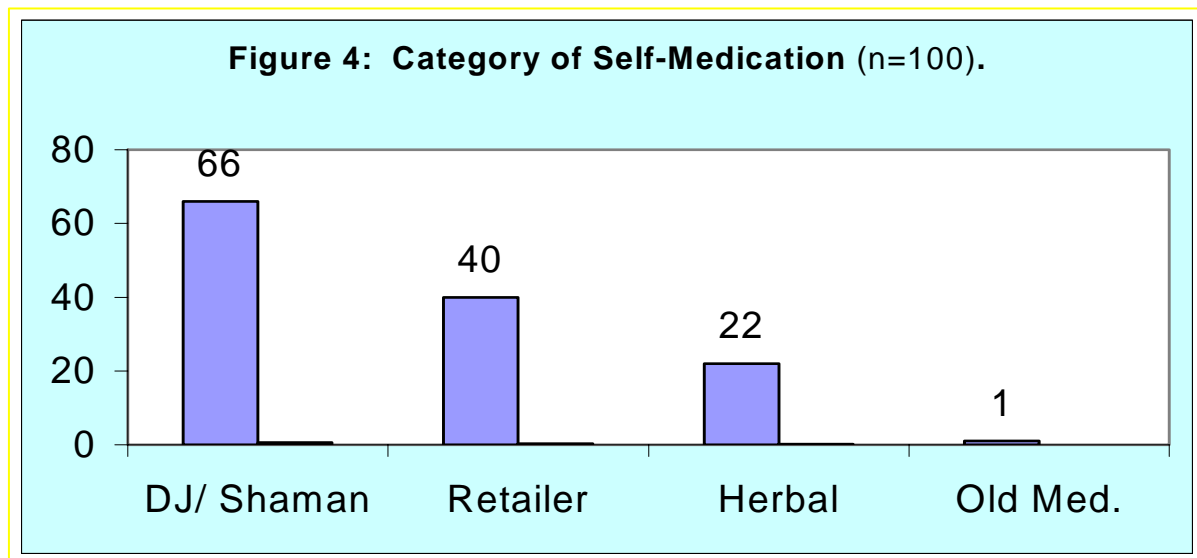


In the community out of 168 people private clinic was used by 72.0%, hospital by 33.3% and SHP/HP by 15.4%. In other words, people often go to private clinic rather than to hospital and health post.

(b) Self-medication

Kafle and Gartaula (1993) and Gartaula (1998) have categorized self medication as Shamanism, Priest, Dhami-Jhakri, herbal, drug retailers, grocery, kit-bag, drug peddler, neighbour, following old medicine prescriptions etc and except the present prescription by a qualified medical practitioners. *Worship* of god as well as go to the traditional healers are accepted practices, while getting sickness are commonly. Anybody readily do this practice herself or himself even before start any treatment. So, Self medication has comprise of Herbal, Drug retailer, Grocery, Kit bag, Drug peddler, neighbor, and following old medicine and prescription and traditional healers as well in the study.

Figure 4. Category of self-medication.



People were found using DJ by 51% (66), retailer by 31%(40) and herbal by 17%(22) and following old medicine from prescription by 1%.(1)

Table 11: Dhami/Jhakris' Healing Practices.

Healing Practices.	Number (n=66)	Proportion Percentage
Phukphak	61	62.4
Worship	53	80.3
Sacrifice	25	14.2

Self-medication was found adopted commonly in the Rajbanshi community. *Dhami/Jhakris* were doing *Phukphak*, *Worship* and *Sacrifice*.. People used to go to *Dhami/Jhakri /Shaman* and were found still having strong belief upon their healing power. They regard DJ as a part of life and without them their lives become incomplete that need in every ritual. They were also familiar with the retailer's shop and used to buy drugs and preparing herbal medicine at home conventionally.

On the theoretical level, medical beliefs and practices constitute a major element in every culture; consequently they are interesting in their own right and also for the insights they give into other aspects of culture of which they are a part. On a practical level, a knowledge of indigenous medical beliefs and practices is important in planning health programmes for, and in delivering health services to traditional peoples. In describing medical systems other than own anthropologists show increasing embarrassment over the problem of terminology. All terms commonly used imply quantitative gaps among medications where 'modern' medicine is product of indigenous cultural developments. There is dichotomy emphasized by contrastive terms such as 'scientific' versus 'primitive', 'western' versus 'non-western' and 'modern' versus 'traditional'. Although the qualitative gap exists, in an era of extreme culture relativism many people are disturbed by terms that suggest evaluation. (Gartoulla, 1998)

In surveying the ethnomedicine practices in the Rajbanshi community dealing with causality concepts, it was found that only a few cognitive frameworks were necessary to explain the presence of disease. It was found that a dual division is sufficient to distinguish major categories, and these may be termed personalistic and naturalistic, as was suggested by Foster (Foster, 1978).

A personalistic system can be identified when illness is believed to be caused by the active, purposeful intervention of an agent who may be supernatural being (a deity or a god), a non-human being (such as a ghost, ancestor, or evil spirit), or a human being (a witch or sorcerer). The sick person literally is a victim, the object of aggression or punishment directed specifically against him, for reasons that concern him alone.

A sick person can be treated through any one more of the following:

Propitiation of gods and goddesses. Propitiation or driving away the evil spirit(exorcism and witchcraft); Treatment by magic. Use of charms and amulets; and application of empirical medicine. (a) Western medicine (b) Ethnomedicine.

(Gartoulla, 1998)

The characteristics of the traditional healers in this community found as follows:

In Nepal, as in the rest of the world, there are doubts about the creation of universe, but credit for creation is frequently given to a supernatural power, to gods and goddesses. Most people at times of trouble turn to the god for help. Blessing from the gods is always sought before commencing any new ventures. The concept of atma (spirit or soul) is also important in understanding the health care practices in the communities in Nepal. If the "atma" is disturbed, the system will be in disequilibrium with possible mental or physical stresses and strains. (Gartoulla, 19998)

Prayag Raj Sharma in his study of the divinities in the western Nepal has found that there are some striking features in the religious practices of the people. The leading divinities in the karnali basin resolve themselves into five classes. In the first category come the Mastos who are 16 in number (in the region where he carried out his study). He has not however mentioned that the name and number of such Masto divinities may vary

because, in fact they are the clans deities and every family would know what Masto to its Kul devata (clan deity), or benefactor to whom references may be made if there is any cause of distress.

In the second category are included a number of divinities whose names so not bear Masto suffix, but whose nevertheless wield considerable power and prestige. In the third category fall the deified spirits. In the fourth category comes the female goddesses, and in the last are included Chandan Nath and Bhairav Nath, who wield much influence upon the fate of the females in particular. Sharma has mentioned that most of the leading divinities manifest themselves through a human medium, the oracle, who in the local parlance, is called the. The institution of Dhami is based on the principle of reincarnation. When an old Dhami dies, the vacated position is filled up, after a certain time, by another person of the same family or clan group in whom the divinity chooses to reappear (autinu). (Gartoulla, 1998)

Hitchcock presents that four types of spirit possession in the Nepal Himalayas can be distinguished on the basis of time and scope-reincarnate possession, utterly possession, oracular possession and peripheral possession. (Gartoulla, 1998)

Recourse to Shamans, that the Dhami and Jhakris is a common practice everywhere and with all communities in Nepal. One of the smallest groups among the Tibeto-Burman speaking population of Nepal are the channel of the Dhaulagiri zone. Of them, Wolf Mitchael wrote that they claim to be Hindus but they are much less influenced by Hinduism than even the northern Magars. Among the deities worshipped by the Chantal only a few belong to classic Hindu pantheon, the most important, however, being the local deities, like Bhume , Bara and Siddha. Witches (bokshi, dayani), goblin or demon like being (bir, Masan) and the spirits of dead (moc, prêt, siyo) play a dominant role in the religious beliefs and observances of the Channels. (Gartoulla, 1998)

The various appellations by which shamans are called in Nepal vary from community to community, and also there are subtle differences in the practices of some of them. Such appellations are as follows: Dhami, Jhakri, Lama, Guvaju, Fedangwa and Bijuwa. Fedanwa is a shaman from Limbu community and Bijuwa is from Rai community. The Guvaju are Newars and it must be noted that Guvaju is used for shamans priests as also some others. But there is some interesting difference between the Dhami and Jhakris. Most important of all, the Dhami belong to Brahmin, Jaisi or Chhetri castes where Jhakris who do not belong to such twice born categories. In a story, The Jhakris could not reach the heavens with the help of his incantations and magic while Lama could achieve the same.

Alternative Medication.

Dr. Ritu Prasad Gartoulla has mentioned about Alternative medication in a book *Therapy pattern of conventional medicine with other alternative medication: A study in medical anthropology in Nepal as follows:*

“Alternative medicine is a rather vague term used loosely to distinguish ancient and culture bound health care practices which existed before the application of science to

health matters. Some frequently used synonyms are indigenous, unorthodox, folk, fringes and unofficial healings.

Alternative medication practices have different meaning to different people. Some are inclined to include even ethnomedicine in it while others prefer to restrict, various practices excluding ethnomedicine under this category. Beside the supernatural healing practices, medications done without contacting modern/ allopathic medical practitioners, like contacting drug retailers, over the counter sales, using private kit-boxes, consulting neighbours and various other legitimacy with reference to the supernatural realm, and resorted to before contacting the modern medical practitioners.

Medication practices have taken several forms in different parts of the globes. The history of modern medicine can be traced undoubtedly from remote past and also from the practices evolving gradually and indigenously among various people not only from the west alone but also from the eastern societies. But one important differentiating factor has been the application of experimental logic to the modern science of medicine. The therapeutic intricacies are examined and how exactly the medicine works and why have been sought to be unearthed. In alternative medication practices the whole channel of cause and effect relation is not sufficiently explicit, even though investigations are being conducted into some of them in recent times to reveal the inner relations, as in the case of, say, acupuncture, which has been one of the alternative medication practices evolving in China.

Acupuncture and moxibustion have been applied in China for the last 2000 years or so. The simplicity of their application, their minimum side-effects, and their low cost and rapid effect have made to remain popular. It may be pointed out that some practitioners of acupunctures still adhere strictly to traditional medical theory, while others use it empirically, without reference to the indigenous Chinese belief, and strictly in accordance with westers style diagnosis and concepts of pathophysiology. Internationally there is a diversity of opinion regarding the techniques of acupuncture, the pre-requisite qualification of an acupuncturist, the usefulness of the notion of channels and the specificity of the acupuncture points.

Accupuncture, Unani or Chandsi medication (indigenous to eastern Bengal), like many other recent ones such as Homeopathy, have made their inroads into Nepal through diffusion of culture. But, here, in this account of the alternative medication practices in Nepal, such items are not included because they are external influences and also because they are by and large urban centred even now.”

Ayurvedic and Homeopathic medication have earned a good reputation though services were available in the urban only for small number. They were possessing the

beliefs that source of many modern medicines are Ayurvedic raw materials. So they were friendly in using Ayurvedic medicines. Likewise they were having belief that despite its slow action Homeopathic medicine can eliminate the root of disease.

Table 12. Category of Alternative medicine.

Alternative medication (n=40)	Number	Percentage
Ayurvedic	28	70.0
Homeopathic	12	30.0

Table 13 illustrates the categories of Alternative medicine i.e., Ayurvedic and Homeopathic. Out of the total 175 respondents 22.8% (40) were adopting alternative medication and among them 70.0% (28) had adopted Ayurvedic and by 30.0% (12) patients had adopted Homeopathic medication. Remaining had gone to other area.

4.1.7 Causes of taking Services.

Some studies say that people's behaviour of taking care was mainly guided by their perceived satisfaction. Places where they get good investigation, diagnosis and treatment, as well as good inter-personal communication were place of their choices. Other determinants were distance, custom, cost and other. Patient mostly used to go to health facility with the advice of his/her family, neighbour/friends and by self-knowledge, IEC such as Radio and TV, and health workers.

Table 13. Reasons for taking health services.

Reasons	Number (n=175).	Proportional Percentage.
Satisfaction	145	82.8
Short distance	49	26.2
Custom	24	13.7
Cost/ Cheap	16	9.1
Other	1	0.5

(Note: Response by duplication).

This table shows that why people were going to take a particular health care service. 82.8% people were driven towards where they felt satisfied. Second guiding factor was short distance (26.2%) and custom (13.7%) cost (9.7%) and other 0.5% respectively.

Figure 14. Advice for referral.

Advice for refer	Number (n=175)	Proportional Percentage.
Family member	107	61.1
Self	80	45.7
Neighbour/ friends	16	9.1
IEC/Radio/TV	2	1.1
Health Workers	1	0.5

The contribution on giving advices for referral by family members the proportion was 61.1% and self-knowledge 45.7%, neighbour/ friends 9.1%, IEC/Radio/TV 1.1%, and Health workers 0.5% respectively.

4.1.8 Frequency of Visits.

Table No.15. Frequency of visits for treatment.

Frequency	Number (n=175)	Percentage.
Once	57	32.5
Twice	62	35.4
Thrice	26	14.8
Four times	10	5.7
Five or more times.	20	11.4

Out of 175 patients 57 (32.5%) patients visited once and 35.4% visited twice for treatment. Similarly, 14.8%, 5.7%, 11.4% patients visited thrice, four times and five or more respectively for the treatment.

Figure 5: Satisfaction and number of visits.

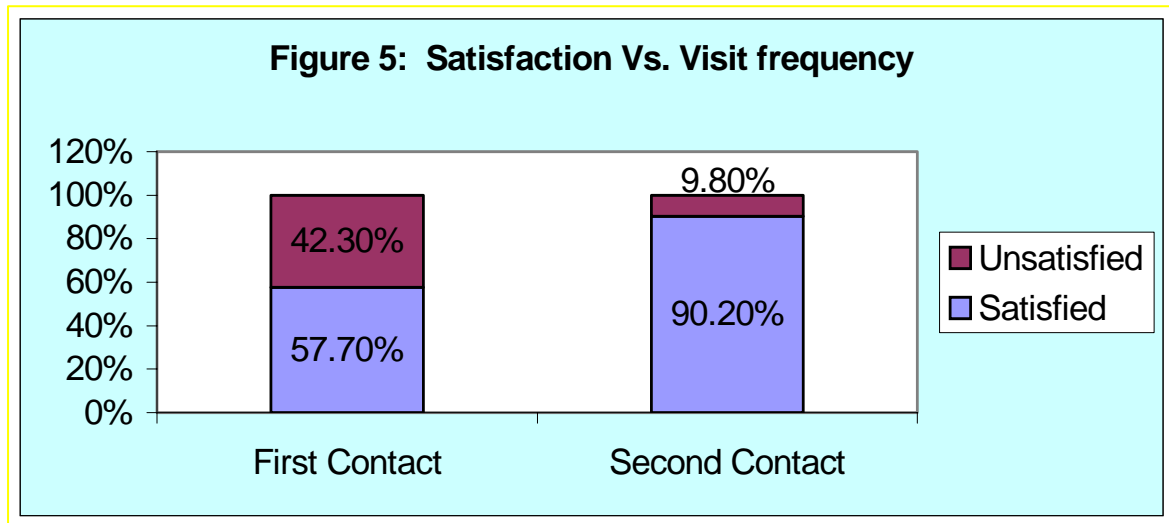


Table indicates that patients were satisfied with their second visit rather than first visit. In their first contact 57.7% patients were satisfied with the treatment and 90.2% satisfied with second visit.

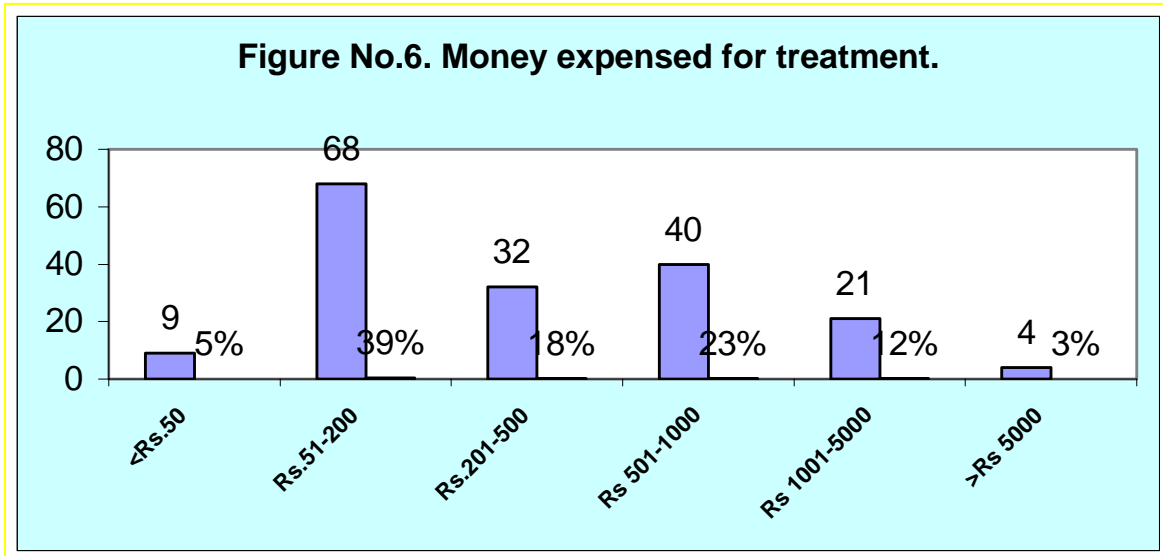
4.1.9 Expenses for Treatment.

Table 16: A cross-section of an average expense (in Rupees).

Buying drugs	598.35
Paying fees	201.68
Transportation	52.30
Helper	38.58
Other	142.77

Average expenditure per sick is Rs.1 031.64. Bulk amount of expense was (58.0%) for purchasing drugs and paying fees (19.5%). And 5.0% for transportation, 3.7% for helper and 13.8% for others.

Figure No. 6: Cost of Treatment.



It was found that usually people (39%) were paying 50-200 rupees for their treatment. Likewise, 23% had paid Rs. 501-1000, 18% paid 201-500, 12% paid 1001-5000, 5% paid less than Rs.50 and 3% paid more than Rs.5000. But it was indeed; found that average person was paying Rs. 1031.64 per sick for a treatment. Bulky proportion of money used to go for the cost of drugs and fees for doctor or healer. Rest of their money was expended for helper, transportation and others.

4.1.10. Affordability.

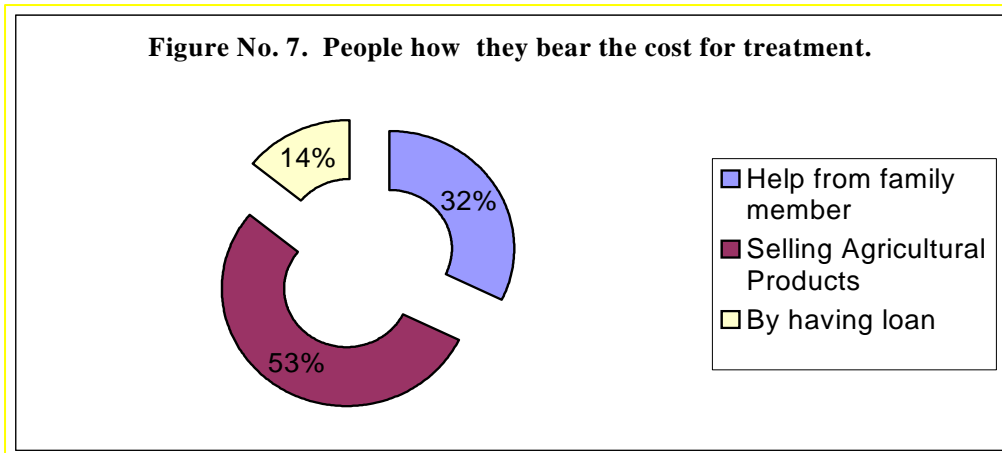
Table 17: Affordability as perceived by the Respondents.

Affordability	Number	Percentage.
Yes	47	26.8
No	128	73.2
Total	175	100.0

Table 12. Suggests that 73.2% people were reported to be unable to afford the cost for treatment. Only 26.8% people were able to afford treatment cost. So it is striking to note that, only less than one-third people were found to be able to afford the cost for treatment.

Figure No.7. Bearing of the cost for treatment.

Figure suggests that 32% people took help or borrowed from their family members. 53% sold their belongings such as agricultural products, land etc., and 14% took loan for treatment. More than two third people were found unable to afford cost for the accomplishment of treatment.



4.1.11 Satisfaction.

User's satisfaction from service providers determines by the local people who might have taken various forms depending on who administers what medicine to whom and how. Sometimes it happened that even when modern medicine is used, it is done without the advice of a regular doctor. Such cases occurred when a person consumed medicine on his own or procured it from someone who did not possess the necessary knowledge in medicine. In such cases it is immaterial whether the medicine administered is the correct one. Despite having skills and knowledge a doctor or a paramedical could not function well in a hospital/PHC/ HP settings at desired level due to limited resources, support and burden of works. It also plays a vital role on the satisfaction of a consumer.

There are several chances of being misuse of health human resources in our health system. A Village Health Worker who has got training for certain preventive and promotive in public health areas. They are supposed to work in the field of immunization, health education and sanitation. But people expect more during their frequent visits. So, sometime VHW/ MCHW or paramedical are providing services more then their expected level.

Kirana shops Keepers (Grocers) are those who hold shops of daily use such as rice, pulse, oil etc. But they sell certain medicines such as Paracetamol, Antihelminths, Antibiotics, ointments for eye, skin etc. It is easily estimated that there is maximum irrational use of drugs from the grocery but it is not easy to control since large number of people were getting service from there.

Dhami-Jhakris are regarded as the representative of the supernatural powers and with their aid they can cast off evil spirits that cause affliction to people. While curing the patient through some rituals practices, they are held to be in communion with gods and goddesses.

Despite the health facilities provided by the government more than 50 percent of health problems never reach the health services. They are treated through a system of self-care and plural medications which is based on home remedies. Other methods of unconventional treatments include commercial sales of over the counter (OTC) drugs often combined with religious healing practices and culturally based treatments which are economically beneficial to the people. (Gartoulla, 1998)

Figure 8: Satisfaction with the process of investigation during treatment.

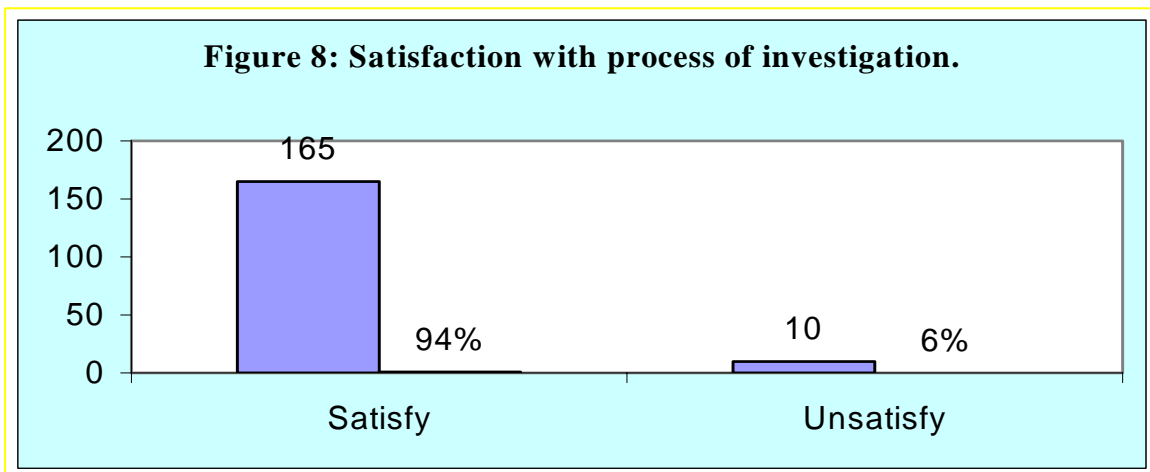


Figure noted that 94.0% patients were found satisfied with the process of investigation during the treatment. Only 6.0% were dissatisfied with the process of investigation during treatment.

4.1.12 Usual Visit to taking cares.

It was found that people were taking services from multiple medications such as - Modern medication, Self-medication and Alternative medication practices.

Figure 9: Usual visit for medication.

Usual place to visit for 96.0%(168) people was modern medication, self-medication for 57.1%(100) and Alternative medication for 22.8%(40). (N=175).

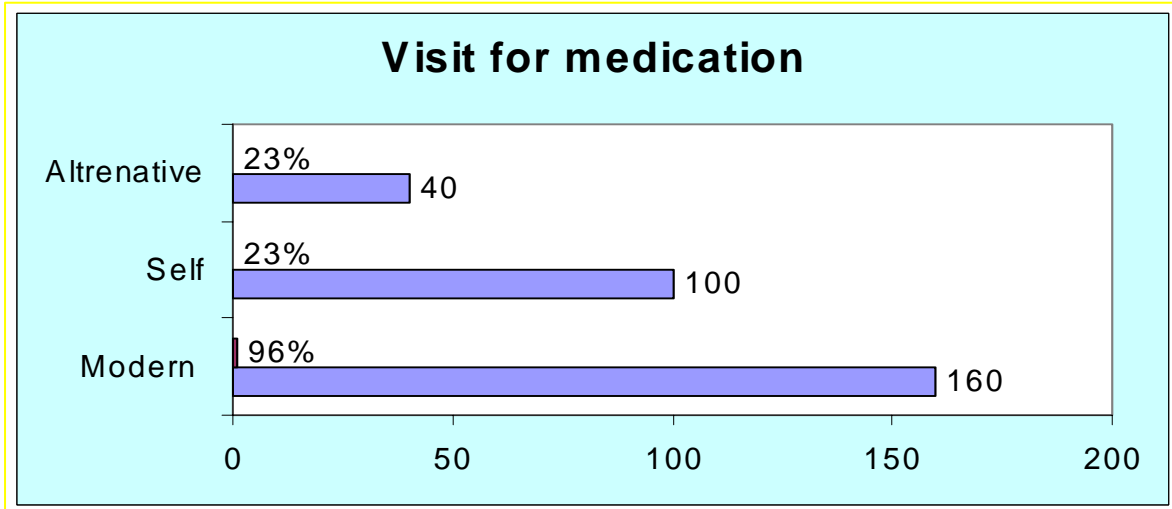
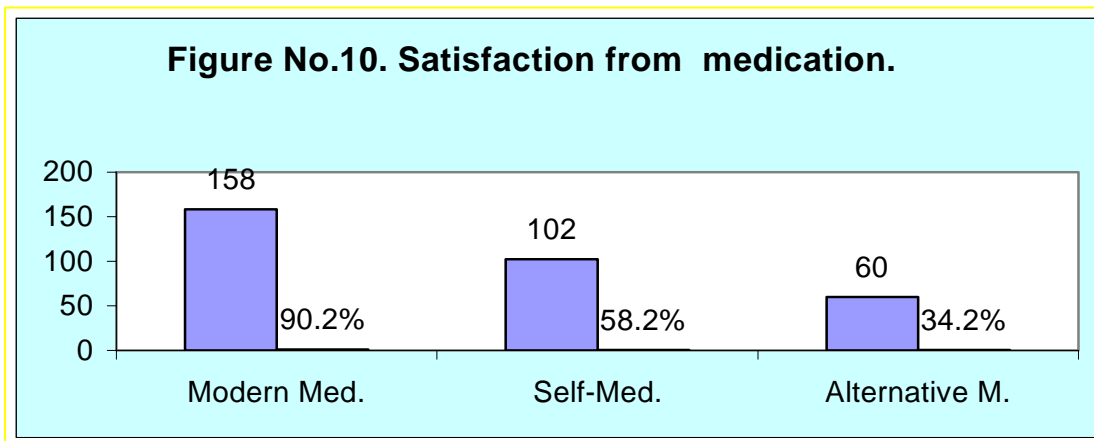


Figure No 10: Satisfaction as perceived from their medication practices adopted.



Out of 175 respondents 158 (90.2%) were satisfied with modern medication, 102(58.2%) satisfied with self-medication and 60 (34.2%) satisfied with alternative medication. It was due to the cure rate, low cost, provider behaviour, free medicines, good counselling which are the causes for satisfaction.

Following points are viewed by users for satisfaction.

Medicine facility, experienced service provider, emergency services, quick services, previous experience, quality of care, better examination, good behaviour of service provider, proper treatment, proper advice, Female service provider for female cases, service availability, laboratory facility, x-ray facility etc.

Likewise, Following points are viewed by users for dissatisfaction.

Irregular presence of service providers, Physical facility, water, sanitation, expensive medicine, No lab, No latrine, No x-ray, Wrong behaviour of service providers, No home visits, No surgical facility, No specialist service, No transportation service, necessary medicines are not available etc.

4.1.13 Satisfaction of medication on the basis of Education.

Figure No.18. Satisfaction of medication on the basis of education.

Medication	Educated (n=45)	Uneducated (n=130)	P - Value.
Modern	41 (91.1)	111 (85.3)	0.3271
Self	14 (31.1)	45 (34.6)	0.669
Alternative	42 (93.3)	39 (30.0)	0.0000

There was no difference between educated and uneducated in the use of modern medication that is statistically insignificant (P=0.03271). Similarly, there was no difference between educated and uneducated in adopting the self medication that is statistically insignificant (P= 0.669). But educated were adopting more alternative medication practices than uneducated that is statistically highly significant (P=0.0000).

4.1.14. Satisfaction from different medication practices on the basis of economic status.

Table No.19. Satisfaction with medication on the basis of economic status.

Medication	Satisfaction			P - Value
	Poor (n=107)	Medium (n=22)	Rich (n=46)	
MeM				
Modern	99 (92.5%)	18 (81.8%)	41 (89.1%)	0.28947
Self	42 (39.2%)	5 (22.7%)	13 (28.2%)	0.2000
Alternative	56 (52.3%)	10 (45.4%)	36 (78.2%)	0.0050

It was noted that there was no difference among poor, medium and rich in the use of modern medication that is statistically insignificant (P=0.28947). Similarly, there was no difference among different strata in using self medication that was statistically insignificant (P=0.2000). But rich were adopting alternative medication more than other economic strata that is statistically significant (P=<0.005).

Focus Group Discussion

The situations created during different Focus Group Discussions with Rajbanshi people in Katahari and Baijanathpur VDCs of Morang district that facilitate the study to experience the real situation by taking their views, by interacting with the groups. So, the discussions helped to collect their ideas about their health seeking behaviours. They expressed their views regarding modern, self and alternative medications. They were found eager to express their demands to the government and Institute of medicine as well. There were found different NGO/INGO intervention in these VDCs. Many people said that they have already taken different trainings. They also want more training about

health they expressed. Here are some views regarding our health system which are somewhat critical too. Researcher has felt that these FGD were not only useful to collect or explore things but also useful in evaluation of data collection as well.

Total FGD = 10

Group No.	Male	Female	Total
1	8	0	8
2	0	8	8
3	3	5	8
4	6	2	8
5	7	1	8
6	1	7	8
7	6	2	8
8	5	3	8
9	2	6	8
10	3	5	8
Total	41	39	80

Point No.1. Could you please explain your views on medication pattern at your village?

Response	General Responses
1	We use modern, self and alternative medications.
2	Modern medication is effective but also going to be expensive.
3	Self medications are cheap and common. It comes in first step. If it does not cure we go to the clinic.
4	Ayurvedic drugs and doctors are cheap. No side effect.
5	Homeopathic drugs are slow in action but eliminate cause. Drugs, fees are heap.

Point No.2. Describe about consultation practice at your village ?

Response	General Responses
1	Our usual visits are private clinic because it is easy to access all the time.
2	First our practice is self medication thereafter modern medication.
3	First our practice is self medication thereafter Ayurvedic or homeopathic.
4	Health post and hospital services are expensive and not so good but we use it.
5	family member and sometimes Faith healer decide where to go to cure.

Point No.3. People's faith with Faith healers and their impact on health.

Response	General Responses
1	We partly believe on faith healer. It can make us free from fear and tension only.
2	We believe in the faith healers it can cure mental diseases.
3	They are decreasing in number so government should give training for faith healer.
4	We believe them. Because they need in our every rituals.
5	Some faith healers are cheating us, but we cannot ignore them.

Point No.4. People's faith with Pandit/ lama/ astrologer and their impact on health.

Response	General Responses
1	We partly believe them. But sometime we need them urgently.
2	They can make our fortune good. So we take advice from them.
3	Their number is very few so we cannot say.
4	They are our traditional healer. Today they are our service/ advice providers.
5	We need to ignore their healing because we have modern medicine in easy ccess.

Point No.5. People's faith with Ethnomedicine and their impact on health.

Response	General Responses
1	It is disappearing day by day. It is slow in action.
2	It is still existed. We need to preserve it. It work for many things.
3	Ethnomedicine is difficult to access today rather than modern medicine.
4	Because it is cheap and if not get well contact the modern, alternative cares
5	It takes time so we have no time to go to ethnomedicine. Modern medication-quick

Point No.6. People's faith with Supernatural beings and their impact on health.

Response	General Responses
1	We partly believe them.
2	We believe it but we cannot say more.
3	We cannot say about it.
4	It is responsible for sickness but we are not sure.
5	We ignore the supernatural beings because it is not scientifically proved.

Point No.7 Source of information for medication.

Response	General Responses
1	Radio, TV, Health worker, friends
2	Family member, neighbour, Faith healer, FCHV
3	Friends, HP, Hospital, teacher, students, radio, TV
4	Family member, neighbour, Faith healer, TV, Radio
5	Radio, TV, Health worker, friends, neighbour.

Point No.7 Any other suggestions/ information on the health care practices.

A middle aged gentleman at Katahari VDC(Group No.6) said: *Modern medication is good but it has many side-effects.*

Other gentlman said (Group No.7) : *Since doctors are not looking as good at hospital and health post as like their private clinics, so they should not be allowed to open their private clinic by government.*

A middle aged women at Baijanathpur VDC (Group No.2) said: *Drugs as well as doctor's fees are much expensive. So, drugs should be available at cheaper price at clinic, shop, HP and hospital.*

A young man at Katahari VDC (Group No.9) said that *Health Post's doctor does not examine us properly so s/he cannot diagnose the disease. Therefore, it is worthless to visit health post.*

A woman (Group No.8) *The same doctor examine well in his clinic. Drugs should be purchased either in health post or in his clinic. So, I prefer to go to private clinic.*

A old man (group no.4) said; *Dhami/ Jhakris are needed in every rituals and they can do something for our ailments. We always go to DJ for almost all health problems. If he gives suggestion then we go to seek care such HP, hospital, clinic or else.They are accepted as a part of our culture till now.*

But a middle aged gentleman (group no. 5) said as : *DJ are cheating us they cannot cure our disease. They can only make us free from fear and free of tension.*

A middle aged women at Baijanathpur asked: *Since the Dhami/Jhakris's numbers are going to decrease today. Dhami/Jhakris also should be made available by the government.*

A gentleman (group no.10) said that; *But they need to be trained and should be recognized by the government.*

A young man (group no 5) said: *I am using Homeopathic drugs from Biratnagar. It can eliminate the root cause of disease so it cannot let disease relapse again.*

An old man said (group no.4) that : *Iam using Ayurvedic medicine. Ayurvedic is the main source of drugs of modern medicine so I prefer the Ayurvedic medicine.*

Another gentleman (group no.1) added that *it takes long time to cure so it is useless in emergency.*

Expectations and Suggestion

1. Provision of cheap drugs to be provided for them while in treatment..
2. Provision of free-mobile health camps.
3. Training and health education programs should be provided to Rajbanshi.
4. Such provision should be made that either Hospital doctor/paramedic should see patient as like as their clinic or Government doctor/ paramedical should not be allowed to see patient in private clinic.
6. Dhami/Jhakri should be provided training and be recognized by government. Thereafter they should be made available in the community by the government.

4.2 Discussion.

Rajbanshis live in Morang and Jhapa districts in Nepal. Rajbanshi ethnic in Katakari and Baijanathpur VDC were found having literacy rate 65% in the taken sample. Principal occupation is agriculture. Majority of people falls in the category of having no land to less than 2 bigahs. Average family size is 5.76 persons. Attempts to interviews with mostly head of the 175 households were made in two VDCs. And there were 61% male and 39% female reported sick.

Common type of ailments was reported such as headache, bodyache, weakness (50.8) and then ARI (44), fever (30.8), Eye/ENT (18.8), diarrhoea (13.7) was reported respectively. Distribution of reported illness was highest on over 66 year of age then 55-65 and 46-55 years of age respectively.

Private allopathic clinics conducted by paramedics were abundant in the local market, which were familiar in the community. So, minor injuries and ailments were being treated there. People were getting satisfaction through private clinics (72.0%) rather than from nearby situated Sub-health post (15.4%). There was relatively larger number of people going to private allopathic clinics where they got good treatment in terms of examination, counseling and drugs which made them satisfied. It was noted that despite being easy access majority of people was found unsatisfied with the treatment given by Sub-Health Post. Large number of people was reporting that there is no worthwhile to go to Health posts. Since they don't examine properly, they are unable to diagnose the disease and consequently treatment becomes worthless. It was just to waste time and money.

They have also got facility of Koshi Zonal Hospital for emergency and special services. People those who need sophisticated facilities such as Emergency, obstetrics and chronic cases, used to go to higher service centers at Biratnagar, Dharan, Kathmandu and India accordingly.

Likewise people were found to be deeply attached with their Self-medication practices. They readily go to Dhama/Jhakri/Shaman due to cultural factor and because of their satisfaction. And sometimes lack of adequate money to pay modern medication also drive to Self-medication. Since cultural belief was deep rooted, people would feel oneself incomplete without the presence of Dhama/Jhakri/Shaman or Self-medication in the society. It was felt that even people those blaming Dhama/Jhakri as merely cheating in the name of healing; were also admitting that they could make us at least free from tension and fear.

There was no difference in the use of modern medication among different economic level that is statistically insignificant ($P= 0.3871$). It was found that there has highly significant practice of self-medication been adopted by poor i.e., statistically significant ($P=0.0160$). Likewise, rich are largely adopting alternative medication that is statistically highly significant ($P= 0.0000$).

It was found that there was no difference in the use of modern medication between educated and uneducated that is statistically insignificant ($P=0.3753$). But use of self-medication by uneducated was significantly higher than educated that is statistically highly significant ($P= 0.0000063$). And there was no difference in the use of alternative medication between educated and uneducated that is statistically insignificant ($P= 0.2635$).

They were found familiar to go to EPI-Camp (79.4%) for getting vaccination for their children. They are also familiar with FCHV and recognize her services. Most of the people know their FCHV (50.2%) and used to take service from her. On the other hand, more than 89.2% population was found still unknown to MCHW, TBA and PHC-ORC and its services.

There was no difference between educated and uneducated in the use of modern medication that is statistically insignificant ($P=0.03271$). Similarly, there was no difference between educated and uneducated in adopting the self medication that is statistically insignificant ($P= 0.669$). But educated were adopting more alternative medication practices than uneducated that is statistically highly significant ($P=0.0000$). It was noted that there was no difference among poor, medium and rich in the use of modern medication that is statistically insignificant ($P=0.28947$). Similarly, there was no difference among different strata in using self medication that was statistically insignificant ($P=0.2000$). But rich were adopting alternative medication more than other economic strata that is statistically significant ($P=<0.005$). They were also found having some critical perception regarding modern medication practice; as it is expensive and doctors and paramedics are not treating patients as like their private clinics. Self-medication practices are common for minor and common type of ailments. And it is an integral part of their culture. Likewise they are relatively less familiar with Alternative medication because of unavailability locally. But they keep believe in its usefulness for chronic diseases and assume its potentiality of eliminating disease slowly.

An average treatment per case cost has found Rs. 1031.64 ($SD=6$). 73.1% patients were reporting to be unable to afford the expenses for treatment. They had taken either loan (14%) or had to sell land, animals, grains or personal belongings (53%). The bulky proportion (57.8%) expenses felled on buying drugs and for fees (19.55%) thereafter, for transportation 5%, helper 3.74%, others 13.84%. Therefore, the concern of unaffordability of treatment cost for modern medication is one really striking.

People go for health care where they are supposed to get satisfaction and feel reliable. So, it was found that choosing of medication was mainly influenced by their perceived satisfaction. The satisfaction was in terms of curedness, process of investigation, interpersonal relationship, and treatment. Patients were usually visiting more than one time. Second visit had provided more satisfaction. Similarly other guiding factors were distance, usual custom, cost etc. Family members and self-knowledge were driving forces to adopt certain medication. People also expressed the need of service of Dhami/Jhakris, training for Dhami/Jhakri and recommendation by government.

5.1 Conclusion

1. Major occupation of Rajbanshi in Katahari and Baijanathpur was agriculture. And Other were labour-work, business, and service etc.
2. Most of the people fall in the category of having no land to less than 2 bigahs. Common type of ailments was reported such as headache, bodyache, weakness (50.8) and then ARI (44), fever (30.8), Eye/ENT(18.8), diarrhoea (13.7) was reported respectively. Distribution of reported illness was highest on over 66 year of age then 55-65 and 46-55 years of age respectively.
3. People were found using Modern medication equally. Higher use of Self-medication by poor was significant ($P=0.0160$). Similarly higher use of alternative medication by rich was statistically highly significant ($P=0.0000$).
4. Literacy rate in sample was 65%.. The 29% percent people were found educated (above SLC). Uneducated people were using more self-medication was found Statistically highly significant ($P=0.000063$).
5. More than 90% Rajbanshi in these two VDCs had got modern health facilities within 30 minutes distance. Utilization of PHC services: They were found familiar to go to EPI-Camp (79.4%) for getting vaccination for their children. Half of the people know their FCHV (50.2%) and take service from her. On the other hand, more than 89.2% population were found still unknown to MCHW, TBA and PHC-ORC and its services.
7. Self-medication- Dhami/Jhakri/Shaman were main service providers of Self-medication. They used to Phukphak, worship, and sacrifice 62.4%, 80.4%, 14.2% respectively. Retailer and herbal were also common in this community.
8. Causes: People were mostly guided by their perceived satisfaction (82.8). Other determinants of choosing certain practice were distance, custom, cost etc. Family member and self-knowledge had played the driving role to decide the probable options.
10. Visits: Most patients go more than one time to take health care and their second visits provided significant satisfaction.
11. Cost: The proportion of people paying between Rs.51-200 was 39% of sample. But average expenditure per case was Rs. 1031.64 (i.e. mean; and $SD=6$) for a treatment. It was reported to be unaffordable for more then 73% people so they take either loan or sell their belongings to accomplish the treatment. Most of the proportion of their expense goes for buying drugs and paying fees. Rest portion was expensed for transportation, helper cost and other.
14. Satisfaction: Rich were found satisfied with alternative medication that was found statistically significant (0.0050). Educated was found satisfied with alternative medication was highly significant ($P=0.0000$).

5.2 Recommendations

Based on the findings, following recommendations could be made as follows:

Since majority of the poor people go for self medication and the private clinic was perceived to be expensive; the personnel of the self-medication or service provider such as Dhama/ Jhakri/ Shaman, retailer need to be oriented on referral system. Since 73.2% people are unable to afford treatment; free mobile health camp should be provisioned for the poor. Since 89.2% of the population was unknown to MCHW, TBA and PHC-ORC services; training and awareness program should be provisioned to both service providers and users.

The suggestions received from qualitative study match with that of the findings from qualitative analysis; and thus the following recommendation was made as follows.

Since consumers were reporting that doctors or health workers used check up a patient very well in their private clinics with giving sufficient time and effort than in a HP/ SHP/ Hospital, so they preferred to go to a private clinic than HP/SHP. Some specific rules were expected from the respondents to get changed the situation from the government.

References

1. Academy of Chinese Medicine, (1975), An outline of Chinese Acupuncture, Beijing, Foreign Language Press, China.
2. Achard, T. (1983); Primary Health Care in the Hills of Nepal, Integrated Hill Development Project, Kathmandu.
3. Agarwal, S.K. (n.d.), A Guide to Alternative Medicine, IBAM Calcutta India.
4. Annae, Ferguson, (1981), "Commercial Pharmaceutical Medicine and Medicalization; a Case study from El.Salvador", in Curative Medicine and Psychiatry, Vol.5.
5. Ashraf, A.,Choudhary, S.,Strafland, P. (1983): "Health Disease and Health care in rural Bangladesh" in Social science and Medicine,
6. Bastola, S., (1999), A study on the factors affecting user's satisfaction from the services in Primary health cares setting in Khopashi, Kavrey district (MPH - Thesis), TU, IOM, Kathmandu.
7. Bhattachan, K.B., (1999),"Globalization and its impact on Nepalese society and culture" Impact of Globalization in Nepal, NEFAS, FES, and Kathmandu, Nepal.
8. Blum, R., Kreitman, K. (1983): "Factors affecting individual use of medicines" in Blum, R. Herxheimer,Al et.al eds, Pharmaceutical and Health policy HAI paper back edition, reprint by social Adult Ltd.
9. Blustain, H. S., (1976), Level of Medicine in a central Nepali village, Contribution to Nepalese studies.
10. Bonnerman, (1983), Traditional Medicine and health care coverage, Geneva, WHO.
11. Central Bureau of Statistics, (1991), Statistical Pocket Book Nepal, NPC/ CBS, Kathmandu Nepal.
12. Chalker, J.C., Kapali, M. & Khadka, B., (n.d.) Health Post Usage in a mountain district in Eastern Nepal, A focus group study submitted for publication to: Health Policy & Planning, London school of Hygiene & Tropical Disease, Kappel Street London.
13. Chaturvedi, N.Rai,H.Ben-Shomo,Y (1997), Lay diagnosis and health care seeking behaviour for chest pain in south Asian an Europeans, Lancet 350(9091), EURODIAB, Department of Epidemiology and Public Health, University College London, UK.
14. Clark, (1970), "Thai injection doctor", in Social Science and medicine, Vol. 4.
15. Dixit, H., (1999), The quest for Health_ Educational Enterprises Ktm Nepal.
16. Febrega, Horacio,Jr. (1972): "Medical anthropology", in Biennial Review of Anthropology, B.J. Siegel, ed., Stanford, Calif: Stanford University Press.
17. Foster, G.M., Anderson, B.G.(1978): Medical Anthropology, Alfred A. Knopf, New York.
18. Gartoulla, R.P., (1998), Therapy pattern of conventional medicine with other Alternative Medicine, RECID, Kathmandu Nepal.
19. Gartoulla, R.P. (1998), An introduction to Medical Sociology and Medical Anthropology, RECID, Kathmandu, Nepal.
20. Haak, H.,Hardon, A.P. (1988): "Self medication indigenised pharmaceuticals in developing countries, Widely used, widely neglected" in The Lancet (2).
21. Herxheimer, A. Stimson, G.V. (1983): "The use of medicines for illness" in Blum R.,Herxheimer A,et.al. eds. Pharmaceuticals and health policy; HAI paperback edition, reprint by social adult LTD.
22. HMG, MLD, (2000), National Committee for Development of Nationalities, Prospectus.

23. Kafle, K.K., Gartoulla, R.P., (1993), Self-medication and its impact on Essential Drug Scheme in Nepal, W.H.O. DAP - 10.
24. Lieban, K. Austin, L., Hogg, C. Ferguson, B. Smith, K.(1997), Patients view of nurse prescribing, Nurse – Time 93 (17), England.
25. Mabuhang, B.K., (2000), "Policy Approaches to Indigenous People Health Issues" Population and Development in Nepal Journal, TU CDoPS, Vol.7, Kathmandu.
26. Murray, J.L., Lopez, A.D., (1996), The global burden of disease. WHO, HCPH, WB.
27. NHRC, (1995), NHRC and Health Research Priorities in Nepal, NHRC, Kathmandu.
28. Nicther, (1978), Pattern of resort in the use of therapy; system and their significance for Health planning in South Asia" in Medical Anthropology, spring 1978.
29. Onta, S., (2000), Public Health amidst the liberal market economy, Health Prospect, Vol. 2, No 2. Nepal Public Health Students' Society, Ktm.
30. Overgaard, L.B., Holme, H.E. (1985): "The active medicine user" in Scandinavian Journal of Primary Health Care, 3.
31. Poudel, K., Joshi A.B., Poudel, K., (1998), Factors related to the utilization of Traditional Healers in Kavrey district, Journal of Nepal Public Health Association, Vol.1, no.1, NEPHA, Kathmandu Nepal.
32. Parker (1979), "Self-medication indigenous pharmaceuticals in developing countries, Widely used, widely neglected" in the Lancet (2).
33. Saldon, (1981), "Physical access and utilization of health services in rural Guatemala, Social Science and Medicine, Vol.15
34. SCF (UK), (1997), Traditional Healers and Healthpost peons as Alternative Health care Providers: Experience of SCF (UK) Nepal.
35. Sjask, (1982), "The illegal distribution of Western medicines in developing countries" Vol.6 (4).
36. Sorbin, (1972), Hypnotism, New York, Irvington.
37. Shrestha, M.P., (2000), Vishwa swastha ko Bartaman sangkat...Ktm Nepal.
38. Shrestha, R.M. & Lediard, M., (1980), Faith Healers: A force for change, Educational Enterprises Kathmandu Nepal.
39. Subba, C., (1999), "Nepal Ko Samajik Samrachana ra Sanskritic sambardhan ko Sawal" Janajati, year-1 Vol.1+2, National Committee for Development of Nationalities, Anamnagar Kathmandu.
40. Tan, M.L. (1989): "Traditional or Traditional Medical System? Pharmacotherapy as a case for analysis" in Social science and Medicine, 29 (3)
41. Ukyab, T., Adhikari, S., (2000), The Nationalities of Nepal, HMG/MLD, National Committee for Development of Nationalities, Anamnagar, Kathmandu, Nepal.
42. UNICEF, (1996), Atlas of South Asian Children and Women, UNICEF Regional Office for South Asia, Kathmandu, Nepal.
43. WHO, (1997), The World Health Report, WHO, Geneva.
44. WHO, IDRC, (1991), Designing and conducting Health System Research Projects, Vol.2, Part 1, WHO, Geneva.
45. Wolf, K.W., Pant, R.P, (2000), Social Science Research and Thesis writing, Buddha Academic Enterprises P.Ltd. Kathmandu, Nepal.
46. WSMI (2001), World Self Medication Industry (WSMI), UK, www.wsmi.org

Appendix-I.

Questionnaire

Name of the Interviewer: Date: 2057/ /
 Name of the Respondents: Age: ... Sex: ... Education:
 Family Number: ...
 Dist..... VDC..... Ward No..... Village Name:

Demographic Information.

Household No....

S. N.	Family members	Relation-ship with HH	Age (A)	Sex M/F	Educa-tion (B)	Profe-ssion. (C)	Prop-erty (D)	Illness within 3 months. Y/ N	
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									

Note:

A= (a) 0-10 (b) 11-20 (c) 21-35 (d) 36-45 (e) 46-55 (f) 56-65 (g)66-over.
 B= (1) Illiterate. (2) Literate. (3) Primary (4) SLC (5) IA (6) BA and over.
 C = (1) Agriculture (2) Business. (3) Service. (4) Dependent.
 D = Land (1) 0-2 bigahas, (2) 2.1-4 bigahas (3) 4 bigahas and over.

Tribhuvan University
 Institute of Medicine, Central Campus
 Maharajgunj, Kathmandu, Nepal.

A Dissertation in a partial fulfillment of the requirement for the Master in Public Health
 (MPH).

Topic:- Health Seeking Behavior of Rajbanshi Community in Katahari and
 Baijanathpur VDCs of Morang.

Questionnaire Form.

Name of Interviewer: Date: 2057/ /

Name:
 Religion:

Demographic No.

1. What illness or diseases you got during last three months? (serially)

1..... 2..... 3.....

2. What you did ?

- 1. Self-medication
- 2. Modern medicine
- 3. Alternative Medicine
- 4. Nothing done

2.1. If self medication which of the following:

- 1. Shaman/ priest/ dhama/jhakri.
- 2. Herbal/ root/grass/plant etc.
- 3. Drug Retailers.
- 4. Grocery.
- 5. Kit bag.
- 6. Drug peddler.
- 7. Neighbour.
- 8. Following old medicine.

If any other.....

2.2. If modern medicine which of the following?

- 1. HP/SHP
- 2. Hospital.
- 3. Private clinic/Nursing home
- 4. Other.....

2.3. If Alternative medicine which of the following?

- 1. Ayurvedic.
- 2. Homeopathic.
- 3. Other.....

3. What was the total process that your consulted unit followed ?

..... ..

3.1. When you have visited the Shaman/Dhami/jhakri/priest what he did?

- 1. Phukphak.
- 2. Worship.
- 3. Sacrifice.
- 4. Other.....

4. Why did you visit /do so?

.....

4.1. What factor influenced you to go there?

- 1. Quality/Satisfaction
- 2. Near.
- 3. Cheap.
- 4. usual practice.
- 5. Other.....

4.2. Were you satisfied with the care's investigation process ?

- 1. Yes.
- 2. No.

Why

5. Were there any more visits to other place?

- 1. Yes
- 2. No

5.1. If Yes, Where ? Why.....

5.2. How many times you visit to: -

6. How much money you did expenditure for a sickness?

- 1. Less than Rs.50.
- 2. Rs.50-200
- 3. R.201-500.
- 4 Rs.501-1000
- 5. 1001- 5000
- 6. Rs. 5001 and over

7. What was the cost for?

- 1. Transprtation.....
- 2. Helper.....
- 3. Medicine.....
- 4. Any other.....

8. Could you afford that cost ?

- 1. Yes
- 2. No

8.1. If No, how did you manage the cost?

- 1. Self had
- 2. Loan
- 3. Selling
- 4. Other.....

9. Were you satisfied with the first contact ?

- 1. Yes
- 2. No

Why

10. If had second contact; were you satisfied?

- 1. Yes
- 2. No

Why

11. Who advised or referred you to go to take service for sickness?
.....

12. your mostly first visit to health care is: -
.....

13. Are you satisfied with Health Worker/Doctors or with treatment?

1. Yes 2. No

Why

14. Are you satisfied with Shaman/Dhami/jhakri/priest etc.?

1. Yes 2. No

Why

15. Are you satisfied with Ayurvedic/Homeopathic doctor or health workers ?

1. Yes 2. No

Why

16. Did you take service from: -

- | | | |
|--------------------|--------------|------------------|
| 1. FCHV | 2. TBA | 3. MCH Worker. |
| 4. VHW | 5. EPI-Camp. | 6. PHC-ORC Camp. |
| 7. Mother's Group. | | |

17. How far is your nearest Sub-Health Post or Health Post ?

1. Less than 30 mins. 2. More than 30 mins.

18. Could you please explain your views on?

18.1. Medication pattern at your villages.....
.....

18.2. Consultation practices at your villages.
.....
.....

18.3. People's faith with and their impact on health.

(a) Faith Healers.
.....

(b) Pandit/lama/guvaju/Astrologer.
.....

(c) Ethnomedicine.

.....

(d) Supernatural beings.

.....

19. Sources of information for medication.

.....

20. Any other suggestions/ information on the health care practices.

Appendix - III

Guidelines for Focus Group Discussion.

Could you please explain your views on medication pattern at your villages?

.....
.....

Describe about consultation practices in your village ?

.....
.....

3. People's faith with and their impact on health.

(a) Faith Healers.

.....

(b) Pandit/lama/guvaju/Astrologer.

.....

(c) Ethnomedicine.

.....

(d) Supernatural beings.

.....

4. Sources of information for medication.

.....

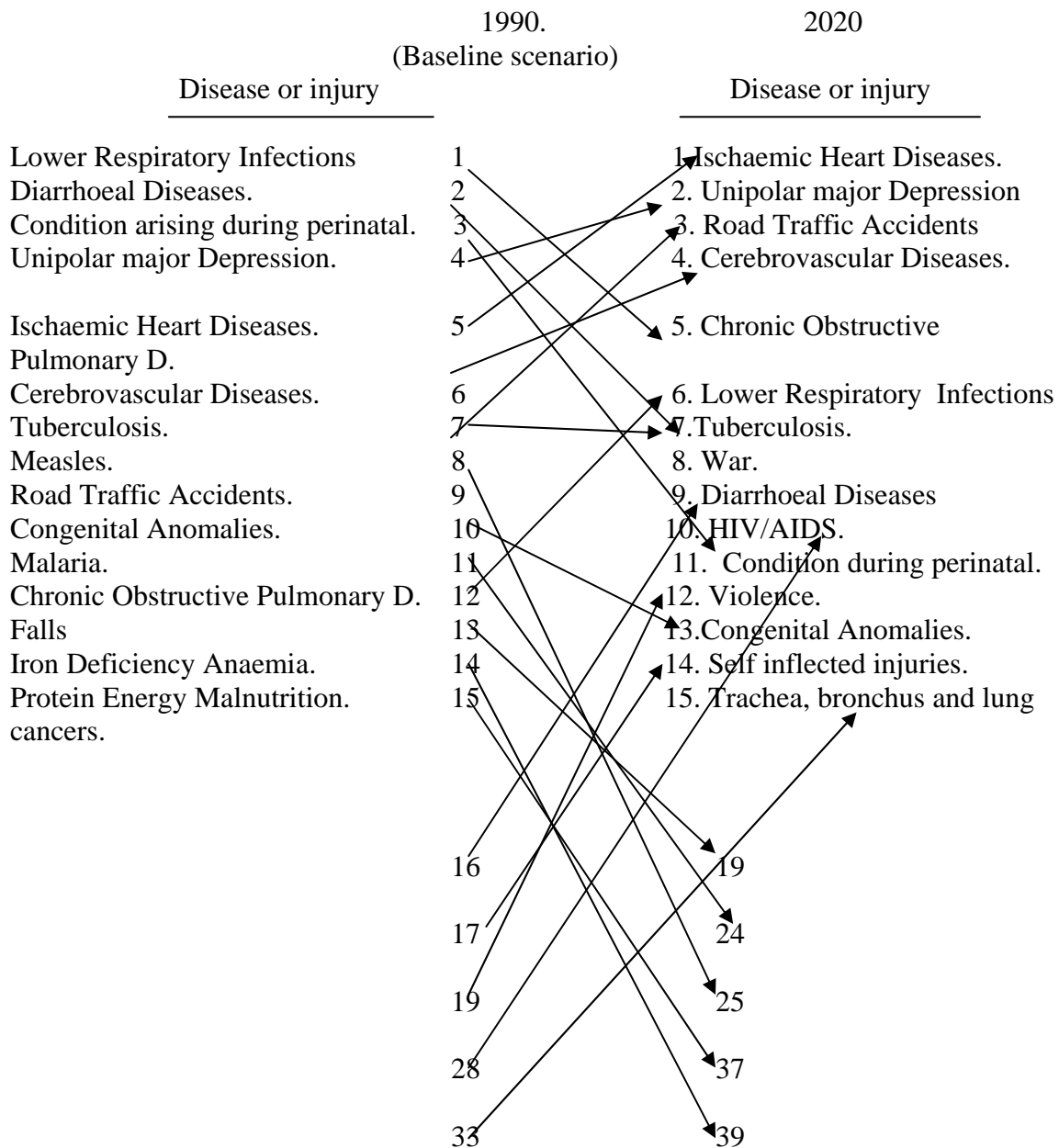
5. Any other suggestions/ information on the health care practices.

.....
.....

Global Situation. Changes in the rank order of diseases. (World Bank)

Changes in the rank order of disease burden for 15 leading causes, world, 1990 -2020.

Disease burden measured in Disability-Adjusted Years (DALYs)



So, this changing pattern of diseases easily affects the health system, Manpower, Financial as well as technology of a country. It is a great burden and challenge for the poor country Nepal.